Swaziland

KEY FACTS

Joined Commonwealth:	**1968**
Population:	**1,203,000 (2011)**
GDP per capita growth:	**1.8% p.a. 1990–2011**
GNI per capita:	**US$3,300 (2011)**
UN HDI 2011 ranking:	**140 out of 187 countries**
Life expectancy:	**49 years (2011)**
Under-five mortality rate (per 1,000 live births):	**104 (2011)**
Maternal mortality ratio – reported (per 100,000 live births):	**590 (2007–11)**
Maternal mortality ratio – adjusted (per 100,000 live births):	**320 (2010)**
Largest contribution to mortality:	**Communicable diseases, maternal, perinatal & nutritional conditions**
HIV prevalence rate for people aged 15–49 years:	**26% (2011)**
Government health expenditure:	**4% of GDP (2010)**

General information

The Kingdom of Swaziland is a small landlocked country in the east of Southern Africa, bounded to the east by Mozambique and elsewhere by South Africa. The country comprises four regions: Hhohho (in the north), Manzini (west-central), Lubombo (east) and Shiselweni (south).

Climate: The Highveld is near-temperate and humid, the Middleveld and Lubombo subtropical and the Lowveld near-tropical. Swaziland is one of the best-watered countries in southern Africa although, in common with the rest of the region, rainfall may be unreliable and periods of drought occur in the Lowveld – for example – in 2004–05. Summer (October–March) is the rainy season. There is occasional, short-lived frost in the Highveld and the Middleveld.

Environment: The most significant environmental issues are overgrazing, soil degradation, soil erosion, limited supplies of drinking water and depletion of wildlife populations by excessive hunting.

Population: 1,203,000 (2011); 21% lives in urban areas; growth 1.6% p.a. 1990–2011; birth rate 29 per 1,000 people (49 in 1970); life expectancy 49 years, having fallen sharply since the latter 1990s due to AIDS (48 in 1970, 59 in 1990 and 53 in 1997).

Swazis make up 90%; persons of other African, European or mixed descent 10%. Large numbers of Mozambicans fled to Swaziland to escape the civil war, but repatriation was completed in 1993.

Economy: Swaziland is classified as a lower-middle-income economy by the World Bank.

Mental health

Morbidity: There is a lack of recent data to suggest the most commonly diagnosed mental illness in Swaziland. Neuropsychiatric disorders contributed an estimated 4.5% of the global burden of disease in 2008.

Health systems: An officially approved mental health policy does not exist and mental health is not specifically mentioned in the general health policy. There is no mental health plan but dedicated mental health legislation has existed since 1978 when the Mental Health Order was enacted. Legal provisions concerning mental health are not covered in other laws.

According to the Swaziland Ministry of Health, all government hospitals and health centres offer mental health services. The Psychiatric Government Hospital, a government referral hospital, is another major provider of mental health care services. Between 2006 and 2011, the majority of primary healthcare doctors and nurses did not receive official in-service training in mental health.

There are 0.8 day treatment facilities and 12.5 beds in psychiatric hospitals per 100,000 people. There are no mental health

outpatient facilities in Swaziland and no community residential facilities (2011).

Health

Child and maternal health: Infant mortality in Swaziland was 69 deaths per 1,000 live births in 2011, with an under-five mortality rate of 104 deaths per 1,000 live births. As shown in Graph 1, there has been a decline in the under-five mortality rate since 2005. Prior to this, under-five mortality rate increased from approximately 83 deaths per 1,000 live births in 1990 to 128 deaths per 1,000 live births in 2005. Although the recent improvement is encouraging, the under-five mortality rate is not yet in line with the country's target of 28 deaths per 1,000 live births, as defined by Millennium Development Goal 4 (MDG 4). In 2010 the three most prominent causes of death for children below the age of five years were HIV (23%), pneumonia (4%) and prematurity (15%). Other contributory causes were birth asphyxia (9%), diarrhoea at (7%), and neonatal sepsis and injuries (both 5%). In the period 2007–11 Swaziland had a reported maternal mortality ratio of 590 deaths per 100,000 live births (this figure was estimated at 320 deaths per 100,000 by UN agencies/World Bank in 2010).

Burden of disease: Non-communicable diseases (NCDs) in Swaziland accounted for an estimated 28% of all mortality in 2008. The most prevalent NCDs in Swaziland are cardiovascular diseases, which accounted for 12% of total deaths across all age groups in 2008. Non-communicable variants of respiratory diseases, cancers and diabetes contributed 4%, 3% and 2% to total mortality respectively (2008).

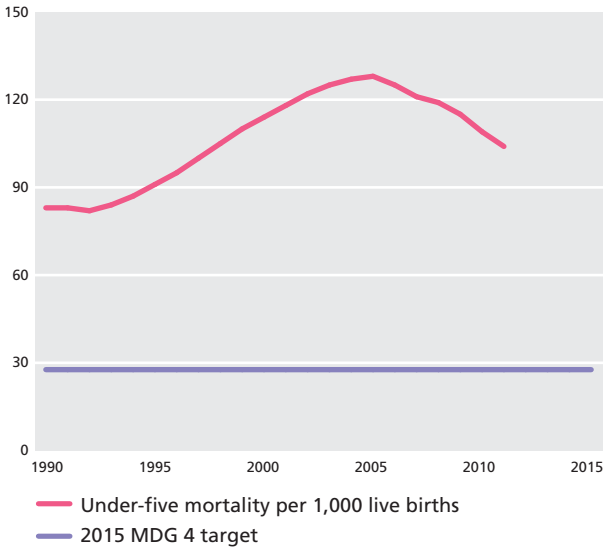
Communicable diseases along with maternal, perinatal and nutritional conditions in Swaziland accounted for an estimated 61% of all mortality in 2008. The prevalence of HIV in Swaziland, as a percentage of population aged 15–49 years, stood at 26% in 2011. HIV prevalence increased consistently in the period 1990–2005, following which the figures become more level but continue on an incline. In 2010 there were 147 reported cases of malaria in Swaziland. There has been a considerable fall in deaths from malaria as well as confirmed cases of malaria in the decade 2001–11. In the period 1990–2010, there was a great increase in the estimated incidence of tuberculosis (TB) in Swaziland, accompanied by an increase of around one-third in estimated mortality (when mortality data excludes cases co-morbid with HIV) from the disease. There were a reported 138 cases of rubella and 19 reported cases of cholera in 2009.

Health systems: Swaziland's public spending on health was 4% of GDP in 2010, equivalent to US$203 per capita. In the most recent survey conducted between 1997 and 2010 there were 16 doctors and 320 nurses and midwives per 100,000 people. Additionally, 82% of births are attended by qualified health staff (2007–12), and 98% of one-year-olds are immunised with one dose of measles (2011). In 2010 71% of the country's population was using an improved drinking water source and 57% had access to adequate sanitation facilities. The most recent survey, conducted in the period 2000–11, reports that Swaziland has six pharmaceutical personnel per 100,000 people.

Private expenditure on health accounted for some 36% of total healthcare expenditure in Swaziland in 2005. The country's main

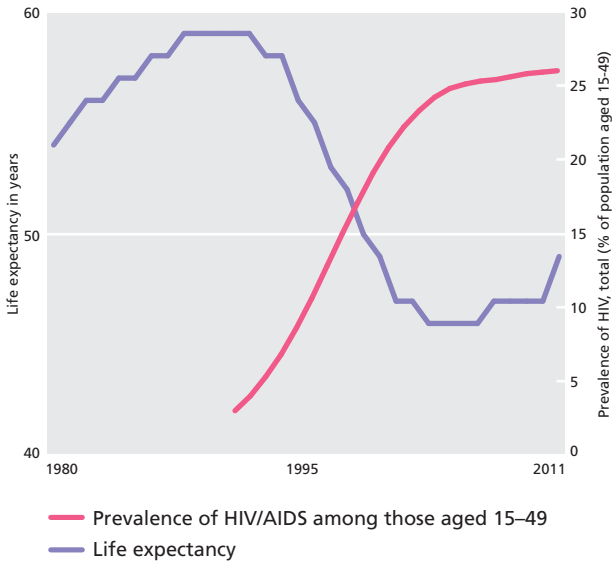
GRAPH 1

Under-five mortality



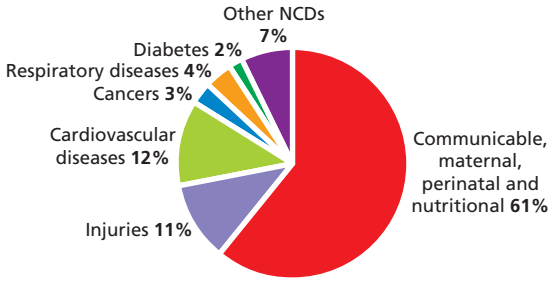
GRAPH 2

Life expectancy and HIV/AIDS



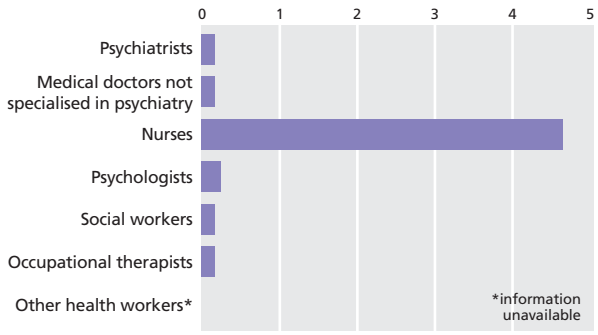
GRAPH 3

Mortality by cause of death (% of all deaths), 2008



GRAPH 4

Health professionals working in the mental health sector per 100,000 of the population



referral hospital is the Government Hospital in the capital, Mbabane. Health providers other than the government include faith organisations as well as private companies. Most pharmaceuticals are imported from countries such as India and South Africa. There is currently one pharmaceutical manufacturing company in Swaziland, producing a range of solid and liquid formulations.

Progress towards the 2015 health MDGs: Swaziland is currently working towards achieving the Millennium Development Goals. To achieve the targets for the reduction of child mortality, which forms MDG 4, Swaziland should reduce under-five deaths per 1,000 live births to 28, and increase measles immunisation to 100% by 2015. In 2011, under-five mortality stood at 104 deaths per 1,000 live births, and measles immunisation at 98%. As such, Swaziland is likely to achieve the target regarding measles immunisation by 2015. Given the current rate of progress in the under-five mortality rate, it is unlikely that Swaziland will meet this target by 2015.

The global MDG 5 target for maternal health is to reduce the number of women who die in pregnancy and childbirth by three-quarters between 1990 and 2015. When applying this target to Swaziland, the maternal mortality should fall to 75 cases per 100,000 live births. In the period 2007–11 Swaziland had a reported maternal mortality ratio of 590 deaths per 100,000 live births (this figure was estimated at 320 deaths per 100,000 by UN agencies/World Bank in 2010). Based on the data reported by the country, it can be seen that this target is far from being achieved. Part of the goal also stipulates that 100% of births must be attended by a skilled health professional. In the period 2007–12 this figure stood at 82%, so progress towards this target is also off track.

MDG 6 aims for a reduction in the prevalence of HIV, malaria and other diseases. It is encouraging that deaths from malaria have fallen in the period 2001–11. HIV prevalence in Swaziland was 26% in 2011 (in the 15–49 age group); not only is this figure extremely high but there has also been no reduction in prevalence of the disease since records began in 1990. Additionally, there has been an increase in the estimated incidence of, and mortality from, TB since 1990 (when mortality data excludes cases co-morbid with HIV). Accordingly, dramatic progress in these areas is required and the country is unlikely to achieve MDG 6 by 2015.

For definitions, sources and explanations on the Millennium Development Goals see page XXX.

Further information

Ministry of Health: www.gov.sz

Commonwealth Health Online: www.commonwealthhealth.org/health/africa/swaziland