MULTIDIMENSIONAL CHILD POVERTY
in the Kingdom of Eswatini

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THE GOVERNMENT OF THE KINGDOM OF ESWATINI

Ministry of Economic Planning and Development

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MULTIDIMENSIONAL CHILD POVERTY IN THE KINGDOM OF ESWATINI

Ministry of Economic Planning and Development

FOREWORD

Poverty reduction is a national priority for the Government of Eswatini. The Poverty Reduction Monitoring and Evaluation Division under the Ministry of Economic Planning and Development, coordinates programmes aimed at promoting inclusive growth resulting in poverty reduction as guided by the country strategy for Sustainable Development and Inclusive Growth (2022).

In 2017, the Ministry in collaboration with UNICEF conducted a child poverty assessment with the purpose of providing empirical evidence on child poverty to inform government efforts in fighting against poverty, particularly among children. The assessment used multidimensional overlapping deprivation methods to determine the level of child poverty in Eswatini. The data was generated from the 2014 Multiple Indicator Cluster Survey (MICS) and the report goes beyond mere deprivation rates and identifies the depth of child poverty by analysing the extent to which the different deprivations are experienced simultaneously.

The 2017 child poverty assessment report is the product of collaborative efforts of different institutions. The Ministry of Economic Planning and Development would like to extend its sincere gratitude to the Central Statistical Office (CSO) for providing technical support for the meaningful interpretation of the MICS data, the child poverty assessment technical writing team who provided guidance on the construction of the child deprivation indicators for Eswatini. The team also provided inputs and comments during the drafting and finalization of this report.

A special thanks to all the Principal Secretaries from the Deputy Prime Minister's Office, Ministry of Health, Ministry of Natural Resources, Ministry of Agriculture and Ministry of Housing and Urban Development for assigning experts to constitute members of this technical writing team. We also acknowledge with much appreciation all those who participated in the N-MODA workshops supported by UNICEF Eswatini in 2017 and provided their invaluable inputs.

The Ministry of Economic Planning and Development would also like to acknowledge the valuable support of Dr. Chris De Neubourg, Victor Cebotari, Nesha Ramful and Liên Boon from the Social Policy Research Institute (SPRI), who led the analysis and preparation of this report from the inception stage.

In particular, the Ministry extends its gratitude to the United Nations Children's Fund (UNICEF) for their financial support to prepare this first-ever non-monetary child poverty report, which unveils the key areas of child poverty and improves future targeting of programmes.

Bertram Stewart

Principal Secretary

EXECUTIVE SUMMARY

PURPOSE AND AIMS

Despite efforts to reduce the prevalence of poverty in the Kingdom of Eswatini, it remains an occurring deprivation that disproportionally affects children. Building an understanding of the multidimensional nature of child poverty is essential for addressing the needs of children through suitable programmes and policies.

This report provides up to date empirical evidence on the multidimensional nature of child poverty in the country and aims to set the baseline figure for child deprivation and future monitoring of progress in achieving target 1.2 of the Sustainable Developmental Goal 1 aiming at reducing child poverty by at least half by the year 2030. To the extent that child poverty leads to limited opportunities and violation of basic human rights, this report defines child poverty as a vulnerability that encompasses multiple domains of child well-being.

APPROACH

This study used the multiple overlapping deprivation analysis (MODA) methodology to map the multidimensional poverty of children in the country. In order to understand the complexity of child poverty, the approach uses and quantifies children's vulnerabilities in a holistic manner and measures the multidimensional nature of poverty that leads to the identification of interventions that more accurately meet the needs of children.

The analysis was conducted using secondary data from the Multiple Indicator Cluster Survey (MICS) 2014. Given that children have different needs at different stages of their childhood, they were divided into four age groups (0-23 months, 24-59 months, 5-14 years and 15-17 years).

The dimensions of well-being used by MODA in Eswatini were: nutrition, health, HIV/AIDS, child protection, education, child development, clothing, water, sanitation, housing, and information, communication and technology (ICT). These dimensions of well-being vary according to the different age groups.

The proxy indicators used for each dimension and the deprivation threshold for each indicator are presented in Annex 1 of the report.

KEY FINDINGS

CHILD DEPRIVATION BY DIMENSION OF WELL-BEING

There is diversity in the findings, in that child deprivation differs across dimensions of well-being. The deprivation rates in each dimension of child well-being are as follows:

- The highest prevalence of deprivation among children is in the dimension of **child protection** with 9 out of 10 children aged 0-14 being affected.
- The deprivation in the dimension of **health** affects 73 per cent of children aged 0-23 months and 15-17 years, 68 per cent of children aged 24-59 months and 72 per cent of children aged 5-14 years.
- The dimension of **nutrition** yields a deprivation rate of 62 per cent for children aged 0-23 months and 27 per cent for children aged 24-59 months.
- The vulnerability in the **HIV/AIDS** dimension is highest for eldest children (age group 15-17 years, 79 per cent) and lowest for youngest children (age group 0-23 months, 62 per cent).
- The deprivation rate in the dimension of **child development** stands at 89 per cent. This dimension was measured for children aged 24-59 months only.
- Vulnerability in **education** affects 19 per cent of children aged 5-14 years and 58 per cent of children aged 15-17 years.
- The deprivation rate in the dimension of **clothing** is 11 per cent for children aged 5-14 years and 10 per cent for children aged 15-17 years.
- Across the four age groups, the deprivation rates in **water** range between 36 per cent and 37 per cent.
- The **sanitation** dimension yields deprivation rates of 55 per cent for children aged 0-23 months, 21 per cent for children aged 24-59 months, 20 per cent for children aged 5-14 years and 19 per cent for children aged 15-17 years.
- The dimension of **housing** shows deprivation rates in the range of 37 per cent to 38 per cent for children in the four age groups.
- The deprivation rates in the **ICT** dimension range between 30 per cent and 33 per cent for children in the four age groups.

CHILD POVERTY IS MULTIDIMENSIONAL

A large majority of children in the country were simultaneously deprived in several dimensions of well-being. In this study, a child is defined as multidimensionally poor if she/he is simultaneously deprived in 4 or more dimensions of well-being.

56.5% OF CHILDREN (AGED 0-17 YEARS) IN ESWATINI ARE MULTIDIMENSIONALLY POOR; THAT IS, THEY ARE DEPRIVED IN 4 OR MORE DIMENSIONS OF WELL-BEING.

The baseline figure for child poverty in the country is 56.6 per cent. In line with the SDG target 1.2, the aim is to progressively reduce the proportion of multidimensionally poor children by at least half, to 28.3 per cent, by 2030. The progress towards achieving this goal should be monitored over the next 12 years.

PROFILING MULTIDIMENSIONAL CHILD POVERTY

- A higher proportion of children living in **rural areas** were multidimensionally poor (65 per cent) compared to children living in **urban areas** (23 per cent).

- At the **regional** level, Shiselweni had the largest proportion of multidimensionally poor children (71 per cent) followed by Lubombo (67 per cent) and Hhohho (55 per cent). Manzini, on the other hand, had the lowest prevalence of multidimensionally poor children (43 per cent).

- With regards to **gender** disparities, it was found that multidimensional child poverty in the Kingdom is slightly more prevalent amongst boys compared to girls (60 per cent and 54 per cent, respectively).

- A higher proportion of children living in **larger households** are multidimensionally poor as opposed to children living in households with less members.

- Slightly higher child poverty rates were found amongst households with a **female household head** compared to households with a male head (59 per cent and 53 per cent, respectively).

- The more **educated the household head and/or the mother of the child**, the better off their children are in terms of multidimensional poverty. For example, around half the children whose mother achieved higher/secondary education are multidimensionally poor compared to more than two-thirds of children with a non-educated mother.

- A larger proportion of children who are **orphans** of both parents are multidimensionally poor compared to children living with at least one biological parent (61 per cent and 54 per cent, respectively).

- Multidimensional poverty is more prevalent amongst girls aged 15-17 years old who are, or have been, **pregnant**. Specifically, 58 per cent of girls who have been pregnant are multidimensionally poor as opposed to 38 per cent of girls who have not been pregnant.

POLICY INITIATIVES TO REDUCE CHILD VULNERABILITY

Based on the findings of the study, 3 sets of recommendations are proposed to address child poverty in the Kingdom of Eswatini.

First, sectoral responses need to be provided in all aspects of the well-being of children mentioned in this report.

Second, in order to alleviate multidimensional child poverty, it is important to adopt a multi-sectoral approach to create policy responses that involve different sectors to target multidimensionally poor children. Multi-sectoral efforts to address child poverty are also more cost-effective when limited resources are available.

Lastly, policy actions targeting the most vulnerable groups of children identified in this study are urgently required, although it is recommended to provide safety nets to all emaSwati children through social protection programmes in the long run.

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CONTENTS

FOREWORD IV

EXECUTIVE SUMMARY V

1. INTRODUCTION 5

2. METHODOLOGY 8

2.1 MODA methodology 9

2.2 Data and sample 9

2.3 Dimensions, indicators and age groups 10

2.4 Analytical approach 13

3. RESULTS 14

3.1 The profile of multidimensionally poor children 16

3.2 Results by age group 19

3.2.1 Children aged 0-23 months 19

3.2.2 Children aged 24-59 months 36

3.2.3 Children aged 5-14 years 53

3.2.4 Children aged 15-17 years 70

4. CONCLUSIONS AND POLICY RECOMMENDATIONS 86

4.1 Addressing child deprivation by dimensions of well-being 87

4.2 A multidimensional approach to poverty 92

4.3 Profiling vulnerable children 93

5. REFERENCES 95

6. ANNEXES 97

Annex 1 98

Annex 2 101

LIST OF FIGURES

Figure 1: Child poverty rate (%) at various cut-off points at the national level, 0-17 years....16

Figure 2: Percentage of multidimensionally poor children by their characteristics, 0-17 years....17

Figure 3: Deprivation headcount ratio (%) by each indicator at the national level, 0-23 months.... 21

Figure 4: Deprivation headcount ratio (%) by dimension at the national level, 0-23 months 21

Figure 5: Deprivation headcount ratio (%) by dimension and area of residence, 0-23 months 24

Figure 6: Deprivation headcount ratio (%) by each indicator and area of residence, 0-23 months 25

Figure 7: Deprivation headcount ratio (%) by each indicator and sex of the child, 0-23 months 26

Figure 8: Deprivation headcount ratio (%) by dimension and education level of the household head, 0-23 months 27

Figure 9: Deprivation headcount ratio (%) by dimension and education level of the mother, 0-23 months.... 28

Figure 10: Deprivation headcount ratio (%) by dimension and number of children in the household, 0-23 months 29

Figure 11: Number of simultaneous deprivations experienced by children aged 0-23 months at the national level and by area of residence.... 30

Figure 12: Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 0-23 months 31

Figure 13: Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level and by rural-urban location, 0-23 months.... 32

Figure 14: Multidimensional child poverty indices at the national level, by urban-rural area and by region, children aged 0-23 months deprived in at least 4 dimensions.... 33

Figure 15: Decomposition of the multidimensional child poverty index (M0), 0-23 months.... 33

Figure 16: Deprivation overlap for each dimension, 0-23 months.... 34

Figure 17: Deprivation overlap between the dimensions of nutrition, health and water at the national level, 0-23 months 35

Figure 18: Deprivation overlap between the dimensions of nutrition, health and water in rural areas, 0-23 months 35

Figure 19: Deprivation overlap between the dimensions of nutrition, health and water in urban areas, 0-23 months 36

Figure 20: Deprivation headcount ratio (%) by dimension at the national level, 24-59 months 37

Figure 21: Deprivation headcount ratio (%) by each indicator at the national level, 24-59 months 37

Figure 22: Deprivation headcount ratio (per cent) by each indicator and area of residence, 24-59 months 40

Figure 23: Deprivation headcount ratio (%) by dimension and area of residence, 24-59 months 41

Figure 24: Deprivation headcount ratio (%) by each indicator and sex of the child, 24-59 months 42

Figure 25: Deprivation headcount ratio (%) by dimension and education level of the household head, 24-59 months 43

Figure 26: Deprivation headcount ratio (%) by dimension and education level of the mother, 24-59 months.. 44

Figure 27: Deprivation headcount ratio (%) by dimension and number of children in the household, 24-59 months 45

Figure 28: Deprivation headcount ratio (%) by dimension and orphan status, 24-59 months 46

Figure 29: Number of simultaneous deprivations experienced by children aged 24-59 months at the national level and by area of residence 47

Figure 30: Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 24-59 months 48

Figure 31: Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level and urban-rural, 24-59 months 49

Figure 32: Multidimensional child poverty indices at the national level, by area and by region, children aged 24-59 months deprived in at least 4 dimensions 50

Figure 33: Decomposition of the multidimensional child poverty index (M0), 24-59 months 50

Figure 34: Deprivation overlap for each dimension, 24-59 months 51

Figure 35: Deprivation overlap between the dimensions HIV/AIDS, child protection and child development at the national level, 24-59 months 52

Figure 36: Deprivation overlap between the dimensions HIV/AIDS, child protection and child development in rural areas, 24-59 months 52

Figure 37: Deprivation overlap between the dimensions HIV/AIDS, child protection and child development in urban areas, 24-59 months 53

Figure 38: Deprivation headcount ratio (%) by dimension at the national level, 5-14 years 54

Figure 39: Deprivation headcount ratio (%) by each indicator at the national level, 5-14 years 54

Figure 40: Deprivation headcount ratio (%) by each indicator and area of residence, 5-14 years 56

Figure 41: Deprivation headcount ratio (%) by dimension and area of residence, 5-14 years 57

Figure 42: Deprivation headcount ratio (%) by each indicator and sex of the child, 5-14 years 58

Figure 43: Deprivation headcount ratio (%) by dimension and education level of the household head, 5-14 years 59

Figure 44: Deprivation headcount ratio (%) by dimension and education level of the mother, 5-14 years 60

Figure 45: Deprivation headcount ratio (%) by dimension and number of children in the household, 5-14 years 61

Figure 46: Deprivation headcount ratio (%) by dimension and orphan status, 5-14 years 62

Figure 47: Number of simultaneous deprivations experienced by children aged 5-14 years at the national level and by area of residence 63

Figure 48: Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 5-14 years 64

Figure 49: Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 5-14 years 65

Figure 50: Multidimensional child poverty indices at the national level, by area and by region, children aged 5-14 years deprived in at least 4 dimensions 66

Figure 51: Decomposition of the multidimensional child poverty index (M0), 5-14 years 67

Figure 52: Deprivation overlap for each dimension, 5-14 years 68

Figure 53: Deprivation overlap between the dimensions HIV/AIDS, child protection and ICT at the national level, 5-14 years 69

Figure 54: Deprivation overlap between the dimensions HIV/AIDS, child protection and ICT in rural areas, 5-14 years 69

Figure 55: Deprivation overlap between the dimensions HIV/AIDS, child protection and ICT in urban areas, 5-14 years 70

Figure 56: Deprivation headcount ratio (%) by each dimension at the national level, 15-17 years 71

Figure 57: Deprivation headcount ratio (%) by each indicator at national level, 15-17 years 71

Figure 58: Deprivation headcount ratio (%) by area, 15-17 years 73

Figure 59: Deprivation headcount ratio (%) by each indicator and by area, 15-17 years 74

Figure 60: Deprivation headcount ratio (%) by each indicator and by gender of the child for the dimensions clothing and education, 15-17 years 75

Figure 61: Deprivation rates by dimension and by education level of household head, 15-17 years 76

Figure 62: Deprivation rates by dimension and by education level of mother, 15-17 years.....76

Figure 63: Deprivation rates by dimension and by number of children in the household, 15-17 years 77

Figure 64: Deprivation rates by dimension and by the pregnancy status of girls, 15-17 years..... 78

Figure 65: Number of simultaneous deprivations experienced by children aged 15-17 years at the national level and by area of residence..... 79

Figure 66: Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 15-17 years 80

Figure 67: Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 15-17 years 80

Figure 68: Multidimensional child poverty indices at the national level and by area and region, children aged 15-17 years deprived in at least 4 dimensions 81

Figure 69: Decomposition of the multidimensional child poverty index (M0), 15-17 years..... 82

Figure 70: Deprivation overlap for each dimension, 15-17 years..... 83

Figure 71: Deprivation overlap between the dimensions HIV/AIDS, education and ICT at the national level, 15-17 years 84

Figure 72: Deprivation overlap between the dimensions HIV/AIDS, education and ICT in rural areas, 15-17 years..... 84

Figure 73: Deprivation overlap between the dimensions HIV/AIDS, education and ICT in urban areas, 15-17 years..... 85

LIST OF TABLES

Table 1: Dimensions for MODA analysis per age group 11

Table 2: Dimensions and indicators per age group 12

Table 3: Baseline and target 1.2 of SDG 1 for children in Eswatini 15

Table 4: Deprivation headcount ratio (%) by dimension and region, 0-23 months 26

Table 5: Number of simultaneous deprivations experienced by region, 0-23 months 31

Table 6: Deprivation headcount ratio (%) by dimension and regions, 24-59 months 41

Table 7: Number of simultaneous deprivations experienced by region, 24-59 months 47

Table 8: Deprivation headcount ratio (%) by dimension and region, 5-14 years 57

Table 9: Number of simultaneous deprivations experienced by children aged 5-14 years by region 63

Table 10: Deprivation rates by dimension and by region, 15-17 years 74

Table 11: Number of simultaneous deprivations experienced by children aged 15-17 years by region 79

Table 12: Overlap between combinations of three dimensions, children aged 0-23 months 101

Table 13: Overlap between combinations of three dimensions, children aged 24-59 months 103

Table 14: Overlap between combinations of three dimensions, children aged 5-14 years 106

Table 15: Overlap between combinations of three dimensions, children aged 15-17 years 109

LIST OF BOXES

Box 1: Main trends observed for the multidimensional poverty analysis for children aged 0-23 months... 20

Box 2: Main trends observed for the multidimensional poverty analysis for children aged 24-59 months. 36

Box 3: Main trends observed for the multidimensional poverty analysis for children aged 5-14 years 53

Box 4: Main trends observed for the multidimensional poverty analysis for children aged 15-17 years 70

01. INTRODUCTION

The Kingdom of Eswatini is a landlocked country situated in the north-western part of South Africa. The 2017 Population and Housing Census reported a population count of 1.09 million inhabitants (Kingdom of Swaziland, 2017a). With a gross domestic product (GDP) per capita of $2,960 in 2016 (down from an all-time high GDP per capita of $4,010 in 2013) (World Bank, 2016), the country is classified as a lower middle-income country. Despite this status, it ranks low in human development. Specifically, it ranks 148th of 188 countries in the combined measurements of the most recent Human Development Index (UNDP, 2016).

It is estimated that 63 per cent of the people live below the national poverty line and the GINI coefficient of 51.5 (UNDP, 2016) indicates a high level of income inequality in the country. Indeed, the wealthiest 10 per cent of the population account for almost half of the total consumption in the economy and there is a significant gap in the development and consumption standards between urban and rural dwellers (IFAD, 2017). The total unemployment rate in Eswatini stands at 25.6 per cent and 22.9 per cent of those who work are working poor (i.e. those who are employed earning less than 3.10 USD a day) (UNDP, 2016).

Perhaps more striking are the effects of HIV/AIDS in the country. Among those aged 15 to 49 years, the HIV/AIDS prevalence rate is 27.7 per cent, the highest in the world (Kingdom of Swaziland, 2016; WHO, 2016). HIV/AIDS depletes the country's working age population and, as a result, life expectancy stood below 55 years in 2016, one of the lowest in the world. Many of these effects were exacerbated by an El Nino-induced drought that severely affected certain regions of the country. In 2016, 26 per cent of the population were food insecure, meaning they were unable to meet dietary energy requirements at all times and required emergency food assistance (Kingdom of Swaziland, 2017c). The Government of Eswatini has stepped up efforts to address the vulnerability and consumption levels of households countrywide with some notable improvements observed in nutrition status, water storage, access to safe water, dietary diversity and maize production in the relay year of 2017.

The median age in the Kingdom of Eswatini is 21.7 years and children (0-17 years) represent 42.8 per cent of the total population (Kingdom of Swaziland, 2017a). It indicates that this is a country with a very young population. Based on survey data from 2010, 70 per cent of all children were found to live in poverty, compared to the 63 per cent national poverty rate (UNICEF, 2013). Child poverty and extreme poverty was found to particularly affect households with more than two children.

Chronic malnutrition is also a major concern. Stunting affects 26 per cent of children under five (Central Statistical Office and UNICEF, 2016), while 2 per cent of children in the same age group are wasted and 6 per cent are underweight. Although primary education is inclusive of most primary school-age children, only 86 per cent of children who finish primary school enrol in the first grade of secondary education.

Moreover, gender inequality is widespread (i.e. Eswatini's Gender Inequality Index is 0.566, ranking 137 out of 188 countries worldwide), with girls and young women vulnerable to early pregnancy, and disproportionally affected by school drop-out, adolescent marriage and HIV/AIDS, when compared to boys (Central Statistical Office and UNICEF, 2016; Kingdom of Swaziland, 2017b; UNDP, 2016; UNICEF, 2017). About 20 per cent of children under the age of 18 have one or both parents deceased and these children are generally poorer than other children in the country (Central Statistical Office and UNICEF, 2016)). These data suggest that children in Eswatini may experience patterns of vulnerability that go beyond monetary poverty and may simultaneously encompass various domains of a child's life such as health, education, nutrition, discrimination, and protection, to name a few.

To the extent that children represent a vulnerable population that deserve special attention, there is an urgent need to empirically measure the complexity of child vulnerability to inform better targeting of policy actions.

This study is timely and fits both the national and international agendas of child development. Eswatini's Government has addressed the situation of children through various programmes and progress has been made to allocate resources and improve the lives of some of the most vulnerable segments of the child population in the country. The country has shown commitment to its international obligations under the United Nations' Convention on the Rights of the Child by including a section on children's rights in the country's Constitution and by adopting the Children's Protection and Welfare Act in 2012 to ensure the statutory framework for child development and protection.

At the international level, the Sustainable Development Goals (SDGs) came into effect in 2016 to target specific areas of development and provide support and guidance to policy making in achieving national development plans and policies. The SDGs set up the new development agenda and aim to eradicate poverty, reduce inequalities and extend the benefits of sustainable economic development to all, particularly the poorest and most vulnerable populations, including children. There are 17 SDGs elaborated into 169 targets and 230 indicators. The alleviation of child poverty is part of SDG target 1.2, which aims at reducing at least by half, by 2030, the proportion of children, men and women living in poverty in all its dimensions according to national definitions. Child poverty and well-being indicators are further linked to 10 of the 17 SDGs.

The main objective of this study is to set the baseline figure for multidimensional poverty among Swazi children, to allow for tailored policy implementations and future monitoring of progress in achieving the development agenda for children as per the SDG target above. In doing so, the analysis looks at child poverty in its complexity and employs an innovative methodological tool developed by the UNICEF Office of Research, namely the multiple overlapping deprivation analysis (MODA) (Neubourg, Chai, Milliano, & Plavgo, 2013; Neubourg, Chai, Milliano, Plavgo, & Wei, 2012). This methodology is specifically designed for children and their needs and identifies the type, intensity and the overlap of deprivations children face in each stage of their life. The current analysis distinguishes four stages of a child's life cycle: 0-23 months, 24-59 months, 5-14 years and 15-17 years. This analysis tool includes several profiling characteristics, namely the child's gender, orphanhood and geographical regions amongst others, to identify and describe the most vulnerable children in the country. Data for this study are provided by the 2014 Multiple Indicator Cluster Survey (MICS).

The structure of this report comprises three core parts. The first part details the study's methodology: the MODA approach; the data and the sample; the dimensions, indicators, and the age groups; and the analytical strategy. The second part presents the results of the single deprivation analysis, the deprivation distribution, the multiple deprivation overlap and the multiple deprivation indices. The last part discusses the core results with the aim to identify the areas of children's well-being to be addressed by policymakers and to present relevant recommendations.

02. METHODOLOGY

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2.1 MODA METHODOLOGY

The measurement of multidimensional child poverty was operationalised using the MODA framework, a methodological tool described in UNICEF's technical reports (Neubourg et al., 2013; Neubourg et al., 2012). MODA is a relatively new approach to measuring child poverty and is designed to account for the local context when looking at child vulnerabilities. The MODA methodology complements traditional income-based measures of poverty, such as UNICEF's Global Study on Child Poverty and Disparities (Gordon, Nandy, Pantazis, Pemberton, & Townsend, 2003), as well as the Oxford Poverty and Human Development Initiative's Multidimensional Poverty Index (Alkire & Foster, 2011) by adopting a holistic definition of child well-being which concentrates on the access of children to various goods and services which are crucial for their long-term development. The approach to MODA recognizes that child vulnerability is multi-faceted and interrelated and that multiple overlapping deprivations are context specific and likely to occur with greater adversity among certain socio-economically disadvantaged groups. Understanding the complexity of child poverty is key to develop policy responses that ensure maximum impact on children and their well-being.

The MODA methodology adds novelty to existing approaches by concentrating on the following four key elements. First, MODA brings in the child as the unit of analysis, rather than the household, since children may have different needs and often experience poverty differently compared to adults. In doing so, MODA relies to a greater extent on individual-level data so that children can be identified and analysed individually, including those living in the same household, so that differences across gender, age and access to resources may be observed and thoroughly documented. Second, MODA adopts a life cycle approach, following the theoretical and empirical evidence that children of different ages have different needs and developmental trajectories. In doing so, the analysis selects different dimensions and indicators specifically targeting the needs of children in early childhood, primary childhood and adolescence. Third, it includes the prevalence and the depth of child deprivation by looking at the number of deprivations that children experience simultaneously, thus revealing the most vulnerable children and broadening the scope of targeting and policy response. It is often that children experience more than one deprivation at a time and it is important that different policy sectors have evidence-based recommendations that help them work together in addressing children's needs. Finally, the child-oriented MODA includes an equity focus, because it enables one to concentrate on the most vulnerable children in the society by generating profiles of poverty in terms of geographical and socio-economic characteristics.

2.2 DATA AND SAMPLE

This report assesses children's multidimensional poverty by using data from the 2014 MICS to provide large-scale empirical evidence for the country. The 2014 MICS measures key indicators to provide up-to-date estimates of the country's developmental outcomes to inform policies and programmes and to monitor progress towards SDGs and other nationally and internationally agreed commitments. Among these commitments are the national Poverty Reduction Strategy and Action Plan, the National Multisector HIV/AIDS Strategic Framework (2014 – 2018), the National Health Sector Strategic Plan, the National Plan of Action for Children, the Children's Protection and Welfare Act, the United Nations' A World Fit for Children Declaration and Plan of Action, the goals of the United Nations General Assembly Special Session on HIV/AIDS, and the Education for All Declaration.

The 2014 MICS's sampling frame followed that of the 2007 National Population and Housing Census. Data were collected between July and October 2014 and employed a nationally representative sampling design within 347 sampling clusters (enumeration areas) in urban and rural locations in the 4 regions: Hhohho, Manzini, Shiselweni and Lubombo. Sampling weights were added to the collected data to account for variations in the sampling design.

The MICS included four sets of questionnaires. First, a household questionnaire was administered to the household head to collect basic demographic information on all usual residents, the household and the dwelling. In total, 5 205 households were randomly selected, of which 4 981 were found to have living residents and 4 865 were interviewed.

Second, all women aged 15-49 years filled in an individual questionnaire. This questionnaire collected information on women's demographics, fertility, attitudes towards domestic violence, HIV/AIDS, health and more. In interviewed households, a total of 5 001 women aged 15-49 were usual residents, of which 4 762 filled in the questionnaire, yielding a response rate of 95 per cent.

Third, a questionnaire similar to that filled in by women was administered to a sub-sample of individual men aged 15-59 in one out of every three selected households. A total of 1 629 men aged 15-59 were usual residents in these households, of which 1 459 completed the questionnaire, resulting in a response rate of 90 per cent. Collecting data on a third of all males aged 15-59 years implies that this segment of the local population was under-sampled and this should be kept in mind when reading through the results.

Finally, a questionnaire was administered to the mother, or the child's primary caregiver, for children aged 0-5 years in all selected households. This questionnaire included information on children's birth registration, early childhood development, breastfeeding, dietary intake, immunization, illness and anthropometrics. There were 2 728 children aged 0-5 years in the selected households and questionnaires for 2 693 children were completed, corresponding to a response rate of 99 per cent.

All questionnaires were administered in the local siSwati language. The response rates were similar across regions, with the exception of Manzini, which recorded a lower response rate for the women's questionnaire of 93 per cent. In all interviewed households, data on 9 141 children aged 0-17 years (50.3 per cent males and 49.7 per cent females) were collected.

2.3 DIMENSIONS, INDICATORS AND AGE GROUPS

In MODA, the choice of indicators and dimensions is informed by the international human rights standards that are embedded in the Convention on the Rights of the Child and the SDGs. Therefore, the dimensions and indicators for MODA are those that are essential for the well-being of children and their development and include, among others, food, safe drinking water, sanitation facilities, health, shelter, education, protection and access to information. In this study, the final choice of dimensions and indicators was driven by the availability of measurable indicators in the 2014 MICS. The final selection of data reflects the common agreement of the involved stakeholders on those dimensions, indicators and thresholds in the MICS survey that are most relevant to measure multidimensional child poverty. The selected dimensions for each age group are presented in Table 1.

Table 1: *Dimensions for MODA analysis per age group*

0-23 MONTHS	24-59 MONTHS	5-14 YEARS	15-17 YEARS
Nutrition	Nutrition	Education	Education
Health	Health	Health	Health
HIV/AIDS	HIV/AIDS	HIV/AIDS	HIV/AIDS
-	Child development	Clothing	Clothing
Protection	Protection	Protection	-
Water	Water	Water	Water
Sanitation	Sanitation	Sanitation	Sanitation
Housing	Housing	Housing	Housing
ICT	ICT	ICT	ICT

Source: 2014 SMICS

The dimensions cut across four age groups (0-23 months, 24-59 months, 5-14 years and 15-17 years) to better reflect the needs of children according to MODA's life cycle approach. There are three types of indicators included across the dimensions and age groups. The first group comprises information related directly to the child – i.e. nutrition, health (vaccinations), child development, education, child protection, sanitation (disposal of child's stools), clothing and information, communication and technology (ICT). The second group of indicators are those that record the household level information – i.e. health (cooking fuel), water (distance to water facility), child development (availability of books), child protection (violent acts), sanitation, housing and ICT. Finally, the third cluster of indicators records information reflecting adult perceptions and knowledge – in this report, it relates only to HIV/AIDS. All indicators used national and international insights to define the thresholds for inclusion in the dimension. The international standards are those universally applicable within the developmental frameworks of the UN, UNICEF and the World Health Organization (WHO).

Table 2 presents the list of indicators per dimension, and their inclusion/exclusion in the age groups. A detailed description of indicators and thresholds is included in Annex 1. The aggregation of indicators for each dimension is based on **MODA's union approach**, that is, a child is identified as deprived in a dimension if she/he is deprived in at least one of the indicators of that dimension. All indicators in the dimension have an equal weight, following the Convention on the Rights of the Child approach that assumes that children's needs are equally important for children's well-being and development. Similarly, each dimension is considered as being equally important for children because they each reflect a basic human right.

Table 2: *Dimensions and indicators per age group*

DIMENSION	INDICATOR	AGE GROUP			
		0–23 MONTHS	24–59 MONTHS	5–14 YEARS	15–17 YEARS
Nutrition	Exclusive breastfeeding	✓			
	Minimum acceptable diet including food frequency and diversity	✓			
	Stunting	✓	✓		
Health	Vaccinations	✓			
	Cooking fuel	✓	✓	✓	✓
HIV/AIDS	Caretaker's knowledge of HIV/ AIDS	✓	✓	✓	
	Child's knowledge about HIV/ AIDS				✓
Child development	Availability of books		✓ (24-59 months)		
	Early childhood programme attendance (ECD)		✓ (36-59 months)		
Child protection	Birth certificate	✓	✓ (2-59 years)		
	Violence and negligence	✓	✓	✓	
Education	School attendance			✓ 6-17 years	✓ 6-17 years
	Grade-for-age			✓ 6-17 years	✓ 6-17 years
Water	Drinking water source	✓	✓	✓	✓
Sanitation	Toilet type	✓	✓	✓	✓
	Disposal of youngest child's faeces	✓			
Housing	Overcrowding	✓	✓	✓	✓
	Shelter	✓	✓	✓	✓
Clothing	Access to clothing and shoes				✓
ICT	Exposure to mass media				✓
	Access to a radio, tv and phone	✓	✓	✓	✓

Source: 2014 MICS

2.4 ANALYTICAL APPROACH

The analysis of child poverty was based on the MODA methodology and included four steps. These steps were applied for all dimensions and indicators for each of the four age groups.

The **single deprivation** (sector specific) analysis presents the proportion of children deprived in each indicator and in each dimension. It gives a first perspective on how child deprivation unfolds in the country and which deprivations drive child vulnerability across the four age groups. Additionally, it enables one to profile those children that are deprived in the different dimensions of well-being, using profiling indicators such as gender, region and the urban-rural location.

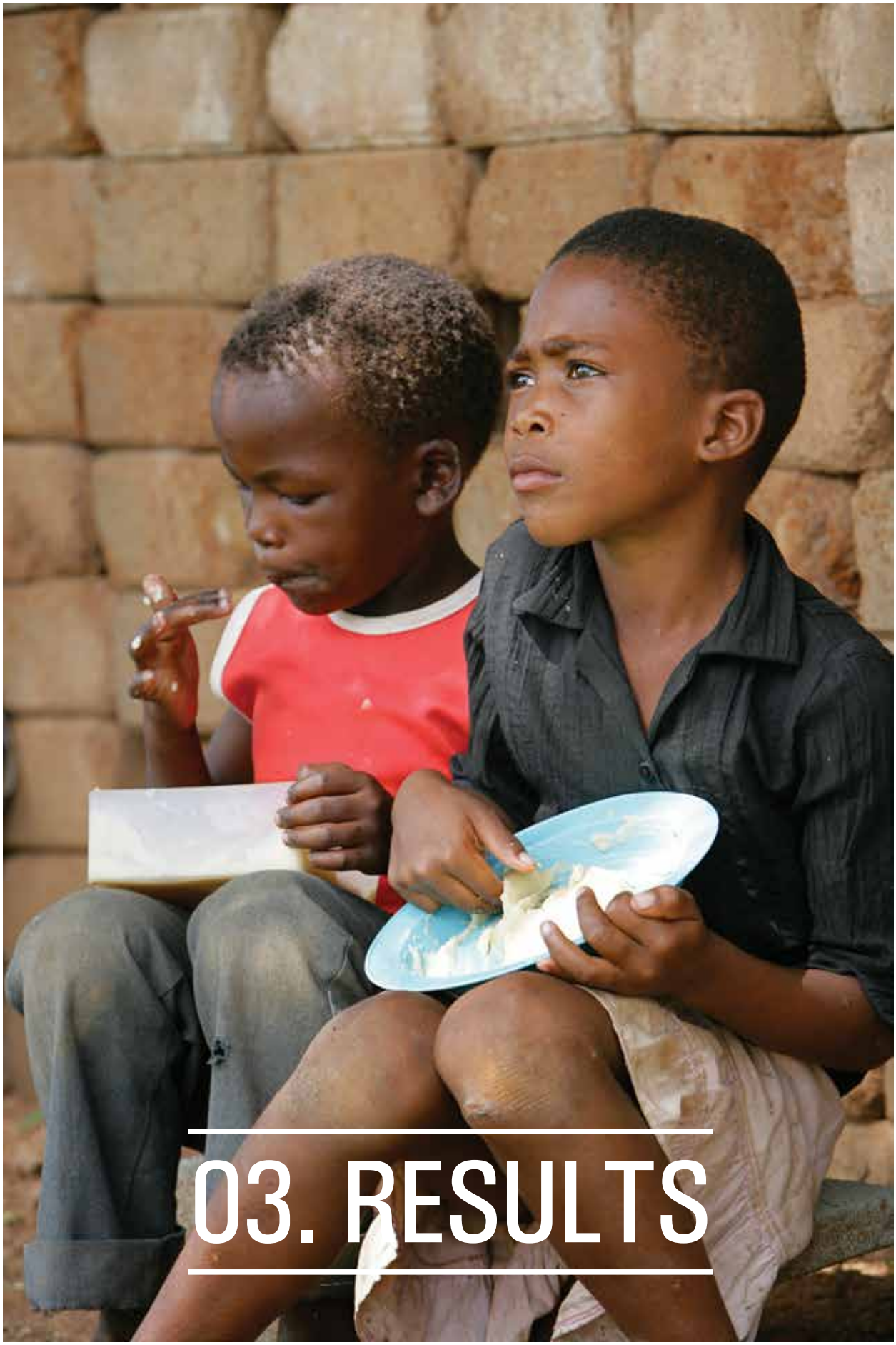
The **deprivation count** is performed next. It includes the distribution of deprivations across dimensions. The deprivation count is important as it explores the depth of vulnerability of children in Eswatini. The deprivation count is also revealed in relation to the profiling variables – i.e. gender, region and the rural-urban location.

The **multidimensional deprivation overlap** looks at different deprivations that children experience simultaneously. Depending on the age group, the combination of deprivations may range from zero (no deprivation) to nine deprivations that children may experience at a time.

The analysis of **multiple deprivation indices** provides results for the following items:

- The *headcount ratio:* looks at the incidence of multiple deprivation in various dimensions.
- The *average intensity:* counts the number of deprivations that a poor child has as a percentage of all measured deprivations.
- The *adjusted deprivation headcount*: is a product of both the incidence and the depth of poverty.

The results are presented for children of the different age groups (0-23 months, 24-59 months, 5-14 years and 15-17 years) and each includes the four types of analyses, namely, the single deprivation (sector specific) analysis, deprivation count, multidimensional deprivation overlap and the multiple deprivation indices.



03. RESULTS

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The results are presented in two steps. Firstly, the section provides an overview of how child poverty in the country is embedded in the context of SDG 1, target 1.2.

Secondly, results on the child poverty analysis are detailed by different age groups (0-23 months, 24-59 months, 5-14 years and 15-17 years) as per the single deprivation (sector specific) analysis, deprivation count, multidimensional deprivation overlap and the multiple deprivation indices.

Following the methodological rationale, **a child in the Kingdom of Eswatini is defined as multidimensionally poor if she/he is deprived in at least 4 dimensions of her/his well-being**. The dimensions of well-being used are nutrition, health, HIV/AIDS, education, child development, protection, clothing, water, sanitation, housing and ICT and they vary according to the age of the child depending on her/his needs at different stages of the childhood (as shown in Table 1). **The baseline figure is that 56.5 per cent of all children (aged 0-17 years) in Eswatini are multidimensionally poor** (see Table 3). According to SDG 1, target 1.2, the aim is to progressively reduce this proportion of multidimensionally poor children by at least half, to 28.3 per cent, by 2030. The progress made towards achieving this target should be monitored over the next 12 years.

Table 3: *Baseline and target 1.2 of SDG 1 for children in Eswatini*

END POVERTY IN ALL ITS FORMS EVERYWHERE

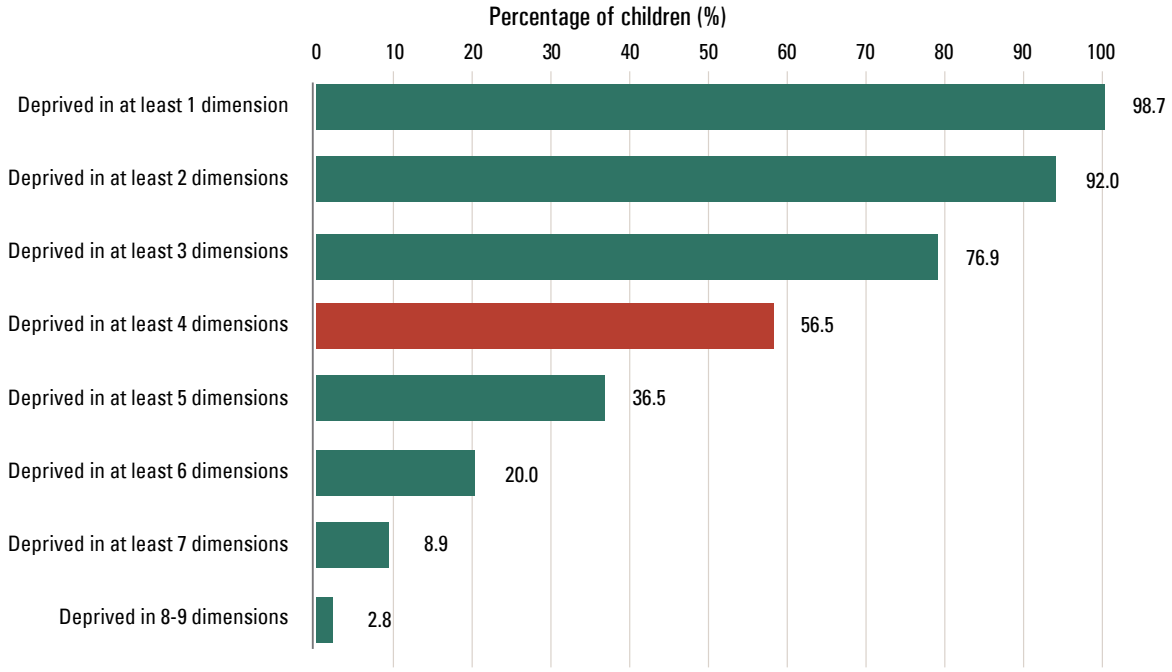
TARGET 1.2	DESCRIPTION OF BASELINE FOR CHILDREN	POVERTY THRESHOLD	POVERTY RATE FOR CHILDREN (BASELINE 2016)	POVERTY RATE FOR CHILDREN (TARGET BY 2030)
By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions	The percentage of children of all ages living in poverty in all its dimensions according to national definitions	A child is defined as poor if she/he is deprived in at least 4 of the total dimensions used to measure her/his well-being (see Annex 1 for list of dimensions used)	56.5 per cent	28.3 per cent

CHILD POVERTY RATES AT DIFFERENT CUT-OFF POINTS

The findings showed that almost the entire population of children (98.7 per cent) are deprived in at least one dimension of well-being. If the threshold is increased to include being simultaneously deprived in 2 or more deprivations, the child poverty rate is 92.0 per cent. As earlier said, a child is considered multidimensionally poor if she/he is simultaneously deprived in 4 or more dimensions of well-being. This threshold was agreed by a committee panel consisting of the Ministry of Economic Planning and Development, UNICEF and other line ministries.

When considering the threshold of 4 dimensions, the percentage of multidimensionally poor children is 56.5 per cent of the entire child population. It offers the empirical baseline and a general overview of multidimensional child poverty in the country as depicted in Figure 1.

Figure 1: *Child poverty rate (%) at various cut-off points at the national level, 0-17 years*



The next set of results disaggregates and presents data on child poverty for different characteristics of children in order to determine the profile of multidimensional poor children.

3.1 THE PROFILE OF MULTIDIMENSIONALLY POOR CHILDREN

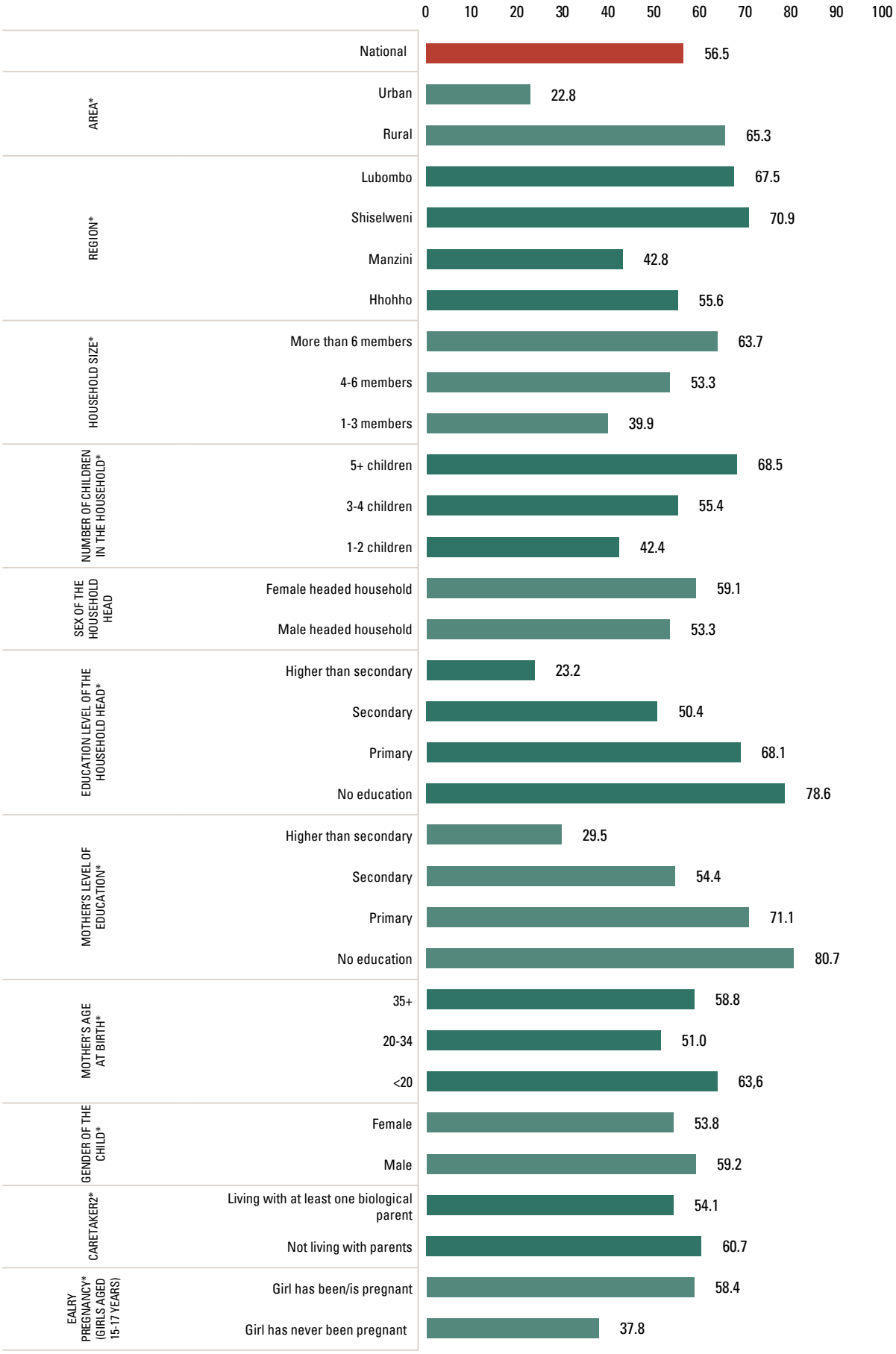
This section presents the results of different characteristics of multidimensionally poor children in the country. The aim is to profile the most vulnerable children in order to guide the design of policies and reduce targeting errors.

Disparities in child poverty rates by geographical location

Besides the aggregate information useful for evaluating and monitoring the overall performance of the country, it is important to construct geographically disaggregated poverty indicators to provide information about the spatial distribution of poverty.

In Eswatini, there is a much higher proportion of multidimensionally poor children in the rural areas (65.3 per cent) compared to the urban areas (22.8 per cent). At the regional level, Shiselweni has the largest proportion of multidimensionally poor children (70.9 per cent) followed by Lubombo (67.5 per cent) and Hhohho (55.2 per cent). Manzini, on the other hand, has the lowest proportion of multidimensionally poor children (42.8 per cent). Some of the main characteristics of the multidimensionally poor children are shown in Figure 2.

Figure 2: *Percentage of multidimensionally poor children by their characteristics, 0-17 years*



Disparities in child poverty rates by household size and composition

Larger households and those households with more children have higher proportions of multidimensionally poor children. In households with more than 6 members, the multidimensional child poverty rate is as high as 63.7 per cent in comparison to 39.9 per cent in those households with 1 to 3 members. Similar results are observed for children living in households with more children as shown in Figure 2.

Disparities in child poverty rates by sex of household head

Female-headed households have a higher proportion of multidimensionally poor children (59.1 per cent) compared to male-headed households (53.3 per cent). Households headed by single adults, whether male or female, are potentially vulnerable and more attention should be given to children living in these settings.

Disparities in child poverty rates by education level of household head

Children whose mother or the household head have higher levels of education were found to be less multidimensionally poor. The more educated the household head and/or the mother of the child, the better off their children are in terms of multidimensional poverty. Deprivation rates were compared for household heads and/or mothers with no education level, primary education, secondary education and higher than secondary education. There is a decrease in multidimensional deprivation among children when comparing primary education and no education of their significant adults (from 78.6 per cent to 68.1 per cent for the education level of the household head and from 80.7 per cent to 71.1 per cent for the educational level of the mother). However, a more considerable decrease in multidimensional child poverty of around 30 percentage points is observed when the household head or the mother has secondary education. There is an even lower proportion of multidimensionally poor children living in households with the household head (23.2 per cent) or the mother (29.5 per cent) having higher than secondary education. The attainment of secondary or higher than secondary education should be encouraged amongst the current generation of children as this will influence the poverty rates of the next generation of children.

Disparities in child poverty rates by age of mothers

Children born to younger mothers are more multidimensionally poor. Child poverty is the highest amongst children whose mother was less than 20 years when she gave birth (63.6 per cent). By contrast, multidimensional child poverty is the lowest when the mother is 20 to 34 years at the time of birth (51.0 per cent). More research on the correlation between age at birth and the poverty level is needed as this may relate with other unobserved characteristics.

Disparities in child poverty rates by gender

Multidimensional child poverty is higher amongst boys. It was found that child poverty is more prevalent amongst boys in comparison to girls (59.2 per cent and 53.8 per cent, respectively). The analyses by age groups (see next section) reveal that boys are particularly deprived in *stunting* (nutrition dimension), *grade-for-age* (education dimension) and *clothing*. Particular attention should be given to emaSwati boys with regards to these indicators.

Disparities in child poverty rates by orphanhood

Orphan children are more multidimensionally deprived. A larger proportion of children who are orphans are multidimensionally poor compared to children living with at least one biological parent (60.7 per cent and 54.1 per cent, respectively).[1] This population of children is potentially vulnerable and deserves special attention in terms of policy assistance.

[1] It is important to note that data used for this study, the 2014 MICS, is a household survey which captures information only on children living in a household. Data on children living in orphanages or street children were not collected.

Disparities in child poverty rates by early pregnancy

Girls who experienced an early pregnancy are more multidimensionally poor. The profiling indicator of early pregnancy was measured for girls aged 15-17 years. In this population of children, multidimensional poverty is more prevalent amongst girls who are or have been pregnant. Specifically, 58.4 per cent of the girls who are/have been pregnant are multidimensionally poor as compared to 37.8 per cent of the girls who are not/have not been pregnant. The high deprivation rates among girls who have experienced a pregnancy is a serious cause for concern as their children are also more likely to live in severe poverty as measured by the age of maternal birth shown above. Multi-sectoral response targeting both the young mothers and their children are advised to achieve a maximum effect in poverty reduction among these vulnerable populations of children.

3.2 RESULTS BY AGE GROUP

As outlined in the methodology chapter, the MODA methodology adopts a life cycle approach whereby different dimensions and proxy indicators are used for children of different ages. The choice of those dimensions and indicators are mostly driven by the needs of the child at a specific age and the availability of data. In this section, the child poverty analysis is disaggregated by the following age groups: 0-23 months, 24-59 months, 5-14 years and 15-17 years. Different dimensions and indicators are used for each age group although some of the dimensions measured at household level (e.g. water, sanitation, ICT) cut across all age groups.

3.2.1 CHILDREN AGED 0-23 MONTHS

For children of the age group 0-23 months, eight dimensions are used to measure their well-being, notably nutrition, health, HIV/AIDS, child protection, water, sanitation, housing and ICT.

A child aged 0-23 months is considered multidimensionally poor if she/he is simultaneously deprived in 4 or more of these dimensions.

Box 1 presents the main trends in child deprivation for children aged 0-23 months. The presentation of results follows the two main analytical steps, namely (i) the single deprivation analysis and (ii) the multidimensional deprivation analysis.

Box 1: *Main trends observed for the multidimensional poverty analysis for children aged 0-23 months*

MAIN TRENDS FOR CHILDREN AGED 0-23 MONTHS

- 69.8% of children aged 0-23 months are multidimensionally poor.
- 99.9% of these children are deprived in at least 1 dimension of well-being.
- Child protection is a vulnerability that stands out in severity: of all children in this age group, 93.7% live in a family environment in which physical and verbal abuse is tolerated.
- Children in rural areas are more deprived than urban children in dimensions of well-being and in the number of simultaneous deprivations.
- Children living with 5 or more other children in the household are more deprived in all dimensions of well-being compared to children living in households with 1-2 children.
- Stunting is 10% higher for boys than for girls (28.7% and 18.4%, respectively).
- Children with more educated mothers are less deprived in all dimensions of well-being.
- Children in Manzini are less deprived, in relative terms, whereas children in Shiselweni and Lubombo are more deprived.
- The intensity of deprivation among multidimensionally poor children is largely similar across regions and rural-urban areas, meaning that multidimensionally poor children are equally poor across the country.

Single deprivation analysis

The single deprivation analysis presents the results for each of the dimensions and indicators that measure child poverty. It shows the proportion of children deprived in any given dimension (and their indicators) as a percentage of all children in that specific age group (Figures 3 and 4). The results of the single deprivation analysis give an indication of which sectors should be targeted to provide relief for children of different age groups.

The findings show that the proportion of children deprived in any given indicator, on each dimension, at the national level for children aged 0-23 months is significant.

Figure 3: *Deprivation headcount ratio (%) by each indicator at the national level, 0-23 months*

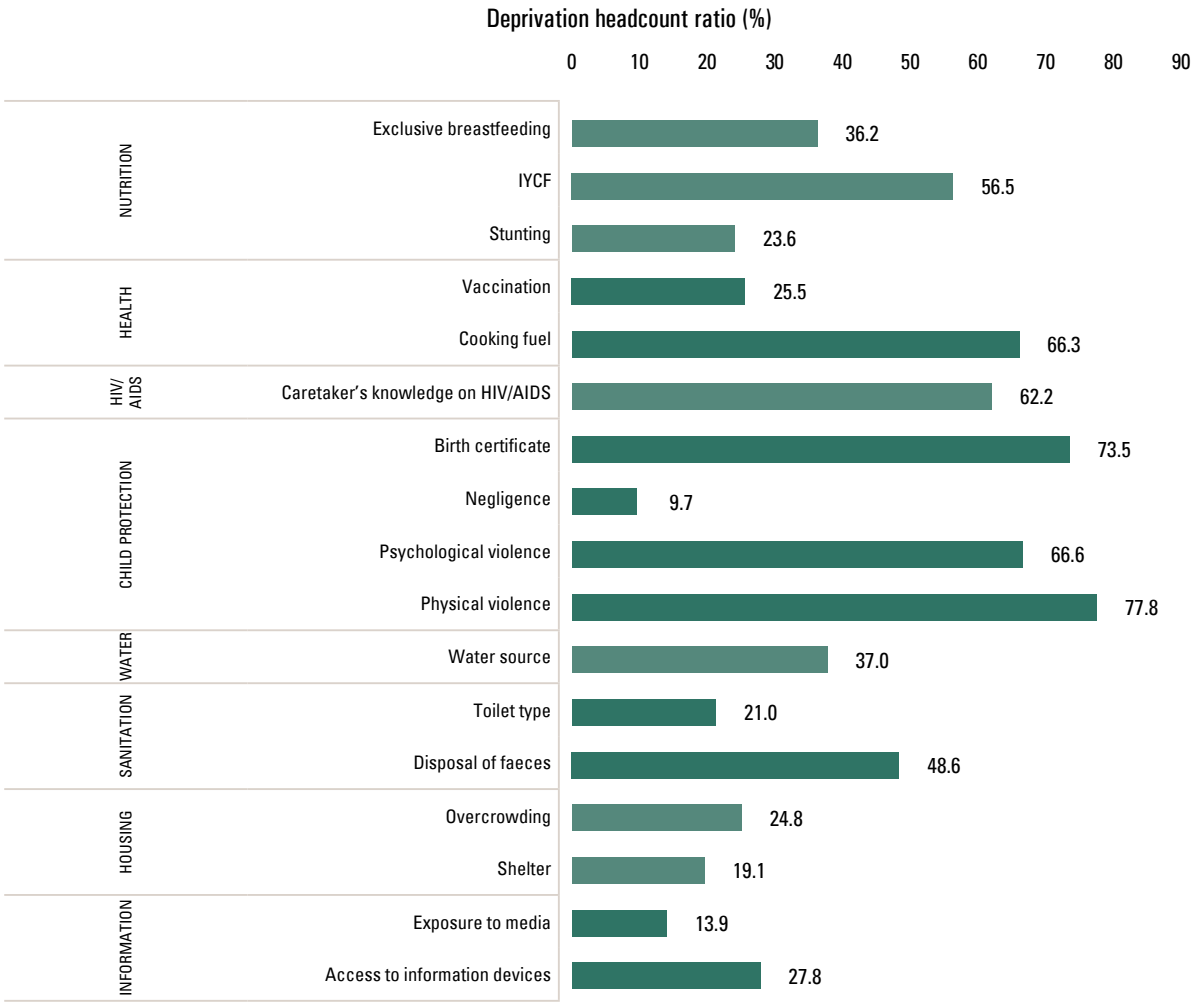
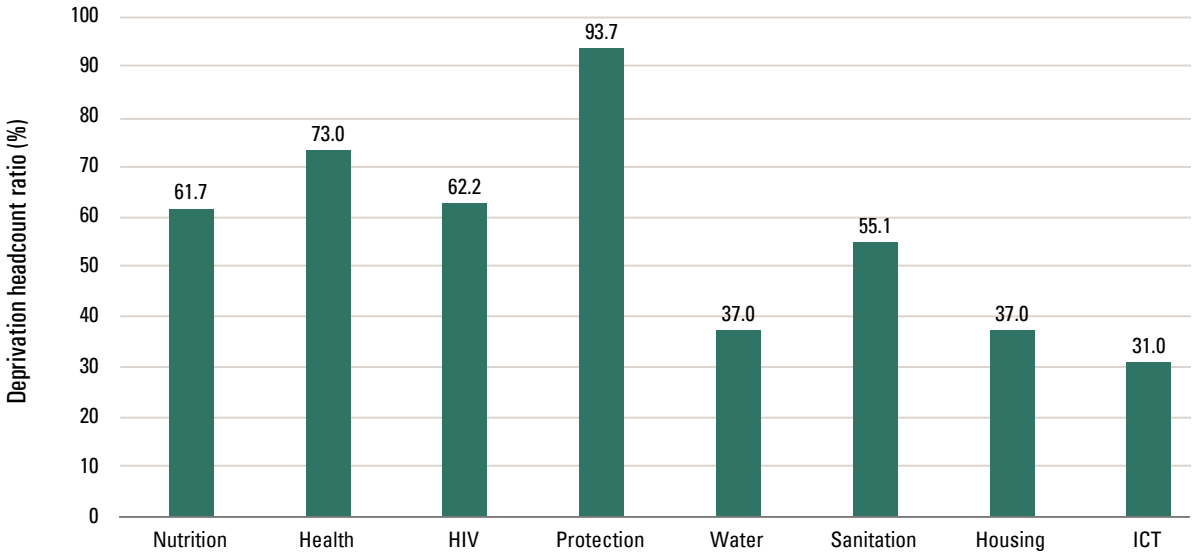


Figure 4 clusters the deprivation headcount rates of indicators at the dimension level for children in the same age group. The analysis of deprivation for children aged 0-23 months includes eight dimensions and shows a very high incidence of deprivation in child protection, health, nutrition, and HIV/AIDS.

Figure 4: *Deprivation headcount ratio (%) by dimension at the national level, 0-23 months*



Deprivation rates by child protection

More than **nine out of 10 children aged 0-23 months (93.7 per cent) are deprived in the child protection dimension**. This high deprivation rate is mainly driven by physical and psychological violence (77.8 per cent and 66.6 per cent, respectively) and by the absence of a birth certificate (73.5 per cent) (Figure 3). Physical violence is measured by whether the child lives in a household where children have been spanked, hit or slapped on the bottom with a bare hand; have been hit on the bottom or elsewhere with a belt, brush, stick, etc.; have been hit or slapped on the face, head or ears; have been hit or slapped on the hand, arm or leg; or have been beaten up during the last one month. There is psychological violence when the children are shook, shouted at, yelled or screamed at or are called dumb, lazy or another name.

Living in a household that tolerates physical and verbal abuse appears to be a key determinant for child vulnerability in the country. Under the child protection dimension, it is observed that 9.7 per cent of children aged 0-23 months are deprived in the indicator *negligence* meaning that they have been left alone or in the care of another child younger than 10 years of age for more than an hour during the last month.

Deprivation rates by nutrition

Of all children aged 0-23 months, **61.7 per cent are deprived in the nutrition dimension**. The dimension of nutrition is measured by the indicators exclusive breastfeeding (<6 months), infant and young child feeding (IYCF) (6-23 months) and stunting. The high deprivation rate in nutrition is mainly driven by IYCF, measured by minimum meal frequency and dietary diversity[2] recommended by the WHO (56.5 per cent), and by the lack of exclusive breastfeeding of children younger than 6 months (36.2 per cent). The proportion of stunted children in the age group 0-23 months is 23.6 per cent.

Deprivation rates by health

The **health** deprivation headcount ratio of **children aged 0-23 months is 73.0 per cent**. This rate is driven by the use of unimproved cooking fuel[3] (66.2 per cent) and by the absence of all basic recommended vaccinations as per the national immunization schedule (25.5 per cent).

Deprivation rates by HIV/AIDS

The **HIV/AIDS** deprivation of children aged 0-23 months is measured by the caretaker's knowledge of HIV/AIDS. Of all children in this age group, 62.2 per cent are in the care of someone that is insufficiently informed about the disease. The country tops the world ranking in HIV/AIDS prevalen ce among its population and optimal information channels about the disease must be a priority for policy making.[4]

Deprivation rates by water

More than a third of all children aged 0-23 months are **deprived in the water dimension (37.0 per cent)**, that is they live in a household where the main source of drinking water is unimproved as per the WHO requirements. Improved drinking water sources include piped into dwelling, piped into yard/plot, piped into neighbour's plot, public tap/standpipe, tube well/borehole, protected dug well, protected spring, rainwater

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2 See Annex 1 for the WHO requirements with regards to minimum meal frequency and dietary diversity.

3 In the context of Eswatini, unimproved cooking fuel include coal/lignite; charcoal; wood; straw/shrubs/grass; animal dung; kerosene/paraffin.

4 Eastern and Southern Africa UNICEF website. Overview of HIV and AIDS. Available at: https://www.unicef.org/esaro/5482_HIV_AIDS.html.

and bottled water if water source is improved. Unimproved drinking water sources include unprotected well, unprotected spring, surface water, tanker truck, cart with small tank/drum, bottled water if water source is unimproved and other. The water source is particularly important for children in this age group as they have distinct dietary needs which require high quality water sources.

Deprivation rates by sanitation

The proportion of children aged 0-23 months **deprived in the sanitation dimension is 55.1 per cent**. This deprivation level is driven by the use of an unimproved toilet facility (21.0 per cent) and by the unsanitary ways of disposal of an infant's stool (48.6 per cent). The WHO definition of an unimproved toilet has been used and includes flush to somewhere else, pit latrine without slab/open latrine/incomplete latrine and no facility/bush/field/flying toilet (plastic). Unsanitary ways of disposal of an infant's stool are put/rinsed into drain or ditch, thrown into garbage (solid waste), buried, left in the open and when the respondent (mother/caregiver) doesn't know how it is disposed of.

Deprivation rates by housing

The **deprivation level in housing is 37.0 per cent** among children aged 0-23 months. Around one out of every four children in this age group live in overcrowded conditions (24.8 per cent). This report adopts the UN Habitat definition of overcrowding, that is a person lives in a household which has on average more than three people per sleeping room. The proportion of children deprived in shelter is 19.1 per cent, meaning they live in a house in which the floor, roof or walls are made of unimproved materials.

Deprivation rates by ICT

Information-related indicators show the lowest level of deprivation among children aged 0-23 months, although **31.0 per cent of children** in this age group are still deprived in this particular dimension. The dimension of ICT is measured by the indicators *exposure to media* and *access to a radio, television or phone*. With respect to *exposure to media*, it is observed that 13.9 per cent of the children in this age group live in a household where no adult has access to either one of the following: newspaper, radio, television or internet on a weekly basis. On the other hand, 27.8 per cent of the children live in a household where there is only one of the following assets: radio, television or mobile phone.

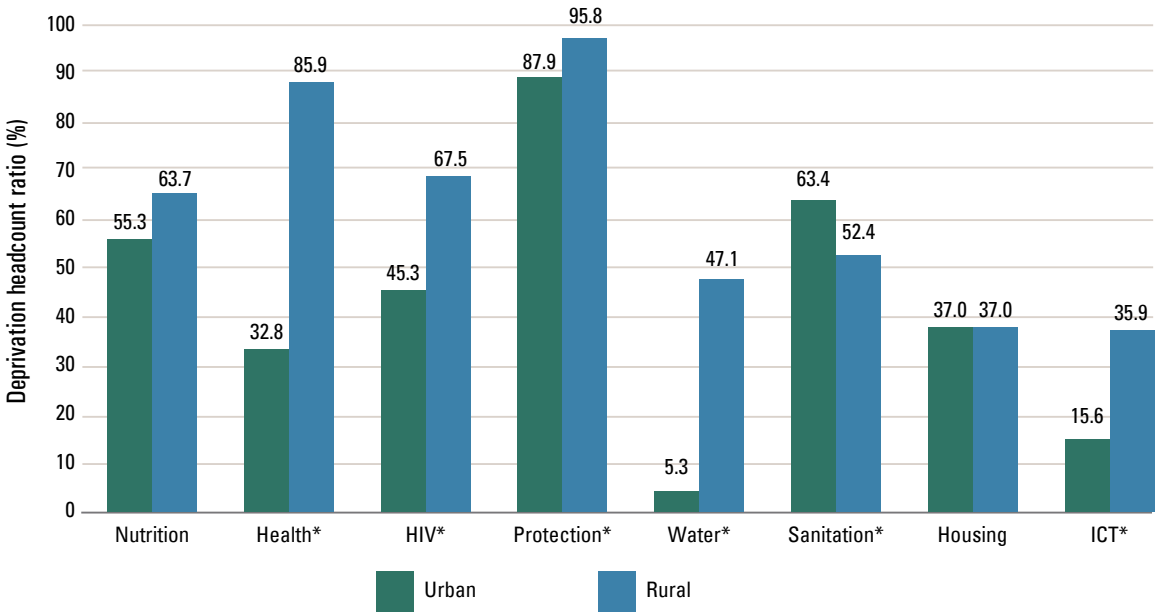
PROFILING THE DEPRIVED CHILDREN AGED 0-23 MONTHS

The deprivation rates according to different profiling characteristics reveal whether children of different backgrounds face varying levels of deprivation and which of these children are at greater risk of vulnerability.

Deprivation rates by area of residence

For children aged 0-23 months, results show that the deprivation incidence **is higher in rural areas compared to urban areas** for all dimensions of well-being, with the notable exception of sanitation. Urban and rural children in the housing dimension have similar deprivation rates (37.0 per cent). Furthermore, the gap between deprivation rates of urban and rural children is rather close in the dimensions of child protection (87.3 per cent and 95.8 per cent, respectively) and nutrition (55.3 per cent and 63.7 per cent, respectively). Larger gaps between urban and rural children can be observed in dimensions of health (32.8 and 85.9 per cent, respectively), HIV/AIDS (45.3 per cent and 67.5 per cent, respectively), and water (5.3 per cent and 47.1 per cent, respectively) as shown in Figure 5.

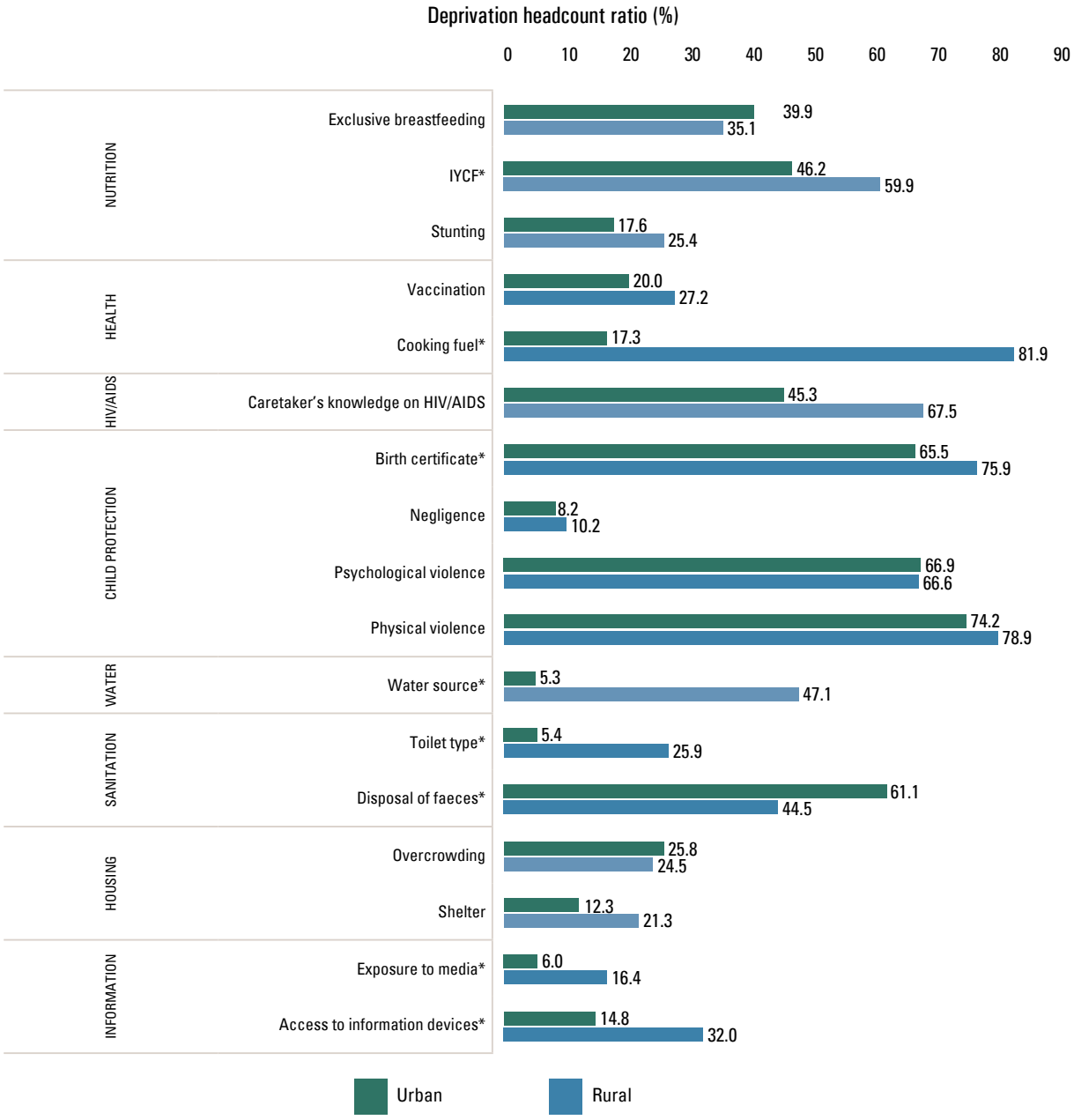
Figure 5: *Deprivation headcount ratio (%) by dimension and area of residence, 0-23 months*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Figure 6 further disaggregates the deprivation rates of urban and rural children aged 0-23 months by all the indicators on each dimension. Significant differences between urban and rural deprivations were observed when measuring cooking fuel within the health dimension (17.3 per cent and 81.9 per cent, respectively), caretaker's knowledge within the HIV/AIDS dimension (45.3 per cent and 67.5 per cent, respectively), drinking water source within the water dimension (5.3 per cent and 47.1 per cent, respectively), toilet type within the sanitation dimension (5.4 per cent and 25.9 per cent, respectively) and access to information within the ICT dimension (14.8 per cent and 32.0 per cent, respectively). These are specific areas of vulnerability which need urgent targeting to help alleviate deprivation among children living in rural areas.

Figure 6: *Deprivation headcount ratio (%) by each indicator and area of residence, 0-23 months*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by region

Table 4 shows the proportion of children aged 0-23 months that are deprived in each dimension as per the geographical region in the country. Children in Manzini have lower deprivation rates whereas children in **Shiselweni and Lubombo are more deprived** across the dimensions. Across regions, the closest gap in deprivation rates is in the dimensions of nutrition and child protection, meaning that in these dimensions, children are almost similarly deprived across regions.

Table 4: *Deprivation headcount ratio (%) by dimension and region, 0-23 months*

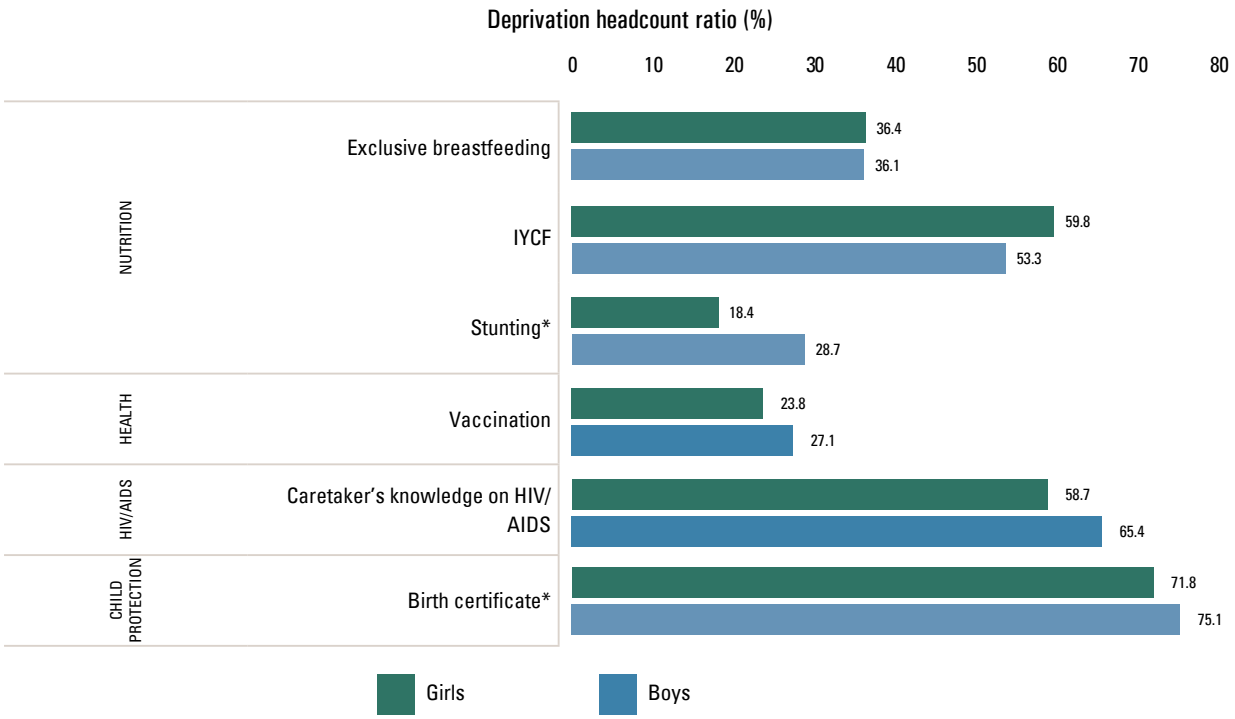
	NUTRITION	HEALTH*	HIV*	PROTECTION	WATER*	SANITATION*	HOUSING*	ICT*
Lubombo	64.9	83.6	67.3	92.9	50.5	60.4	49.0	41.8
Shiselweni	65.0	89.5	74.9	95.5	55.8	55.8	41.6	32.8
Manzini	57.2	54.3	53.8	94.3	23.1	48.4	28.8	25.7
Hhohho	63.4	80.6	60.4	92.0	31.3	60.6	35.5	28.1

*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by gender

Figure 7 shows the proportion of children deprived in indicators and dimensions by gender. Only individual level indicators were presented as it is assumed that girls and boys will be equally deprived in data that is available at the household level (for instance, water source or toilet type are likely to impact all children in the household in a similar way). For children aged 0-23 months, the analysis shows that the deprivation incidence is not universally higher for girls or for boys. While some indicators appear to affect more boys (e.g. vaccination, caretaker's knowledge of HIV/AIDS, birth certificate and stunting), other deprivations are higher among girls (e.g. IYCF and exclusive breastfeeding, although by a very small margin). Notably, the deprivation level for the indicator stunting is 10 per cent higher for boys than for girls aged 0-23 months (28.7 per cent and 18.4 per cent, respectively).

Figure 7: *Deprivation headcount ratio (%) by each indicator and sex of the child, 0-23 months*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by education of the household head and mother

Figure 8 and Figure 9 present the deprivation rates of children 0-23 months by the education level of the household head and the mother. In all dimensions of well-being, the level of deprivation is significantly lower as the measured level of education of the mother and the household head is higher. Importantly however, the educational achievement does not seem to reduce the deprivation of children in the child protection dimension remarkably. For instance, 89 per cent of children whose mothers have tertiary education still live in an environment prone to physical and psychological violence. This is indicative of the fact that the attitudes of violence are not influenced much by the educational norms in the country. On a positive note, children benefit most from the education of adults in the dimensions of ICT, housing, water and health. For instance, a staggering 65 per cent of children whose mothers have no education are deprived in water compared to only 24 per cent of children whose mothers have completed tertiary education.

Figure 8: *Deprivation headcount ratio (%) by dimension and education level of the household head, 0-23 months*

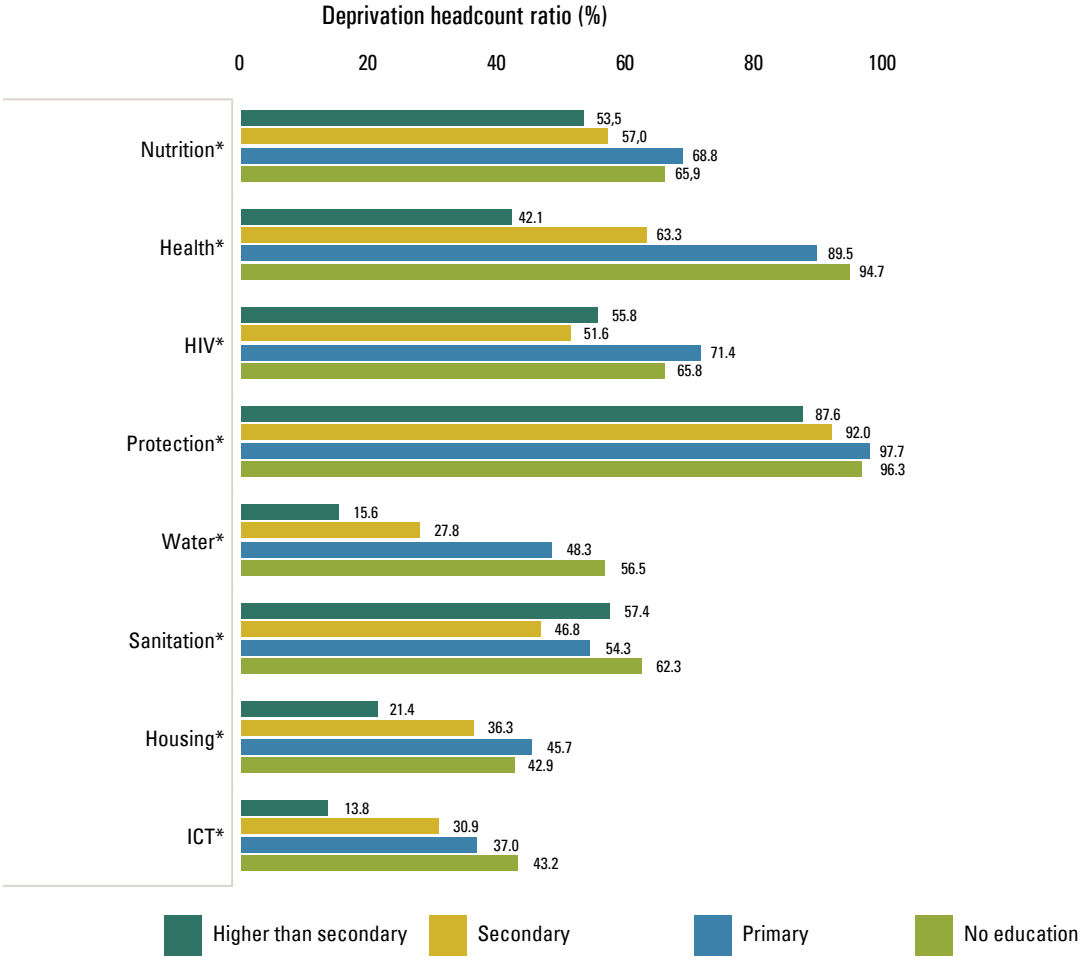
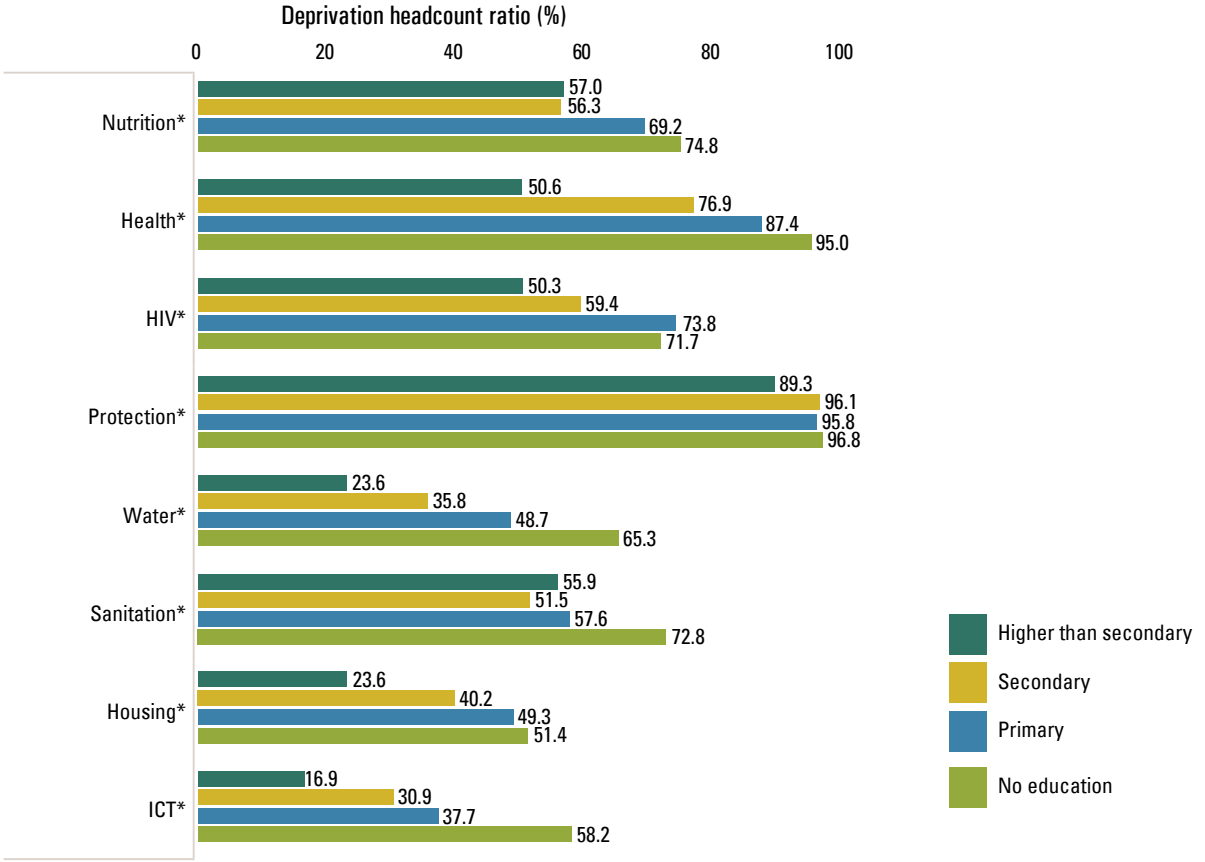


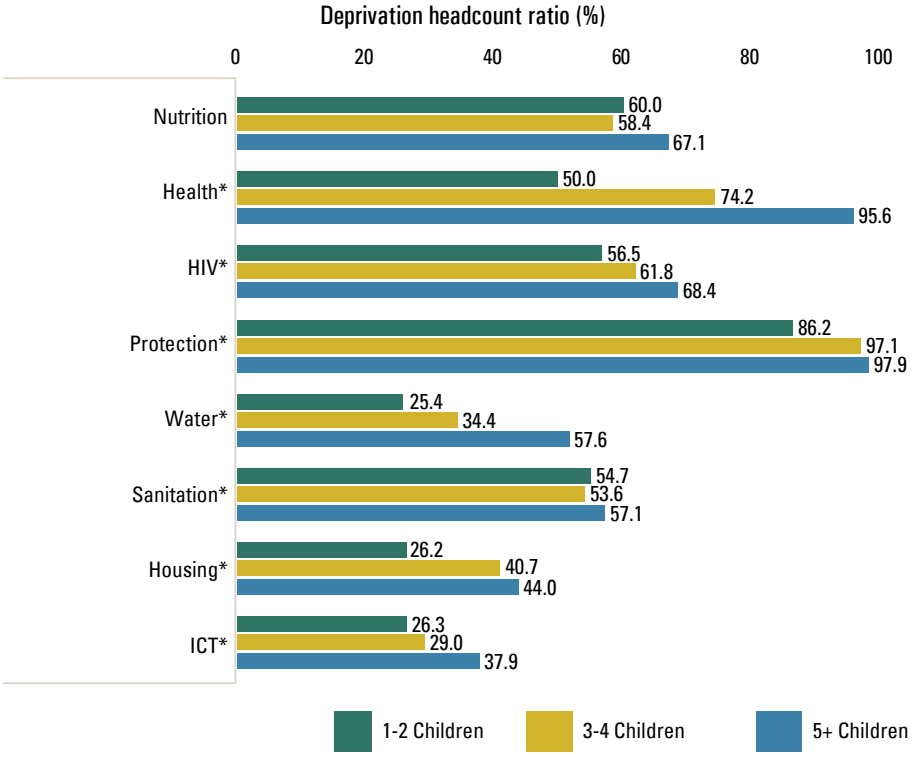
Figure 9: *Deprivation headcount ratio (%) by dimension and education level of the mother, 0-23 months*



*Note: * indicates a statistically significant difference (at a 95per cent confidence level) between the sub-groups.*

Deprivation rates by number of children in the household

Figure 10: *Deprivation headcount ratio (%) by dimension and number of children in the household, 0-23 months*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

The comparison of deprivation levels using the number of children in the household is shown in Figure 10. Overall, children aged 0-23 months experience **higher levels of deprivation when the number of children in the household is higher**. This is especially true when measuring deprivation rates in the dimensions of health, HIV/AIDS, water, housing and ICT. If we take, for instance, the deprivation rates in the health dimension, it is observed that a disturbing 95.6 per cent of all children aged 0-23 months are deprived in this dimension when five or more children are living in the household, compared to a 50.0 per cent deprivation rate when only 1-2 children are present in the household. Notably, the total number of children in the household does not appear to significantly influence the deprivation rates in the housing and nutrition dimensions.

Multidimensional deprivation analysis

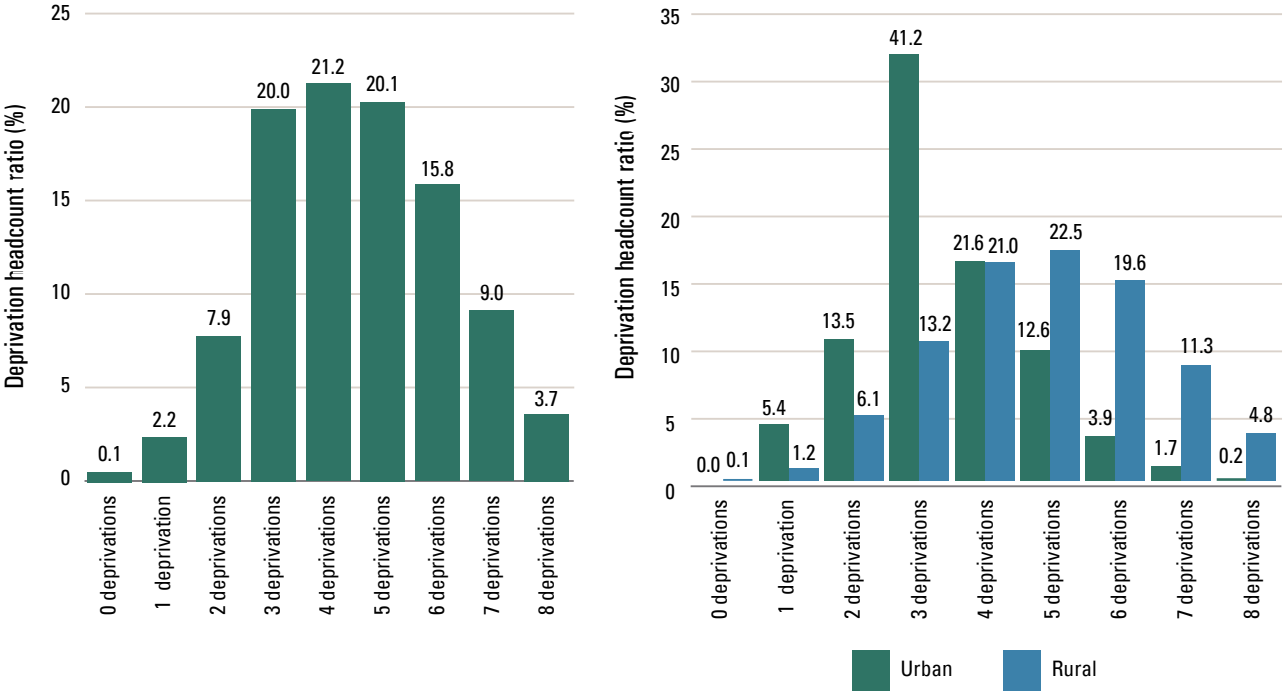
Child deprivation is complex and often children experience more than one deprivation at a time. To measure the severity of child poverty, it is useful to examine the interrelation and the overlap between different deprivations. It allows for the understanding of those children who are most deprived. This study integrates a multidimensional approach to child poverty and shows five types of results:

- The distribution of the number of deprivations;
- the deprivation overlap between dimensions;
- multidimensional deprivation ratios;
- the profile of the multidimensionally deprived children; and
- the contribution of various characteristics and dimensions to the adjusted deprivation headcount ratio.

Number of deprivations by area of residence

The distribution of the number of deprivations that children aged 0-23 months experience simultaneously at the national level and by the rural-urban location is shown in Figure 11. The distribution of deprivations at the national level is skewed to the right, meaning that the breadth of deprivation among children is high. Indeed, almost no child (0.1 per cent) is non-deprived in the 8 dimensions of well-being measuring child poverty in this age group. A staggering 97.7 per cent of all children aged 0-23 months face 2 or more simultaneous deprivations, almost two-thirds (61.3 per cent) experience 3, 4 or 5 deprivations, and 3.7 per cent are deprived in all 8 dimensions at a time. Overall, **children in rural areas experience more simultaneous deprivations** as the vast majority of them (79.2 per cent) are deprived in 4 or more dimensions of well-being (Figure 11). This does not mean that children in urban locations are doing much better, as the same proportion (81.2 per cent) are deprived in 3 or more dimensions of well-being at a time (Figure 11). It can also be observed from Figure 11 that the largest proportion of children (41.2 per cent) in urban areas have exactly 3 deprivations while for rural areas, the percentages of deprived children are more spread.

Figure 11: *Number of simultaneous deprivations experienced by children aged 0-23 months at the national level and by area of residence*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Number of deprivations by region

Table 5 disaggregates the distribution of simultaneous deprivations by region. Overall, children in Manzini are relatively better off in terms of multidimensional poverty, although a majority of them (53.4 per cent) are still deprived in 4 or more dimensions of well-being at a time. In contrast, children in Shiselweni and Lubombo are more severely deprived, with 87.9 per cent and 82.4 per cent respectively deprived in 4 or more dimensions. In comparison to Shiselwini and Lubombo, Hhohho is doing relatively better with 70.0 per cent of children deprived in 4 or more dimensions.

Table 5: *Number of simultaneous deprivations experienced by region, 0-23 months*

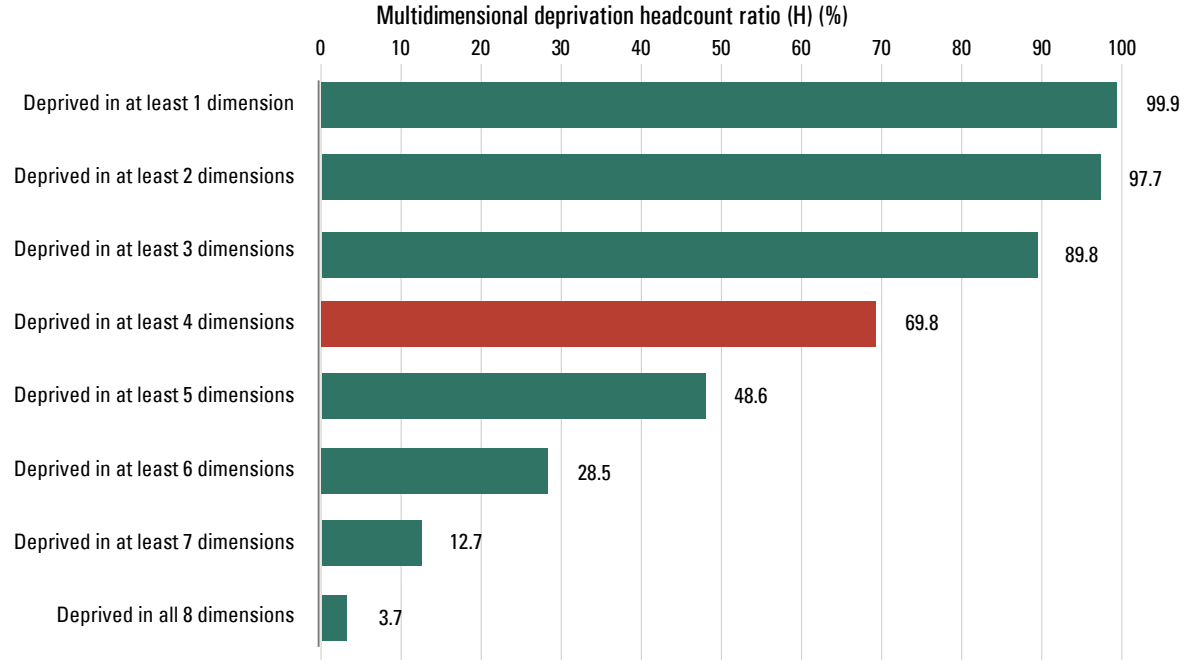
	NUMBER OF SIMULTANEOUS DEPRIVATIONS EXPERIENCED BY THE CHILD								
	0	1	2	3	4	5	6	7	8
Lubombo	0.0	0.7	2.9	14.1	22.3	20.5	14.6	16.9	8.1
Shiselweni	0.0	1.1	4.3	6.7	23.1	24.5	21.6	13.1	5.6
Manzini	0.0	4.0	11.9	30.8	21.2	17.1	11.1	3.1	0.9
Hhohho	0.5	1.6	9.0	18.8	18.4	21.1	20.0	8.0	2.5

Multidimensional deprivation indices

The multidimensional deprivation indices complement the analysis of the distribution and the overlap of deprivations, by showing the incidence and the intensity of deprivation of children according to their different characteristics.

Figure 12 presents the **multidimensional deprivation headcount ratio** (H), which reports the proportion of children aged 0-23 months who are deprived according to a specific cut-off point (K) of multidimensional deprivations. Using four dimensions (out of eight dimensions) as the multidimensional deprivation threshold (K=4), **69.8 per cent of children in this age group were found to be multidimensionally poor**.[5] Notably, 99.9 per cent of all children in this age group are deprived in at least 1 dimension of well-being.

Figure 12: *Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 0-23 months*



[5] In consultation with the national and international stakeholders, the threshold of 4 deprivations, out of the total number of possible deprivations, has been agreed to define multidimensional child poverty in Eswatini.

Figure 13 shows the multidimensional deprivation headcount (H) at different cut-off points at the national level and by rural-urban location. Compared to children in rural areas, urban children are relatively better off in the distribution of their multidimensional deprivation. The distributions of rural and urban children do not intersect at any cut-off point, meaning that rural children are consistently more deprived while urban children are consistently better off at any level of the distribution.

Figure 13: *Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level and by rural-urban location, 0-23 months*

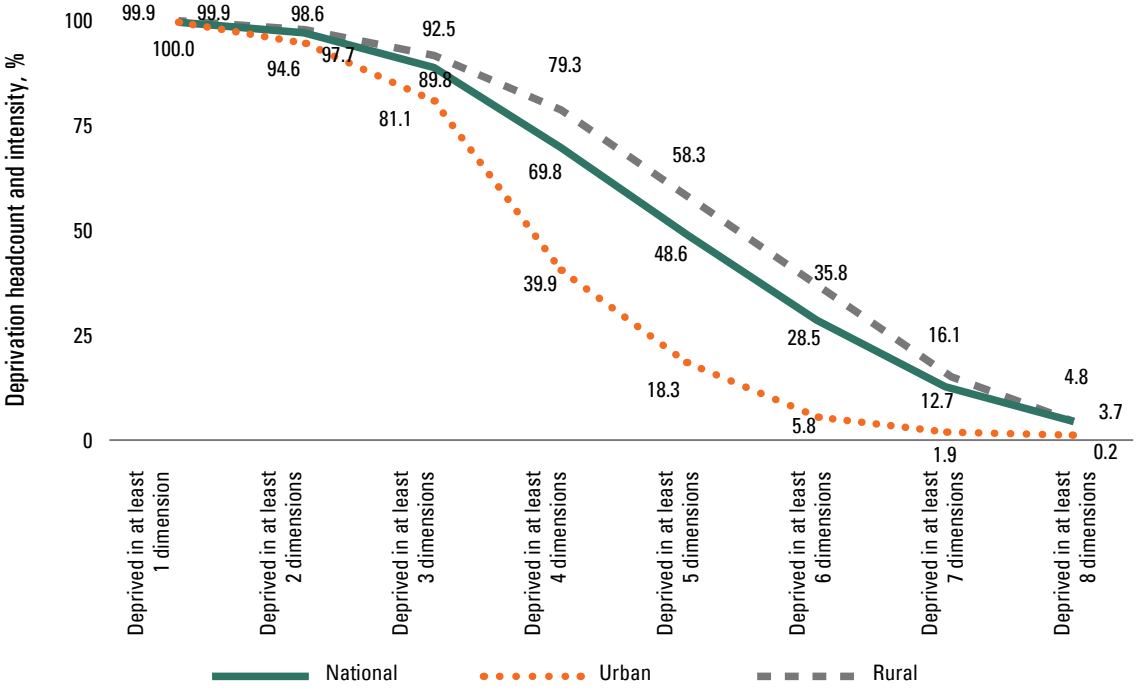
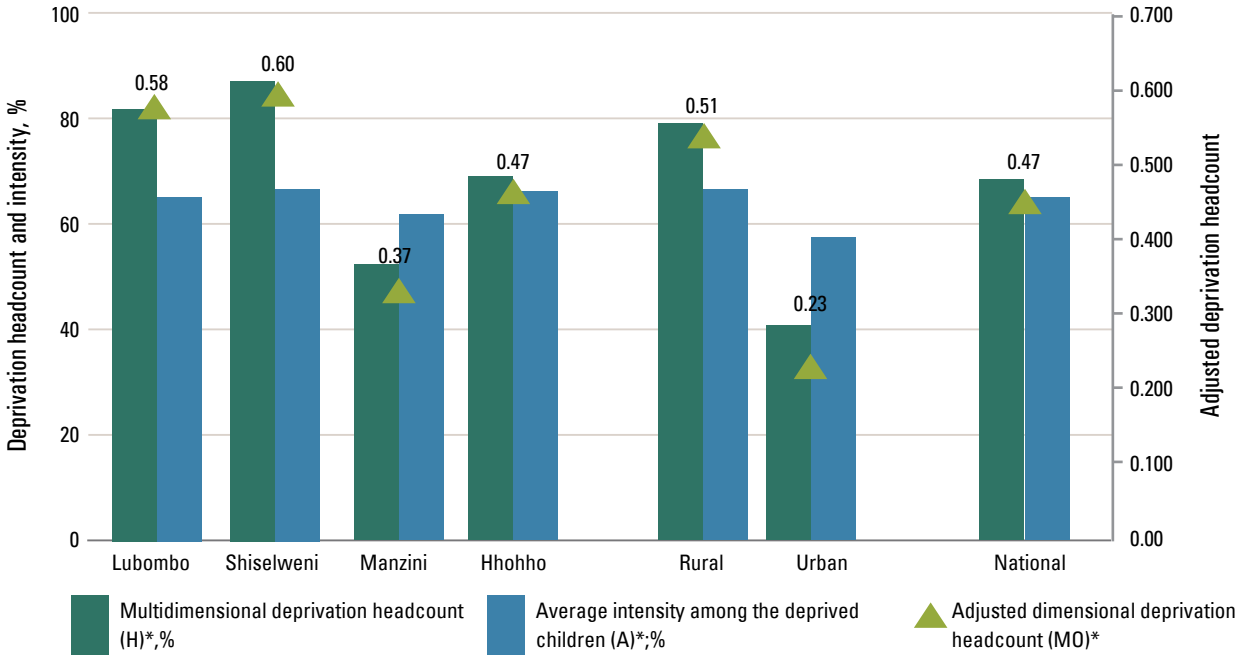


Figure 14 presents the multidimensional child poverty indices at the national level, by rural-urban location and by the country's regions for children aged 0-23 months who are multidimensionally poor (i.e. deprived in at least 4 out of the 8 dimensions of well-being). In addition to the **multidimensional deprivation headcount ratio (H)**, Figure 14 also shows the average intensity (A) among multidimensionally poor children and the **adjusted multidimensional deprivation headcount (M0)**.

The A indicates the depth of deprivation among multidimensionally poor children. At the national level, all multidimensionally poor children aged 0-23 months (i.e. experiencing at least 4 deprivations at a time) are deprived in 66.7 per cent of all 8 dimensions of well-being. Although urban children are doing slightly better, the A across regions is rather similar, meaning that multidimensionally poor children across the country are equally poor.

The M0 is the multidimensional deprivation headcount ratio (H) multiplied by the average intensity of deprivation (A). The multidimensional headcount index adjusted for the intensity of deprivation shows lower values of deprivation among urban children compared to children living in rural areas (M0 is 0.23 and 0.54, respectively). The M0 is also lowest in Manzini (0.33) and highest in Shiselweni (0.60).

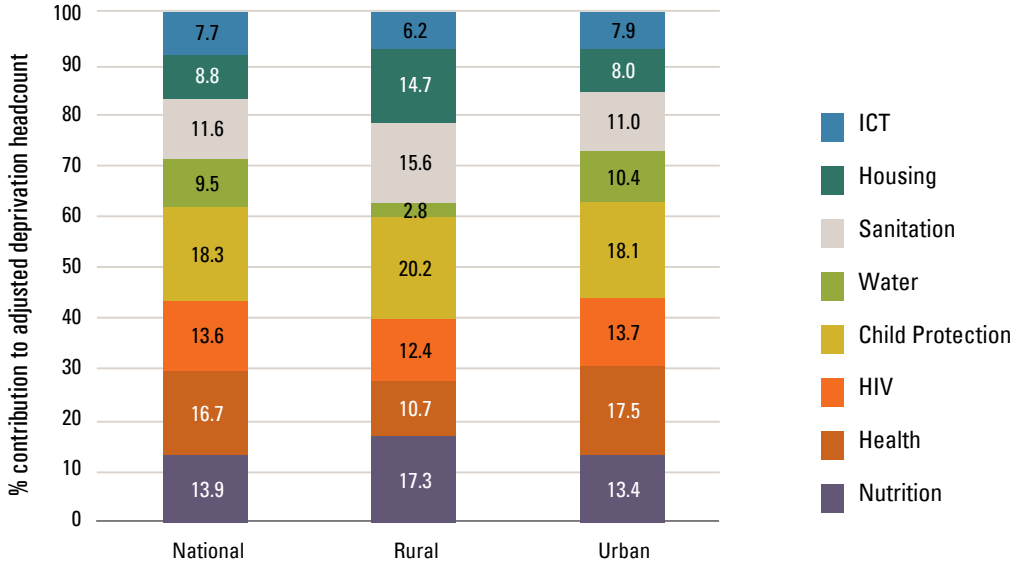
Figure 14: *Multidimensional child poverty indices at the national level, by urban-rural area and by region, children aged 0-23 months deprived in at least 4 dimensions*



How does each dimension contribute to the multidimensional child poverty index?

The M0 can be further decomposed to observe how each dimension of well-being contributes to the multidimensional poverty, adjusted for the intensity of deprivation (Figure 15). Data show that different dimensions contribute differently to the severity of deprivation for children aged 0-23 months. While the housing dimension contributes 14.7 per cent to the level of deprivation in rural areas, its contribution is 8.0 per cent in urban areas. Similarly, the water dimension contributes 2.8 per cent to the multidimensional poverty for rural children and 10.4 per cent for children in urban areas. The health dimension, on the other hand, contributes more to multidimensional child poverty in urban areas than in rural locations (17.5 per cent and 10.7 per cent, respectively). Notably, child protection is the biggest contributor to the multidimensional child poverty in both rural and urban areas (20.2 per cent and 18.1 per cent, respectively).

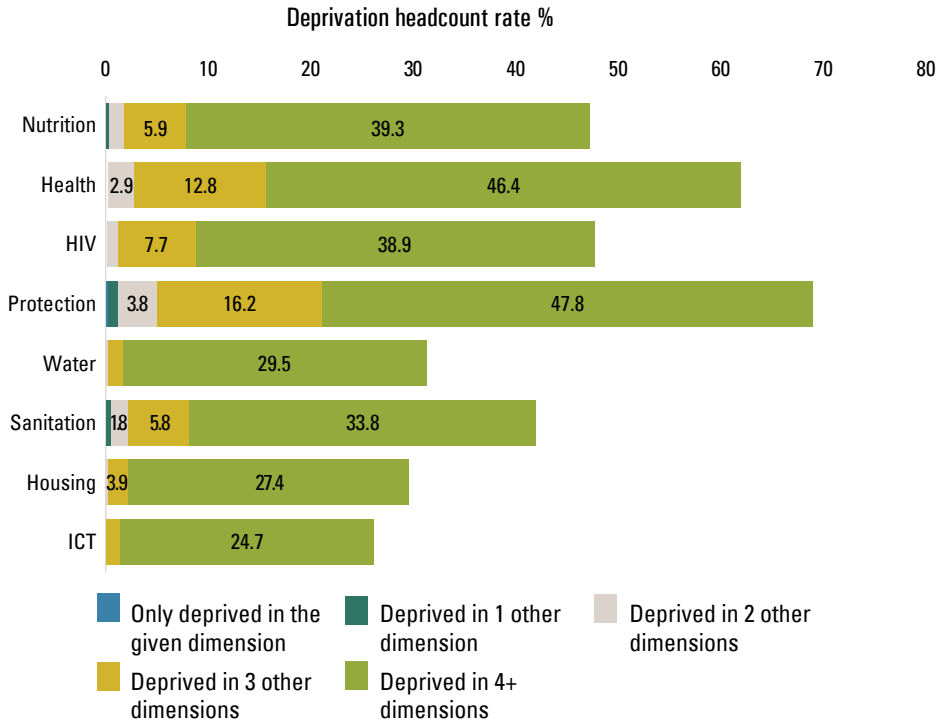
Figure 15: *Decomposition of the multidimensional child poverty index (M0), 0-23 months*



Deprivation overlap analysis

The analysis of the deprivation overlap for each dimension of children aged 0-23 months shows the proportion of children deprived in one or more additional dimensions (Figure 16). Data demonstrate that almost no child in this age group is deprived solely in the given dimension. More often than not, children deprived in a specified dimension are also deprived in several other dimensions of well-being. For instance, 47.8 per cent and 46.4 per cent of children deprived in child protection and health, respectively, are additionally deprived in 4 or more other dimensions. It means that child deprivation in the Kingdom interconnects across multiple dimensions of well-being and reducing child poverty requires multi-sectoral efforts of policy and action.

Figure 16: *Deprivation overlap for each dimension, 0-23 months*



The deprivation overlap between several dimensions of well-being can be graphically displayed using Venn diagrams. Figure 17 to Figure 19 show an example of deprivation overlap of three dimensions, namely nutrition, health and water for children aged 0-23 months, at the national level and by rural-urban location. While a quarter of all children in this age group (24.2 per cent) are deprived in the overlap between nutrition, health and water, a much lower proportion of children are deprived in nutrition only (13.1 per cent), health only (15.2 per cent) or water only (0.9 per cent). Notably, 11.7 per cent of children are not deprived in any of the three dimensions.

The Venn diagrams for rural-urban location show important disparities in the overlap between nutrition, health and water. Specifically, while 31.2 per cent of rural children aged 0-23 are deprived in all three dimensions, only 2.2 per cent of urban children have the same deprivation overlap. Moreover, while 30.2 per cent of urban children are not deprived in all three dimensions, only 5.8 per cent of rural children are similarly non-deprived. This demonstrates a close relationship between the three dimensions in profiling child poverty, particularly in rural areas.

The deprivation overlap analyses between any three dimensions of well-being can be found in Annex 2.

Figure 17: *Deprivation overlap between the dimensions of nutrition, health and water at the national level, 0-23 months*

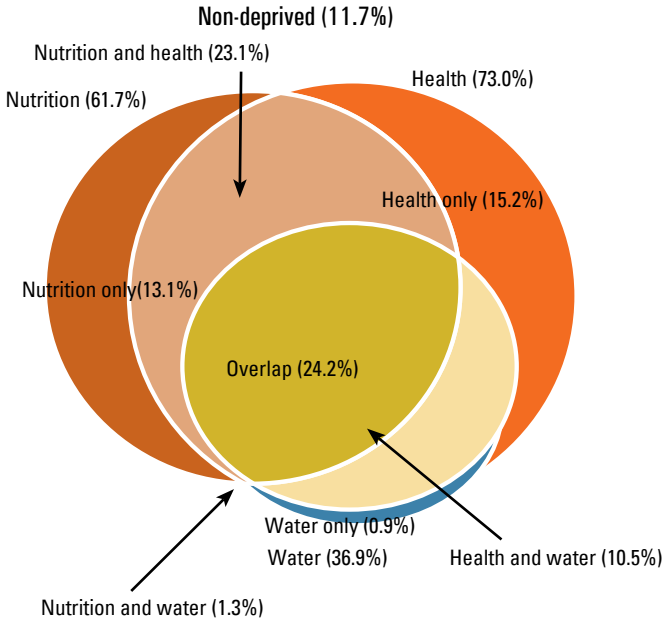


Figure 18: *Deprivation overlap between the dimensions of nutrition, health and water in rural areas, 0-23 months*

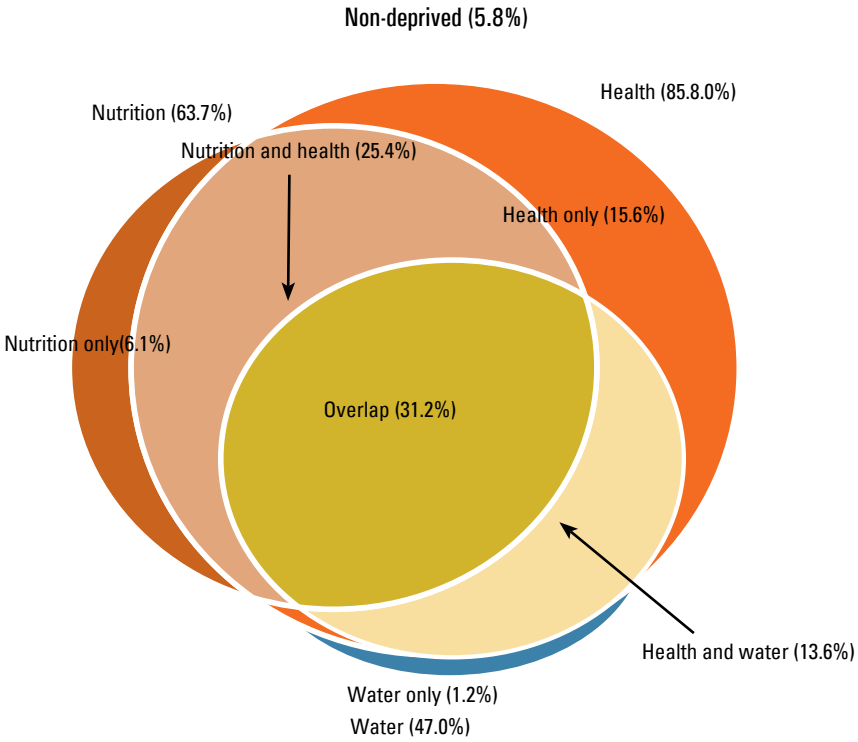
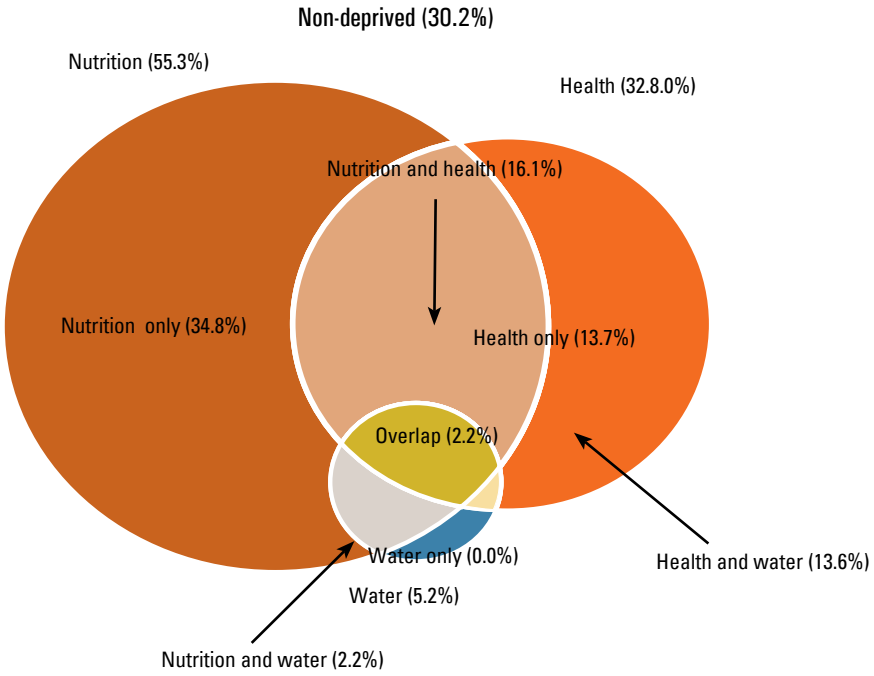


Figure 19: *Deprivation overlap between the dimensions of nutrition, health and water in urban areas, 0-23 months*



3.2.2 CHILDREN AGED 24-59 MONTHS

For children aged 24-59 months, the nine dimensions used to measure their well-being are nutrition, health, HIV/AIDS, child development, child protection, water, sanitation, housing and ICT. A child aged 24-59 months is considered multidimensionally poor if she/he is simultaneously deprived in 4 or more of those dimensions. The main trends observed in child poverty for children in this age group are shown in Box 2.

Box 2: *Main trends observed for the multidimensional poverty analysis for children aged 24-59 months*

MAIN TRENDS FOR CHILDREN AGED 24-59 MONTHS

- 73.3% of children aged 24-59 months are multidimensionally poor.
- Child protection (95.2%) and child development (88.7%) are the leading dimensions in terms of deprivation rates.
- Across all indicators and dimensions, children are overall worst off in rural areas.
- Children with more educated mothers and household heads are less deprived in all dimensions of well-being.
- Children living with 5 or more other children in the household are more deprived.
- Stunting is higher among boys than among girls (29.6% and 23.7%, respectively).
- Orphan children are on average more deprived in all dimensions of well-being.
- Children in Manzini are less deprived, in relative terms, whereas children in Shiselweni and Lubombo are more deprived.
- The intensity of deprivation among multidimensionally poor children is lower in urban areas and in Manzini, meaning that multidimensionally poor children face less simultaneous deprivations in these locations.

Single deprivation analysis

The single deprivation analysis presents the results for each separate dimension of well-being and their composite indicators (Figure 20 and Figure 21).

Figure 20: *Deprivation headcount ratio (%) by dimension at the national level, 24-59 months*

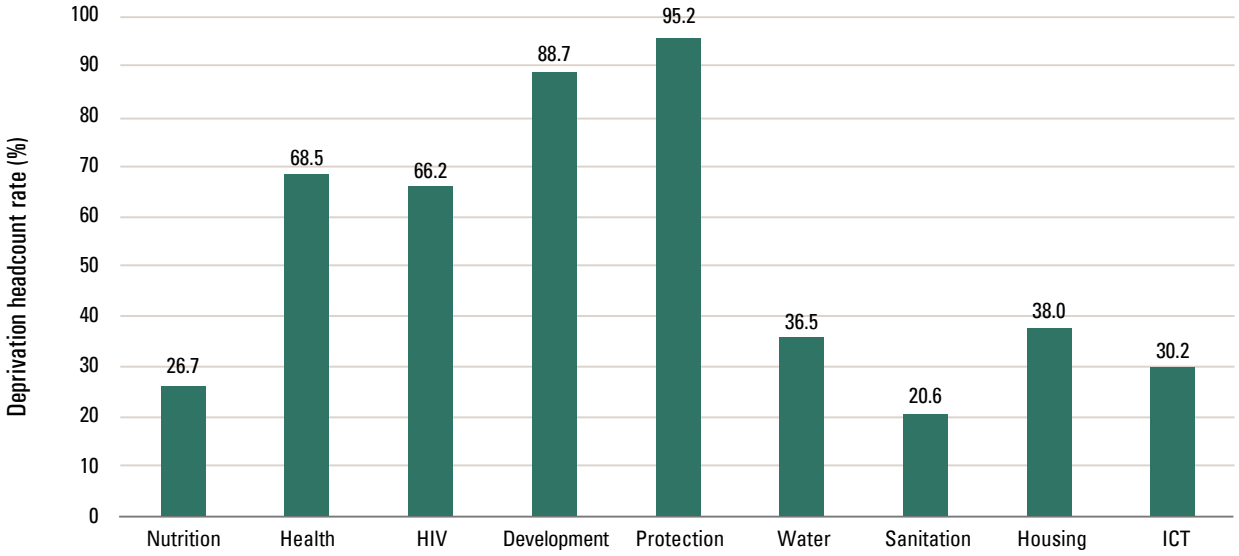
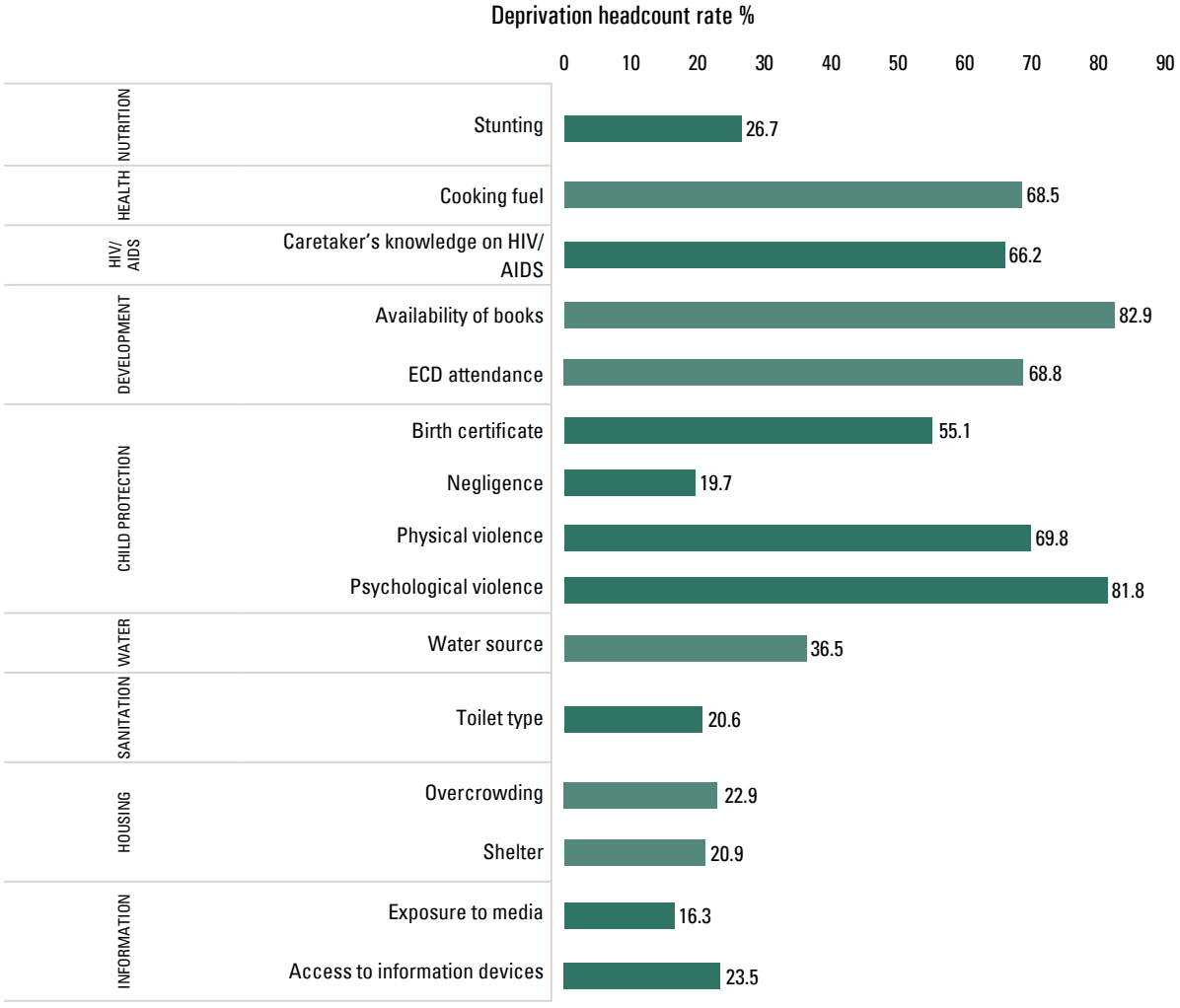


Figure 21: *Deprivation headcount ratio (%) by each indicator at the national level, 24-59 months*



Deprivation rates by child protection

Similar to findings from the previous age group, the highest deprivation rate in the dimensions of well-being for children aged 24-59 months is within the **child protection** dimension (95.2 per cent) (Figure 20). The high deprivation rate in the child protection dimension is mainly driven by indicators measuring children's exposure to physical and psychological violence within the household (69.8 per cent and 81.8 per cent, respectively). In addition, more than half of children in this age group do not have a birth certificate (55.1 per cent) whereas one out of five children (19.7 per cent) are exposed to negligence, that is they are regularly left alone or in the care of another child (Figure 21).

Deprivation rates by child development

The second highest rate of deprivation experienced by children aged 24-59 months was in the **child development** dimension (88.7 per cent). Within this dimension, children are deprived in the *availability of books*[6] (82.9 per cent) and *early childhood programme attendance (ECD)*[7] (68.8 per cent). The Government of the Kingdom of Eswatini has recognized the importance of early child education through comprehensive policies and strategies such as the National Children's Policy (2009) and the National Early Childhood Care and Education (ECCE) Guidelines and has started training early childhood care and development (ECCD) teachers at Ngwane Teacher Training College.

Deprivation rates by health

The third highest deprivation rate experienced by children aged 24-59 months is in the **health** dimension, measured by the use of unimproved cooking fuel in the household. Of all children in this age group, 68.5 per cent are deprived in the health dimension, meaning their families use unimproved cooking fuel such as coal, wood, paraffin to mention a few.

Deprivation rates by HIV/AIDS

The deprivation rate of children in the **HIV/AIDS** dimension was measured by the caretaker's knowledge of the disease and stands at 66.2 per cent. The introduction of prevention programmes such as antiretroviral therapy and prevention of mother to child transmission (PMTCT) has contributed to improved knowledge of HIV/AIDS among the citizens, but programme coverage rates remain low throughout the country (World Bank, 2016). The finding that two-thirds of children's caretakers are not sufficiently informed of HIV/AIDS is worrying. More efforts are needed to increase the provision of programmes in vulnerable areas in the country.

Deprivation rates by housing

Of all children aged 24-59 months, 38.0 per cent were found to be deprived in the **housing** dimension; this figure is similar to the one in the younger age group, 0-23 months (37.0 per cent). This deprivation rate is driven by overcrowding (i.e. a child lives in a household with three or more persons per sleeping room) (22.9 per cent) and shelter (i.e. walls, roof or floor made of unimproved materials) (20.9 per cent).

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6 The child is deprived in the indicator availability of books if she/he lives in a household where there are no books.

7 The child is deprived in the indicator early childhood programme attendance (ECD) if she/her does not attend any early childhood education programme.

Deprivation rates by water

More than one child in three is deprived in the **water** dimension, measured by the type of drinking water source. For children, access to an improved water source is important, as it drives the hygiene and the type of food that children eat. A study by Fink, Günther and Hill (2011) on 1.1 million children under the age of five in 70 developing countries, found that children who lack access to improved water sources are on average more at risk of diarrhoea and stunting.

Deprivation rates by ICT

With a headcount of 30.2 per cent, almost one out of three children aged 24-59 months are deprived in the **ICT** dimension. This dimension is measured by *exposure to mass media,*[8] with a deprivation rate of 16.3 per cent, and by *access to information devices* (radio, TV or phone),[9] in which 23.5 per cent of children in this age group are deprived.

Deprivation rates by nutrition

The **nutrition** dimension for children aged 24-59 months is measured by stunting. This measurement shows a deprivation rate of 26.7 per cent; the rate for stunting is slightly higher than in the younger age group, 0-24 months (23.6 per cent). It indicates a progressive rate across children's life cycle and is a certain cause for concern.

Deprivation rates by sanitation

The **sanitation** dimension holds the lowest deprivation rate of 20.6 per cent, among children aged 24-59 months. This deprivation is entirely driven by the use of an unimproved toilet facility. Although the deprivation is the lowest in sanitation, it still implies that one in every five children does not have access to improved toilet facilities, an important commodity at this stage of life cycle.

Profiling the deprived children aged 24-59 months

The single analysis presented above shows the degree of deprivation among children aged 24-59 months in each dimension of well-being at the national level. However, it is likely that child deprivation varies according to specific characteristics of children in the country.

Deprivation rates by area of residence

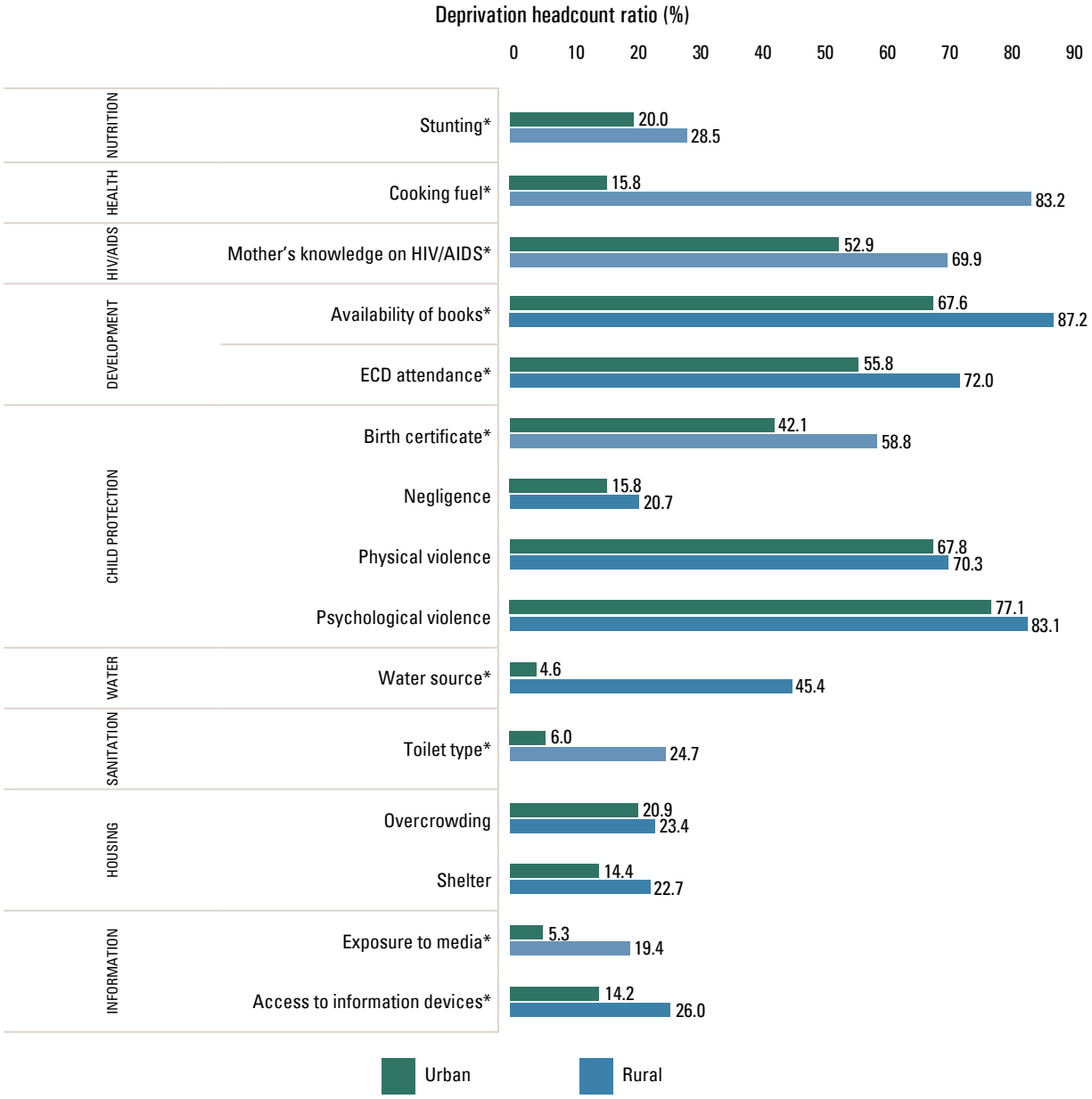
Figure 22 shows the deprivation rate by each indicator and by rural-urban area. Subsequently, Figure 23 displays the difference in the deprivation rates by dimension among rural and urban children. There are notable differences in the degree of deprivations depending on the rural-urban profile of children in this age group. Across all indicators and dimensions, children are overall worst off in rural areas. The biggest gap in the deprivation rates of **rural** and **urban children** can be observed in the following dimensions: health, measured by the use of unimproved cooking fuel (83.2 per cent and 15.8 per cent, respectively); water, measured by access to unimproved water sources (45.4 per cent and 4.6 per cent, respectively); sanitation, measured by access to unimproved toilet type (24.7 per cent and 6.0 per cent, respectively); and ICT, measured by exposure to media and access to information devices (34.3 per cent and 15.6 per

[8] A child is considered as deprived in the indicator exposure to mass media if no adult has access to either one of the following: newspaper, radio, television or internet weekly.

[9] A child is considered as deprived in the indicator access to information devices if she/he lives in a household where there is less than 2 out of the following assets available: radio, TV, mobile phone.

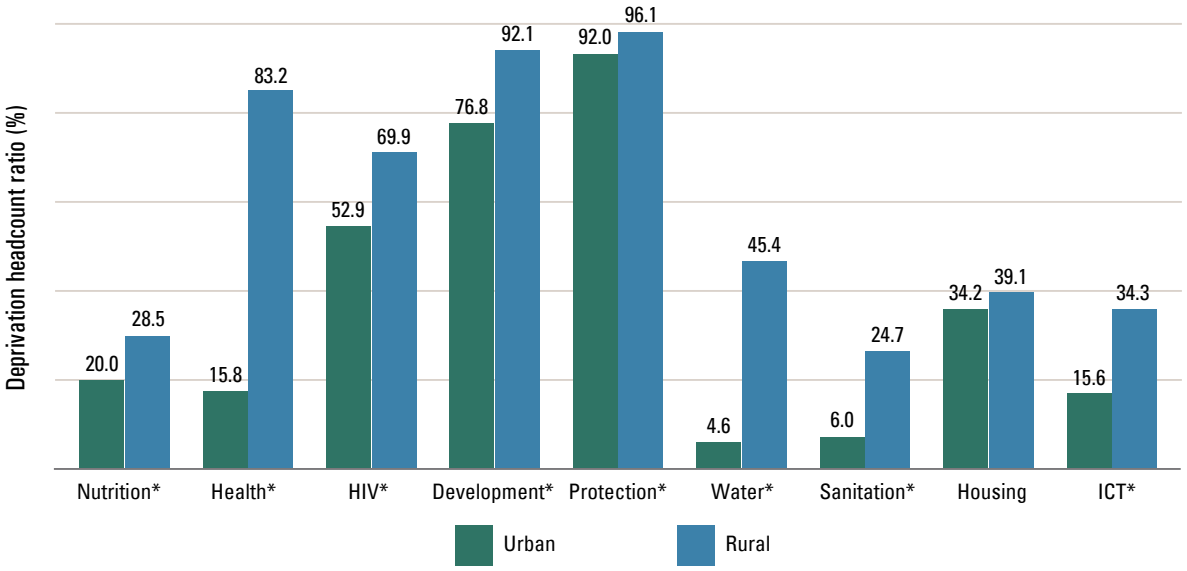
cent, respectively). At the same time, the deprivation rates of rural and urban children are closer to each other in the dimensions of housing (39.1 per cent and 34.2 per cent, respectively), and child protection (96.1 per cent and 92.0 per cent, respectively). Most notably, the child protection deprivation is the global 'leading' vulnerability among both rural and urban children.

Figure 22: *Deprivation headcount ratio (per cent) by each indicator and area of residence, 24-59 months*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Figure 23: *Deprivation headcount ratio (%) by dimension and area of residence, 24-59 months*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by region

Table 6 shows the deprivation rates of dimensions of well-being by the **country's regions**. Of the four regions, children aged 24-59 months in Manzini had the lowest deprivation rates in nutrition, health, water, sanitation, housing and ICT. Comparatively, children in Shiselweni are the most deprived, particularly in nutrition, health, HIV/AIDS, water, housing and ICT. Children in Lubombo are also highly deprived in some of the dimensions, namely child development, sanitation and housing. For the dimension of child protection, the deprivation rates are high and not very different across all regions.

Table 6: *Deprivation headcount ratio (%) by dimension and regions, 24-59 months*

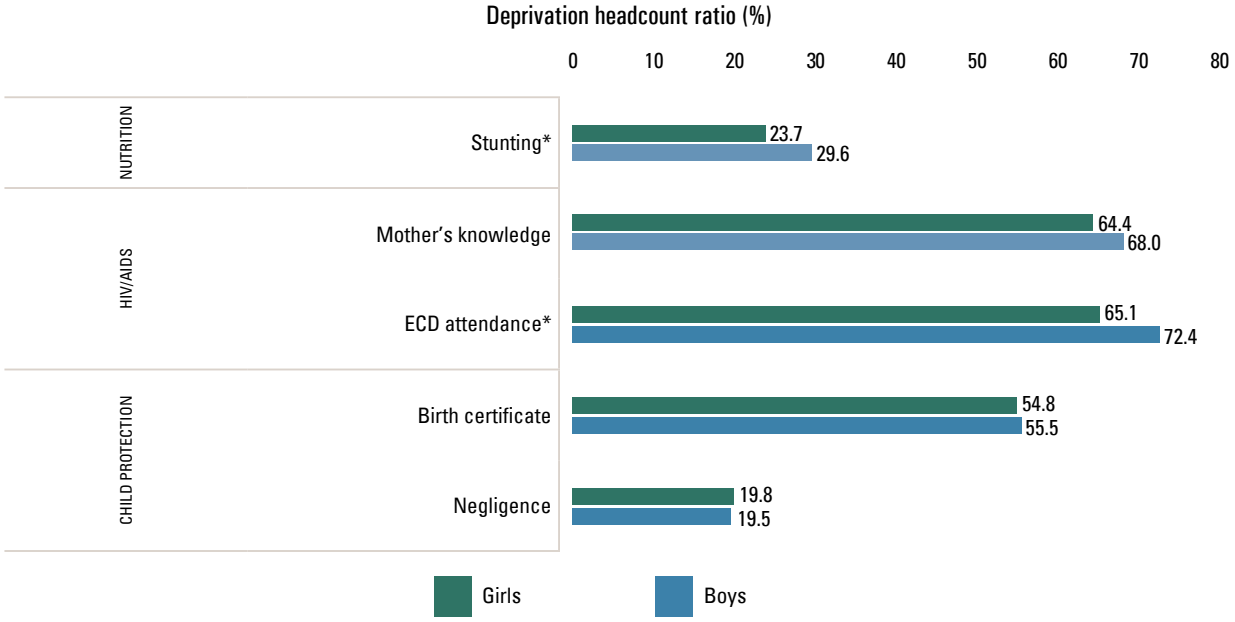
	NUTRITION	HEALTH*	HIV*	DEVELOPMENT*	PROTECTION	WATER*	SANITATION*	HOUSING*	ICT*
Lubombo	26.4	77.1	61.1	94.1	95.5	46.3	35.9	48.6	36.3
Shiselweni	31.8	86.8	78.6	84.8	95.7	55.3	20.4	39.2	36.4
Manzini	24.9	50.1	62.6	88.4	95.7	24.4	8.8	30.2	23.3
Hhohho	25.0	73.6	65.8	87.9	93.7	30.2	25.2	39.5	30

*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by gender

Figure 24 presents the deprivation rates for selected indicators and dimensions by the **child's gender** for the age group 24-59 months. Only indicators that include measurements at the individual child's level are presented as it is assumed that indicators measured at the household level have a similar impact on children in the family. Overall, boys are more deprived than girls in measured indicators, albeit by small margins. The gap between girls and boys in stunting is 6 per cent (23.7 per cent and 29.6 per cent, respectively). Compared to the younger age group, 0-23 months, the rates of stunting for children aged 24-59 months have increased, particularly for girls from 18.7 per cent to 23.7 per cent. There is a need for policy action to address the rising rates in stunting and its gender gap among children under 5. The highest gap between girls and boys can be observed in ECD attendance, of 7 per cent (65.1 per cent and 72.4 per cent, respectively). The deprivation rates for birth certificate and child negligence are rather similar across boys and girls aged 24-59 months.

Figure 24: *Deprivation headcount ratio (%) by each indicator and sex of the child, 24-59 months*

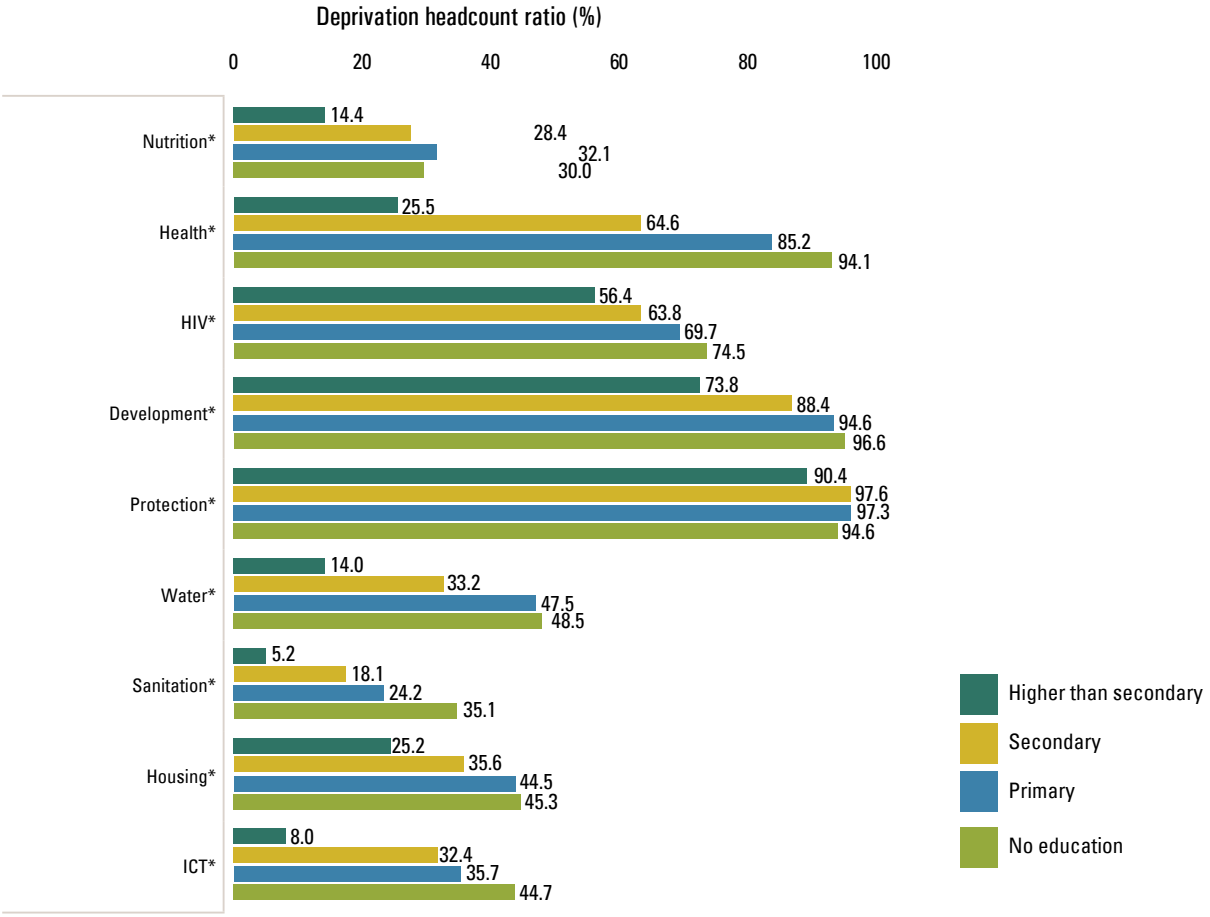


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by education of the household head and mother

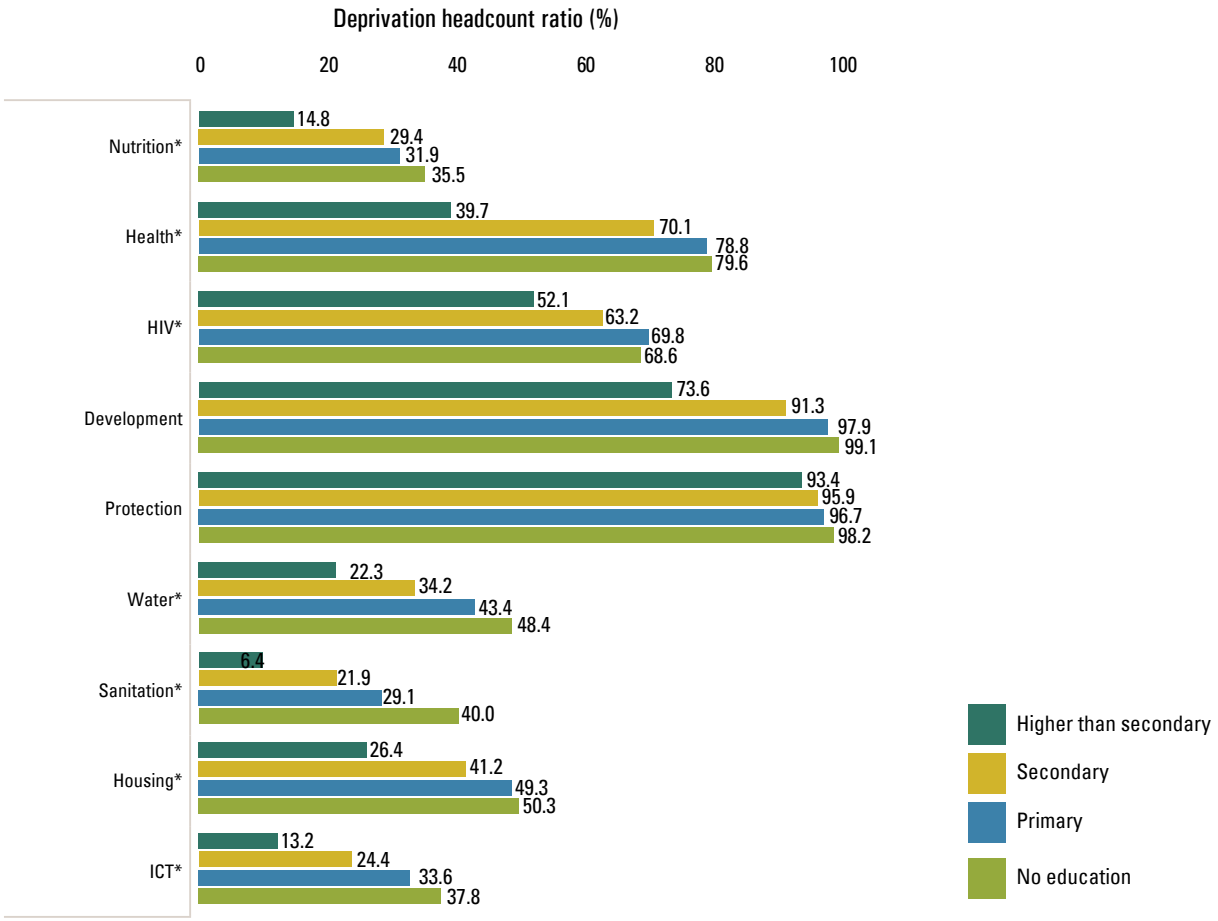
The deprivation rates in all dimensions of well-being for children aged 24-59 months by the education level of the household head and the child's mother are shown in Figure 25 and Figure 26, respectively. The relationship between higher education levels of the mother/household head and less deprivation is evident for children in this age group. When the education of adults is higher, the deprivation rates of children plummet significantly in all dimensions of well-being, but most notably in nutrition, health, water, sanitation, housing and ICT. Higher education among adults brings in knowledge, human capital, better jobs and pay, which are often invested in children and their development and may explain the observed relationships. However, it is observed that deprivation rates in HIV/AIDS, child development and child protection are still large for children whose mother and the household head have tertiary education. It implies that adult education does not always benefit the well-being of children in some of the dimensions.

Figure 25: *Deprivation headcount ratio (%) by dimension and education level of the household head, 24-59 months*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups*

Figure 26: *Deprivation headcount ratio (%) by dimension and education level of the mother, 24-59 months*

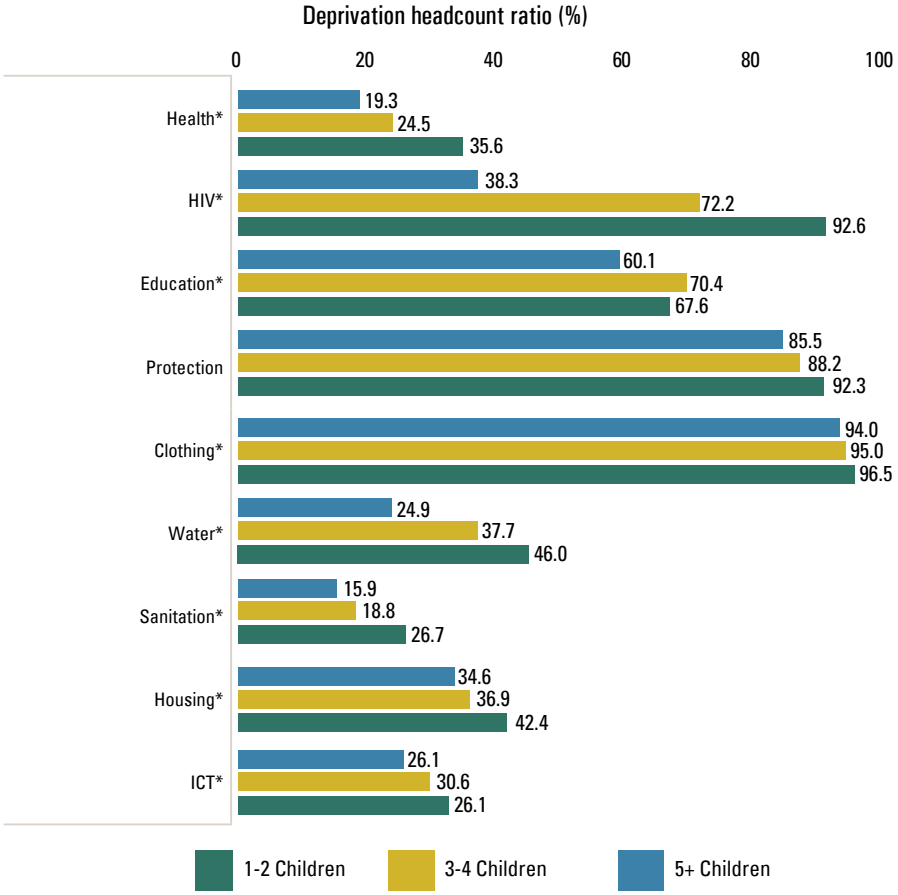


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by number of children in the household

Figure 27 shows the deprivation headcount rates of children aged 24-59 months by the dimension of well-being in relation to the number of children present in the household. Data show a direct negative relationship between the number of resident children and the level of deprivation in each dimension. When comparing children living in households with 1-2 children and those living in households with 5 or more children, the latter are particularly more deprived in health (38.3 per cent and 92.6 per cent, respectively), water (24.9 per cent and 46.0 per cent, respectively), nutrition (19.3 per cent and 35.6 per cent, respectively), sanitation (15.9 per cent and 26.7 per cent, respectively) and ICT (26.1 per cent and 33.5 per cent, respectively). The gap between the two populations of children is rather close in the dimensions of child protection, child development, housing and HIV/AIDS. As shown in previous statistics, the deprivation rates in child development and child protection are particularly high irrespective of the number of children living in the household.

Figure 27: *Deprivation headcount ratio (%) by dimension and number of children in the household, 24-59 months*

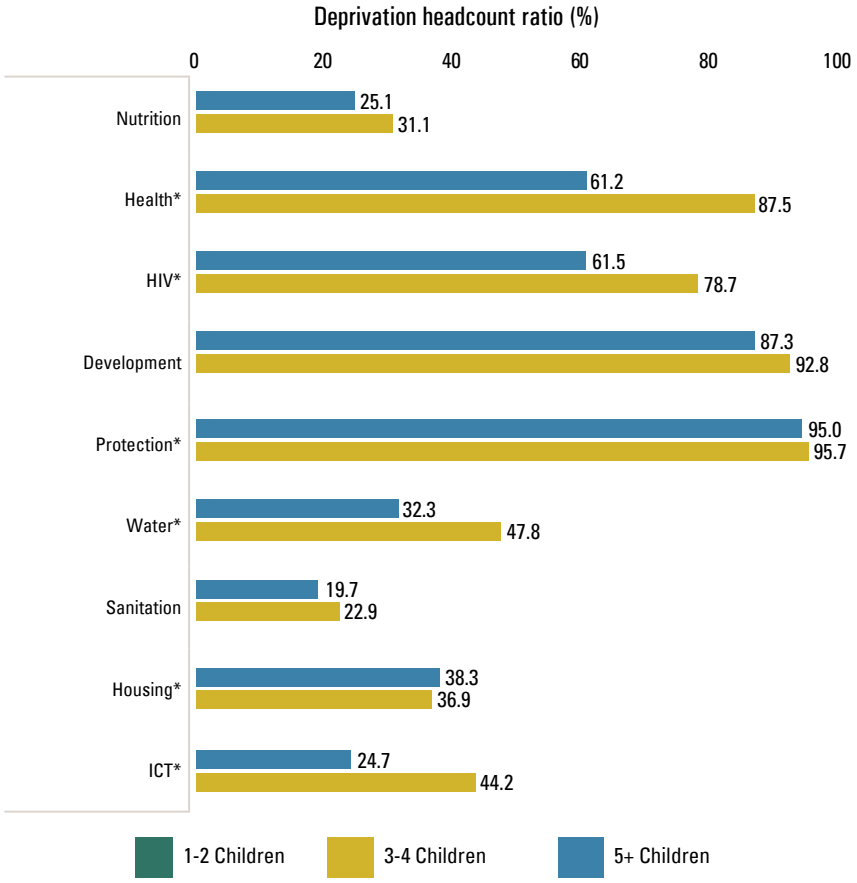


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by orphanhood

The deprivation rates by orphanhood status are presented in Figure 28. Orphan children in the age group 24-59 months are generally more deprived across dimensions compared to their counterparts living with at least one biological parent. The gap in the deprivation rates between orphan and non-orphan children is higher in the dimensions of health (87.5 per cent and 61.2 per cent, respectively), HIV/AIDS (78.7 per cent and 61.5 per cent, respectively), ICT (44.2 per cent and 24.7 per cent, respectively), water (47.8 per cent and 32.3 per cent, respectively) and nutrition (31.1 per cent and 25.1 per cent, respectively). The difference in deprivation rates is relatively similar in the dimensions of child development, child protection, sanitation, and housing. Overall, orphan children face higher deprivation in child protection (95.7 per cent), child development (92.8 per cent), health (87.5 per cent) and HIV/AIDS (78.7 per cent). Policy actions that prioritize these vulnerabilities would do well to mitigate the well-being of orphan children.

Figure 28: *Deprivation headcount ratio (%) by dimension and orphan status, 24-59 months*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Multidimensional deprivation analysis

This study integrates a multidimensional approach to child poverty and shows five types of results:

1. the distribution of the number of deprivations;
2. the deprivation overlap between dimensions;
3. multidimensional deprivation ratios;
4. the profile of the multidimensionally deprived children; and
5. the contribution of various characteristics and dimensions to the adjusted deprivation headcount ratio.

Number of deprivations by area of residence

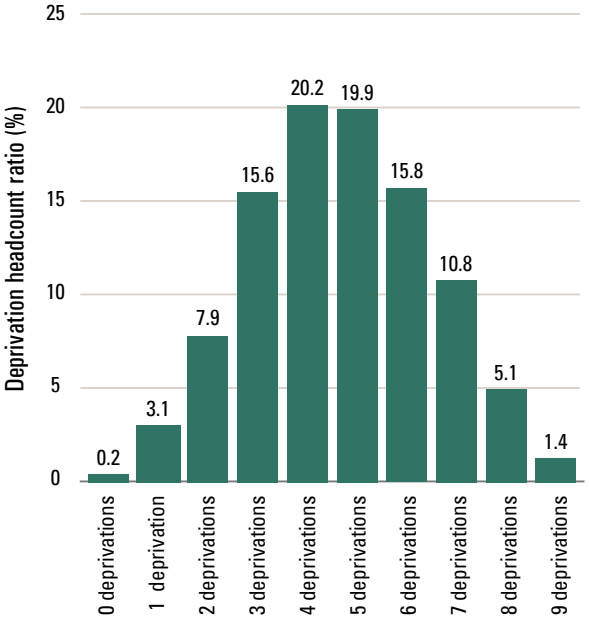
Figure 29 shows the number of deprivations that children aged 24-59 months experience at a time, at the national level and by the rural-urban divide. Similar to the younger age group, 0-23 months, a small proportion (3.1 per cent) of children aged between 24 and 59 months were deprived in only one dimension of well-being. Consequently, the vast majority of them (96.7 per cent) were deprived in two or more dimensions at one time. The peak in the number of deprivations experienced by children in this age group is at 4 and 5 dimensions at a time (20.2 per cent and 19.9 per cent, respectively).

However, the number of deprivations experienced by rural and urban children is slightly different (Figure 29). The distribution of the number of deprivations for rural children is skewed to the right while that of

urban children was skewed to the left, meaning the former experience more simultaneous deprivations. Specifically, most urban children experience on average 2-3 simultaneous deprivations, while most rural children face on average 4-6 deprivations at a time. These data provide evidence that reducing child poverty requires efforts that combine different sectors of well-being, rather than in sectorial isolation.

Figure 29: *Number of simultaneous deprivations experienced by children aged 24-59 months at the national level and by area of residence*

Number of deprivations by region



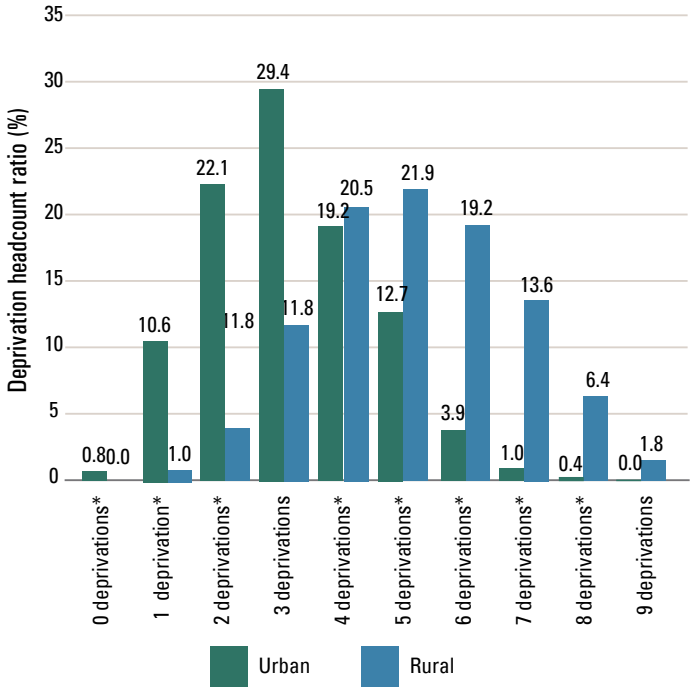


Table 7 presents the distribution of children's simultaneous deprivations by the country's regions. Overall, children in Manzini face a lower number of deprivations at a time, while children in Shiselweni and Lubombo were more deprived in the multidimensional poverty. Notably, more than a quarter of all children aged 24-59 months are simultaneously deprived in 7 or more dimensions in the two worst affected regions (Shiselweni and Lubombo). Hhohho is doing relatively better than Shiselwini and Lubombo with a higher proportion of children experiencing a fewer number of deprivations.

Table 7: *Number of simultaneous deprivations experienced by region, 24-59 months*

	NUMBER OF SIMULTANEOUS DEPRIVATION EXPERIENCED BY THE CHILD									
	0	1*	2*	3*	4	5	6	7*	8*	9*
Lubombo	0.0	1.0	6.0	16.6	14.2	17.8	16.2	15.3	8.6	4.4
Shiselweni	0.0	0.9	2.9	9.7	18.9	23.1	19.8	16.0	7.4	1.3
Manzini	0.2	5.4	12.7	19.0	23.4	19.4	12.8	4.8	2.1	0.3
Hhohho	0.5	3.3	6.3	14.5	22.0	19.9	16.8	11.8	4.6	0.3

*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Multidimensional deprivation indices

Figure 30 shows the **multidimensional headcount rate (H)** at different cut-off points calculated for children aged 24-59 months. For the purpose of this study and in agreement with national and international stakeholders, the cut-off point for multidimensional poverty was established at 4 deprivations (K=4). It implies that children who simultaneously experience 4 or more deprivations (out of a total of 9 dimensions) were classified as multidimensionally poor. In the country, **73.3 per cent of children aged 24-59 months were multidimensionally poor**. This rate is higher than for the younger age group, 0-23 months, at 69.8 per cent.

Figure 30: *Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 24-59 months*

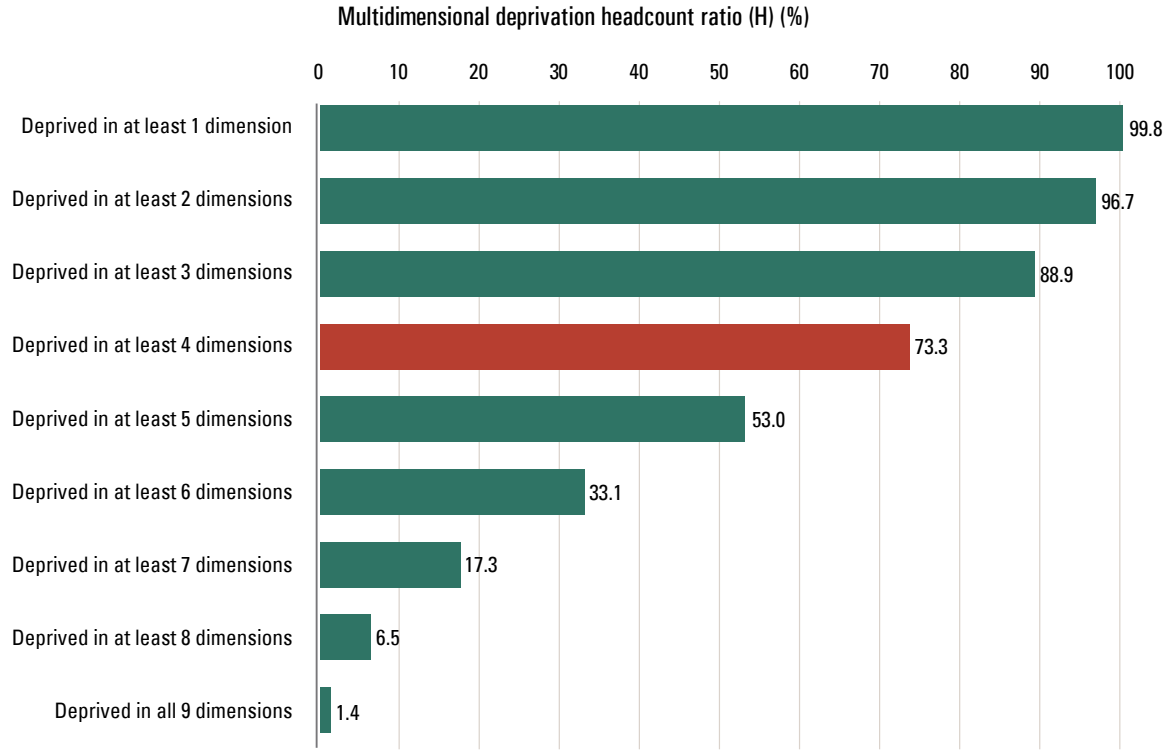


Figure 31 presents the H for children aged 24-59 months at different cut-off points per rural-urban location. The distribution of the number of deprivations among rural and urban children do not intersect across all cut-off points, meaning that rural children are consistently deprived in more dimensions at a time than urban children.

Figure 31: *Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level and urban-rural, 24-59 months*

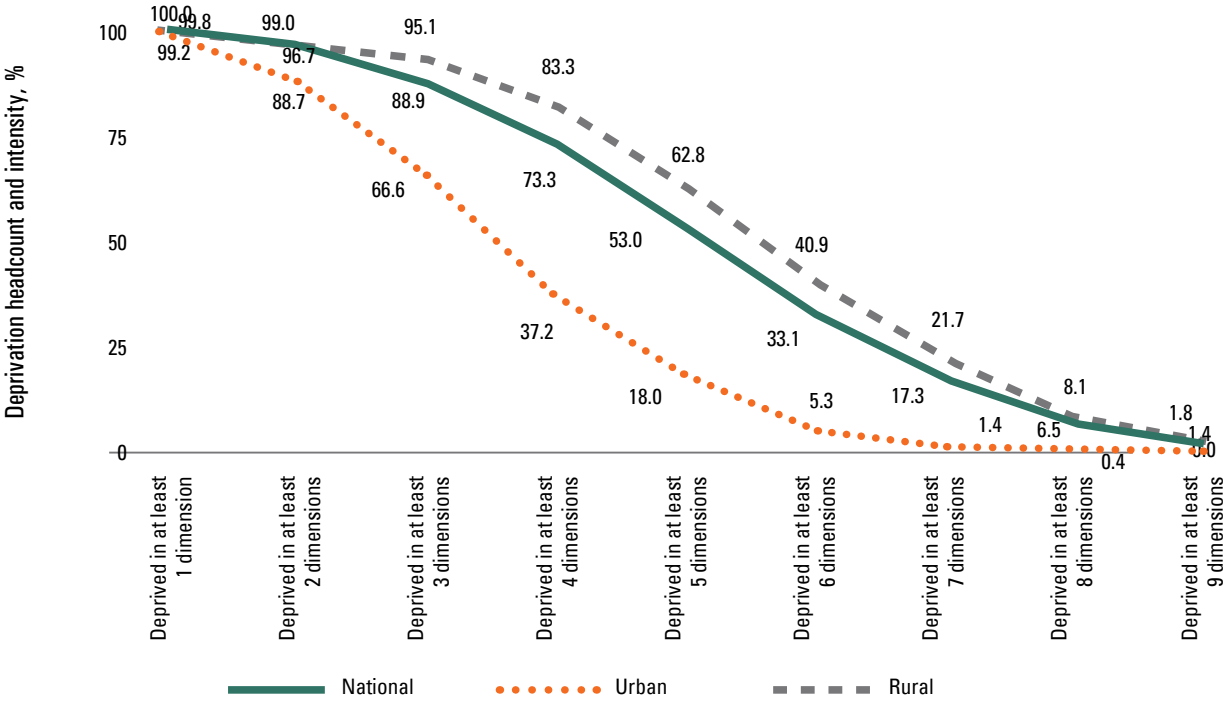
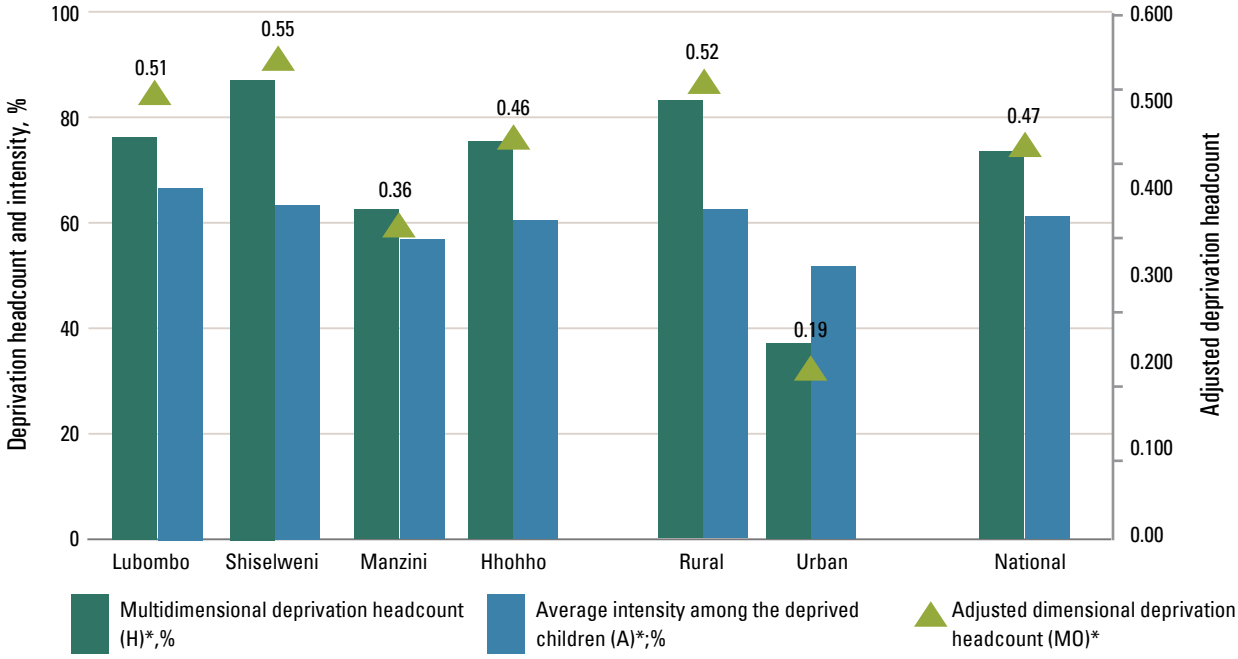


Figure 32 shows the multidimensional child poverty indices for children aged 24-59 months, namely H, the **average intensity of multidimensional poverty (A)** and the **adjusted multidimensional poverty headcount (M0)** at the national level, by urban-rural location and by the country's regions. The A shows how poor the multidimensionally poor children are. At the national level, multidimensionally poor children in this age group are deprived in 61.3 per cent of the total number of deprivations. The location divide shows that urban and rural multidimensionally poor children are deprived in 51.9 per cent and 62.5 per cent of the total number of deprivations, respectively. Across regions, the A is roughly the same at values between 57.7 per cent (Manzini) and 66.6 per cent (Lubombo). It implies that, with small variations, the multidimensionally poor children are equally poor across the country. The M0 is the H multiplied by A and provides a more precise evaluation of multidimensional child poverty. The M0 supports the findings on the severity of multidimensional poverty across the rural-urban divide and across regions.

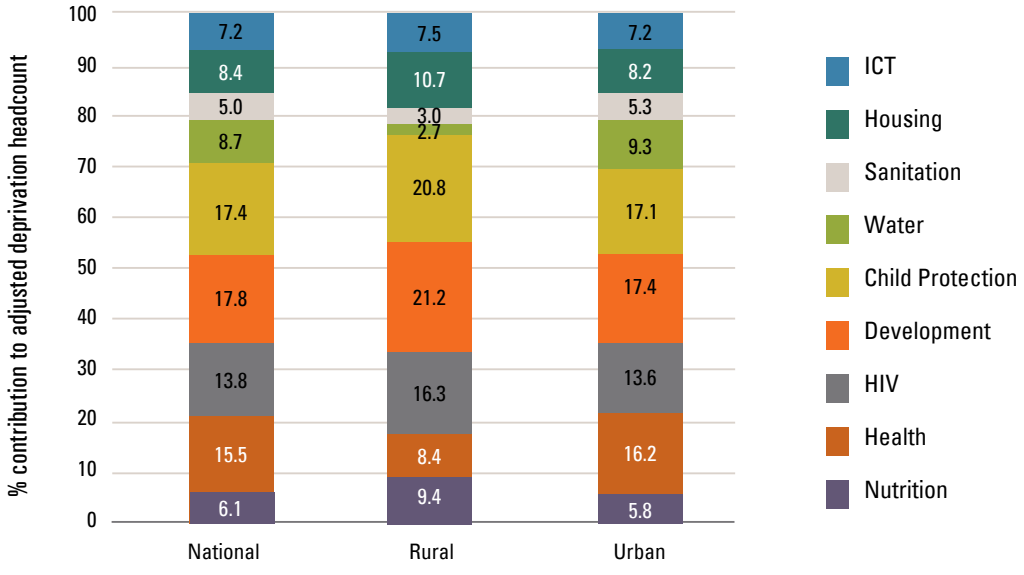
Figure 32: *Multidimensional child poverty indices at the national level, by area and by region, children aged 24-59 months deprived in at least 4 dimensions*



How does each dimension contribute to the multidimensional child poverty index?

Figure 33 decomposes **the contributing dimensions to the multidimensional child poverty index** for children aged 24-59 months at the national level and by the rural-urban location. In both rural and urban areas, the first two contributing dimensions to multidimensional child poverty are child protection (20.8 per cent and 17.1 per cent, respectively) and child development (21.2 per cent and 17.4 per cent, respectively). Other dimensions contribute differently to the level of deprivation of urban and rural children. While health contributes 16.2 per cent to the level of deprivation in urban areas, its contribution is 8.4 per cent in rural locations. Similarly, water contributes relatively more to child multidimensional deprivation in urban than in rural locations (9.3 per cent and 2.7 per cent, respectively). Conversely, nutrition contributes more to child poverty in rural than in urban areas (9.4 per cent and 5.8 per cent, respectively).

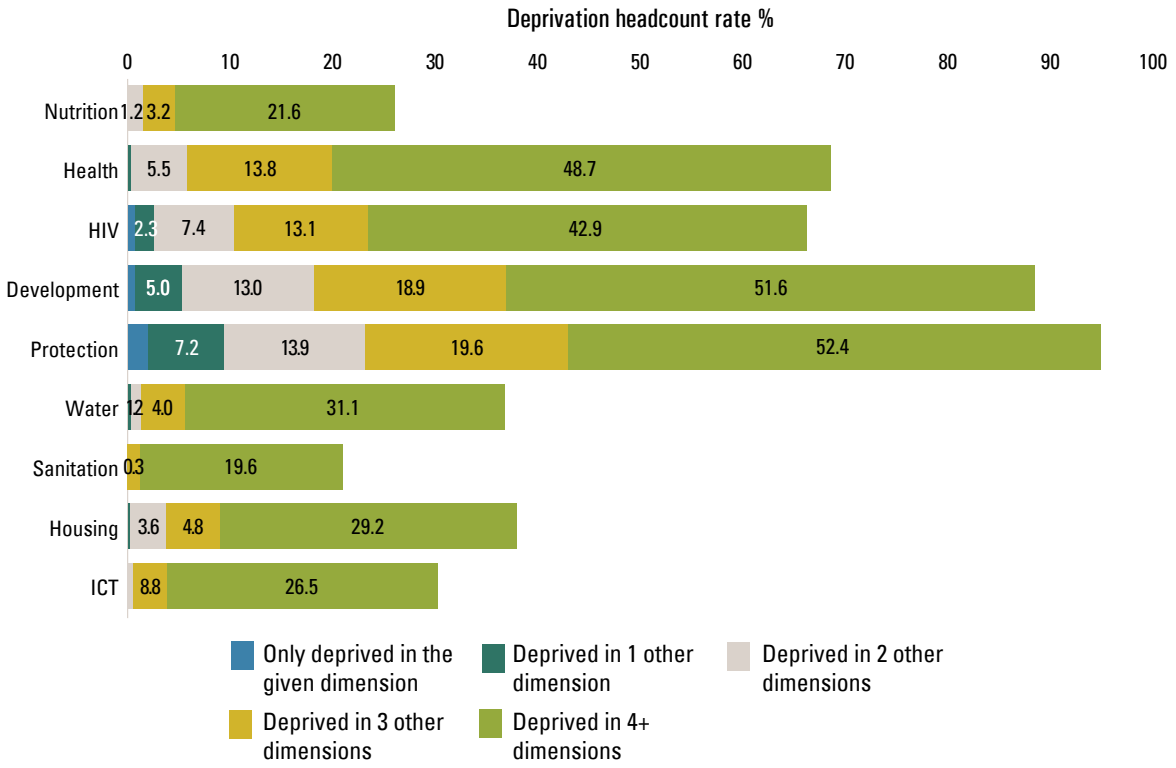
Figure 33: *Decomposition of the multidimensional child poverty index (M0), 24-59 months*



Deprivation overlap analysis

Figure 34 presents the **deprivation overlap for any given dimension in relation to all other dimensions** experienced by children in the age group 24-59 months. As observed with the younger age group, 0-23 months, only a negligible proportion of children aged 24-59 months were deprived in only the given dimension. More often than not, children deprived in a given dimension are also deprived in several other dimensions at a time. More common for children in this age group is to be deprived in the given dimension, plus in 4 or more other dimensions at a time. Ultimately, these data again support a multi-sectoral approach to tackling child poverty, rather than approaching each vulnerability separately.

Figure 34: *Deprivation overlap for each dimension, 24-59 months*



Any three dimensions can be graphically displayed in the form of **Venn diagrams** to show the overlap combination in a given age group. Figure 35 shows an example of the deprivation overlap of three dimensions of interest, namely HIV/AIDS, child protection and child development, for children aged 24-59 months at the national level. While a large majority of children are deprived in the HIV/AIDS (66.2 per cent), child protection (95.1 per cent) and child development (88.7 per cent) dimensions, a very low proportion of children are deprived in HIV/AIDS only (1.1 per cent), child protection only (4.2 per cent) and child development only (0.9 per cent). Instead, a majority of children aged 24-59 months (57.2 per cent) are simultaneously deprived in all three dimensions of well-being. A large share of children (28.2 per cent) are simultaneously deprived in child development and child protection whereas only 2.4 per cent are deprived in HIV/AIDS and child development. In addition, 5.5 per cent of children are deprived in HIV/AIDS and child protection. From these data, one can conclude that the overlap in the three dimensions and the overlap between child development and child protection are emergency areas to address child vulnerability.

The results disaggregated by urban and rural areas show different overlaps in the two types of locations (Figures 36 and 37). In rural areas, the deprivation overlap in the three dimensions is much more than in

urban areas (66.4 per cent and 38.5 per cent, respectively). A higher proportion of children also tend to be deprived in only one given dimension or in the overlap between any two dimensions in urban areas. In both urban and rural areas, the highest overlap of two dimensions is between child protection and child development (33.4 per cent and 26.8 per cent, respectively).

Data on the deprivation overlap of any three dimensions for children aged 24-59 months are available in Annex 2.

Figure 35: *Deprivation overlap between the dimensions HIV/AIDS, child protection and child development at the national level, 24-59 months*

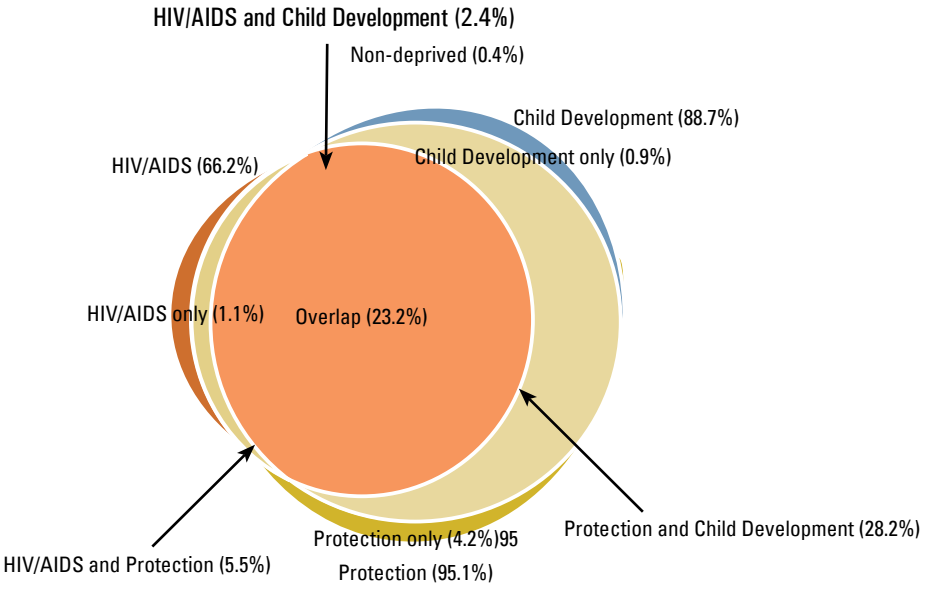


Figure 36: *Deprivation overlap between the dimensions HIV/AIDS, child protection and child development in rural areas, 24-59 months*

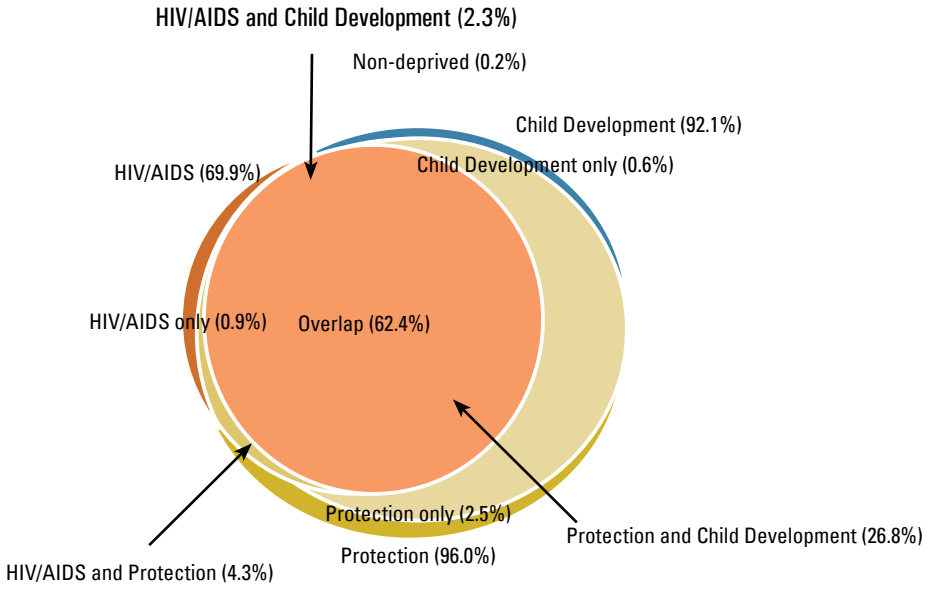
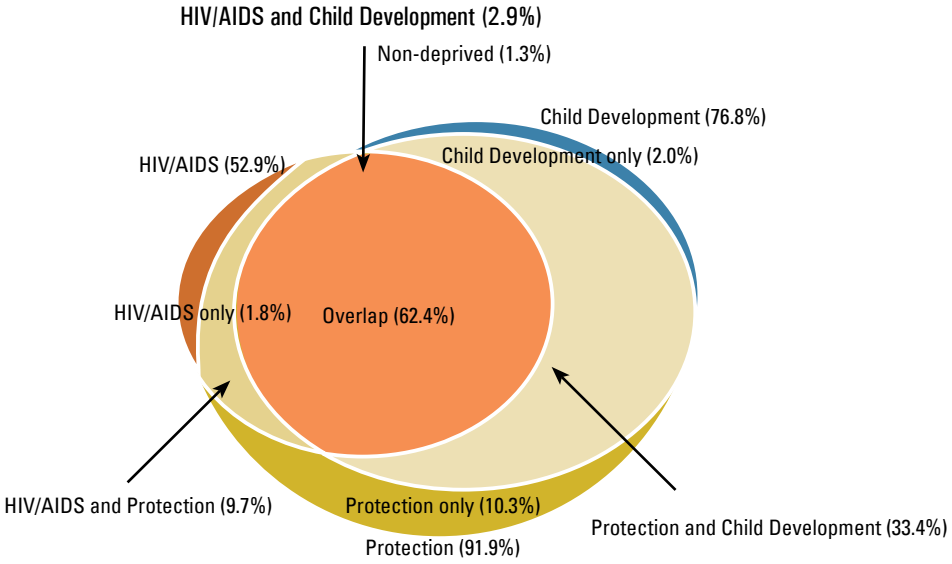


Figure 37: *Deprivation overlap between the dimensions HIV/AIDS, child protection and child development in urban areas, 24-59 months*



3.2.3 CHILDREN AGED 5-14 YEARS

For children aged 5-14 years, nine dimensions are used to measure their well-being, notably education, health, HIV/AIDS, clothing, child protection, water, sanitation, housing and ICT. A child aged 5-14 years is considered multidimensionally poor if she/he is deprived in at least 4 of those dimensions. The main trends observed in child poverty for children in this age group are shown in Box 3.

Box 3: *Main trends observed for the multidimensional poverty analysis for children aged 5-14 years*

MAIN TRENDS FOR CHILDREN AGED 5-14 YEARS

- 52.6% of children aged 5-14 years are multidimensionally poor.
- Children living in rural areas have higher deprivation rates in all dimensions and they also experience a higher number of simultaneous deprivations than urban children.
- A higher education level of the household head and mother indicates less deprivation for children.
- The multidimensionally poor children have on average 5.1 deprivations out of a total of 9 dimensions.
- The highest overlap between three dimensions can be found for the combination of health, HIV/AIDS and child protection.
- At the national level, the dimensions of health, child protection and HIV/AIDS contribute most to the multidimensional child poverty index (18.4%, 16.7% and 16.1% respectively).

Single deprivation analysis

The deprivation headcount rates for the dimensions of well-being and their indicators for children aged 5-14 years are presented in Figure 38 and Figure 39 respectively. Out of nine dimensions of well-being, the highest deprivation rates are observed for child protection, health and HIV/AIDS (Figure 38).

Figure 38: *Deprivation headcount ratio (%) by dimension at the national level, 5-14 years*

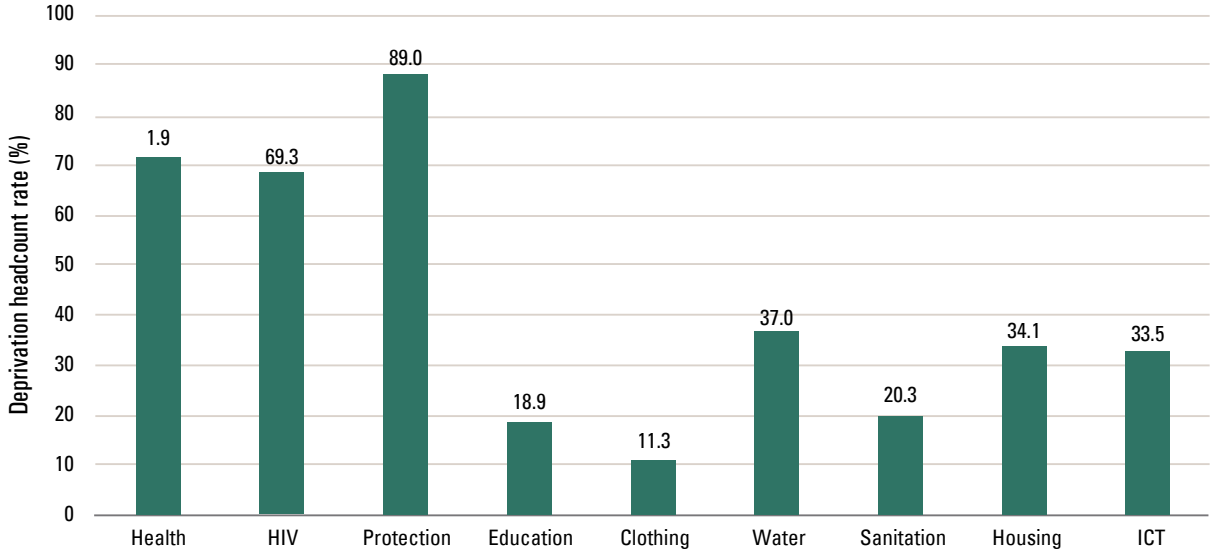
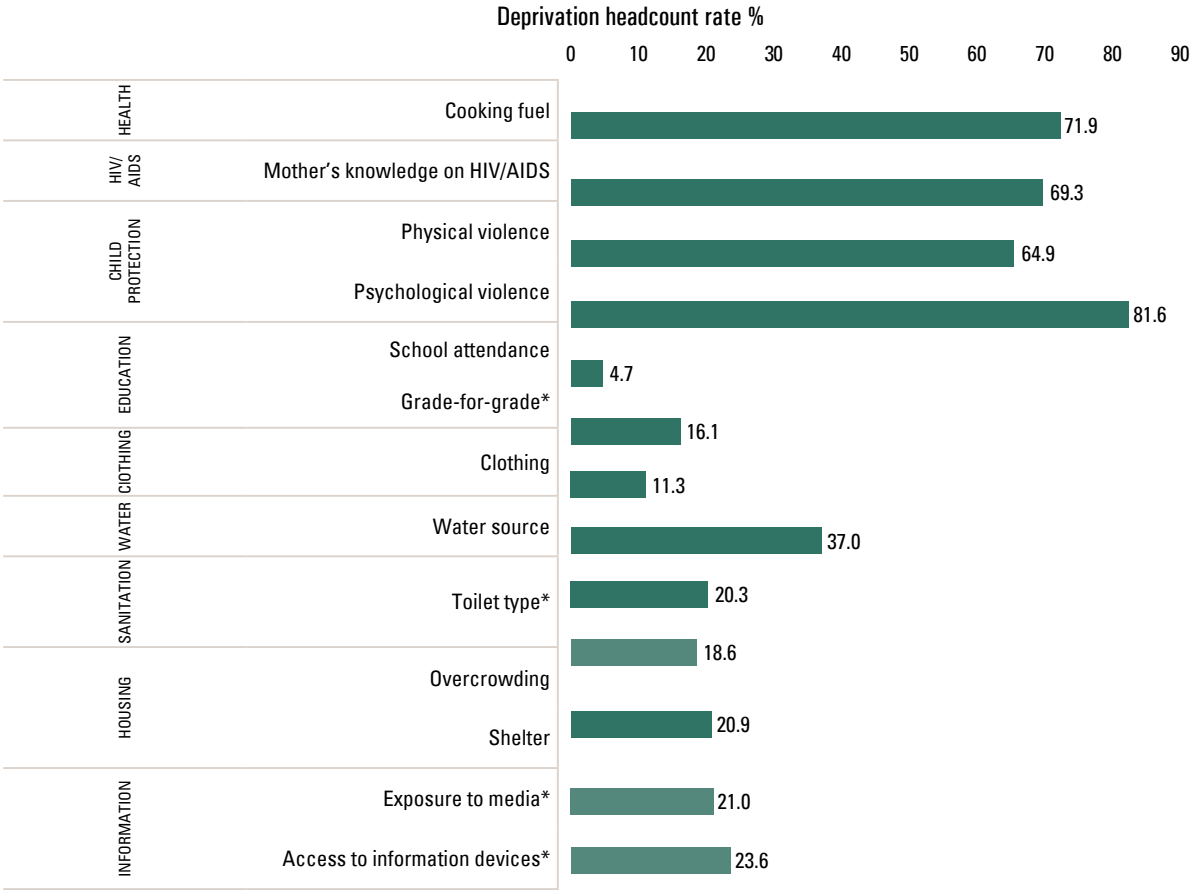


Figure 39: *Deprivation headcount ratio (%) by each indicator at the national level, 5-14 years*



Deprivation rates by child protection

Nine out of ten children aged 5-14 years are deprived in **child protection**. This dimension is measured by two indicators, namely *physical violence* and *psychological violence*. Around 8 out of 10 children come into contact with psychological violence in their households whereas 64.9 per cent of children are exposed to physical violence.

Deprivation rates by health

The dimension of **health** was measured by the use of unimproved cooking fuel (coal/lignite; charcoal; wood; straw/shrubs/grass; animal dung; kerosene/paraffin) and shows a deprivation rate of 71.9 per cent.

Deprivation rates by HIV/AIDS

The **HIV/AIDS** dimension is measured by the caretaker's knowledge of the disease and affects 69.3 per cent of children in this age group.

Deprivation rates by education

Education is measured by s*chool attendance* and *grade-for-age*. Only a small fraction of children aged 5-14 years (4.7 per cent) are deprived in *school attendance*, that is they do not attend school. Primary school education is compulsory and free, and the attendance of children of primary school-age is generally enforced. While most children of primary school-age attend school, 16 per cent lag two or more years behind in education (the indicator of *grade-for-age*).

Deprivation rates by clothing

Relatively few children face deprivation in the dimension **clothing**. Approximately 11 per cent of children aged 5-14 years do not have access to at least one pair of shoes and two sets of clothing.

Deprivation rates by water

The dimension of **water** is measured by w*ater source* and indicates that 37.0 per cent of children do not have access to improved drinking water sources.

Deprivation rates by sanitation

Sanitation consists of the indicator *toilet type*. One fifth of children live in households using unimproved toilet facilities (20.1 per cent).

Deprivation rates by housing

The **housing** dimension has a deprivation rate of 34.1 per cent and is measured by *overcrowding* (18.6 per cent) and by *shelter* (20.9 per cent).

Deprivation rates by ICT

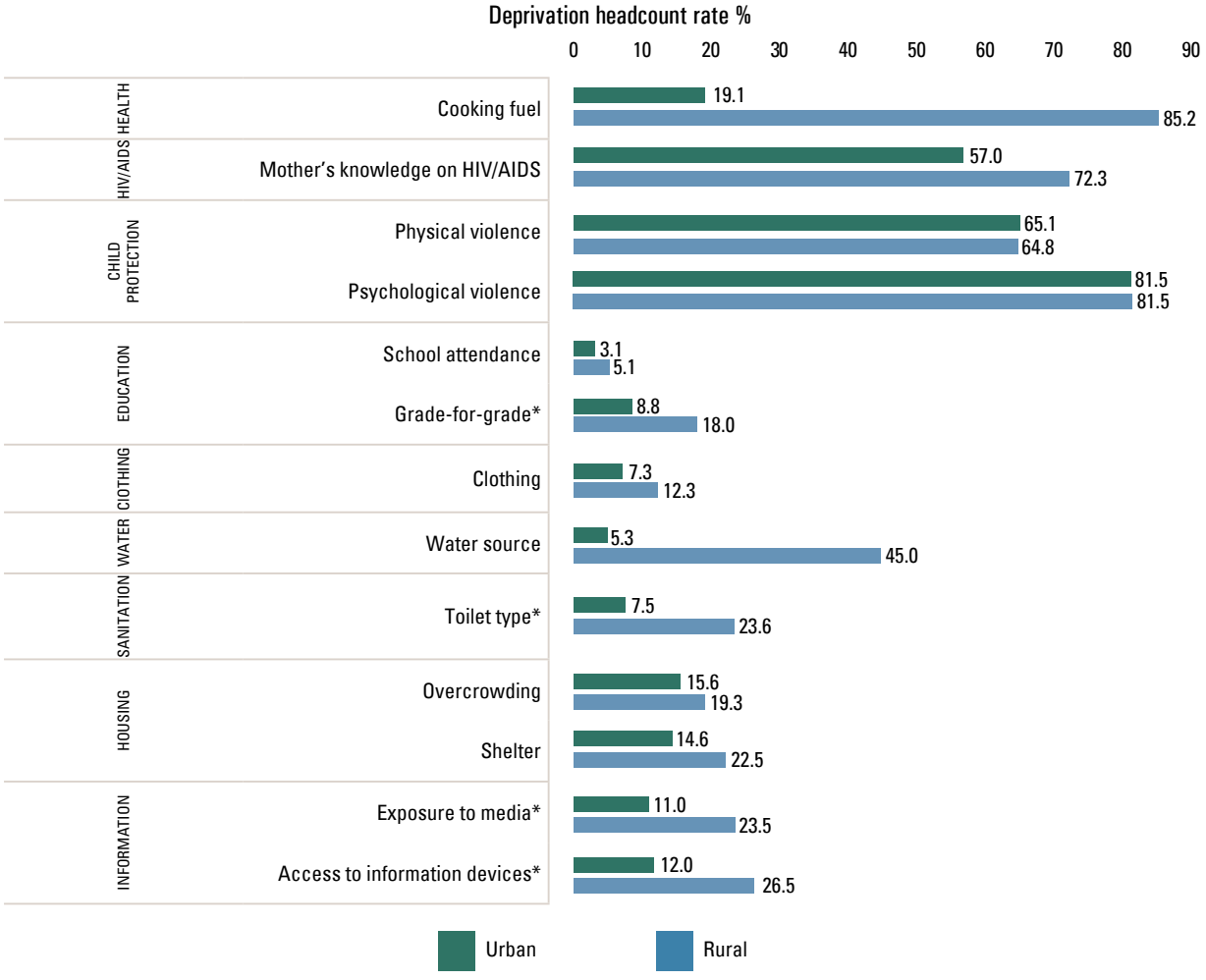
Finally, the dimension related to **ICT** holds a deprivation rate of 33.5 per cent among children aged 5-14 years. The dimension is composed of two indicators: *exposure to media* (21.0 per cent), and *access to information devices* (23.6 per cent).

Profiling the deprived children aged 5-14 years

Deprivation rates by area of residence

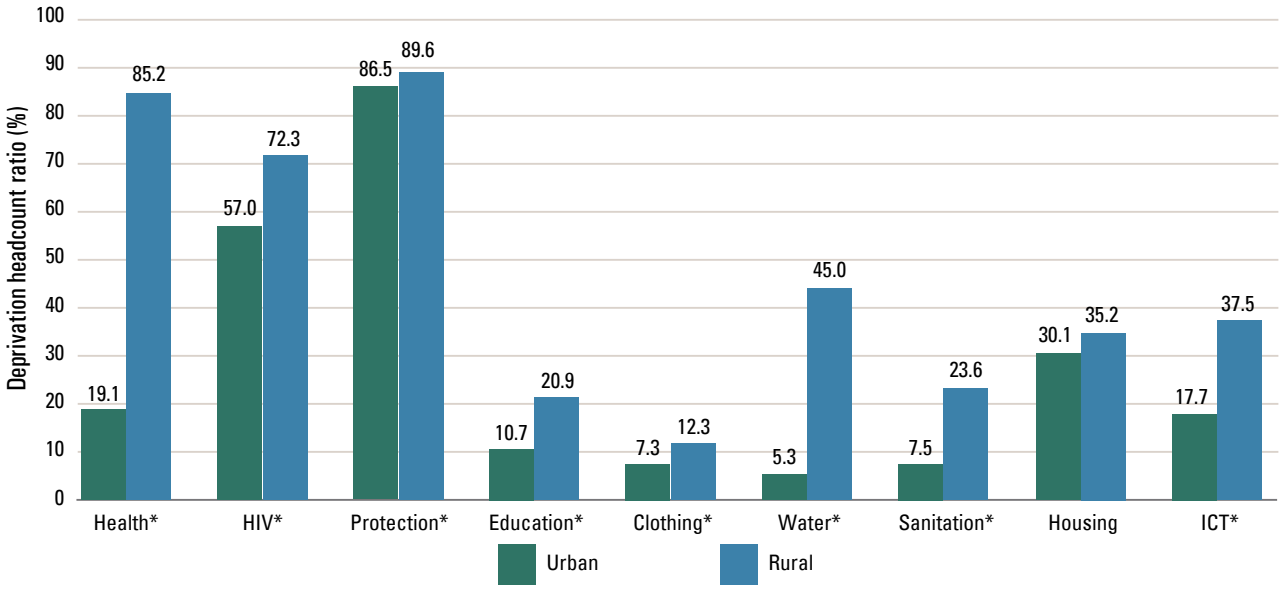
This section presents data on child deprivations according to a number of profiling indicators. Figure 40 presents the deprivation rates of children aged 5-14 years per dimensions and indicators by the area of residence. Similar to previous age groups, children living in rural areas are doing considerably worse in all dimensions compared to children living in urban areas. The largest distinction can be observed in the health dimension, where 85.2 per cent of children in rural areas are deprived compared to 19.1 per cent of urban children. Additionally, the dimension of water shows a difference of nearly 40 percentage points between urban and rural children (5.3 per cent and 45.0 per cent, respectively).

Figure 40: *Deprivation headcount ratio (%) by each indicator and area of residence, 5-14 years*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Figure 41: *Deprivation headcount ratio (%) by dimension and area of residence, 5-14 years*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by region

Table 8 shows the deprivation rate by dimension for each of the four regions of the country. It can be observed that children living in Manzini are generally doing better, in relative terms. A large majority of children are deprived in child protection across all regions. Of all regions, Lubombo shows the highest deprivation rates in the dimensions of education, clothing, housing and ICT (23.4 per cent, 22.3 per cent, 34.1 per cent and 41.3 per cent respectively). On the other hand, children living in Shiselwini have the highest deprivation rates in health, HIV/AIDS, child protection and water.

Table 8: *Deprivation headcount ratio (%) by dimension and region, 5-14 years*

	HEALTH*	HIV*	PROTECTION	EDUCATION*	CLOTHING*	WATER*	SANITATION*	HOUSING*	ICT*
Lubombo	77.4	67.4	87.7	23.4	22.3	48.1	34.1	46.0	41.3
Shiselweni	87.5	80.0	91.9	16.6	11.0	53.4	21.8	37.3	38.6
Manzini	58.6	66.2	88.8	17.5	10.0	26.4	10.0	24.0	26.5
Hhohho	73.6	66.8	87.9	18.6	3.6	29.2	21.7	35.5	32.5

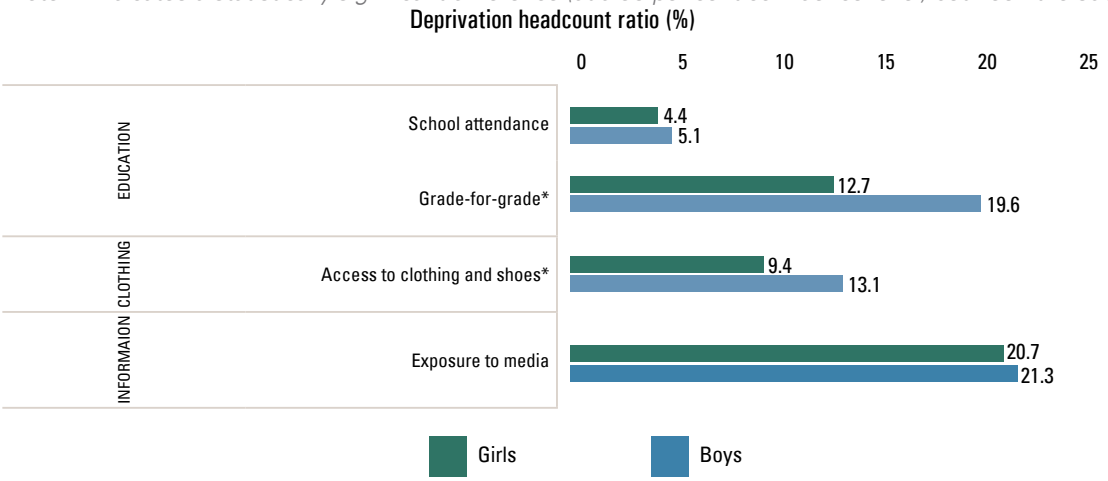
*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by gender

Profiling child deprivation by gender (Figure 42) shows that girls are doing better overall than boys in the measurements of education, clothing and ICT. Although boys and girls have almost equal rates of deprivation in school attendance, more boys lag behind in school by two or more years (19.6 per cent) compared to girls (12.7 per cent). Furthermore, 9.4 per cent of girls do not have access to a minimum of one pair of shoes and two pairs of clothing compared to 13.1 per cent of boys.

Figure 42: *Deprivation headcount ratio (%) by each indicator and sex of the child, 5-14 years*

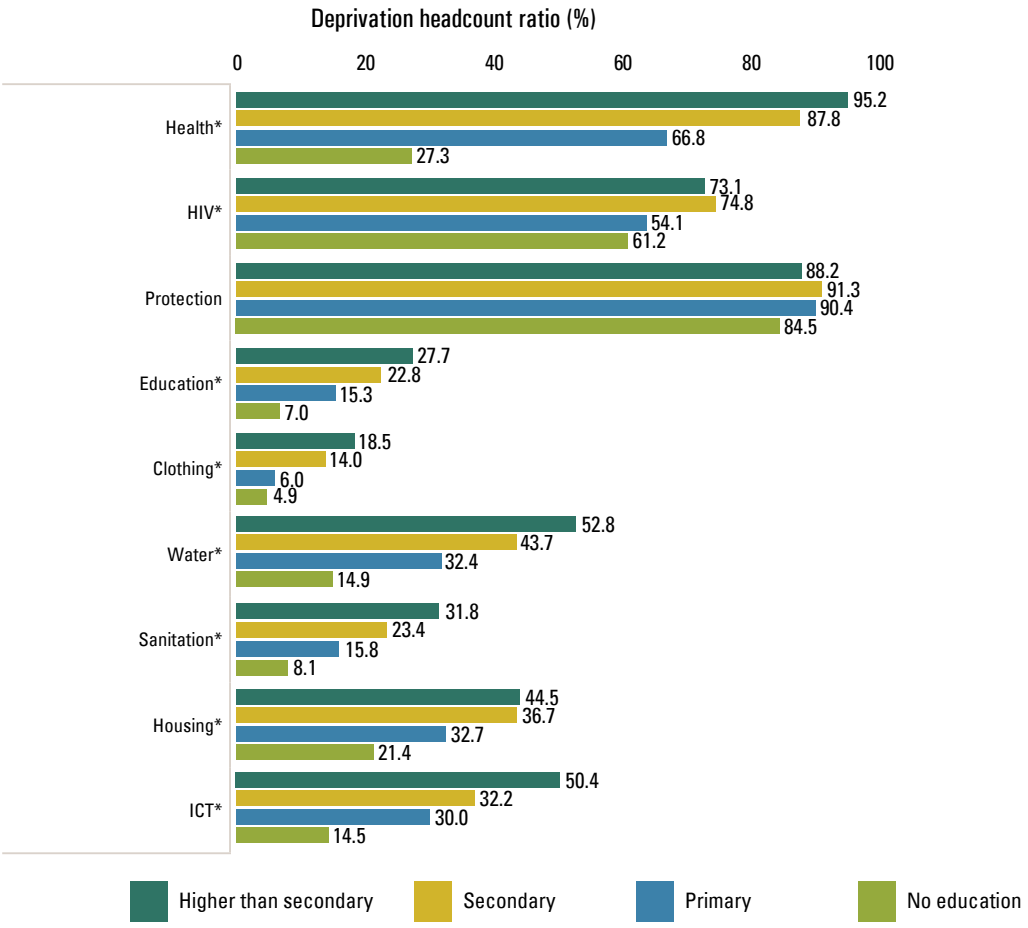
*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*



Deprivation rates by education of the household head and mother

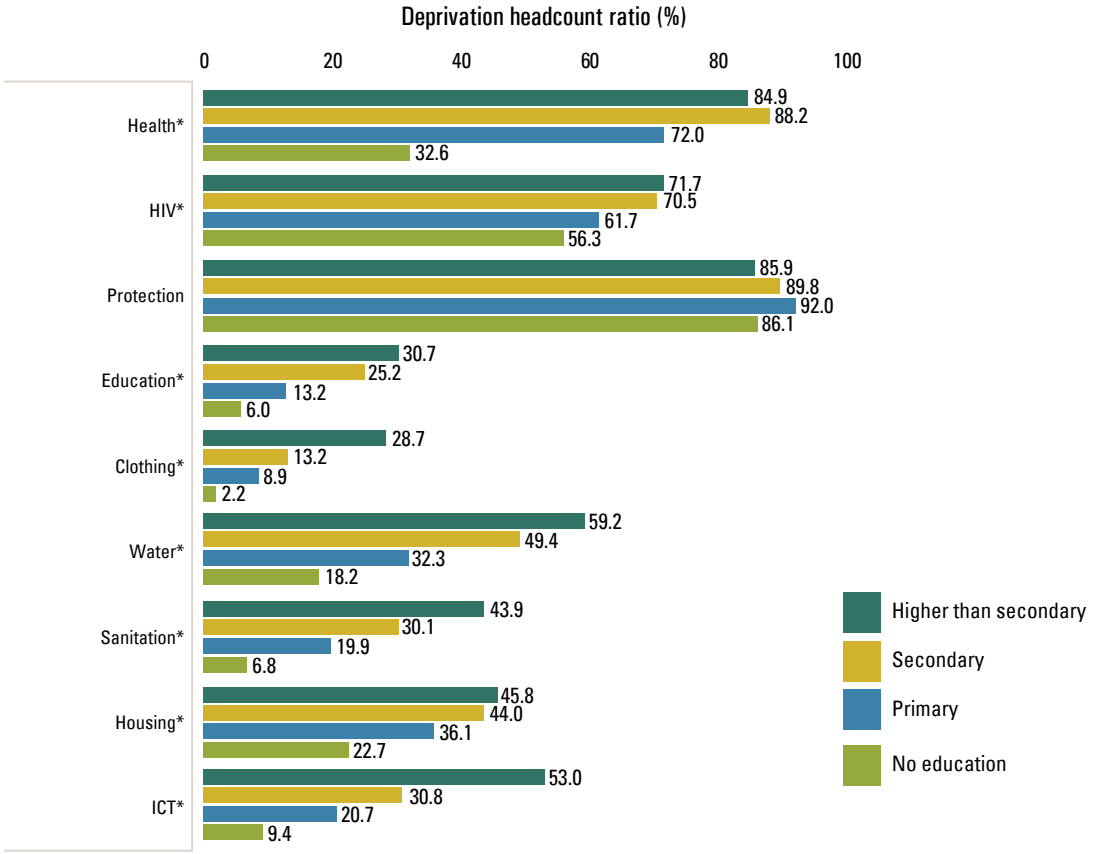
The deprivation rates by the level of education of the household head and the child's mother are presented in Figure 43 and Figure 44, respectively. Data show a direct relation between the education level of adults and children's deprivation rates. Specifically, children have on average lower levels of deprivation in all dimensions when the education level of adults is higher. This is especially visible in dimensions such as health, education, clothing, sanitation, water, housing and ICT (Figure 43 and Figure 44). Despite its potential to provide knowledge, the education of adults does not seem to significantly reduce the deprivation of children in child protection and HIV/AIDS. These results mirror those found for the younger age groups.

Figure 43: *Deprivation headcount ratio (%) by dimension and education level of the household head, 5-14 years*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Figure 44: *Deprivation headcount ratio (%) by dimension and education level of the mother, 5-14 years*

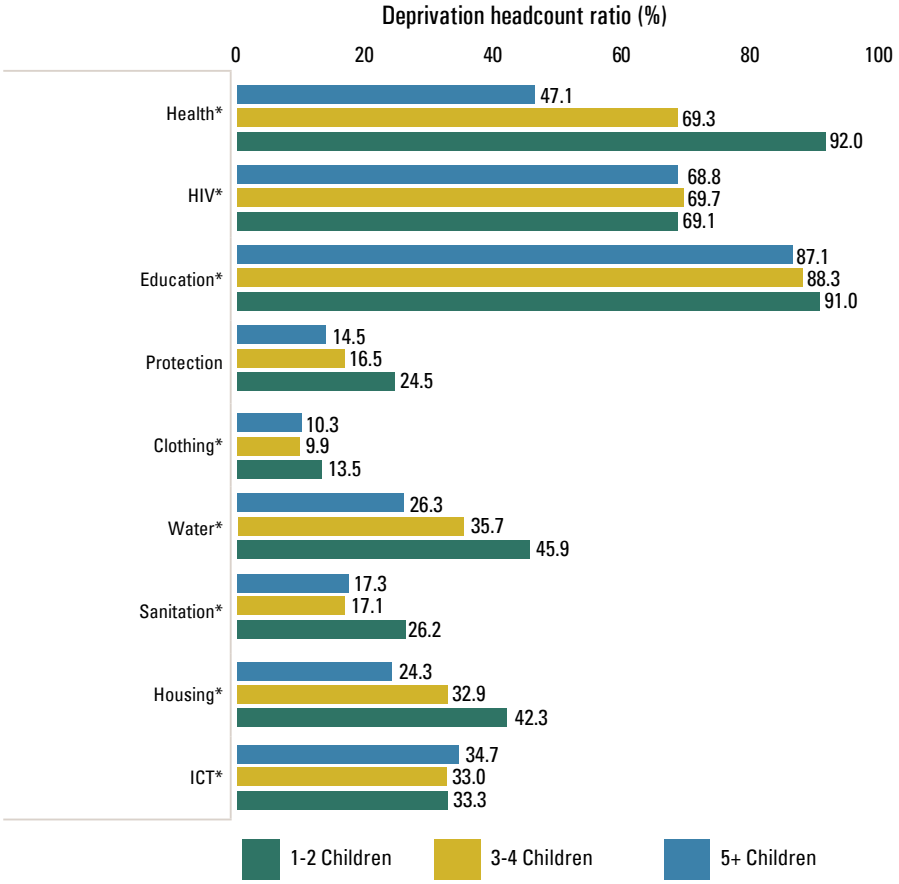


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by number of children in the household

Figure 45 shows the deprivation rates by dimensions and indicators in relation to the number of children living in the household. Children living with fewer other children are doing slightly better than children living in households with 5 or more children. For example, nearly all children (92.0 per cent) living in households with 5 or more children are deprived in health, whereas this is the case for 47.1 per cent of children living in households with 1-2 children. The number of children in the household seems to have little impact on the deprivation rates of children in the dimensions of HIV/AIDS, child protection, clothing and ICT.

Figure 45: *Deprivation headcount ratio (%) by dimension and number of children in the household, 5-14 years*

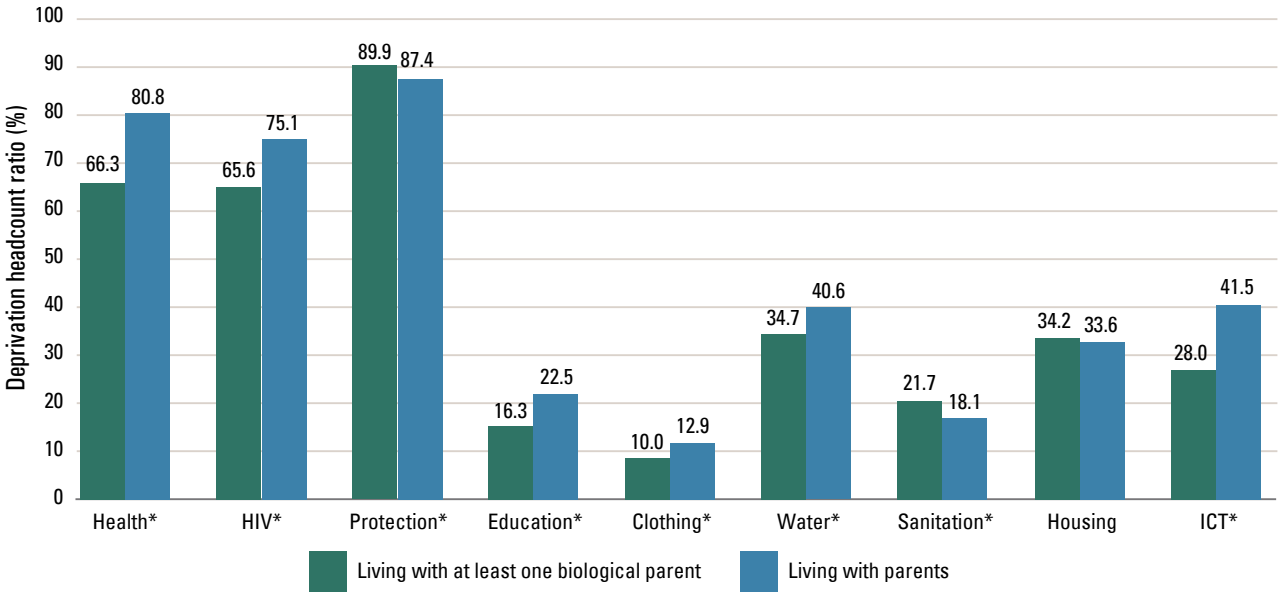


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by orphanhood

Figure 46 shows the deprivation rates by dimensions and **orphanhood** for children aged 5-14 years. Orphans experience on average higher deprivation rates than children living with at least one biological parent. The differences observed are most prominent for the dimensions of health, ICT and HIV/AIDS. Around 80.8 per cent of orphans are deprived in health compared to 66.3 per cent of children living with at least one biological parent. Importantly however, orphan children aged 5-14 years have lower deprivation rates in sanitation and housing, and rather similar rates in clothing, compared to their non-orphan counterparts. It shows that under certain conditions, orphan children are provided with resources to match the well-being of children living with at least one biological parent.

Figure 46: *Deprivation headcount ratio (%) by dimension and orphan status, 5-14 years*



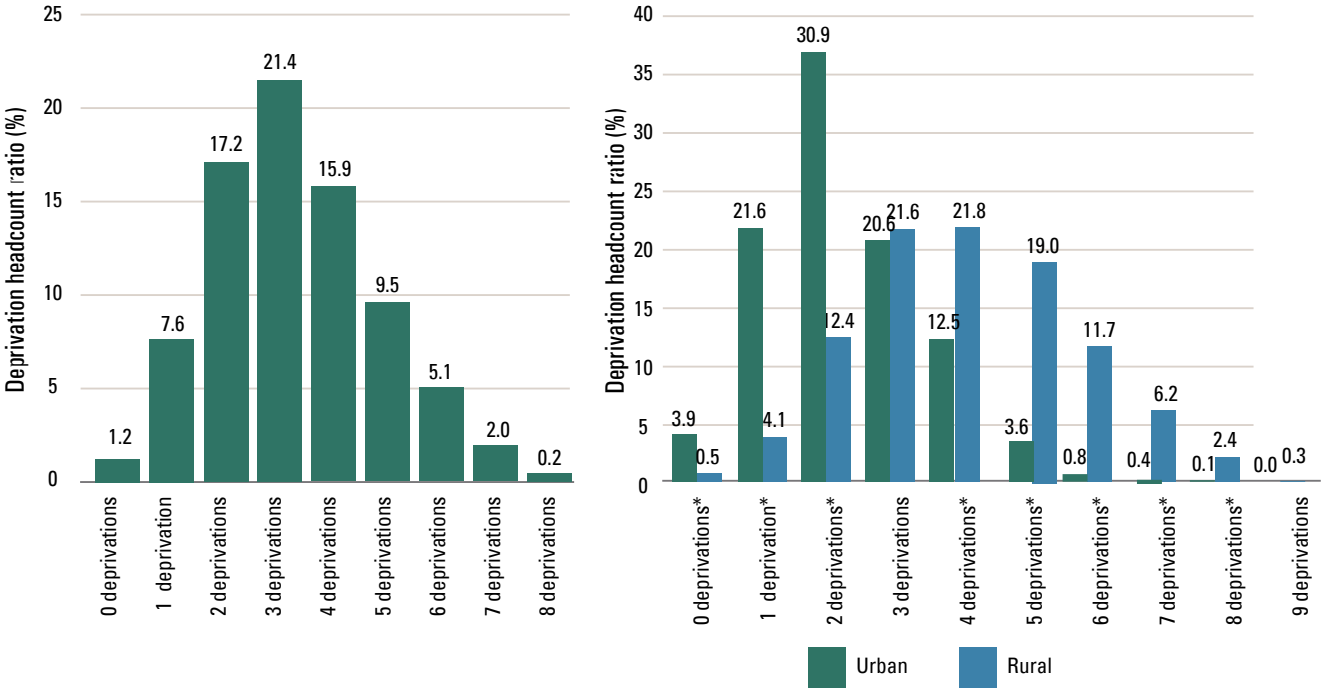
*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Multidimensional deprivation analysis

Number of deprivations by area of residence

Figure 47 shows the multidimensional deprivation headcount ratio for children aged 5-14 years. The majority of children in this age group face 3, 4 or 5 deprivations at a time out of a total of 9 dimensions (57.3 per cent). Moreover, only 1.2 per cent of all children aged 5-14 years are not deprived in any of the dimensions. When disaggregating the distribution of deprivations by area of residence, it is observed that rural children experience more simultaneous deprivations than urban children. The deprivation distribution for urban children is more skewed to the left with a large majority of children facing 1-3 deprivations at a time. By contrast, the distribution of deprivations among rural children is skewed to the right with a large proportion of children (64.2 per cent) experiencing 3-5 simultaneous deprivations.

Figure 47: *Number of simultaneous deprivations experienced by children aged 5-14 years at the national level and by area of residence*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Number of deprivations by region

At the regional level, children aged 5-14 years who reside in Manzini are doing better, in relative terms, with regard to multidimensional poverty (Table 9). Manzini has the highest proportion of children experiencing 0 or 1 deprivation (13.2 per cent) and the lowest proportion of children facing 6 or more simultaneous deprivations (8.6 per cent). On the contrary, nearly 3 out of 10 children living in Lubombo are deprived in at least 6 dimensions (29.4 per cent). In addition, Shiselweni has a relatively high proportion of children facing 6-9 deprivations at a time (22.7 per cent).

Table 9: *Number of simultaneous deprivations experienced by children aged 5-14 years by region*

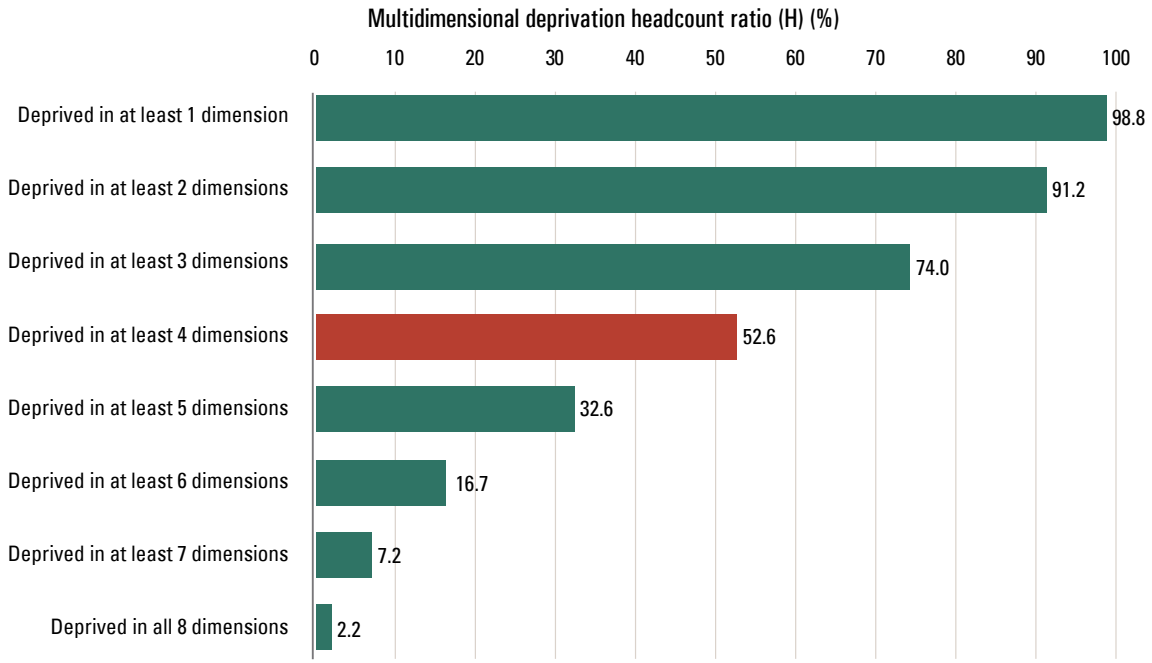
	NUMBER OF SIMULTANEOUS DEPRIVATION EXPERIENCED BY THE CHILD									
	0	1*	2*	3	4*	5*	6*	7*	8*	9*
Lubombo	0.7	3.6	12.5	19.3	18.5	16.1	14.2	9.4	5.4	0.4
Shiselweni	0.5	3.4	7.6	21.0	25.9	18.8	12.7	7.0	2.5	0.5
Manzini	1.7	11.5	24.7	23.7	17.0	12.9	5.8	2.5	0.2	0.1
Hhohho	1.3	8.9	18.5	20.4	20.8	17.6	8.2	3.4	0.9	0.1

*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Multidimensional deprivation indices

Figure 48 presents the multidimensional deprivation headcount ratio for children aged 5-14 years, at the national level. In the country, almost all children aged 5-14 years are deprived in at least 1 dimension (98.8 per cent). When using a threshold of K=4, 52.6 per cent of children aged 5-14 years are considered multidimensionally poor, meaning they experience at least 4 simultaneous deprivations. Less than 10 per cent of children in this age group are deprived in 7 or more dimensions. The proportion of children aged 5-14 years who are multidimensionally poor (52.6 per cent) is relatively low compared to previous age groups, 0-23 months (69.8 per cent) and 24-59 months (73.3 per cent). This may reflect the type of indicators used to measure deprivation in each age group and the fact that children build resilience as they grow older.

Figure 48: *Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 5-14 years*



The **multidimensional deprivation headcounts for each cut-off point** are presented comparatively at the national level and by rural-urban location for children aged 5-14 years (Figure 49). The deprivation rates for children in urban areas are considerably lower compared to children living in rural areas. Moreover, the distribution of deprivations for urban and rural children does not intersect across all cut-off points, meaning that rural children are consistently poorer across the number of deprivations. The trend in the distribution of deprivations for urban and rural children in this age group is similar with that of younger age groups. Overall, more than thrice as many rural children are multidimensionally poor (deprived in 4 or more dimensions at a time) compared to urban children (61.4 per cent versus 17.4 per cent). However, a fairly large proportion of children are deprived in at least 1 dimension regardless the area of residence.

Figure 49: *Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 5-14 years*

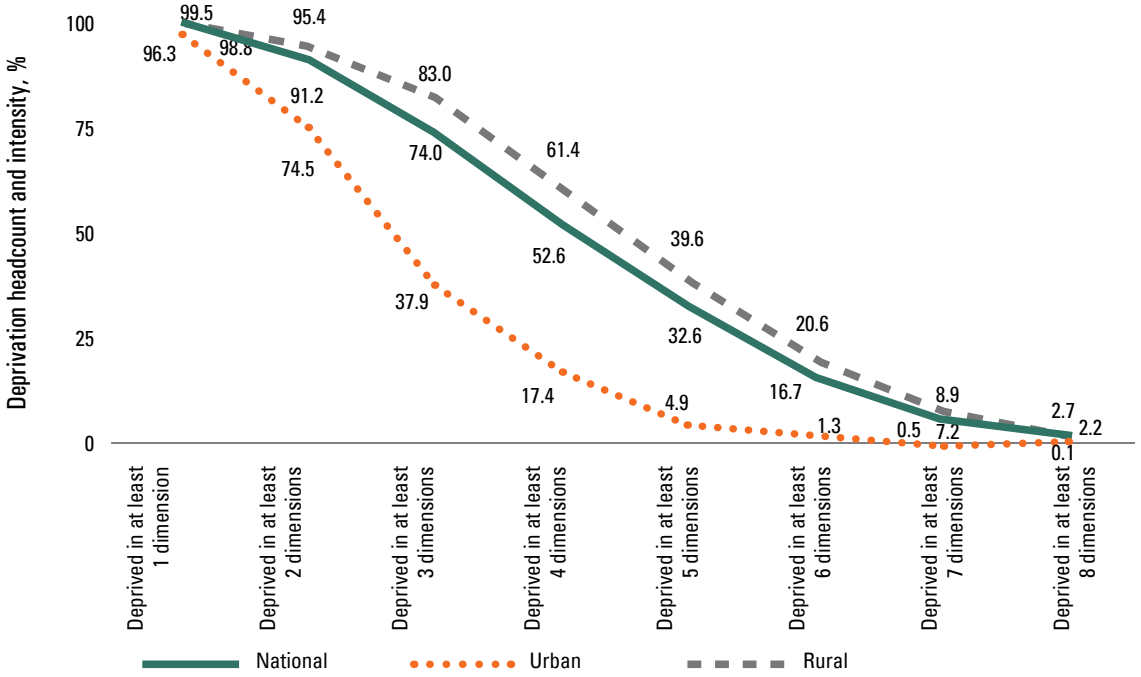
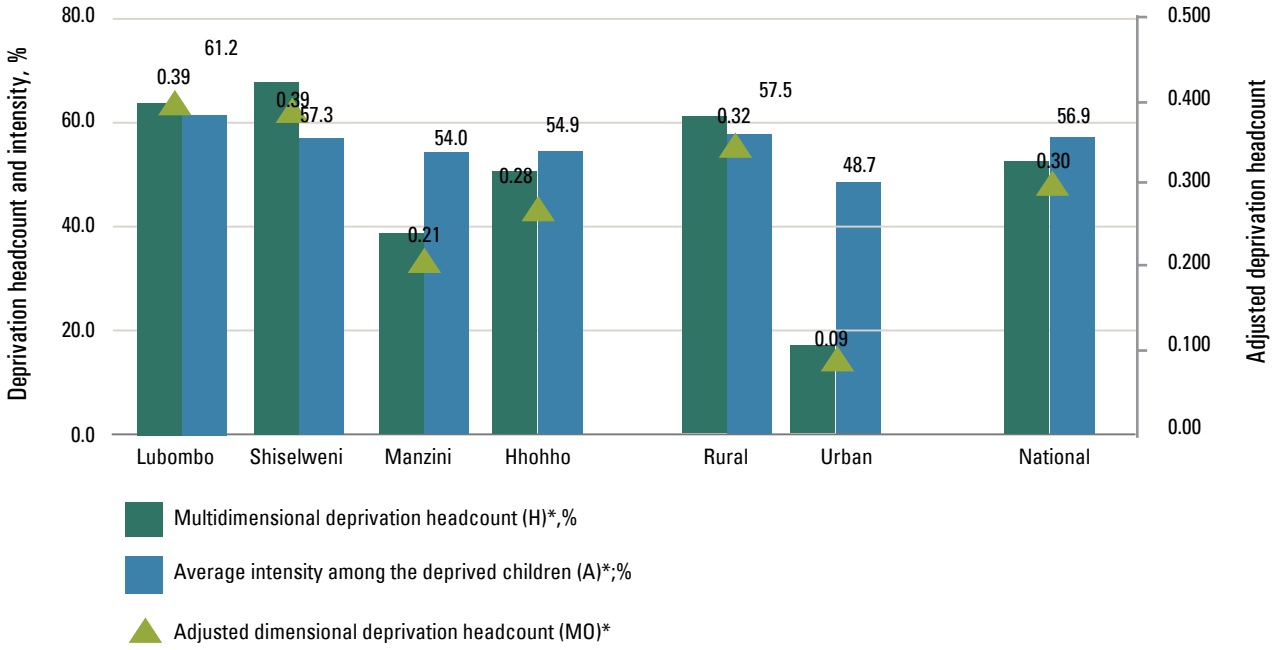


Figure 50 presents the multidimensional child poverty indices by area of residence, regions and at the national level. The intensity of deprivation (A) is the average number of dimensions that multidimensionally poor children (deprived in at least 4 dimensions) experience at a time. This value provides additional information on the depth of deprivation (i.e. how poor the poor children are). Children aged 5-14 years who are multidimensionally poor have on average 5.1 out of a total of 9 deprivations, which is 56.9 per cent of the total number of deprivations.

The multidimensional child poverty index (M0) accounts for both the multidimensional deprivation headcount (H) and average intensity of the deprived children (A). The index cannot be interpreted on its own but is used in comparative ways when looking at H and A. The higher the M0, the more vulnerable children are.

It is shown in Figure 50 that both the deprivation headcount (H) and the average intensity of deprivation (A) is higher for multidimensionally poor children living in rural areas than for those in urban areas. Children living in Manzini have the lowest deprivation headcount (H), and the lowest average intensity among the deprived children out of all regions. Subsequently, the value of M0 in Manzini is 0.21. However, the intensity (A) does not vary as much across regions compared to the actual deprivation headcount (H). It means that although the proportion of multidimensionally poor children (i.e. H) vary across regions, those who are multidimensionally poor are equally poor (i.e. A). The highest M0, on the other hand, can be observed for both Shiselweni and Lubombo (0.39). For children living in Shiselweni, the high M0 value is driven by the deprivation headcount (H) whereas for Lubombo, it is due to the average intensity of the deprived (A).

Figure 50: *Multidimensional child poverty indices at the national level, by area and by region, children aged 5-14 years deprived in at least 4 dimensions*

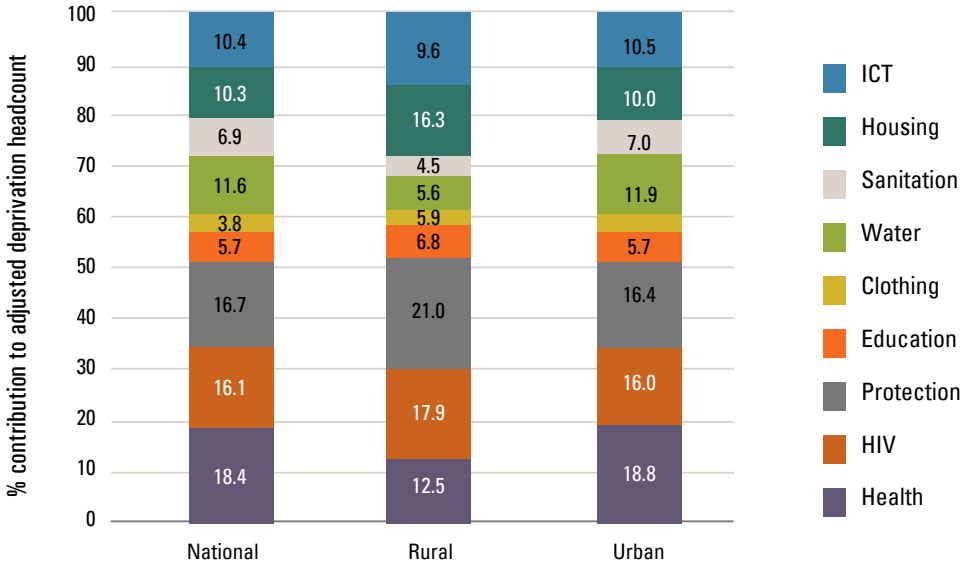


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

How does each dimension contribute to the multidimensional child poverty index?

For children aged 5-14 years, the dimensions of health, child protection and HIV/AIDS contribute most to the multidimensional child poverty index (M0) at the national level (18.4 per cent, 16.7 per cent and 16.1 per cent, respectively) (Figure 51). In rural areas, the dimension of housing seems to be more relevant for M0: it affects the index by 16.3 per cent in rural areas compared to 10.0 per cent in urban areas. Similarly, the dimension of child protection affects more rural than urban children (21.0 per cent and 16.4 per cent, respectively). On the other hand, the dimension of water has a larger contribution to M0 for urban children compared to rural children (11.9 per cent and 5.6 per cent, respectively). Similarly, the dimension of health deprives more children in urban areas than in rural locations (18.8 per cent and 12.5 per cent, respectively). These distinctions lead to 2 reflections. First, the contribution of dimensions to multidimensional child poverty is not uniform across characteristics such as rural-urban location. Second, there is a need for a multi-sectoral response in tackling child poverty as the spectrum of deprivations often comprises multiple vulnerabilities that children experience simultaneously.

Figure 51: *Decomposition of the multidimensional child poverty index (M0), 5-14 years*



Deprivation overlap analysis

Since children often experience multiple deprivations at a time, it is important to observe how each dimension of well-being overlaps with other deprivations. Figure 52 shows this overlap for children aged 5-14 years. Data show that many children deprived in any given dimension are also simultaneously deprived in 4 or more other dimensions. For example, 22.3 per cent of children deprived in **water** are additionally deprived in 4 or more other dimensions at the same time.

Figure 52: *Deprivation overlap for each dimension, 5-14 years*

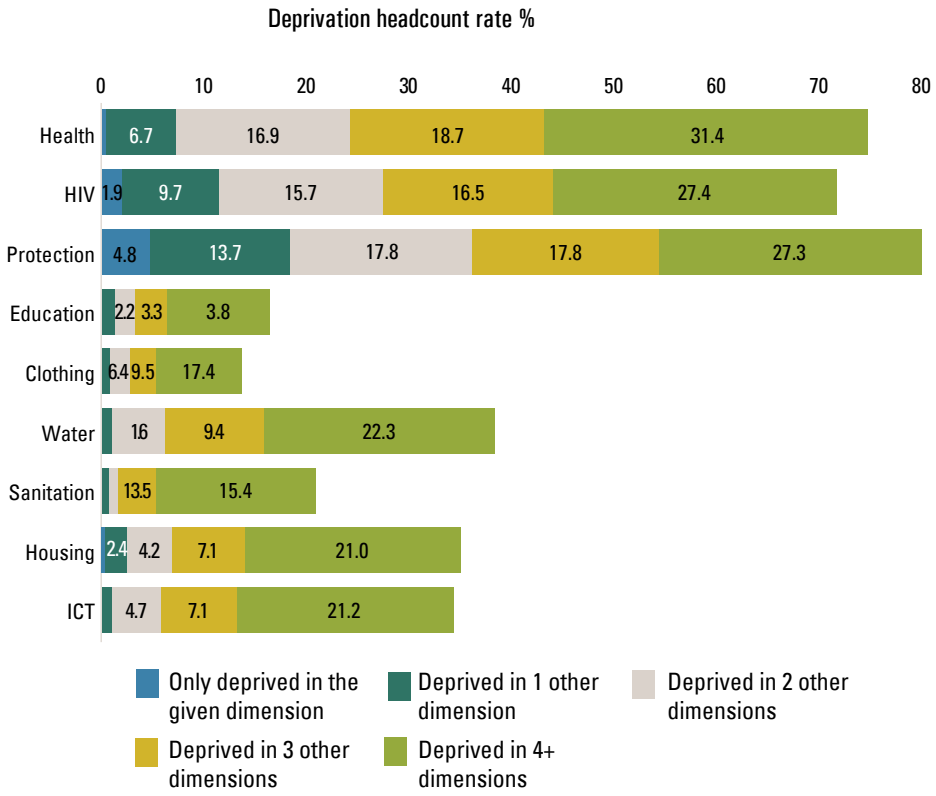


Figure 53 presents an example of deprivation overlap between the dimensions of **HIV/AIDS, child protection** and **ICT** at the national level. It is observed that one fifth (20.2 per cent) of children aged 5-14 years are simultaneously deprived in the dimensions of HIV/AIDS, child protection and ICT. Furthermore, a large proportion of children are deprived in both HIV/AIDS and child protection (33.6 per cent). Yet, only a few children in this age group are simultaneously deprived in HIV/AIDS and ICT (5.9 per cent) and child protection and ICT (6.2 per cent). Similarly, very few children are not deprived in any of the three dimensions (3.9 per cent).

When disaggregating the result by area of residence, Figure 54 indicates that 23.2 per cent of rural children are deprived in all three dimensions at a time compared to only 8.3 per cent of urban children (Figure 55). Interestingly, a similar proportion of urban and rural children are deprived in both HIV/AIDS and child protection (33.5 per cent and 33.6 per cent, respectively) and in child protection and ICT (6 per cent and 6.2 per cent, respectively). These data provide useful insights on those combinations of deprivations that affect children more severely to better target actions that reduce the levels of multidimensional child poverty.

The overlap between all possible combinations of three dimensions are included in Annex 2.

Figure 53: *Deprivation overlap between the dimensions HIV/AIDS, child protection and ICT at the national level, 5-14 years*

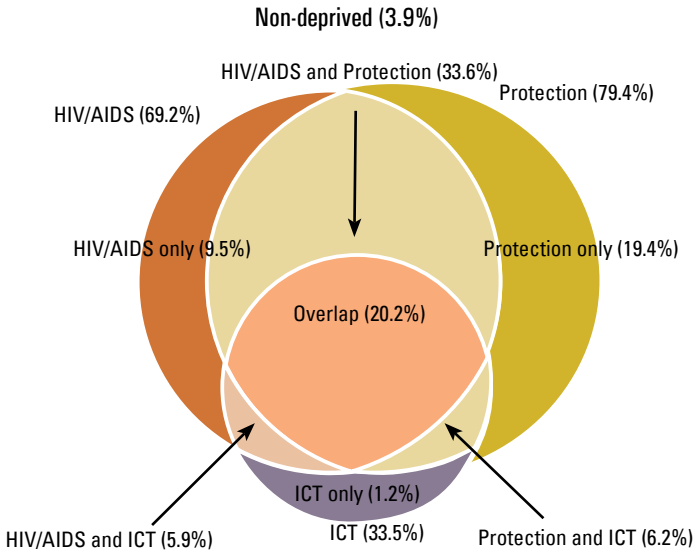


Figure 54: *Deprivation overlap between the dimensions HIV/AIDS, child protection and ICT in rural areas, 5-14 years*

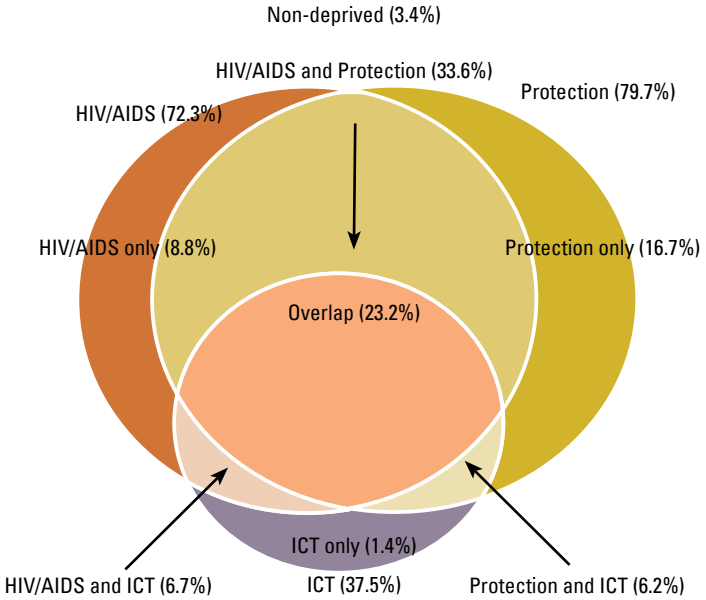
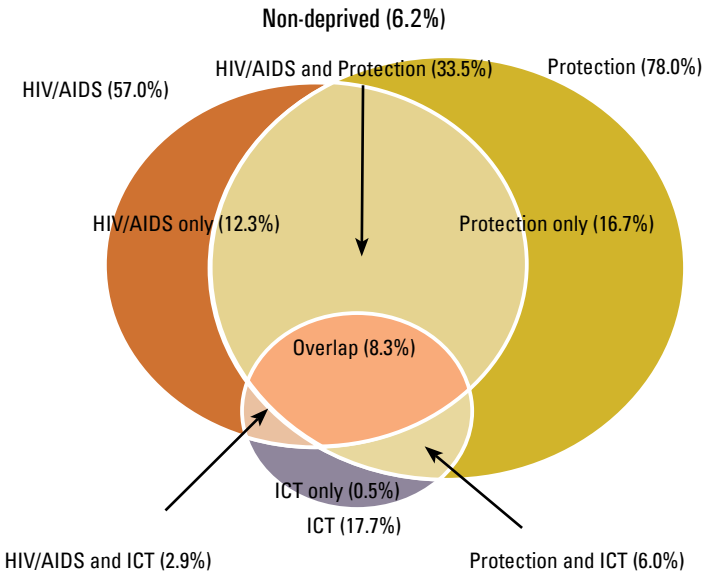


Figure 55: *Deprivation overlap between the dimensions HIV/AIDS, child protection and ICT in urban areas, 5-14 years*



3.2.4 CHILDREN AGED 15-17 YEARS

For children aged 15-17 years, eight dimensions are used to measure their well-being, notably education, health, HIV/AIDS, clothing, water, sanitation, housing and ICT. A child aged 15-17 years is considered multidimensionally poor if she/he is simultaneously deprived in 4 or more of these dimensions. The main trends observed in child poverty for children in this age group are shown in Box 4.

Box 4: *Main trends observed for the multidimensional poverty analysis for children aged 15-17 years*

MAIN TRENDS FOR CHILDREN AGED 15-17 YEARS

- 43.8% of children aged 15-17 years are multidimensionally poor.
- 96.3% of children are deprived in at least 1 dimension of well-being.
- Children living in rural areas are more vulnerable than children living in urban areas.
- More boys lag behind in school (2 years or more) compared to girls (58.8% and 46.7%, respectively).
- Children of more educated mothers are less deprived in all dimensions of well-being, except for HIV/AIDS.
- Girls who experienced a pregnancy are generally more deprived, especially in education, sanitation and housing.
- The multidimensionally poor children face on average 4.9 deprivations out of a total of 8 dimensions.
- The combination between the dimensions of health, HIV/AIDS and education show the highest overlap, with 38.0% of children simultaneously deprived in all three dimensions.
- At national level, the dimensions of health, HIV and education contribute most to the multidimensional child poverty index (19.4%, 18.0% and 16.7% respectively).

Single deprivation analysis

Figure 56 and Figure 57 show the deprivation headcount rates for dimensions and indicators, respectively, at the national level.

Figure 56: *Deprivation headcount ratio (%) by each dimension at the national level, 15-17 years*

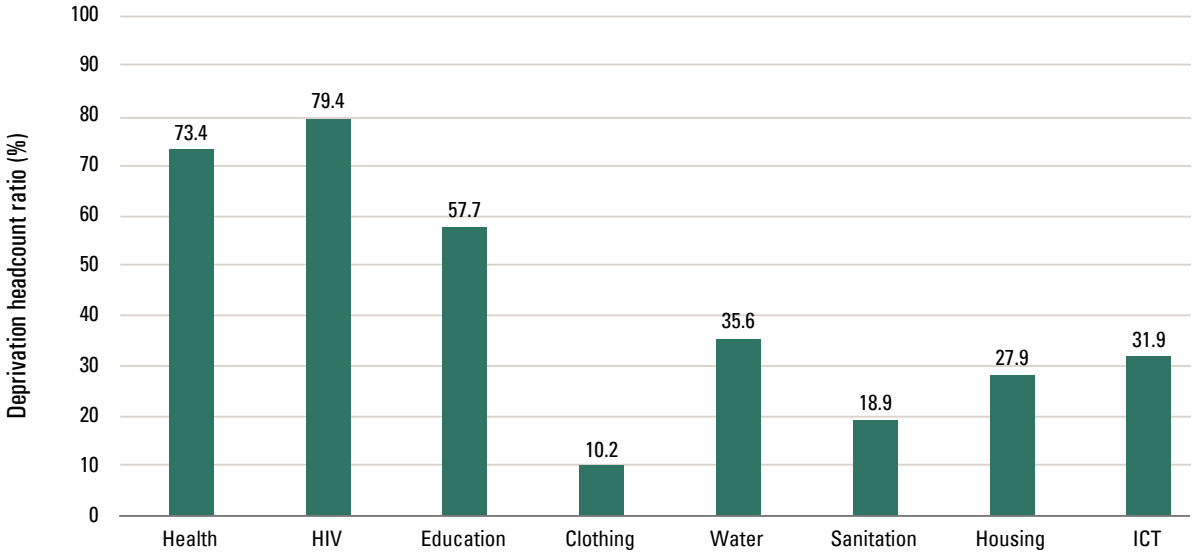
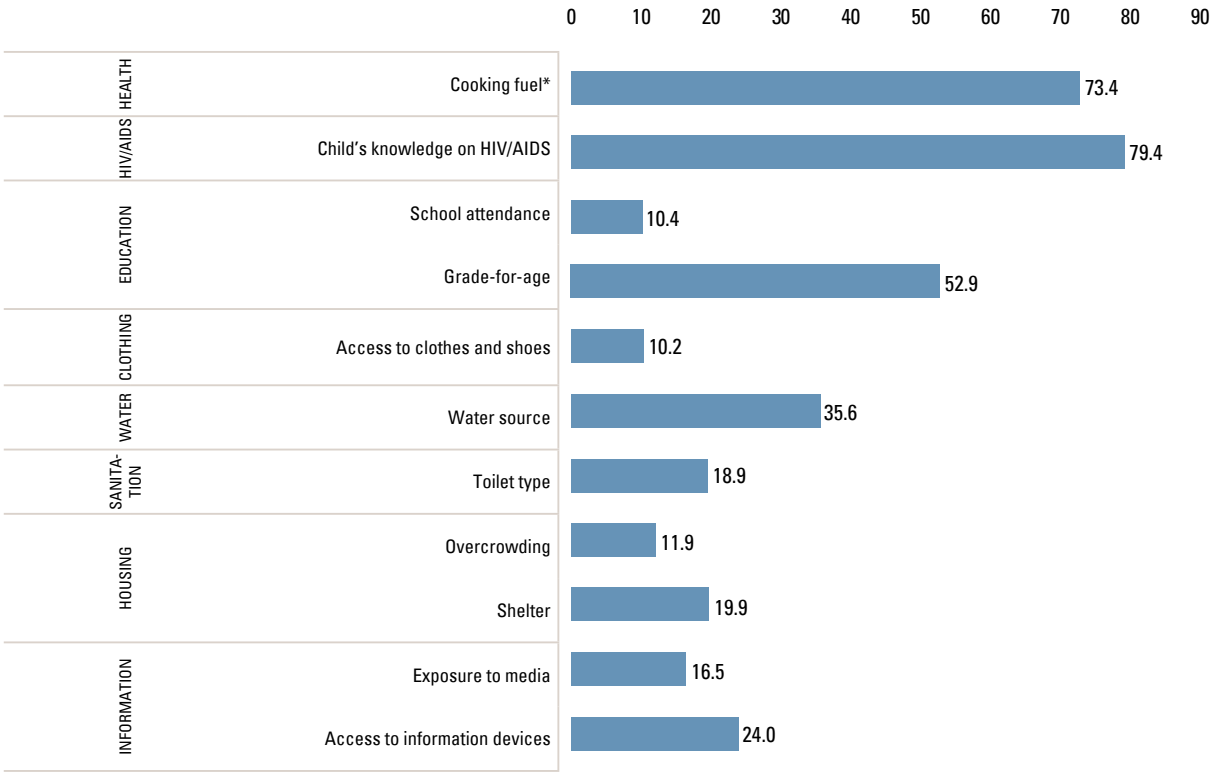


Figure 57: *Deprivation headcount ratio (%) by each indicator at national level, 15-17 years*



Deprivation rates by HIV/AIDS

Amongst all dimensions, **HIV/AIDS** shows the highest deprivation rate (79.4 per cent) for children in this age group. This dimension is measured by one indicator that shows the child's knowledge of HIV/AIDS.

Deprivation rates by health

The deprivation rate in the **health** dimension is the second highest for children aged 15-17 years and stands at 73.4 per cent. It is measured by an indicator that includes information on whether children live in a household that uses unimproved cooking fuel.

Deprivation rates by education

The deprivation rate in the **education** dimension is 57.7 per cent. It is driven by two indicators: s*chool attendance*, in which 10.4 per cent of children in this age group are deprived and g*rade-for-age* with a deprivation rate of 52.9 per cent.

Deprivation rates by water

The **water** dimension is measured by children's access to an improved drinking water source and has a deprivation rate of 35.6 per cent among children aged 15-17 years.

Deprivation rates by sanitation

The **sanitation** dimension has a deprivation rate of 18.9 per cent and reflects the proportion of children in this age group who do not have access to improved toilet facilities.

Deprivation rates by clothing

The **clothing** dimension has a deprivation rate of 10.2 per cent and shows the proportion of children aged 15-17 that cannot afford at least one pair of shoes and two sets of clothing.

Deprivation rates by housing

The **housing** dimension affects 27.9 per cent of all children aged 15-17 years. This deprivation rate is driven by o*vercrowding* (11.9 per cent), and s*helter* (19.9 per cent).

Deprivation rates by ICT

The **ICT** dimension deprives 31.9 per cent of all children aged 15-17 years. This dimension consists of two indicators: *exposure to media*, in which 16.5 per cent of children are deprived, and *access to information devices,* with a deprivation of 24.0 per cent.

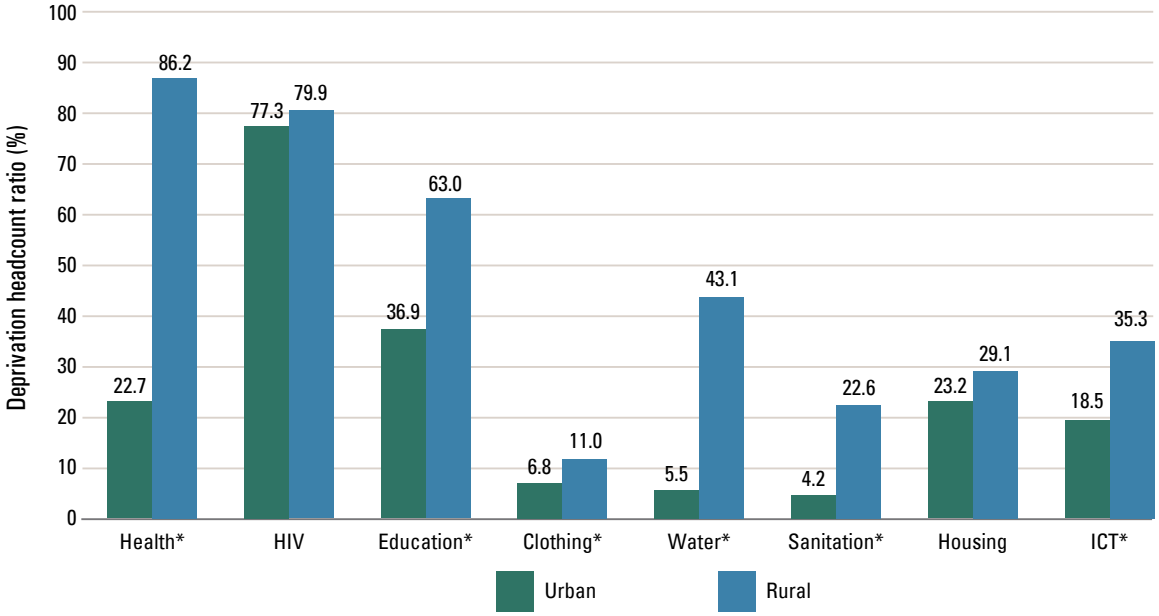
PROFILING THE DEPRIVED CHILDREN AGED 15-17 YEARS

This section profiles deprived children based on several characteristics, namely rural-urban location, region, child gender, the education level of the mother and the household head, the number of children in the household and early pregnancy.

Deprivation rates by area of residence

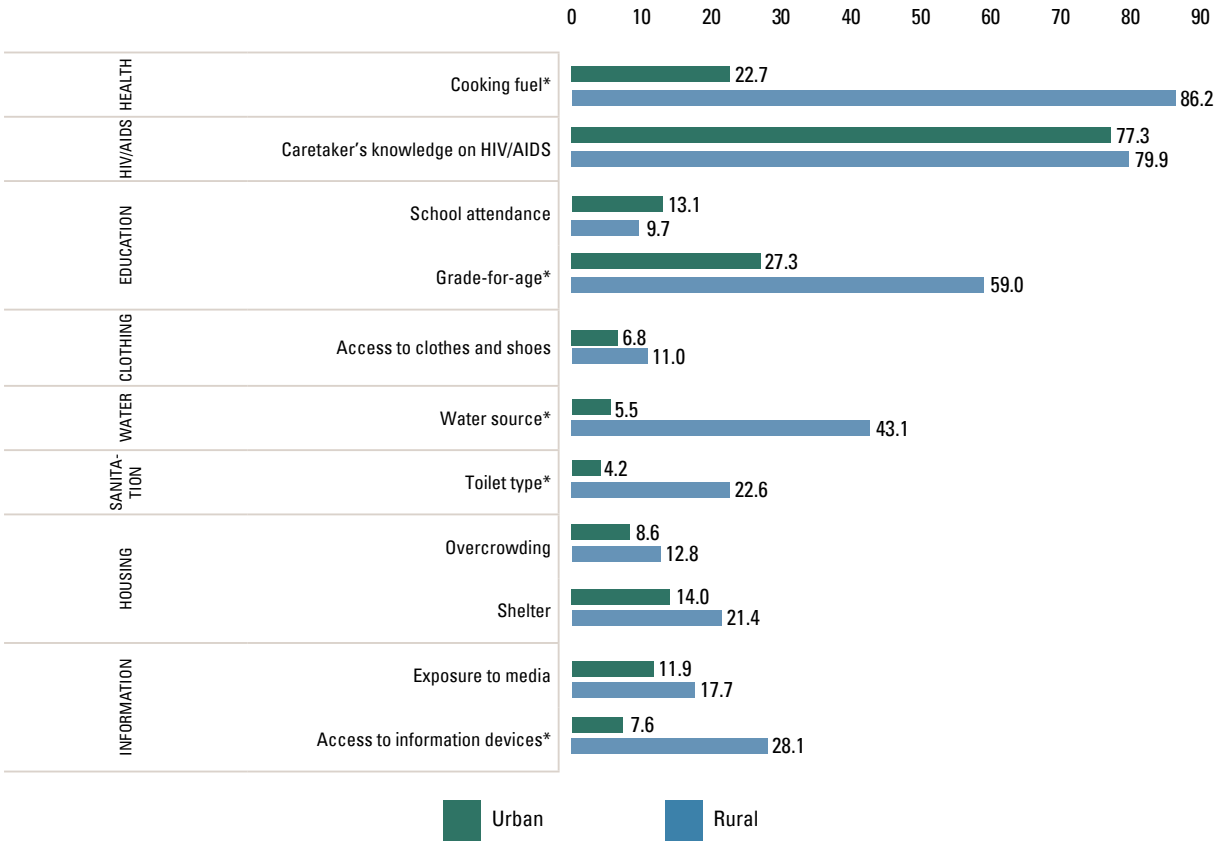
In all dimensions, **urban** children show lower deprivation rates compared to **rural** children (Figure 58). The biggest gap in the deprivation rates among urban and rural children is in health (23 per cent and 86 per cent, respectively), water (6 per cent and 43 per cent, respectively), sanitation (4 per cent and 23 per cent, respectively), education (37 per cent and 63 per cent, respectively) and ICT (19 per cent and 35 per cent, respectively). A rather close gap in the deprivation rates of urban and rural children is in housing (23 per cent and 29 per cent, respectively), clothing (7 per cent and 11 per cent, respectively), and HIV/AIDS (77 per cent and 80 per cent, respectively). A detailed display of deprivation rates for all indicators by rural-urban location is presented in Figure 59. For instance, data indicate that the deprivation rate in the education dimension is driven mostly by a much higher proportion of rural children who lag behind in school 2 or more years compared to urban children (59.0 per cent and 27.3 per cent, respectively).

Figure 58: *Deprivation headcount ratio (%) by area, 15-17 years*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Figure 59: *Deprivation headcount ratio (%) by each indicator and by area, 15-17 years*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by region

Table 10 presents the deprivation rates by dimensions and by the country's four **regions**. Overall, Manzini has the lowest proportion of children deprived in all dimensions, except in clothing. Notably, children living in Hhohho and Shiselweni are doing better in terms of clothing than children in Manzini. Yet, Shiselweni has the largest proportion of children deprived in health, HIV/AIDS and water (87.2 per cent, 84.2 per cent and 51.3 per cent respectively). Similarly, children living in Lubombo have the highest deprivation rates in education (63.1 per cent), clothing (24.7 per cent), sanitation (29.9 per cent), housing (41.8 per cent) and ICT (47.2 per cent).

Table 10: *Deprivation rates by dimension and by region, 15-17 years*

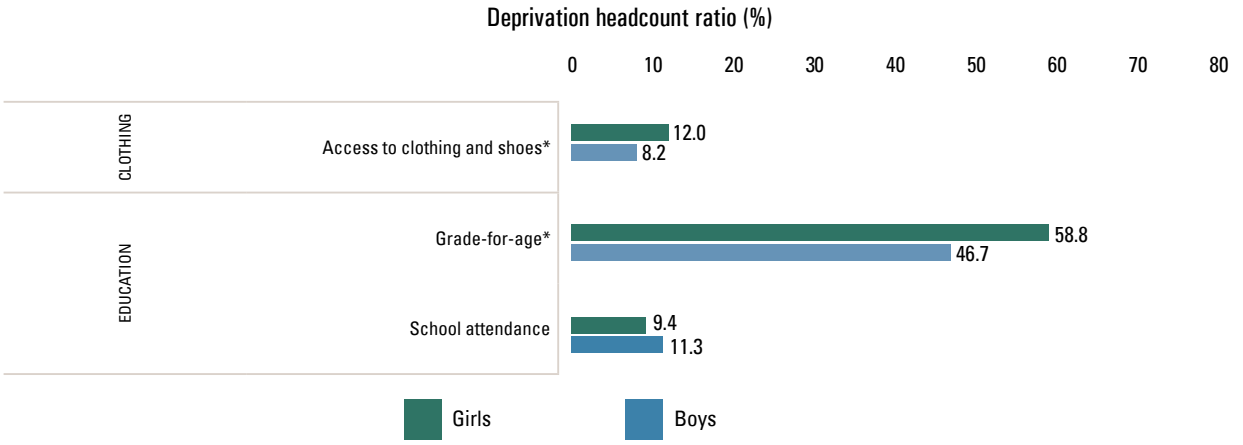
	HEALTH*	HIV	EDUCATION	CLOTHING*	WATER*	SANITATION*	HOUSING*	ICT*
Lubombo	73.1	81.8	63.1	24.7	46.9	29.9	41.8	47.2
Shiselweni	87.2	84.2	61.9	7.3	51.3	21.9	30.8	33.9
Manzini	61.8	76.7	53.3	9.0	24.4	8.0	16.4	22.7
Hhohho	79.4	77.2	56.2	1.8	29.7	22.8	30.5	30.9

*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by gender

Some differences in the deprivation rates by a child's **gender** are observed for children aged 15-17 years (Figure 60). Only the child-level indicators are presented here. In general, boys in this age group are more deprived than girls. Specifically, 12.0 per cent of boys do not have access to proper clothing compared to 8.2 per cent of girls. In addition, more boys lag behind in school compared to girls (58.8 per cent and 46.7 per cent, respectively). By a small margin, more girls are out of school compared to boys (11.3 per cent and 9.4 per cent, respectively).

Figure 60: *Deprivation headcount ratio (%) by each indicator and by gender of the child for the dimensions clothing and education, 15-17 years*

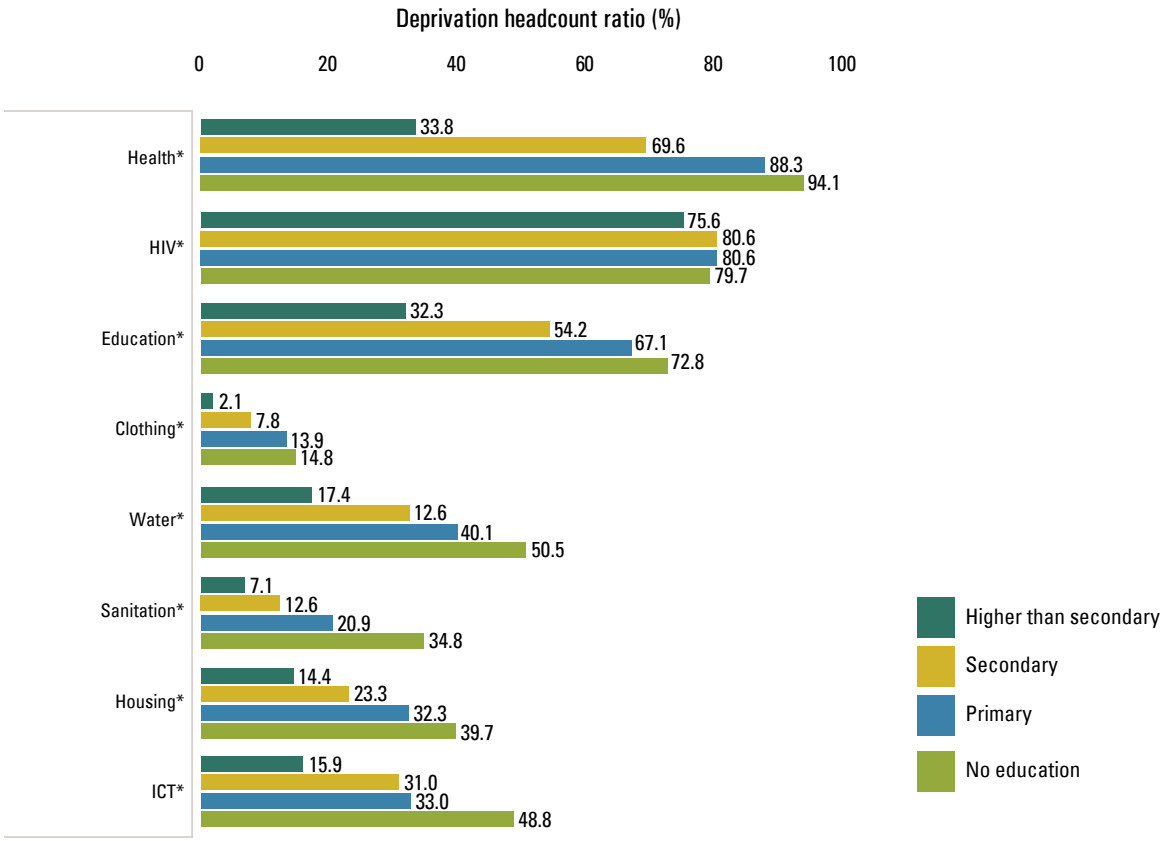


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by education of the household head and mother

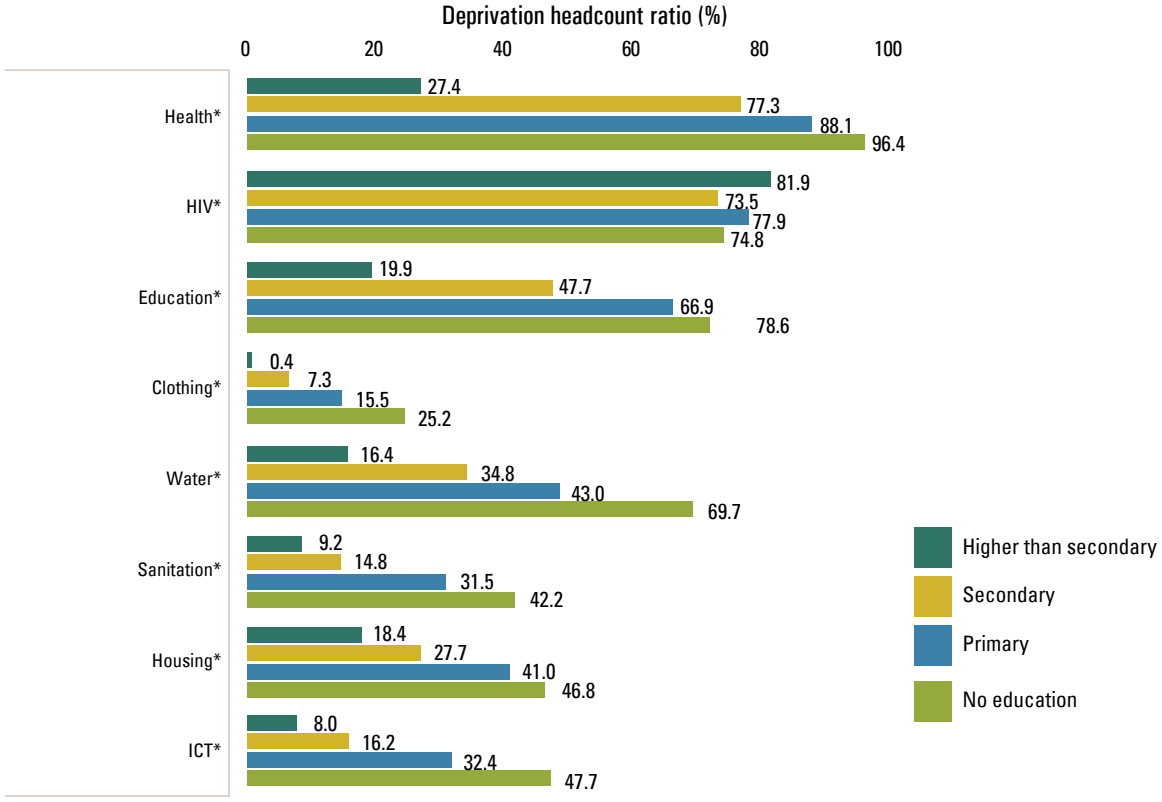
The education level of the **household head** and the **mother** are key profiling indicators in relation to child well-being (Figure 61 and Figure 62). Overall, the higher the education level, the lower the deprivation rates experienced by a child. This is the case for all dimensions of well-being, except for HIV/AIDS in relation to maternal education. The education levels of adults correlate mostly with the well-being of children in the health, clothing, water, housing, ICT, education and sanitation dimensions. For instance, the deprivation rates for children whose mother attained at least secondary education are approximately five times lower in the sanitation dimension in comparison to children whose mother have no education (7.1 per cent versus 34.8 per cent, respectively). Notably, the education level of adults does not seem to influence the child's knowledge of HIV/AIDS.

Figure 61: *Deprivation rates by dimension and by education level of household head, 15-17 years*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Figure 62: *Deprivation rates by dimension and by education level of mother, 15-17 years*

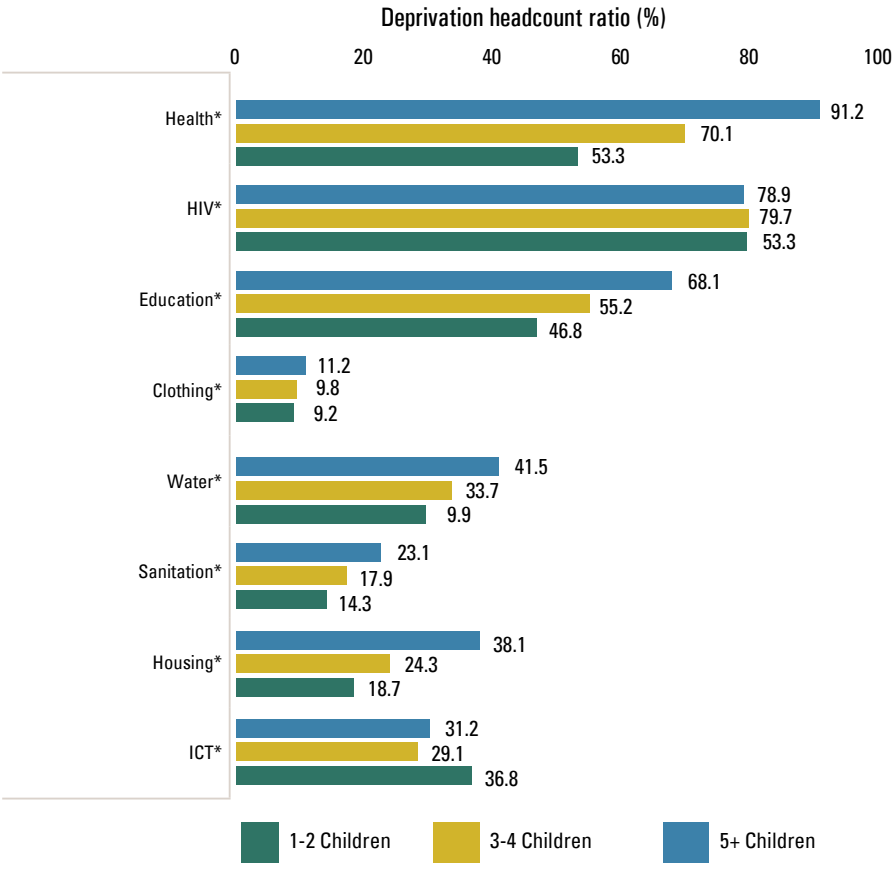


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by number of children in the household

Figure 63 shows the deprivation rates in dimensions of well-being for children aged 15-17 years by the **number of children in the household**. Following the generic trend observed among younger age groups, children in this age group who live in a household with 5 or more children have higher deprivation rates across all dimensions but most notably in health, education, water, sanitation and housing. It is interesting to observe that the deprivation rates for HIV/AIDS, clothing and ICT are rather equally distributed across children living with a higher or lower number of children in the household. For instance, 79.7 per cent of children living in households with 1-2 children are deprived in HIV/AIDS compared to 78.9 per cent of children living in households with 5 or more children.

Figure 63: *Deprivation rates by dimension and by number of children in the household, 15-17 years*

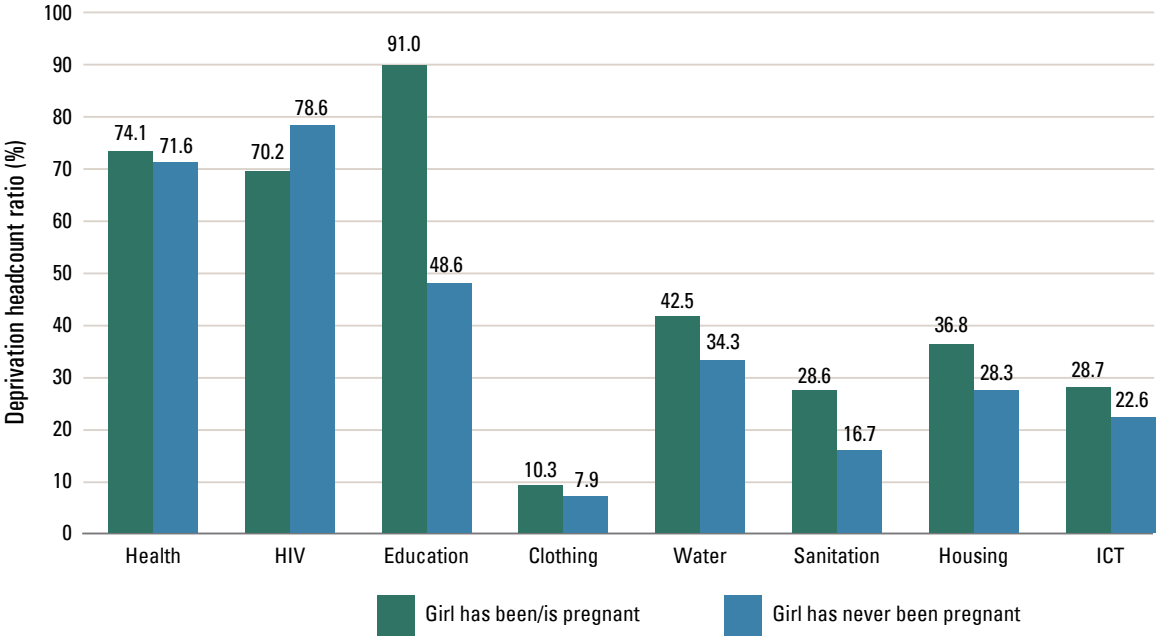


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Deprivation rates by early pregnancy

A profiling analysis by early pregnancy has been added for girls aged 15-17 (Figure 64), following the exposure of teenage girls to this vulnerability. Overall, girls in this age group who have been pregnant or are currently pregnant have higher deprivation rates in all dimensions, except for HIV/AIDS, compared to girls of similar age who have not experienced pregnancy. The gap in the deprivation rates is more visible in the education dimension, in which 91.0 per cent of girls who experienced a pregnancy are deprived compared to 48.6 per cent of girls who have never been pregnant.

Figure 64: *Deprivation rates by dimension and by the pregnancy status of girls, 15-17 years*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

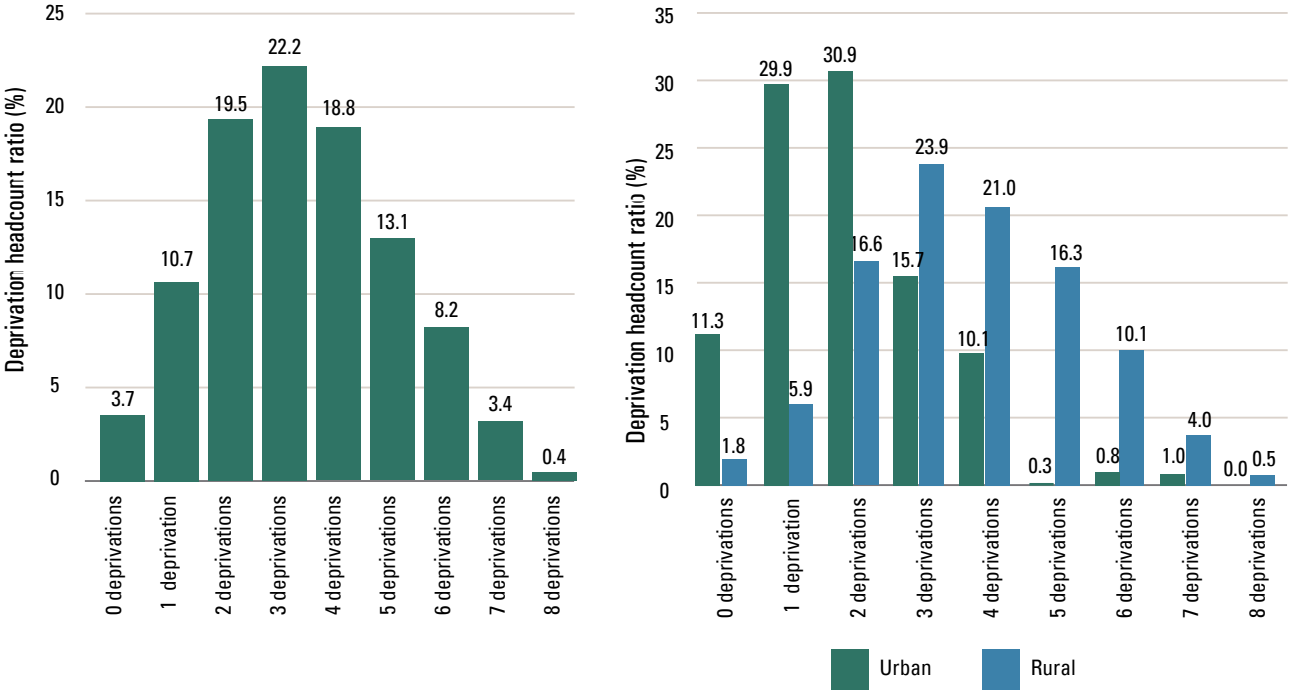
Multidimensional deprivation analysis

Number of deprivations by area of residence

Figure 65 shows the number of simultaneous deprivation that children aged 15-17 years' experience at the national level and by the rural-urban location. While few children experience no deprivation (3.7 per cent), most children in this age group face several deprivations at a time. The deprivation distribution at the national level peaks at 3 dimensions (22.2 per cent), followed by 2 (19.5 per cent) and 4 dimensions (18.8 per cent).

For children living in urban areas, the deprivation distribution is skewed to the left while for rural children the distribution is skewed to the right. It implies that rural children experience more simultaneous deprivations compared to urban children. Indeed, most urban children face 1-2 deprivations out of a total of 8 dimensions (60.8 per cent). By contrast, the same proportion of rural children (61.2 per cent) experience 3-5 deprivations at a time.

Figure 65: *Number of simultaneous deprivations experienced by children aged 15-17 years at the national level and by area of residence*



*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

Number of deprivations by region

Table 11 shows the distribution of deprivations by region. In Manzini, children are less deprived, in relative terms, in the number of deprivations they experience at a time. On the other hand, children living in Lubombo experience more simultaneous deprivations. For instance, in Lubombo, 61.5 per cent of children experience 4 or more deprivations at a time.

Table 11: *Number of simultaneous deprivations experienced by children aged 15-17 years by region*

	NUMBER OF SIMULTANEOUS DEPRIVATIONS EXPERIENCED BY THE CHILD								
	0	1	2	3	4	5	6	7	8
Lubombo	1.8	6.2	14.4	16.1	20.3	16.6	13.8	9.6	1.2
Shiselweni	1.5	4.9	13.7	25.1	22.7	17.4	10.2	4.5	0.0
Manzini	7.4	15.7	24.9	23.3	15.9	8.1	4.1	0.3	0.3
Hhohho	1.9	11.9	20.5	23.5	18.5	13.9	8.0	1.7	0.0

Multidimensional deprivation indices

The multidimensional deprivation headcount at the national level is presented in Figure 66. Similar to previous age groups, almost all children aged 15-17 years are deprived in at least 1 dimension of well-being (96.3 per cent). At the same time, 43.8 per cent of children in this age group are multidimensionally poor, in that they experience 4 or more deprivations at a time. Notably, only 0.4 per cent of children aged 15-17 years are simultaneously deprived in all 8 dimensions.

Figure 66: *Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 15-17 years*

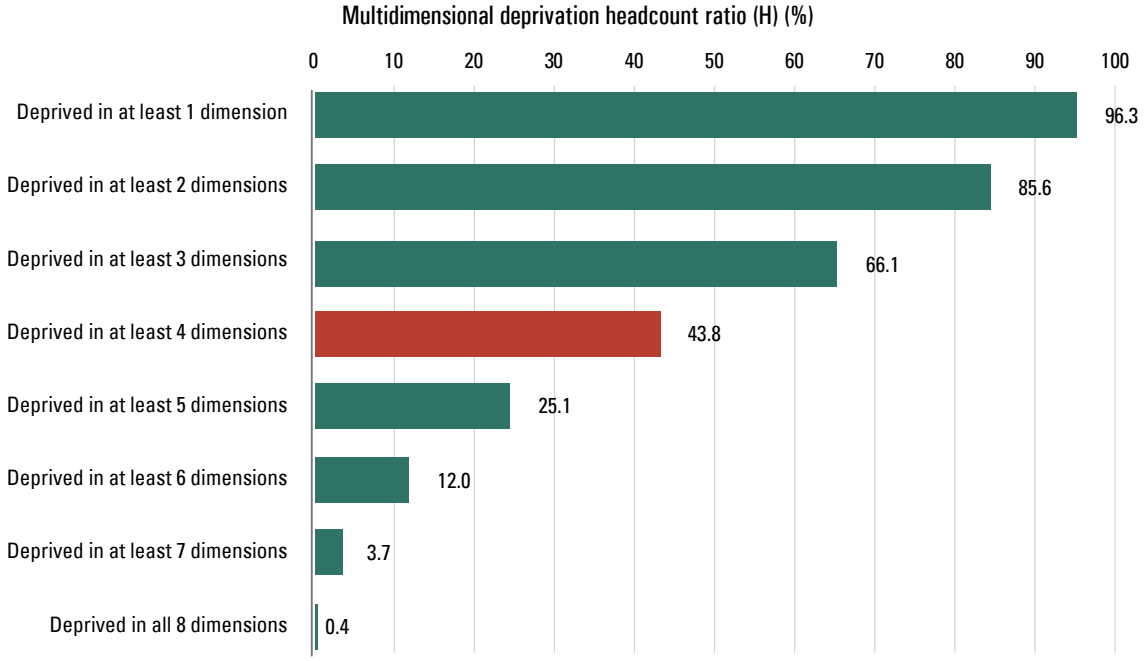


Figure 67 shows the multidimensional deprivation headcount for each cut-off point comparatively at the national level and by rural-urban location. Children in urban areas have significantly lower deprivation rates at each cut-off point compared to children in rural areas. The gap in the distribution of deprivations between rural and urban is largest at 3 and 4 dimensions – i.e. the cut-off points in the distribution of deprivations at which the difference between rural and urban is most visible. For instance, when comparing rural and urban children that are simultaneously deprived in at least 3 dimensions, the rates are strikingly different (75.7 per cent and 28.0 per cent, respectively).

Figure 67: *Multidimensional deprivation headcount ratio (%) at various cut-off points at the national level, 15-17 years*

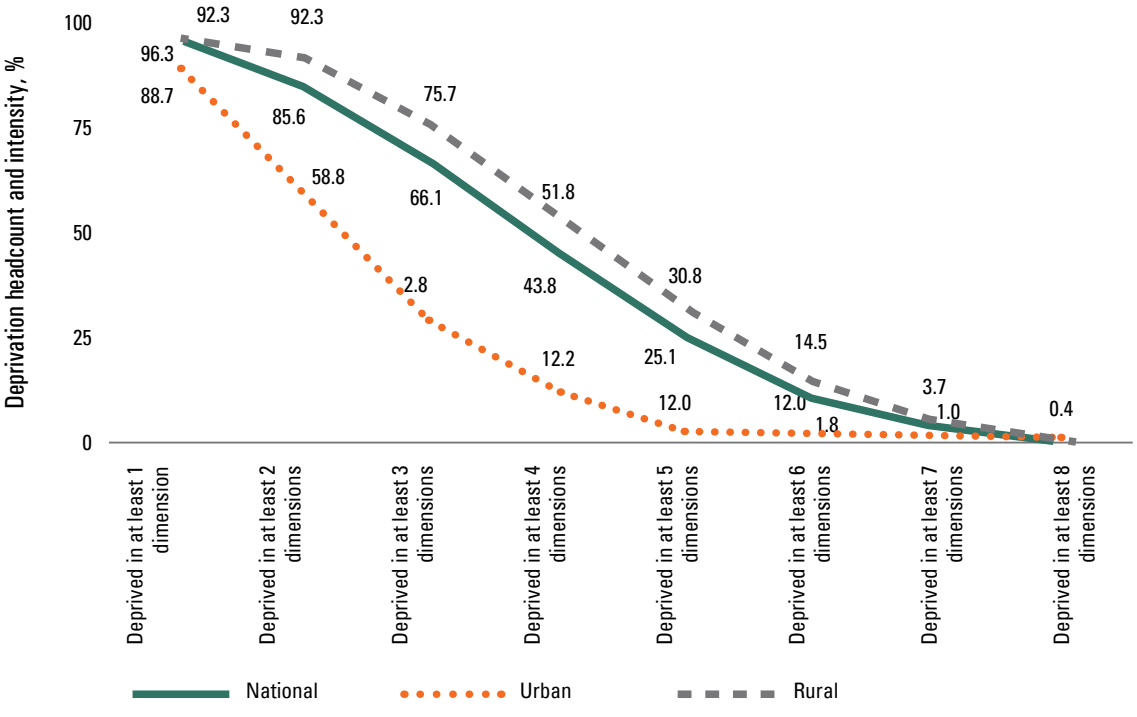
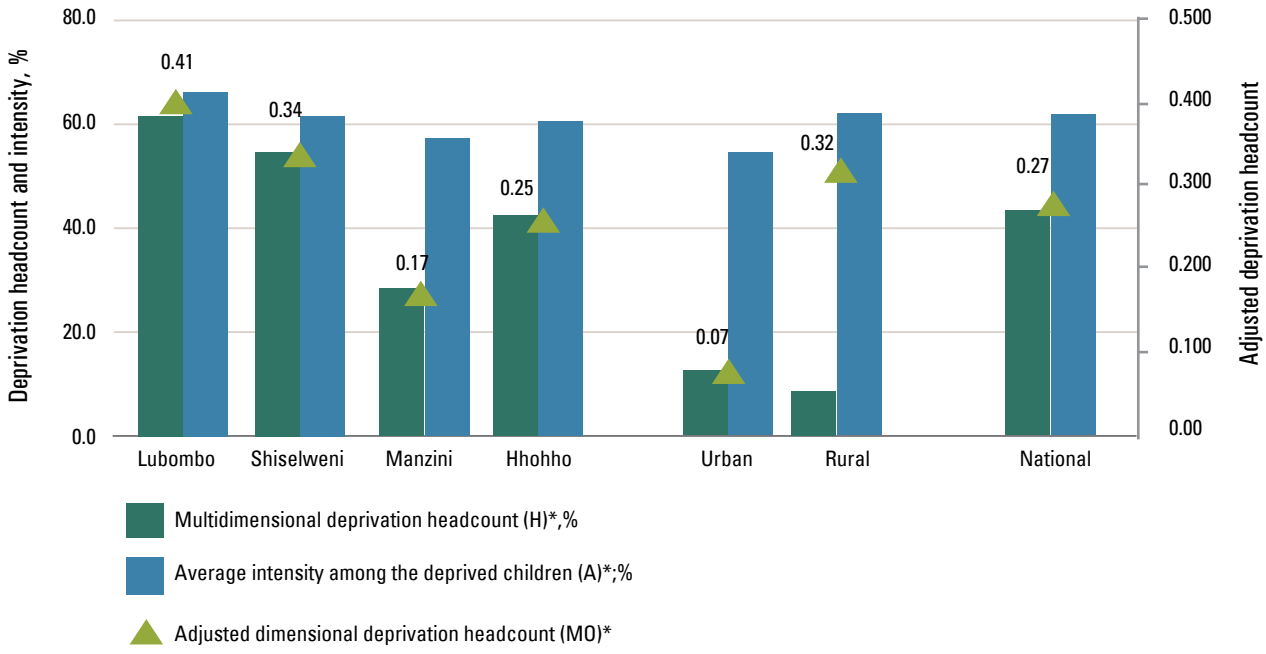


Figure 68 presents the multidimensional child poverty indices, namely the multidimensional deprivation headcount (H), the intensity of deprivation (A) and the adjusted multidimensional poverty headcount (M0), for children aged 15-17 years at the national level by rural-urban location and by the country's regions.

The intensity of deprivation (A) shows the average number of dimensions that multidimensionally poor children (deprived in at least 4 dimensions) experience at a time. This value provides additional information on the depth of deprivation (i.e. how poor the poor children are). Children aged 15-17 years who are multidimensionally poor have on average 4.9 out of a total of 8 deprivations, which is 61.7 per cent of the total number of deprivations. Although the A is slightly lower in urban areas and in Manzini, it is only reduced by a small margin compared to rural areas and other regions in the country. It implies that multidimensionally poor children aged 15-17 years are equally poor throughout the country. The intensity of deprivation of children in this age group is similar to that found for younger children.

The adjusted multidimensional child poverty index (M0) is calculated by multiplying the multidimensional deprivation headcount (H) and the average intensity (A). A higher indexed value indicates more vulnerability. Data in Figure 68 show that urban children are doing significantly better in comparison to children living in rural areas (0.07 and 0.32, respectively). The indexed value of M0 for rural children is driven by a low value in H. Out of all regions, Manzini is doing better, in relative terms, with a M0 of 0.17 whereas children living in Lubombo have the highest deprivation as measured by M0 (0.41). However, since the average intensity (A) of deprived children does not vary much across regions, the differences in M0 are mostly driven by the deprivation headcount (H).

Figure 68: *Multidimensional child poverty indices at the national level and by area and region, children aged 15-17 years deprived in at least 4 dimensions*

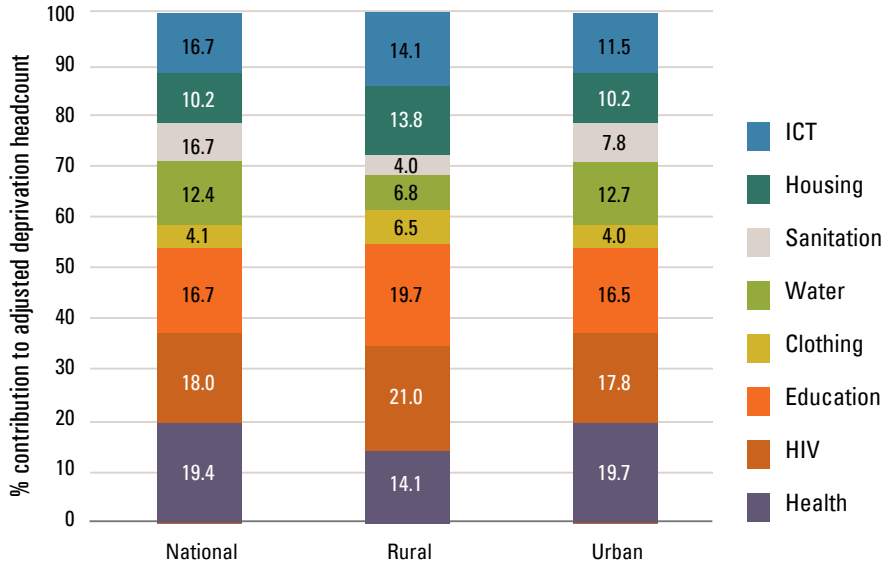


*Note: * indicates a statistically significant difference (at a 95 per cent confidence level) between the sub-groups.*

How does each dimension contribute to the multidimensional child poverty index?

Figure 69 decomposes the multidimensional child poverty index (M0) by its contributing dimensions. At the national level, the dimensions of health, HIV/AIDS and education contribute most to M0 for children aged 15-17 years (19.4 per cent, 18.0 per cent and 16.7 per cent, respectively). When disaggregating by rural-urban location, it is observed that the dimensions of ICT, housing, clothing, education and HIV/AIDS contribute more to multidimensional deprivation in rural areas compared to urban locations. For example, housing contributes 13.8 per cent to M0 in rural areas and 10.0 per cent in urban areas. On the contrary, sanitation, water and health show higher deprivation rates in urban areas compared to rural areas.

Figure 69: *Decomposition of the multidimensional child poverty index (M0), 15-17 years*



Deprivation overlap analysis

Figure 70 displays the deprivation overlap of any given dimension in relation to other dimensions among children aged 15-17 years. Overall, children are often deprived in the given dimension and in 3, 4 or more dimensions at a time. For instance, out of the 79.4 per cent of children deprived in HIV/AIDS, 7.7 per cent are deprived in HIV/AIDS alone, while 38.9 per cent of children are additionally deprived in 3 or more other dimensions.

Figure 70: *Deprivation overlap for each dimension, 15-17 years*

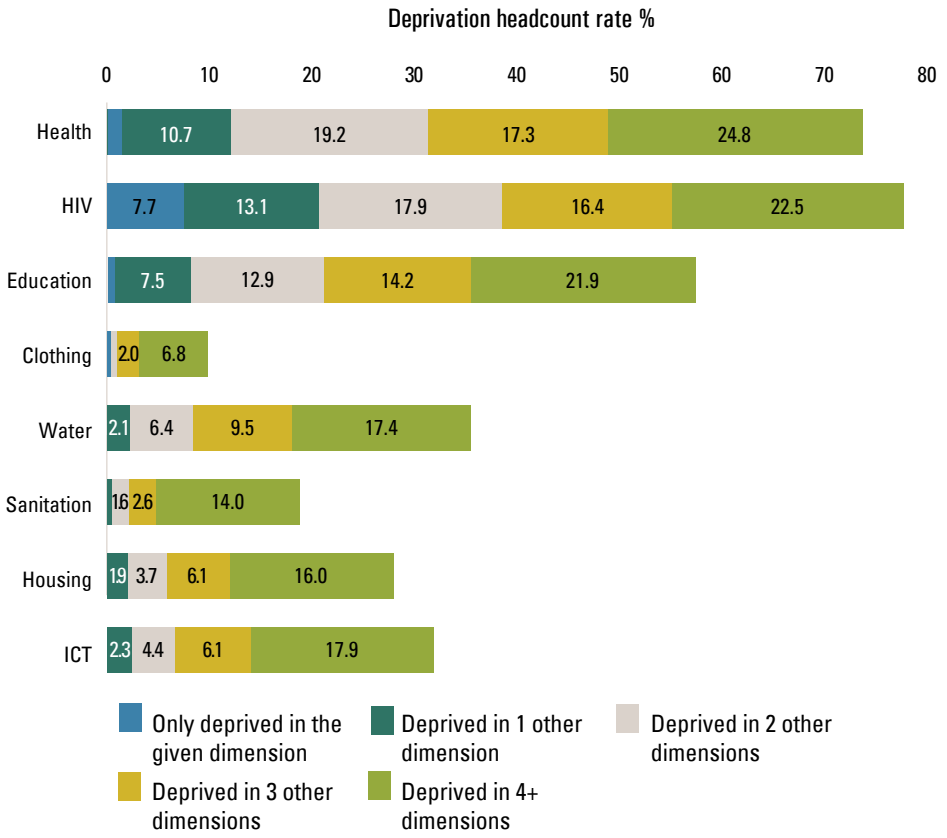


Figure 71 shows an example of the deprivation overlap of three dimensions, namely HIV/AIDS, education and ICT, which is presented in the form of a Venn diagram. Among children aged 15-17 years, 18.1 per cent are deprived in the overlap between HIV/AIDS, education and ICT. The overlap is more prominent in rural areas compared to urban areas (Figure 72 and Figure 73). At the same time, only 8.7 per cent of children are not deprived in any of the three dimensions. Furthermore, 27.2 per cent of children are deprived in both HIV/AIDS and education but only 3.9 per cent of children are deprived in education and ICT.

Figure 71: *Deprivation overlap between the dimensions HIV/AIDS, education and ICT at the national level, 15-17 years*

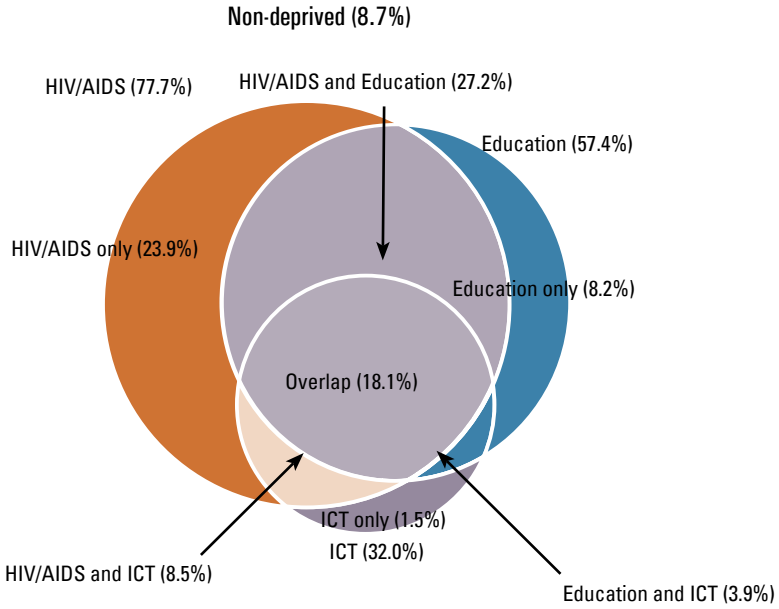


Figure 72: *Deprivation overlap between the dimensions HIV/AIDS, education and ICT in rural areas, 15-17 years*

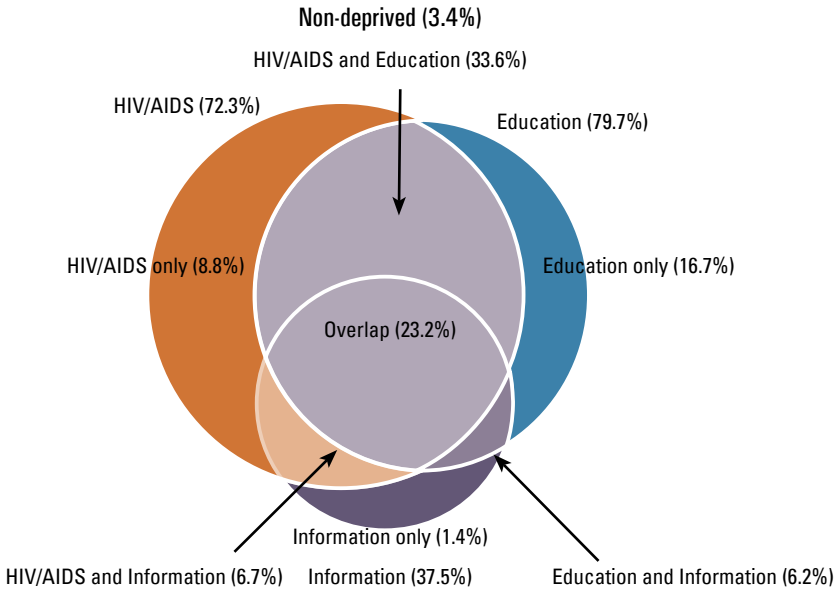
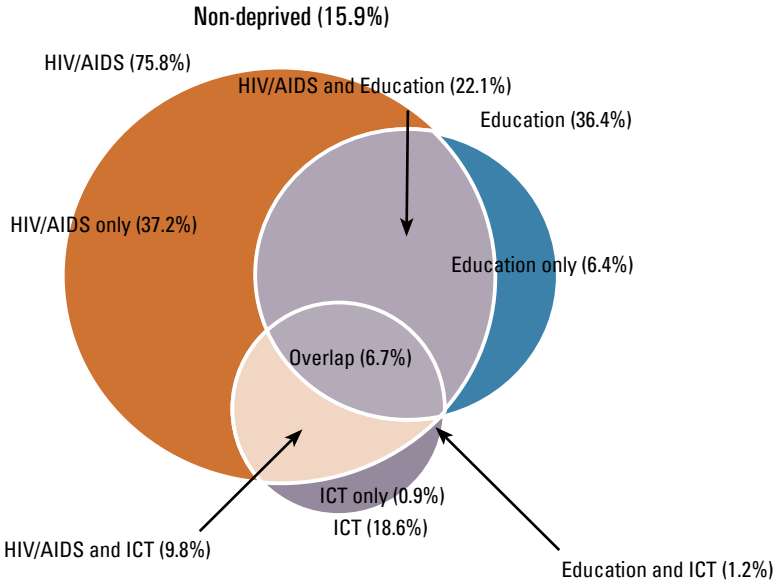
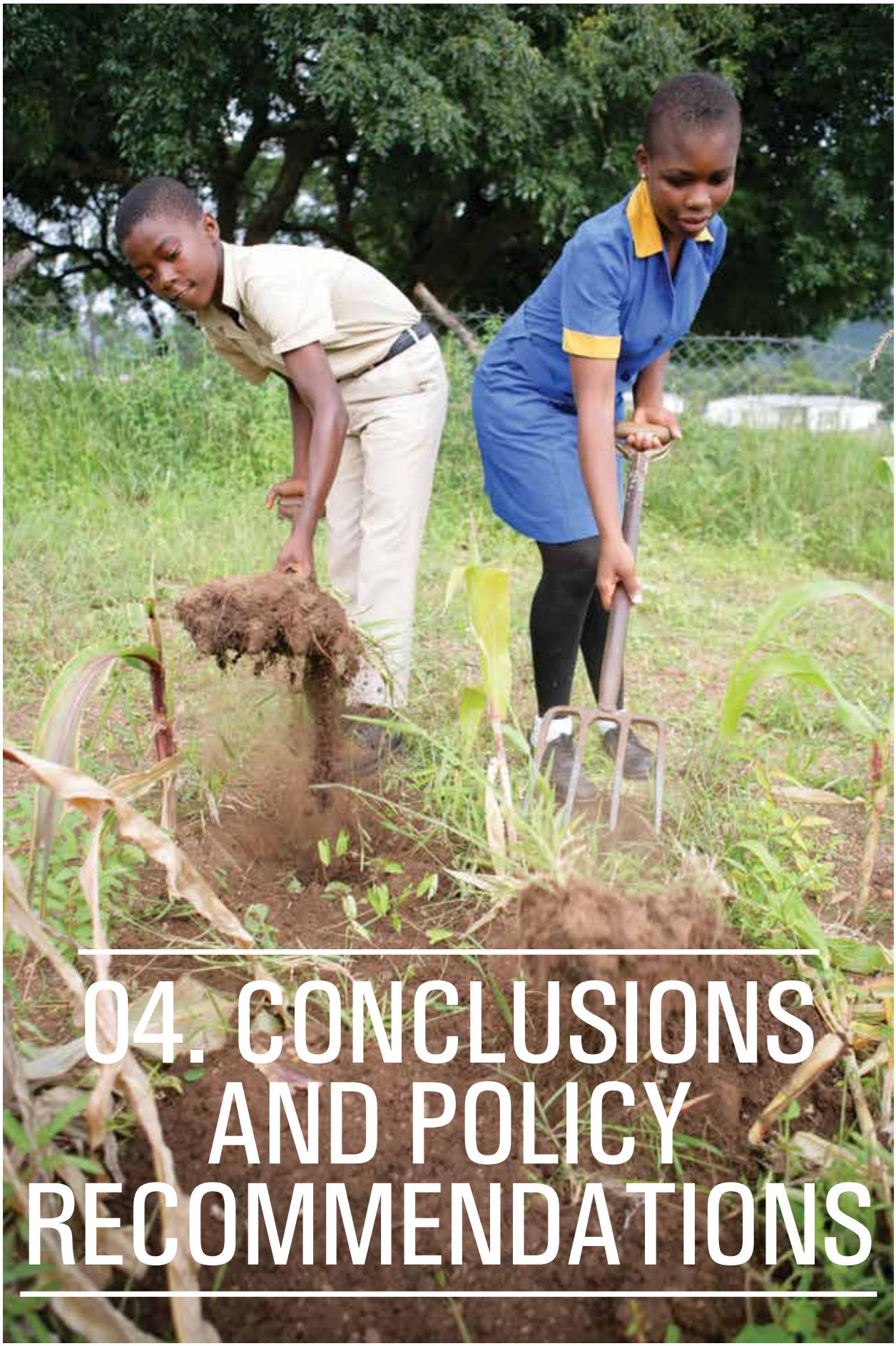


Figure 73: *Deprivation overlap between the dimensions HIV/AIDS, education and ICT in urban areas, 15-17 years*





04. CONCLUSIONS AND POLICY RECOMMENDATIONS

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The multidimensional child poverty analysis in the country included the following dimensions of well-being: *nutrition, health, HIV/AIDS, child development, child protection, education, water, sanitation, housing, clothing and ICT.*

In this study, multidimensional child poverty was studied for the following age groups: 0-23 months, 24-59 months, 5-14 years and 15-17 years. The indicators and dimensions of well-being used to capture the multidimensional child poverty vary according to the age of the child. Reflections on findings and policy recommendations are discussed below.

The main purpose of the study was to ascertain the baseline figure for target 1.2 of SDG 1 which is: "By 2030, reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions". Based on the study, the deprivation score was found to be 56.5 per cent, which is targeted to be halved by 2030 to 28.3 per cent. This will be realized through effective implementation of policy initiatives targeted at children who are severely deprived (a child is defined as multidimensionally poor if she/he is deprived in at least 4 dimensions of well-being at a time).

4.1 ADDRESSING CHILD DEPRIVATION BY DIMENSIONS OF WELL-BEING

1. **Child protection** had the highest proportion of deprived children. Around 9 out of 10 children below 14 years are deprived in this dimension which is mainly driven by indicators measuring physical and psychological violence. Both types of violence are harmful to children and impede their normal development. The following recommendations were made:
    - Strengthen the institutional arrangement aimed at safe guarding the rights of children.
    - Conduct sensitivity campaigns that inform parents of the negative repercussions for children when living in an environment prone to domestic violence.
    - Strengthen national coordination for violence against children (VAC).
    - Strengthen case management on VAC.
    - Strengthen surveillance of VAC.
    - Strengthen community engagements for prevention of VAC (community leaders).
    - Routine data collection on VAC including sexual violence (children up to 17 years).
    - Continue capacity building for multi-sectoral teams responsible for anti-VAC service provision.
    - Sensitize on the need for age disaggregation of data collection and presentation.
    - Strengthen child participation.
    - Formulation and implementation of parenting programmes.
    - Strengthen positive discipline in schools and communities.
2. The absence of birth certificates, used as an indicator of deprivation under the dimension of **child protection**, affects 73.5 per cent of children aged 2-23 months and 55.1 per cent of children aged 24-59 months. The recommendations were:
    - Enforce the law on child registration rights at birth and facilitate the procedures of obtaining birth certificates for younger children.
    - Re-align the Constitution of the Kingdom of Eswatini (2005), Child Protection and Welfare Act (CPWA), Birth Marriage and Death (1983) to facilitate registration of children.

- Develop regulations for CPWA.
- Strengthen campaigns to sensitize mothers of children about the registration of children.

3. The deprivation rate in the **child development** dimension is 88.7 per cent for children aged 24-59 months. Child development was measured by ECD attendance and availability of books. The Government of the Kingdom of Eswatini has established the baseline for promoting early child education through policies such as The National Children's Policy (2009) and the National Early Childhood Care and Education (ECCE) Guidelines. Although the ECD budget allocation is the main constraint for the development of the sector (World Bank 2016), more efforts are needed to prioritize resources and enforce policies leading to ECD.
    - Increase the education budget and adhere to the Education Declaration of 10 per cent of national budget allocation for the education sector to cater for ECD.
    - Incorporate ECCD policy and strategy to national planning for budget purposes.
    - Investment case through social protection system.
    - Cost the ECCD programme for effective implementation.
4. Investing in **children's human capital** now will bring benefits to the country in the medium term when current children will enter the labour market and will become the next generation driving the country's progress and hence the following were recommended:
    - Increase the education budget and adhere to the Education Declaration of 10 per cent of national budget allocation for the education sector to cater for ECD.
    - Strengthen the health system for pre and post antenatal care to include ECD programmes.
    - Improve neighbourhood care points for ECD.
    - Sensitize parenting practices through the ECD programme, e.g. ensuring availability of books.
    - Integrate ECD into existing child health services, antenatal care and post maternal care and child health services (development and updating of guidelines that are outdated or do not exist).
5. More than 7 out of 10 children aged 0-17 years are deprived in the dimension of **health**. This dimension was measured by indicators looking at vaccinations (only for children aged 0-23 months) and the use of unimproved cooking fuel. Being deprived in either of these indicators is harmful to the health of children. This can be improved by doing the following:
    - Scale up rural electrification and increase access to clean (renewable) energy, especially in the rural areas.
    - Sensitize on the use of clean cooking technology.
    - Introduce fuel efficient stoves and use alternative energy sources such as solar power.
    - Ensure effective implementation of the National Energy Policy by the Ministry of Natural Resources and Energy.
    - The Deputy Prime Minister's Office should identify child-headed homes and the Ministry of Natural Resources and Energy should assist by providing fuel efficient stoves and other alternative energy sources.
    - The coverage should be increased for the vaccination sensitization campaigns.
    - Ministry of Health should decentralise vaccination services.
    - CPWA's regulations should be known, implemented and monitored to ensure that children are given vaccinations timeously.

More than 60 per cent of children aged 0-14 years have a caretaker (i.e. mother or another adult) that does not have proper knowledge on HIV/AIDS. To reduce this deprivation, the following are recommended:

- Routine sensitization campaigns should be held in local health care centres and communities to inform adults of the perils, prevention and living with HIV/AIDS.
- Establish an HIV/AIDS communication strategy that will ensure that all caretakers are well educated on HIV/AIDS.
- Comprehensively train health personnel on HIV/AIDS to better educate caregivers on HIV/AIDS.
- Develop an implementation strategy that will ensure standardized formats of education by all HIV/AIDS stakeholders.
- Collaborate with entities and institutions that will collectively implement HIV/AIDS-curbing resolutions.
- Map out the work and allocate duties to different institutions that will ensure funding is also correctly allocated.

For children aged 15-17 years, 79.4 per cent do not have comprehensive knowledge on HIV/AIDS. Hence the following recommendations:

- Include the subject in the school curriculum and put more emphasis on it.
- Life skills education should be implemented by all schools.
- Create awareness on HIV/AIDS in all platforms, e.g. churches.

6. **Nutrition** is one of the most important dimensions of the child's well-being during the first years of life. Measured by exclusive breastfeeding for children under 6 months, infant and young child feeding (meal frequency and dietary diversity) and stunting, deprivations rates were quite high in all these indicators. Among children aged 0-6 months, 36.2 per cent are not exclusively breastfed. More than half of children aged 6-23 months (56.5 per cent) are not fed according to the WHO standards,10 and around one quarter of children less than 5 years are stunted. The following strategies are recommended:

   - Encourage exclusive breastfeeding of children in their first 6 months of life.
   - Information about breastfeeding should be shared during pre and antenatal care sessions.
   - Conduct regular breastfeeding sensitivity campaigns and advocate for flexible hours for working mothers, paid maternal leave and monetary benefits to boost the practice of breastfeeding.
   - Strengthen capacity of the Nutrition Council, revise its strategic plan and develop clear roles and responsibilities.
   - Strengthening the Swaziland Infant Nutrition Action Network to fulfil its mandate on breastfeeding.
   - Review the national nutrition strategy.
   - Provide food packages to the mother of the child to enable her to get sufficient nutrients so that she can breastfeed the child.

[10] The WHO standards for meal diversity and frequency are as follows: (1) minimum meal frequency is 2 times for breastfed infants aged 6–8 months, (2) 3 times for breastfed children aged 9–23 months, and (3) 4 times for non-breastfed children aged 6–23 months. Dietary diversity refers to the child receiving 4 or more of the following food groups: (1) grains, roots and tubers, (2) legumes and nuts, (3) dairy products (milk, yogurt, cheese), (4) flesh foods (meat, fish, poultry and liver/organ meats), (5) eggs, (6) vitamin A rich fruits and vegetables, and (7) other fruits and vegetables.

- Food subsidies should be considered for children to allow for proper nutritional intake in their first 1000 days of life, a crucial period for the survival and future physical and mental development of children.
- The Social Welfare Department should identify the most vulnerable families to receive subsidies.
- The Ministry of Labour should enforce and monitor the implementation of flexible hours for breastfeeding and educate all employees about this privilege.

7. The **educational development** of children is a reason for concern. More than one in ten children (10.4 per cent) aged 15-17 years do not attend school and more than half of children (52.9 per cent) in this age group lag behind in school by 2 or more years. It is also observed that boys are more deprived than girls in education and hence the following recommendations:
    - Review studies carried out by stakeholders such as UNICEF, Ministry of Education, UNESCO, European Union and implement their recommendations.
    - Strengthen technical vocational education and training and ensure its introduction at lower secondary level.
    - Advocate for the implementation of the repetition policy of less than 5 per cent repetition rate.
    - Initially standardize high school education fees and thereafter introduce subsidized secondary education.
    - Make junior secondary education compulsory.
    - Mobilize resources for free secondary education.
    - Add junior secondary education in CPWA guidelines.
8. More than one third of children aged 0-17 years do not have **access to a safe drinking water source** as per the requirements of the WHO.[11] The following strategies were recommended:
    - Develop a maintenance plan for the water infrastructure in the country to enhance existing infrastructure.
    - Build new water sources to collect and deliver improved water sources across the country, especially in rural areas and in places where the water deprivation is endemic.
    - Develop a national maintenance plan and funded programme. The plan should have a monitoring and evaluation component to see the impact of the maintenance. The plan must be funded through advocacy on the cost of action.
    - Promotion of household water treatment alternatives, encouraging safe water access from unimproved water sources. Share with and capacitate communities on the available alternatives for water treatment and encourage innovations.
    - Encourage community members to use the climate adaptation technologies for water harvesting such as rain water harvesting.
    - Develop new water systems. Have a constituency-based approach to water systems which should be evidence based.
    - Build a strong case for public private partnerships for the water sector.

[11] According to the WHO requirements, improved drinking water sources include piped into dwelling, piped into yard/plot, piped into neighbor's plot, public tap/standpipe, tube well/borehole, protected dug well, protected spring, rainwater, bottled water if water source is improved. Unimproved drinking water sources include unprotected well, unprotected spring, surface water, tanker truck, cart with small tank/drum, bottled water if water source is unimproved, other.

- Advocate for strong involvement of constituency leadership systems in planning and designing of water projects to ensure sustainability of the projects.

9. Around one in five children (20 per cent) are deprived in **sanitation**, measured by the use of unimproved toilet facilities (children aged 0-17 years) and the improper disposal of children's stools (children aged 0-23 months). Below are the recommended strategies:
    - Strengthen the existing programme and improve sanitation infrastructure especially in rural areas where deprivation rates are much higher.
    - Sensitivity campaigns on the disposal of children's stools should be scaled up.
    - This should go hand in hand with creating facilities allowing for proper disposal of waste in urban and rural locations. The collection of waste must be improved and enforced.
    - Strengthen existing programmes. Roll out the community-led total sanitation programme to create demand for sanitation.
    - Sensitization of the community on the basic improved toilet.
    - Strengthen the health promotion unit to emphasize good hygiene practice.
    - Routinely conduct sensitization campaigns on the disposal of child's stools. The baby water, sanitation and hygiene campaign should be mainstreamed within the existing sanitation programmes.
    - Create facilities allowing proper disposal of waste. These could be done through rural community-based waste management programmes.
    - Collection of waste must be improved and enforced. Communities both in the rural and urban areas should be sensitized on waste reduction, recycling and reuse.
10. Around one third (34 per cent) of children aged 0-17 years are deprived in the dimension of **housing**, measured by quality of shelter (roof, floor and walls) and overcrowding (more than 3 people per sleeping room as per the UN definition). Ensuring that everyone has access to proper housing should be one of the priority areas in the country. This could be done by implementing the following recommendations:
    - Subsidies for improving houses in which families with children reside may help, as higher costs impede the use of improved materials.
    - Sensitivity campaigns are recommended to inform the population of the risks of overcrowding for children, including health risks (e.g. spread of respiratory diseases), lack of privacy and reduced educational performance as children have little private space to learn and do homework.
    - Informal settlements should be upgraded.
    - Land should be sold at low prices and advocate for a building plan of affordable houses.
    - The country must identify and permit use of more affordable building materials such as mud blocks.
    - The Deputy Prime Minister's Office should identify vulnerable households throughout the country and these will then qualify for subsidized building materials and building plans from the Ministry of Works.
    - Vulnerable households should be zero-rated on building materials.
    - The Ministry of Housing should conduct a study to inform cheaper building materials.
    - Government should subsidize the Swaziland National Housing Board for the provision of affordable houses and land.

- Create awareness on overcrowding and possible curbing interventions by the Ministry of Housing, Ministry of Tinkhundla and the environmental health unit.

11. More than one in ten children (11 per cent) aged 5-17 years do not have access to enough **clothing**, measured by having at least 2 pairs of clothes and 1 pair of shoes. The following were the recommended strategies:
    - The distribution of clothes and shoes amongst vulnerable children to improve their well-being.
    - Strengthen social safety net programmes and corporate social responsibility from the private sector to assist those vulnerable children. Schools or charitable organizations can be used as platforms for these actions, especially in the most deprived communities.
    - Government should make a national policy on the social responsibilities of companies, churches and individuals through structures such as neighbourhood care points.
    - The Deputy Prime Minister's Office should revive social awareness campaigns such as Futfumeta umntfwana as they were effective.
    - Citizens should develop and cultivate the culture of giving out clothes within communities as a social responsibility that could be through structures such as churches, neighbourhood care points, the Deputy Prime Minister's Office, welfare offices, etc.
    - Second hand/affordable clothing should be promoted by the Ministry of Commerce.
12. Close to one third of children (32 per cent) aged 0-17 years were deprived in the dimension of **ICT**. The current generation of children is living in an ICT-driven environment and being deprived in access to media or communication devices is a serious vulnerability for contemporary children.
    - For children who do not have access to media or ICT devices, information on important subjects should be made available via other platforms such as local community centres, schools and teachers.
    - Community centres in each chiefdom should be equipped with reading materials and communication facilities (resource centres equipped with internet).
    - Municipalities should provide resource centres in townships.
    - Government needs to establish ward-based community resource centres.
    - Each inkhundla should be furnished with resource centres.

4.2 A MULTIDIMENSIONAL APPROACH TO POVERTY

An important conclusion of this study is that a large majority of emaSwati children are deprived in more than one dimension of well-being at a time. It is therefore imperative to create policy responses that involve different sectors to better target multidimensionally poor children. Multi-sectoral efforts to address child poverty are also cost-effective in a context of limited resources. Based on results, particular attention should be given to addressing the following combinations of deprivations simultaneously.

a) Children aged 0-23 months: the combination between *nutrition*, *health* and *water* showed an overlap of 24.2 per cent, that is almost a quarter of children in this age group are deprived in all three dimensions. Actions targeting infrastructural frameworks that cater to the three areas of deprivation may help these vulnerable children.
    - For instance, health care centres can be used as focal points to provide food packages and safe drinking water when children come for vaccinations or for regular check-ups.

b) Children aged 24-59 months: more than half of children (57.2 per cent) in this age group are simultaneously deprived in *HIV/AIDS*, *child development* and *child protection.*

- The child's caretaker can be sensitized on these dimensions of well-being, in that information can be simultaneously delivered on HIV/AIDS, the importance of ECD, the need for a birth certificate and the vulnerability of children to physical and psychological abuse.

c) Children aged 5-14 years: the dimensions of *HIV/AIDS*, *child protection* and *ICT* have an overlap of 20.2 per cent among children in this age group.

- Targeting the vulnerability of information through access to media and ICT devices can also be exploited to provide information on the spread of HIV/AIDS and issues pertaining to child protection.

d) Children aged 15-17 years: in this age group, 18.1 per cent are deprived in the overlap of *education*, *HIV/AIDS* and *ICT*. School infrastructure could be used as a platform to address all three issues simultaneously.

- Subsidizing and enforcing high school attendance may help reducing this deprivation overlap as long as access to information devices and information on HIV/AIDS are provided in schools.

4.3 PROFILING VULNERABLE CHILDREN

When identifying poor children, it is important to profile those characteristics that make children more vulnerable, so as to design the most effective policy responses. A number of profiling characteristics and how they relate to child poverty are presented below.

- **Children living in rural areas** are consistently more multidimensionally deprived than urban children. Thus, rural children represent a vulnerable population which has to be targeted with priority.
- At the **regional level**, Shiselweni has the largest proportion of multidimensionally poor children (70.9 per cent) followed by Lubombo (67.5 per cent) and Hhohho (55.2 per cent). Manzini, on the other hand, has the lowest proportion of multidimensionally poor children (42.8 per cent). The difference in child poverty across these regions is relative, as the intensity of deprivation shows that multidimensionally poor children are equally poor across the country. Policy actions should target the most deprived children (i.e. those facing on average more deprivations at a time), irrespective of the region they are living in.
- There is higher multidimensional child poverty among children living in **households with more members, including more children**. Targeting households with many children for social protection interventions may help ease multidimensional poverty across this population.
- Higher child poverty is observed amongst **female-headed households**. Households headed by single female adults are potentially vulnerable and more attention should be given to children living in these settings.
- Children whose **mother or the household head have higher levels of education** are less multidimensionally poor. Subsidized secondary education should be encouraged amongst the current generation of children as this will influence the poverty rates of the next generation of children.
- **Children of younger mothers** (aged less than 20 years) are more multidimensionally poor. It is often that both the child and the mother are below the age of 18. Policy actions that support young

mothers to finish school or find subsidized employment may help two deprived populations of youth (i.e. the young mother and the child).

- Multidimensional poverty is higher amongst **boys** than girls. This is especially true for stunting, grade-for-age, and clothing. Particular attention should be given to emaSwati boys with regards to those vulnerabilities.
- **Orphan** children are more multidimensionally poor. This population of children is potentially vulnerable and deserves special attention. Policies focusing on child fostering may help orphan children find a family environment which provides a decent level of living and protection.
- Girls who experienced an **early pregnancy** are more multidimensionally poor. This is especially visible in the education dimension. Policy responses that help young mothers remain in school will go a long way to reduce the vulnerability in this population of children.

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06. ANNEXES

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ANNEX 1

List of agreed dimensions, indicators and thresholds using the 2014 MICS dataset for MODA in Eswatini

DIMENSION	INDICATOR	THRESHOLD (CHILD IS DEPRIVED IF…)
NUTRITION	Exclusive breastfeeding	<6 months: Child is not exclusively breastfed
	Infant and young child feeding (IYCF)	6-23 months: Deprived if child is not meeting the WHO requirement for dietary frequency and diversity including breastfeeding. Minimum meal frequency is defined: 2 times for breastfed infants 6–8 months 3 times for breastfed children 9–23 months 4 times for non-breastfed children 6–23 months Dietary diversity refers to the child receiving 4+ of the following food groups: 1. grains, roots and tubers 2. legumes and nuts 3. dairy products (milk, yogurt, cheese) 4. flesh foods (meat, fish, poultry and liver/organ meats) 5. eggs 6. vitamin A rich fruits and vegetables 7. other fruits and vegetables
	Stunting	0-59 months: Deprived if child's height for age is <-2 SD from international median (WHO 2006)
HEALTH	Vaccinations	0-23 months: Deprived if child did not receive all recommended vaccinations in the national immunization schedule (including Vitamin A)
	Cooking fuel	0-17 years: Deprived if household uses solid cooking fuel *Improved*: Electricity, liquefied petroleum gas (LPG), natural gas, biogas *Unimproved*: Coal/lignite; charcoal; wood; straw/shrubs/grass; animal dung; kerosene/paraffin
HIV/AIDS	Caretaker's knowledge of HIV/AIDS	0-14 years: The caretaker of the child or any female in the household is not sufficiently informed about HIV/AIDS (never heard of AIDS, does not know appropriate methods of prevention and possible means of transmission including PMTCT)
	Child's knowledge about HIV/AIDS	15-17 years: The child is not sufficiently informed about HIV/AIDS (never heard of AIDS, does not know appropriate methods of prevention and possible means of transmission) - extrapolate results for boys
CHILD DEVELOPMENT	Availability of books	2-4 years: Deprived if child has no books in the household
	Early childhood programme attendance (ECD)	36-59 months: Deprived if child does not attend any early childhood education

DIMENSION	INDICATOR	THRESHOLD (CHILD IS DEPRIVED IF…)
CHILD PROTECTION	Birth certificate	2-59 months: Child has no birth certificate
	Negligence	0-4 years: Child is left alone or in the care of another child younger than 10 years of age for more than one hour at least once in the last week
	Psychological violence[1]	1-14 years: Child lives in a household where children aged 1 to 14 years old experience psychological aggression (shook child/shouted, yelled or screamed at the child/ called child dumb, lazy or another name) during the last one month
	Physical violence[14]	1-14 years: Child lives in a household where children aged 1 to 14 years old experience physical punishment (spanked, hit or slapped child on the bottom with bare hand/hit child on the bottom or elsewhere with belt, brush, stick, etc/hit or slapped child on the face, head or ears/hit or slapped child on the hand, arm or leg/ beat child up as hard as one could) during the last one month
EDUCATION	Grade-for-age	5-17 years: Deprived if child is not attending school or is 2 or more years behind in schooling
WATER	Water source	0-17 years: Household's main source of drinking water is unimproved (as per WHO requirements) OR time needed to go get water and come back is more than 30 minutes *Improved*: piped into dwelling, piped into yard/plot, piped into neighbour's plot, public tap/standpipe, tube well/borehole, protected dug well, protected spring, rainwater, bottled water if water source is improved *Unimproved*: unprotected well, unprotected spring, surface water, tanker truck, cart with small tank/drum, bottled water if water source is unimproved, other
SANITATION	Toilet type	0-17 years: Deprived if household uses an unimproved toilet facility *Improved*: Flush to piped sewer system, flush to septic tank, flush to pit (latrine), flush to unknown place/not sure/DK where, ventilated improved pit latrine (VIP), pit latrine with slab *Unimproved*: Flush to somewhere else, pit latrine without slab/open latrine/incomplete latrine, no facility/bush/field/flying toilet (plastic), other
	Disposal of stools	0-2 years: Deprived if disposal of children's faeces is inadequate *Improved*: Child using toilet/latrine, put/rinsed into toilet/latrine *Unimproved*: Put/rinsed into drain or ditch, thrown into garbage (solid waste), buried, left in the open, don't know, other

[12] For the module on child discipline (including the variables used to measure the indicators physical and psychological violence) in the Swaziland MICS survey, the question was asked for only one child selected at random aged between 1 and 14 years. It has been assumed that if one child lives in a violent environment, his/her siblings will be as well affected. The deprivation level of the randomly selected child is therefore imputed to all the children living in the same household.

DIMENSION	INDICATOR	THRESHOLD (CHILD IS DEPRIVED IF…)
HOUSING	Overcrowding	0-17 years: Household has on average more than three people per sleeping rooms (UN definition)
	Shelter	0-17 years: The floor, roof or walls are made of natural or rudimentary materials Floor *Improved*: wood planks, parquet or polished wood, vinyl or asphalt strips, ceramic tiles, cement, carpet, other *Unimproved*: Earth/sand, dung Roof *Improved*: metal/tin (corrugated iron), wood, calamine/cement fibre, ceramic tiles, cement/concrete, roofing shingles, asbestos *Unimproved*: Thatch/palm leaf, wood, asbestos, other Walls *Improved*: cement, stone with lime/cement, bricks, cement blocks, wood planks/shingles *Unimproved*: Dirt, bamboo/stick with mud, stone with mud, mud blocks, wood planks/shingles, other
CLOTHING	Access to clothing and shoes	5-17 years: Deprived if child does not have at least 2 sets of clothing and 1 pair of shoes
INFORMATION, COMMUNICATION AND TECHNOLOGY	Exposure to mass media	0-17 years: Deprived if no adult has access to either one of the following: newspaper, radio, television or internet weekly
	Access to a radio, tv and phone	0-17 years: Deprived if child lives in a household where there is less than 2 out of the following assets available: radio, television or mobile phone

ANNEX 2

Table 12: *Overlap between combinations of three dimensions, children aged 0-23 months*

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
Sanitation, Housing, ICT	11.4%	12.3%	7.4%	4.5%	23.9%	8.7%	7.6%	24.1%
Water, Housing, ICT	8.7%	6.4%	7.0%	7.3%	14.9%	14.6%	8.0%	33.2%
Water, Sanitation, ICT	11.0%	10.0%	4.7%	7.8%	11.2%	26.2%	7.5%	21.6%
Water, Sanitation, Housing	10.8%	10.3%	4.3%	13.0%	11.6%	21.0%	8.9%	20.1%
Child protection, Housing, ICT	15.5%	20.5%	14.5%	0.5%	43.3%	0.5%	0.5%	4.8%
Child protection, Sanitation, ICT	18.0%	32.5%	12.0%	0.9%	31.3%	3.8%	0.1%	1.5%
Child protection, Sanitation, Housing	22.8%	27.6%	13.2%	1.0%	30.1%	3.7%	0.0%	1.6%
Child protection, Water, ICT	15.5%	20.4%	14.5%	0.3%	43.3%	0.8%	0.7%	4.4%
Child protection, Water, Housing	14.8%	21.1%	21.2%	0.2%	36.7%	0.8%	0.8%	4.4%
Child protection, Water, Sanitation	20.3%	15.5%	30.1%	0.7%	27.8%	0.3%	3.9%	1.3%
HIV, Housing, ICT	10.8%	12.5%	9.6%	5.2%	29.2%	8.5%	5.4%	18.9%
HIV, Sanitation, ICT	13.1%	21.0%	7.4%	5.8%	20.7%	15.2%	4.8%	12.1%
HIV, Sanitation, Housing	15.5%	18.5%	7.9%	8.2%	20.2%	12.8%	5.4%	11.5%
HIV, Water, ICT	11.5%	14.8%	8.9%	4.2%	26.9%	6.5%	6.4%	20.8%
HIV, Water, Housing	11.4%	14.9%	12.0%	3.7%	23.9%	7.0%	10.0%	17.2%
HIV, Water, Sanitation	15.5%	10.8%	18.6%	5.6%	17.3%	5.0%	15.4%	11.8%
HIV, Child protection, ICT	19.7%	39.0%	0.8%	10.3%	2.7%	24.8%	0.2%	2.5%
HIV, Child protection, Housing	22.4%	36.3%	1.0%	13.6%	2.5%	21.5%	0.0%	2.7%
HIV, Child protection, Sanitation	31.4%	27.3%	2.7%	19.1%	0.8%	16.0%	1.9%	0.8%
HIV, Child protection, Water	25.6%	33.1%	0.7%	10.3%	2.8%	24.8%	0.3%	2.4%
Health, Housing, ICT	14.3%	15.1%	12.5%	1.7%	31.2%	5.9%	2.5%	16.8%
Health, Sanitation, ICT	16.6%	22.9%	10.1%	2.2%	23.4%	13.3%	2.1%	9.3%
Health, Sanitation, Housing	18.5%	21.0%	10.9%	5.3%	22.7%	10.3%	2.4%	9.0%
Health, Water, ICT	15.0%	19.7%	11.7%	0.7%	26.6%	1.5%	3.6%	21.2%
Health, Water, Housing	14.7%	20.0%	14.6%	0.3%	23.7%	1.9%	7.3%	17.5%
Health, Water, Sanitation	20.5%	14.3%	19.1%	0.6%	19.2%	1.6%	14.9%	9.8%
Health, Child protection, ICT	26.2%	44.8%	0.5%	3.7%	1.6%	19.0%	0.5%	3.7%
Health, Child protection, Housing	29.1%	41.9%	0.3%	6.9%	1.8%	15.8%	0.7%	3.5%
Health, Child protection, Sanitation	38.6%	32.5%	1.0%	11.9%	1.1%	10.9%	3.7%	0.5%

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
Health, Child protection, Water	33.8%	37.3%	1.0%	2.1%	1.0%	20.6%	0.1%	4.1%
Health, HIV, ICT	18.5%	30.6%	8.2%	2.0%	15.7%	11.1%	2.3%	11.6%
Health, HIV, Housing	19.8%	29.2%	9.5%	3.5%	14.5%	9.6%	4.1%	9.8%
Health, HIV, Sanitation	26.8%	22.3%	12.7%	7.3%	11.3%	5.8%	8.3%	5.6%
Health, HIV, Water	24.8%	24.2%	9.9%	1.5%	14.1%	11.6%	0.7%	13.1%
Health, HIV, Child protection	47.6%	1.5%	23.4%	11.0%	0.6%	2.1%	11.7%	2.2%
Nutrition, Housing, ICT	11.1%	12.7%	10.2%	4.9%	27.7%	8.3%	4.8%	20.3%
Nutrition, Sanitation, ICT	13.5%	20.0%	7.7%	5.3%	20.4%	16.3%	4.4%	12.4%
Nutrition, Sanitation, Housing	14.8%	18.7%	9.0%	9.0%	19.1%	12.6%	4.2%	12.6%
Nutrition, Water, ICT	10.8%	14.6%	10.4%	4.9%	25.8%	6.6%	4.9%	22.0%
Nutrition, Water, Housing	10.8%	14.6%	13.0%	4.2%	23.2%	7.3%	9.0%	17.9%
Nutrition, Water, Sanitation	15.1%	10.4%	18.4%	5.9%	17.8%	5.5%	15.6%	11.2%
Nutrition, Child protection, ICT	20.7%	37.4%	0.6%	9.3%	3.0%	26.3%	0.4%	2.3%
Nutrition, Child protection, Housing	23.3%	34.8%	0.5%	12.7%	3.1%	22.9%	0.5%	2.2%
Nutrition, Child protection, Sanitation	31.0%	27.2%	2.6%	19.5%	1.0%	16.2%	2.1%	0.6%
Nutrition, Child protection, Water	24.9%	33.2%	0.5%	10.9%	3.0%	24.7%	0.5%	2.1%
Nutrition, HIV, ICT	14.4%	25.6%	6.9%	6.1%	14.8%	16.1%	3.6%	12.5%
Nutrition, HIV, Housing	15.9%	24.0%	7.9%	7.4%	13.9%	14.8%	5.7%	10.4%
Nutrition, HIV, Sanitation	22.1%	17.8%	11.4%	11.9%	10.3%	10.3%	9.6%	6.5%
Nutrition, HIV, Water	18.4%	21.5%	7.1%	7.9%	14.7%	14.3%	3.6%	12.5%
Nutrition, HIV, Child protection	37.8%	2.1%	20.3%	20.8%	1.5%	1.4%	14.8%	1.3%
Nutrition, Health, ICT	18.8%	28.5%	2.4%	7.9%	11.9%	17.8%	1.8%	10.8%
Nutrition, Health, Housing	20.1%	27.3%	3.7%	9.3%	10.6%	16.4%	3.9%	8.7%
Nutrition, Health, Sanitation	26.3%	21.1%	7.2%	13.2%	7.1%	12.5%	8.3%	4.3%
Nutrition, Health, Water	24.2%	23.1%	1.3%	10.5%	13.1%	15.2%	0.9%	11.7%
Nutrition, Health, Child protection	46.2%	1.2%	11.9%	24.9%	2.4%	0.8%	10.8%	1.8%
Nutrition, Health, HIV	32.7%	14.7%	7.3%	16.4%	7.1%	9.3%	5.8%	6.8%

Table 13: *Overlap between combinations of three dimensions, children aged 24-59 months*

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
Sanitation, Housing, ICT	7.2%	4.7%	3.2%	9.5%	5.5%	16.7%	10.3%	43.0%
Water, Housing, ICT	8.7%	7.1%	5.8%	8.0%	15.0%	14.3%	7.7%	33.4%
Water, Sanitation, ICT	6.8%	5.6%	7.6%	3.6%	16.4%	4.5%	12.1%	43.2%
Water, Sanitation, Housing	7.7%	4.8%	8.0%	4.2%	16.0%	3.9%	18.1%	37.3%
Child protection, Housing, ICT	16.2%	20.8%	12.9%	0.5%	45.4%	0.6%	0.7%	3.1%
Child protection, Sanitation, ICT	10.1%	9.9%	18.9%	0.3%	56.3%	0.3%	0.9%	3.4%
Child protection, Sanitation, Housing	11.6%	8.4%	25.3%	0.3%	49.8%	0.2%	0.8%	3.5%
Child protection, Water, ICT	14.1%	21.1%	14.9%	0.3%	45.1%	1.0%	0.8%	2.7%
Child protection, Water, Housing	15.3%	19.9%	21.6%	0.4%	38.4%	0.9%	0.7%	2.8%
Child protection, Water, Sanitation	12.1%	23.0%	7.9%	0.3%	52.1%	1.0%	0.2%	3.2%
Development, Housing, ICT	16.3%	19.7%	12.4%	0.4%	40.4%	1.7%	1.1%	8.0%
Development, Sanitation, ICT	10.3%	9.8%	18.4%	0.1%	50.3%	0.4%	1.4%	9.3%
Development, Sanitation, Housing	11.9%	8.2%	24.1%	0.1%	44.6%	0.5%	2.0%	8.7%
Development, Water, ICT	13.8%	20.4%	14.9%	0.7%	39.7%	1.7%	0.9%	8.0%
Development, Water, Housing	15.3%	18.9%	20.7%	0.4%	33.9%	1.9%	1.6%	7.3%
Development, Water, Sanitation	12.2%	22.0%	7.9%	0.2%	46.7%	2.1%	0.3%	8.6%
Development, Child protection, ICT	27.7%	57.7%	0.9%	1.3%	2.4%	8.4%	0.3%	1.3%
Development, Child protection, Housing	34.9%	50.5%	1.0%	2.0%	2.2%	7.7%	0.0%	1.5%
Development, Child protection, Sanitation	19.7%	65.8%	0.4%	0.4%	2.9%	9.3%	0.1%	1.4%
Development, Child protection, Water	33.1%	52.3%	1.0%	2.1%	2.2%	7.7%	0.3%	1.2%
HIV, Housing, ICT	12.2%	13.6%	10.6%	4.5%	29.8%	7.7%	2.9%	18.6%
HIV, Sanitation, ICT	8.3%	7.0%	14.5%	2.1%	36.4%	3.2%	5.3%	23.2%
HIV, Sanitation, Housing	9.1%	6.1%	16.7%	2.8%	34.3%	2.5%	9.5%	19.0%
HIV, Water, ICT	11.5%	14.8%	11.3%	3.0%	28.6%	7.2%	4.4%	19.1%
HIV, Water, Housing	11.9%	14.3%	13.9%	3.8%	26.1%	6.4%	8.4%	15.1%
HIV, Water, Sanitation	9.4%	16.9%	5.8%	3.0%	34.1%	7.2%	2.3%	21.2%
HIV, Child protection, ICT	21.9%	40.8%	0.8%	7.1%	2.7%	25.4%	0.3%	1.0%
HIV, Child protection, Housing	25.0%	37.7%	0.8%	11.9%	2.7%	20.6%	0.3%	1.0%

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
HIV, Child protection, Sanitation	14.9%	47.9%	0.4%	5.2%	3.1%	27.3%	0.1%	1.2%
HIV, Child protection, Water	25.3%	37.4%	1.0%	9.9%	2.5%	22.6%	0.3%	1.0%
HIV, Development, ICT	21.7%	37.9%	1.1%	6.9%	5.6%	22.2%	0.5%	4.2%
HIV, Development, Housing	24.3%	35.3%	1.5%	11.7%	5.1%	17.5%	0.6%	4.1%
HIV, Development, Sanitation	15.0%	44.6%	0.3%	5.1%	6.3%	24.0%	0.2%	4.4%
HIV, Development, Water	24.8%	34.8%	1.5%	9.4%	5.1%	19.8%	0.9%	3.8%
HIV, Development, , Child protection	57.2%	2.4%	5.5%	28.2%	1.1%	0.9%	4.2%	0.4%
Health, Housing, ICT	14.9%	13.3%	11.0%	1.8%	29.4%	8.1%	2.6%	19.0%
Health, Sanitation, ICT	10.0%	9.0%	15.9%	0.4%	33.7%	1.2%	3.9%	26.0%
Health, Sanitation, Housing,	11.5%	7.5%	16.7%	0.5%	32.8%	1.1%	9.4%	20.5%
Health, Water, ICT	13.7%	19.5%	12.1%	0.7%	23.1%	2.5%	3.6%	24.6%
Health, Water, Housing,	15.1%	18.1%	13.0%	0.6%	22.2%	2.7%	9.3%	18.9%
Health, Water, Sanitation,	11.8%	21.4%	7.2%	0.6%	28.1%	2.7%	1.0%	27.2%
Health, Child protection, ICT	25.1%	40.9%	0.7%	3.9%	1.7%	25.2%	0.5%	1.9%
Health, Child protection, Housing,	27.6%	38.5%	0.6%	9.4%	1.9%	19.7%	0.5%	1.9%
Health, Child protection, Sanitation	18.6%	47.5%	0.4%	1.5%	2.0%	27.6%	0.1%	2.3%
Health, Child protection, Water	32.1%	34.0%	1.2%	3.1%	1.3%	26.0%	0.2%	2.2%
Health, Development, ICT	24.6%	39.0%	1.2%	4.0%	3.6%	21.1%	0.3%	6.1%
Health, Development, Housing	26.9%	36.8%	1.2%	9.1%	3.6%	16.0%	0.8%	5.6%
Health, Development, Sanitation	18.6%	45.1%	0.4%	1.5%	4.4%	23.6%	0.1%	6.3%
Health, Development, Water	31.3%	32.4%	2.0%	2.9%	2.8%	22.1%	0.3%	6.1%
Health, Development, Child protection	61.6%	2.1%	4.5%	23.8%	0.4%	1.2%	5.3%	1.2%
Health, HIV, ICT	19.5%	28.3%	6.4%	3.3%	14.4%	15.2%	1.0%	12.0%
Health, HIV, Housing	19.9%	27.8%	8.2%	5.9%	12.5%	12.6%	4.0%	9.0%
Health, HIV, Sanitation	14.0%	33.8%	5.0%	1.3%	15.7%	17.2%	0.3%	12.7%
Health, HIV, Water	23.8%	24.0%	9.5%	2.5%	11.3%	15.9%	0.7%	12.3%
Health, HIV, Child protection	45.8%	2.0%	20.3%	16.9%	0.5%	1.6%	12.2%	0.8%
Health, HIV, Development	44.5%	3.3%	19.2%	15.1%	1.6%	3.4%	9.9%	3.1%
Nutrition, Housing, ICT	5.4%	6.0%	4.7%	11.2%	9.8%	15.3%	8.8%	38.6%
Nutrition, Sanitation, ICT	3.6%	3.2%	6.5%	6.8%	12.7%	7.0%	13.2%	47.0%
Nutrition, Sanitation, Housing	3.8%	3.0%	7.7%	8.1%	11.6%	5.7%	18.5%	41.8%

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
Nutrition, Water, ICT	5.3%	6.0%	4.8%	9.1%	9.9%	16.1%	10.9%	37.9%
Nutrition, Water, Housing	5.5%	5.8%	6.0%	10.3%	8.7%	15.0%	16.3%	32.5%
Nutrition, Water, Sanitation	4.1%	7.2%	2.7%	8.3%	12.0%	16.9%	5.5%	43.3%
Nutrition, Child protection, ICT	10.1%	15.3%	0.1%	19.0%	0.5%	50.8%	1.1%	3.1%
Nutrition, Child protection, Housing	11.4%	14.0%	0.1%	25.6%	0.5%	44.2%	1.0%	3.2%
Nutrition, Child protection, Sanitation	6.7%	18.7%	0.1%	13.4%	0.5%	56.4%	0.4%	3.8%
Nutrition, Child protection, Water	11.0%	14.4%	0.3%	24.2%	0.3%	45.6%	1.0%	3.2%
Nutrition, Development, ICT	9.7%	14.5%	0.5%	19.0%	1.4%	45.6%	1.1%	8.3%
Nutrition, Development, Housing	11.0%	13.2%	0.5%	25.0%	1.3%	39.6%	1.6%	7.9%
Nutrition, Development, Sanitation	6.7%	17.5%	0.1%	13.4%	1.7%	51.2%	0.4%	9.0%
Nutrition, Development, Water	10.6%	13.6%	0.7%	23.6%	1.1%	41.0%	1.6%	7.8%
Nutrition, Development, Child protection	23.8%	0.4%	1.6%	61.7%	0.2%	2.9%	8.1%	1.3%
Nutrition, HIV, ICT	7.5%	10.7%	2.6%	15.3%	5.2%	32.7%	4.8%	21.2%
Nutrition, HIV, Housing	8.0%	10.2%	3.5%	17.8%	4.3%	30.2%	8.8%	17.3%
Nutrition, HIV, Sanitation	4.9%	13.3%	1.9%	10.4%	5.9%	37.6%	3.4%	22.6%
Nutrition, HIV, Water	8.3%	10.0%	3.0%	18.0%	4.7%	30.0%	7.2%	18.8%
Nutrition, HIV, Child protection	17.7%	0.5%	7.6%	45.0%	0.1%	3.0%	24.8%	1.2%
Nutrition, HIV, Development	17.0%	1.2%	7.2%	42.6%	0.6%	5.4%	22.0%	4.1%
Nutrition, Health, ICT	9.1%	12.1%	1.1%	16.8%	3.8%	30.6%	3.3%	23.4%
Nutrition, Health, Housing	9.7%	11.4%	1.8%	18.4%	3.1%	28.9%	8.1%	18.5%
Nutrition, Health, Sanitation	6.4%	14.7%	0.4%	12.6%	4.5%	34.8%	1.2%	25.4%
Nutrition, Health, Water	10.7%	10.5%	0.6%	22.6%	4.2%	24.8%	2.7%	24.0%
Nutrition, Health, Child protection	20.6%	0.5%	4.7%	45.4%	0.1%	1.9%	24.4%	2.3%
Nutrition, Health, Development	19.7%	1.5%	4.5%	44.0%	0.3%	3.4%	20.6%	6.1%
Nutrition, Health, HIV	14.8%	6.3%	3.4%	32.9%	1.4%	14.4%	15.1%	11.6%

Table 14: *Overlap between combinations of three dimensions, children aged 5-14 years*

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
Sanitation, Housing, ICT	7.1%	4.3%	3.7%	8.4%	5.3%	14.4%	14.4%	42.5%
Water, Housing, ICT	8.3%	7.2%	7.5%	7.2%	14.1%	11.5%	10.6%	33.7%
Water, Sanitation, ICT	6.6%	5.1%	9.1%	4.2%	16.2%	4.5%	13.6%	40.7%
Water, Sanitation, Housing	7.2%	4.5%	8.3%	4.2%	17.1%	4.5%	14.5%	39.8%
Clothing, Housing, ICT	3.5%	2.3%	2.4%	12.0%	3.0%	16.4%	15.6%	44.8%
Clothing, Sanitation, ICT	3.0%	1.1%	3.0%	7.8%	4.2%	8.5%	19.8%	52.7%
Clothing, Sanitation, Housing	2.6%	1.5%	3.2%	8.8%	3.9%	7.5%	19.6%	52.9%
Clothing, Water, ICT	3.2%	2.6%	2.7%	12.5%	2.7%	18.7%	15.1%	42.5%
Clothing, Water, Housing	3.0%	2.8%	2.8%	12.4%	2.6%	18.8%	15.9%	41.6%
Clothing, Water, Sanitation	2.6%	3.2%	1.4%	9.0%	4.0%	22.2%	7.3%	50.3%
Education, Housing, ICT	4.3%	3.6%	4.0%	11.1%	6.9%	15.1%	14.1%	40.9%
Education, Sanitation, ICT	3.5%	2.3%	4.7%	7.2%	8.2%	7.3%	18.0%	48.7%
Education, Sanitation, Housing	3.6%	2.2%	4.3%	7.7%	8.7%	6.8%	18.5%	48.2%
Education, Water, ICT	4.3%	4.3%	4.0%	11.4%	6.2%	17.0%	13.8%	39.0%
Education, Water, Housing	4.3%	4.3%	3.6%	11.1%	6.6%	17.3%	15.1%	37.6%
Education, Water, Sanitation	3.7%	4.9%	2.2%	8.0%	8.1%	20.5%	6.5%	46.3%
Education, Clothing, ICT	2.1%	1.4%	6.2%	3.8%	9.1%	3.9%	21.4%	52.1%
Education, Clothing, Housing	1.7%	1.8%	6.2%	4.1%	9.1%	3.6%	22.1%	51.3%
Education, Clothing, Sanitation	1.6%	1.9%	4.3%	2.5%	11.0%	5.2%	12.0%	61.5%
Education, Clothing, Water	2.0%	1.5%	6.6%	3.8%	8.7%	3.9%	24.6%	48.8%
Child protection, Housing, ICT	12.8%	15.7%	13.6%	2.7%	37.4%	3.0%	4.4%	10.4%
Child protection, Sanitation, ICT	8.3%	7.8%	18.1%	2.5%	45.2%	1.8%	4.7%	11.7%
Child protection, Sanitation, Housing	9.4%	6.7%	19.0%	1.9%	44.3%	2.3%	3.8%	12.5%
Child protection, Water, ICT	12.5%	17.1%	13.9%	3.2%	36.0%	4.2%	3.9%	9.2%
Child protection, Water, Housing	12.6%	16.9%	15.8%	2.8%	34.0%	4.6%	2.9%	10.2%
Child protection, Water, Sanitation	8.9%	20.7%	7.2%	2.8%	42.6%	4.7%	1.5%	11.7%
Child protection, Clothing, ICT	4.7%	4.1%	21.7%	1.2%	48.9%	1.2%	5.9%	12.2%
Child protection, Clothing, Housing	4.7%	4.1%	23.8%	1.2%	46.9%	1.3%	4.6%	13.6%
Child protection, Clothing, Sanitation	3.0%	5.8%	13.0%	1.0%	57.6%	1.4%	3.2%	14.9%
Child protection, Clothing, Water	4.5%	4.3%	25.1%	1.3%	45.6%	1.1%	6.1%	12.0%

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
Child protection, Education, ICT	5.5%	7.0%	20.9%	2.8%	46.0%	3.5%	4.3%	9.9%
Child protection, Education, Housing	5.8%	6.7%	22.7%	2.1%	44.3%	4.2%	3.6%	10.7%
Child protection, Education, Sanitation	4.0%	8.5%	12.1%	1.9%	54.8%	4.4%	2.4%	11.9%
Child protection, Education, Water	6.0%	6.5%	23.6%	2.6%	43.4%	3.8%	4.9%	9.4%
Child protection, Education, Clothing	2.4%	10.1%	6.4%	1.1%	60.5%	5.2%	1.3%	12.9%
HIV, Housing, ICT	11.7%	12.7%	14.5%	3.8%	30.4%	6.0%	3.6%	17.4%
HIV, Sanitation, ICT	8.4%	6.5%	17.7%	2.3%	36.6%	3.0%	5.0%	20.3%
HIV, Sanitation, Housing	8.4%	6.5%	16.0%	2.9%	38.4%	2.5%	6.8%	18.5%
HIV, Water, ICT	12.5%	14.7%	13.6%	3.2%	28.4%	6.6%	4.2%	16.8%
HIV, Water, Housing	11.7%	15.5%	12.7%	3.7%	29.3%	6.1%	6.0%	14.9%
HIV, Water, Sanitation	9.0%	18.2%	5.9%	2.6%	36.1%	7.1%	2.7%	18.2%
HIV, Clothing,	4.8%	3.8%	21.3%	1.1%	39.3%	1.5%	6.3%	21.9%
HIV, Clothing, Housing	4.6%	4.0%	19.8%	1.2%	40.9%	1.4%	8.5%	19.6%
HIV, Clothing, Sanitation	3.3%	5.3%	11.6%	0.7%	49.0%	1.9%	4.6%	23.5%
HIV, Clothing, Water	4.4%	4.2%	22.8%	1.4%	37.8%	1.2%	8.4%	19.7%
HIV, Education, ICT	6.6%	7.2%	19.6%	1.7%	35.9%	3.3%	5.6%	20.1%
HIV, Education, Housing	5.8%	8.0%	18.6%	2.2%	36.8%	2.9%	7.6%	18.1%
HIV, Education, Sanitation	4.6%	9.2%	10.4%	1.3%	45.1%	3.7%	4.1%	21.6%
HIV, Education, Water	6.3%	7.5%	20.9%	2.3%	34.5%	2.8%	7.5%	18.2%
HIV, Education, Clothing	2.6%	11.2%	6.0%	0.9%	49.4%	4.1%	1.7%	24.0%
HIV, Child protection, ICT	20.2%	33.6%	5.9%	6.2%	9.5%	19.4%	1.2%	3.9%
HIV, Child protection, Housing	20.1%	33.7%	4.2%	8.3%	11.2%	17.3%	1.5%	3.6%
HIV, Child protection, Sanitation	11.6%	42.3%	3.4%	4.5%	12.1%	21.1%	0.9%	4.3%
HIV, Child protection, Water	21.5%	32.3%	5.7%	8.1%	9.7%	17.6%	1.7%	3.4%
HIV, Child protection, Clothing	6.5%	47.3%	2.1%	2.3%	13.3%	23.3%	0.3%	4.8%
HIV, Child protection, Education	8.9%	44.9%	4.9%	3.6%	10.6%	22.0%	1.5%	3.7%
Health, Housing, ICT	14.2%	13.3%	14.4%	1.2%	29.9%	5.4%	3.6%	17.9%
Health, Sanitation, ICT	10.3%	8.1%	18.3%	0.4%	35.1%	1.4%	4.5%	21.8%
Health, Sanitation, Housing	10.9%	7.6%	16.6%	0.4%	36.8%	1.4%	6.2%	20.1%
Health, Water, ICT	14.9%	19.3%	13.8%	0.8%	24.0%	2.0%	4.0%	21.2%
Health, Water, Housing	15.0%	19.2%	12.5%	0.4%	25.2%	2.4%	6.2%	19.1%

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
Health, Water, Sanitation	11.4%	22.8%	7.1%	0.2%	30.7%	2.6%	1.6%	23.6%
Health, Clothing, ICT	5.6%	4.4%	23.0%	0.3%	38.8%	0.9%	4.6%	22.3%
Health, Clothing, Housing	4.9%	5.1%	22.6%	0.9%	39.3%	0.3%	5.7%	21.2%
Health, Clothing, Sanitation	4.0%	6.1%	14.5%	0.1%	47.4%	1.1%	1.8%	25.1%
Health, Clothing, Water	5.8%	4.3%	28.4%	0.0%	33.5%	1.2%	2.8%	24.1%
Health, Education, ICT	7.7%	8.7%	20.9%	0.5%	34.6%	1.8%	4.3%	21.4%
Health, Education, Housing	7.3%	9.1%	20.2%	0.6%	35.2%	1.8%	6.0%	19.7%
Health, Education, Sanitation	5.6%	10.8%	12.9%	0.3%	42.6%	2.1%	1.6%	24.1%
Health, Education, Water,	8.2%	8.2%	26.0%	0.3%	29.5%	2.0%	2.5%	23.2%
Health, Education, Clothing,	3.4%	13.1%	6.7%	0.1%	48.8%	2.2%	1.1%	24.6%
Health, Child protection, ICT	22.7%	34.8%	6.0%	3.7%	8.4%	18.2%	1.1%	5.0%
Health, Child protection, Housing	23.1%	34.4%	4.4%	5.3%	10.0%	16.6%	1.3%	4.8%
Health, Child protection, Sanitation	14.5%	43.0%	4.0%	1.6%	10.4%	20.3%	0.2%	5.9%
Health, Child protection, Water	27.3%	30.2%	6.9%	2.3%	7.5%	19.7%	0.5%	5.6%
Health, Child protection, Clothing	8.0%	49.5%	2.0%	0.8%	12.4%	21.2%	0.4%	5.7%
Health, Child protection, Education	11.1%	46.3%	5.3%	1.3%	9.1%	20.6%	1.0%	5.1%
Health, HIV, ICT	22.3%	29.4%	6.3%	3.8%	13.8%	13.7%	1.0%	9.6%
Health, HIV, Housing	20.1%	31.7%	7.4%	4.3%	12.7%	13.2%	2.3%	8.3%
Health, HIV, Sanitation	14.0%	37.7%	4.4%	0.9%	15.7%	16.6%	0.9%	9.7%
Health, HIV, Water	25.3%	26.5%	8.9%	2.0%	11.2%	15.5%	0.9%	9.7%
Health, HIV, Clothing	7.6%	44.2%	2.4%	1.0%	17.7%	16.5%	0.2%	10.4%
Health, HIV, Education	12.1%	39.7%	4.4%	1.7%	15.7%	15.7%	0.6%	10.0%
Health, HIV, Child protection	40.7%	11.1%	16.8%	13.1%	3.3%	4.3%	8.8%	1.8%

Table 15: *Overlap between combinations of three dimensions, children aged 15-17 years*

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
Sanitation, Housing, ICT	6.0%	3.4%	4.4%	6.7%	5.0%	11.8%	14.8%	47.8%
Water, Housing, ICT	6.5%	6.8%	7.4%	6.2%	14.9%	8.4%	11.8%	38.0%
Water, Sanitation, ICT	5.8%	4.5%	8.1%	4.6%	17.2%	4.0%	13.4%	42.4%
Water, Sanitation, Housing	5.9%	4.4%	7.3%	3.5%	17.9%	5.0%	11.1%	44.8%
Clothing, Housing, ICT	2.4%	2.2%	3.0%	10.4%	2.5%	13.0%	16.2%	50.4%
Clothing, Sanitation, ICT	2.0%	1.0%	3.3%	8.4%	3.6%	7.4%	18.3%	56.0%
Clothing, Sanitation, Housing	1.7%	1.4%	2.8%	7.7%	4.1%	8.1%	15.7%	58.6%
Clothing, Water, ICT	2.7%	2.4%	2.7%	11.2%	2.2%	19.2%	15.4%	44.1%
Clothing, Water, Housing	2.4%	2.7%	2.1%	10.9%	2.8%	19.6%	12.5%	47.0%
Clothing, Water, Sanitation	2.0%	3.1%	1.1%	8.3%	3.8%	22.2%	7.5%	52.0%
Education, Housing, ICT	10.1%	8.7%	11.8%	2.6%	26.7%	6.5%	7.4%	26.2%
Education, Sanitation, ICT	8.0%	5.9%	13.9%	2.4%	29.5%	2.6%	7.6%	30.0%
Education, Sanitation, Housing	7.4%	6.5%	11.5%	2.1%	32.0%	2.9%	7.0%	30.6%
Education, Water, ICT	10.1%	13.1%	11.8%	3.8%	22.4%	8.6%	6.2%	24.0%
Education, Water, Housing	9.7%	13.5%	9.2%	3.6%	25.0%	8.8%	5.5%	24.8%
Education, Water, Sanitation,	7.6%	15.5%	6.2%	2.7%	28.0%	9.7%	2.3%	27.9%
Education, Clothing, ICT	4.2%	2.9%	17.8%	1.2%	32.5%	1.8%	8.9%	30.8%
Education, Clothing, Housing	3.1%	4.0%	15.8%	1.4%	34.6%	1.5%	7.6%	32.0%
Education, Clothing, Sanitation	2.3%	4.7%	11.5%	0.7%	38.8%	2.2%	4.3%	35.4%
Education, Clothing, Water	3.8%	3.3%	19.4%	1.3%	30.9%	1.6%	11.1%	28.6%
HIV, Housing, ICT	10.4%	11.9%	16.2%	2.3%	39.1%	3.2%	3.0%	13.7%
HIV, Sanitation, ICT	8.6%	6.7%	18.0%	1.8%	44.4%	1.8%	3.5%	15.2%
HIV, Sanitation, Housing	7.6%	7.6%	14.7%	1.8%	47.7%	1.8%	3.7%	15.0%
HIV, Water, ICT	11.4%	16.6%	15.2%	2.5%	34.5%	5.0%	2.8%	11.9%
HIV, Water, Housing,	10.7%	17.4%	11.7%	2.6%	38.0%	4.9%	3.0%	11.8%
HIV, Water, Sanitation	8.6%	19.5%	6.7%	1.7%	43.0%	5.8%	1.9%	12.9%
HIV, Clothing, ICT	4.1%	3.5%	22.5%	1.2%	47.6%	1.2%	4.1%	15.8%
HIV, Clothing, Housing	3.4%	4.3%	19.0%	1.2%	51.1%	1.2%	4.4%	15.5%
HIV, Clothing, Sanitation	2.2%	5.4%	13.0%	0.9%	57.0%	1.5%	2.7%	17.2%
HIV, Clothing, Water	4.0%	3.6%	24.0%	1.1%	46.1%	1.3%	6.5%	13.4%
HIV, Education, ICT	18.1%	27.2%	8.5%	3.9%	23.9%	8.2%	1.5%	8.7%
HIV, Education, Housing	15.1%	30.1%	7.2%	3.7%	25.2%	8.4%	1.8%	8.4%

COMBINATION OF THREE DIMENSIONS	OVERLAP BETWEEN ALL DIMENSIONS	OVERLAP BETWEEN FIRST TWO DIMENSIONS	OVERLAP BETWEEN FIRST AND THIRD DIMENSIONS	OVERLAP BETWEEN SECOND AND THIRD DIMENSIONS	DEPRIVATION IN ONLY FIRST DIMENSION	DEPRIVATION IN ONLY SECOND DIMENSION	DEPRIVATION IN ONLY THIRD DIMENSION	DEPRIVED IN NONE OF THE THREE DIMENSIONS
HIV, Education, Sanitation	11.0%	34.2%	4.2%	2.9%	28.2%	9.3%	0.8%	9.4%
HIV, Education, Water	18.1%	27.2%	10.0%	5.1%	22.4%	7.0%	2.4%	7.8%
HIV, Education, Clothing	5.6%	39.7%	2.0%	1.5%	30.4%	10.6%	0.9%	9.3%
Health, Housing, ICT	11.3%	12.3%	15.6%	1.4%	34.2%	2.9%	3.6%	18.7%
Health, Sanitation, ICT	10.0%	7.7%	16.9%	0.4%	38.9%	0.8%	4.6%	20.7%
Health, Sanitation, Housing	9.2%	8.4%	14.4%	0.2%	41.4%	1.0%	4.1%	21.3%
Health, Water, ICT	12.6%	20.0%	14.3%	1.3%	26.6%	1.7%	3.7%	19.8%
Health, Water, Housing	12.8%	19.8%	10.8%	0.5%	30.1%	2.5%	3.8%	19.7%
Health, Water, Sanitation	10.1%	22.4%	7.5%	0.2%	33.4%	2.8%	1.0%	22.5%
Health, Clothing, ICT	5.1%	3.9%	21.8%	0.3%	42.7%	0.8%	4.8%	20.7%
Health, Clothing, Housing	3.7%	5.2%	19.9%	0.8%	44.6%	0.3%	3.5%	22.0%
Health, Clothing, Sanitation	3.1%	5.8%	14.6%	0.0%	50.0%	1.1%	1.2%	24.2%
Health, Clothing, Water	5.0%	3.9%	27.6%	0.1%	36.9%	0.9%	2.9%	22.6%
Health, Education, ICT	20.1%	28.4%	6.8%	1.8%	18.1%	7.0%	3.2%	14.5%
Health, Education, Housing	17.3%	31.2%	6.3%	1.5%	18.6%	7.3%	2.8%	15.0%
Health, Education, Sanitation	13.1%	35.5%	4.6%	0.8%	20.4%	8.0%	0.4%	17.3%
Health, Education, Water,	22.0%	26.5%	10.6%	1.2%	14.3%	7.7%	1.8%	15.9%
Health, Education, Clothing	6.6%	41.9%	2.3%	0.4%	22.6%	8.4%	0.7%	17.1%
Health, HIV, ICT	22.1%	35.6%	4.8%	4.5%	11.0%	15.5%	0.5%	6.0%
Health, HIV, Housing	18.9%	38.8%	4.7%	3.4%	11.1%	16.6%	0.9%	5.7%
Health, HIV, Sanitation	14.6%	43.1%	3.0%	0.6%	12.7%	19.4%	0.6%	5.9%
Health, HIV, Water	25.5%	32.2%	7.1%	2.6%	8.7%	17.4%	0.4%	6.1%
Health, HIV, Clothing	6.9%	50.8%	2.0%	0.7%	13.7%	19.3%	0.4%	6.2%
Health, HIV, Education	38.0%	19.7%	10.5%	7.3%	5.2%	12.8%	1.6%	5.0%

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