The Present Context

Ranking 97th on the UNDP Human Poverty Index scale, Swaziland had a GDP per capita income of USD 1,669 in 2003. Indicators show widespread poverty and large inequalities in access to basic services. About 77% of the population is rural-based and depends on subsistence farming. Two-thirds of those living in urban areas dwell in unplanned townships where water, sewage and solid waste disposal are precarious. Rural-urban disparities are prominent: 91% of the urban population has access to safe water versus only 37% of the rural population.

Three converging trends contribute to vulnerability: recurrent droughts and land degradation, deepening poverty and HIV/AIDS (38.8% of the adult population). According to the VAC, around 263,000 people, or 25% of the population, will face severe food shortages until March 2006.

Crisis involving: The Whole Population

Millennium Development Goals in Swaziland

<table>
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<tr>
<th>Eradicate extreme poverty &amp; hunger</th>
<th>Achieve universal primary education</th>
<th>Promote gender equality</th>
<th>Reduce child mortality</th>
<th>Improve maternal health</th>
<th>Combat HIV/AIDS, malaria etc.</th>
<th>Ensure environmental sustainability</th>
<th>Global partnership for development</th>
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<tbody>
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<td>Far behind</td>
<td>On track/far behind</td>
<td>On track</td>
<td>Slipping back</td>
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Note: Information is based on one to two specific targets for each major goal. The selection of goals and targets in the table is based principally on data availability.


Main Public Health Issues and Concerns

Health Status

- In 2003, infant and under-five mortality rates were estimated at 105 and 153 per 1,000 per year respectively. According to the UNDP Development Report 2005, life expectancy at birth is 33 years, down from 50 in the early 1970s.
- In 2004, the three most common causes of diseases, representing 50% of outpatient visits, were Acute Respiratory Infections (ARI), diarrhoeal and skin disorders.
- For the same period, diarrhoeal disorders were the leading cause of mortality followed by TB, AIDS, pneumonia and malaria. Among children under five and infants, diarrhoea, ARI, tuberculosis and malaria were the main causes of mortality.
- According to a survey carried out in 2000, one in ten children under five was underweight and 2% severely underweight. Chronic under nutrition was 30% in 1983, 27% in 1995 and up again to 30% in 2000.
- According to sentinel surveillance sites, the HIV prevalence in pregnant women has increased from 4% in 1992 to 39% in 2003. There has been a concurrent rise in TB, with the number of reported cases increasing steadily from 1,400 per year in 1993 to 6,830 in 2003.
- The country is experiencing a heavy burden of mental health problems, including schizophrenia, epilepsy and depressive disorders.
- About 90% and 40% of urban and rural people respectively have access to safe water. Sanitation coverage is 77% and 63% for urban and rural dwellers.

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Health System

- The public health system of Swaziland is functioning at a reasonable level although it needs support to respond to emerging demands.
- The primary level is composed of 153 clinics focusing on outpatient services to the community supplemented by outreach services conducted by health workers once a month. Around 2,000 Rural Health Motivators, based in both urban and rural areas, complement these services by providing advice and care to the communities.
- The secondary level provides referral care, support and supervision. It includes nine health centres with a 24 to 42-bed capacity offering preventive, promotive and curative care as well as surgery, maternal and dental services.
- The third level includes six main hospitals, including the national referral hospital in Mbabane, focusing on emergency and specialty care. A 1998 World Bank review showed that 90% of the inpatient beds were concentrated in urban areas.
- Traditional healers, although not formally coordinated with the MoH provide health care in their communities.
- The annual expenditure on health ranges between 7 and 9% of the total government expenditure. Despite the fact that most of the country’s disease burden is preventable, 70 to 80% of the expenditure continues to go to curative care for only 20 to 30% to primary health care.
- Swaziland adopted a system of user charges as a cost-recovery mechanism in 1987. Exemption mechanisms to cushion those who cannot afford to pay have proved difficult to implement, resulting in substantial inequalities in access to health care.

Main Sector Priorities

The overall priority is to address the most urgent determinants of excess morbidity and mortality that result from the combined impact of drought, poverty and HIV/AIDS, by 1) providing emergency relief to the most vulnerable communities and 2) strengthening the coordination of disaster prevention and mitigation to promote recovery and risk reduction. The most immediate interventions relate to food relief and nutrition, agriculture, capacity building, access to education, child protection, gender empowerment and health.

WHO’s main aims to respond to the current crisis are twofold:

- Filling the gaps in surveillance, early warning of and capacity to respond to health threats though:
  - Further development of assessment tools and annual health sector assessments to monitor the impact of the crisis;
  - Continued support to the implementation of the Integrated Disease Surveillance and Response (IDSR) strategy and responses to disease outbreaks;
- Enhancing Capacity for Emergency Preparedness through:
  - Monitoring of the capacity of the health sector to manage crisis situations;
  - Support to vulnerability assessments and development of emergency preparedness plans;
  - Capacity building for assessment and response to crises by ensuring the presence of adequately trained and appropriately skilled staff.