2019 SITUATION ANALYSIS OF CHILDREN & ADOLESCENTS IN THE KINGDOM OF ESWATINI

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EXECUTIVE SUMMARY

The Kingdom of Eswatini, a low-middle-income country of 1.15 million, has embodied peace, stability and resilience in a world of flux and uncertainty. In its quest for sustainable, inclusive development, the Kingdom is at a critical juncture with respect to the needs and realities of one of its most precious resources: its children and adolescents. This report provides findings and recommendations from a UNICEF-commissioned analysis of the situation related to children and adolescents. Different profiles of children and adolescents, in addition to other stakeholders, were consulted as part of the process.

THE NATIONAL CONTEXT: The country's 2017 Population and Housing Census paints a picture of a very young and overwhelmingly rural population. Forty-three percent of residents are between the ages of 0 and 17 years, and adolescents (10-19 years) account for one-fourth of the total population. Therefore, developing human capital and investing in all aspects of child and adolescent well-being are central to Eswatini's ability to reap a demographic dividend (i.e., accelerated economic development as a result of changes in population age structure, coupled with declines in mortality and fertility). The country is, however, contending with major challenges such as economic/fiscal crises, climate-induced hazards (e.g., the 2015/16 drought) and disease outbreaks or epidemics (including but not limited to HIV, which has a national adult prevalence of 27.3% in 2018). Micro-level shocks to families (resulting from factors such as parental death, illness, loss of livelihoods and other factors) is highly salient in Eswatini as it underpins a range of vulnerabilities affecting children (e.g., inadequate parental care, multidimensional poverty).

Internal migration from rural to urban areas is also changing the dynamics of urban areas and the locus of need and vulnerability among children and adolescents. The Kingdom of Eswatini's urbanization rate stands at 24% in 2019 but is projected to reach as high as 34% by 2050. Understanding the drivers of rural-urban migration, the dynamics of informal settlements in urban/peri-urban settings, and the profile of women, children and families who live in those settings is critical to achieving national impact related to child and adolescent well-being in Eswatini. Expanding the analysis to include the concept of 'children on the move' sheds light on how migration patterns can introduce or exacerbate vulnerabilities in children and adolescents. There is a paucity of data on children on the move in Eswatini but compelling anecdotal information on child migration between Eswatini, South Africa and Mozambique, and the elevated vulnerability of children on the move to exploitation and other adverse outcomes.

Despite challenges such as those noted above, the country has undergone important shifts in creating an enabling environment for child and adolescent well-being. There have been milestone policy and legislative achievements in recent years (e.g., Sexual Offences and Domestic Violence Act of 2017). However, there remains an absence of a national policy instrument to mainstream child participation across all actors and sectors. In addition, the current economic climate and limited public finance for children have major implications for the pace and extent to which the Kingdom can achieve child-sensitive Sustainable Development Goals (SDGs) by 2030. In addition to finance-related challenges, SDG assessments to date have highlighted challenges related to targeting, quality of services, data for performance monitoring and responsiveness of planning and implementation to hazards and risks.

Sustainable development for all cannot be achieved without tackling inequalities, and one key inequality in Eswatini relates to gender. The Kingdom ranks 141st out of 160 countries in gender equality (144th in terms of the overall Human Development Index), reflecting lagging performance on some gender equality measures (e.g., 14.7% of parliamentary seats are held by women), maternal mortality reduction and female labor market participation. Proxy measures of gender equality and women's empowerment—for example, a woman's level of education—also emerge as drivers of inequities and shortfalls related to children and adolescents.

Poverty also emerges a key factor underlying vulnerability. According to the 2016/17 Eswatini

Household Income and Expenditure Survey, 29.6% of the population is moderately poor, and 12.5% is extremely poor. Children are disproportionately affected, accounting for 49% of household members in general, but among extremely poor and labor-constrained households, the average share of children is 66%. It should be noted, however, that monetary poverty statistics belie the nature and extent of child poverty in the country. According to a Multiple Overlapping Deprivation Analysis (MODA) conducted in 2018, almost 6 out of every 10 children in Eswatini (56.5%) are multidimensionally poor, experiencing deprivations in dimensions such as health; nutrition; education; protection and water, sanitation and hygiene (WASH). The rate of multidimensional child poverty (MCP) is almost three times as high in rural areas (65%) than in urban areas (23%). The MCP rate is also higher for boys than for girls (60% versus 54%, respectively). Regional variations also exist, with children in Shiselweni, followed by Lubombo, faring the worst.

Given the complexity of needs, coordinated action is paramount. The partnership landscape in Eswatini consists of numerous actors but there is a need for "whole system" coordination and mutual accountability across stakeholders. There are strategically placed entities (e.g., National Children's Unit within the Deputy Prime Minister's Office) that can provide leadership in multi-stakeholder coordination and harmonized monitoring and evaluation (M&E). However, that potential has not been realized. In the interim, there are some coordinating mechanisms that exist within certain stakeholder groups (e.g., civil society) and on specific issues (e.g., adolescents, early childhood development [ECD]). Private-sector engagement is limited, although development partners such as UNICEF have begun to engage the business community to galvanize action around discrete issues related to children (e.g., ECD, neonatal health and survival, youth employment). However, there remain missed opportunities to systematically sensitize the business community, make investment cases for their involvement in an array of child-sensitive efforts, foster corporate social responsibility and create mutual accountability in achieving meaningful results for the children and adolescents of Eswatini.

THE SITUATION RELATED TO PROTECTION: Children in Eswatini are affected by a host of protection issues; however, violence is, by far, the most-prominent child protection issue in the country. The 2014 Multiple Indicator Cluster Survey (MICS) estimated that 88% of children aged 1—14 years experienced at least one form of psychological or physical punishment by household members during the previous month.[1] Inadequate parental care warrants greater focus; it is a by-product of factors or circumstances that exacerbate vulnerabilities which compromise child protection. It is also a major underlying factor in adverse outcomes related to children and adolescents in other sectors. Sentiments expressed by children underscore the violence-gender equality nexus and serve as a clarion call for gender equality efforts to engage both males and females of all ages. Child marriage is not as prevalent in Eswatini as it is in other countries in the Africa region. However, the lack of data on all dimensions of child protection (e.g., violence, child labor, child trafficking and sexual exploitation, justice for children) and the absence of a formalized, systems approach to child protection limit the space in which both prevention and responses related to child protection can be improved, promoted and implemented at scale.

THE SITUATION RELATED TO YOUNG CHILD SURVIVAL AND DEVELOPMENT: There have been several strides in mortality reduction and other outcomes in young childhood. For example, 2018 estimates released by the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) show that Eswatini's under-five mortality rate is 54 per 1,000 live births (with a higher rate among boys [58] than girls [49]), the infant mortality rate (IMR) is 41 per 1,000 and the neonatal mortality rate (NMR) is 17 per 1,000. These estimates are lower than what was documented in the 2014 MICS and are a vast improvement over the under-five, infant and neonatal mortality rates documented in the 2010 MICS (104, 79 and 20 per 1000, respectively). Another national data source, the 2017 Population and Housing Census, estimated that the IMR is 53 per 1,000, which is far higher than the

[1] Government of Swaziland et al., Multiple Indicator Cluster Survey: final report, 2016, at http://MICS-surveys-prod.s3.amazonaws.com/MICS5/Eastern%20and%20Southern%20Africa/Swaziland/2014/Final/Swaziland%202014%20MICS%20Final%20Report_English. pdf.

latest UN IGME estimates. Hence, there remains an unfinished agenda related to child survival, particularly during the first year of life. There have been strides in the population-based coverage of some high-impact interventions (e.g., the 2014 MICS estimated that the rate of skilled delivery was 88%), although Shiselweni and Lubombo continue to fare worse than other regions on several indicators . For example. However, Shiselweni, followed by Lubombo,. Eswatini is making strides in relation to the prevention of mother-to-child transmission of HIV (PMTCT), with PMTCT services integrated into maternal and newborn health services. In 2018, 93% of pregnant women living with HIV received ART, and 76% of children living with HIV aged 0-14 years received ART.

There remain national shortfalls in several high-impact interventions such as child immunization, postnatal care and optimal infant and young child feeding practices such as exclusive breastfeeding during the first six months of life and complementary feeding after six months of life. The post-neonatal period—which is the period after the first month of life up to a child's first birthday—warrants equal attention to the neonatal period, as the mortality burden is actually higher during that period in a child's early existence than during the neonatal period, according to MICS data.

Malnutrition is a major determinant of child survival and development. Rates of child stunting (a measure of chronic malnutrition) have declined over time; The 2014 MICS documented a high child stunting rate of 23.0%, although it is lower than the rate documented in 2010 (30.9%). However, regional disparities persist. Whereas there are signs that chronic malnutrition in children is on the decline, that is not the case with acute malnutrition. Wasting (low weight-for-height) prevalence was 2% in 2014 and 2.5% in 2017. During that same period, child wasting rates in Hhohho region increased from 1.5% to 3.2%. The potential for high rates of overweight/obesity, whether emerging in childhood or in adulthood, are an important consideration for programs that are addressing nutrition in childhood. According to the 2014 MICS, the childhood overweight prevalence is 9%, although children in the richest wealth quintile are three times as likely as children in the lowest wealth quintile to be overweight (17.5% and 5.8%, respectively). Maternal nutritional status does not receive the same degree of attention as child nutritional status; however, a large proportion of women of reproductive age (WRA) in Eswatini are malnourished. According to 2018 Global Nutrition Report estimates, 27.2% of WRA are anemic. Also, a Comprehensive Nutrition Survey (2017) found that 32.3% of WRA are overweight. In total, the high rates of anemia, overnutrition and undernutrition indicate that Eswatini is experiencing a "triple burden of malnutrition," warranting sharper focus.

The critical first two years of life must remain a priority point of intervention to ensure that children embark on a path to both survive and thrive throughout childhood. This reality shines a light on the importance of ECD as a foundation for comprehensive interventions that touch upon all dimensions of young child development. Although awareness and buy-in for ECD is increasing in Eswatini, ECD is not yet regarded as a non-negotiable national priority that requires resourcing and program attention in both development and humanitarian scenarios. Primary school attendance is near-universal (more than 97%, even among the poorest children). Despite its importance in establishing a strong foundation for good educational outcomes as a child progresses through the school system, pre-primary enrollment is far lower. The 2014 MICS estimated that 60% of children attending first grade had attended preschool in previous year. Other dimensions of ECD (e.g., caring practices, early learning) are not sufficiently addressed. The national average for the ECD Index (65%), a composite measure that indicates the percentage of children aged 36-59 months who are developmentally on track in at least three of four key domains (literacy-numeracy, physical, social-emotional, learning) were not dramatically different between the last two MICS assessments (65% in 2014, compared with 62% in 2010). In addition, urban children fare much better than rural children on this index (74% and 63%, respectively).

Public finance for children addressing all operational requirements to link children with high-impact, age-appropriate and gender-sensitive services and interventions is critical. The allocation of financial resources, human resources (HR) and material resources to address needs throughout the span of childhood and adolescence also warrants attention. With the exception of primary schooling, there is a

paucity of age-appropriate services for children aged five years and older, before they enter adolescence. This is a segment of the young child population that is currently being left behind.

THE SITUATION RELATED TO ADOLESCENTS: There is an urgent need to continue to invest in the first decade of a child's life and rapidly expand efforts and investments in adolescent development and participation. Adolescent sexual and reproductive health predominates efforts focused on adolescents. Consecutive MICS have documented only a negligible difference in the adolescent birth rate between 2010 and 2014 (89 and 87 per 1,000, respectively). However, one noteworthy observation is that the urban-rural divide in adolescent fertility was higher in 2014 than it was in 2010. Also, adolescent birth rates in Manzini and Lubombo increased substantially between 2010 and 2014 (from 90 to 107 per 1000 in Lubombo, and from 63 to 82 per 1000 in Manzini). There is a paucity of nutrition data on adolescents. However, as stated earlier, evidence on all WRA (15-49 years) indicates that almost 3 out of every 10 WRA in Eswatini are overweight/obese. The link between child nutrition, growth and development, adolescent nutrition and other outcomes, and adult outcomes (e.g., related to health and productivity) warrants further attention.

Some rural adolescents consulted for the purposes of the SITAN perceived that health services are not as youth friendly as they should be, particularly in the area of maintaining confidentiality. There is also a perception among some adolescents that rural adolescents are being left behind in the adolescent and youth friendly movement within the country.

In contrast to primary education, for which Eswatini has achieved near-universal net enrolment, a very high proportion of adolescents are currently excluded from the secondary education system. Net attendance at the secondary school level is less than 30% (less than 13% at upper secondary education) and the reasons for this attrition are multi-fold. First, despite the higher number of secondary-school-age population, there are far fewer secondary schools than primary schools in the country. Second, the phenomena of over-age and school repetition result in children taking longer than the intended seven years to complete the entire primary education cycle. There is also lack of uniformity across schools in applying criteria to determine whether a child is promoted to the next grade versus held back to repeat a grade.

Unlike at the primary school level, where females have demonstrated a higher 'survival rate' to the last grade of primary education than males (e.g., in 2016, the primary education survival rates were 86% and 82%, respectively), the female and male survival rates to the last grade of secondary education have converged (76%), according to 2016 data from the UNESCO Institute for Statistics database.

Available evidence shows that 11.6% of secondary-school-age females, compared with 7.4% of secondary-school-age males, are completely out of school. Urban areas actually have a higher proportion of out-of-school adolescents than rural areas (12.2% and 8.8%, respectively), according to the 2014 MICS. The tangible vulnerabilities of out-of-school adolescents is reflected in the limited data that are available on out-of-school adolescents. For example, HIV incidence and prevalence are almost four times higher among out-of-school adolescent girls and women than among those in school.

To facilitate their economic contributions to society, it is essential that adolescents enter the labor market possessing skills that are aligned with services and competencies required by employers. There are missed opportunities for private/business sector engagement in cultivating skills for employability. The youth unemployment rate (47%) is double the national unemployment rate, which has implications for the country's ability to harness a demographic dividend. There are multiple avenues to cultivate skills for employability among adolescents (e.g., formal education system, non-formal education actors, Directorate of Industrial and Vocational Training within the Ministry of Education and Training [MoET]), and adolescents might—and often do—vacillate between the different entities involved. However, there is scope to improve coherence and coordination between the different stakeholders and entities, as well as reimagine education for adolescents.

There are noteworthy strides in galvanizing action related to adolescents (e.g., via an Adolescent Technical Working Group, led by the Ministry of Health, with active involvement from MoET and Ministry of Youth). Measures are being taken on the supply side to address system readiness to provide adolescent- and youth-friendly health services. However, once again, the focus is largely on sexual and reproductive health. Stakeholders perceive that unmet needs related to nutrition; suicide prevention, substance abuse and other mental health issues; and violence are great. Those aspects of adolescent well-being are not well documented and remain 'blind spots' in current efforts to promote adolescent development and participation.

In summary, efforts and opportunities to cultivate adolescent participation (labor, civic, political) are under-developed and insufficient as tools to reap the benefits of the dividend in Eswatini. The consistently low performance of Lubombo on inter-related outcomes such as secondary school enrolment, multidimensional poverty and adolescent fertility highlight key elements in a possible theory of change for adolescent programs in the Kingdom of Eswatini.

THE SITUATION RELATED TO EQUITABLE CHANCES AT LIFE: Children and adolescents constitute 59% of all people living in extremely poor households, and they face distinct challenges such as severe hunger (which adversely affects their health, cognitive function and development). The Government of Eswatini implements three types of social protection programs (Old Age Grant, Disability Grant and Orphans and Vulnerable Children (OVC) Education Grant). The OVC grant is the only child-focused social protection mechanism. Without a package of child-specific social protection mechanisms, there are limitations in terms of the reach and responsiveness of current efforts to the circumstances and needs of all vulnerable children. The absence of a harmonized, child-sensitive approach to social protection has resulted in missed opportunities to reach and effectively support the most-vulnerable children and adolescents in the Kingdom of Eswatini. This systemic gap has contributed to the emergence of a diverse set of children and adolescents being left behind, as described in the report.

Cultivating equitable chances at life requires taking a critical look at coping capacities and core vulnerabilities in specific parts of the country. Eswatini's 2019 Vulnerability Assessment and Analysis has shown that Lubombo continues to fare the worst, employing a greater number of negative coping strategies in response to shocks. Female-headed households also have been documented to possess lower coping capacity than male-headed households. System resilience is not widely studied in Eswatini; however, the shortage of qualified frontline service providers in the social sectors, challenges with supply-chain and logistics, and other dimensions of functional systems suggest that systems resilience is another stream of work to support the country in withstanding and/or effectively rebounding from shocks.

RECOMMENDATIONS: The recommendations stemming from the SITAN have been grouped into five broad categories, as described below.

Advocacy and actions related to policies and legislation

1. Develop requisite policies and/or guidelines that address key issues for which policy and legal frameworks are lacking (e.g., child participation, compulsory education age, reimagined approach to education and skills-building for the country's adolescents and young people), or for which greater clarity is required to govern practices and set the stage for greater accountability across stakeholders.
2. Accelerate the finalization and approval of new/updated policy instruments (e.g., National Plan of Action for Children, National Gender Policy).
3. Redouble advocacy efforts related to budgetary allocations and approvals for full implementation of policies at scale.

Governance and coordination

4. Formalize institutional arrangements that establish one multi-sectoral, multi-stakeholder platform on children and adolescents that is led by the Government (e.g., National Children's Unit/DPMO).
5. Via the above platform, develop harmonized annual work plans that clearly delineate roles, responsibilities, targeting, resourcing and expected results of Government versus various non-State actors.
6. To integrate children and adolescents in governance and coordination, hold consultations with various types of children and adolescents on the best channels and forums to engage children and youth.

Evidence to support policy and program action

7. Develop a national child- and adolescent-focused research agenda to address evidence needs and gaps that can be filled through methodologically sound research.
8. Strengthen sector-specific management information systems that can and should provide routine administrative data to all stakeholders on all aspects of child and adolescent well-being (including evidence on outcomes that reflect the quality of services (e.g., learning achievements among students), ECD-related information on responsive caregiving and early stimulation, alternative service delivery models (e.g., non-formal education) and children and adolescents with disabilities).
9. Map current and planned pilot initiatives and devise a joint evaluation agenda to generate and consolidate evaluative evidence and inform decisions regarding replication and scale-up.
10. On an annual basis, synthesize data and learning across sectors and stakeholders to provide a comprehensive and common understanding of the state of Eswatini's children and adolescents.

Leaving no child behind

11. Given the broad array of issues affecting children and adolescents with disabilities, prioritize disability mainstreaming for inclusive young child and adolescent programming, working in close collaboration with the various organizations for persons with disabilities.
12. Working with social and behavior change experts, design strategies that address social beliefs, norms and discriminatory practices that underpin vulnerabilities faced by some children and adolescents who are currently slipping through the cracks.
13. Develop, evaluate and replicate a minimum package of tailored, gender-sensitive and age-appropriate interventions for the entire span of childhood and adolescence, positioning schools as a viable platform to link primary-school-age children and in-school secondary-school-age children with age-appropriate, gender-sensitive and disability-friendly information, commodities, services and interventions.
14. Design and implement an integrated child-sensitive package of interventions for children in informal settlements, leveraging existing entry points (e.g., informal day care providers) to position ECD as a flagship issue to address drivers and root causes of adverse outcomes among children in informal settlements.
15. Strengthen the interface between Department of Corrections, relevant line ministries (e.g., MoH, MoET) and key CSO actors providing alternative care arrangements and/or child and social protection support to better address the diverse types of child non-offenders found within the correctional system.
16. In light of lagging performance of Shiselweni and Lubombo on various outcome indicators, design an acceleration program to address key barriers and bottlenecks, explore specific opportunities for private/business sector engagement, geographical convergence of different interventions and program integration at point of service in those two regions.
17. Map key institutional and community entry points with access to children and adolescents, and utilize the multi-sectoral platform to improve their access to high-impact commodities (e.g.,

menstrual hygiene management [MHM] supplies, dual-benefit contraception, antiretroviral therapy [ART], tuberculosis [TB] treatment, etc.) via those entry points.

18. Identify and leverage opportunities to engage the private sector (e.g., through corporate social responsibility efforts related to nutrition) on strategies for prevention and reduction of overweight and obesity.

Building resilience

19. Support the introduction of child-sensitive social protection programs, with support from development partners (UN agencies, World Bank), private sector, CSOs and faith-based organizations (FBOs).
20. Optimize existing social protection programs to enhance their child-sensitive features, examining elements such as inclusion/exclusion criteria, targeting and outcome monitoring. One clear priority for optimization is the existing OVC Grant for secondary education.
21. In light of the fact that suboptimal parenting and, more broadly, destabilization or disintegration of the family unit has been identified as a contributing factor to an array of adverse outcomes, design and implement strategies nationwide that (a) strengthen parenting and caring practices and (b) bolster mechanisms to identify and support children who have inadequate parental care.

ACRONYMS

AMICAALL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
ART	Anti-retroviral Therapy
AYFHS	Adolescent and Youth Friendly Health Services
CMIS	Client Management Information System
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
DIVT	Directorate of Industrial and Vocational Training
DPMO	Deputy Prime Minister's Office
DSW	Department of Social Welfare
ECCDE	Early Childhood Care, Development and Education
ECD	Early Childhood Development
ECE	Early Childhood Education
EMIS	Education Management Information System
FBO	Faith-based Organization
FCS	Food Consumption Score
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IGME	Inter-agency Group for Child Mortality Estimation
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
MCP	Multidimensional Child Poverty
MHM	Menstrual Hygiene Management
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MODA	Multiple overlapping deprivations analysis
MoET	Ministry of Education and Training
MoH	Ministry of Health
MoSCYA	Ministry of Sports, Culture and Youth
MSME	Micro, Small and Medium Enterprises
NCD	Noncommunicable Disease
NCU	National Children's Unit
NERCHA	National Emergency Response Council on HIV and AIDS
NGO	Nongovernmental Organization
NMR	Neonatal Mortality Rate
NDP	National Development Plan
OVC	Orphans and Vulnerable Children
PMTCT	Prevention of Mother-to-Child Transmission
SACU	Southern African Customs Union
SB	Stillbirth
SDG	Sustainable Development Goal
SHIES	Eswatini Household Income and Expenditure Survey
SITAN	Situation Analysis
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SNECD	Swaziland Network for Early Childhood Development
SPRI	Social Policy Research Institute
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWAGAA	Swaziland Action Group Against Abuse
TB	Tuberculosis
TOR	Terms of Reference
TVET	Technical and Vocational Training and Education
U5MR	Under-five Mortality Rate
UIS	UNESCO Institute for Statistics
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WRA	Women of Reproductive Age

INTRODUCTION

The Kingdom of Eswatini is a small country with an estimated total population of 1.15 million in 2019.[2] However, small, by no means, implies simplicity. The country is the last absolute monarchy in Africa and has demonstrated an ability to maintain peace and stability in the midst of an ever-changing geo-political landscape. It has also shown resilience against shocks such as the HIV epidemic in recent decades. However, in an era when all countries are responding to the global mandate to leave no one behind on the path toward sustainable development, the Kingdom is at a critical juncture with respect to the needs and realities of one of its most-precious resources: its children and adolescents. A Situation Analysis (SITAN) is a comprehensive, evidence-driven, equity-focused and risk-informed assessment of the status of children and adolescents in a country. In preparation for its new Country Programme (2021-2025), UNICEF Eswatini has commissioned a SITAN to support evidence-informed advocacy, planning and monitoring with the Government of Eswatini.

Purpose of the SITAN

A SITAN is designed to provide a balanced view of successes, shortfalls and challenges in meeting the holistic needs of all children and adolescents. In addressing the above, it examines inequities, identifies drivers of inequities and shortfalls, unearths emerging issues of strategic importance to ensuring the total well-being of children and adolescents, and documents aspects of the current landscape (political, social, economic, policy, programmatic, partnerships) in which the needs of children and adolescents are being addressed.

Children and adolescents were consulted extensively as part of the SITAN process. *Annex 1* provides a description of the methodology employed for the Kingdom of Eswatini's 2019 SITAN.

How this Report is Structured

This report is divided into seven main chapters. The **first chapter** is on the "National Context" and explores a spectrum of macro-level issues that affect the world in which Eswatini's children and adolescents live. The **second chapter** focuses on "Protection for All Children and Adolescents," covering various crosscutting issues that are not just salient to protecting and safeguarding the rights of children and adolescents but are often root causes or underlying circumstances that drive poor outcomes in areas such as health and education. The **third chapter** examines "Young Child Survival and Development," providing a cross-sectoral overview related to children from birth until their 10th birthday. The **fourth chapter** on "Adolescents" provides a cross-sectoral overview related to the adolescent age group, which the United Nations (UN) defines as males and females age 10-19 years.[3] The **fifth chapter** explores the issue of "Equitable Chances at Life," which is a foundational principle to inclusive, sustainable development. The **sixth chapter** is a brief examination of recurring themes and inter-related factors that appear to exist in Eswatini, looking across the different program areas and the entire span of childhood and adolescence. Lastly, the **seventh chapter** of this report provides a concise set of actionable recommendations to tackle identified shortfalls and inequities, direct focus to segments of children and/or adolescents who are "slipping through the cracks," and optimize inputs from various actors to improve outcomes for all children and adolescents within the Kingdom of Eswatini's borders.

Caveats and Limitations

As a process that is grounded in nationally endorsed data sources, a SITAN is limited by the breadth and quality of available evidence. The assessment of trends is contingent upon the availability of data from at least three different points in time that were generated *using the same tools and same methods*. In most instances, trend data that meet those criteria are not available but, for the purposes of this report,

[2] United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019: Data Booklet (ST/ESA/SER.A/424).

[3] United Nations Population Fund (UNFPA). n.d. Adolescent and Youth Demographics: A Brief Overview, https://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf. Accessed on 29 May 2019.

data sources such as the Multiple Indicator Cluster Survey (MICS), which was conducted in 2010 and 2014 in Eswatini, and administrative data from different sectors provide opportunities to compare estimates from a particular data source for at least two different points in time. In those instances, the report highlights progress/direction of change using the following symbols and color scheme:

↑	An increase in an indicator's value, with the GREEN color depicting progress (e.g., improved net enrolment ratio for primary school)
↑	An increase in an indicator's value, with the RED color depicting a worsening situation (e.g., a rise in chronic malnutrition)
↓	A decrease in an indicator's value, with the GREEN color depicting progress (e.g., reduced under-five mortality)
↓	A decrease in an indicator's value, with the RED color depicting a worsening situation (e.g., reduced vaccination coverage for a particular antigen such as measles)
--	No major change in an indicator's value
NC	Indicator not calculated/tabulated for more than one point in time

Because children/adolescents and practitioners have insights to critical issues and dynamics that might not be sufficiently documented and/or measured, the SITAN also highlights qualitative information gleaned from the SITAN process, particularly for issues raised directly by different types of children and adolescents, with the caveat that further investigation or data gathering is required to rigorously examine and respond to the issues.

1. NATIONAL CONTEXT

KEY MESSAGES:

- **There have been milestone policy and legislative achievements that establish a solid foundation for transformational changes in the lives of Eswatini's children and adolescents.**
- **Children and adolescents are demographically and economically important segments of society. However, the current economic climate and limited public spending in some domains have major implications for the pace and extent to which the Kingdom can achieve child-sensitive Sustainable Development Goals (SDGs) by 2030.**
- **Assessments of SDG progress have highlighted gaps in five key areas: (1) targeting, (2) quality of services, (3) financing, (4) data for performance monitoring and other actions, and (5) responsiveness of planning and implementation to hazards and risks.**
- **The partnership landscape consists of numerous actors but is characterized by a palpable absence of "whole system" coordination and mutual accountability across the various stakeholders. There are strategically placed entities (e.g., National Children's Unit) that could provide leadership in multi-stakeholder coordination and harmonized monitoring and evaluation (M&E). However, that potential has not been realized. In the interim, there are some coordinating mechanisms that exist within certain stakeholder groups (e.g., civil society) for discrete issues. However, those siloes of coordination, in some ways, reinforce fragmentation due to the absence of a 'big picture' mechanism to leverage synergies, expertise, resources and learning across different stakeholders/stakeholder groups.**
- **As a low-middle-income country, a more-nuanced view of child poverty is required in light of the pervasiveness of multidimensional child poverty in the Kingdom. Addressing child poverty must be done through an equity lens, which requires targeted and tailored implementation to address needs and dynamics in different settings and/or subpopulations of children.**
- **Demographic changes within the Kingdom of Eswatini—though not as extreme as in other countries that are experiencing rapid population growth and/or rapid urbanization—have major implications in terms of the locus of need and vulnerability (e.g., with the emergence and expansion of informal settlements) as well as the size of hidden and/or hard-to-reach segments of children and adolescents (e.g., 'children on the move').**
- **Eswatini can bear witness to the destabilizing impact of climate-induced hazards based on the effects of the 2015/16 drought. However, there are other, equally salient hazards (e.g., climate-related, economic, disease-related) that are having (or have the potential to have) a destabilizing impact on households, communities and the nation at large.**

1.1. Sustainable Development Goals Progress

In 2015, 17 Sustainable Development Goals (SDGs) were set by the UN as part of its Agenda 2030, serving as a blueprint for inclusive, sustainable development for all.[4] Eswatini's National Development Strategy (2018) is aligned with the 17 SDGs, as well as the African Union's Agenda 2063. Based on

[4] Retrieved from https://www.un.org/sustainabledevelopment/sustainable-development-goals/

findings from Eswatini's 2019 SDG Voluntary National Review, *Table 1* summarizes the country's key SDG successes and challenges.[5]

Table 1. Eswatini's SDG Progress, as assessed through 2019 Voluntary National Review

Theme and Relevant SDGs	Illustrative Successes	Illustrative Challenges
REDUCING POVERTY, INEQUALITY AND VULNERABILITY: SDG 1 ("No Poverty"), SDG 2 ("Zero Hunger"), SDG 10 ("Reduced Inequalities")	+ Poverty decline + Legislative reforms (e.g., with passage of legislation such as the Sexual Offences and Domestic Violence Act)	✖ Persistent vulnerabilities and inequalities ✖ Sustainability of interventions ✖ Adaptation to climate change ✖ Persistent high levels of stunting; off track for meeting nutrition targets ✖ Targeting for social grants
NATURAL RESOURCES, CLIMATE CHANGE, ENVIRONMENTAL SUSTAINABILITY: SDG 6 ("Clean Water and Sanitation"), SDG 7 ("Affordable and Clean Energy"), SDG 12 ("Responsible Consumption and Production"), SDG 13 ("Climate Action"), SDG 14 ("Life Below Water"), SDG 15 ("Life on Land")	+ Enabling policy environment (e.g., through National Water Policy (2018); Transboundary water agreements with Mozambique and South Africa; Climate Change Policy (2016), Energy Policy and Master Plan (2018))	✖ Water pollution in rivers ✖ Costly, inefficient energy technologies ✖ Lack of adaptation to climate change
HUMAN CAPITAL DEVELOPMENT: SDG 3 ("Good Health and Wellbeing"), SDG 4 ("Quality Education")	+ Declines in national HIV incidence (238 per 1000 in 2014 to 136 per 1000 in 2017) and TB infections (565 per 100000 in 2014 to 389 per 100000 in 2017) + Subsidized and free medical services (e.g., antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT)), free primary education with school feeding program	✖ Persistently high maternal and child mortality ✖ Emerging noncommunicable disease (NCD) and overweight/obesity burdens ✖ Limited medical supplies ✖ Compromised quality of education ✖ School dropouts ✖ Teenage pregnancies ✖ Low proportion of young children developmentally on track
GOOD GOVERNANCE FOR INCLUSIVE, AND SUSTAINABLE GROWTH AND PROSPERITY: SDG 8 ("Decent work and economic growth"), SDG 9 ("Industry, Innovation and Infrastructure"), SDG 16 ("Peace, Justice and Strong Institutions")	+ Decline in unemployment rate (28.1% in 2014 to 23% in 2016), + Decline in youth unemployment + National Micro, Small and Medium Enterprises (MSME) Policy (2018) to increase youth access to finance + Establishment of Royal Scientific & Technology Park for promoting innovation and MSME incubation + Special economic zones for foreign direct investment	✖ High internet costs ✖ Poor infrastructure maintenance ✖ Few industrial zones ✖ Small non-diversified manufacturing sector ✖ Dwindling foreign direct investment ✖ Perceived corruption, crime and violation of human rights
PARTNERSHIPS AND COLLABORATIVE EFFORTS TOWARDS SUSTAINABLE DEVELOPMENT: SDG 13 ("Climate Action"), SDG 17 ("Partnerships for the Goals")	+ National Aid Policy (2000) that guides the flow and utilization of donor support	✖ Inability to access concessional funding; challenged by high poverty level, inequalities, vulnerability and fiscal crisis ✖ Middle-income status not favorable for increased donor support

DATA SOURCE: UNDP, 2019. Retrieved from https://sustainabledevelopment.un.org/memberstates/swaziland, 27th July 2019.

[5] Retrieved from https://sustainabledevelopment.un.org/memberstates/swaziland, 27th July 2019.

Although the findings highlighted in Table 1 have implications for children and adolescents, the thematic areas highlighted in the table, with the exception of the human capital development theme, have not been rigorously assessed through child- and adolescent-sensitive lenses. The causes and implications of some of the identified successes and challenges will be further explored in subsequent sections of this report. However, the table already provides clarity with respect to **systemic shortcomings that have direct implications for child and adolescent well-being, namely the following: (1) targeting, (2) quality delivery of services, (3) financing and (4) responsiveness to hazards and risks (e.g., climate-induced events). A fifth shortcoming in assessing SDG performance relates to data availability** and will be a recurring theme throughout this report.

According to a recently released analysis of SDG progress across Africa,[6] Eswatini has insufficient data available to assess progress for the following SDGs: SDG 8: Decent Work and Economic Growth; SDG 10: Reduced Inequalities; SDG 11: Sustainable Cities and Communities; SDG 13: Life Below Water; and SDG 16: Peace, Justice and Strong Institutions. However, as will be explored later in this report, there are also 'blind spots' related to the magnitude, nature and drivers of some child and adolescent outcomes**.**

Sustainable development for all cannot be achieved without tackling inequalities. One key inequality relates to gender. The Kingdom ranks 141st out of 160 countries in gender equality, reflecting lagging performance on some gender equality measures (e.g., 14.7% of parliamentary seats are held by women, maternal mortality remains high with 389 maternal deaths per 100000 live births (based on the 2014 MICS), female labor market participation is only 42.7%, compared to 67.2% for males).[7] The issue of gender equality will be examined when exploring various inequities among children and adolescents but, **as will be later described, proxy measures of gender equality and women's empowerment—for example, a woman's level of education—also emerge as drivers of inequities and shortfalls related to children and adolescents.**

1.2. Demographic overview

The country's 2017 Population and Housing Census paints a picture of a very young and overwhelmingly rural population.[8,9] **Forty-three percent of residents are between the ages of 0 and 17 years, and adolescents (10-19 years) account for one-fourth of the total population**. The potential to reap the demographic dividend—accelerated economic development as a result of changes in population age structure, coupled with declines in mortality and fertility—has never been higher.[10] As will be described in the chapter on adolescents, there are noteworthy strides in galvanizing focus on the needs of adolescents; however, there remains a plethora of missed opportunities to cultivate and harness the potential of this critical segment of the population.

Other demographic phenomena are also shaping the world in which Eswatini's children and adolescents live. For example, according to the latest *World Urbanization Prospects* estimates, the country is on a slow trajectory toward increased urbanization. The Kingdom of Eswatini's urbanization rate stands at 24% in 2019 and will not change dramatically in the near future—hovering around 26%, even in 2030—but it is projected to reach as high as 34% by 2050.[11]

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[6] SDG Center for Africa and Sustainable Development Solutions Network, Africa SDG Index and Dashboards Report 2019. Kigali and New York: SDG Center for Africa and Sustainable Development Solutions Network, 2019.

[7] *Ibid*.

[8] Central Statistical Office, The 2017 Population and Housing Census: Preliminary Results, 2017.

[9] United Nations Population Division, Urban/Rural Population database, via https://esa.un.org/unpd/wup/DataQuery/, accessed July 2019.

[10] James N. Gribble and Jason Bremner. 2012. Achieving a Demographic Dividend, *Population Bulletin* 67, No. 2 Washington, DC: Population Reference Bureau.

[11] United Nations, World Urbanization Prospects: The 2018 Revision, 2018. Eswatini/Swaziland data tables retrieved from https://population.un.org/wup/Country-Profiles/, accessed 10 July 2019

Another demographic factor relates to population movement. **Internal migration from rural to urban areas is changing the dynamics of urban areas and the locus of need and vulnerability in children and adolescents**. As highlighted in the current National Development Plan, the Census showed a shift in population numbers towards Hhohho and Manzini regions, with individuals and families leaving rural areas for urban/peri-urban areas due to greater prospects for livelihoods and income generation.[12] Informal settlements have emerged in and around urban centers; however, informal settlements are rarely reflected adequately in urbanization figures. Understanding the drivers of rural-urban migration, the dynamics of informal settlements in urban/peri-urban settings, and the profile of women, children and families that live in those settings are nonetheless salient to achieving national impact with respect to child and adolescent well-being in Eswatini.

Expanding the examination of population movement to the concept of 'Children on the Move' sheds light on how migration patterns can introduce or exacerbate vulnerabilities in children and adolescents. There is a paucity of data on children on the move in Eswatini but compelling anecdotal information on child migration between Eswatini, South Africa and Mozambique, and the **elevated vulnerability of children on the move to exploitation and other protection violations**.[13]

1.3. Socio-economic overview

In addition to demographic changes, the socio-economic context also has a direct impact on children and adolescents. Eswatini is classified as a 'medium human development' country (*Box 1*). However, its 2017 Human Development Index (HDI) score (0.588) is lower than the average HDI for countries in the medium human development category (0.645), placing Eswatini 144st out of 189 countries and territories.[14]

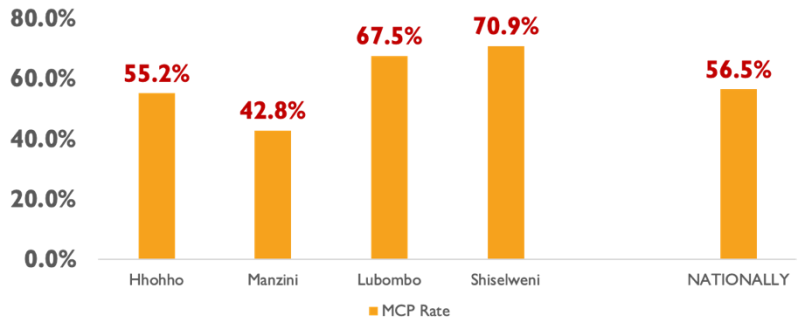
Until 2016, the Kingdom of Eswatini was characterized as economically stable; however, since 2016, there has been considerable deterioration of economic conditions.[15] Two external factors have had major macro-economic impacts: (1) a prolonged El Niño drought in 2015/16 and (2) a major decline in Southern African Customs Union (SACU) revenues. The Government's response to the above has spurred other economic realities such as growing fiscal deficits (almost 10% of gross domestic product (GDP) in fiscal year 2016/17) and a drastic decline in economic growth (from 7.3% in fiscal year 2015/16 to -0.7% in 2016/17).[16]

The 2016/17 Eswatini Household Income and Expenditure Survey (SHIES) estimated that 29.6% of the population is moderately poor, and 12.5% is extremely poor.[17] Children are disproportionately affected, accounting for 49% of household members in general, but among extremely poor and labor-constrained households, the average share of children is 66%.[18]

[12] Ministry of Economic Planning and Development/Kingdom of Eswatini. National Development Plan 2019/20 – 2021/22: Towards Economic Recovery.
[13] SWAGAA. eSwatini – A Destination for Children on The Move. Retrieved from http://www.swagaa.org.sz/child-migration-eswatini/, 27th July 2019.
[14] United Nations Development Programme. Briefing Note on Eswatini/ Human Development Indices and Indicators: 2018 Statistical Update. Retrieved from http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/SWZ.pdf, 26th July 2019.
[15] UNICEF. 2019. National Budget Brief 2018/2019 for the Kingdom of Eswatini.
[16] *Ibid*.
[17] 2016/17 Eswatini Household Income and Expenditure Survey (SHIES).
[18] 2016/17 Eswatini Household Income and Expenditure Survey (SHIES).

Monetary poverty statistics belie the nature and extent of child poverty in the country. According to a Multiple Overlapping Deprivation Analysis (MODA), almost 6 out of every 10 children in Eswatini (56.5%) are multidimensionally poor.[19] The rate of multidimensional child poverty (MCP) is **more than twice as high in rural areas** (65%) than in urban areas (23%). The MCP rate is slightly **higher for boys** than for girls (60% versus 54%, respectively).

Figure 1. Multidimensional Child Poverty (MCP) Rate, According to Region



As shown in *Figure 1*, regional variations also exist, with **children in Shiselweni, followed by Lubombo, faring the worst**.

Both the macro- and micro-economic situations will have implications for resources (financial and non-financial) that are allocated and spent to meet the multi-faceted needs of children and adolescents in the present and for years to come. This issue is further examined in the chapter on Equitable Chances at Life (Chapter 5).

1.4. Political overview

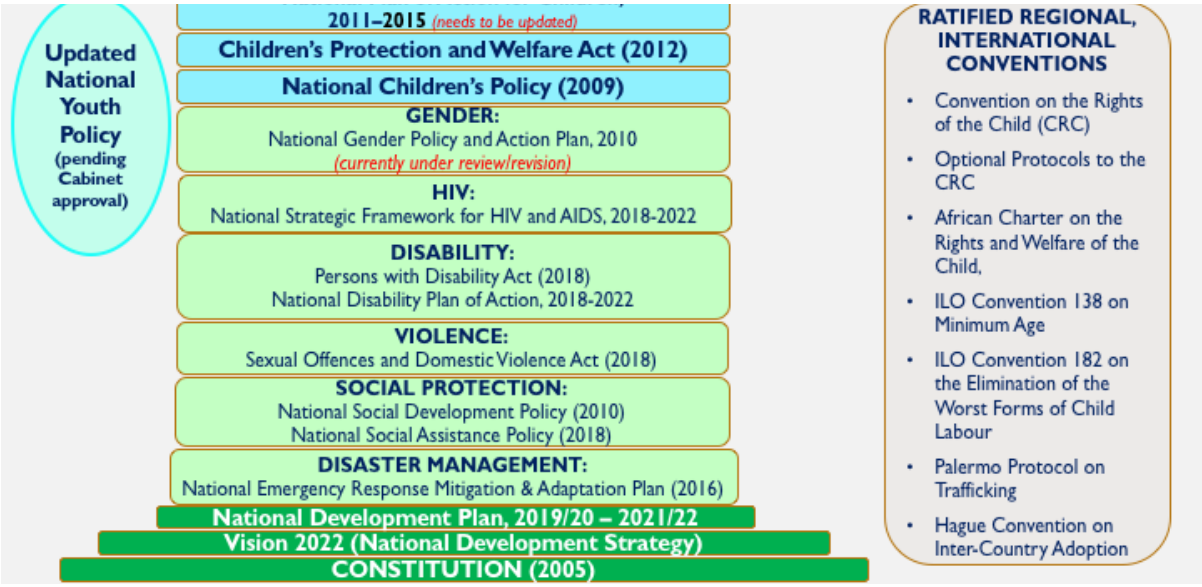
As stated earlier, the Kingdom of Eswatini is the last absolute monarchy in all of Africa. Although King Mswati III is the supreme Head of State, there is a dual system of governance that ascribes importance to both Western forms of governance (Parliamentary system) and traditional institutions and governance (namely, the *Tinkhundla*–based electoral system of government).[20] The Kingdom, which is subdivided into four administrative regions (Hhohho, Lubombo, Manzini and Shiselweni), has enjoyed tremendous political stability. However, as described below, there are a myriad of other factors related to the enabling environment for child and adolescent well-being.

1.5. Legislation and policy landscape

In recent years, there have been noteworthy additions to the national legislative and policy landscape. Milestone policy and legislative achievements that can contribute to the holistic well-being of children and adolescents entail broad-scale policies related to inclusive national development, some of which focus on specific segments of the population (e.g., disabled persons, youth) or specific development themes (e.g., gender). *Figure 2* highlights some of the key broad-scale national policies. National policies, strategies and plans focused on specific sectors are highlighted later in this report.

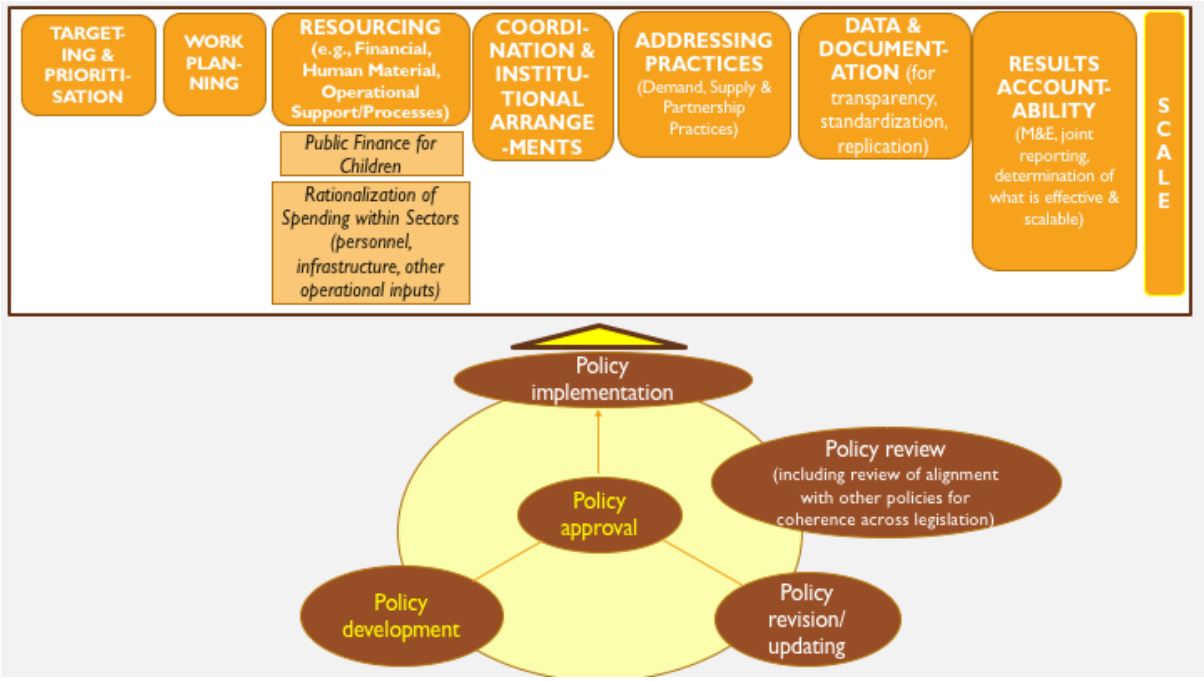
[19] SPRI. Multidimensional Child Poverty in Swaziland, March 2018.
[20] Ministry of Economic Planning and Development/Kingdom of Eswatini, National Development Plan 2019/20 – 2021/22: Towards Economic Recovery, 2019.

Figure 2. Highlights from Eswatini's Policy and Legislative Landscape



The proliferation of important policies and legislation is only one of many requirements to support efforts to link children and adolescents to lifesaving, promotive information, commodities and services. In the Kingdom of Eswatini, there have been notable bottlenecks in moving from policy to practice. *Figure 3* highlights key elements of bridging the policy-practice divide. To date, achievements in the Kingdom have largely related to policy development and policy approval. Multiple elements of policy implementation (e.g., targeted and strategic implementation, child- and adolescent-sensitive resourcing, cooperation and harmonized programming across stakeholders, results accountability, generation and use of data or strategic information to inform decisions regarding effectiveness and scale-up) remain as hurdles.

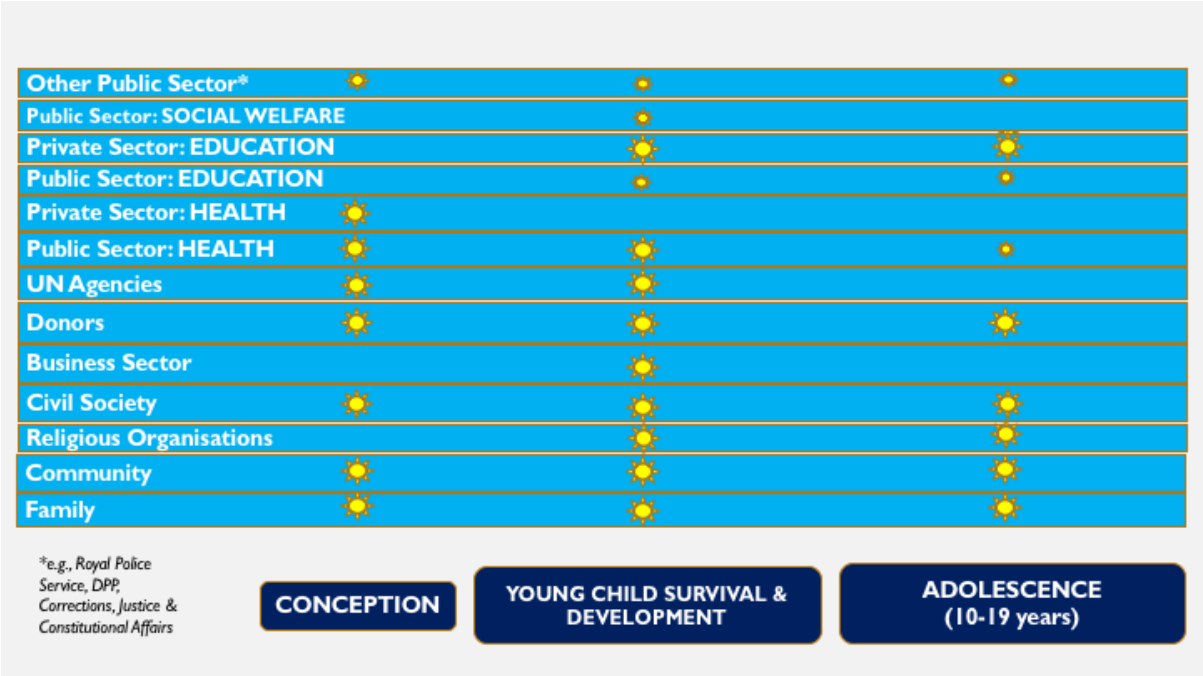
Figure 3. Key Elements in Moving from Policy to Practice to Impact in the Kingdom of Eswatini



1.6. Landscape for partnerships and intersectoral coordination

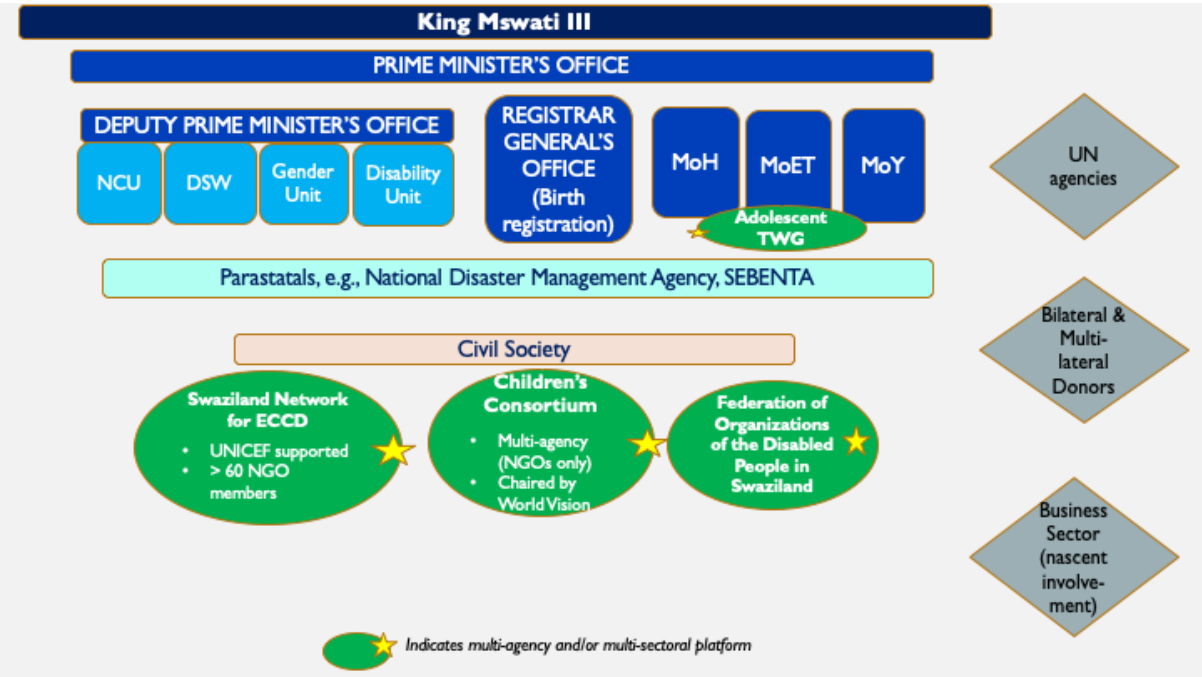
The current landscape in Eswatini is replete with actors representing different sectors and interests. *Figure 4* maps the different stakeholder types across the span of childhood and adolescence. As depicted in the figure, actors span multiple sectors and levels of intervention (e.g., family, community). At present, there is no multi-sectoral, multi-stakeholder, multi-level platform to: (1) support coordinated action across stakeholders, (2) strategically engage in advocacy in areas of need (e.g., in relation to public finance for children) and/or (3) support the identification and/or accelerated replication of best practices.

Figure 4. Key Stakeholders Across the Span of Childhood and Adolescence



As shown in *Figure 5*, there are some coordination and/or sharing mechanisms within certain groups (e.g., civil society, line ministries), as denoted by the green ovals. However, the co-existence of multiple platforms contributes to fragmentation of responses. **The Kingdom lacks a single platform or mechanism, and there is a lack of clarity regarding the specific entity within Government that should be providing oversight of a coordinated multi-sectoral, multi-stakeholder response for children and adolescents**. Structurally, some key child-sensitive issues have been elevated to the level of the Deputy Prime Minister's Office (DPMO) rather than housed within a single line ministry. They include Gender, Disability and Social Welfare. As an entity within the DPMO whose purview is cross-sectoral, the National Children's Unit should play a focal role in coordinating a response to improve the well-being of all children and adolescents.

Figure 5. A Fragmented Partnership Landscape for Children and Adolescents in the Kingdom of Eswatini



1.7. Role(s) of the private sector

The involvement of the private sector, defined for the purposes of this analysis as the business sector (i.e., not other non-State providers of social services such as NGOs, CSOs and FBOs), in child- or adolescent-focused efforts is minimal, although some entities such as Junior Achievement have made explicit linkages to the private sector (see chapter on Adolescents). Some private-sector entities (e.g., Standard Bank) have also supported campaigns under the auspices of corporate social responsibility. However, child-sensitive private-sector contributions are presently not coordinated, and the absence of one multi-stakeholder, multi-sectoral platform creates missed opportunities to: (1) sensitize the business community on priority issues, (2) make investment cases for their involvement in specific efforts related to children including adolescents, (3) foster corporate social responsibility, (4) formalize linkages and synergies with other non-State development partners such as UN agencies and (5) create mutual accountability in achieving meaningful results for children and adolescents.

As service providers, the private sector does play roles in health, pre-primary education and, to a lesser extent, secondary education. Recent efforts have been made by UNICEF to create a platform for private/business sector investments in neonatal health and survival and early childhood development (ECD). However, private-sector engagement remains in the nascent stages, and there is a need for continued, strategic engagement around critical issues such as the promotion and marketing of food products and breastmilk substitutes.

1.8. Role(s) of civil society

Civil society organizations (CSOs) including international non-governmental organizations (NGOs) and faith-based organizations (FBOs) play active roles with respect to child and adolescent well-being in Eswatini. There is a glut of CSO/NGO actors in some areas and a palpable absence of CSOs/NGOs in other areas. For example, with the exception of World Vision, there is very limited CSO programming to address nutrition.[21] CSOs have, however, been instrumental in championing child

[21] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

protection issues such as: (1) violence against children (e.g., World Vision and the Swaziland Action Group Against Abuse (SWAGAA) play prominent roles in elevating the issue of violence in national dialogue and creating a legal framework such as the Sexual Offences and Domestic Violence Act of 2018 for action and (2) alternative care for children (with CSOs such as S.O.S Children's Villages Eswatini working with Government to develop legal frameworks and an enabling environment for positive change). ECD is another issue for which CSO action is coalescing. Over 60 CSOs and private pre-school owners involved in ECD programming formed the Swaziland Network for Early Childhood Care and Development (SNECD), which serves as a platform for coordination and exchange among those implementers.

As will be described later in this report, the community-level programs and services being implemented by CSOs are reaching some segments of children and adolescents that are often outside of the grasp of formal systems of care in the public sector. CSOs have also been modelling inter-agency coordination, with the existence of a Children's Consortium that is chaired by World Vision as a formal CSO platform. Thus**, there is untapped potential to leverage the strengths of civil society and CSO networks to pursue "whole system" action that harmonizes efforts and creates synergies between public-sector, private-sector and CSO actors**.

1.9. Funding landscape for children and adolescents

Classification of Eswatini as a middle-income country might elicit assumptions that public finance for children is adequate. However, a 2018 National Budget Brief produced by UNICEF highlights issues related to (1) budget transparency, (2) an over-reliance on Southern African Customs Union (SACU) revenue, (3) macro-economic challenges that limit spending in social sectors such as health and education, (4) imbalanced resource allocation that directs the majority of investments in recurrent costs such as salaries (as opposed to social infrastructure such as WASH infrastructure, health facilities, schools and roads) and (5) social protection spending that is far below international targets.[22] Although there are laudable public investments—for example, the Government of Eswatini fully funds procurement of child vaccines[23]—all aspects of service delivery do not receive commensurate levels of spending to ensure effective coverage of child vaccination services. These and other issues are revisited in subsequent chapters.

1.10. Emerging issues

The 2019 SITAN documented a myriad of emerging issues that have not featured prominently in national dialogue and action but are important issues impacting children's lives, as described below.

- The overlooked post-neonatal period as a critical window for surviving and thriving ***(further explored in the chapter on "Young Child Survival and Development")***
- A hidden population of infants, children and adolescents who have not committed crimes but are being accommodated by the correctional system ***(further explored in the chapter on "Protection for All Children and Adolescents")***
- Unmet sexual and reproductive health needs of sexually active disabled adolescents ***(further explored in the chapter on "Adolescents")***
- Absence of tailored, age-appropriate services and programming for children above the age of five but before they enter adolescence ***(further explored in the chapter on "Young Child Survival and Development")***
- Unique vulnerabilities of children, adolescents and women residing in urban/peri-urban informal settlements ***(further explored in all remaining chapters of this report)***
- Unmet mental health needs of children and adolescents, and how those needs impact exposure to various risks and adverse outcomes ***(further explored in the chapters on "Protection for All Children and Adolescents" and "Adolescents")***

[22] UNICEF. 2019. National Budget Brief 2018/2019 for the Kingdom of Eswatini.
[23] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

- Peer violence amongst children and adolescents ***(further explored in the chapter on "Protection for All Children and Adolescents")***
- Cognitive, learning and/or behavioral disorders in children and adolescents ***(further explored in the chapter on "Protection for All Children and Adolescents")***
- Micro-level shocks that destabilize the family unit ***(further explored in the following section on Hazards and Risks)***
- Importance of parenting and caring practices as protective factors (e.g., for ECD) and as factors that mitigate risks faced by children and adolescents ***(further explored in the chapters on "Young Child Survival and Development" and "Protection for All Children and Adolescents")***

1.11. Hazards and risks

As a risk-informed analysis with both retrospective and prospective purviews, the SITAN has considered the effects of possible hazards on child and adolescent well-being in Eswatini. According to the 2019 INFORM Index for Risk Management,[24] ,[25] the Kingdom of Eswatini has a lower risk score (3.3) than neighboring Southern African countries (Mozambique's and South Africa's INFORM risk scores are 6.0 and 4.7, respectively).[26] However, it ranks 44th globally in terms of vulnerability measures and 63rd in terms of lack of coping capacity. That ranking is consistent with observations made under the auspices of the 2019 SDG Voluntary National Review (Table 1), which highlighted issues around the country's responsiveness to climate change.

The Kingdom has a National Emergency Response Mitigation and Adaptation Plan (2016). In addition, the National Disaster Risk Management Agency (NDMA), a parastatal entity that plays a focal role related to humanitarian issues, will be undertaking a national, multi-sectoral risk assessment in late 2019/early 2020. That assessment will yield vital information that should inform future efforts related to children and adolescents.

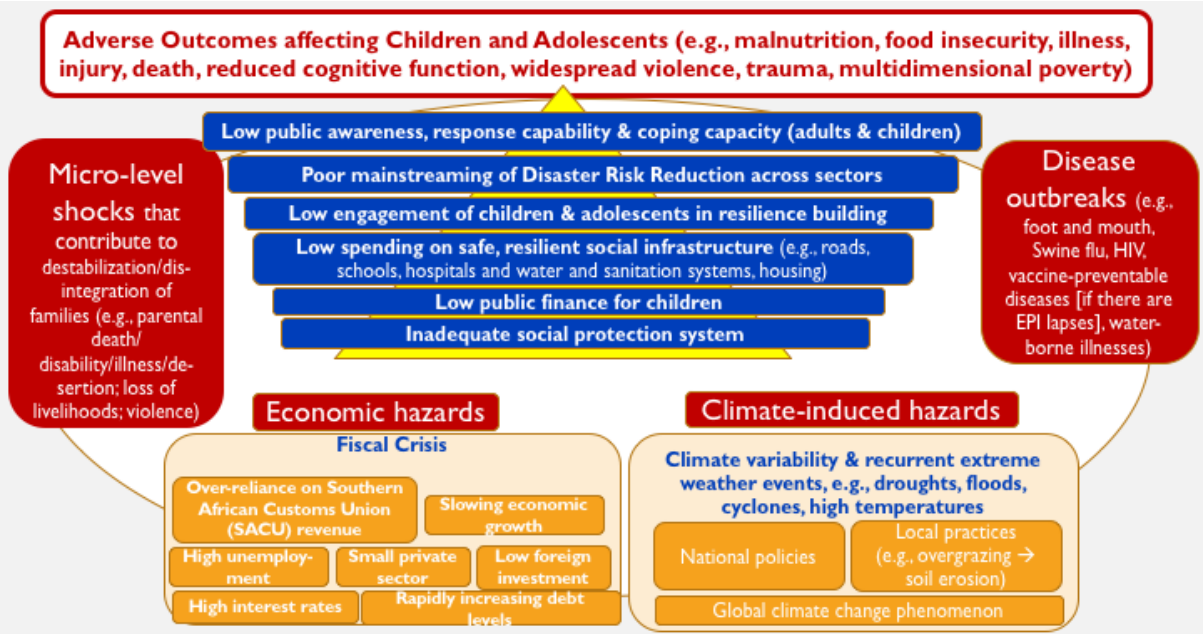
Figure 6 depicts key hazards and contributing factors to adverse outcomes in children and adolescents. As shown in the figure, there are three conventional categories of hazards of relevance to Eswatini: (1) economic hazards, (2) climate-induced hazards and (3) disease outbreaks. However, a fourth type of hazard—micro-level shocks to families/households—is highly salient in Eswatini as it underpins a range of vulnerabilities that are by-products of those shocks (e.g., inadequate parental care, multidimensional poverty).

[24] The aforementioned risk index is a composite measure that is used to estimate and rank 191 countries according to various indicators of risk of disaster and humanitarian crisis.

[25] Marin-Ferrer, M., Vernaccini, L. and Poljansek, K., Index for Risk Management INFORM Concept and Methodology Report — Version 2017, EUR 28655 EN, doi:10.2760/094023

[26] Retrieved from http://www.inform-index.org/Portals/0/InfoRM/2019/Country_Profiles/SWZ.pdf, 26th July 2019.

Figure 6. How Hazards Affect Children and Adolescents, Kingdom of Eswatini, 2019



Climate-induced hazards are recurrent phenomena; for example, droughts are an expected occurrence every three years.[27] The recent drought (2015/16) gave a glimpse into the disruptive nature of climate-induced hazards, with an estimated cost of E3.843 billion (approximately 7% of Swaziland's Gross Domestic Product (GDP) and 18.58% of government expenditure in 2016).[28] As described in the "Young Child Survival and Development" chapter, the El Niño drought of 2015/16 impacted the availability of natural water resources, as well as other dimensions of young child survival and development (e.g., caring/parenting practices including but not limited to infant and young child feeding [IYCF]), agriculture, livestock and rural livelihoods. For example, a qualitative study by The United Nations Population Fund (UNFPA) documented negative effects on parenting, with reported instances of parents as perpetrators of violence against their own children, a rise in gender-based violence (GBV), lack of balanced diets among children and increased alcohol consumption by men emerging from challenges faced as a result of the drought.[29] Hence, the issue of hazards and risks need to inform planning, resourcing and service delivery related to children and families.

Economic hazards are a present-day reality for the Kingdom of Eswatini. As alluded to earlier in this chapter, the current fiscal crisis has the potential for deleterious effects on public-sector services. Micro-level shocks will be examined further in the Child Protection chapter. **Disease outbreaks** also require intensified focus. The impact of the HIV and AIDS epidemic has been felt across all segments of society. According to 2018 UNAIDS estimates, 210,000 adults and children are living with HIV in Eswatini, which equates to a prevalence rate of 27.3%.[30] While there are few diseases that have rivalled the scope and scale of the global HIV pandemic, the risk of various communicable disease outbreaks needs to factor into Eswatini's risk forecasting.

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[27] Ministry of Economic Planning and Development/Kingdom of Eswatini, National Development Plan 2019/20 – 2021/22: Towards Economic Recovery, 2019.

[28] Swaziland Economic Policy Analysis and Research Centre (SEPARC). Policy Brief: The Socioeconomic Impacts of the 2015/16 El Niño Induced Drought in Swaziland. Retrieved from https://www.separc.co.sz/wp-content/uploads/2019/06/Drought-Policy-Brief.pdf, 27th July 2019.

[29] UNFPA. Evidence Brief: An Assessment of the Impact of the El Niño-Induced Drought on Children, Youth, and Pregnant Women and Lactating Mothers in Swaziland, 2017.

[30] UNAIDS. 2019. Country factsheets: ESWATINI 2018. Retrieved from https://www.unaids.org/en/regionscountries/countries/swaziland, 2 August 2019.

The differential impact of hazards on different segments of the population should also factor into examination of risk scenarios. For example, some assessments have documented the disruptive nature of the recent drought on ART and TB treatment adherence among persons living with HIV in food-insecure households.[31] The concept of multi-layered vulnerabilities—for example, when persons have pre-existing conditions (TB, HIV), must travel far distances to health facilities, lack finances for basic necessities and other factors—are important considerations when examining the impact of potential hazards and thus building resilience.

[31] ADD CITATION(S)

2. PROTECTION FOR ALL CHILDREN AND ADOLESCENTS

KEY MESSAGES:

- **In the Kingdom of Eswatini, shortfalls related to child protection emerge early in life. The low percentage of children with birth certificates means that many children have already embarked on a path with multiple hurdles for legal protection and access to various formal services.**
- **Children with disabilities are an often-mentioned group by duty bearers but largely overlooked, in a programmatic sense, as a critical population of rights holders. Also, a more-nuanced view of disability is required in order to be responsive to the diverse special needs that exist among children and adolescents in Eswatini. For example, there is anecdotal evidence on the extent of unmet needs related to cognitive and behavioral disabilities.**
- **Violence is a pervasive part of a child's existence in Eswatini. Where objectively verifiable evidence might be lacking or outdated, children and adolescents consulted during the SITAN process have yielded compelling evidence on their vulnerability and/or experiences with violence. Boys spoke openly about their vulnerability to bullying, negative influences and physical harassment by out-of-school boys in their communities. They also expressed concerns about different societal perceptions of sexual or physical violence against boys versus girls. Girls spoke openly about concerns for their physical safety in their communities. They also spoke extensively about physical and/or sexual harassment by older boys.**
- **Consultations with children and adolescents underscored that the issue of peer violence must be addressed. In reality, while children are often victims of different forms of violence and abuse, some children are also perpetrators of violence against other children, in both schools and the community at large. The root causes of this behavior (e.g., unresolved trauma from their own experiences with violence) warrants further attention.**
- **The issues of children with inadequate parental care, as well as child participation, also warrant greater attention.**

2.1. The policy and program landscape

Eswatini has a Children's Protection and Welfare Act (2012) that serves as the legal framework for child protection. *Box 2* highlights key actors in the child protection landscape. There are multiple actors within the child protection space but no clear coordinating mechanism to support a systems approach and greater accountability across stakeholders. Although there is no multi-stakeholder, multi-sectoral platform or entity for child protection, CSOs play active roles in addressing specific dimensions of child protection. As stated previously, the Children's Consortium, which is chaired by World Vision Eswatini, addresses multiple issues related to child protection.

Although there is the 2012 Act, as well as a National Children's Policy (2009), there is no overarching policy or guidelines on child participation, an integral element in safeguarding the rights and addressing the needs of children and adolescents. Individual CSOs have developed their own organizational guidelines related to child participation. However, there remains an absence of a national policy instrument to mainstream child participation across all actors and sectors.

2.2. Violence against children

Violence data are outdated, but available evidence shows that **routine violence against children is the norm, not the exception**. The 2014 MICS estimated that 88% of children aged 1—14 years experienced at least one form of psychological or physical punishment by household members during the previous month.[32] The rate of violent discipline is higher among children aged 3-9 years (90-91%) than among younger children (83%) or older children (87%).[33]

Violence against children is occurring in many forms and in many settings (e.g., domestic settings, in schools). Consultations with some children during the SITAN process highlighted the role of other children as perpetrators of violence.

> **"Boys. . .touch you where you don't like; call you names you don't want to hear… [*when asked to stop*] sometimes they listen, sometimes they don't."**
>
> **"I want a school just for girls! Boys can abuse you. Boys can disturb you when learning."**
> **"I don't like—the older boys. They bully. They want things…"**
>
> ***---A group of rural girls, ages 7-12***

Sentiments such as those expressed by girls (see above text box) are reminders of the violence-gender equality nexus and serve as a clarion call for gender equality efforts to engage both males and females of all ages.

Box 2.
KEY ACTORS IN CHILD PROTECTION

While all sectors and stakeholders have roles to play with respect to child protection, the following actors are actively engaged in the child protection space in Eswatini:

- Office of the Deputy Prime Minister
  - Department of Social Welfare
  - Disability Department
  - Gender Unit
- Ministry of Education and Training (MoET)
  - Special Education Needs Department
- MoH
  - Particularly in regard to clinical management of rape/sexual violence
- Ministry of Justice
- Registrar General's Office
  - Birth registration
- Civil Society/NGOs
  - Children's Consortium
  - SNECD
  - Swaziland Action Group Against Abuse (SWAGAA) is a non-governmental organization that has been working for almost 30 years to end gender-based violence (GBV), sexual abuse and human trafficking in Eswatini
  - World Vision
  - Other CSO/NGOs

2.3. Child trafficking and sexual exploitation

Evidence on trafficking is sparse. However, children who reside near borders with other countries (South Africa, Mozambique) are particularly vulnerable to child trafficking for domestic labor and/or sexual exploitation.[34] Perpetrators of the violation can run the gamut: from lorry drivers to family relatives.[35] There are also reportedly high levels of ignorance in many border communities about what constitutes 'trafficking' of children.

[32] Government of Swaziland et al., Multiple Indicator Cluster Survey: final report, 2016, at http://MICS-surveys-prod.s3.amazonaws.com/MICS5/Eastern%20and%20Southern%20Africa/Swaziland/2014/Final/Swaziland%202014%20MICS%20Final%20Report_English. pdf.
[33] Ibid.
[34] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.
[35] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

2.4. Child marriage and harmful cultural practices

Sixteen years is the age at which females can legally marry, provided that there is both parental consent and official approval from the Ministry of Justice.[36] It should be noted, however, that, according to traditional law, the age of permitted marriage is 13 years. Hence this lack of alignment between Western/federal and traditional law presents a space for child marriage to occur with impunity. Nevertheless, among the many dimensions of child protection, child marriage is not very prevalent in Eswatini. The 2014 MICS documented that 1.3% of women and 0.2% of men were married or in first union before age 15, and that 8.8% of women and 1.7% of men were first married or in union before age 18. Other harmful practices are not documented.

2.5. Children and justice

There are many 'blind spots' in relation to children and justice due largely to the absence of data on the numbers and profiles of children in the justice system, various barriers and inequities for children and adolescents. There is no routine tracking and reporting on children in pre-trial detention, nor is there gender-disaggregated data. Nonetheless, stakeholders note physical barriers (e.g., availability and accessibility of police stations, courts, age-appropriate correctional facilities), financial, and other types of barriers. Children from low-income families are constrained by the fact that the legal aid framework to improve access to justice for those with limited resources is still under development. Children and adolescents in rural areas appear to be particularly disadvantaged in terms of access to justice for children services.

The SITAN has also documented hidden populations of children who are not real or accused perpetrators of crimes but are being accommodated within the correctional system due to the lack of more-appropriate options. The following subpopulations of children are currently slipping through the cracks:

- Infants and children under the age of three whose mothers are incarcerated.
- Children of incarcerated parents who do not have viable options for alternative care (e.g., kinship care)
- Children seeking reintegration in their communities of origin.

These children are further profiled in the chapter on "Equitable Chances at Life" (Chapter 5).

2.6. Child labor

As with other dimensions of child protection, there is a paucity of current evidence on child labor. There are some institutional arrangements related to child labor. For example, the Ministry of Labor and Social Affairs has established and staffed a Child Labor Unit, which is a major achievement in creating institutional structures to support child protection. The absence of a staff person or unit with a similar mandate in each of the four regions limits the extent to which enforcement can occur, however. In addition, the absence of a compulsory education age is a legal gap that spurs the exploitation of adolescents and younger children to engage in the worst forms of child labor (e.g., forced domestic work, livestock herding).[37]

2.7. Emerging priorities

The issue of violence has been highlighted as a major child protection priority in the country. However, as alluded to in the first chapter of this report, destabilization and/or disintegration of the family is a major hazard that has implications for child protection. **The issue of inadequate parental care also warrants increased attention as a root cause of child and adolescent vulnerability**. Data on the

[36] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.
[37] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

magnitude of children with inadequate parental care are outdated. Evidence from the 2016/17 Eswatini Household Income and Expenditure Survey showed that 2.3% of children age 0-17 years and 11% of young people age 18 -21 years were double orphans.[38] However, that is just one subset of children with inadequate care. The HIV epidemic has contributed to large numbers of children with inadequate parental care.[39] However, there are a plethora of other circumstances and factors that may result in inadequate parental care such as: parental abandonment or neglect of various forms and degrees (e.g., absentee biological fathers; mother and/or father leaving a child in the care of other caregivers; parental death).[40]

As stated in a preceding section on children and justice, there can be unconventional landing spots for children with inadequate parental care (e.g., Department of Corrections). Anecdotally, there is some coordination with MoH and CSOs, but basic necessities are not budgeted for by any sector.

The country is, however, on the cusp of strengthening the policy and legal landscape to better respond to the broader issue of alternative care, with national guidelines on foster care currently under development by the Department of Social Welfare/DPMO.

2.8. Key drivers of shortfalls and inequities in protection

Table 2 highlights the situation vis-à-vis child protection. As noted in the table, the extent of birth registration and possession of birth certificates is improving, but the majority of children do not possess birth certificates, a foundational aspect of child protection. Disparities also exist, with rural children and children in Shiselweni generally faring worse than other children.

Shortfalls and inequities related to child protection can largely be attributed to social and systems factors.

Social and gendered beliefs and norms are structural factors that underpin child protection in many forms. For example, in the 2014 MICS, 66% of household respondents believed that physical punishment is a necessary part of child rearing. Other social beliefs can foster discrimination and marginalization of different types of children. For example, stigma is still attached to disability, which perpetuates children with disabilities as a 'hidden' population within families and communities. Research and anecdotal evidence also show that social and gender norms perpetuate violence (e.g., against girls) and fuel a culture of silence, even when legislation and 'up-stream' actors try to promote an enabling environment for violence prevention, reporting and timely mitigation responses. During the SITAN process, some youth expressed concerns related to confidentiality.

> **In these clinics and places, they gossip. We see it. We hear it. There is no confidentiality."**
>
> **"As for myself, I feel isolated from any programs. Most of them are in urban areas."**
>
> ***---A group of rural adolescent females ages 16-19 (Lubombo)***

Parenting and caregiver practices and, more broadly, the stability of the family unit, is an underlying factor that is linked to various child protection outcomes, creating exposure to risky situations and/or practices. Various shocks to the family unit—whether at a micro-level (e.g., death, illness such as HIV, substance abuse and other factors) or at a macro-level (e.g., climate-induced hazard such as drought which, in turn, can result in food insecurity, loss of livelihoods and other adverse outcomes)—can also be disruptive forces in the home environment and in communities.[41]

[38] *Ibid*.
[39] Central Statistical Office, Eswatini Household Income and Expenditure Survey 2016/17: Key Findings Report, May 2018.
[40] UNICEF. 2016. National Study on the Drivers of Violence Affecting Children in Swaziland, Draft, July 2016.
[41] UNICEF. 2016. National Study on the Drivers of Violence Affecting Children in Swaziland, Draft, July 2016.

The lack of a systems approach to child protection is the other key driver of inequities and shortfalls. As an underlying factor, multi-stakeholder, multi-sectoral coordination should create opportunities to foster an enabling environment at different levels to protect children and respond to child protection violations. However, there is an absence of formal coordination and an overarching systems approach that addresses all operational requirements (qualified personnel, information systems, essential commodities e.g., educational materials on violence prevention, rape kits for proper clinical management of cases of sexual violence, tools and structures to support child-friendly spaces such as One-Stop Centers). Ensuring quality through a child-sensitive lens is also part of that causal pathway. Suboptimal financing of child protection efforts remains a structural factor that impedes the 'translation' of legal frameworks such as the Children's Protection and Welfare Act (2012) into integrated programs that build on synergies between families, community stakeholders, frontline service providers, CSO and religious actors and others.

2.9. Major Conclusions

Although children in Eswatini are affected by a host of protection issues, violence is, by far, the priority issue related to child protection. Inadequate parental care warrants greater focus; it is a by-product of factors or circumstances that exacerbate vulnerabilities which compromise child protection. It is also a major underlying factor in adverse outcomes in children and adolescents. However, the lack of data and a formalized, systems approach to child protection limit the space in which both prevention and responses can be improved.

Table 2. Progress/Direction of Change and Key Disparities related to Child Protection, a Data Comparison from two MICS (2010 and 2014), Eswatini

(CELLS SHADED IN YELLOW DENOTE CATEGORIES OF CHILDREN THAT ARE LOWEST PERFORMING VIS-À-VIS THE INDICATORS)

INDICATOR	INDICATOR PROGRESS	LATEST NATIONAL ESTIMATE	DISPARITIES BY:								
			A. Place of Residence		B. Gender		C. Region				D. Other Characteristics of Children, Their Mothers/Caregivers or their Households associated with Poor Outcomes
			URBAN	RURAL	MALE	FEMALE	SHISELWENI	LUBOMBO	MANZINI	HHOHHO	
% of children under age 5 whose birth is registered with civil authorities	↑	53.5%	63.5%	50.6%	50.9%	56.2%	40.2%	52.1%	59.4%	57.1%	MOTHER'S EDUCATION: No education (47.5%); Higher than tertiary (83.5%) HOUSEHOLD WEALTH QUNITILE: Poorest (38.7%); Richest (78.4%)
% of children under age 5 whose birth certificate was seen by the interviewer	↑	21.3%	28.3%	19.2%	20.5%	22.0%	20.6%	25.7%	18.8%	21.6%	MOTHER'S EDUCATION: No education (15.9%); Higher than tertiary (40.1%) HOUSEHOLD WEALTH QUNITILE: Poorest (14.1%); Richest (37.6%)
% of children 0-17 years with at least one parent living abroad	NC	13.0%	8.3%	14.2%	13.1%	12.8%	21.4%	11.5%	10.3%	11.3%	CHILD'S AGE: Peak rate for children age 5-9 years (15.3%)
% of children 0-17 years who can be classified as an orphan or vulnerable child	↑	70.7%	62%	72.9%	70.2%	71.2%	73.3%	75.0%	69.7%	66%	HOUSEHOLD WEALTH: Peak rate for the poorest children (79%) ADOLESCENCE: 10-14-year-olds (74.9%); 15-17-year-olds (77.7%)
% with a chronically ill parent	↑	53.6%	48.3%	55%	53.5%	53.6%	54.3%	57.6%	52.4%	51.1%	HOUSEHOLD WEALTH: Peak rate for the poorest children (59.8%)
% with one or both parents dead	↓	20.4%	16.3%	21.4%	20.0%	20.7%	21.8%	19.7%	20.1%	20.2%	CHILD'S AGE: Peak rate for 15-17-years-olds (41.4%)
Percentage of children age 1-14 years who experienced any violent discipline	--	88.3%	85.1%	89.1%	89.2%	87.5%	91.3%	83.8%	88.0%	86.9%	
NC: Not calculated in 2010 MICS; data unavailable											

3. YOUNG CHILD SURVIVAL AND DEVELOPMENT

KEY MESSAGES:

- **Awareness and buy-in for ECD is increasing in Eswatini. However, ECD is not yet regarded as a non-negotiable national priority that requires resourcing and program attention in both development and humanitarian scenarios.**

- **Efforts need to be accelerated, but some gains are being made in the area of early learning. However, both objectively verifiable evidence (e.g., MICS 2014) and anecdotal evidence (e.g., from ECD program implementers) suggest major shortfalls with respect to infant and young child feeding (IYCF) practices and, more broadly, caring/parenting practices.**

- **The intersection of HIV (and the prevention of mother-to-child transmission, in particular) and IYCF warrants further attention to address shortfalls related to feeding practices.**

- **The country has made major strides with respect to child survival and nutrition. However, there is an unfinished agenda:**
  - **Despite gains in chronic malnutrition, persistent regional disparities in stunting and wasting indicate that some children are still being left behind. Nutrition-specific and nutrition-sensitive programs need to be responsive to the specific drivers and determinants of both chronic and acute malnutrition that exist in different settings.**
  - **There is an urgent need to redouble efforts to improve neonatal heath, particularly since Eswatini's neonatal mortality rate has not declined to the extent observed for child mortality.**
  - **However, the post-neonatal period has emerged as an equally important window of intervention as the neonatal period.**

- **With the exception of primary schooling, there is a paucity of age-appropriate services for children in middle childhood (ages 5-9). This is a segment of the young child population that is currently being left behind.**

- **Complexities in addressing WASH are coming to the fore, in light of (a) hazards and risks, (b) the distinct realities of WASH in urban/peri-urban versus rural settings and (c) unintended consequences of WASH interventions such as menstrual hygiene management.**

- **There is a systemic mismatch between resources and burden. For example, Shiselweni has the highest mortality rates but the lowest allocation of health and social resources. In high-volume health institutions such as the national referral hospital in Mbabane, lack of basic functionality and service delivery readiness (manifesting as unavailability of essential health commodities, massive health workforce shortages, shortcomings in basic hygiene and sanitation and other limitations) is actually exacerbating mortality risks.**

3.1. The policy and program landscape

Boxes 3 and 4 highlight key features of the policy and program landscape related to young child survival and development.

Outside of healthcare and formal primary education, NGOs are key actors in addressing various dimensions of young child survival and development. As highlighted earlier, CSOs (including FBOs) and international NGOs are active, particularly at the community level, and they have functional platforms for CSO exchange and coordination (e.g., SNECD, Children's Forum). In addition, UN agencies such as UNICEF and UNFPA are actively supporting both Government entities and CSO partners in different sectoral programs to optimize young child survival and development.

3.2. The concept of early childhood development (ECD)

ECD is the starting point in young child survival and development, placing a child on a trajectory of optimal growth and development through childhood and into adolescence, and setting the stage for productive adulthood. ECD is not just vital to an individual child; it is a foundational investment for sustainable national development.[42] Although awareness and buy-in for ECD is increasing in Eswatini, ECD is not yet regarded as a non-negotiable national priority that requires resourcing and program attention in both development and humanitarian scenarios.

In the Kingdom of Eswatini, the 'First 1,000 Days,' or the critical period from conception to a child's second birthday, has been a key focus. Although the Kingdom of Eswatini does not have a national ECD policy, there is a National ECD Framework that clearly articulates intended results and key dimensions of ECD programming. In moving from that framework to practice, the education sector (e.g., through pre-primary education) and the health sector (e.g., through child survival interventions such as immunization, nutrition prevention and treatment, WASH) are implementing ECD-sensitive services. MoET has positioned early childhood education under the rubric of ECD.

Box 3.
KEY POLICIES, GUIDELINES, STRATEGIES & PLANS

In addition to the policies and legislation noted in Figure 1, the following support the well-being of young children in the Kingdom of Eswatini:

Health
- National Health Policy (2017)
- Third National Health Sector Strategic Plan (NHSSP III), 2019 – 2023
- Guidelines for Newborn Care (2019)
- National Sexual Reproductive Health and Rights Strategic Plan 2014 – 2018

HIV/STIs
- National PMTCT Guidelines
- Health Sector Response HIV/AIDS Plan (2014-18)—*No new plan developed*
- Swaziland Integrated HIV Management Guidelines (2015)
- National Strategic Plan for Ending AIDS and Syphilis in Children (2018 – 2022)
- National HIV and AIDS Strategic Framework (2018 – 2023)
- Swaziland Male Circumcision Strategic and Operational Plan for HIV Prevention 2014 – 2018
- National Policy Guidelines for Community-Centred Models of ART Service Delivery (CommART) in Swaziland (June 2016)

Education
- Free Primary Education Act (2010)
- Multi-sectoral ECCD Framework (2019)
- National Education and Training Sector Policy (2018)
- Education Sector Strategic Plan (2010 – 2022)
- National Education and Training Sector Policy (2018)
- Gender Responsive Strategy for Addressing Secondary School Dropout, Grade Repetition, and Transition in Eswatini (2018)
- Ministry of Education and Training, Kingdom of Eswatini

Child Protection
- Guidelines on Alternative Care (2010)

[42] Black, R.E., et al. 2013. Maternal and Child Undernutrition and Overweight in Low-income and Middle-income Countries." The Lancet 382, no. 9890 (2013): 427–451. doi:10.1016/s0140-6736(13)60937-x

Administrative data on early childhood education (e.g., via the country's Education Management Information System [EMIS]) is highly limited. However, MICS data are available on selected indicators related to early childhood education (ECE). The 2014 MICS estimated that 61% of children attending first grade attended preschool in the previous year. The starkest disparity exists by place of residence (81% of urban first-graders and 57% of rural first-graders attended preschool the previous year). However, children whose mothers had no formal education, who came from the poorest wealth quintile and/or resided in Lubombo fared the worst in this regard (38%, 44% and 43%, respectively).[43] The 2014 MICS also showed that 29.5% of children aged 36-59 months were attending an organized ECE program at the time of the survey (33.2% for girls, 25.8% for boys). The survey also showed that a much higher proportion of urban children than rural children in that age group attended ECE programs (42.6% and 26.2%, respectively). However, the greatest variation exists according to mother's level of education: only 17.9% of children whose mothers had no formal education were attending ECE programs, compared with 61.6% of children whose mothers had a tertiary level of education. There is also a stark divide according to socioeconomic status: 27.7% of the poorest children aged 36-59 months, compared with 48.4% of their counterparts in the richest wealth quintile. Thus, even though there is a national shortfall with respect to pre-primary education, there is already compelling evidence on the exclusion of certain segments of the child population.

Both supply-side and demand-side factors affect the coverage preschool education in Eswatini. For example, awareness of the benefits of pre-primary education for future primary school performance is not high among parents/caregivers and other household and community decision makers and influencers. On the supply side, the availability of formal classes, qualified pre-primary teachers and pupil-teacher ratios (on average, there are 12.5 pupils per teacher for pre-primary schooling) can affect both access to and quality of pre-primary education. It is also noteworthy that early childhood care, development and education receives limited state support.[44] For example, pre-primary education accounted for only 1.1% of government expenditure in 2014.[45] The private sector is largely involved in pre-school education—a stark contrast to primary education, for which the Government is almost the sole provider (98% of primary schools, according to UNESCO's Institute for Statistics).

Other dimensions of ECD (e.g., health and nutrition, WASH) are examined in later sections of this report. However, ECD has not been sufficiently mainstreamed within conventional maternal, newborn and child health services. As a result, there are missed opportunities to promote and systematically address issues such as optimal infant and young child feeding (IYCF) practices. Other aspects of ECD such as (1) early learning and stimulation before pre-primary, (2) caring practices and (3) child protection require elevated attention in both institutional and community settings.

At the community and household levels, CSOs are active in promoting some aspects of ECD, and donor resources are being directed to those non-State actors to extend the reach of ECD-sensitive interventions not currently being pursued by formal systems of care in the Government sector. However, coordinated, joint programming that centers on integrated delivery and monitoring of complementary, ECD-sensitive interventions, as well geographical convergence of different actors addressing discrete dimensions of ECD, has not yet been realized.

Caregivers and communities have vital roles in ECD, although practices that can be harmful to survival and development need to be addressed. The proliferation of informal day cares (e.g., in informal settlements) presents an opportunity to address currently overlooked aspects of ECD in community settings. In those settings, there is untapped potential to orient caregivers on no-cost ECD activities (e.g., exploring and describing one's surroundings with children; singing songs; telling stories; counting

[43] 2014 MICS.

[44] Van Der Berg, S., Van Wyk, C., Hofmeyr, H. & Ferreira, T. Out-of-School Children in Swaziland: A Report to the Swaziland Ministry of Education and Training and UNICEF-Swaziland, 2018.

[45] Eswatini data obtained from UNESCO Institute for Statistics (UIS) database.

or drawing; optimal IYCF) and, when feasible, introduce low-cost yet effective commodities (e.g., age-appropriate learning materials, WASH facilities, safe food storage supplies) to maximize ECD impact.

3.3. Mortality levels, trends and differentials

Eswatini has experienced major reductions in national under-five and infant mortality rates. However, there is an unfinished agenda with respect to child survival. According to the latest estimates released from the United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) in 2018, Eswatini's under-five mortality rate was estimated at 54 per 1,000 live births, with a higher rate among boys (58) than girls (49).[46] The UN IGME estimates that Eswatini's infant mortality rate (IMR) as 41 per 1,000 and its neonatal mortality rate (NMR) at 17 per 1,000.

The above estimates are lower than what was documented in the 2014 MICS (*see Figure 7*) and a vast improvement over the under-five, infant and neonatal mortality rates documented in the 2010 MICS (104, 79 and 20, respectively). However, both sets of estimates yield similar insights: **(1) mortality rates are higher in boys than in girls and (2) the first year of life is the most challenging period during the first five years of life to navigate threats to survival**. More specifically, the youngest children under five are bearing the mortality burden.

Figure 7. Gender Differences in Mortality during the First Five Years of Life (Data Source: 2014 MICS)

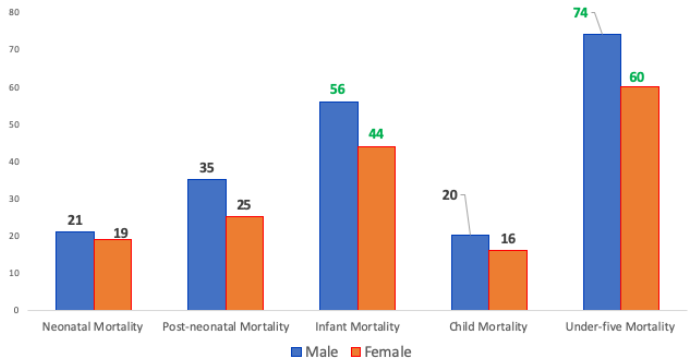


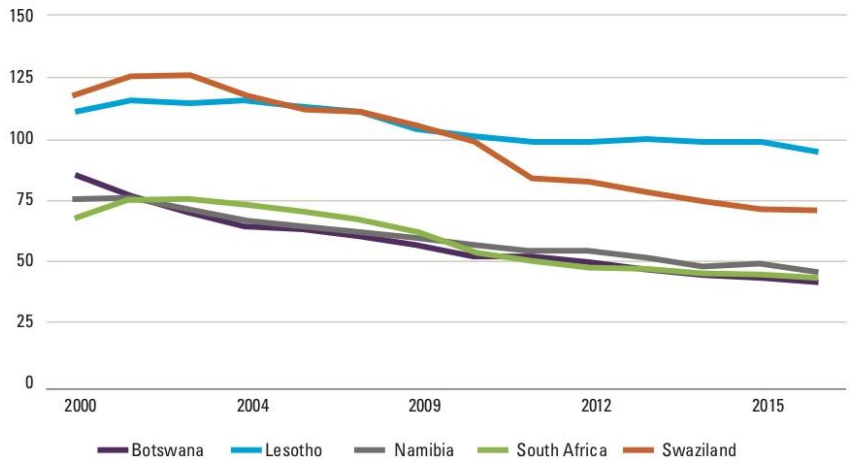
Figure 8 shows that, despite a declining trend, Eswatini has had the second-highest under-five mortality rates in Southern Africa since the mid-2000s.[47]

The post-neonatal period—which is the period after the first month of life up to a child's first birthday—warrants equal attention to the neonatal period, as the mortality burden is actually higher during that period in a child's early existence than during the neonatal period. In addition, it is the period in which Shiselweni separates itself from other regions in terms of a disproportionately high mortality rate (51 versus 24-27 per 1,000 in the other three regions).

[46] United Nations Inter-agency Group for Child Mortality Estimation (UN IGME). Levels and Trends in Child Mortality, Report 2018: Estimates developed by the UN Inter-agency Group for Child Mortality Estimation., 2018.

[47] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

Figure 8. Under-five mortality in Lesotho and other Southern African Countries, 2004-2016 (taken from UNICEF, 2018)



Source: World Development Indicators

The correlation between maternal mortality and neonatal mortality is well documented. Eswatini does not have recent maternal mortality ratio (MMR) estimates; the last survey-based estimate of maternal mortality is from 2012, when the country conducted a Demographic and Housing Survey that yielded an estimate 593 maternal deaths per 100,000 live births. It is estimated that 19% of maternal deaths are HIV-related.[48] However, an MMR of 593 suggests that major barriers and bottlenecks exist during the delivery process and during the postpartum period to manage obstetric complications. In addition, the documented rise in stillbirths—according MoH data, from 41 in 2013 to 107 in 2017—signals missed opportunities to detect and treat syphilis in pregnant women and shortcomings in management of labor and delivery.[49]

3.4. Levels, trends and differentials in other outcomes in young children

Table 3 highlights the direction of change in selected indicators related to young child survival and development. There have been strides in mortality indicators and in the coverage of some high-impact indicators, as describe below. As shown in the table, Shiselweni, followed by Lubombo, fares worse than other regions on several indicators. There is also a rural disadvantage for outcomes such as multidimensional poverty and various measures of undernutrition, whereas urban areas have a higher overweight/obesity burden. Care-seeking patterns are also changing. For example, there has been a substantial shift towards the private sector for delivery care, a pattern that did not exist in 2010 when only 5% of births were delivered by private providers.

The national average for the ECD Index (65%), a composite measure that indicates the percentage of children aged 36-59 months who are developmentally on track in at least three of four key domains (literacy-numeracy, physical, social-emotional, learning) has not changed dramatically since 2010 (62%). Urban children fare much better in terms of this index than rural children (73.9% and 62.7%, respectively).[50,51]

[48] WHO. 2015. Trends in maternal mortality:1990 to 2015: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Retrieved from: http://apps.who.int/iris/bitstream/handle/10665/194254/9789241565141_eng.pdf;jsessionid=194CBE65C205CE9DE916EBDF1063FD12?sequence=1.

[49] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

[50] Central Statistical Office and UNICEF. Multiple Indicator Cluster Survey: final report, 2016.

[51] Central Statistical Office and UNICEF. Swaziland Multiple Indicator Cluster Survey 2010, 2011.

3.4.1. Nutritional status

Stunting—Although almost 1 out of every 4 children under five is stunted (low height-for-age, a measure of chronic malnutrition), stunting rates have been on a decline: chronic malnutrition affected 23.0% of children in 2017 compared to 30.9% in 2010.[52] Persistent regional disparities suggest that children in particular parts of the Kingdom are still being left behind. Shiselweni and Manzini have the highest rates. There is also a gender disparity, and the fact that boys have higher stunting rates than girls (29.2% and 21.2%, respectively, according to the 2014 MICS) warrants further exploration as a possible explanation for higher mortality rates in boys than girls. A 2017 Comprehensive Survey established a link between WASH and stunting.[53] As described in a later section on WASH, the suboptimal levels of population access to safely managed water and sanitation services therefore needs to be highlighted as both a key component of creating a safe and clean environment for children and as a key program area for nutrition-sensitive intervention.

Wasting—Whereas there are signs that chronic malnutrition in children is on the decline, that is not the case with acute malnutrition. Wasting (low weight-for-height) prevalence was 2% in 2014 and 2.5% in 2017. The most-striking differentials in wasting prevalence exist according to region, not other factors such as gender. Between 2014 and 2017, child wasting rates in Hhohho region increased from 1.5% to 3.2%. According to the 2018 Annual Health Report produced by the MoH, other signs of acute malnutrition paint a similar picture. In 2018, the MoH observed a decline in moderate acute malnutrition (MAM) but a rise in severe acute malnutrition (SAM) admissions by the end of the year.

Hazards such as drought can have a direct impact on food security, food consumption patterns and the quality of diets. This, in turn, can impact rates of acute malnutrition. Notably, during the period of the El Niño drought (2015/16), minimal dietary diversity was only 13%, minimal meal frequency fell from 81.2% to 76.3%, and minimal acceptable diet fell from 39.2% to 9.7%.[54]

Underweight—The 2014 MICS, a 2016 rapid nutrition assessment conducted by the MoH and 2017 administrative data from the MoH show that underweight prevalence, which is a composite indicator of both wasting and stunting, hovers around 6% (5.8% MICS estimate; 5.5% rapid nutrition assessment estimate, 6.3% 2017 MoH estimate). The 2014 MICS estimate is identical to the 2010 MICS estimate for underweight. Thus, according to available MICS data, there has been no improvement in the early 2000s in this nutrition outcome.

Overweight in Children—Overweight prevalence among children is 9% nationally, with overweight and obesity being slightly more prevalent in urban areas (11.6%) than in rural areas (8.2%). Hhohho is the region with the highest overweight prevalence (Table 3). However, the most-striking correlate of childhood overweight/obesity is socioeconomic status. Children in the richest wealth quintile are three times as likely as children in the lowest wealth quintile to be overweight/obese (17.5% and 5.8%, respectively).

Micronutrient deficiencies—Nationally representative data on the prevalence of anemia and other micronutrient deficiencies in children is limited. However, a 2017 Standardized Monitoring and Assessment of Relief and Transitions (SMART) Survey found that, while anemia prevalence was high in all age groups, a higher number of males than females under the age of five were identified as anemic in both 2016 and 2017.[55] In light of this gender disparity and the gender disparity in stunting, differential treatment of males versus females in relation to nutrition and nutrition practices warrants further exploration.

[52] The 2014 MICS documented a rate of 26%.
[53] Government of Swaziland, Swaziland Comprehensive Survey Report, 2017.
[54] UNICEF. Synthesis of Secondary Data on Children and Adolescents in Eswatini, 2018.
[55] Government of Swaziland. Swaziland Comprehensive Nutrition and Health Survey, 2017.

Other micronutrient deficiencies are also salient to young child survival and development, although data are limited. Data from 2017 indicates that coverage of vitamin A supplementation (78%), below the national target of 90%.[56]

Maternal nutritional status does not receive the same degree of attention as child nutritional status, despite the fact that a woman's nutritional status is linked to the survival and development of her children, as well as noncommunicable diseases. Available evidence indicates that a large proportion of women of reproductive age (WRA) in Eswatini are malnourished, and the country is off track to meet World Health Assembly and SDG targets related to women's nutritional status. For example, according to 2018 Global Nutrition Report estimates, 27.2% of WRA are anemic.[57] A Comprehensive Nutrition Survey conducted by the Government of Eswatini (2017) found that overweight and obesity, and not undernutrition (or thinness/low body mass index), is the more-critical malnutrition outcome in WRA in Eswatini, with 32.3% being overweight (28.8% being obese).[58]

Considering the high rates of anemia, overnutrition and undernutrition in women and/or children, the Kingdom of **Eswatini can be characterized as a country experiencing a "triple burden of malnutrition."**[59] This phenomenon adds another layer of complexity in addressing malnutrition within households, communities and the population as a whole across the life span, with particular risks to healthy pregnancies and birth outcomes. The high prevalence of overnutrition will have implications in terms of a high burden of chronic diseases in the population.

Infant and young child feeding (IYCF) is an important contributor to nutritional status outcomes in children. Although the body of evidence on nutrition practices, drivers and dynamics in Eswatini is limited, the 2014 MICS documented suboptimal IYCF practices, which can contribute to compromised health, learning and development outcomes in children and adolescents. For example, the average duration of exclusive breastfeeding is only 3.8 months in Eswatini, far lower than the recommended six months of exclusive breastfeeding, as promoted by WHO. The 2014 MICS estimated that less than two third of 0-5 month olds are breastfed. Annual reports prepared by the MoH, which are based on Health Management Information System (HMIS) data, have shown a reduction in the rate of exclusive breastfeeding (from 65% in 2017 to 58% in 2018).[60] The rate of early initiation of breastfeeding (i.e., breastfeeding within one hour of birth) is also suboptimal (48.3%).[61] Only 39.5% of children aged 6-23-months are currently breastfed and receive solid, semi- solid or soft foods.[62] As shown in Table 3, urban children have better quality diets than rural children, as reflected in their rates of minimum dietary diversity and minimum acceptable diets. Hence, the MICS data paint a clear picture that the quality of children's diets must be prioritized in Eswatini.

3.4.2. Birth registration and documentation

In the Kingdom a child needs a birth certificate to register for school examinations or to obtain a passport, but 74% of children under the age of two in Eswatini do not possess birth certificates.[63] Nonetheless, both the percentage of children under five years whose birth is registered with civil authorities and the percentage of children under five years whose birth certificate was seen by the interviewer increased between the 2010 and 2014 MICS assessments (from 49.5% to 53.5% and from

[56] UNICEF. Synthesis of Secondary Data on Children and Adolescents in Eswatini, 2018.
[57] Development Initiatives. 2018 Global Nutrition Report: Shining a Light to Spur Action on Nutrition, 2018.
[58] Government of Swaziland. Swaziland Comprehensive Nutrition and Health Survey, 2017.
[59] World Health Organization. Double Burden of Malnutrition Factsheet. Retrieved from www.who.int/nutrition/double-burden-malnutrition/en/, 7 August 2019.
[60] Ministry of Health. 2019. Annual Program Report 2018. National Child Health (Expanded Program on Immunization (EPI), Management of Neonatal and Childhood Illnesses (IMNCI) Program, Nutrition Program).
[61] Central Statistical Office and UNICEF. Multiple Indicator Cluster Survey: final report, 2016.
[62] Central Statistical Office and UNICEF. Multiple Indicator Cluster Survey: final report, 2016.
[63] UNICEF. Synthesis of Secondary Data on Children and Adolescents in Eswatini, 2018.

15.3% to 21.3%, respectively). Despite this upward trajectory, the national shortfall in birth registration and documentation warrants attention given its bearing on other outcomes in young childhood.

3.4.3. Maternal and newborn health

Both coverage for at least one antenatal care visit (ANC 1) and institutional delivery are quite high in Eswatini (99% and 89%, respectively). However, that high coverage does not apply to multiple ANC visits (at least four) and timely postpartum and post-natal care. According to 2014 MICS data, rural women are more likely than urban women to deliver in public health facilities (62% and 51%, respectively). In contrast, urban women are almost twice as likely as rural women to deliver in private facilities (42% and 24%, respectively). Comparison of data from the 2010 and 2014 MICS show a massive shift towards the private sector for delivery care (from 4.3% in 2010 to 28.4% in 2014). Women in Shiselweni and Hhohho are almost twice as likely as women in Lubombo and Manzini to deliver in public facilities; in Lubombo and Manzini, at least 4 out of 10 deliveries occur in private facilities. Notably, Lubombo has the highest rate of home-based deliveries (17%).

There is a national shortfall related to timely post-natal care. Nationally, for only 7.6% of births, the infant received at least one post-natal care visit from a health provider after birth.[64] In only 4% of cases, the infant underwent a post-natal check within 2 days of delivery, excluding the customary post-natal newborn check that is conducted in 90% of cases in the country. There is no difference between urban and rural areas in this regard. **Post-natal care therefore remains an unfinished agenda within maternal and newborn health**, as the country is far from achieving high coverage levels for the 4+ postnatal checks within the first six weeks of life, as recommended by the World Health Organization (WHO).[65]

[64] Central Statistical Office and UNICEF. 2016. Swaziland Multiple Indicator Cluster Survey 2014. Final Report. Mbabane, Swaziland, Central Statistical Office and UNICEF. Table RH.13.

[65] WHO. WHO Recommendations on Postnatal Care of the Mother and Newborn. October 2013. Geneva: WHO, 2013.

Table 3. Progress/Direction of Change and Key Disparities related to Young Children, a Data Comparison from two MICS (2010 and 2014), Eswatini

INDICATOR	INDICATOR PROGRESS SINCE 2010	LATEST NATIONAL ESTIMATE	DISPARITIES BY:								
			A. Place of Residence		B. Gender		C. Region				D. Other Characteristics of Children, Their Mothers/Caregivers or their Households associated with Poor Outcomes
			URBAN	RURAL	MALE	FEMALE	SHISELWENI	LUBOMBO	MANZINI	HHOHHO	
MCP rate, 0-23 mos.	NC	69.8%	39.9%	79.3%	--	--	87.9%	82.4%	53.40%	70.0%	HOUSEHOLD SIZE (6+ members) MOTHER'S EDUCATION (MCP when mother has no formal education more than 2x MCP when mother has more than a secondary education)
MCP rate, 24-59 mos.	NC	73.3%	37.2%	83.4%	--	--	86.5%	76.5%	62.8%	75.4%	
MCP rate, 5-14 years*	NC	52.6%	17.4%	61.4%	--	--	67.4%	64.0%	38.5%	51.0%	
Maternal mortality ratio (per 100,000)	↑	593	NC	NC	NC	NC	NC	NC	NC	NC	
Under-five mortality rate (per 1000)	↓	67	(67)	67	74	60	92	-71	68	45	
Infant mortality rate (per 1000)	↓	50	50	50	56	44	78	(42)	48	37	
Neonatal mortality rate (per 1000)	–	20	24	18	21	19	27	17	24	11	
Post neonatal mortality rate (per 1000)	↓	30	26	31			51	(26)	24	27	
No. of reported stillbirths	↑	107	--	--	--	--	--	--	--	--	
Underweight prevalence, under-fives	–	5.8%	4.3%	6.2%	7.3%	4.3%	6.5%	6.1%	5.4%	5.5%	
Stunting prevalence, under-fives	↓	25.5%	19%	27.3%	29.2%	21.2%	28%	26.9%	24.5%	23.5%	
Wasting prevalence, under-fives	↑	2%	2.1%	1.8%	2.3%	1.7%	2%	3.2%	1.6%	1.5%	

INDICATOR	INDICATOR PROGRESS SINCE 2010	LATEST NATIONAL ESTIMATE	DISPARITIES BY:								
			A. Place of Residence		B. Gender		C. Region				D. Other Characteristics of Children, Their Mothers/Caregivers or their Households associated with Poor Outcomes
			URBAN	RURAL	MALE	FEMALE	SHISELWENI	LUBOMBO	MANZINI	HHOHHO	
Overweight prevalence, under-fives	↓	9%	11.6%	8.2%	9%	8.9%	6.1%	9.7%	9.4%	10.2%	
Institutional deliveries	↑	87.7%	92.9%	85.8%	--	--	85.8%	82.5%	89.4%	90.6%	HH WEALTH (lowest wealth quintile=lowest rate (76.4%); highest wealth quintile=highest rate (95.1%))
public facility birth	↓	59.4%	51.2%	62.4%	--	--	80.7%	42.3%	44.6%	81.1%	
private facility birth	↑	28.4%	41.7%	23.5%	--	--	5.1%	40.2%	44.8%	9.5%	
home birth	↓	10%	5.1%	11.8%	--	--	13.7%	16.7%	6.5%	7.5%	
Skilled delivery rate (%)	↑	88.3%	93%	86%	--	--	85.8%	82.5%	90.6%	90.9%	
ANC1	↑	99%	99.4%	98.2%	--	--	98.8%	99 .6%	98.9%	96.9%	
ANC4	–	76%	82.4%	73.8%	--	--	72.7%	68.3%	78.3%	81.4%	
Any postnatal health check of newborn**	NC	90%	92.6%	89.5%	--	--	91.6%	85.8%	90.8%	92.3%	
Postnatal care visit 1 or 2 days after birth	NC	4.3%	4.8%	4.1%	--	--	4.1%	4.6%	5.0%	2.8%	
Low birth weight (weighing below 2,500 grams at birth)	–	8%	7.1%	8.3%	--	--	8.7%	8.4%	6.8%	9.1%	Inverse relationship with mother's level of education
Early initiation of breastfeeding (within one hour of birth)	↓	48.3%	48.0%	48.5%	--	--	39.8%	56.8%	45.4%	52.7%	Less likely among home births (38.2%) than health facility births (49.6%)
Exclusive breastfeeding rate, 0-5 months	↑	63.8%	60.3	64.9	64	63.7	62.3	70.5	58.2	68	
6-23 mos. currently breastfeeding and receiving solid, semi-solid or soft foods	–	39.5%	38.7%	39.7%	38.6%	40.4%	40.1%	39.0%	35.3%	46.5%	

INDICATOR	INDICATOR PROGRESS SINCE 2010	LATEST NATIONAL ESTIMATE	DISPARITIES BY:								
			A. Place of Residence		B. Gender		C. Region				D. Other Characteristics of Children, Their Mothers/Caregivers or their Households associated with Poor Outcomes
			URBAN	RURAL	MALE	FEMALE	SHISELWENI	LUBOMBO	MANZINI	HHOHHO	
0-23 mos. appropriately breastfed	↑	45.3%	43.6%	45.8%	45.2%	45.4%	45.0%	46.8%	40.8%	51.8%	
Rate of Minimum Dietary Diversity in Children (Number of children age 6–23 months who received foods from 4 or more food groups102 during the previous day)	NC	62.4%	72.0%	59.3%	64%	60.8%	58.9%	54.2%	74.3%	53.1%	
Rate of Minimum Acceptable Diets in Children (% of breastfed children age 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day - AND- % of non-breastfed children age 6–23 months who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day)	NC	38.1%	50.2%	34.4%	38.6%	37.6%	33.4%	34.8%	47.6%	32.7%	

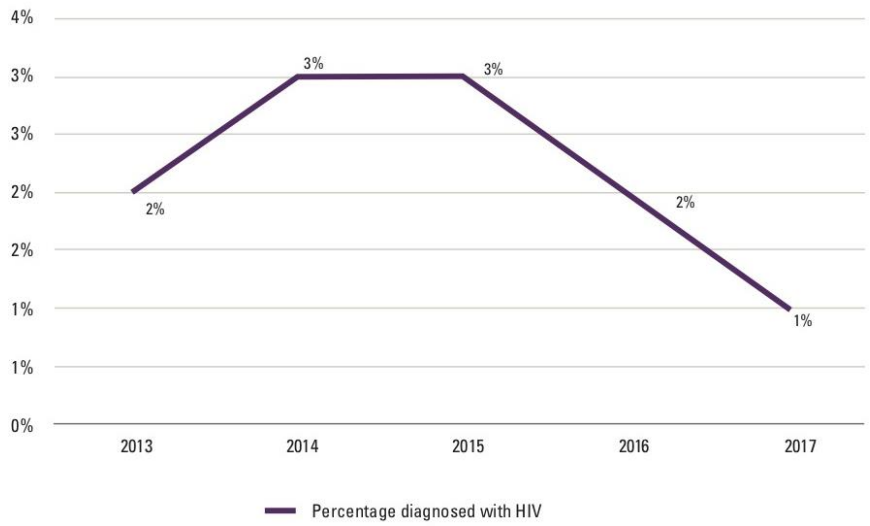
INDICATOR	INDICATOR PROGRESS SINCE 2010	LATEST NATIONAL ESTIMATE	DISPARITIES BY:								
			A. Place of Residence		B. Gender		C. Region				D. Other Characteristics of Children, Their Mothers/Caregivers or their Households associated with Poor Outcomes
			URBAN	RURAL	MALE	FEMALE	SHISELWENI	LUBOMBO	MANZINI	HHOHHO	
Full vaccination, 12-23-month olds	↓	75.0%	78.4%	74.1%	76.8%	73.3%	73.5%	75.4%	78.7%	70.4%	MOTHER'S EDUCATION: <69% if mother has primary education or less Examining differences by HOUSEHOLD WEALTH, rate is actually highest among the poorest children (79%)
Primary school net enrolment ratio	↑	97.7%	98.2%	97.5%	97.3%	98.0%	97.9%	97.3%	97.9%	97.5%	
ECD Index (Percentage of children age 36-59 mos. who are developmentally on track in at least 3 of the following 4 domains: literacy-numeracy, physical, social-emotional, learning)	–	64.9%	73.9%	62.7%	63.5%	66.4%	76.9%	55.1%	63.8%	65.7%	MOTHER'S EDUCATION: Vast differences between children whose mother have a tertiary education (82.7%) and other children (60.0-67.7%)
(*) Rates based on fewer than 250 unweighted exposed person years ( ) Rates based on 250 to 499 unweighted exposed person years											
NC: Not calculated in 2010 MICS; data unavailable to assess direction of change between MICS assessments											
*the age grouping reflected in this indicator includes the youngest adolescents (10-14 years)											
**Refers any health check performed while in the health facility or at home following birth -AND- postnatal care (PNC) visits within two days of delivery..											

3.4.4. Infant and child health

3.4.4(a) Infants and HIV

Eswatini is making strides in relation to the prevention of mother-to-child transmission of HIV (PMTCT), with PMTCT services integrated into maternal and newborn health services. It is estimated that 91% of women above the age of 15 who are living with HIV and 76% of children age 0-14 years are receiving ART.[66] ART coverage for PMTCT is lower; 79% of HIV-infected pregnant women receive antiretrovirals for PMTCT.[67] As shown in Figure 9, of infants seen six-to-eight weeks after birth who were born to HIV mothers, the HIV positivity rate was reduced to 1% by 2017.

Figure 9. HIV positivity rate at 6-8 weeks, 2013-2017 (source: HMIS/MoH)



Anecdotally, there are concerns about vertical transmission of HIV during breastfeeding.[68] However, early infant diagnosis and testing services do not extend past eight weeks postpartum. Hence, this is a gap in ascertaining continued HIV risks and actual HIV burden in infants after that early diagnosis window. This gap has implications for pediatric HIV programming as well as programmes and services targeting young childhood.

3.4.4(b) Immunization

Based on the 2014 Multiple Indicator Cluster Survey (MICS), 3 out of every 4 children in Eswatini are fully immunized.[69] Regional differences are not stark; the full immunization rate in 2014 was lowest in Hhohho (70.4%) and highest in Manzini (78.7%). The national rate documented by the 2014 MICS was far lower than what had been documented in 2010 (83.1%).

[66] UNAIDS, 2019. Country Factsheets: ESWATINI 2018. Retrieved from https://www.unaids.org/en/regionscountries/countries/swaziland

[67] *Ibid*.

[68] UNICEF. Synthesis of Secondary Data on Children and Adolescents in Eswatini, 2018.

[69] Central Statistical Office and UNICEF. 2016. Swaziland Multiple Indicator Cluster Survey 2014. Final Report. Mbabane, Swaziland, Central Statistical Office and UNICEF.

Since the 2014 MICS assessment, there have been notable developments that have yielded positive results related to child immunization. The Government of Eswatini now fully funds vaccines and injection commodities for child immunization through UNICEF's procurement system.[70,71] Targeted Child Health Days were conducted in Shiselweni and Lubombo, two regions that historically lagged in a number of child-health-related areas. In 2018, the Government reported that full immunization coverage increased substantially between 2017 and 2018, from 78% to 91%.[72] However, annual reports from the regions still highlight challenges (e.g., immunization defaulting) in some parts of the country. For example, in Lubombo, vaccination for DPT1 had the highest coverage (92%) of all the antigen-specific vaccines in 2018. However, the 2018 is still lower than what was documented in 2015 (98%), and the coverage rate for the third required dose of DPT (DPT3) was only 78%--far lower than the DPT3 rate observed in 2017 (85%).[73] In Hhohho, the region with the lowest MICS estimate of full immunization coverage in 2014, the rate of defaulting between the first and third doses of DPT is much lower than observed in Lubombo: Hhohho's 2018 DPT1 and DPT3 rates were 89% and 84%, respectively.[74] Hence, the demonstrated commitment on the part of the Government to fund vaccine procurement is highly laudable but not a panacea in protecting all children against highly preventable, life-threatening diseases. Other operational elements in linking children with life-saving immunization services warrant investment.

3.4.4(c) Treatment of common childhood illnesses

According to the 2018 Annual Health Report produced by the MoH, diarrheal disease is the leading cause of death during the first year of life in Eswatini. However, the MoH reports that only 49% of children with diarrhea received the correct treatment (oral rehydration solution and zinc).

Pneumonia is another common illness in children, and the MoH reports that in 2018, 6% of the 331 children admitted to health facilities was for pneumonia.[75] The MoH's Integrated Management of Neonatal and Childhood Illnesses (IMNCI) guidelines stipulate that the first-line treatment for pneumonia is amoxicillin, with the second-line treatment being erythromycin. However, data from the Client Management Information System (CMIS) show that only 24% of pneumonia cases received the correct treatment.

Rural Health Motivators (RHMs) are instrumental in delivering community-based interventions such as health education, growth monitoring, malnutrition screening and referrals of sick children to appropriates sites for treatment and care.[76] The limited data on the burden of common childhood illnesses, coupled with data on immunization rates suggest that RHMs will continue to have crucial roles to play in both the prevention and treatment of common childhood illnesses.

3.4.5. Education

Issues related to early childhood education were examined in the earlier section on ECD. This section highlights several issues related to primary schooling.

[70] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

[71] Ministry of Health. 2019. Annual Program Report 2018. National Child Health (Expanded Program on Immunization (EPI), Management of Neonatal and Childhood Illnesses (IMNCI) Program, Nutrition Program).

[72] Ministry of Health. 2019. Annual Program Report 2018. National Child Health (Expanded Program on Immunization (EPI), Management of Neonatal and Childhood Illnesses (IMNCI) Program, Nutrition Program).

[73] Ministry of Health. 2019. Lubombo Regional Health Performance Report 2018.

[74] Ministry of Health. 2019. Hhohho Regional Health Performance Report 2018.

[75] Ministry of Health. 2019. Annual Program Report 2018. National Child Health (Expanded Program on Immunization (EPI), Management of Neonatal and Childhood Illnesses (IMNCI) Program, Nutrition Program).

[76] Ministry of Health. 2019. Annual Program Report 2018. National Child Health (Expanded Program on Immunization (EPI), Management of Neonatal and Childhood Illnesses (IMNCI) Program, Nutrition Program).

3.4.5(a) Primary education

Primary education is free in the Kingdom of Eswatini. In 2010, Parliament approved the Free Primary Education Act and, in 2012, the country achieved Universal Primary Education.[77] Gender parity ratios for primary education suggest that gender-based inequity is not an issue at that level of schooling as it is at higher levels of schooling. Even among the poorest children, the primary school net attendance ratio in 2014 was 97%.[78]

The issue of primary education extends beyond enrollment figures, however. Children in Eswatini start primary school quite late; there are more 11-year-olds enrolled in primary school than seven-year-olds.[79] According to 2017 data, 28% of students enrolled in primary school in 2017 were overaged.[80] Grade repetition is another common phenomenon, thus signaling inefficiencies within Eswatini's education system. It has been estimated that less than 10% of learners complete primary school without repeating a grade.[81] A study conducted by MoET in 2017 found that factors such as poverty and lack of parental support contributed to poor educational outcomes such as grade repetition in primary school.[82]

The over-age and grade repetition phenomena, which are inter-related, prompt greater scrutiny of the quality of primary education. They also highlight missed opportunities to position pre-primary education as a strong foundation that needs to be established to ensure that primary-school-age children excel and progress within the formal education system. Learning assessments in reading and mathematics were conducted in 2018. Further analysis of data from those assessments can provide insight on quality shortcomings within the educational system and necessary improvements to curricula and other aspects of educational service delivery that affect learning performance. Other data being tracked and reported by the education sector also shed light on progress in improving educational quality and areas for further improvement. For example, at the primary level, the percentage of *trained* teachers increased from 70% in 2016 to 88% in 2017.[83,84] The percentage of qualified teachers increased from 71% in 2016 to 75% in 2017.[85] An opposite direction of change is emerging in the pupil-to-trained teacher ratio in primary education: from 39% in 2016 to 30% in 2017. Corresponding estimates for the pupil-to-qualified teacher ratio were 38% in 2016 and 36% in 2017.

3.4.5(b) Out-of-school children

A MoET study on out-of-school children found that dropout rates are highest between Grades 6 and 7, between Forms 2 and 3, and between Forms 4 and 5.[86] An examination of the proportion of learners enrolled in Form 5 as a proportion of those enrolled in Grade 1 reveals that rates are lowest in Lubombo (31%) and Shiselweni (38%), far lower than the rates calculated for Hhohho (45%) and Manzini (41%).[87] Available evidence indicates that girls account for a higher proportion of out-of-school youth at the secondary level compared to the primary level. For example, the 2014 MICS showed that girls

[77] Government of Eswatini. Annual Education Census 2012.
[78] Eswatini MICS 2014.
[79] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.
[80] Eswatini data contained in the UNESCO Institute for Statistics database.
[81] Khethiwe Mavundla and Dawid-Willem Pienaar, Fiscal Space for Children: An Analysis of Options in Swaziland, UNICEF, March 2018.
[82] Ministry of Education and Training. Grade Repetition and its Implications for the Swaziland Primary School System, 2017.
[83] According to UNESCO a 'trained' teacher has the minimum amount of formal teacher training, whether via pre-service or in-service training, to perform their job.
[84] Eswatini data from the UNESCO Institute for Statistics.
[85] *Ibid*.
[86] Ministry of Education and Training. 2018. A Report on Out-of-School Children in Eswatini.
[87] *Ibid*.

accounted for 41% of out-of-school children at the primary school level.[88] In contrast, girls accounted for 60% of the out-of-school secondary-school-age population.[89]

There are multiple factors and circumstances that can result in a child being out of school and being out-of-school increases a child's vulnerability to adverse outcomes and circumstances such as violence, socio-cultural factors and economic constraints.[90,91] Other potential correlates of being out of school (e.g., disabilities) has not been widely studied or documented. The issue of out-of-school children is revisited in the chapter "Adolescents," a stage in childhood when attrition from the formal education system is highest.

3.4.6. Water, sanitation and hygiene (WASH)

WASH is foundational to ensuring that all children have access to a safe and clean environment that fosters their health, security and well-being. In the SDG era, there is an emphasis on *quality* and systems capacity to assess and maintain quality vis-à-vis WASH, not just increased access to improved drinking water sources and improved sanitation facilities.

Climate-induced hazards such as the El Niño drought have had, and will continue to have, major WASH implications for communities and institutions (e.g., schools, health facilities). Both rural and urban areas are affected by water scarcity due to factors such as protected springs and boreholes drying up, lower river flows and lower levels in dams relied upon for urban water supply.[92] Thus, WASH improvement must be risk-informed to establish resilient WASH infrastructure and sustain improvements in WASH practices and WASH-related outcomes.

3.4.6(a) Safely managed water

WASH quality and access are dynamic conditions that need to be continuously monitored, with mechanisms and infrastructure in place that are resilient to climate-induced hazards such as drought. The WASH impact of drought has been previously documented in Eswatini. For example, in rural parts of Lubombo and Shiselweni regions, protected springs and boreholes produced low yields which, in turn, led to low access to domestic water supply during the most-recent drought.[93] Institutional WASH, not just WASH in domestic settings, is also a shortcoming.

Despite improved population access to water, that access is not consistent, and there remain noteworthy disparities. For example, urban areas have far greater access to improved sources of drinking water (92.5%) than rural areas (67.4%), and only 30% of households have functional access to water through the Swaziland Water Services Corporation grid.[94]

Vigilance in water quality testing is a necessity, particularly since only 16.8% of household members in households using unimproved drinking water employ an appropriate water treatment method.[95] Time spent for water collection (a responsibility that more often than not rests with women and girls), availability of water on a household's premises and drinking water storage practices are all criteria that are now being assessed globally and, thus of importance to Eswatini in ensuring that unsafe, unreliable and/or inadequate quantity of water are not impediments to child survival and development.

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[88] Central Statistical Office and UNICEF. 2016. Swaziland Multiple Indicator Cluster Survey 2014. Final Report. Mbabane, Swaziland, Central Statistical Office and UNICEF.
[89] Ibid.
[90] UNICEF, National Study on the Drivers of Violence Affecting Children in Swaziland, Draft, July 2016.
[91] Van Der Berg, S., Van Wyk, C., Hofmeyr, H. & Ferreira, T. Out-of-School Children in Swaziland: A Report to the Swaziland Ministry of Education and Training and UNICEF-Swaziland, 2018.
[92] Swaziland Committee on Vulnerability/Kingdom of Eswatini. 2016. Swaziland Annual Vulnerability Assessment & Analysis Report 2016.
[93] Government of Swaziland. Swaziland Comprehensive Nutrition and Health Survey, 2017.
[94] Government of Swaziland. 2016-2017 Eswatini Household Income and Expenditure Survey,
[95] 2014 MICS.

3.4.6(b) Safely managed sanitation

There are noted shortfalls with respect to safely managed water, but the shortfalls related to safely management sanitation are even more striking. According to the 2014 MICS, only 53% of the household population uses improved sanitation facilities that are not shared with other households.

Populations in informal settlements are actually performing worse than rural areas on various WASH issues. Informal settlement residents often share toilet facilities in addition to drinking water sources.

Anecdotally, the occurrence of recent drought created opportunities to address WASH issues. Pit latrine construction was not previously allowed in urban areas, but with recent water problems in Mbabane, officials have allowed pit latrine constriction. It should be noted, however, that the situation needs to be monitored, particularly in light of the fact that urban areas are characterized by a low water table. As a result, the potential for contamination of drinking water sources needs to be monitored as an unintended consequence of increased pit latrine construction in urban settings.

3.4.6(c) Optimal hygiene practices

Nationally, 7 out of every 10 households report handwashing with soap or ash at critical times (e.g., after using the toilet, before and after serving and eating meals).[96] However, regional variation exists, with the rate of the above practices as high as 86% in Manzini and as low as 51% in Shiselweni. Differences between regions in the extent of poor handwashing (30% in Hhohho, 24% in Lubombo, 14% in Manzini, 49% in Shiselweni) suggests the need for tailored strategies that address drivers and determinants of handwashing in different settings.

Optimal hygiene is not limited solely to handwashing, nor is achieving optimal hygiene contingent solely upon practices. **Linking children and adolescents with essential commodities is vital to achieving key outcomes**. However, the availability, use and disposal of key commodities can also have other implications. For example, waste management practices such as improper disposal of baby nappies/diapers contribute to an unsafe, unclean environment for children and adolescents living in informal settlements in urban/peri-urban areas. Although not well documented, there is also anecdotal information from the MoH about negative unintended consequences of menstrual hygiene management (MHM). More specifically, improper, unmanaged disposal of sanitary pads in latrines is shortening the life span of toilet facilities (e.g., pit latrines) in schools.

Hazards and humanitarian events can also alter hygiene practices. For example, before the 2015/16 drought, some menstruating females used pieces of cloth that would be washed and reused, or they would use toilet paper that would be discarded in pit latrines. Water shortages stemming from the drought impacted women's and girls' water usage and hygiene practices during menstruation.[97] Thus, the full spectrum of enabling and inhibiting factors and conditions for optimal hygiene must be considered.

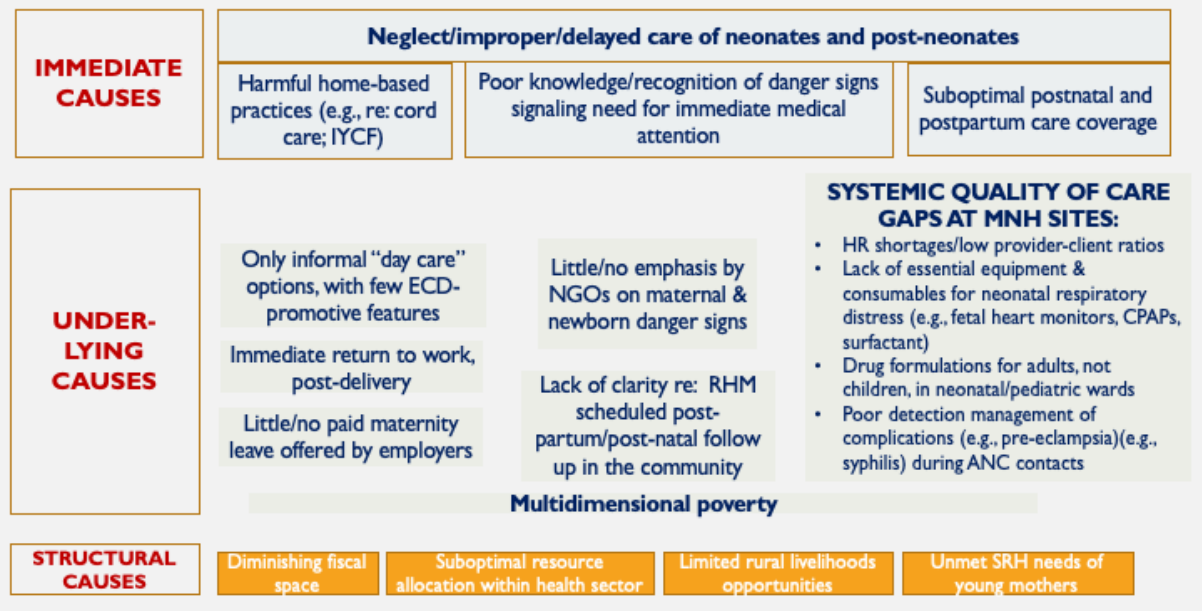
In summary, hygiene remains an under-addressed domain for Eswatini. A foundation exists; for example, the concept of community-led total sanitation (CLTS) was previously introduced, but no communities have been declared 'open defecation free' due to a lack of investment and programming to support communities in all stages of transitioning from poor practices such as open defecation to optimal practices.

[96] Government of Swaziland, 2017 Comprehensive Survey.

[97] UNICEF. Synthesis of Secondary Data on Children and Adolescents in Eswatini, 2018.

3.5. Key drivers of identified shortfalls and inequities in early and middle childhood

Figure 10. Factors that Contribute to Infant Mortality



STRUCTURAL FACTORS

Levels and sub-sector allocation related to public finances affect interventions, services and programs across the span of childhood and adolescence. In the social sectors, there is an imbalance of spending, with a focus on recurrent costs—in particular, personnel/civil servant salaries—as opposed to infrastructure and operational costs such as transport, equipment maintenance and "last mile" supply chain and pharmaceutical management.[98] Spending on education provides a useful illustration: Despite being the sector receiving the highest proportion of Government budget, there are shortfalls in Government expenditure on education. The Government falls short of its commitment to the Global Education for All Declaration (1990), which calls for 20% of total government expenditure on education. In fiscal year 2018/19, education spending accounted for 15% of the government budget.[99] An examination of how education sector resources are allocated across the different levels of education, 51% of the education budget allocations is dedicated to the primary level, followed by the secondary level (34%), tertiary level (13%), pre-primary level (1.1%) and other forms of education (0.3%).[100] With rising employment costs, the share of capital spending is expected to decrease,[101] which will have implications for service coverage and service quality.

Limited systems thinking related to financing also manifests in the health sector. The Government made a highly laudable commitment to fully fund vaccines. However, a reduction in budget allocations for vaccines was a contributing factor to vaccine stock-outs in 2017. In addition, low budget allocations to cover operational requirements of child vaccination services (e.g., cold-chain maintenance, transport costs for service delivery in the hardest-to-reach areas) contribute to shortfalls.[102]

[98] UNICEF. National Budget Brief 2018/2019 for the Kingdom of Eswatini, 2019.
[99] UNICEF Eswatini. Education Budget Brief 2018/2019.
[100] UIS database, based on 2014 data.
[101] UNICEF. Synthesis of Secondary Data on Children and Adolescents in Eswatini, 2018.
[102] *Ibid*.

Resource allocation decisions related to how Government resources are apportioned to each of the four regions also contributes to regional disparities. For example, Shiselweni continues to have highest under-five mortality rates but receives the lowest government allocation for health services.[103]

As mentioned in the child protection chapter, and reiterated in subsequent chapters, gender and social norms are salient structural factors that contribute to shortfalls and inequities. Lower levels of maternal education, a proxy for gender equality and women's empowerment, is consistently correlated with adverse outcomes such as child nutritional status. Thus, the causal pathway for improving outcomes in young childhood consists of both demand-side and supply-side elements.

UNDERLYING CAUSES

Household poverty is an underlying factor in the causal pathway, with children in the poorest household wealth quintile often faring the worst in relation to various outcomes related to young child development and survival.

Service availability is still a contributor to shortfalls and inequities. Strides have been made in infrastructure expansion (e.g., new schools, health facilities); however, the presence of physical infrastructure cannot be equated with increased service availability. For example, while the number of schools has increased, this has not been matched with a commensurate increase in the availability of well-trained teachers.[104]

Food insecurity resulting resource scarcity (e.g., related to water, arable/grazable land) attributable to climate-induced hazards such as drought affects livestock and agriculture production and ultimately food security.[105] The impact of hazards on young child survival and development extends beyond food security, impacting maternal nutritional status, which has been documented to negatively impact IYCF practices.

Shortfalls in service quality, which includes the availability of essential commodities, is applicable to all programs that support young child survival and development. Using a health illustration, commodity security exists when individuals are able to obtain and use essential commodities whenever and wherever they need them.[106] The Government of Eswatini procures vaccines for childhood immunization, but there are documented stockouts that contribute to shortfalls in meeting childhood immunization targets. Quality shortfalls are evident in other areas as well. For example, workforce challenges relate to both the quantity of qualified providers of different cadres and the skills or capacities of those providers (e.g., capacity for health facility staff to reinforce optimal IYCF practices, qualifications of teachers in pre-primary education).

3.6. Major conclusions

Despite some strides in mortality and other outcomes in young childhood, the critical first year of life must remain a priority point of intervention to ensure that children embark on a path to both survive and thrive throughout childhood. This reality shines a light on the importance of ECD as a foundation for a comprehensive set of interventions that touch upon all dimensions of young child development. Available evidence highlights the inter-relatedness of domains and outcomes (e.g., links between IYCF, WASH, nutrition outcomes and survival); however, a theory of change for optimizing young child survival and development needs to be adopted across stakeholders. With a growing focus on ECD and adolescent development and participation (as examined in the next chapter), there is a need for tailored,

[103] UNICEF. Synthesis of Secondary Data on Children and Adolescents in Eswatini, 2018.

[104] Ministry of Education and Training. 2018. A Report on Out-of-School Children in Eswatini.

[105] Swaziland Committee on Vulnerability/Kingdom of Eswatini. 2016. Swaziland Annual Vulnerability Assessment & Analysis Report 2016.

[106] Rao, Raja. 2008. Commodity Security for Essential Medicines: Challenges and Opportunities. Arlington, VA: USAID: DELIVER Project, Task Order 1.

gender-sensitive, age-appropriate services across the span of childhood. The allocation of financial, HR and material resources to address needs in both early and middle childhood also warrants attention.

4. ADOLESCENTS

KEY MESSAGES:

- **Efforts focused on adolescents are limited in scope and reach, which limits the country's ability to fully reap the benefits of a demographic dividend.**
- **There is compelling evidence (including studies published in *The Lancet* that highlight the return on investment in addressing adolescent education and health) that girls' secondary education and a holistic approach to adolescent development and participation can: (1) be transformational in terms of national growth and development and (2) create protective factors against adverse outcomes such as teenage/unplanned pregnancy, HIV and multidimensional poverty. However, a sizable proportion of adolescents in Eswatini are not in education, employment or training.**
- **There is a need to 'reimagine' secondary-age education in Eswatini, emphasizing the full spectrum of learning and skills to support success in life. A stronger interface between formal education providers (MoET), key actors offering alternative education/non-formal education options, and the labor market/employers to ensure alignment between skills-building, certification, and the marketplace is required. There is also a need for greater focus on accredited, flexible alternatives options, with strong wrap-around services such as internships and job shadowing.**
- **The full spectrum of adolescent well-being is largely overlooked. In present-day Eswatini, there is growing attention paid to adolescent sexual and reproductive health, but not to other crucial aspects of adolescent development and well-being (e.g., mental health, nutrition, risky practices such as substance abuse, needs of disabled adolescents, youth employability).**
- **Consultations with adolescents in different parts of the country indicate that pregnancy risk carries greater weight than HIV risk among adolescents. This perception among some adolescents warrants further investigation. Quantitative and qualitative evidence show that teenage pregnancy deepens vulnerabilities, introduces new risks and grounds adolescent mothers in multidimensional poverty. However, this insight has not spurred coordinated action.**
- **"Free" education services (e.g., primary education; secondary education for beneficiaries of OVC grants) are not completely free, and financial barriers persist in relation to services for adolescents.**
- **There are formal avenues to reach and engage adolescents (e.g., schools, Teen Clubs for HIV-infected adolescents). However, there are also under-exploited community entry points (e.g., soup kitchens operated by CSOs) for reaching adolescents that would otherwise slip through the cracks. Stronger linkages to social protection schemes and programs are required to reach the most-marginalized adolescents.**

4.1. The policy and program environment

Specific sectors, in particular health and education, have made strides with respect to the development of policies and guidelines that can serve as legal frameworks, standards and/or road maps for adolescent development and participation (*Box 4*).

The MoH chairs an Adolescent Technical Working Group (TWG), with participation from the Ministries of Education and Youth (Box 5). The TWG develops joint annual work plans, and other partners (e.g., UN agencies, CSOs) are invited to contribute to the TWG. Nonetheless, there is still fragmentation of effort, with missed opportunities for the different actors that come in contact with specific segments of the adolescent population (e.g., parastatals, CSOs and faith-based organizations that are meeting discrete needs of vulnerable adolescents such as non-formal education, training and basic necessities such as food) to work in a synergistic manner with adolescents, and mutual accountability for improved outcomes. Development partners are supporting Government to improve the scope and responsiveness of services and programs to the multi-faceted needs of adolescents. However, existing communication and coordination platforms are not fully leveraged to ensure that, in total, adolescent-focused efforts reflect a theory of change that capacitates adolescents in different ways and best positions the Kingdom to reap the benefits of a demographic dividend.

Box 4.
KEY POLICIES, GUIDELINES, STRATEGIES & PLANS

In addition to the policies and legislation noted in Figure 1, the following support the well-being of adolescents in the Kingdom of Eswatini:

Health

- National Health Policy (2017)
- Third National Health Sector Strategic Plan (NHSSP III)—2019 - 2023
- National Sexual Reproductive Health and Rights Strategic Plan 2014 – 2018
- National Adolescents and Youth Sexual and Reproductive Health Quality Improvement Package (2017)—national standards for adolescent and youth friendly health services *(MoH)*
- Adolescent Health Guidelines for Health Workers *(MoH)*

HIV/STIs

- National PMTCT Guidelines
- Swaziland Integrated HIV Management Guidelines (2015)
- National Strategic Plan for Ending AIDS and Syphilis in Children (2018 – 2022)
- Swaziland Male Circumcision Strategic and Operational Plan for HIV Prevention 2014 – 2018
- National Policy Guidelines for Community-Centred Models of ART Service Delivery (CommART) in Swaziland (June 2016)

Education

- Free Primary Education Act (2010)
- National Education and Training Sector Policy (2018)
- Education Sector Strategic Plan (2010-2022)
- National Technical and Vocational Education and Skills Development Policy (2010)
- Gender Responsive Strategy for Addressing Secondary School Dropout, Grade Repetition, and Transition in Eswatini (2018)

Child Protection

- Guidelines on Alternative Care (2010)

4.2. Adolescent health, including sexual and reproductive health

Adolescent sexual and reproductive health predominates efforts focused on adolescent health in Eswatini. Consecutive MICS have documented only a negligible difference in the adolescent birth rate[107] between 2010 and 2014 (89 and 87 per 1,000, respectively).[108,109] It should be noted, however, that the **urban-rural divide in adolescent fertility was higher in 2014 than it was in 2010**. In fact, the rural adolescent birth rate did *not* decrease between the two surveys (91 and 92, respectively), whereas there was a

[107] Defined as the age-specific fertility rate for women age 15-19 years (i.e., the number of births to women age 15-19 years during the three-year period preceding the survey, divided by the average number of women age 15- 19 years (number of women-years lived between ages 15 through 19, inclusive) during the same period, expressed per 1,000 women)

[108] Central Statistical Office and UNICEF. 2016. Swaziland Multiple Indicator Cluster Survey 2014. Final Report. Mbabane, Swaziland, Central Statistical Office and UNICEF.

[109] Central Statistical Office and UNICEF. 2011. Swaziland Multiple Indicator Cluster Survey 2010. Final Report. Mbabane, Swaziland, Central Statistical Office and UNICEF.

sizable decrease in the urban adolescent birth rate (79 and 69 per 1,000, respectively). Also, adolescent birth rates in Manzini and Lubombo increased substantially between 2010 and 2014 (from 90 to 107 per 1000 in Lubombo, and from 63 to 82 per 1000 in Manzini).

These disparities carry even more weight, in light of the fact that early childbearing/teenage pregnancy is associated with MCP: Among 15-17-year-old females, the MCP rate is 58% among girls who have been pregnant and 38% among girls who have not.[110]

Measures are being taken on the supply side to address system readiness to provide adolescent- and youth-friendly health services. However, once again, the focus is largely on sexual and reproductive health. The MoH has introduced an Integrated Youth Friendly Health Services Programme, as well as trained health workers to be more responsive to the needs of adolescents and young people.[111] However, there appears to be an unfinished agenda in this regard: some rural adolescents consulted for the purposes of the SITAN perceived that health services are not as youth friendly as they should be, particularly in the area of maintaining confidentiality. There is also a perception among some adolescents that rural adolescents are being left behind in the adolescent and youth friendly movement within the country.

Box 5
KEY ACTORS IN ADDRESSING THE NEEDS OF ADOLESCENTS

- Ministry of Education
- Ministry of Health (MoH)
- Ministry of Youth (MoY)
- Ministry of Labour (MoL)
- Parastatals and other players involved in non-formal education/alternative education (e.g., Sebenta National Institute)
- Department of Social Welfare (DSW)/Deputy Prime Minister's Office (DPMO)
- Adolescent Technical Working Group (chaired by the MoH; active participation from MoET and MoY)
- Teen Clubs for HIV-infected young people
- Girls Clubs in Secondary Schools
- Boys Clubs in Secondary Schools
- International NGOs

Assessing how the above achievements are translating into improved care seeking by adolescents and, ultimately, improved health outcomes, is a challenge. Age disaggregation of service utilization data makes it difficult to ascertain the degree to which strides are being made.

In addition, holistic health needs have not been a focus of efforts to date. Although not quantified, unmet mental health needs are perceived to be great, particularly given anecdotal information on trends in violence and suicide. This aspect of adolescent health is not widely documented and remains a 'blind spot' in current efforts to promote adolescent development and participation.

"Nooooo! In these clinics and places, they gossip. We see it. We hear it. There is no confidentiality."

"As for myself, I feel isolated from any programs. Most of them are in urban areas."

---A group of rural adolescent females ages 16-19 (Lubombo)

Violence against children was examined in the child protection chapter. However, the issue of violence, including gender-based violence, has a direct bearing on adolescent development and well-being. As highlighted in the *Adolescent Sexual and Reproductive Health: Health Sector National Guidelines* (2013), a UNICEF study estimated that 28% of females aged 13–18 years have experienced sexual violation during their lifetime. Although women and girls are disproportionately affected by sexual violence, tackling the issue will require challenging gender norms around male survivors of sexual violence and/or harassment, as well as deliberate engagement of men and boys.

[110] SPRI, Multidimensional Child Poverty in Swaziland, March 2018.
[111] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

The various types of unions pursued by adolescents also have a bearing on adolescent development. As described in the Child Protection chapter, child marriage is not as prevalent in Eswatini as it is in other countries in the Africa region. However, civil marriages or unions are a common phenomenon in Eswatini, and the Government recognizes civil marriages.[112]

4.3. HIV prevention, care and treatment

Based on 2017 estimates from the MoH, there are an estimated 10,768 adolescents (10-19-year-olds) living with HIV in Eswatini.[113] With a national adult HIV prevalence of 27.3%,[114] Eswatini's attainment of the ambitious "90-90-90" global goals—90% of all people living with HIV knowing their HIV status, a 90% sustained ART rate and a 90% rate of viral suppression[115]—is crucial for adolescent development.

Available evidence suggests that premarital sex and risky sexual practices are common phenomena among adolescents and youth in Eswatini. Between 2014 and 2017, condom use fell substantially among young people (15-24-year-olds), particularly for males. During that timeframe, the rate of reported condom use fell from 69.6% to 61.8% among females and 94.8% to 74.7% among males.[116] July 2010 consultations with adolescents in different parts of the country indicate that pregnancy risk and HIV risk do not carry the same weight among adolescents.

As shown in Table 3, there remain major shortfalls in comprehensive HIV knowledge among youth. Only 44.5% of females aged 15-19 years and 44.4% of males aged 15-19 years have comprehensive knowledge of HIV.[117,118] A comprehensive sex education/life skills education program is being rolled out in secondary schools.[119] However, the use of secondary schools as a platform when, as will described in a later section, the majority of adolescents are slipping through the cracks in the formal education system, begs the question of what segments of the population are excluded or under-served by the aforementioned efforts.

HIV testing is another area of attention. There is no "opt-out" HIV testing for adolescents; the service is only provided if adolescents request it, or if it is clinically indicated.[120]
Statistics on the HIV treatment cascade, which tracks the progress from HIV diagnosis to viral suppression,[121] are far-less encouraging for adolescents than for the general population. HIV incidence and prevalence are almost four times higher among out-of-school adolescent girls and women than among those in school.[122]

Of the 14,541 pediatric cases on ART in 2017, 10-14-year-olds accounted for 26.7% of cases and 15-19-year-olds accounted for 32.2% of cases.[123] There are also gender disparities in initiation of ART. Among the adolescents aged 15-19 years, there were more females being newly initiated on ART than

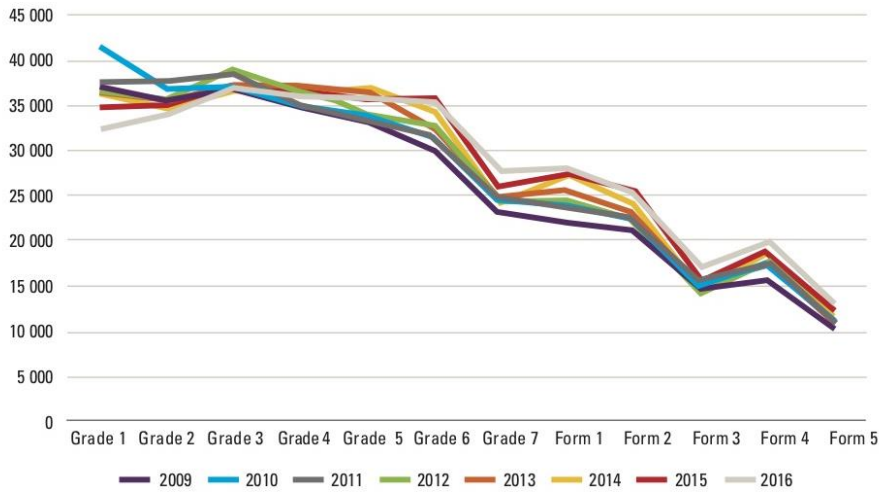
[112] *Ibid*.
[113] Ministry of Health/Kingdom of Eswatini. 2018. HIV 2017 Annual Program Report.
[114] UNAIDS. 2019. Country factsheets: ESWATINI 2018.
[115] UNAIDS. 2014. 90-90-90: An ambitious treatment target to help end the AIDS epidemic.
[116] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.
[117] Comprehensive knowledge of HIV is defined as: knowing that: (1) a healthy looking person can have HIV, (2) HIV cannot be transmitted by mosquito bites, (3) HIV cannot be transmitted by supernatural means, (4) a person cannot become infected by sharing food with a person who has HIV and (5) a healthy-looking person can have HIV and who reject the two most common local misconceptions.
[118] Central Statistical Office and UNICEF. 2016. Swaziland Multiple Indicator Cluster Survey 2014. Final Report. Mbabane, Swaziland, Central Statistical Office and UNICEF.
[119] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.
[120] Ministry of Health/Kingdom of Eswatini. 2018. HIV 2017 Annual Program Report.
[121] UNAIDS. 2014. 90-90-90: An ambitious treatment target to help end the AIDS epidemic.
[122] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.
[123] Ministry of Health/Kingdom of Eswatini. 2018. HIV 2017 Annual Program Report.

males during the same period. Facility Teen Clubs, a model that was initiated in 2006 by Baylor College of Medicine in Eswatini to support the HIV-infected 15-19-year-olds, in particular,[124] have been established to support adolescents living with HIV; however, in 2017, only 3,742 adolescents living with HIV were enrolled in those special clubs.[125] Nonetheless, Teen Clubs have proven to be an effective platform to support HIV-infected teen with full disclosure of their HIV status, treatment adherence, and achievement of the third 90 of the global "90-90-90" goals, viral load suppression. An evaluation of the Baylor College of Medicine model found that viral load suppression among Teen Club members was 88.7%, compared with a national average of 44.2% among the 15 to 24-year-olds.[126]

4.4. Secondary education

In contrast to primary education, for which Eswatini has achieved near-universal net enrolment, a very high proportion of adolescents are currently excluded from the secondary education system. Between 2009 and 2016, available evidence shows a precipitous drop in school enrollment after Grade 6 (i.e., the transition out of primary school and into secondary school).[127] As shown in Figure 11, this pattern has existed for several years. According to 2014 expenditure data, secondary education accounted 34.2% of government expenditures in that year.[128]

Figure 11. Enrolment numbers according to grade/form, 2009-2016, EMIS/MoET
(Graph taken directly from UNICEF. Synthesis of Secondary Data on Children and Adolescents in Eswatini, 2018.)



Source: Derived from EMIS data 2011-2016

Net enrolment at the lower secondary school level is less than 30%,[129] and the reasons for this attrition are multi-fold. First, despite the higher number of secondary-school-age population, there are far fewer secondary schools than primary schools in the country, which results in high numbers of adolescents

[124] Baylor College of Medicine Swaziland and UNICEF. 2018. Impact Evaluation of the Teen Club Programme for Adolescents Living with HIV in Eswatini.
[125] *Ibid*.
[126] *Ibid*.
[127] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.
[128] Eswatini data from the UNESCO Institute for Statistics database. 2014 is the most-recent year for which data are available.
[129] Eswatini data from UNESCO Institute for Statistics database.

out of school (see next section on out-of-school adolescents), with underlying factors such as poverty and pregnancy contributing to low enrolment. As described in subsequent sections, there is an urgent need for reimaging education, with alternative models to building knowledge and an array of skills in adolescents. Second, as mentioned earlier in the Young Child Survival and Development chapter, there are the phenomena of over-age and school repetition, which result in it taking far longer than the intended seven years to complete primary school.[130] According to MICS 2014 data, for rural areas for example, 44% of the secondary-age children were attending primary education. There is also lack of uniformity across schools in applying criteria to determine whether a child is promoted to the next grade versus held back to repeat a grade.[131]

The challenges related to helping adolescent navigate through the formal education system are even more salient, considering the role of girls' education as a 'protective factor.' For example, data that examine key outcomes according to mother's education level suggest both an individual benefit to the female (e.g., reduced vulnerability to exploitation, teenage pregnancy multidimensional poverty) and intergenerational benefits (mother's education level, which can also be regarded as a proxy for women's empowerment, is strongly correlated with the MCP in Eswatini). For example, 81% of children of mothers with no formal education are multidimensionally poor—far higher than children whose mothers had up to a primary education (71%), secondary education (54%) and beyond a secondary education (30%).[132]

The poorest adolescents (34.1%) and adolescents whose mothers have no formal education (23.8%) or no more than primary school education (34.4%) have the lowest secondary school net attendance rates.[133] In contrast, children of more-educated mothers are less deprived in all dimensions of well-being, except for HIV/AIDS.[134]

4.5. Out-of-school adolescents

As shown in Table 4, 11.6% of secondary-school-age females are out of school, compared with 7.4% of secondary-school-age males. As stated earlier in this chapter, the adolescent fertility rate is not decreasing; thus, pregnancy remains one underlying factor (in addition to other factors such as poverty) for some adolescent girls out-of-school). Urban areas actually have a higher proportion of out-of-school adolescents than rural areas (12.2% and 8.8%, respectively), according to the 2014 MICS. This pattern, which is only valid for girls (17% vs. 10%), might be attributed to the greater income-generation prospects in urban versus rural settings, although the relationship has not been previously examined.

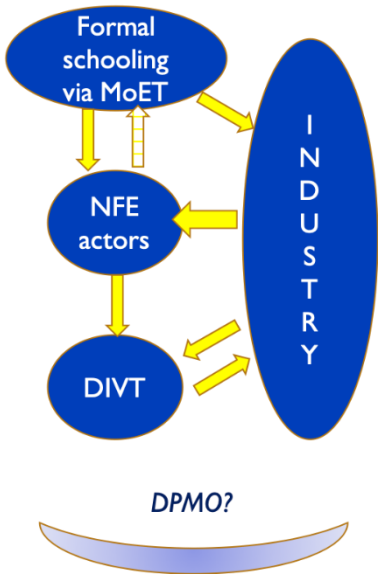
However, the tangible vulnerabilities of out-of-school adolescents is reflected in the limited data on adolescents, for example, in the HIV arena. HIV incidence and prevalence is almost four times higher among out-of-school adolescent girls and women than among those in school.[135] Anecdotal reports indicate that educational inclusion of other subpopulations such as adolescents with disabilities is suboptimal, although there is a paucity of data.

[130] UNICEF. 2015. Evaluation of the Process, Impact, Efficiency and Effectiveness of the Swaziland Child Friendly Schools (CFS) Programme, INQABA and Recommendations for Future Strategies.
[131] Ministry of Education and Training. 2017. Grade Repetition and its Implications for the Swaziland Primary School System.
[132] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.
[133] Table ED.5 from the 2014 MICS.
[134] SPRI. Multidimensional Child Poverty in Swaziland, March 2018.
[135] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

4.6. Skills for employability

To facilitate their economic contributions to society, it is essential that adolescents enter the labor market possessing relevant and critical skills including foundational skills such as literacy and numeracy and transferrable skills such as communication, decision making and self-confidence—in addition to technical and vocational skills[136,137] that are aligned with services and competencies required by employers in Eswatini. The school-to-work transition is a process of preparing young people by developing skills required by the labor market and facilitating the actual transition of older adolescents and young people to viable work opportunities. The country does have a National Technical and Vocational Education and Skills Development Policy. However, TVET is not perceived as a prestigious avenue, and the 2018-2022 National Education and Training Sector Policy identifies the need for repositioning and marketing TVET.[138] The current education management information system (EMIS) does not include data from TVET or non-formal education providers.

Figure 12. Different actors in the landscape promoting skills for employability



At present, there are missed opportunities to: (1) better equip adolescents with transferable and foundational skills, using both formal and non-formal pathways; (2) foster greater breadth and depth of private/business sector engagement to support human capital development as demanded by the labor market; and (3) facilitate adolescents' ability to access opportunities (e.g., through referral systems that effectively link the supply and demand sides of the labor market). The National Development Plan 2019/20-2021/22 acknowledges that there is a mismatch between training and skills of recent graduates from the formal education system and the skills demanded by the labor market. Alignment is specifically required for tourism, food processing, manufacturing and mining.[139] Figure 12 depicts key actors whose inputs and inter-agency relationships need to be optimized to maximize adolescents' skills for employability and facilitate their access to safe and decent work opportunities in the labor market.

As suggested in the figure on the right, there are multiple avenues to cultivate skills for employability among adolescents, and adolescents might—and often do—vacillate between the different entities involved. However, there is scope to improve coherence and coordination between the different stakeholders and entities.

4.7. Adolescent labor participation

Data on adolescent labor participation is limited. The national unemployment rate hovers around 23%; however, the youth unemployment rate (47%) is more than twice the national average.[140] As stated in the Child Protection chapter, the absence of a compulsory education age is a legal gap that spur the exploitation of adolescents and younger children to engage in the worst forms of child labor (e.g., forced domestic work, livestock herding).[141]

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[136] For older adolescents and young people, the emphasis is on building skills for employability (e.g., through internships); for younger adolescents, the focus is on foundational and transferable skills (e.g., for age-appropriate adolescent development and participation).

[137] The International Labour Organization (ILO) and UNICEF. GirlsForce: Skills, Education and Training for Girls Now, 2018.

[138] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

[139] *Ibid*.

[140] Ministry of Economic Planning and Development/Kingdom of Eswatini. National Development Plan 2019/20 – 2021/22: Towards Economic Recovery.

[141] UNICEF. 2018. Synthesis of Secondary Data on Children and Adolescents in Eswatini.

4.8. Adolescent participation and civic engagement

The landscape to cultivate adolescent participation and civic engagement is highly limited. There are, however, entities (e.g., Junior Achievement Eswatini) that are addressing discrete issues such as financial literacy, entrepreneurship and business skills development in-school and out-of-school youth.[142] To ensure that the most-marginalized and/or vulnerable adolescents are not left behind, there is a need to map the different entry points and platforms that exist and leverage existing networks and platforms to reach more adolescents, especially those who are out of school. Primary and secondary schools present formal and sustainable platforms for adolescent participation and civic education at scale. Through this platform processes for the establishment and selection of children to lead a children's parliament can be facilitated. Policy guidelines and frameworks are required to provide guidance for the establishment and resourcing of these platforms.

[142] Retrieved from Junior Achievement Eswatini: http://www.jaswaziland.org/in-school.html and http://www.jaswaziland.org/out-of-school.html

Table 4. Progress/Direction of Change and Key Disparities related to Adolescents, a Data Comparison from two MICS (2010 and 2014), Eswatini

INDICATOR	INDICATOR PROGRESS	LATEST NATIONAL ESTIMATE	DISPARITIES BY:								
			A. Place of Residence		B. Gender		C. Region				D. Other Characteristics of Children, Their Mothers/Caregivers or their Households associated with Poor Outcomes
			URBAN	RURAL	MALE	FEMALE	SHISELWENI	LUBOMBO	MANZINI	HHOHHO	
MCP rate, 15-17 years	NC	43.8%	12.2%	51.9%	--	--	54.8%	61.5%	28.7%	41.6%	
% of 10-14-year-olds who are orphaned or vulnerable	↑	74.9%	NC	NC	NC	NC	NC	NC	NC	NC	
% of 15-17-year-olds who are orphaned or vulnerable	↑	77.7%	NC	NC	NC	NC	NC	NC	NC	NC	
Secondary school net attendance rate	↑	50.4%	64.6%	46.9%	46.1%	54.7%	54.8%	43.4%	49.4%	54.1%	The poorest adolescents (34.1%) and adolescents whose mothers have no formal education (23.8%) or no more than primary education (34.4)
% of secondary-school-age children who are out of school	NC	9.5%	12.2%	8.8%	7.4%	11.6%	7.9%	9.2%	11.5%	8.2%	
Transition rate from primary to secondary school	--	85.5%	89.2%	84.7%	86.2%	85.0%	85.3%	90.0%	80.7%	88.7%	
Adolescent birth rate (per 1000)	--	87	69	92	NA	87%	96	107	77	82	GIRLS EDUCATION: Adolescent females with no more than a primary education have the highest birth rate (141 per 1000) HOUSEHOLD WEALTH QUINTILE: Girls in the two lowest quintiles have much higher rates (121-124 per 1000) than girls in the upper three wealth quintiles (47-84 per 1000)

INDICATOR	INDICATOR PROGRESS	LATEST NATIONAL ESTIMATE	DISPARITIES BY:								
			A. Place of Residence		B. Gender		C. Region				D. Other Characteristics of Children, Their Mothers/Caregivers or their Households associated with Poor Outcomes
			URBAN	RURAL	MALE	FEMALE	SHISELWENI	LUBOMBO	MANZINI	HHOHHO	
% of females age 15-19 years who have already had a live birth	--	13.9%	11.5%	14.6%	NA	13.9%	14.0%	18.0%	11.7%	14.0%	GIRLS EDUCATION: Second-highest rate (21.3%) of all categories of females 15-19; HOUSEHOLD WEALTH QUINTILE: The poorest girls had the highest rate (22.3%)
% of 15-24-year olds with comprehensive knowledge of HIV	↓	49.1%	NC	NC	NC	NC	NC	NC	NC	NC	
% of 15-19-year olds tested for HIV in last 12 months and told the results: males	↑	30.4%	NC	NC	NC	NC	NC	NC	NC	NC	

NC: Not calculated for more than one point in time or not calculated according to different background characteristics
NA: Not applicable

4.9. Key drivers of shortfalls and inequities in adolescence

The following is a real-life scenario faced by an adolescent female consulted during the SITAN. Her story reflects the complex inter-play of factors that contribute to inequities and shortfalls during adolescence. Her story is not unique; it reflects the realities of some adolescent girls in Eswatini.

I left school before I became pregnant. I left because there was not enough food at home. I went to school on an empty stomach. It was unbearable. . . . Oh, I loved going to school, but I was the eldest in the school and felt out of place. . . Initially, I didn't go to school at the right age because I didn't have a birth certificate. My mum didn't know how to get one…When I was about 7 years, my sis tried to find a school for primary, but she couldn't so she enrolled me in pre-primary.
[WHEN ASKED IF HER 9 MONTH-OLD BABY HAS A BIRTH CERTIFICATE]
Yes. I had to make sure my baby got one. *[NGO X]* assisted me to get one when she was 5 months old.

My mom really loved me and I want to show that love to my child--Except that she really used to hit me. I won't do that to my daughter.

-An out-of-school, 19-year-old adolescent mother (dropped out of school in grade 6), who lost both parents, is unemployed and lives with her older sister (who also has children), Manzini

Drivers of shortfalls and inequities can be classified as immediate causes, underlying causes or factors and structural causes or factors, as described below.

IMMEDIATE CAUSES—Immediate causes largely relate to the inadequate coverage of a comprehensive package of age-appropriate services and interventions for different profiles of adolescents (e.g., female, male, disabled/special needs, urban, rural). Much of what fuels shortfalls and inequities in adolescence are factors that underpin those coverage gaps, as described below.

UNDERLYING CAUSES OR FACTORS—Underlying factors are multi-fold. Parenting and the stability of the family unit is one such factor that exposes adolescents to risks of abuse, exploitation and neglect. This, in turn, spurs other adverse outcomes such as grade repetition, as mentioned earlier in this chapter.[143]

The availability of age-appropriate, gender-sensitive services and commodities (e.g., adolescent and youth-friendly health services for different profiles of adolescents including disabled adolescents, adequate numbers secondary schools and alternative channels for education and training) is another underlying factor. However, the substandard quality of available services is also a contributor. Factors such as a shortage of qualified secondary school teachers, particularly in the areas of science and mathematics. For example, MoET estimates that there is only one mathematics teacher for every 84 learners enrolled at secondary school.[144] The limited participation of adolescents in designing services and programs and supporting the monitoring of their implementation is a key bottleneck.

As observed for young children, commodity security, or ensuring that individuals are able to obtain and use essential commodities whenever and wherever they need them,[145] is a highly salient driver of shortfalls and inequities among adolescents in Eswatini. The following are illustrative commodity gaps:

[143] Ministry of Education and Training. Grade Repetition and its Implications for the Swaziland Primary School System, 2017.
[144] Ministry of Education and Training. A Report on Out-of-School Children in Eswatini, 2018.
[145] Rao, Raja. 2008. Commodity Security for Essential Medicines: Challenges and Opportunities. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1.

- Disabled youth's poor access to family planning commodities was highlighted by practitioners and adolescents alike.
- Access to modern technology such as computers facilitates learning and training as well as communication, social networking and civic participation. Consultations with young adolescents in primary school students, as well as older adolescents in secondary schools, highlighted the mismatch between supply and demand for access to computers and the internet. This point was raised by both in-school youth and young people who are not part of the formal education system.
- Access to menstrual hygiene management supplies such as sanitary pads and environmental/WASH-friendly means of disposing of sanitary pads.

As alluded above, access in all its forms is particularly important for adolescents. Financial barriers for some segments of adolescents persist, particularly in relation to secondary education.

As shown Table 4 on disparities in selected indicators and reflected in the text box at the start of this section, poverty and shortfalls in girls' level of education fuel inequities. Hazards and shocks are also part of the causal pathway. For example, a 2017 study by UNFPA found that food insecurity resulting from the drought was a key driver for transactional sex and harmful behaviors among youth, particularly among girls.[146]

STRUCTURAL FACTORS—Social and gender beliefs and norms are a structural driver of inequalities and shortfalls related to adolescents in Eswatini. This applies to all settings such as the home, schools, the general community and with formal systems of care (e.g., health sector, police). Even though legal frameworks such as the Sexual Offences and Domestic Violence Act have emerged, and there is increased understanding around issues such as exploitation, gender beliefs and norms related to female sexuality still fuels vulnerability of adolescent girls.

The influence of gender norms manifests in different ways. For example, there is low female representation in the field of science and technology, which is associated with a female disadvantage relative to men in terms of high-earning, stable employment opportunities. It is noteworthy that some adolescent females consulted for the SITAN expressed a keen interest in science, technology and mathematics; however, as girls, they shared that they do not receive the same level of encouragement to pursue those avenues as boys.

Financing and resource allocation are another structural cause. There is evidence that both the overall level of spending on adolescents and the resource allocation for prevention versus care and response contributes to shortfalls and inequities. For example, although it is not easy to track spending on HIV prevention, a 2018 UNICEF budget brief on health reports that less than 0.1 per cent of the Government's budget is spent on the AIDS information center, while 80% is allocated to buy HIV-related drugs.[147]

4.10. Major conclusions

There is an urgent need to redouble efforts and invest resources in adolescent development and participation. In addition, efforts and opportunities to cultivate adolescent participation (labor, civic, political) are under-developed and insufficient as tools to reap the benefits of the demographic dividend

[146] UNFPA. Evidence Brief: An Assessment of the Impact of the El Niño-Induced Drought on Children, Youth, and Pregnant Women and Lactating Mothers in Swaziland, 2017.
[147] UNICEF Eswatini. Health Budget Brief 2018/2019.

in Eswatini. The consistently low performance of Lubombo on inter-related outcomes such as secondary school enrolment, multidimensional poverty and adolescent fertility highlight key elements in a possible theory of change for adolescent programs in the Kingdom of Eswatini.

5. EQUITABLE CHANCES AT LIFE

5.1. The policy and program landscape

As stated previously, 29.6% of Eswatini's population is moderately poor, and 12.5% is extremely poor.[148] Children and adolescents constitute 59% of all people living in extremely poor households,[149] and they face distinct challenges such as severe hunger (which adversely affects their health, cognitive function and development). Their households are also characterized by a myriad of vulnerabilities such as unemployment, death, illness or disability of parents/guardians and/or working-age adults. Box 6 provides an overview of the policy and program landscape related to equitable chances at life. As indicated in the text box, the landscape for child-sensitive social protection programs in Eswatini is highly limited. The Government of Eswatini implements three types of social protection programs: Old Age Grant, Disability Grant and the OVC Education Grant.[150] With the exception of the OVC grant mechanisms, which have inherent limitations in terms of their reach and responsiveness to the circumstances and needs of all vulnerable children, there are no formalized child-specific social protection mechanisms.

BOX 6.
KEY POLICY TO PROMOTE EQUITABLE CHANCES AT LIFE

- The National Social Development Policy of the Government of Eswatini (2010)

KEY ACTORS IN SOCIAL PROTECTION & INCLUSION

- DPMO
  - Department of Social Welfare
  - Disability Unit
  - Gender Unit
- UNICEF
- The World Bank
- European Union

KEY SOCIAL PROTECTION PROGRAMS
(denotes child-focused programs)*

- OVC Education Grant (spans 260 secondary schools)*
- OVC Cash Grant (pilot initiative spanning only 4 *Tinkhundla*)*
- Disability Grant

5.2. Effectiveness of existing social protection mechanisms

Segmentation of households facing monetary poverty is vital to directing the appropriate forms of social assistance and ensuring efficient and effective Government spending to address diverse social protection needs (*Figure 13*).

An assessment of the social assistance landscape in Eswatini found that, in addition to the lack of child-sensitive social assistance programs, there are large exclusion errors associated with existing social protection programs.[151] Consequently, the impact of the current constellation of programs on poverty reduction and a reduction of the multitude of deprivations observed among children is highly limited.

For the one social assistance program that directly impacts the largest number of children and adolescents, the OVC Education Grant, there are issues with the stringent criteria that must be met to benefit from the grant. For example, grade repetition disqualifies a child from the grant program. This reality has broader implications: as noted in a MoET assessment of out-of-school children, high repetition rates are strongly correlated with school dropout rates.[152]

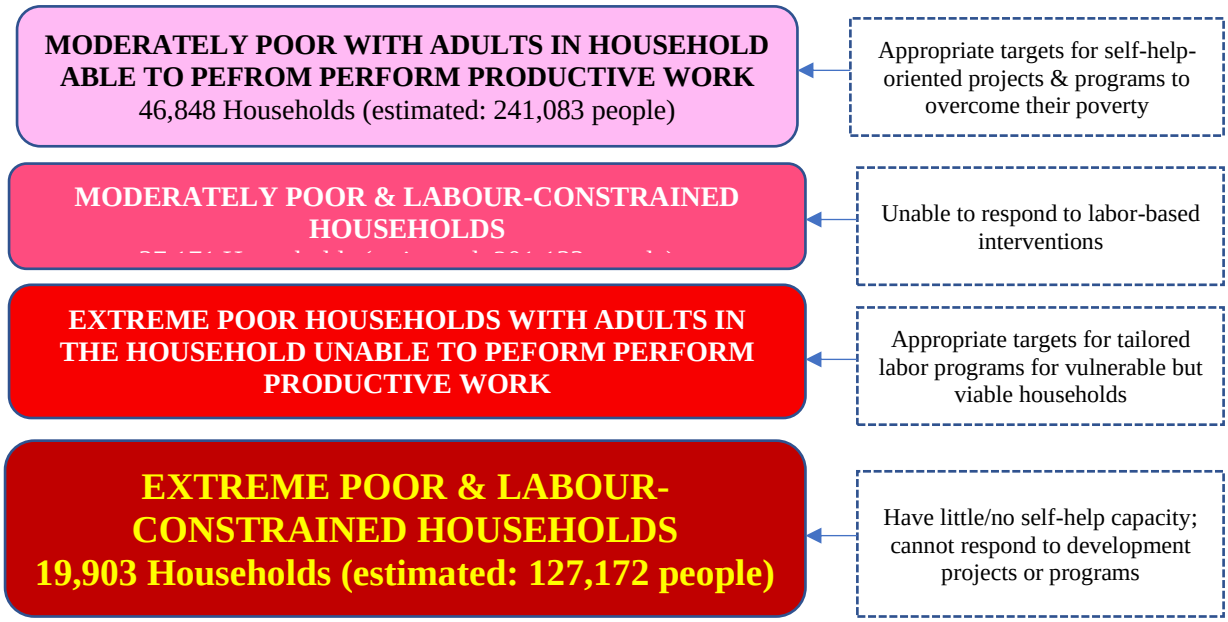
The population of disabled children and adults is a segment of the Kingdom's population that is currently being left behind. The following section provides further insight with respect to the profile and needs of children with disabilities and other special needs. However, it is noteworthy that the

[148] 2016/17 Eswatini Household Income and Expenditure Survey (SHIES).
[149] UNICEF. Quantitative Assessment of the Social Assistance Needs in the Kingdom of Eswatini, 2018.
[150] *Ibid*.
[151] UNICEF. Quantitative Assessment of the Social Assistance Needs in the Kingdom of Eswatini, 2018.
[152] Ministry of Education and Training. 2018. A Report on Out-of-School Children in Eswatini.

Government suspended approval of new beneficiaries of the Disability Grant program, and that the unmet need for social assistance among persons living with disabilities is growing, with the current exclusion error for the Disability Grant estimated at 64%.[153]

Lastly, the delinking of existing social protection activities from social work activities limits the degree to which social assistance benefits can be leveraged to best address identified needs in children and their families, as well as support households in graduating out of social assistance to higher levels of self-reliance.

Figure 13. Gradation and Nature of Social Assistance Need (adapted from UNICEF, Quantitative Assessment of the Social Assistance Needs in the Kingdom of Eswatini, 2018)



5.3. Inclusive communities

The SITAN has documented several subpopulations of children, adolescents and women who are currently being left behind by existing systems of care.

Populations of Need	Nature of Vulnerabilities and Needs	Entry points
Children and adolescents with special needs: ○ Children/adolescents with cognitive, learning or behavioral disorders ○ Children/adolescents with multiple disabilities that limit communication ○ Disabled survivors of various forms of	○ Neglect, abuse, violence, exploitation ○ Multidimensional poverty ○ Limited institutional capacity (e.g., for inclusive education [formal & non-formal]), health facilities, social workers, police, lawyers) to effectively identify & address needs • Unmet SRH needs (among sexually active disabled youth) • No formal education/low educational attainment	Federation of Organizations of the Disabled People in Swaziland & its member organizations (Swaziland National Association of the Physically Disabled Persons, Swaziland National Association of the Deaf, Association of the Visually Impaired Persons, Parents of

[153] *Ibid*.

Populations of Need	Nature of Vulnerabilities and Needs	Entry points
violence (including SGBV)	• Inadequate provisions within justice system	Children with Disabilities in Swaziland) Special schools for children with disabilities Religious organizations Rural Health Monitors Police Justice System
Children, adolescents and women residing in urban/peri-urban informal settlements	○ Multidimensional poverty ○ Exposure to violence, abuse and exploitation ○ Untrained, informal providers of childcare (poor ECD practices) ○ Suboptimal WASH ○ Unmet needs for family planning/SRH services ○ Dangerous modes of income generation (e.g., sex work or transactional sex) ○ Child abandonment/neglect ○ Service defaulting (e.g., for ART, child immunization)	CSOs providing community-level support (e.g., ECD promotion, violence prevention, soup kitchens) Informal day care providers Private industry/employers in industrial zones
Child non-offenders in the correctional system: ○ Infants and children under the age of three whose mothers are incarcerated ○ Children of incarcerated parents who don't have viable options for alternative care ○ Children seeking reintegration in their communities of origin	○ Limited alternative care options (e.g., kinship care, foster care) ○ Marginalization/low community acceptance or re-acceptance ○ Some basic health care in coordination with MoH ○ Poor access to basic necessities ○ Access to schooling provided by Department of Corrections, but no access to other age-appropriate services (e.g., psychosocial/mental health services)	Department of Corrections Alternative care organizations
Young/adolescent mothers	○ HIV treatment defaulting (if HIV-infected) ○ Child abandonment/neglect ○ Unstable or risky family structure/living arrangements/relationships	PMTCT services RMNCH services CSOs

Populations of Need	Nature of Vulnerabilities and Needs	Entry points
	○ School drop-out/disrupted schooling, even when performing well in school ○ Lack of employable skills	Non-formal education providers

5.4. Resilience

Cultivating equitable chances at life requires taking a critical look at coping capacities and core vulnerabilities of specific parts of the country. The 2019 Vulnerability Assessment and Analysis has shown that Lubombo continues to fare the worst of all the regions, employing a greater number of negative coping strategies in response to shocks such as the ones described in the Hazards and Risks section of this report.[154] Female-headed households also have been documented to possess lower coping capacity than male-headed households.

While resilience is a salient concept at the household level, it also applies to service delivery systems. This is an area that is not widely studied in Eswatini; however, the shortage of qualified frontline service providers in the social sectors, challenges with supply-chain and logistics, and other dimensions of functional systems suggest that systems resilience is another stream of work to support the country in withstanding and/or effectively rebounding from shocks.

5.5. Major conclusions

The absence of a harmonized, child-sensitive approach to social protection has resulted in missed opportunities to reach and effectively support the most-vulnerable children and adolescents in the Kingdom of Eswatini. This systemic gap has contributed to the emergence of a diverse profile of children and adolescents being left behind.

[154] Swaziland Committee on Vulnerability/Kingdom of Eswatini. Annual Vulnerability Assessment & Analysis Report 2019.

6. INSIGHTS FROM AN EXAMINATION OF PROGRESS AND DISPARITIES ACROSS PROGRAM AREAS

Looking at the totality of evidence highlighted in Tables 2, 3, and 4, as well as anecdotal evidence from children, adolescents and program implementers, there are insights regarding the linkages and inter-relatedness of some factors across domains and the entire span of childhood and adolescence.

As is widely acknowledged among stakeholders within the country, there is **geographical clustering of shortfalls and disparities, with Shiselweni and Lubombo often lagging behind** Hhohho and Manzini in several indicators, including the rate of multidimensional child poverty. However, taking a more-nuanced view, the *why* behind the above observation might have its roots in fundamental child protection issues.

The evidence base on child protection is not as expansive as it is for other aspects of child and adolescent well-being. Nonetheless, **children's living arrangements and their status vis-à-vis orphan hood and parental care appear to be drivers of vulnerability (Table 2),** with Shiselweni, followed by Lubombo, faring worst in this regard. The limited quantitative evidence on the above issues paints a picture that is consistent with anecdotal evidence on the deterioration and/or destabilization of the family unit, and the catalytic effect it has with respect to adverse outcomes, as acknowledged by both children/adolescents and practitioners in social sectors.

The above phenomenon, coupled with the under-developed child-sensitive social protection space in the country (as described in the previous chapter on "Equitable Chances at Life"), creates a recipe for deepening, inadequately addressed vulnerabilities in children and adolescents and persistent shortfalls related to their well-being.

Other data observations such as the **higher mortality burden among boys in young childhood appears to be correlated with suboptimal nutrition outcomes** that are also more prevalent among boys than girls. However, this issue warrants further investigation. Also noteworthy is the fact that **geographical hotspots for early mortality are also hotspots for suboptimal infant and young child feeding**, further underscoring the importance of the nutrition-mortality link in Eswatini.

Another key observation from the data is the fact that **Lubombo emerges as a "hotspot" for an array of adverse outcomes in adolescence. Poverty (as defined by household wealth quintile) and women's and girls' education** consistently appear as background characteristics **associated with the highest rates of adverse outcomes in both adolescence and young childhood**—yet another indication of shortfalls in social protection and inclusion.

Urban areas are not immune from shortfalls and inequities. Based on the available data, there are **shortfalls that are prominent in Manzini (e.g., related to neonatal mortality, the transition from primary to secondary school) that warrant further investigation**. The higher rate of secondary-school-age children who are out of school in urban areas as opposed to rural areas and anecdotal evidence on pockets of need within urban and peri-urban areas (e.g., amongst the urban poor/residents of informal settlements) warrant further attention.

There are also implications for *how* needs can be addressed. For example, the **substantial increase in private-sector delivery care** since 2010, along with the prominent roles of civil society in reaching marginalized and under-served groups, indicates that the public sector cannot be the only channel through which the issues highlighted in this section are addressed.

7. RECOMMENDATIONS

The recommendations stemming from the SITAN have been grouped into five broad categories: (1) advocacy and actions related to policies and legislation; (2) governance and coordination; (3) evidence to support policy and program action; (4) leaving no child behind; and (5) building resilience to prevent and mitigate risks faced by children.

Advocacy and actions related to policies and legislation

Although Eswatini has numerous legal and policy frameworks, there are policy gaps that are impediments to safeguarding the rights and fostering the total well-being of children and adolescents. In light of the above, there are three key recommendations:

1. Develop requisite policies and/or guidelines that address key issues for which policy and legal frameworks are lacking, or for which greater clarity is required to govern practices and set the stage for greater accountability across stakeholders. Illustrative issues are as follows:
   - Child and adolescent participation
   - Compulsory education age (including a possible compulsory year of pre-school before attending primary school)
   - Federal versus traditional laws on age of consent for marriage
   - Reimagined approach to education and skills-building in adolescents and young people, using both the formal education system and alternative channels, to facilitate their successful transition from school to work

2. Accelerate the finalization and approval of policy instruments that are currently under development or in draft form. Illustrative policies pending approval are the National Plan of Action for Children, National Gender Policy and the National Framework for Foster Care.

3. Redouble advocacy efforts related to budgetary allocations and approvals for full implementation of policies at scale.

Governance and coordination

4. To advance the transition from policy to practice (as illustrated in *Figure 3* earlier in the report), formalize institutional arrangements that establish one multi-sectoral, multi-stakeholder platform on children and adolescents that is led by the Government. The DPMO (in particular, the National Children's Unit) is strategically placed to chair the aforementioned platform but should be capacitated with tools, skills and systems to support joint planning, multi-sectoral coordination, data synthesis and analysis, and advocacy.

5. Leveraging the inputs and strengths of stakeholders participating in the above platform, develop harmonized annual work plans that clearly delineate roles, responsibilities, targeting, resourcing and expected results of Government versus various non-State actors.

6. To integrate children and adolescents in governance and coordination, hold consultations with various types of children and adolescents across the country to clarify and reach agreement on the best channels and forums to engage children and youth. The purposes of those channels and forums should be clear (e.g., to 'ground truth' programmatic priorities, report on progress of key child and adolescent outcomes, plan and implement programs that are responsive to their needs). Children and adolescents consulted for the SITAN have underscored the importance of community-based channels to reach vulnerable and/or marginalized children and adolescents who are currently outside of the grasp of formal systems of care.

Evidence to support policy and program action

7. Develop a national child- and adolescent-focused research agenda to address evidence needs and gaps that can be filled through methodologically sound research. The following are illustrative research priorities:
    - Situation analysis of children and adolescents with special needs (disabilities)
    - National Adolescent and Youth Survey to fill gaps in the knowledge base related to issues and unmet needs such as risk-taking behaviors (e.g., sexual practices, substance use), mental health, coping strategies, in-person and virtual platforms for peer communication and social networking, and other aspects of adolescent development and participation
    - Qualitative investigation into the drivers/determinants of children becoming perpetrators of violence, abuse and harassment against other children
    - In-depth, mixed methods analysis of the main drivers/determinants of high mortality during the post-neonatal period
    - Child and adolescent vulnerability in urban and peri-urban settings
    - The school-to-work transition for various profiles of adolescents (e.g., males, females, rural, urban, adolescent mothers).

8. Strengthen sector-specific management information systems (e.g., HMIS, EMIS) that can and should provide routine administrative data on all aspects of child and adolescent well-being (including evidence on outcomes that reflect the quality of services (e.g., learning achievements among students), ECD-related information on responsive caregiving and early stimulation, alternative service delivery models (e.g., non-formal education) and children and adolescents with disabilities).

9. Map current and planned pilot initiatives (e.g., based on funded projects or programs in the pipeline) and devise a joint evaluation agenda to generate and consolidate evaluative evidence from those initiatives and inform decisions regarding replication and scale-up of effective interventions, models and/or programs (e.g., cost, political economy, impact on the existing system).

10. On an annual basis, synthesize data and learning across sectors and stakeholders to provide a comprehensive and common understanding of the state of Eswatini's children and adolescents. The aforementioned multi-sectoral platform (*Recommendation #4*) is a prime forum for presenting and reviewing evidence to inform joint action (including replication and scale-up) for the next calendar year.

Leaving no child behind

11. Given the broad array of issues affecting children and adolescents with disabilities, we recommend prioritizing the following:
    - Disability mainstreaming for inclusive young child and adolescent programming, working in close collaboration with the various organizations for persons with disabilities (e.g., member organizations of the Federation of Organizations of the Disabled People in Swaziland) to (a) identify and cost requisite adaptations within current service delivery (disability-friendly infrastructure, job aids, tools) and (b) equip frontline service providers in different sectors with critical skills (e.g., sign language, use of early warning signs to identify children with cognitive and behavioral difficulties) and commodities to provide responsive and appropriate support to children with special needs.

- Strengthening referral mechanisms between different grassroots actors (e.g., police, religious organizations, CSOs, health care workers, teachers, social workers, RHMs) to support persons with disabilities who experience various forms of violence, mistreatment and/or neglect.

12. Working with local and regional/international social and behavior change experts, design strategies that address social beliefs, norms and discriminatory practices that underpin vulnerabilities faced by some children and adolescents who are currently slipping through the cracks.

13. Develop, evaluate and replicate a minimum package of tailored, gender-sensitive and age-appropriate interventions for the entire span of childhood and adolescence, positioning schools as a viable platform, especially for primary-school-age children, to deliver age-appropriate, gender-sensitive and disability-friendly information, commodities, services and interventions.

14. Design and implement an integrated child-sensitive package of interventions for children in informal settlements. Given anecdotal information on the proliferation of informal day care providers in those settings, as well as environmental threats (e.g., inadequate WASH infrastructure and practices), use ECD as a flagship issue to address drivers and root causes of adverse outcomes among children in informal settlements.

15. Strengthen the interface between Department of Corrections, relevant line ministries (e.g., MoH, MoET) and key CSO actors providing alternative care arrangements and/or child and/or social protection support to better address the diverse types of child non-offenders found within the correctional system.

16. In light of lagging performance of Shiselweni and Lubombo on various outcome indicators, design an acceleration program to address key barriers and bottlenecks. The multisectoral platform (*Recommendation #4*) can be leveraged to explore specific opportunities for private/business sector engagement, geographical convergence of different interventions, and program integration at point of service in those two regions. However, greater attention should also be paid to understanding structural factors such as resource (human, financial, material) allocation and availability in those contexts, as well as socio-cultural determinants of child well-being.

17. Map key institutional and community entry points with access to children and adolescents, and utilize the multi-sectoral platform (*Recommendation #4*) to improve their access to high-impact commodities (e.g., MHM supplies, dual-benefit contraception, ART, TB treatment, etc.) via those entry points. Illustrative categories of entry points are as follows:
    - health facilities (e.g., MoH Teen Clubs for HIV-infected Adolescents; Adolescent and Youth Friendly Health Services)
    - primary and secondary schools
    - non-formal education providers and platforms (TVET, parastatals such as Sebenta)
    - other entities and platforms capacitating adolescents to be productive members of society (e.g., Junior Achievement)
    - community-level services and platforms (e.g., those managed by MoY and CSOs such as soup kitchens and other mechanisms that are reaching children and youth who are currently outside the grasp of most formal systems of care)

18. Identify and leverage opportunities to engage the private sector (e.g., through corporate social responsibility efforts related to nutrition) on strategies for prevention and reduction of overweight and obesity.

Building resilience

19. Support the introduction of child-sensitive social protection programs, with support from development partners (UN, World Bank), private sector, CSOs and faith-based organizations.

20. Optimize existing social protection programs to enhance their child-sensitive features, examining elements such as inclusion/exclusion criteria, targeting and outcome monitoring. One clear priority for optimization is the existing OVC Grant for secondary education.

21. In light of the fact that suboptimal parenting and, more broadly, destabilization or disintegration of the family unit has been identified as a contributing factor to an array of adverse outcomes (e.g., child neglect, violence against children, suboptimal ECD practices, school repetition and dropouts), design and implement strategies nationwide that (a) strengthen parenting and caring practices and (b) bolster mechanisms to identify and support children who have inadequate parental care.

ANNEXES

Annex 1: SITAN Methodology

1. Desk review

2. Consultations (key informant interviews, focus group discussions) with UN and non-UN stakeholders:
    - Children/adolescents—in-school and out-of-school in Lubombo, Manzini, Mbabane and Shiselweni
    - Government stakeholders
        - Various units within the Deputy Prime Minister's Office (DPMO)
    - Civil society organizations (CSOs)
    - Business sector representatives

Individual and group interviews took place with the following:

UNICEF Eswatini

Children and Adolescents
- Children and Adolescents attended non-formal education classes sponsored by Sebenta National Institute, Mbabane
- Out-of-school adolescents reached by AMICAALL, Manzini
- Primary school students, Shiselweni
- Secondary school students, Lubombo

Government
- Key DPMO units, namely Gender, Disability and Children's Units
- Ministry of Health
- Ministry of Education and Training
- Ministry of Labour and Social Security
- Ministry of Justice & constitutional affairs (National Correctional Services, Director of Public Prosecutions - DPP)

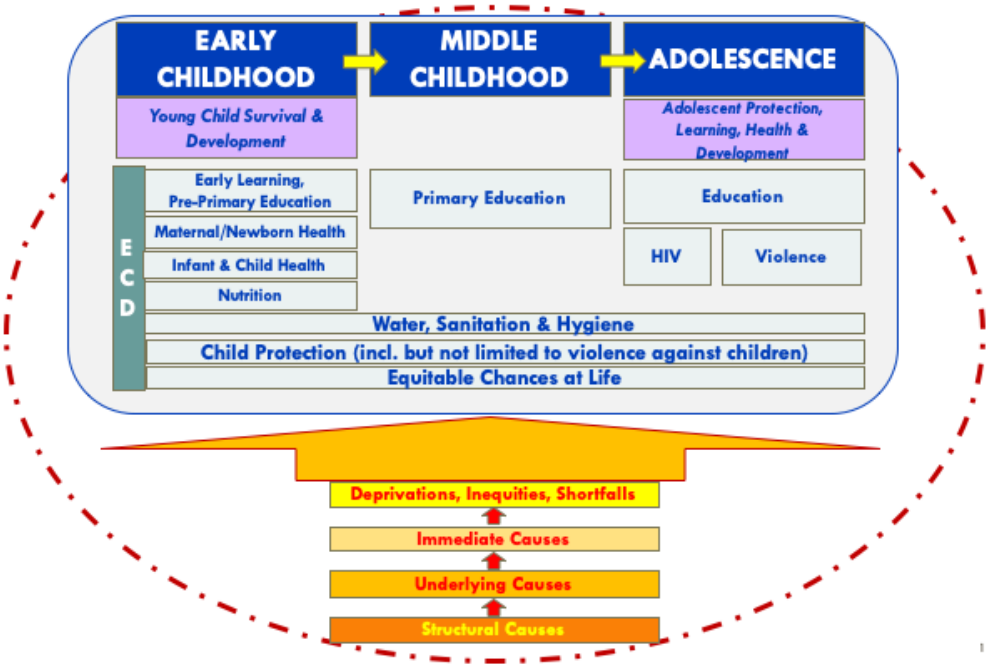
Parastatals
- Sebenta National Institute
- National Disaster Management Agency

NGOs and Civil Society
- Siphilile
- SWAGAA
- World Vision

Private/Business Sector Stakeholders supporting ECD

The National SITAN Validation, which took place on Thursday, 18 July 2019 at the UN compound in Mbabane, engaged a broader representation of stakeholders from key Government line ministries, DPMO units, various UN agencies, parastatal and CSO representatives, and stakeholders from the business sector.

Conceptual Framework that Guided SITAN work



ANNEX 2: Estimates of Selected Indicators from 2010 and 2014 MICS

Selected MICS Indicators related to Protection

INDICATOR	2010 MICS ESTIMATE	2014 MICS ESTIMATE	DIFFERENCE
Birth registration rate (%)	49.5	53.5	4.0 percentage points
Rate of violent discipline (%)	88.9	88.3	-0.6 percentage points
Rate of child marriage, females (%)	10.9	8.8	-2.1 percentage points
Child labor rate (%)	42.2	NC	NC

Selected MICS Indicators related to Young Child Survival and Development

INDICATOR	2010 MICS ESTIMATE	2014 MICS ESTIMATE	DIFFERENCE
Under-five mortality rate (per 1000)	104	67	-37 per 1000
Infant mortality rate (per 1000)	79	50	-29 per 1000
Neonatal mortality rate (per 1000)	19	20	1 per 1000
Under-five stunting rate (%)	30.9	25.5	-5.4 percentage points
Under-five wasting rate (%)	0.8	2.0	1.2 percentage points
Under-five overweight prevalence (%)	10.7	9.0	-1.7 percentage points
Low birth weight rate (%)	8.7	8.0	-0.7 percentage points
Contraceptive prevalence: women married/in union (%)	65.2	66.1	0.9 percentage points
Antenatal care coverage, at least 4 visits (%)	76.6	76.1	-0.5 percentage points
Skilled delivery rate (%)	82	88.3	6.3 percentage points
Postnatal health check for newborn (%)	NC	90.4	NC percentage points
Postnatal health check for mother (%)	NC	87.5	NC percentage points
Exclusive breastfeeding under 6 mos. (%)	44.1	63.8	19.7 percentage points
Minimum dietary diversity (%)	NC	62.4	NC percentage points
Minimum acceptable diet (%): breastfed children	NC	48.6	NC percentage points
Minimum acceptable diet (%): non-breastfed children	NC	29.7	NC percentage points
Full immunization coverage (%)	83.1	70.7	-12.4 percentage points
Early childhood development index	62.0	64.9	2.9 percentage points
Attendance to early childhood education	33.0	29.5	-3.5 percentage points
Primary school net attendance ratio (adjusted %)	96.5	97.7	1.2 percentage points

INDICATOR	2010 MICS ESTIMATE	2014 MICS ESTIMATE	DIFFERENCE
Gender parity index--primary school	1.01	1.01	0
Population use of improved drinking water source (%)	67.3	72.0	4.7 percentage points
Population use of improved sanitation (%)	56.8	53.0	-3.8 percentage points

Selected MICS Indicators on Adolescents

INDICATOR	2010 MICS ESTIMATE	2014 MICS ESTIMATE	DIFFERENCE
Adolescent birth rate	89	87	-2 per 1000
Transition rate to secondary school (%)	84	85.5	1.5 percentage points
Secondary school net attendance ratio	47.2	50.4	3.2 percentage points
Gender parity index--secondary school	1.24	1.19	0.05
Percentage of 15-24 year old females with comprehensive knowledge about HIV transmission	58.2	49.1	-9.1 percentage points