KINGDOM OF ESWATINI

FACTS AND PROSPECTS

Sexual and Reproductive Health and Rights 2019

Indicator	Value	Source/Year
Total Population in Millions (% Female)	1.09 (51.4%)	2017 Census
Youth Population (10-24 years)	32.0%	2017 Census
Total Fertility Rate (TFR)	3.2	2017 Census
Adolescent Birth Rate (15-19yrs)	87 per 1,000	MICS 2014
Maternal Mortality Rate (MMR)	452 per 100,000 live births	2017 Census
Modern Contraceptive Prevalence Rate (CPR)	66.1%	MICS 2014
Unmet Need for Family Planning (FP)	15.2%	MICS 2014
HIV Prevalence	27%	GOe 2017
Gender Inequality Index (GII)	0.569 ranked 141st	HDR 2018
Gross Domestic Product (GDP) Growth (%)	0.2%	HDR 2018
Gini Index	51.5%	HDR 2018
Human Development Index (Inequality HDI)	0.588 ranked 141st (0.414/29.7% loss)	HDR 2018

BACKGROUND

The Kingdom of Eswatini[1] is a small, landlocked monarchy in Southern Africa, bordering Mozambique to its northeast and South Africa to its north, west and south, with Mbabane as its capital city. In April 2018 the official name was changed to Kingdom of Eswatini. The majority of Eswatini's population is ethnically Swazi, mixed with a small number of Zulu and White Africans, mostly people of British and Afrikaner descent. The country is heterogeneous in religious affiliation, with 83 per cent Christian, 2 per cent Muslim, 0.2 per cent Hindu, and 15 per cent other religions.

UNITED NATIONS POPULATION FUND MODE OF ENGAGEMENT

Classified as a **Lower Middle-Income** Country (LMIC), Eswatini is placed in the **orange**[2] quadrant mode of engagement of the United Nations Population Fund (UNFPA), suggesting multiple socioeconomic development inequalities with significant potential to limit the long-term economic aspirations of the country.

[1] This brief draws from published, global comparative data for countries and regions. Key sources are the 2019 State of the World Population Report (SWOP, UNFPA), United Nation's World Population Prospects 2019, Human Development Report 2018 (HDR, UNDP), World Bank Poverty and Equity Data Portal, World Health Statistics (WHO), Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (Maternal Mortality Report [MMR], 2019) and official national data. Recommended citation for this document: United Nations Population Fund (UNFPA), Kingdom of Eswatini Facts and Prospects: Sexual and Reproductive Health and Rights, 2019.

[2] Orange quadrant due to medium range gross domestic product (GDP) and low ability to finance significant national development needs.

POPULATION DYNAMICS

Eswatini's population has increased fourfold over the last 50 years and remains predominantly rural (Figure 1). Annual average rate of population growth declined from 3.5 per cent in 1960 to 0.9 per cent in 2007 and 0.7 per cent in 2017, and is projected to remain at the current level by 2050. The net migration rate is -1.5 per 1,000 people, with South Africa being the common destination for emigrants (89%). **Total Fertility Rate** (TFR) declined from 6.9 children per woman in 1969 to 5.0 in 1994, to the current 3.3. This results in a **youthful population** with an average age of 22 years and a **total dependency ratio** of 67 per cent.

Over the past 50 years, the proportion of the dependent population below 15 years declined by 20 per cent, while that of the working-age population (15–64 years) increased by 15 per cent, presenting a demographic dividend that could be harnessed to drive the country's socioeconomic development. The proportion of the older population above 65 years increased by about one percentage point between 2007 and 2017 and is projected to remain below 5 per cent by 2030 (Figure 2). **Life expectancy at birth** increased from 47 years in 1960 to 58 years in 1994, to 59 years currently. The HIV/AIDS epidemic is a major factor for the slow improvement in life expectancy during the last 25 years.

Figure 1: Total population and percentage of population residing in urban areas, Eswatini, 1969 - 2030

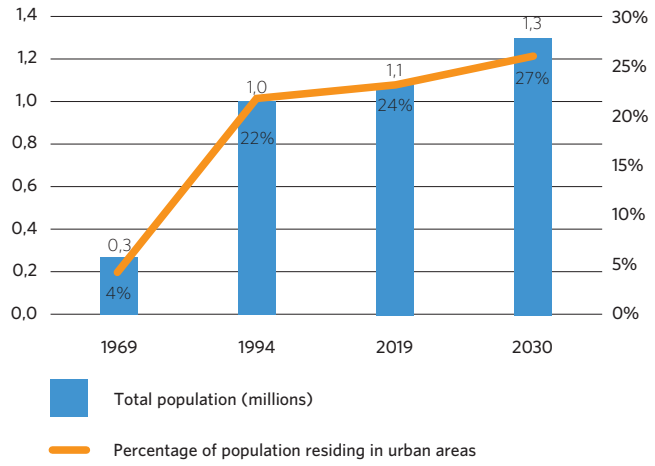
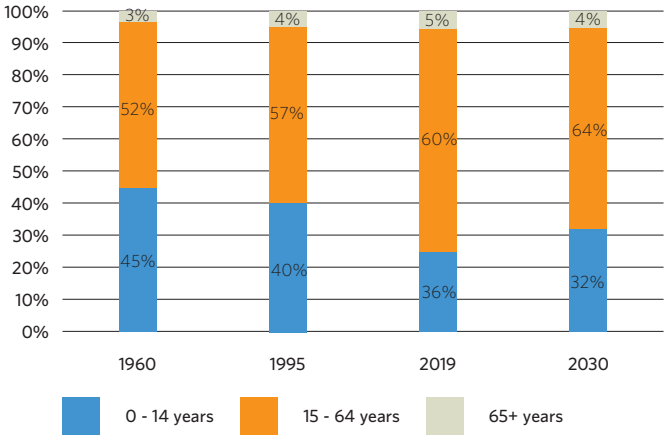


Figure 2: Population composition by age, Eswatini, 1960 - 2030



SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Maternal mortality rate: A performance marker of health systems, the maternal mortality rate (MMR) has declined by 16 per cent from 538 in 1994 to 452 in 2017, but is still more than twice the global average of 211. While the country has high skilled birth attendance coverage (88.3%), there have been recent challenges with medical and commodities supply at health facilities. There is limited reliable data on abortion services in the country, but it is estimated that unsafe abortions account for about 10 per cent of maternal deaths. Abortion is only available in extremely limited circumstances in the country as provided for by the constitution and the bill of rights.

Contraceptive use: Modern contraceptive prevalence rate (CPR) among women of reproductive age increased phenomenally from 2 per cent in the 1960s to 66 per cent in 2014 (Figure 3), but disparities remain by residential area, age and educational levels. Nearly half (46%) of adolescent girls aged 15–19 years who are married or in a union use modern contraceptives. Overall, 81 per cent of demand for family planning (FP) is satisfied with modern methods, with common modern methods being male condom (24%) and injectables (22%).

The unmet need for FP is estimated at 15 per cent, underscoring the importance of continued efforts to expand contraceptive access and method mix.

Adolescent birth rate: Adolescent birth rates declined from 175 per 1,000 girls aged 15-19 years in 1970 to 124 in 1995 and 87 in 2017. Despite the declines, the current adolescent birth rate is still twice the global average of 44. Early sexual debut not only contributes to increased teenage pregnancy, unsafe abortions and sexually transmitted infections, but also heightens young people's risk to HIV and AIDS.

HIV: Eswatini has a high adult HIV prevalence of 27 per cent. Even though the country has recorded a 31 per cent decline in new HIV infections since 2010, new HIV infections among adult females are nearly twice of that in men of the same age group (Figure 4)[3]. Young girls account for 40 per cent of all new HIV infections. The country is, however, making good progress towards the 90-90-90 treatment target by 2020.

[3] HIV/AIDS data based on The Joint United Nations Programme on HIV/AIDS (UNAIDS) special analysis, 2019.

Figure 3: CPR and demand satisfied with modern methods, women 15 - 49, Eswatini, 1969 - 2019

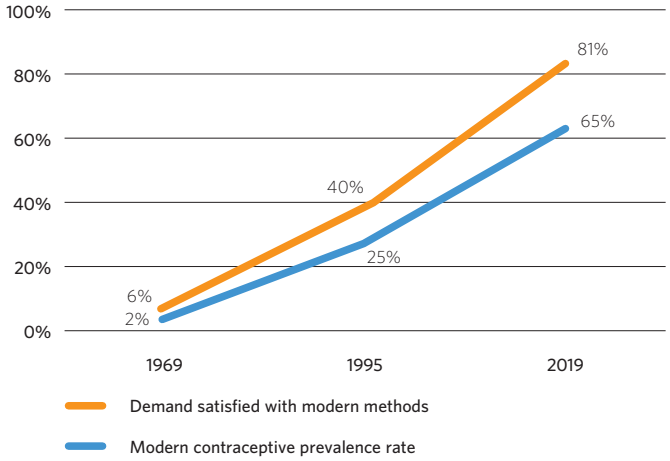
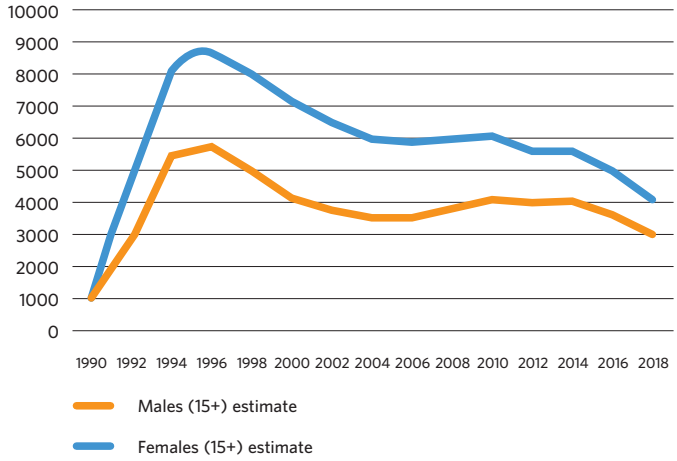


Figure 4: New HIV infections among young people (15+ years), by sex, Eswatini, 1990 - 2018



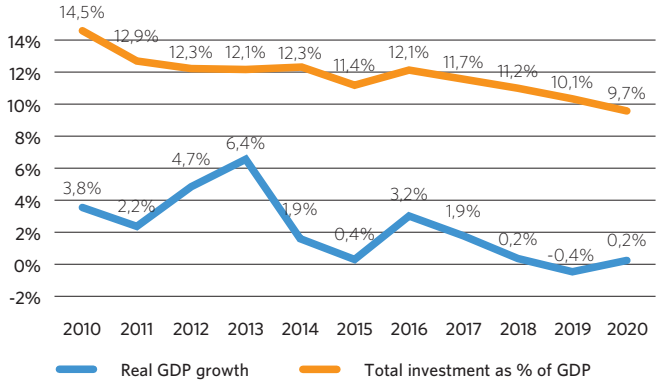
Gender equality: The national Strategy to End Violence in Swaziland (2017–2022) provides guidance on the prevention, management and response to gender-based violence (GVB). However, gender equality gaps remain in the country with women holding about a quarter (23%) of **seats in parliament**[4]. An estimated 5 per cent of girls aged 20–24 years report to have been married before they turned 18 years.

The country's overarching legal framework for marriage is founded upon a dual system of an uncodified Swazi customary law and the marriages act. The legal marital age for women is 18 years with parental consent and 21 years without consent, while customary law does not set a minimum age. **Child marriage** (under 18 years of age) is considered a form of gender inequality as it diminishes future prospects for acquiring education and gaining employment.

ECONOMIC PERFORMANCE AND EQUITY

Gross domestic product (GDP) declined from 6 per cent in 2013 to 0.2 per cent in 2018 with projections of negative growth in 2019, alongside declines in total investment as a percentage of GDP, based on estimates by the International Monetary Fund (Figure 5)[5]. Increasing income inequality is represented by a high **Gini index** of 52 per cent against a backdrop of high levels of poverty. The proportion of the population living below the poverty line is estimated at 59 per cent, with 21 per cent and 18 per cent of young people aged 15–24 and 15–35 years, respectively, living in extreme poverty[6]. The poverty situation is compounded by a high **unemployment rate** of about 26 per cent and **youth unemployment** of 55 per cent, presenting a serious development challenge.

Figure 5: Real GDP growth rate and changes in total investment as a percentage of GDP, Eswatini, 2010 - 2019



OTHER DEVELOPMENT COMPLEXITIES

Climatic and environmental vulnerability: Eswatini is classified as a low consuming party in the Montreal Protocol, with negative greenhouse gas emissions. Over the past decade, Eswatini has experienced more frequent and intense extreme weather events, including an El Niño-induced drought in 2015 and 2016. The country has also seen drops in its crop production due to climatic variability. The government has established the National Climate Change Committee, developed the National Climate Change Strategy and Action Plan, and enacted the National Climate Change Policy (Ministry of Tourism and Environmental Affairs, 2016) that aim to support climate change adaptation programmes.

The country's goal is to build resilience to climate changes towards sustainable development and poverty eradication (Afrobarometer Survey, 2018).

Education: Eswatini has universal enrolment in primary schools, but lower progression rates to secondary schools (67%) and tertiary level education (5%). An estimated 6 per cent and 13 per cent of all young people aged 15–24 and 15–34 years, respectively, were not in formal education, employment or training (NEET) in 2017, representing limited progression to higher education levels.

[4] United Nations Development Programme, Human Development Report 2018.
[5] International Monetary Fund (IMF), Regional economic outlook: Sub-Saharan Africa, April 2019.
[6] Eswatini Household Income and Expenditure Survey, 2017.

ACCELERATING THE PROMISE IN 2019 AND BEYOND

Harnessing the demographic dividend: Eswatini's changing population age structure presents a demographic dividend that can be harnessed to the country's advantage. However, a 2017 National Transfer Accounts analysis indicates late age of entry into the workforce compared to countries in the same development category. This scenario results in a shorter period during which income is greater than consumption needs, further resulting in a short period with a working-age population and labour surplus. The high youth unemployment rate calls for interventions to increase decent employment opportunities for the young population in the country and improve the quality of human capital. Strategic priorities for harnessing the demographic dividend include investment in higher education, development of appropriate skills and economic reforms that promote innovation, higher productivity, purchasing power, and decent job opportunities.

Sexual reproductive health and rights: The goal is to intensify actions by government and partners to reduce MMR and HIV prevalence. This encompasses physical infrastructure development, improved quality of care, adequate skilled human resources for health, repositioning FP, integration of sexual reproductive health (SRH) services with HIV/AIDS services, and strengthening surveillance and response systems to monitor maternal and perinatal deaths. To address the gender inequalities faced by women and adolescent girls across social, cultural, political, legal and economic spheres of life, there is need for targeted actions such as harmonizing and enacting progressive and inclusive laws and customs, including conclusion of law reforms related to the Marriage Act, 1964.

Addressing other persistent inequalities: Deliberate efforts are necessary to improve the ease of doing business and to ensure equitable access to decent jobs and inclusive economic opportunities for young people. This can be reached through financial inclusion mechanisms and access to credit and entrepreneurial skills for small and medium-sized enterprises (SMEs). In addition, closing the existing gender gap in employment, through inclusive strategies for women in labour market opportunities, will support the country's economic transformation agenda. In line with the Strategy for Sustainable Development and Inclusive Growth (SSDIG), poverty reduction strategies that include a robust social protection programme, targeting vulnerable population groups, will be key in addressing development inequalities. Addressing equitable access to secondary and tertiary education will be critical, including technical and vocational education and training with gender parity and improved quality of learning. Expanding access to comprehensive sexuality education (CSE) across formal and vocational training will support reduction in high rates of teenage pregnancy, GBV and HIV prevalence. Also, effective implementation of the Eswatini Social Development Policy (2009) and strategic plan aimed at providing care and support to vulnerable groups – children, adolescents, young people, elderly, persons living with disabilities and other marginalized groups – will ensure the required empowerment, protection and fulfilment of rights.

Climate change: Implementation of the National Climate Change Strategy and Action Plan, and the enacted National Climate Change Policy (2016), as well as effective coordination by the National Climate Change Committee, will advance the intended climate change adaption programmes. These include actions on food security, water supply, and access to social services.

Addressing lifestyle diseases: The increase in the older population and urbanization in Eswatini has been accompanied by a rise in non-communicable diseases (NCDs), including cardiovascular diseases, type 2 diabetes, cancer and chronic respiratory illnesses, which are estimated to account for 37 per cent of all deaths. Multisectoral promotion and support for lifelong healthy living is required to respond to this epidemiologic transition.

Universal periodic review: Eswatini's next third Universal Periodic Review (UPR) is scheduled for April/May 2021. It is important that the UNFPA, as part of the United Nations Country Team (UNCT) or on its own, submits information for this UPR, focusing on the progress in the implementation of the outcomes of previous reviews and the situation of neglected SRH related issues. The tentative deadline for United Nations submissions is 24 September 2020.

Strengthening availability and use of data to guide development: UNFPA collaborated with the Central Statistical Office (CSO) for the 2017 Housing and Population Census, for which thematic reports and monographs have been developed. The next stage of generating population projections, and further analysis through small area estimations, will provide more refined data to guide decision making, influence resource allocation and targeted investments, and it will model the impact of different policies and business solutions. In addition, approval of the Draft National Strategy for the Development of Statistics (NSDS) will ensure a more effective and efficient statistical system responsive to the socioeconomic development trajectory of the country.

Strengthening and forging strategic partnerships: Intersectoral and multi-stakeholder partnerships have potential to effectively address the prevailing development inequalities through improved coordination for sustainable development goals (SDGs) implementation, monitoring and accountability, and financing for development, to mention a few.

UNFPA

Ensuring rights and choices for all **since 1969**

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