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A Framework for a Coordinated Multi-Sectoral Approach

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August 2021

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WORLD BANK GROUP

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This Note was prepared at the request of the Government of the Kingdom of Eswatini as a guidance on how to ensure a coordinated and harmonized approach across key human development sectors in addressing low Human Capital Index (HCI) and in securing that all children grow up healthy, reaching their maximum learning and development potential. The objective is to first and foremost improve efficacy of existing programs and to ensure that programs "talk to each other". New programs should only be introduced where significant service delivery gaps hampering human capital formation are detected. The Note has already informed the design of the Health System Strengthening for Human Capital Development Project supported by the World Bank and is guiding the development of two forthcoming projects– the Early Childhood and Basic Education Development Project that will be jointly financed by the World Bank and the Global Partnership for Education (GPE) and the Technical and Vocational Education (TVET) and Youth Employability Project that will be supported by the World Bank.

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ACRONYMS

ANC	Antenatal care
ART	anti-retroviral treatment
CDS	cardiovascular disease
CGE	Center for Girls' Education
DPMO	Deputy Prime Ministers Office
ECD	Early Childhood Development
ELA	Empowerment and Livelihood for Adolescents
ESHEC	Eswatini Higher Education Council
FAO	Food and Agriculture Organization
GBV	Gender Based Violence
GDP	Gross Domestic Product
GNI	Gross National Income
GPE	Global Partnership for Education
HCI	Human Capital Index
IMCI	integrated management of childhood illnesses
LMIC	Lower-Middle Income Country
MIS	Management Information System
MoET	Ministry of Education and Training
NAMBoard	National Agricultural Marketing Board
NCD	Noncommunicable disease
NCP	Neighborhood Care Point
NEET	Not in Employment Education or Training
NERCHA	National Emergency Response Council on HIV and AIDS
NGO	Non-governmental organization
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care

PMT	Proxy Means Test
PNC	Postnatal care
RHM	Rural health motivator
SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
SACU	Southern African Customs Union
SDG	Sustainable Development Goals
SSA	Sub-Saharan Africa
SWAGAA	Swaziland Action Group Against Abuse
UNICEF	United Nations International Children's Emergency Fund
WFP	World Food Program
WHO	World Health Organization

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CONTEXT

1. ***Although classified as a lower middle-income country (LMIC) (with Gross National Income (GNI) per capita of US$ 2,960[1]), high poverty, especially in rural areas, food insecurity and income inequality (Gini coefficient of 49.3) challenge Eswatini's economic growth and human development potential.*** The national poverty rate fell only modestly between 2010 and 2017 (from 63 percent to 58.9 percent) and poverty incidence remains high in rural areas (70 percent) and in two regions (Lubombo and Shiselweni with poverty rates of 71.5 percent and 67.3 percent, respectively). Poverty affects all aspects of life including households' ability to invest in human capital development, with a high potential to have adverse life-long effects on individuals. Almost two thirds of the population are food insecure[2] with detrimental effects on pregnant women and children.

2. ***Economic growth has been slow, and as a result of the coronavirus, growth projections indicatefurther deceleration.*** Annual GDP growth rate declined from 3.2 percent in 2016 to 1.9 percent in 2017 and further to 0.2 percent in 2018.[3] The economy grew by 2.6 percent in 2019; however, following the onset of the COVID-19 pandemic, the economy shrunk by 3.3 percent in 2020 and growth projections for 2021 remain muted at around 1.4 percent.[4]

3. ***Preliminary estimates suggest that the COVID-19 pandemic may push poverty up in Eswatini.***[5] Job and income losses related to the lockdown imposed due to the COVID-19 pandemic are pushing many people into poverty. Estimates show that a 3-month lockdown may push an estimated 38,500 people into poverty, while in the case of a 6-month lockdown the estimates increase to 64,900 people. These correspond to a 3.5 percentage point and 5.9 percentage point increase in poverty, respectively. Average consumption loss estimates range from 6.3 percent in a 3-month shutdown to 10.6 percent in the 6-month case. The estimates suggest stronger impact of the pandemic on men and households in urban areas.

4. ***The National Development Strategy, Vision 2022 aspires to position Eswatini among the "top 10 percent of the medium human development group of countries".*** To this end, it aims to define a growth trajectory founded on sustainable development, social justice and political stability. However, progress to achieve this vision has been delayed and hampered by slow implementation, the 2010-11 fiscal crisis, 2015-16 drought and volatile transfers from the Southern African Customs Union (SACU). The COVID-19 related crisis is further hampering prospects for improved human capital outcomes.

5. ***The country's human capital potential is not fulfilled.*** The Human Capital Index (HCI) (a composite measure of survival of children under age five, educational attainment, and adult survival rate and stunting) is slightly better than the average scores for Sub-Saharan Africa (SSA) and LMICs (Table 1) (World Bank, 2018a, 2020a and Dulvy et. al., 2021). Eswatini's HCI score is 0.48, which indicates that a childborn today in Eswatini will only be 48 percent as productive when s/he grows up as s/he could be if s/he were to attain good health and complete available education by the age 18.[6] To meet the Vision 2022 target for human development, about a 10-percentage point increase is required from Eswatini's current HCI score, an impossible task to achieve in the remaining one year.

1 https://data.worldbank.org/country/Eswatini Atlas Method.

2 EHIES 2017; Word Bank 2020.

3 Budget Speech, Ministry of Finance, Government of Eswatini, 14 February 2020.

4 Real GDP growth estimates from the International Monetary Fund (IMF) obtained on August 9, 2021 from https://www.imf.org/en/Countries/SWZ#countrydata.

5 EHIES 2017; Word Bank 2020.

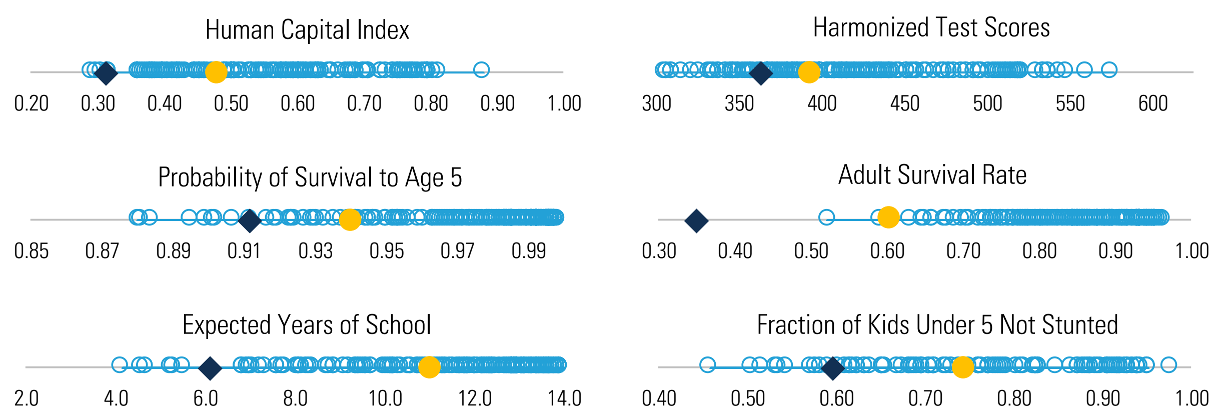
6 https://www.worldbank.org/en/publication/human-capital/brief/ insights-from-disaggregating-the-human-capital-index.

TABLE 1. Eswatini's Human Capital Index Performance, Benchmarked to Sub-Saharan Africa and Income Groups

HCI Components	Eswatini	SSA	LIC	LMIC	UMIC	High Income
Survival Probability of Survival to Age 5	0.94	0.934	0.92	0.96	0.98	0.99
Expected Years of School	11.0	8.1	7.8	10.4	11.7	13.3
Harmonized Test Scores	440	374	363	391	428	506
Survival Rate from Age 15-60	0.59	0.73	0.75	0.81	0.86	0.92
Fraction of Children Under 5 Not Stunted	0.74	0.68	0.66	0.73	0.87	0.94
Human Capital Index (HCI)	0.48	0.40	0.38	0.48	0.58	0.74

Source: World Bank 2020a for Eswatini HCI scores and World Bank, 2018a for comparators.

FIGURE 1. Eswatini's Score on HCI



Large circles and diamonds indicate scores for Eswatini in 2020 and 2010 respectively.

Source: World Bank, 2020, Human Capital Project.[7]

Note: Expected years of schooling and therefore the overall HCI score for Eswatini are preliminary, based on updated numbers presented in Dulvy et. al., 2021.

6. *Across the different HCI indicators, relative to other LMICs, Eswatini's performance is encouraging* (Table 1 and Figure 1). On average, it does equally or relatively better than comparators on expected years of schooling, harmonized test scores and stunting. However, it performs below other LMICs on survival rate of adults (0.59 compared to 0.81) and probability of survival to age 5 (0.94 compared to 0.96).

7. *Between 2010 and 2020, the HCI score for Eswatini increased from 0.31 to 0.48.* Figure 1 shows the change in the various components of the HCI for Eswatini as well as the comparison to other countries in the latest HCI scores (i.e., 2020). Significant improvements were achieved both in the health and education-related components of the HCI. While adult survival rate remains low in Eswatini (0.59), it has greatly improved from a very low point in 2010 (0.35). However, HIV/AIDS and other communicable diseases continue to pose challenge in the country and contribute significantly to the low adult survival rate– more than 1 in 4 adults between the ages of 15 and 49 are HIV positive in Eswatini, affecting

7 www.worldbank.org/humancapitalproject

men and women in their most productive years. The fraction of kids under 5 not stunted has increased from 0.60 to 0.74 between 2010 and 2020 and some improvement is also observed in the probability of survival to age 5. Expected years of schooling has improved from 6.1 years to 11 years over the past decade with some improvement in test scores. This shows the encouraging progress the country is making; however, there is a long way to go in order to ensure that all children and youth are position to use their full potential.

8. ***Eswatini invests significant public resources in education and healthcare, while, spending on social protection programs is low.*** Education accounted for the highest share of total public spending in 2018/19 at 15.2 percent (5.3 percent of GDP). In 2018/19, 10.1 percent of total public expenditure (3.4 percent of GDP) went to health. Government spending on social protection programs is equivalent to approximately 1 percent of GDP. This level of spending on social protection is low compared to other SACU countries. Given Eswatini's sluggish economic growth rate turned negative due to the COVID-19 crisis and unpredictable external support for human development sectors, the Government will need to think about innovative financing mechanisms and more efficient and integrated ways to deliver social services to the population, including by involving the private sector.

9. ***Upon taking office in 2019, the new Government of Eswatini (GoE) has committed to a 'turnaround strategy' to attainmacro-fiscal stability and growth, accompanied by improvements in human capital development.***[8] Recognizing the importance of human capital as a contributor to economic growth, in March 2019, the Government joined the group of countries as the 'early adopters' of the Human Capital Project (HCP). However, the onset of the COVID-19 pandemic is significantly impacting the Government's effort to accelerate human capital development. On March 17, 2020, Eswatini declared a state of emergency due to COVID-19. The ongoing health crisis broadly affects human development and the economy. The fundamental concern continues to be the urgent need to contain and curb the spread of COVID-19 infection (World Bank 2020a). Human capital is hit hard by the pandemic, with health, education, food security and household and government financing at risk (see Box 1: Impact of COVID-19 on Human Capital).

10. ***The Government recognizes that the cost of not acting could be detrimental and that an appropriate response to the pandemic includes multisectoral actions in addition to the immediate emergency response.*** The World Bank contributes to Eswatini's emergency response to the crisis through the COVID- 19 Emergency Response Project (P173883), which supports investment in health and water and sanitation and hygiene. Investing in human capital, including phase-two World Bank supported operations in health and education is needed for protection of human capital and recovery. Investing in human capital and improving the resilience of human development sectors is a smart insurance against future crises.

8 Kingdom of Eswatini Strategic Road Map (2019-22).

BOX 1 IMPACT OF COVID-19 ON HUMAN CAPITAL

COVID-19 affects human capital both directly and indirectly. In addition to the loss of life and productivity attributable to it, the pandemic poses risks to human capital through other pathways. First, by disrupting the provision of essential services (lifesaving and primary health services, education and community services), it could lead to additional loss of lives and pose a huge set back to hard-won gains in human capital. Second, containment measures affect livelihoods and food security, posing a risk to nutrition and reducing the ability of households to invest in human capital. In addition, supply disruptions could increase the price of perishable and nutritious foods, among others, posing a risk to child nutrition, adult and child survival, and human capital development. Third, isolation and quarantine-induced domestic violence and abuse could negatively affect children's brain development and women's well-being.

The disruption of health services due to COVID-19 may have significant negative impact on child mortality, maternal mortality and other cause-specific mortality. Under-five and maternal mortality may increase due to disrupted services. Moreover, disruptions in services for HIV, TB and malaria could lead to an increase in number of deaths.

The COVID-19 pandemic has disrupted schooling and is negatively affecting learning. School closures coupled with economic shocks will result in increased dropout rate and a loss in learning that will exact high economic costs in the long run– the developing world stands to lose between 3 to 8 trillion dollars according to initial conservative estimates. These numbers depend on how effective mitigation strategies are to offset any likely school dropouts and learning losses.

COVID-19 could also affect women's well-being and their human capital through increased Gender Based Violence (GBV) and disruption of critical health services. Women are at increased risk of Intimate Partner Violence due to isolation and potential increases in negative coping mechanisms in the household (e.g., excessive alcohol consumption). Moreover, many women may not have access to modern contraceptives. This will increase unintended pregnancies and adolescent fertility. As a result, girls may not come back to school after schools reopen, as was the case after the Ebola outbreak– when schools reopened, girls were 16 percentage points less likely to be in school.

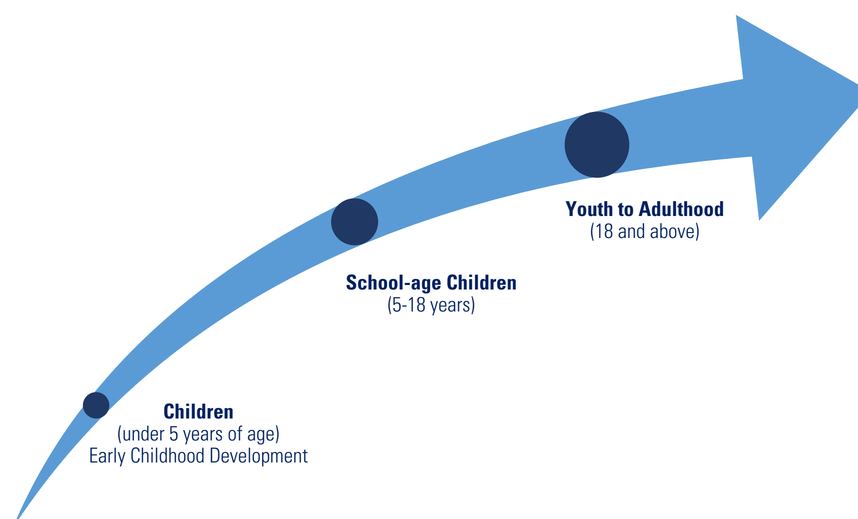
Source: Adjusted from the World Bank material. See: www.worldbank.org/humancapitalproject.

A HARMONIZED APPROACH TO BUILDING HUMAN CAPITAL IN ESWATINI

11. ***Improving human capital development outcomes requires a focus on improving social and economic outcomes for individuals from birth through adulthood***. Typically, and Eswatini is notan exemption, social services are delivered through dedicated government agencies, for quality and efficacy reasons. But the results suffer when programs and institutions work in silo, with littleto no coordination across institutions, agencies, and programs. Strengthening human capital outcomes requires a holistic response to the multiple and varying needs of individuals. That means enhancing the coordination of services towards a more individual-centered service delivery model, which is more flexible and harmonized across different sectors. It requires a change in the mindset and delivery of services in a manner that reflects the 'whole of government approach' by harnessing cross-sectoral synergies. This can entail, coordinated planning, the use of common targeting criteria and tools to reach vulnerable populations, sharingdigital platforms and developing interoperable systems to more effectively and efficiently manage and trace social service delivery.

12. This individual-centered and wholistic service delivery approach has to focus on providing a continuum of support at the different stages of life. This approach is described below by focusing on the three stages of an individual's ***lifecycle***: (i) Early Childhood); (ii) School Age; and (iii) Youth to Adulthood (see Figure 2). Across the three stages, the focus should be on ensuring that all children are entitled to and should receive a comprehensive package of services to ensure they are able to reach their full potential.

FIGURE 2. Life Cycle Approach to Human Development in Eswatini



EARLY CHILDHOOD (FROM PREGNANCY TO AGE 5)

13. ***Investing in young children is one of the best investment countries can make to accelerate human capital development.*** A child's earliest years present a unique window of opportunity to lay a sound foundation for their future. In the long term, this helps to address inequality, break the cycle of poverty, and improve a wide range of outcomes later in life. To fully benefit from future opportunities in life and become productive members of society, by the end of early childhood, young children must be healthy

and well- nourished, securely attached to caregivers and live in safe environment free from violence, able to interact positively with families, teachers and peers, and ready to learn throughout primary school and beyond (Denboba, 2014). Providing children with comprehensive package of services in the first years of life impacts childhood survival, early childhood development (ECD), learning abilities and educational outcomes in school, with long-term positive consequences for work productivity and economic development.

14. ***Addressing issues related to ECD outcomes, goes beyond health and education services.*** Children and their families need access to good nutrition, safe drinking water, sanitation, and hygiene;[9] and for poor households this means access to social assistance in the form of child support grants, school feeding, growth monitoring, and other social assistance and social care services. Education and health services are usually delivered through institutions such as ECD centers, schools, and health centers or via outreach workers such as rural health motivators. However, the role of the household in ensuring the child is properly fed, nurtured, and cared for, safe and protected, and stimulated to learn and grow is very important especially during the early years. Figure 3 presents a framework, adapted for the context, that summarizes key interventions that are essential for a child's survival, growth and development in the early years. These are not exhaustive and can be further customized to reflect Eswatini's current development challenges. Such a framework can be applied to trace the delivery of critical interventions that span across various ministries and service providers.

FIGURE 3. Critical interventions in the first five years

<table>
<tr><th></th><th>Pregnancy</th><th>Birth</th><th>6 Months</th><th>12 Months</th><th>24 Months</th><th>36 Months</th><th>48 Months</th><th>72 Months</th></tr>
<tr><td rowspan="4">Nutrition</td><td>Counseling on adequate diet during pregnancy</td><td rowspan="2">Exclusive Breastfeed-ing</td><td colspan="2">ComplementaryFeeding</td><td colspan="4">Adequate nutrition and safe diet</td></tr>
<tr><td>Iron-folic acid forpregnant mothers</td><td colspan="6">Therapeutic zinc supplementation for diarrhea</td></tr>
<tr><td></td><td colspan="7">Prevention and treatment for acute malnutrition (moderate and severe)</td></tr>
<tr><td colspan="8">Micronutrient: supplementation and fortification</td></tr>
<tr><td rowspan="8">Health</td><td>Quality Antenatal Visits</td><td>Quality Post-natal Visits</td><td colspan="6" rowspan="2"></td></tr>
<tr><td></td><td>Skilled and quality Delivery</td></tr>
<tr><td></td><td colspan="4">Immunization</td><td colspan="3"></td></tr>
<tr><td></td><td colspan="2"></td><td colspan="5">Deworming</td></tr>
<tr><td></td><td colspan="7">Integrated Management of Childhood Illnesses (IMCI)</td></tr>
<tr><td colspan="8">Quality Family Planning and Sexual Reproductive Health (including Youth/Adolescent friendly Services)</td></tr>
<tr><td colspan="8">Coverage of Quality Healthcare Services</td></tr>
<tr><td colspan="8">Prevention and treatment of parental depression</td></tr>
</table>

9 All Hands on the Deck: Reducing Stunting through Multisectoral Efforts in Sub-Saharan Africa. World Bank.

	Pregnancy	Birth	6 Months	12 Months	24 Months	36 Months	48 Months	72 Months
Water, Sanitation and Hygiene	Access to safe water							
	Adequate sanitation							
	Hygiene / Handwashing							
Education	Maternal education							
	Education about early stimulation, growth, and development							
	Continuity to quality primary education				Early childhood and preprimary programs			
Social Protection		Birth Registration						
		Parental leave and adequate childcare						
	Child protection services							
	Social transfer programs							

Source: Adapted by the authors based on Denboba et al. 2014.

15. ***Eswatini is performing better in terms of child survival compared to other countries in SSA but does not do as well as other LMICs.*** Improving early childhood outcomes and accelerating progress toward the health SDG targets requires increased and targeted investments, if the country is to meet its goals. Table 2 below shows some indicators on children's health outcomes and their access to ECD services, benchmarked against averages for SSA and LMIC. While stunting in children below the age of five is lower than in SSA and LMIC, it is still high, as one fourth of young children are stunted. As stunting compromises overall child development, in the long run it reduces their potential for gainful employment and productivity and to contribute to the socio-economic development of the country.

TABLE 2. Status of early childhood survival, growth, and development outcomes in Eswatini

ECD Indicators	Eswatini	Average for SSA	Average for LMICs	SDG Target (2030)
Neonatal mortality (within the first 28 days)	17.4/1000 live births	27.7/1,000 live births	24/1,000 live births	12/1,000 live
Infant mortality (0-24 months)	40.8/1,000 live births	53/1,000 live births	37/1,000 live births	
Under- five mortality	53.9/1,000 live births	78/1,000 live births	49/1,000 live births	25/1,000 live birth
Fraction of children under 5 who are stunted	25.5%	34.0%	31.5%	40% reduction in number of children U5 stunted
Access to ECD services (Gross Enrolment Ratio (GER) for ECD)	29.0% in 2014[10]	26.0% in 2018	37.5% in 2018	

Source: Eswatini Household Income and Expenditure Survey 2017 and World Bank Open Data (accessed Feb 2019); ECD data from UNICEF 2019

16. Neonatal mortality, which accounts for a third of total under-five deaths, is related to problems with pre-natal maternal health and nutrition status, the quality of care of antenatal care (ANC) services, access

10 MICS, 2014.

to quality skilled delivery, and postnatal care (PNC) services, and challenges to manage the health of mothers and babies through the continuum of care. Infant mortality (0- 24 months) is largely related to low birth weight, poor nutrition in the first 1,000 days of life (Heckman and Masterov, 2004; Shekar et al. 2017), as well as the quality of integrated management of childhood illnesses (IMCI), both in hospitals and in the communities.

17. ***Teenage pregnancies are also a significant factor that adversely affect human capital accumulation.*** While the adolescent fertility rate has declined in recent decades, at 77 births per 1,000 girls (World Bank, 2017), it remains very high; it is more than double the rate observed in South Asia, for example. Up to 30.0 percent of all pregnancies in Eswatini are among adolescents.[11] In addition to its negative impact on girls' education (as many as two thirds of girls who drop out of secondary education in Eswatini do so as a result of pregnancy) and the consequent risk of HIV, teenage pregnancy significantly contributes to maternal and child morbidity and mortality and to vicious intergenerational cycles of poor health and poverty. Adolescent girls who become pregnant are more likely to be socially isolated and suffer from depression.[12] [13] They are less likely to attend ANC (67.0 percent attend 4 visits versus 84.0 percent of women ages 35+ years).[14]

18. ***Infants born to adolescent mothers are more likely to be born preterm, have a low birth weight,and die as an infant compared to infants born to older mothers.***[15] [16] Infants born to adolescent mothers are also more likely to grow up in an unsupportive home environment, have poor cognitive development, drop out of school, be unemployed or underemployed, and if female, become pregnant in their adolescence, thereby cementing the perpetual inter-generational poverty cycle.[17] [18] [19]

19. ***Diarrhea is currently the most significant cause of death of children under 5 years in Eswatini***, accounting for nearly 20 percent of all deaths of children under 5 years, mostly attributable to malnutrition, poor hygiene and sanitation and unsafe water source.[20] Evidence suggests that periodic diarrhea impairs childhood growth and contributes to increased risk of subsequent infectious disease episodes with greater severity.

TABLE 3. Rates of Access to Improved Water Supply and Sanitation

	Urban	Rural
Access to improved sources of drinking water	95.8	63.4
Access to piped water on premises	95	28
Access to improved sanitation	47.5	55

Sources: Multiple Indicator Cluster Survey, Central Statistics Office, 2014 and Aguaconsult: Swaziland Rural Water SustainabilityStudy, 2015

20. ***The most important location where the young child is supported is the home where parents, caregivers, and other adults and children interact with the young child.*** Children living in poor and vulnerable

11 Bruni et al. 2016.

12 Depressive symptoms and birth outcomes among pregnant teenagers. Hodgkinson, S.C., et al. 16-22, s.l.: J. Pediatr. Adol. Gynecol. 2010, Vol. 23.

13 Teenage Pregnancy and Mental Health. Corcoran, Jacqueline. 21, s.l.: Societies, 2016, Vol. 6.

14 MICS, 2014.

15 Teenage mothers and the health of their children. Botting B, Rosato M, Wood R. 19-28, s.l.: Population Trends., 1998, Vol. 93.

16 WHO. Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000–2015. Geneva: WHO; 2016.

17 Teenage mothers and the health of their children. Botting B, Rosato M, Wood R. 19-28, s.l.: Population Trends., 1998, Vol. 93.

18 World Bank. 2016.

19 https://youth.gov/youth-topics/pregnancy-prevention/adverse-effects-teen-pregnancy.

20 Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington, 2016. Available from http://vizhub.healthdata.org/gbd-compare. (Accessed October 25, 2018).

homes and with parents and caregivers with lower levels of education often do not have the same pre-conditions for being able to learn and grow. Therefore, support to poor households to help them invest in their young child's development is necessary already at an early age. Social protection services, not just cash transfer programs, but programs which also help provide awareness and stimulate and enable behavioral change for parents and caregivers to adopt practices associated with improved nutrition, sanitation, health seeking behavior, antenatal care, early childhood stimulation etc., have been shown to have positive impacts on the development ofyoung children.

21. In terms of access to ECD services, key entities involved in delivering these services inEswatini include:
    (i) Nutrition: The Ministry of Agriculture, Ministry of Tinkhundla, Ministry of Education and Training, Ministry of Health, National Emergency Response Council on HIV and AIDS (NERCHA);
    (ii) Health: Ministry of Health;
    (iii) Water and Sanitation: Ministry of Natural Resources, Eswatini Water Services Corporation and Ministry of health (Environmental Health Department);
    (iv) Education: Ministry of Education and Training;
    (v) Social Protection: Ministry of Home Affairs, Deputy Prime Minister's Office.

22. In addition to these, there are several private providers and development partners (United Nations International Children's Emergency Fund (UNICEF), World Food Program (WFP), World Health Organization (WHO) for example) and local non-governmental organizations (NGOs) supporting early childhood development services across Eswatini. There is also an extensive network of community platforms (e.g., Rural Health Motivators) that have been successful in the delivery of basic services to the most vulnerable populations in Eswatini.

23. The mandate for coordinating human capital development in early childhood across the country falls under the Deputy Prime Ministers Office (DPMO). The service providers use several service locations to deliver services for children such as Neighborhood Care Points (NCPs); KaGoGo Centers ("Grandmother's house"); health care centers; Grade 0 classrooms in 80 primary schools with a plan to expand to another 100 schools; private ECD centers; community ECD day-care and pre-schools; as well as delivering some services at a child's home. Below is a description of the various service platforms providing ECD services:

- **Neighborhood Care Points (NCPs): under the Ministry of Tinkhundla**. NCPs were initially created to support families dealing with the HIV/AIDS crisis, as well as orphans and vulnerable children. They are staffed with volunteer caregivers on a rotational basis and supported by the local community as well as NGOs and Partners (UNICEF, NERCHA, WFP). The local community falls under Chiefdoms (*Imiphakatsi*) which are responsible for mobilizing resources such as food, volunteers, building structures, cooking tools, toys/books etc. for both NCPs and KaGoGo centers. Building on the strong tradition and history of communities working together, Chiefdoms are supposed to mobilize communities to take ownership and responsibility for the most vulnerable families and children. They are an organized and recognized structure at the local level that receive information on the needs of community members in a timely manner and can move quickly to address to them.

- There are an estimated 1,800 NCPs in Eswatini. The WFP provided feeding for 52,300 children (in 2019) between the ages of 2-8 years old in about 1,700 of these sites; the Government of Taiwan feeds children in a further 30 NCPs and there are multiple NGOs providing servicesin some NCPs (the last is undocumented). In 2016/17, the program reached 8 percent of households. NCPs have evolved and are now also providing ECD services to the local communities. WFP is currently working with 50 primary schools on a home-school feeding program of which, nine schools have a Grade 0 classroom. In some of these schools, there has been a seamless integration of children who are 5 years old in the NCP to transition to the Grade 0 classroom. This collaboration between WFP and NCPs was driven by the local community so that volunteers could servechildren under 5 years of age in both the NCPs and the primary school.

- **KaGoGo centers (Grandmother's house) under NERCHA:** These centers, built and managed by communities, are administered by the NERCHA. Traditionally KaGoGo centers were created to serve as local meeting areas for thecommunity, but with the growing HIV/AIDS crisis, these centers became a safe space for orphans and vulnerable families. Like NCPs, KaGoGo centers are staffed with volunteers and resources are allocated by the Chiefdoms and community members. KaGoGo centers feed and provide ECD services for the children in the community.
- **Primary Health Care (PHC) Facilities:** Approximately 224 PHC facilities can provide health andnutrition services to all children. Rural Health Motivators (RHMs) are assigned households to visit every month in their specific communities. They serve as a first point of entry for healthcare and nutrition services (growth monitoring) for many households. Overall, health workers and RHMs can provide health, nutrition and early stimulation services for children under two, pregnant women, and new mothers.
- **Grade 0 in 80 schools:** The MoET provides education services (since 2019) and school feeding (since 2020) for 5-year-old children in 80 schools in Eswatini, with a plan to expand into 100 additional schools. Enrolment numbers are not yet available for these classes and not all classes are fully prepared to serve Grade 0 students in terms of classroom infrastructure (appropriate ventilation, tables/chairs), learning material, trained teachers, books and play areas.
- **Private ECDE centers:** These are numerous privately run centers in the country. However, data on the numbers of centers and children enrolled as well as the type and quality of services provided at these centers is not collected regularly.
- **Community pre-schools and day-care centers:** These centers are run by communities. The numbers of centers and children enrolled are unclear as data is not collected regularly.

24. Across these service provision locations, there is insufficient information on where these programs are located, what specific services are offered, the costs of service provision and their impact on children.

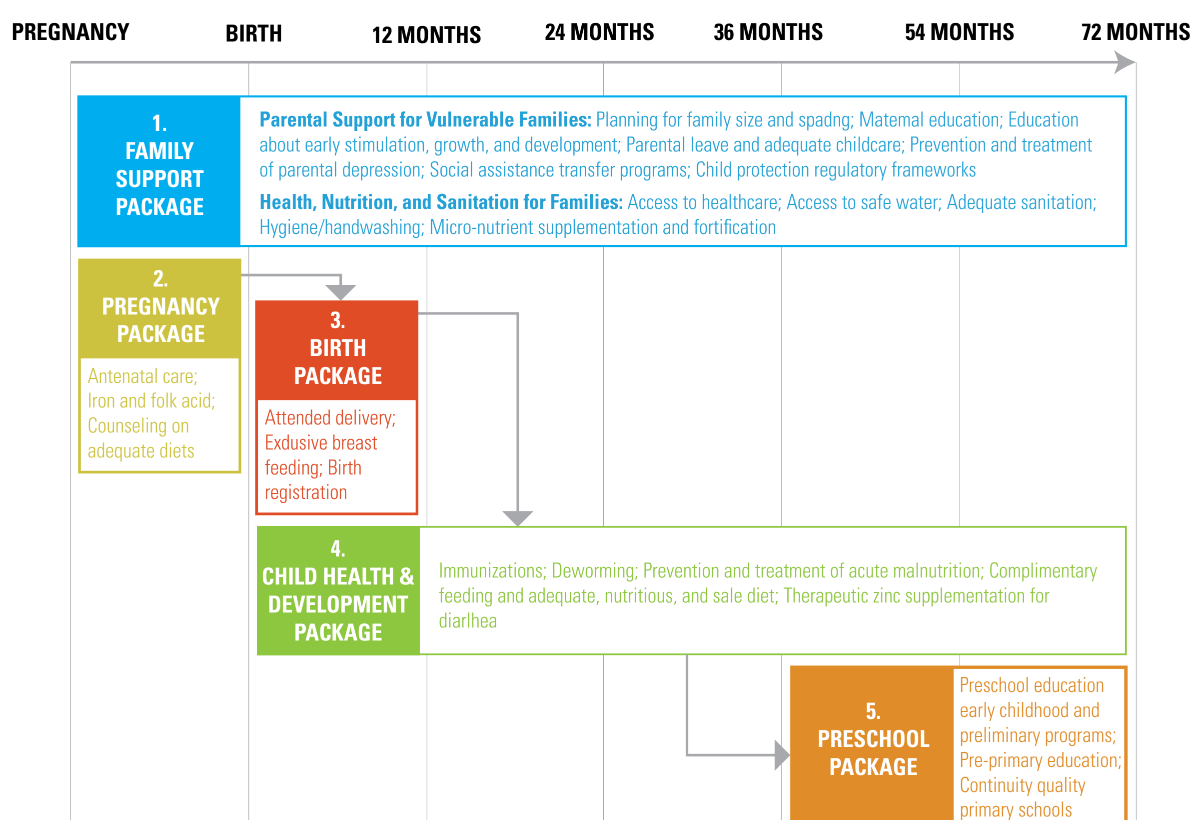
BOX 2 Emergency food aid and disaster risk financing to support children and families

The government offers emergency food aid during periods of drought (a recurrent, common, adverse shock in Eswatini), which can help in protecting the health and nutrition status of children. Implementation of the emergency food aid includes identification of food-insecure households based on several criteria jointly applied by community leadership, local government authorities, and partnering NGOs. These targeting criteria include food-insecure households that are child-headed, have orphans, have children under age five, or have pregnant or lactating mothers. In response to the last drought emergency in 2015/16, food aid by the government in 2016/17 reached over 70 thousand households, with further outreach through direct food and cash assistance by international donors. However, these food aids are mainly cereal, and protein based and lack the essential micronutrients from fresh fruits and vegetables.

25. ***Moving forward, Eswatini should consider the package of services it can offer to children to address their varying needs.*** One way to think about it is around various packages of services (based on priority interventions) offered at different stages of a child's life as depicted in Figure 4 below. This framework, developed by Denboba et al. (2014), describes the integrated package of services to be provided to children and their families from pregnancy through 5 years of age. Introducing a "follow- the-child" system whereby the various services and supports provided to children and youth (especially those from poor households) – from pregnancy to adulthood – are linked and tracked would be important. An integrated information management system linking various services, agencies and providers with an application for local service providers to monitor the services which reach the child at each age would improve the coordination of local service delivery.

26. ***The first step would be for the Government of the Kingdom of Eswatini to define the intervention packages (using cost-effectiveness criteria) to be delivered to children.*** This will entail identifying the responsible public and private implementing entities, the point of service delivery, how multiple services can be integrated and co-located to be more cost-efficient and effective, and how outcomeswill be monitored. This will also require mapping existing services, identifying gaps and detecting barriers for higher access and efficacy. As described above, currently services are delivered by various government agencies and a multitude of service providers. Developing a practical coordination and monitoring mechanism – from the local to the national level, underpinned by an integrated information system,would improve not only the quality of service delivery, but also their efficacy.

FIGURE 4. Integrated Package of Services for children and households with children under 5



Source: Denboba et al, 2014

SCHOOL AGE CHILDREN (AGE 6-18)

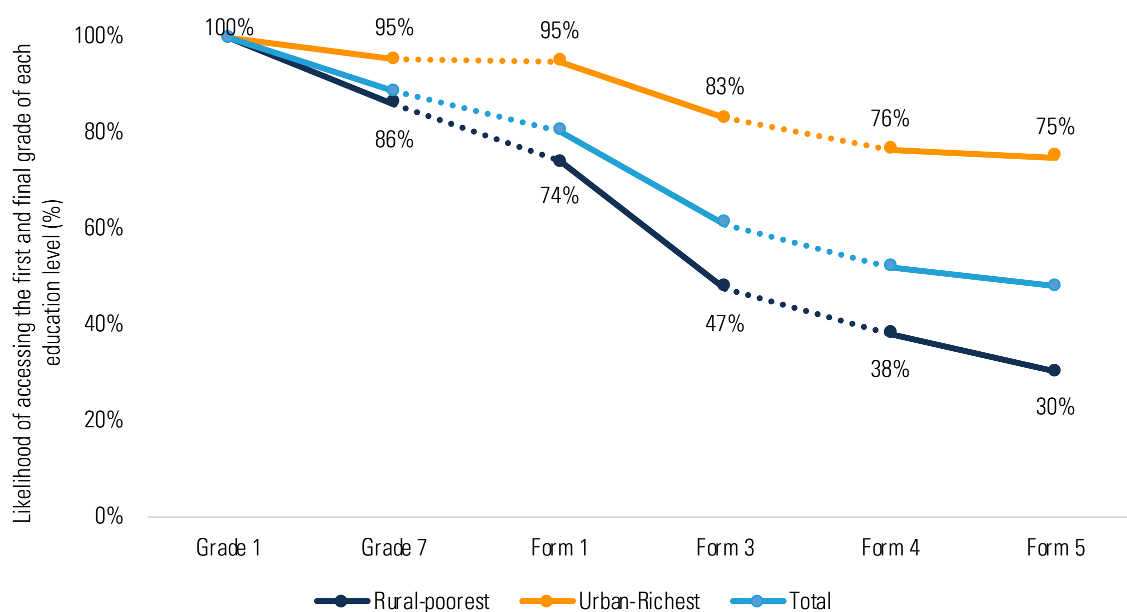
27. ***There are two major issues that need to be addressed during the period when children are in school in Eswatini***. *First*, the retention of children through the end of at least lower secondary education must be improved. *Second*, the overall quality of education needs to improve, so that students leave the education system with strong foundational skills and higher level of cognitive and non-cognitive/ soft skills (such as problem-solving skills, working in teams, and communication skills).

28. *Children in Eswatini are supposed to enroll in primary school at the age of 6. Primary school is seven years, followed by three years of lower secondary and two years of upper secondary school* (a total of 12 years). While access to the first year of primary school (Grade 1) is almost universal in Eswatini (see Figure 5), *children start to drop out of school in lower secondary particularly in Form 2*. The figure below shows that only 61 percent of those who start school in Grade 1 complete lower secondary

education and only 48 percent complete upper secondary education. Repetition rates are also high at 18 percent in primary education and 16 percent in secondary education leading to high level inefficiency in the education system (MICS, 2014).

29. **There are stark disparities between the rural poor and the urban rich, with rural poor children being the most disadvantaged in terms of access and completion at each level of education.** About 74 percent of students from the poorest rural households enroll in the first grade of junior secondary and only 47 percent reach the final grade of junior secondary. In comparison, about 95 percent of children from the richest urban households enroll in junior secondary with 83 percent reaching the final grade. The sharp drop in student retention and the disparities persist into senior secondary grades with only 30 percent of students from the poorest rural households reaching Form 5, the final grade in senior secondary education, compared to 75 percent of the richest urban children.

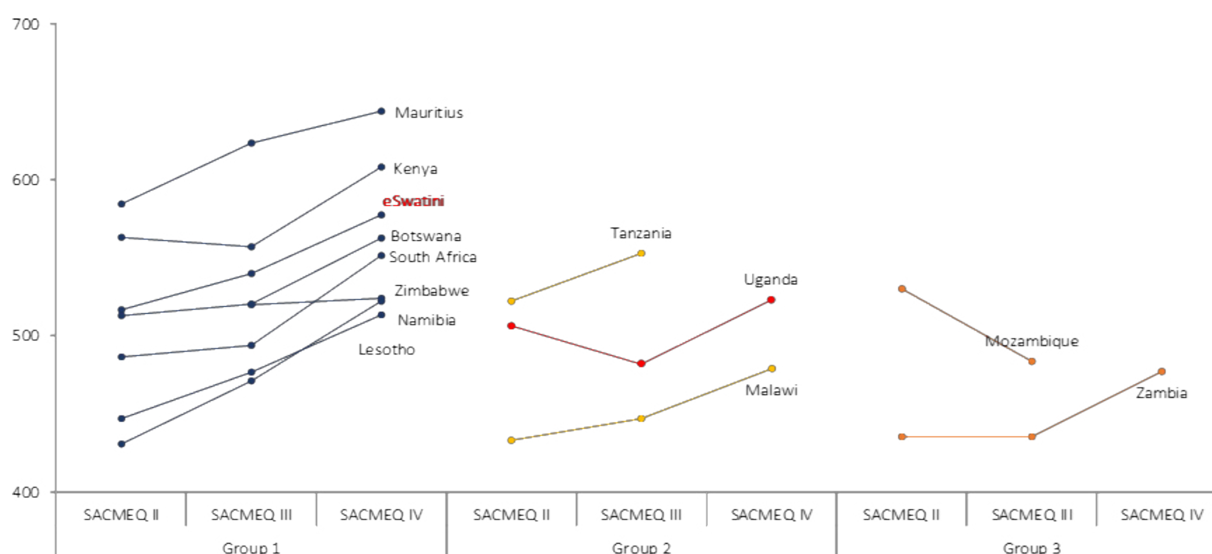
FIGURE 5. Schooling profile for the most disadvantaged and most advantaged groups



Source: Dulvy et. Al., 2021- Eswatini Education Sector Analysis.

30. ***In terms of learning, Eswatini does better than many of its neighbors in Southern Africa and performance has been improving over the years*** **(Figure 6),** ***but learning levels are still lower thanwhat one would expect for its income level***. In the figure below, Eswatini is classified as a "Group 1" country: this group is comprised of most of the SSA region's middle-income countries where population growth rates are relatively low. These countries have universal primary enrollments andhave made major strides towards universal lower-secondary enrollments. In addition, countries inthis group also participate in regional and international assessments, reflecting their growing interest in student learning and building the knowledge capital required for economiccompetitiveness.

FIGURE 6. SACMEQ Mathematics Scores



Source: Bashir et al, 2018

31. ***The Southern and Eastern Africa Consortium for Monitoring Educational Quality - SACMEQ IV results reveal that learners in Eswatini achieved a mean reading score of 570.1, which is higher than the SACMEQ IV average of 513.3.*** The data suggests that 95 percent of grade 6 learners in thecountry reached a level of competence to be able to undertake interpretive reading i.e., Level 5, but there are far fewer grade 6 learners who are able to read at higher levels (analytical and critical readers). Grade 6 learners in Eswatini obtained an average mathematics score of 577.6,higher than the SACMEQ IV average of 523.5. Most learners operate at Level 4 in relation tocompetency i.e., beginning numeracy, but the proportion of learners reaching higher orders ofcompetence i.e., problem solving and abstract problem solving is much lower.

IMPROVING RETENTION IN SCHOOLS

32. ***Addressing the issue of retention is complex and requires cross-sectoral interventions which support a child through her/his journey in school.*** To help think through the types of interventions that are needed, one ought to consider the causes of poor retention in school. They can be broken into three categories: (i) demand-side barriers, such as the direct cost of going to secondary school,the high opportunity cost of going to school (for example, a higher return derived from labor market participation), and family and health issues, such as malnutrition, anemia and overweight/obesity,HIV/AIDS (HIV incidence and prevalence was found to be almost four times higher among those outof school) and the adolescent fertility socio-cultural norms and gender roles and perceived stereotypes (see discussion above and Box 3); (ii) supply-side barriers related to a lack of supply of good quality junior secondary education, and (iii) structural barriers such as the high stakes nature of national examinations at the end of primary and lower secondary along with the high rates of repetition in the grades preceding the national examination.

BOX 3 Protecting Women and Girls in Eswatini

Eswatini has made legislative reforms in recent years to further the promotion and protection of women and girls' rights. In August 2019, the Eswatini High Court ruled that the common law doctrine of marital power (giving a husband the ultimate decision-making power over his wife and the matrimonial property) is unconstitutional as it discriminates against women and denies their constitutional right to equality. The ruling builds on Eswatini's ongoing law reform process that included the passing of the Sexual Offences and Domestic Violence Act of 2018, which provides a framework to curb sexual and gender-based violence in the country. In 2018, the Election of Women Act was also enacted, designed to fulfill the constitutional requirement for quotas for the representation of women and marginalized groups in parliament.

But the situation for girls and women in Eswatini remains fragile. According to a 2018 national study, 48 percent of girls and women between the ages of 13 to 24 reported having experienced some form of sexual violence, with 1 in 3 girls experiencing some form of sexual violence before the age of 18 (Reza et al. 2009). In a country with the highest HIV/AIDS prevalence in the world, GBV is one of the key contributors to new HIV infections. According to the 2018 Income and Expenditure Survey, 40 percent of girls drop out of junior secondary education because they become pregnant. The lower levels of education of girls in Eswatini translates into fewer opportunities for employment and is confirmed by the lower female employment rate (58 percent) compared to the male employment rate (70 percent) in 2018.21

Addressing issues related to empowerment of women and girls is critical in accelerating the demographic transition in Eswatini. Keeping girls in secondary school must be a priority for African countries, including Eswatini. Well-educated girls have better health outcomes and substantially higher earnings in adulthood. They are less likely to have children before they are ready to do so and tend to have fewer children over their lifetimes. Well educated girls are also less likely to marry as children or to suffer from a lack of household decision-making power and from intimate partner violence. In addition, well-educated mothers are better equipped to support the optimal development of their children in the early years, as well as their own transition into adulthood. This leads to intergenerational benefits that influence the long-term development of societies.

Globally, there have been several interventions to address constraints for girls to stay in schools and the most effective interventions are formal and informal programs targeting girls (and their parents and communities) and linking them with female role models or mentors and providing safe learning environments. Experience from other countries shows that interventions such as the Girls Clubs established in secondary schools by the Center for Girls' Education (CGE) in northwestern Nigeria or the Empowerment and Livelihood for Adolescents (ELA) program in Uganda, Tanzania and other countries have not only shown success in delaying marriage and pregnancy but have also had an impact on girls being empowered to redefine and expand on the social limits of what is seen as possible for girls.

There are also interventions that support the provision of financial incentives (both conditional and unconditional) that have proved to be an effective strategy in increasing school attendance for girls and boys. A recent meta-analysis of 50 studies on the impacts of cash transfer programs, 38 unique programs from around the world (8 in the Africa region) suggest consistently positive effects of cash transfers on enrollment and attendance (Snilstveit et al. 2015). The analysis also suggests that there is a reduction in dropout rates as well as an average improvement in school progression and completion rates.

21 http://datatopics.worldbank.org/gender/country/eswatini

33. ***Social assistance support:*** ***On the demand side barriers, lower secondary school is not free and school fees and other costs (uniforms, transportation, books) may prohibit access for children from poor households.*** To address this issue, the Government of Eswatini is implementing a program called Orphans and Vulnerable Children (OVC) Education Grant. The program is providing grants paid out to government secondary schools to defray tuition and exam fees of beneficiary orphans and vulnerable children. It covers about 50,000 children (See Box 4 for more information on OVCs in Eswatini).

BOX 4 Orphans and Vulnerable (OVCs) Children in Eswatini

Even with the provision of free anti-retroviral treatment (ART), more than 1 in 4 adults between the ages of 15 and 49 are HIV positive in Eswatini, affecting men and women in their most productive years. HIV epidemic in Eswatini has resulted in a generation of children without parents and many children today are heading up households or living with grandparents or community caregivers. Most households headed by Orphans and Vulnerable Children (OVC) live in extreme poverty, since no one in the household can work.

The precise number of OVC children in Eswatini is not known. Estimates vary widely: WFP reports that 58 percent of all children in Eswatini are OVCs, while UNICEF estimates indicate a much larger challenge with nearly 71 percent of all children (403,745) being OVCs. Similarly, their socio-economic situation is not well studied, although some evidence on their precarious situation and deprivation has emerged.

- Food shortages are among the major deprivations experienced by child headed households, leading to poor nutrition. (Earnshaw, Njongwe, English, & Worku, 2009; Fielding-Miller, Dunkle, & Murdock, 2015; UNICEF, 2009).
- OVCs are less likely to be in school compared to other children. Girls are impacted more since they are usually asked to be the caretakers of younger siblings.
- OVCs are more likely to drop-out of primary school and lack close relationships with their caregivers (Pufall et al., 2014; Ssewamala et al., 2016).
- OVC children who enter secondary school are less likely to be in the correct age-for-grade and often have poor attendance, which further hampers their education (Pufall et al.,2014).

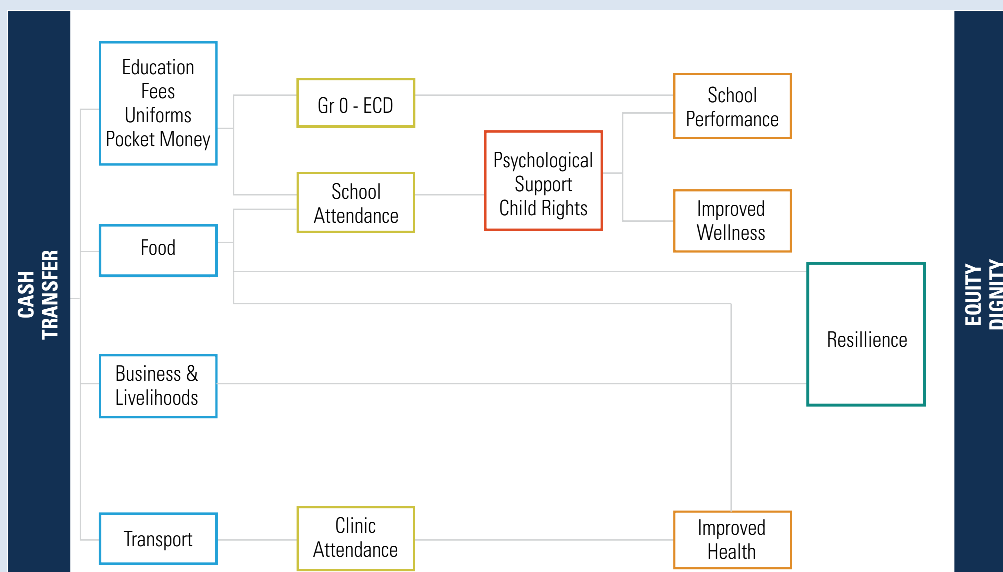
34. **In 2016/17, the OVC grant program reached about 11 percent of all households.** In terms of potential concerns, a share of program beneficiaries continues to pay tuition and exam fees and the program does not cover other, non-trivial costs of schooling such as transportation to school and uniforms. Addressing these concerns can help strengthen the education impacts of the program on orphans and vulnerable children. A project, supported by the World Bank and the European Union, which focused on supporting OVCs on a pilot basis showed promising results, including impact on human capital formation and innovations at the system level (see Box 5).

BOX 5 OVC Cash Transfer Pilot

The Health, HIV/AIDS and TB Project (P110156, closed on September 30, 2018) was the first World Bank engagement in human development in Eswatini. The Project supported interventions in health and social protection, with focus on orphans and vulnerable children (OVC) and pregnant women (World Bank, 2018 b).

Under the Project, a cash transfer program to OVC was piloted. 15,290 OVC benefited from this unconditional cash transfer with co-responsibilities in health and education monitored). The *impact evaluation* of the pilot found statistically significant effects on indicators for social protection (savings, shock resilience), education (school enrollment), and health (care seeking, nutrition, infant weight). The Project introduced innovations in targeting, including the Geographic, Community, and Proxy Means Test (PMT) targeting mechanism, and an e- Payment platform (MTN Mobile Money), which was also adopted by several partners to deliver their programs. The MTN Mobile Money has unintended impact beyond the beneficiaries of the cash transfer as it boosted business opportunities in communities. At the system level, the OVC pilot resulted in a modularly expandable Management Information System (MIS) to improve the management of the cash transfer. The pilot induced households to apply for the national ID (unique person identification number, PIN).

While the pilot program was discontinued when the Project closed, it provides valuable lessons, should the Government of Eswatini decide to introduce such a program, for example to support orphans/ child headed households.



Sources: Orphans and Vulnerable Children Cash Transfer Program (OVC-CT) Deputy Prime Minister's Office and the World Bank, 2018 Impact Evaluation End-line Results September 2018; World Bank, 2018 c. Implementation Completion and Results Report: Swaziland Health, HIV/AIDS and TB Project (Report No.: ICR4723, March 2019).

35. ***School feeding can positively influence school participation and retention, as suggested by international evidence***. The government's *school feeding program*, which provides free cooked lunches to government primary school students, relaxes constraints on intra-household food allocation, which may enhance the health and nutrition status of younger siblings. The extent to which these effects for younger siblings materialize, depends in part on the program implementation performance. This program covered about 360,000 students in government primary and secondary schools in the 2019 school year. In 2016/17, the program reached about 40percent of households. The performance of the program in influencing education, health, and nutrition outcomes at the individual and household levels

can be strengthened by addressing several shortcomings. The issues include inadequate government financing to procure the required quantity of food commodities, officially stipulated nutrition content of food rations that are lower than international standards, delays in fund releases and procurement, and delays in the availability of food commodities at schools for the program due to transportation failures. ***Other programs to support girls and boys to stay in schools:*** ***Supporting children from poor households in rural areas is an important priority that can be addressed through well designed and implemented social assistance programs***. But there are gender norms and cultural and social factors that drive differences in access to education that also need to be addressed. Aside from cash transfers that can support attendance, there are social and behavioral programs for girls and boys that have shown to have success in supporting children and youth to stay in school. Cash transfer programs can also be branded as stipends for progressing in schools and transitioning to the labor market whereby the student (and their family) receives a small cash reward to help the student start their own economic activity or participate in labor market activation and training programs once he or she has completed secondary education.

36. ***In Eswatini, there are regular life skills programs delivered in schools as part of the curriculum.*** In addition, there are several schools that have Girls Clubs and some Boys Clubs in both primary and secondary schools that are run by an NGO called Swaziland Action Group Against Abuse (SWAGAA). The Girls Clubs focus on discussing issues such as violence (including GBV), HIV, sexual reproductive health, children's rights, leadership, gender roles and behaviors. The Boys Clubs work to mentor and inspire boys to adopt positive and transformative gender attitudes, practices and norms. While these initiatives are in place, there is a need to also engage with parents and community leaders to encourage and sustain these positive behaviors. There is also a need to document lessons from specific programs/schools that have been successful at reducing pregnancy and HIV transmission and establishing specific guidelines for Girls/Boys Clubs that can be scaled up across schools in Eswatini. Eswatini is experiencing a growing problem of substance abuse (cannabis) in schools that will require the collective action of schools-including students, communities, families, health services and legal enforcement agents.

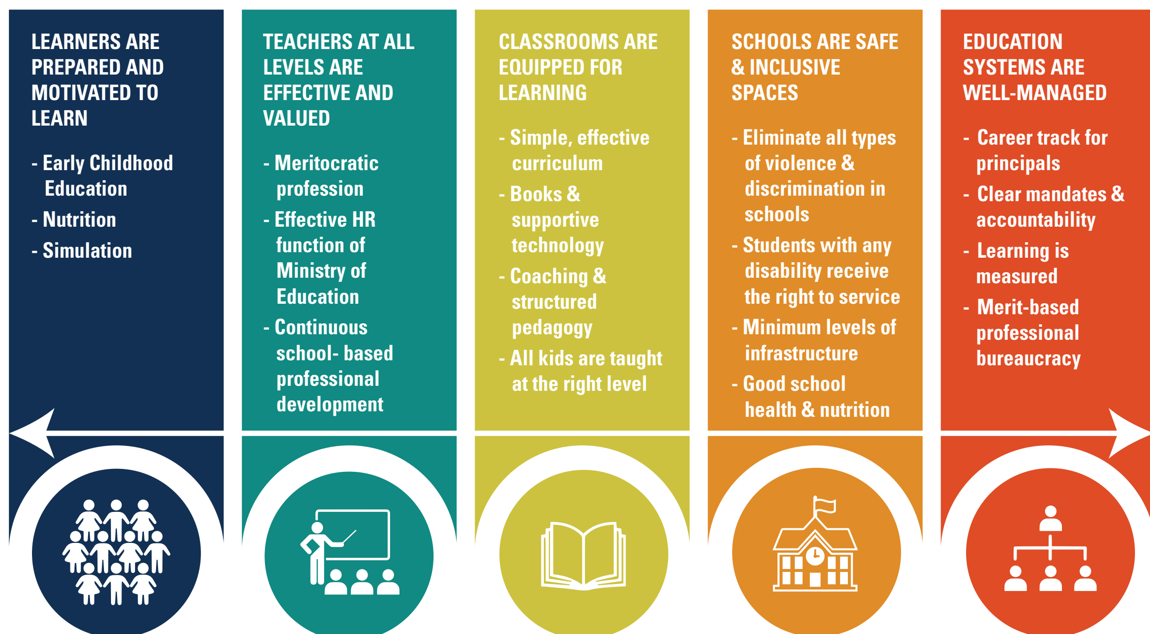
IMPROVING THE QUALITY OF LEARNING

37. ***Focus on foundational skills in early grades:*** The current system in Eswatini does not assess students on basic literacy and numeracy in the early grades. The only national assessment in primary education is the high-stakes examination in Grade 7, which is too late for the system to know how children are performing in the early grades. Without basic reading proficiency, children will most likely fail to become numerate, learn the fundamentals of science, and master key socioemotional skills such as communication. The priority should be to improve the home language instruction program in early grades and assess literacy and numeracy skills early on (in grades 3 or 4). In order to focus the whole system on student learning, Eswatini may consider a two-pronged approach, implementing short-term solutions that will improve service delivery for students going to school now; and establishing systemic changes to improve how the education system functions over the long-term.

38. ***In its recent Literacy Policy Package, the World Bank draws on the science of learning and on successful country experiences, to identity five interrelated components which have proven to be effective in improving basic literacy***. (i) Assure political and technical commitment to literacy by measuring baseline levels of achievement, establishing time bound national reading goals, creating standards for progress with simple and explicit curricula, and monitoring indicators of progress towards those goals; (ii) Ensure effective teaching for literacy, by supporting teachers through detailed guidance, such as structured lesson plans in low capacity settings, and continuous in-school practical pedagogical support through coaching and teachers' professional development; (iii) Ensure access to more and better age-appropriate texts that are engaging and widely available to children on a timely fashion; (iv) Foster a school and teachers mindset that all children must learn by promoting "Teaching at the right level," equipping teachers and schools with the tools to assess progress at the level of the individual student and to get back on track those who fall behind; and (v) Teaching in home language/mother tongue.

39. ***Broader reforms in the education sector***: For interventions targeted at literacy to operate in a sustained way, broad reforms which ensure that the right elements of the system are in place are needed. For a system to improve on a continuous basis, it required meritocratic teacher career progression; basic infrastructure for learning; well-managed systems that deliver the requisite feedback; and inputs for continual improvement. Countries need more time and political commitment for this package to be anchored in system-wide reform. Figure 7 below represents five pillars in which countries need to make progress to craft a system that provides the right experiencefor learners. These pillars focus on learners, teachers, classrooms, schools and education systems as well as using technology wisely to improve teaching and learning.

FIGURE 7. Five pillars of system improvement



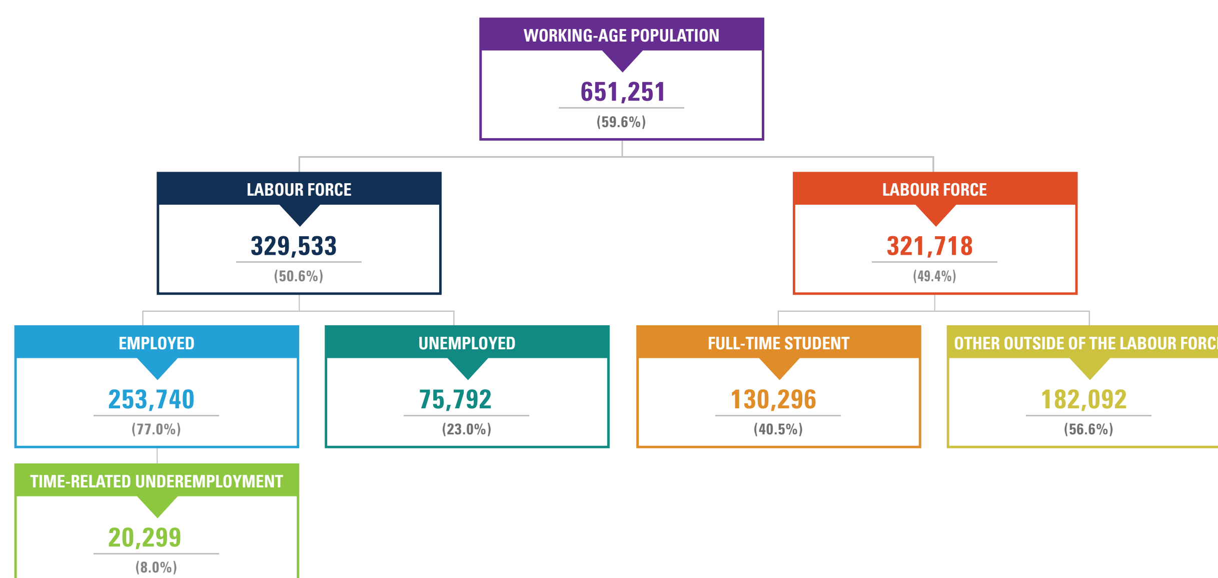
Source: World Bank, 2019a

YOUTH TO ADULTHOOD

40. ***This section focuses on the needs of young people once they leave the schooling system and move to becoming independent adults.*** As described earlier, many young people drop out of school before completing junior or senior secondary education. Figure 9 shows that labor force participation of 15-64 years olds in Eswatini was just over 50 percent in 2016. Of those who are in the labor force, 23 percent are unemployed (this is about 30 percent if discouraged workers are included) and about 8 percent are underemployed. However, with just half of the working age population participating in the labor force and just 39 percent of the working age population employed, core labor market outcomes in Eswatini compare unfavorably, even by regional standards. Informality in employment is also high – including workers that are informally employedin the formal sector firms, 68 percent of workers in Eswatini are informal (World Bank, SCD, 2019b).

41. ***Compounding low labor force participation, low employment and high informality is high povertyrate in Eswatini.*** In 2017, percentage of people living below the national poverty line was 59 percent. 92 percent of the poor live in rural areas (75 percent of the entire Swazi population live inrural areas). Not only do people in rural areas have a higher risk of being in poverty, compared to those living in urban areas, their poverty also tends to be more intense and more severe.[22][23] (WorldBank, SCD, 2019).

FIGURE 8. Status of working age population (15–64), 2016



Source: World Bank, SCD, 2019.

42. ***Deprivation experienced by young people is not simply about a lack of a job or money.*** Lack of income is just one of the many difficulties associated with a poor person's experience of deprivation. Poverty is about deprivation in multiple dimensions of well-being, which can include low levels of education, poor nutrition and health, a lack of employment, inadequate livingstandards and high exposure to violence, as well as low wages and income. Addressing these multiple deprivations requires a comprehensive approach to improve outcomes. The following sections outline some potential interventions to support youth and young adults to become more productive citizens.

22 The poverty gap provides information on the proportion of the poverty line that people require, on average, to escape poverty. The severity of poverty is measured via the squared poverty gap. This is a weighted sum of poverty gaps that gives more weight to those individuals or households who fall well below the poverty line.

SUPPORTING THE YOUTH NOT IN EMPLOYMENT EDUCATION OR TRAINING (NEETS)

43. ***Eswatini has a high number of young people who are considered NEETs.*** Addressing the multiple deprivations faced by these youth is urgent. The longer that young people stay NEET, the more precarious their job prospects and the higher their risk for ill mental health and discouragement, which may in turn keep them from participating in the labor market, training or education (Bransonet al., 2019)

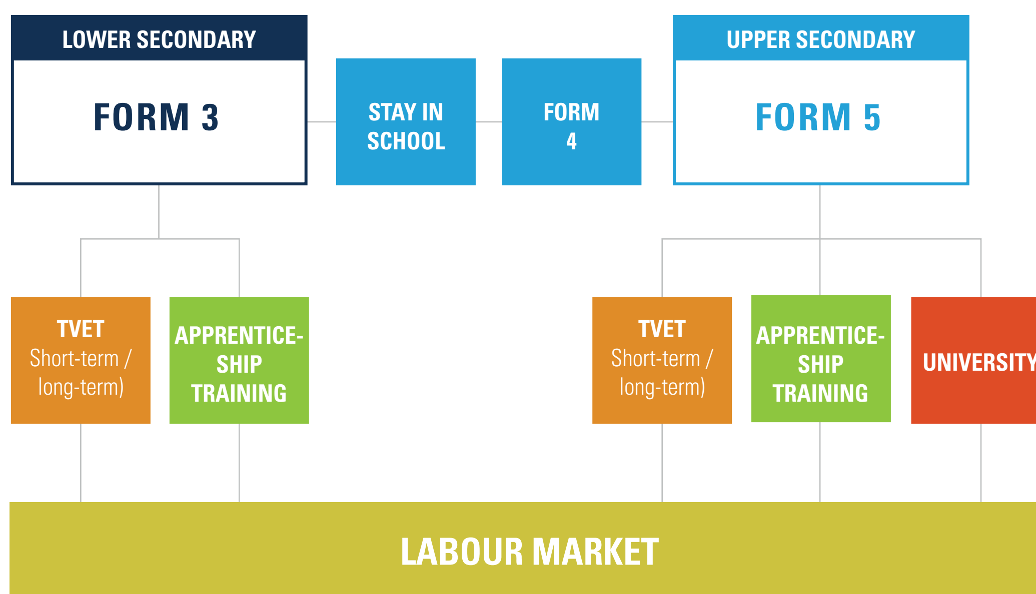
44. ***In Eswatini, the Ministry of Youth, Culture and Sports (through the Youth Council) and the Ministry of Tinkundhla have youth centers that provide support and training for youth who are NEET.*** Under the Youth Council, there are currently 20 Youth Committees established at *Inkundla* level and the aim is to establish these committees in all 59 *Inkundlas*. These committees acknowledge that youth face multiple deprivations and aim to go beyond entrepreneurship and skills training to providing psycho-social support and linking youth to available services in their communities (health centers, SWAGAA, (National Agricultural Marketing Board (NAMBoard), the Youth Enterprise and Revolving Fund, Family Life Association for Sexual and Reproductive Health, etc.). The committees work closely with the Community Development Officers working under the Ministry of Agriculture in partnership with Food and Agriculture Organization (FAO), to provide training to youth on 'Climate Smart Agriculture' through cooperative type arrangements. While this is a promising initiative, these committees are relatively new (established in 2018) and there is currently no systematic evaluation of their functionality or outcomes and satisfaction of youth. Continuing to build on these youth centers to provide the necessary holistic support to youth including better intermediation services by matching the qualifications and skills of youth with the needs of the labor market is a priority for the Government of Eswatini.

SUPPORTING YOUTH WHO WILL ENTER THE LABOR MARKET

45. ***Pathways from school to skills training:*** Providing good quality basic education for all children in Eswatini provides the foundation for young people to gain more diverse and complex skills later intheir lives. Addressing this issue was described in section (ii) of this Note. It is well documented thatmany students leave the schooling system before completing secondary education, most likely in the hopes of finding employment opportunities. Figure 9 illustrates the pathways available into skills training for students who complete lower secondary education (Form 3) and do not proceed to upper secondary education, compared to those who complete upper secondary education (Form5). Those who leave the system at the end of Form 3 have the option of transitioning to a TVET center, with short or long-term training options or moving into apprenticeship training. The added benefit of completing Form 5 or upper secondary education is that students who meet the requirements, can enter a university to obtain a degree or diploma, which ultimately improves their labor market prospects.

46. **However, comparative data from the World Bank's Education Statistics database show that *the gross enrolment rate for tertiary education in 2013 was only 6.7 percent.*** This is significantly lower compared to its neighboring countries i.e., South Africa at 20 percent and Lesotho at 11 percent for the same period (World Bank, 2013). In 2013, there were 70 TVET institutions – 27 public, 29 private, and 14 operated by NGOs, churches and communities. Together, these institutions employed 767 trainers and enrolled a total of 6,881 trainees (World Bank, 2014), which is not enough to meet the demands of students completing upper secondary education.

FIGURE 9. Pathways from school to skills training



47. ***National Qualifications Framework:*** Currently, Eswatini does not have a National Qualifications Framework (NQF) which can provide a regulatory framework for post school education and training i.e., there is no comprehensive system for the classification, registration and publication of articulated and quality-assured national qualifications. Without a qualification framework, there is no clear facilitation of access to, mobility and progression within, education, training and career paths.

48. ***Supply-demand mismatch:*** There are concerns that TVET and university education are not aligned to the needs of the labor market. The government has placed economic recovery as a key policy issue, and skills development through the TVET and university systems that are well- aligned to the labor market are critical to economic recovery (World Bank, 2014). Priority industries for development were previously identified i.e., tourism, food processing, manufacturing, and mining, however, several studies suggest that the alignment particularly between TVET provisioning and market needs were weak. There have also been low levels of satisfaction among employers with TVET institutions, with companies not being able to find appropriately skilled workers. There is an urgent need for the government to develop and focus on demand-responsive skills training.

49. ***Financing***: Technical and Vocational Education and Training receives a tiny portion (at 1.9 percent) of thetotal recurrent budget for education in the Kingdom of Eswatini (UNICEF, 2019). At the same time, there is no allocation to tertiary or university education. By and large, TVET institutions in Eswatini are financed through income from tuition fees and only about a quarter of these institutions receive government subsidies for trainers (World Bank, 2014). The direct costs of attending these institutions is a demand-side barrier for many students, and particularly exclusionary for those coming from poorer households. There is also a high opportunity cost associated with attending university or a TVET institution given the potential of immediate financialgain through labor market participation.

50. ***Management and coordination challenges:*** Eswatini also experiences challenges in relation to the management and coordination of the skills system. There are 8 Ministries involved in delivering skills training programs and many more private training institutes. While the Eswatini Higher Education Council (ESHEC), which falls under the MoET, is responsible for registration and quality assurance of all training institutions in the country, the reality is that very few institutions under other Ministries and private providers register with the Council. As such, the monitoring, quality assurance and regulation of training providers in Eswatini is weak. There is no national level engagement between the MoET and industry on skills development, no national occupational standards for the provision of training and no central assessment and certifying body in the country.Training institutions are left to determine

their engagement with industry, focus of training programs, and student certificates are awarded at the training institution level which does not provide an adequate signal to the market of the quality and relevance of the training within Eswatini region, let alone for the region.

51. ***To deal with the coordination issues in skills development, many countries have chosen to establish semi-autonomous bodies represented equally by public and private stakeholders.*** These bodies are usually responsible for high-level engagement with industry (through Sector Skills Councils or the like); coordination amongst the multitude of stakeholders; establishing national occupational standards; quality assurance of service delivery; administration of a skills levy in some countries, assessment and certification. No similar body exists in Eswatini, nor it is clear what the existing coordination mechanisms are. While the MoET is the line Ministry responsible for training, it does not have a department for TVET nor any individuals working on TVET. Currently, the Senior Inspector for Tertiary Education is given the additional scope of working on TVET. Moving forward, Eswatini needs to consider how it could coordinate the skills development system better in the country.

ADDRESSING THE HIGH DISEASE BURDEN IN ESWATINI

52. ***The adult survival rate, defined as the percentage of 15-year-olds who will survive until the age of 60, is very low in Eswatini (58.8 percent).*** It is driven by high prevalence of HIV and (TB) and related complex comorbidities, high maternal mortality (437 per 100,000 women), poor adolescent and women's health and nutrition, and an increasing burden of noncommunicable diseases (NCDs). Beyond the health sector, adult survival is related to women empowerment, job security, road safety, lifestyle choices, and other socio-economic determinants of health.

53. ***Eswatini has the highest proportion of adults (aged 15-49) living with HIV in the world.*** It now stands at 27.4 percent of the population. The HIV prevalence (female– 32.5 percent and male– 20.4 percent) contributes to poor maternal and child health outcomes (33.0 percent of maternal deaths), increased co-morbidities with TB (70.0 percent co-infection), cervical cancer and other NCDs, such as diabetes and cardiovascular diseases (CVDs). Overall, it is estimated that approximately 205,000 people live with HIV, associated annually with 3,200 AIDS-related deaths, 9,143 new infections, and 130,000 orphans.

54. ***The rapid increase in NCDs prevalence has resulted in a high number of avoidable morbidities and premature deaths, negatively impacting human capital.*** NCDs as a cause of mortality increased from 23 percent in 2007 to 40 percent in 2017, with most NCD-related deaths linked to cardiovascular diseases and diabetes and kidney diseases.[23] Adult prevalence of hypertension and type-2 diabetes – key riskfactors for cardiovascular diseases - is 25 percent and 14 percent respectively, with significant drop-offs across the cascade of care, highlighting system-wide deficits, including failures in primary care and inadequate coordination and continuity of care.[24] Currently, the majority of NCD service delivery, including uncomplicated cases, is provided by physician-led teams at tertiary-level facilities. Screening is done on an ad-hoc basis. Furthermore, there are gender disparities in NCDs; while the prevalence of hypertension and diabetes is higher among women, men are less likely to seek care and achieve disease control.

55. ***Obesity is often a precursor of NCD conditions.*** Obesity causes NCDs and leads to increased health care costs, reduced work productivity, increased disability and premature deaths.[25] Nearly half of the female population between 15-49 years and about 9 percent of children under 5 years are either overweight or obese – indicating a significant public health problem that needs to be addressed.

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23 Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington, 2018. Available from http://vizhub.healthdata.org/gbd-compare.

24 MOH/WHO. 2014. WHO STEPS. Noncommunicable Disease Risk Factor Surveillance Report Noncommunicable Disease Risk Factor Survey.

25 World Bank. 2020 d. Obesity: Health and Economic Consequences of an impending global challenge.

56. ***Health System Challenges***: A specific challenge around nutrition and NCDs is lack of population-level targeted prevention for management of obesity and limited screening and management of NCDs within the country. This prevents early detection and, thereby, increases treatment costs and related morbidity and mortality. Addressing these issues depends on the health system strengthening, including strengthening primary health care and referral links to hospitals with improved technical and managerial capacity. The absence of early detection and effective continuum of care results in patients seeking treatment abroad, financed through medical referral schemes to which the poor have limited access– exacerbating the existing inequities. Overall, increased attention and support to NCD management, including through health system strengthening and decentralizing NCD care, remains central. Delayed investment in managing NCDs pose a powerful threat to human capital– in the short term, mainly through impacts on adult survivaland productivity. They also undermine future human capital creation by impacting educational performance. NCDs affect all stages of life course and cascade from one generation to the next. Countries can reap substantial economic rewards, both short- and long-run, by taking bold action toprevent and control NCDs (World Bank, 2020c).[26]

57. ***The recent coronavirus outbreak has underscored the importance of a responsive and resilient health system, as well as the critical link to water and sanitation and hygiene at facilities and households to reduce the risk of infections.*** Strengthening the health system today is an urgent fist-line investment, critical to protect Eswatini's economic and human capital potential. Sector modernization requires high-level political support. The crisis triggered by COVID-19 can acceleratesector modernization, as well as multi-sectoral engagement, which could be catalyzed further by broader development policy reforms.

58. **Overall, modernizing the foundations of the health system and applying evidence-based improvements are key to achieving better quality care and, through that, reduced child and adultmortality and stunting for human capital formation.**

SOCIAL ASSISTANCE FOR THE POOR

59. ***International evidence suggests that cash transfers can generate gains in child education, health, and nutrition outcomes through different pathways.*** Transfers can relax structural household economic constraints that impair human capital investments. Poverty can exact a heavy toll on the physical and psychological wellbeing of children – cash transfers, by alleviating poverty,can help save them from this fate. Lastly, in the face of negative shocks that produce acute income or asset loss, regular cash transfers can help protect households from resorting to risk coping strategies that sacrifice human capital investments.

60. ***The government of the Kingdom of Eswatini administers only few cash transfer programs, the most important of which is a social grant to the elderly.***[27] Elderly grants are offered to those age 60 or above. Preliminary evidence suggests that the program protects households from falling into poverty as the elderly withdraw from the labor market. These protective effects are felt by children (including orphans and vulnerable children, many resulting from the mortality andmorbidity of parents due to HIV/AIDS) who reside with elderly beneficiaries. Elderly grants cover about 55,000 individuals. Moving forward, the Government should consider a program to alleviate poverty among child headed households.

26 Enhancing Human Capital and Boosting Productivity by Tackling NCDs. A Joint Agenda for Countries and Partners. The World Bank Group Human Capital Project (September 2019).

27 There are two other social assistance programs – disability grants and military pensions – but they are very small in terms of beneficiary counts and contribution to overall SP spending. Disability grant covers only 4.3 thousand persons with disabilities, and it is yet to become a regular monthly grant.

MOVING FORWARD

61. Overall, investing in human capital through multiple interventions is critical throughout the life cycle to maximize the life-time potential of individuals, improve positive intergenerational effects, and at the aggregate level, boost economic productivity and growth opportunities. At the population level, sound investments in reproductive health, health systems, education, social protection and water and sanitation can trigger a demographic dividend that can contribute to a longer period of growth (Bruni, Rigolini and Troiano, 2016; Velenyi, 2016). To maximize efficacy of resources invested in these programs a strong harmonization and coordination of interventions across sectorsis a must. Co-location of human development initiatives at the local level, where conditions for co-location are favorable (office space) can augment positive impacts. Potential gains can be realized by building on existing initiatives that support greater linkages and coordination between multiple implementing entities. For example, introducing interoperable digital platforms can support the provision of client-centered, holistic social services (e.g., across health, education, social protection sectors) more efficiently and with improved accountability.

62. To operationalize Eswatini's integrated human capital development approach, effective multisectoral coordination is vital, which requires high-level political commitment, a policy platform endorsed and spearheaded by the Prime Minister's Office, as well as strong cross-ministry/agency collaboration at every government level – policy, technical, and operational.

SUMMARY OF INTERVENTIONS TO IMPROVE KEY HUMAN CAPITAL DEVELOPMENT INDICATORS

63. Below, we present a summary of interventions, the Government of Eswatini may consider strengthen/ introduce, in order to improve key indicators comprising the HCI.

TABLE 4. Priority interventions

To improve survival birth to age 5		
Reduce Neonatal Mortality	Reducing risk of teenage pregnancies through improved access to reproductive health services and retention of girls through secondaryeducation	Medium term
	Improving nutritional status of pregnant women to reduce risk of lowbirth weight	Medium term
	Improving access to and quality of ANC and PNC	Medium term
	Improving quality of delivery and neonatal care	Medium term
	Early initiation of breastfeeding in hospitals and home deliveries	Short term
Reduce Infantand Under-5 Mortality	Improving quality of IMCI	Medium term
	Investing in nutrition in first 1,000 days, particularly complementaryfeeding (see Table 4)	Medium term
	Improving ECD among children 0-3 years and 3-6 years	Medium term
	Improving water supply, sanitation and hygiene	Medium term
	Support to OVCs	Medium term
	Improving education levels of girls, particularly retention throughsecondary education	Medium term
	Social assistance transfers including awareness raising and community mobilization around feeding, nutrition, and heath related practices	Medium/Long term
	Improved knowledge regarding health related "life skills" and improved access to reproductive health	S/M/Long term
	Women empowerment through increased voice and agency	Medium/Long term

To improve quality adjusted years of schooling		
Improve access to basic and secondary education (reducing repetition and dropouts)	Extend primary education to 9 years of basic education; eliminate highstakes examinations at Grade 7	Long term
	Eliminate the high-stakes nature of examinations at the primary education level in Grade 7 and move towards competency-basedassessments at key milestones (Grades 3, 6 and 9)	Medium term
	Provide scholarships and strengthen cash transfer programs to better support for children from low-income households to attend secondaryschool	Medium term
	Establish adolescent girls' clubs in lower secondary schools	Short term
	Expansion of secondary schools across the country	Long term
	Strengthen the government's school feeding program	Medium term

To improve quality adjusted years of schooling		
Improving the quality of literacy and numeracy outcomes in the early grades	Develop and disseminate SiSwati home language teaching and learningmaterials for Grades 1 to 4	Short term
	Align pre-service teacher training to the curriculum	Medium term
	Implement cost-effective and sustainable models of in-service teachertraining and in-classroom support	Long term
	Develop an assessment framework for the early grades	Short term

To improve stunting levels and adult survival		
Reducing Stunting Under 5	Promote exclusive breastfeeding (180 days), including duringHIV/AIDS	Short term
	Timely introduction of complementary feeding (6-8 m) with continuedbreastfeeding	Short term
	Improved quality of complementary foods and feeding practices inchildren 6-24 months (m)	Short term
	Micronutrient supplementation (iron, Vitamin A and MNP) anddeworming	Short term
	Feeding of sick children during and after illness	Short term
	Management of moderately and severely malnourished children	Medium term
	Improve child anemia among children 6 – 59 m	Medium term
	School-based nutrition, including pre-school, ECD	Medium term
	Social safety net – nutrition support through OVC CT, NCP	Medium term
	Improve child stunting	Long term
Improving Maternal HealthOutcomes	Improving access to and quality of ANC and PNC	
	Reducing Third Delay at Skilled Delivery Improving Quality of Care	Medium term
	Better nutrition during pregnancy and lactation, including anemia and obesity management	Medium term
	Improve education levels of girls, particularly retention throughsecondary education	Medium term
Improving Adolescent and Women's Healthand Nutrition	Reproductive health through communication, empowerment, and social protection interventions	Long term
	Prevention of overweight/obesity during adolescence and reproductive age group through communication strategies	Long term
	School-based nutrition and reproductive health	Medium term
	Social safety net – Cash Transfer / Jobs to Adolescent Girls	Long term
Reducing Adult Mortality and Improve Productivity	Improved continuum of care (screening, care management) for NCDs(hypertension, diabetes, etc.)	Medium term
	Dietary management of NCD's i.e., diabetes, cancer, hypertension and heart diseases along with appropriate medication	Long term
	Improve Emergency Medical Services	Long term
	Road Safety	Long term
	Productive inclusion interventions – cash support, labor marketmeasures	Long term
	Skills Training (foundational skills, technical, digital, business)	Medium term
	Job Security	Long term

ANNEX 1: World Bank Support to Eswatini to Strengthen Human Capital Development

WORLD BANK LENDING OPERATIONS (IBRD) IN THE KINGDOM OF ESWATINI

Eswatini Network Reinforcement and Access Project (P166170, IBRD US$40 million, 2020-25)

- **Project Preparation Status:** World Bank Board Approved on June 27, 2019
- **PDO:** To improve the reliability of electricity supply and increase access to electricity services in targeted areas of the Borrower.
- **Project Beneficiaries:** The project will improve reliability of electricity services and increase access to electricity in the Shiselweni region benefitting an estimated 8,000 households (30,000 people). Existing residential, commercial and industrial customers of EEC will experience improvement in the quality of service.

Eswatini Water Supply and Sanitation Access Project (P166697, IBRD US$45 million, 2020-26)

- **Project Preparation Status**: World Bank Board Approved on October 10, 2019
- **Project Development Objective (PDO)**: To increase access to improved water supply and sanitation services in targeted areas of Eswatini.
- **Project Beneficiaries**: The project will directly benefit approximately 38,233 people located in the three target tinkhundla (Zombodze, Hosea, and Shiselweni I)[28] in the Shiselweni region of Eswatini. An estimated 18,478 people will benefit through new potable water supply and 8,000 people[29] through new sanitation services.[30] Additionally, improved potable water supply and sanitation services will be provided to four health clinics and 32 schools in the targeted areas reaching an estimated 2,000 people and 5,600 people, respectively. The total population of the three target tinkhundla (total 38,233) will benefit from improved sanitation services (either through new infrastructure, supply chain enhancement, behavior change campaign, sanitation marketing campaign, hygiene campaign, or private sector enhancement). Baby WASH interventions will target all households with children under three years old living in the household (about 8 percent of households).

COVID-19 Emergency Response Project (P173883, IBRD US$6 million, 2020-22; Emergency Fast Track Operation

- **Project Preparation Status**: Effective from April 30, 2020
- **PDO Statement:** The Project Development Objective is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness in Eswatini.
- **Multi-sectoral Emergency Response:** The proposed project will be financed by an IBRD loan of US$6 million, using an IPF instrument under the MPA, over a two-year period. The project is multi-sectoral and finances health and water and sanitation and hygiene interventions.

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28 Target tinkhundlas (Zombodze [14,231], Hosea [14,733], and Shiselweni I [9,269], total 38,233) will benefit from improved sanitation services. Baby WASH interventions will target households with children under 3 years old (8% of households).

29 Based on an average household size of four people.

30 Beneficiaries who will receive access to new water supply and sanitation infrastructure.

- **Components**: The project components are aligned with the objectives of the COVID-19 SPRP and comprise 2 components: (1) Emergency COVID-19 Response; and (2) Implementation Management and Monitoring and Evaluation. The components aim to strengthen Eswatini's health system preparedness to respond to the COVID-19 emergency and potential future emergencies. The components will include climate-change adaptation measures and will address gender issues, as necessary.
- **The expected project beneficiaries** will be the population at large given the nature of the disease, infected people, at-risk populations, particularly the elderly and people with chronic conditions including HIV, medical and emergency personnel, medical and testing facilities, and public health agencies engaged in the response.

Eswatini Health System Strengthening for Human Capital Development Project (P168564, IBRD US$20 million; 2020-25)

- **Project Preparation Status and Milestones:** Negotiation: May 15, 2020; World Bank Board Submission: June 2020.
- **PDO:** To improve the coverage and quality of key reproductive, maternal, neonatal, child and adolescent health (RMNCAH), nutrition and NCD services (hypertension and diabetes) in Eswatini.
- **Components:** (1) Improve health service delivery to increase the coverage and quality of health services to build human capital; (2) Increase community demand for RMNCAH, nutrition and NCD services; (3) Strengthen the MOH's stewardship capacity to manage essential health and nutrition services and project activities; and (4) Contingent Emergency Response Component (CERC).
- **The proposed project will build** on the World Bank financed Health, HIV/AIDS and TB Project (P110156) and is complementary to the Eswatini COVID-19 Emergency Response Project (ERP) (P173883); designed to deepen and extend its investment impact through focusing on medium-term structural changes to modernize the health sector.
- **Project Beneficiaries:** Direct beneficiaries are women of childbearing-age, adolescent girls, newborns and children under five years of age (RMNCHA beneficiaries: 146,000; child nutrition: 231,000; NCD service beneficiaries: 96,000). Other direct beneficiaries will be population with NCD risks and patients with NCD. The indirect beneficiaries include the population of the four regions (Hhohho, Manzini, Lubombo and Shiselweni). From an institutional perspective, health personnel, notably doctors,nurses, nutritionists and midwives and rural health motivators will benefit from training in RMNCAH- N care and NCDs. The project will benefit management at all levels of the health sector, MOH, regions, and facility level. Various technical cadres will benefit from training to operationalize and sustain the new models and tools.

Eswatini ECCDE and Basic Education Development Project ***(under preparation)*****.**

- Improving access to and quality of Early Childhood Care and Education (ECCE)
- Supporting reading and numeracy programs for children in early primary grades
- Improving the quality of mathematics and science instruction in junior secondary education using technology
- Addressing the high repetition and drop-out issue in basic education (primary and lower secondary education) addressing supply and demand related constraints
- Support for youth who are at risk of dropping out of school

TVET and Youth Employability Project ***(under concept development Stage)***

- Support the demand and supply sides of skills development for youth including those who are out of school or unemployed.

The proposed Eswatini lending portfolio provides a unique opportunity to support the Kingdom's aspiration for human capital formation, especially relevant in the context of fiscal constraints. Harmonized investments in reproductive health, maternal and child health, nutrition, health systems, water supply, sanitation and hygiene, education, social protection and jobs will contribute to meeting the objectives of the Kingdom of Eswatini Strategic Road Map (2019-22), contributing to growth and excellence in service delivery.

Table A1.1: Support to the Kingdom of Eswatini through Advisory Services and Analytics

	Project Name and Number	Completion Date
1	Strengthening Capacity in Health Financing and Hospital Governance and Management in Eswatini (P163653)	June 2020
2	Designing and Implementing Interventions to Accelerate Human Capital Formation for Adolescents in South Africa, Eswatini and Lesotho (P172420)	May 2021
3	The Future of Medical Work in Southern Africa (P171798)	May 2021
4	Review of Social Protection Systems in Southern Africa (P172175)	June 2021
5	Rapid Education Sector Review (P172539)	September 2020

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