Swaziland

Demography

--- Country – Area size	17000 k m²
--- Population	1.1 million (2004)
--- Growth rate	2.9 % (1997)
--- Fertility rate	4.5 % (1997)
--- Infant mortality rate	78 / 1000 (1997)
--- Maternal death rate	229 / 100.000 (1997)
--- Life expectancy	41.4 years (1997)
--- Urbanization	22.6 % (2004)
Rural	77.4% (1997)
--- HIV/AIDS	46% (2006)

Economic Information

--- GDP (current prices): 14,401 M (2003)
--- GNP per Capita: E13, 783 (2003)
--- GDP Growth Rate: 2.4% (2003)
--- Consumer price index: 184, 97 (2004)
--- Inflation Rate: 3.4 % (2004)
--- Unemployment Rate: 29 % (2001
--- Total Exports: 16,264,100,503 (2003)
--- Total Imports: 12,072,504,222 (2003)

Social Information

--- Poverty Incidence: 69 %
--- Extreme (food) Poverty: 37 % (2001)

--- Literacy Rate: 81.3 % (1997)
--- Immunization coverage 70% (2004)
--- Contraception Prevalence: 38.6% (2002)
--- Exclusive Breastfeeding Rate: 31.2% (2000)
--- Underweight: 10% (2000)
--- Stunting: 30% (2000)
--- Wasting: 2% (2000)
--- New Enrollment Rate Primary: 85% (2004)
--- Gross Enrollment Rate Primary: 10.1% (2004)
--- Overall Enrollment Rate: 80% (2004)

Communications

--- Cellular Subscribers: 4 per 100 populations (2004)
--- Telephone Lines: 10.2 per 100 populations (2004)

Agricultural Production

--- Sugar Production: 59, 7563 M.Ton (2004/5)
--- Wood Pulp Production: 180,590 M.Ton (2004/5)
--- Maize Production: 18,216 M.Ton (2004/2005)
--- Maize Imported: 18,378 M.Ton (2004/5)
--- Cattle: 60, 3051 (2003)
--- Sheep and Goats: 365,642 (2003)

Demographic and Economic Profile

Swaziland is a lower middle-income country with a per capita income of US$ 1,170 and a per capita expenditure on health of approximately US$24.

Even though the country has a middle-income status, there is sufficient evidence to suggest that income is not evenly distributes. Consequently, 48% of the population lives below the food poverty line.

Administratively, the country is divided into 4 regions, 55 tinkhundla and approximately 300 chiefdoms. Topographically, the country is divided into 4 ecologial zones namely the high veldt, middle veldt, low veldt and the Lacombe plateau.

According to the census of 1997, the country has a population 929,718 people and an annual population growth rate of 2.9%. Homesteads and households were

respectively estimated to be 126,414 and 172,416. Rural dwellers make up 78% of the population.

42.5% of the population are children under the age of 15 years. Women of childbearing age (15-49 years) make up 26.2% of the population while all females account for 53%. In 1997, the total fertility rate was estimated to be 5.8 live births per woman from 5.6 in 1991. Contraceptive prevalence increased steadily over the years from 4% in 1980 to 34% in 1998.

Profile of Health Services

The country's health care system is dual: It is made up of traditional and western concepts of medicine. The health service that is based on western medicine is considered to be formal and as such benefits from government funding. There is no current data on the traditional health service. However, according to the Family Health Survey of 1998, the majority of Swazis utilize services of the traditional health sector as their first choice.

The formal health sector is based on the concepts of primary health care and decentralization. Its infrastructure is made up of 7 hospitals, 8 public health units, 12 health centers, 162 clinics and 187 out reach sites. It is serviced by a work force of 188 doctors, 3,200 staff nurses, 900 nurse assistants and a number of allied health professionals and support staff whose work is supplemented by approximately 2,700 rural health motivators and an undetermined number of community birth attendants. These birth attendants have not received formal training in health sciences. Providers of health services include government, religious organizations, Missions, industry and private practitioners. Health services are managed at national, regional and facility levels.

By 1991, up to 85 % of the population was reported to be already living within a radius of 8 km from a health facility, depicting that access to health services had increased tremendously over the years. There is however ample evidence to suggest that the distribution of health resources tends to favor urban over rural based populations.

In spite of the observed decline in infant mortality, Swaziland`s infant mortality rate tends to be higher than that of other Southern African countries. In 1996, when the infant mortality rate in Swaziland was 68 per 1000 live births, in

Botswana, Namibia, Zimbabwe and South Africa, it was respectively 40, 60, 49 and 50. Under- 5 Mortality per 1000 live births similarly decreased from 218 in 1976 to 140 in 1986 and 89 and 1991. Under – 5 mortality was also highest in the country in 1996 when compared to that of Botswana (50/1000), Namibia (77/1000), Zimbabwe (73/1000) and South Africa (66/1000).

Even though there is adequate evidence to suggest that mortality levels have decreased over the years and that life expectancy has similarly increased, the quality of life of the Swazi people is still unacceptable and is under threat from the HIV/AIDS pandemic. Communicable diseases continue to be a major challenge for the country. According to the Health Statistics Reports of 1995 to 1998 respiratory conditions account for more than a quarter of all outpatient visits increasing from 25.3% in 1994 to 25.3% (1995), 26.2%(1996), 27.3%(1997), 27.8%(1998), and 26.0% in 1999. Diarrheal diseases being the second most common cause of morbidity have declined slightly from 15.1% in 1994 to 15.1% in 1995, 11.8% in 1996, 11.6% in 1997, 11.1% in 1998 and 11.2% in 1999. Skin diseases have increased from 8.6% in 1994 to 9.1% in 1995, 10.5% in 1996, 11.5% in 1997, 11.1% in 1998 and 11.3% in 1999. Genital, digestive, musculo-skeletal disorders have remained relatively stable.

In 1998, reasons for admission included gastro-enteritis and colitis, tuberculosis, malaria, injuries, pneumonia and influenza, abortion, skin and sub-cuteneous disorders, acute respiratory infection etc. Mortality was mostly caused by gastro-enteritis and colitis, tuberculosis, pneumonia and influenza, heart diseases, malaria, diabetes, intestinal infections, nutritional deficiencies etc.

Over and above al health problems, ALDS poses a major challenge for the country. According to sentinel surveillance data, the prevalence of HIV infection among pregnant women who attend antenatal services has increased over the years from 3.9% in 1992 to 34.5% in 2000. By March 2001, the country had reported a cumulative total of 8,458 AIDS cases. Tuberculosis has also become a very serious public health concern for the country. The number of new TB cases has increased from 1,400 in 1993 to 4,167 in 1999. Malaria is endemic in selected parts of the country and is generally well managed. The number of malaria cases peaked in 1996. A total of 3,259 malaria cases were reported in 1999.

Vision

By the year 2015, the sector shall have developed into an efficient and effective service and shall have given rise to a manageable population of a people that live longer, healthier and socially fulfilling lives. As such the country's health and social welfare status indicators shall compare favorably to those of countries with a similar level of human development.

Mission

The Health and Social Welfare Sector seeks to improve the health and social welfare status of the people of Swaziland by providing preventive, promotive, curative and rehabilitative services that are of high quality, relevant, accessible, affordable, equitable and socially acceptable.

Objectives

◇ Reduce morbidity, disability and mortality that are due to preventable health and social conditions.

◇ Reduce the risk and vulnerability of the country`s population to social welfare problems as well as the impact thereof.

◇ Ensure equitable access to public health and essential clinical as well as to social welfare services by all people who reside in the country.

◇ Improve cost-effectiveness of investment health and social welfare services.

◇ Improve responsiveness of the health and social welfare service system to societal needs.

◇ Ensure fair contribution in the financing of health and social welfare services.

Disability Position Paper for Swaziland

Introduction

Although Swaziland has made some tremendous progress in addressing the issue of persons with disabilities in the country, disabled people continue to have limited access to community services and opportunities available to non-disabled persons such as education, health, employment, public facilities including buildings and transport. Consequently, disabled people tend to be overrepresented amongst the unemployed, the poor and the uneducated.

Disability is one of the major health problems in Swaziland. The year 2000, disability profile in the country reflected that about 3% of the total population of the country, i.e.,27,689 persons have disabilities, namely: mental illness, deafness, blindness, speech disabilities and physical disabilities. It was highlighted in the profile that the prevalence of disability is increasing more especially due to the escalating rates of road traffic accidents and the burden of disease that is currently facing the country. The Ministry of Health & Welfare has the capability to identify these individuals and intervenes early enough to reduce the impact of these unacceptable levels of disability.

Rehabilitation services are directed at the secondary prevention of avoidable disability and improving function where disability already exist, focusing on the following areas:

- As part of a curative process, to prevent disabilities accruing in people suffering from potentially disabling illnesses or injuries;
- Early intervention in children with congenital or acquired disabilities;
- An intervention to improve the function of those who are already disabled.

Rehabilitation services include physiotherapy, occupational therapy, speech therapy, audiology, orthopedic technology.

The initiative of setting up the National Disability Unit came up as one of the intervention strategies that were recommended during the compilation if the

disability profile. The mission of the National Disability Unit is to champion significant improvement in the quality of life of persons with disabilities by among other things, strengthening disability programming in the country; collaborating with all relevant stakeholders involved in disability work including government sectors. Non Governmental Organizations and Disabled People's Organizations; raising awareness on disability issues; and empowering persons with disabilities.

It cannot be over-emphasized that the situation of persons with disabilities cannot be comprehensively addressed in the absence of a national disability policy more especially because disability issues cannot be tackled by one sector alone it demands a multiscectorial approach. The ministry of Health & Social Welfare is currently working with the WHO in soliciting for funds and technical support in order to be able to develop the disability policy. It is thus one of the urgent tasks of the National Disability Unit to facilitate the formulation of the disability policy. The Ministry is also in the process of formulating National Disability Council, which will be multiscectorial in nature including Disabled People's Organizations. The Council upon approval by Cabinet will be a government gazetted body which will the process of formulating, implementation and monitoring of the policy.

It is the hope of the Ministry of Health & Social Welfare that the Unit will bring about an improvement in the delivery of services to persons with disabilities. The support of all relevant stakeholders is critical in this regard.

Existing Disability Structures

Governmental Organizations

Ministry of Health & Social Welfare has the portfolio responsibility for disability issues in Swaziland. It provides institutional community rehabilitation and social services. The Community Based Rehabilitation programme, which the Ministry established in 1990, has been the major vehicle through which issues and problems facing persons with disabilities have been addressed. In addition, the Ministry provides social welfare services to person with disabilities. The Ministry as mentioned above has upgraded the Community Based Rehabilitation programme to that of National Disability Unit.

Ministry of Home Affairs

The Ministry of Home Affairs provides vocational training geared towards self-employment and some income generation for persons with disabilities. Training is provided in 3 centers: Nhlangano Vocational Centre. This vocational rehabilitation approach encourages persons with disabilities to be self-supportive and independent in life.

Ministry of Education

The Ministry of Education operated a Special Education Unit. The unit seeks to provide special education and early intervention services to children with disabilities and youth with learning disabilities. Its main objective is to promote inclusive education. It has 3 special schools: Ekwetsembeni School for children with learning exceptionalities, Siteki School of the Deaf, and St.Josephs School (which has a resource centre for the blind children).

Non-Governmental Organizations

Cheshire Homes of Swaziland

Cheshire Homes is a charitable organization that deals with the rehabilitation of persons with physical disabilities. It provides the following services:

- A physiotherapy Department which caters for in patients, day care patients, and out patients;
- Vocational training on a small scale in tailoring, leatherwork and knitting;
- Employment and placement for patients who have learnt an appropriate skill in discharge and production of;
- Orthotic appliances for patients requiring them.

Ekululameni Vocational Training Centre

The Ekululameni Training Centre situated at St. Joseph`s Mission provides vocational training to persons with disabilities over 18 years. The centre equips disabled people with skills in the following areas: woodwork and joinery, sewing, poultry, vegetable production, grass work, weaving and fencing. Work done at the centre is sold and precedes help to train more disabled people.

Save the Children Fund has a programme called `disability and development'. The activities of the programme include capacity building for national regional and grassroots disabled people. It seeks to do the following:

- Empower DPO`s with skills and strategies in carrying out effective advocacy initiatives at grass root levels;
- Provide opportunities for DPO`s to be developed in leadership and governance issues;
- Provide helpful devices to people with disabilities.

The National Disability Unit and Its Objectives

- To collaborate with Disabled People's Organization in lobbying government on enacting legislation on disability issues;
- To raise public awareness on disability issues, with a view of changing the negative attitudes towards disability issues;
- To liaise and collaborate with all relevant stakeholders concerned with disability issues to strengthen and co-ordinate their role in disability work;
- To promote activities and measures aimed at preventing disability;
- To promote education in early detection of disabilities in order to ensure early i intervention;
- To advise and make recommendation to government in maters relating to the full and equal participation of persons with disabilities in all aspects on Swazi society;
- To review current and emerging issues and policies at all levels of government affecting and concerning the status of persons with disabilities;
- To review the provision of funding , services and programs to persons with disabilities;
- To empower persons with disabilities through identification of income generation projects ;
- To perform any other functions that will advance the welfare of persons with disabilities.

Core Activities

1, Policy Development

The National Disability Unit will coordinate the development of the national disability policy. In addition the unit is expected to make inputs to other national policies in order to ensure that the interest of disabled people's incorporated.

2, Advocacy

The National Disability unit will undertake advocacy companies to increase awareness and understanding of disability issues. In addition, the unit is expected to address systemic and unilateral barriers that deny persons with disabilities, their rights and discriminate against them.

3, Monitoring and Evaluation

The National Disability Unit is expected to develop standards and tools for monitoring the performance of the support system with disabilities and disability programmes.

4, Research

The National Disability Unit will formulate a research agenda on disability issues and commission research studies as appropriate.

5, Training

The National Disability Unit is expected to asses training needs for various groups working with persons with disabilities, including health and social care givers in early detection and management of disabilities, sign language communication skills, parents of children who have disabilities on care giving skills, leadership and business management skills for disabled people's groups involved in income generation projects.

6, Resource Mobilization and Allocation

The National Disability Unit with other stakeholders is expected to formulate strategies for mobilizing resources, financial and others to cater for programmes and activities of persons with disabilities. The unit should also ensure that the resources are fairly distributed to organizations and institutions involved in disability work.

- Social Impact Assessment – has not been adequately carried out(study is limited to economic aspects). SIA is important for in-depth understanding of social issues in particular vulnerable groups, issues of employment opportunities, benefits, health, cultural and historical aspects.
- Traffic Impact Study – has not been considered to address impacts related to transporting of waste from transfer stations to land fill site and also from residents to transfer stations.

The review report for this project concluded that while NES appreciates the agency of the landfill the submitted documents lacks critical info for decision-making and the following issues were highlighted as conclusions and recommendations:

- The submission does not meet requirements for an EIS of a project of this magnitude.
- MCC and the Consultant to compile a plan of action and discuss it with stakeholders which include but not limited – consultation on specific issues, capacity building doe affected parties, feedback to public and stakeholders.
- Specialists with relevant experience should be engaged.
- Improve information exchange MCC and the Consultant, NES, other stakeholders.
- Prior to submission, MCC should own the document.

Conclusion

It is concluded that with this training the officer will be able to address the challenges alluded to in this report not only through lectures that shi will be receiving but also through information sharing and networking with nominees from other countries, thereby contributing to sustainable development objectives nationally and internationally.