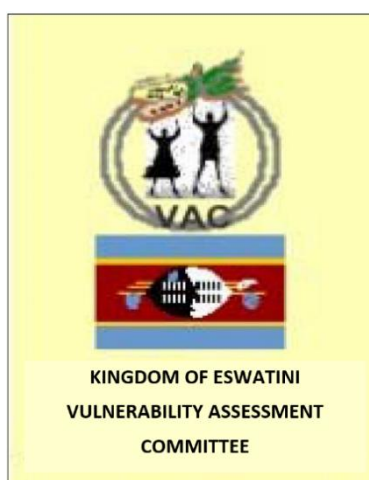




KINGDOM OF ESWATINI

ANNUAL VULNERABILITY ASSESSMENT & ANALYSIS REPORT 2020



July 2020



A. ACKNOWLEDGEMENT

The 2020 Annual Livelihoods and Vulnerability Assessment (VAA) was undertaken in the midst of so much uncertainty and apprehension due to the COVID-19 pandemic outbreak. This warrants unreserved appreciation to the technical team that found it appropriate to engage in this exercise to help inform policy and programming responses, especially in mitigating the impacts of the pandemic.

The Government of the Kingdom of Eswatini is also grateful for the unparalleled support – financially, technically and otherwise, extended by development partners to ensure that resources are available to facilitate the delivery of this product.

My sincere thanks also go to the community leaders who facilitated the selection of the respondents in the various communities. At the time when so much was going on, they committed themselves to the identification and selection of respondents in accordance with the prescribed criteria, ultimately playing a very significant role in kick-starting the exercise. Their leadership is commended. Tiring as they were, the long telephone interviews conducted during the data collection were successful because of the patience of the respondents, some of whom had to abandon important tasks and attend to our data collection teams. For that tolerance, we are so grateful, and we will endeavour to give them feedback on the findings so that they can appreciate and also take the responsibility to play a part in the development of their communities in all ways possible.

Last, but not least, the stakeholder involvement in pursuing and strengthening the VAA agenda in the country cannot be undermined. We look forward to your continued support as the findings and recommendations of this study are put into practice.

Makhosini Mndawe

Principal Secretary- Deputy Prime Minister's Office

B. EXECUTIVE SUMMARY

Faced with a number of challenges that had significant bearing on the vulnerability of the Swazi population, the COVID-19 pandemic significantly compromised the ability of a number of households to provide for their livelihoods. The country experienced a late onset of the rainfall seasons, with most rains received in the last week of October. November, December and February had total monthly rainfall exceeding the corresponding long-term average. There were periods in the season which had dry spells, particularly mid-December and end of January. This had an adverse impact on tasselling maize plants thus significantly affecting crop productivity. However, crop harvest was significant for maize and very low for other crops namely: legumes, sorghum and sweet potatoes which could potentially fail to sustain households until the next farming season. Maize production in 2019/20 is estimated to be 86,547.90 MT which is 10% lower than last year's harvest. On livestock production, the rains had positive impacts. Pastures and water conditions were good in the wet season for livestock production to thrive.

The main goal of this year's assessment was to establish the status of vulnerability for both rural and urban households and also generate current information on health sector/facilities preparedness to deal with COVID-19. The outputs from the assessment were further used to inform the Integrated Food Security Phase Classification (IPC), as direct and indirect evidence. The IPC Analytical Framework was used to further classify rural and urban populations into Phases.

A total number of over 330 000 (30%) of the population in the country was classified on Phase 3 and 4 for the period June – September 2020 (current situation). For the period October to March 2021 a total number of 366,261 will require support as they are in Phase 3 and 4. Over the course of the year, households were faced with a number of shocks that had an impact on households' ability to meet their food and nutritional needs for the current and projected period. Overall, 80% of households reported to have experienced shocks over the past 12 months. Both urban and rural households reported to have been exposed to shocks, however, with the urban population being slightly more vulnerable to shocks than its rural counterparts (82% vs 80%). The high level of exposure of urban areas to shocks can be attributed to the COVID-19 lockdown and restrictions which immediately reduced incomes from informal jobs and self-employment activities, putting households dependent on these incomes at risk of food insecurity. The Government has made efforts to address the growing humanitarian needs in collaboration with partners, coordinated by the National Disaster Management Agency. The government has committed substantial resources for the emergency and has requested technical and financial assistance from the international community to support the emergency response plan.

C. ABBREVIATIONS AND ACRONYMS

AIDS	:	ACQUIRED IMMUNE-DEFICIENCY SYNDROME
ART	:	ANTI-RETROVIRAL THERAPY
ARV	:	ANTI-RETROVIRAL
CSO	:	CENTRAL STATISTICAL OFFICE
EA	:	ENUMERATION AREA
EHIES	:	ESWATINI HOUSEHOLD INCOME AND EXPENDITURE SURVEY
E- VAC	:	ESWATINI VULNERABILITY ASSESSMENT COMMITTEE
FAO	:	FOOD AND AGRICULTURE ORGANIZATION
GDP	:	GROSS DOMESTIC PRODUCT
GoE	:	GOVERNMENT OF ESWATINI
HIV	:	HUMAN IMMUNE-DEFICIENCY VIRUS
IPC	:	INTEGRATED FOOD SECURITY PHASE CLASSIFICATION
LZ	:	LIVELIHOOD ZONE (ALSO KNOWN AS FOOD ECONOMY ZONE)
MEPD	:	MINISTRY OF ECONOMIC PLANNING AND DEVELOPMENT
MICS	:	MULTIPLE INDICATOR CLUSTER SURVEY
MOA	:	MINISTRY OF AGRICULTURE
MT	:	METRIC TONNES
NEWU	:	NATIONAL EARLY WARNING UNIT
NHSSP	:	NATIONAL HEALTH SECTOR STRATEGIC PLAN
NMC	:	NATIONAL MAIZE CORPORATION
NMS	:	NATIONAL METEOROLOGICAL SERVICES
SADC RVAA	:	SOUTHERN AFRICAN DEVELOPMENT COMMUNITY REGIONAL VULNERABILITY ASSESSMENT AND ANALYSIS
VAA	:	VULNERABILITY ASSESSMENT AND ANALYSIS
WFP	:	WORLD FOOD PROGRAMME
WHO	:	WORLD HEALTH ORGANIZATION

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1.0 BACKGROUND AND OVERVIEW

In 2020, the need for a comprehensive Vulnerability Assessment and Analysis (VAA) became more necessary than any other time in the history of the livelihoods analysis in the country. Traditionally, the timing of the VAA over the years would coincide with the post-harvest period and would mainly focus on rural areas and provide analysis on the state of food (in)security at household level, but with the need for more information to inform programming and response to the impact of COVID-19, the inclusion of urban areas became necessary. Urban areas were equally impacted, particularly by the global COVID-19, hence the need for the inclusion of some pockets of urban areas in the current assessment. The advent of the COVID-19 pandemic, which affected almost all sectors of the country's economy, necessitated a change in approach in conducting this year's assessment (VAA 2020). Although the current VAA assessment and analysis was largely constrained by the COVID-19 restrictions and control measures, among other issues, extra precautions were taken to ensure the survey standards were upheld for the validity and reliability of the assessment report. The adopted methodology and data collection procedure followed in this year's assessment is outlined and detailed in the methodology section of this report.

Just like in many other countries globally, the nature of the COVID-19 shock was unfamiliar and rapid, with a greater potential of being more devastating, hence the Kingdom of Eswatini declared a state of emergency. Immediately after the declaration, control measures were put in place to curb the spread of the virus. Such measures included the introduction of lockdowns, restricted movement, limited business operations, restricted gatherings (limited number of people at a given time) and improvement of personal hygiene practices. These conditions would, potentially, impact livelihoods and food security in the short and medium term in both rural and urban areas.

Three months into the declaration of the state of emergency, employment and income earning opportunities remain constrained despite the relaxation of the COVID-19 regulations to allow operations of some business establishments. Recovery into full operations of most enterprises remains subject to relief and rescue plans that have been proposed.

1.1 Macro- Economic Indicators

The 2019 performance of the country's economy showed a growth of 1.3% from the 2.4% level in 2018. Economic growth forecasts for 2020 had indicated prospects of recovery with a value of more than 2%, however, with the outbreak of the global novel corona virus disease (COVID-19), the country's economic growth projections have been revised downwards and a significant contraction in economic activity is anticipated in 2020.

The headline inflation rate in May 2020 (i.e. the annual percentage change in the CPI in May 2020 compared to that of May 2019) for the country was 4.0% (Figure 1). This annual rate is 0.1 index points higher than the corresponding annual rate of 3.9% observed in April 2020. From May 2019, the level of consumer inflation has been on a steady increase and had been below the 2% mark up to December 2019. From the beginning of 2020, an increasing trend has been observed - rising from about 2.7% in January to 4.0 in May, an indication that the spread of the Covid-19 has had a negative effect (Figure 1).

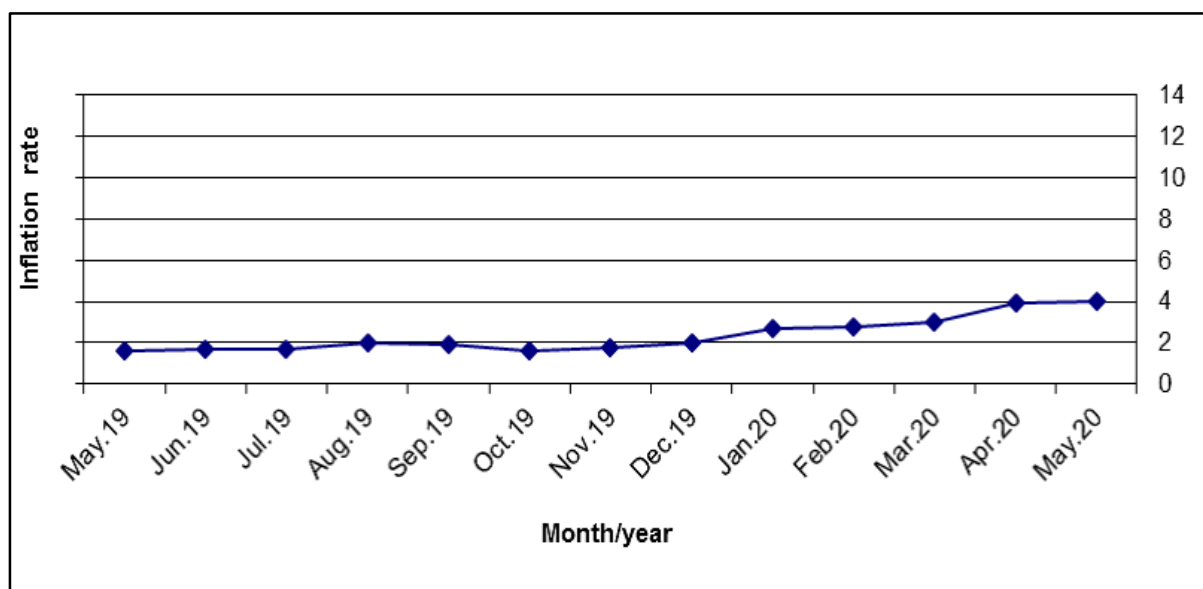


Figure 1: Consumer Inflation 2019-2020

Source: Central Statistical Office

1.2 Agriculture

The past agricultural season was characterized by delays in onset of rainfalls, resulting to a delay in the start of the harvesting season. The crop harvest was significant for maize, however, very low for other crops namely: legumes, sorghum and sweet potatoes which could potentially fail to sustain households until the next farming season. On livestock production, the rains had positive impacts. As such, livestock numbers are displaying an upward trend, suggesting a recovery from previous droughts numbers. Pastures and water conditions were generally good in the wet season for livestock to thrive.

The start of COVID 19 in March 2020 did not have much impact to the cropping season since it had already started. The effects of the partial lockdown resulted to a lot of households establishing backyard gardens in complementing their dietary needs and use of the free time that was a result of the break from work (working from home and restricted travel). The Ministry of Agriculture, through National Agricultural Marketing Board, had provided agricultural inputs, mainly seedlings and seeds, to individual farmers as a government intervention to improve the nutritional status in the country during the pandemic period.

In addition, the Ministry of Agriculture, through National Agricultural Marketing Board (NAMBOARD) and in collaboration with Food Agriculture Organization (FAO), had established a winter cropping programme to meet the maize deficit needs in the country. FAO had donated an amount of E1 million to support the winter cropping programme.

1.3 Health and Nutrition

The Coronavirus Disease (COVID-19) outbreak was first detected in Wuhan, China in December 2019. The World Health Organization (WHO) declared the epidemic a Public Health Emergency of International Concern on 30th January 2020. The World Health Organization declared the epidemic a pandemic on 11th of March 2020. COVID-19 is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). As of the 21st of May 2020, there were more than 5.01 million COVID-19 cases globally, affecting more than 188 countries and territories. More than 328,000 people had been reported dead due to the COVID-19 global pandemic.

The first case of COVID-19 in Eswatini was diagnosed on the 14th of March 2020. As of the 21st of May 2020, there were 220 confirmed cases of COVID-19 and out of the 220 cases, 112 had recovered and two COVID-19 related deaths had been recorded in the country. The Government of the Kingdom of Eswatini declared the COVID-19 pandemic a National Emergency on the 17th of March 2020, thereby invoking Section 29 of the Disaster Management Act of 2006.

A World Bank report “Global Economic Prospects, 2020” anticipates an economic crisis that will lead, among other catastrophes, to “severe underfunding of important health and welfare programs” in developing economies. It predicts that beyond fatalities from the virus, many will die of untreated diseases. The report further predicts some deprivation of the right to education for many children in countries of the global South.

Furthermore, the Government announced a partial lockdown with effect from the 27th March 2020. It installed several public health measures to i) contain the epidemic and slow down its spread ii) flatten the epidemic curve to a level that the health system can manage without being overwhelmed and iii) to defer the peak of the epidemic to give the government time to strengthen health infrastructure and capacity to cope with the disease. The Government of Eswatini has established a hospital for the admission of moderate, severe, and critical patients as well as creating a 500-bed facility for admission of mild and asymptomatic cases that could not self-isolate at home. The country was working on expanding its local testing capacity. By the 21st of May, the Ministry of Health had performed 4,994 tests for COVID-19, with 220 positive results, with the majority testing negative.

The prevalence of malnutrition, under – nutrition to be specific, shows an improvement in the country for the past 10 years. Although stunting, which is a chronic form of malnutrition, is still classified as being high according to WHO standards, an overall downward trend has been observed (which currently stands at 26%) for the past years. Wasting and underweight are classified as low/normal according to the standards and stand at 2% and 6% respectively. However, due to the impact of COVID – 19, it is anticipated that wasting (acute form of malnutrition) might increase due to the movement restrictions, which hinders access to

market places and health facilities, among others. Some children under 5 years have no access to immunization packages and are not screened routinely at grass root level. This might affect the nutritional status of the children.

1.4 Education Sector

The Education sector is comprised of a significant proportion of the population as key stakeholders, with each one of them playing a different role. This sector is made up of learners, professional and support staff. In 2020, the outbreak of the COVID-19 pandemic resulted in the closure of all education facilities in a move aimed at reducing the spread of the virus. The closure of education facilities resulted in an increased burden on households as this meant that the time children had to be home would be longer and indefinitely draw immensely from household resources against the backdrop of layoffs from work for the employed, restricted movement for most of the time, and inconsistent food supplies in retail outlets. The closure of education institutions which includes schools and tertiary institutions had the potential to attract other social vices such as domestic violence, child abuse and sexual exploitation. To minimise the impact of the continued closure of schools, a number of initiatives were launched to pursue learning objectives which includes the use of print and electronic media. Despite the delivery methods not being accessible to all learners, granted the school calendar is pursued to completion, there would be an impact of the lessons.

1.5 Market Access and Trade

Prior to the beginning of the National lockdown, there was reportedly a lot of panic buying, with some consumers stocking up commodities that they anticipated would be a necessity during the lockdown, in preparation for any unforeseen disruptions in the supply chain. The lockdown regulations prioritized the exemption of retail outlets for essential goods and services, however, at the beginning of the period, other impediments existed such as restriction of travel, thus compromising access to some goods. The other notable threat was the level of stocks of some consumer goods that were threatened by the over reliance on imports. Beyond these unavoidable risks, some business operators started inflating prices. Had it not been for the quick observation of members of the public and the intervention of

trade regulatory authorities, consumers would have borne the full scale of the brunt from the unscrupulous behaviour of traders.

2 THE 2020 VAA METHODOLOGY

2.1 Objectives

The main goal of the VAA, 2020 was to establish the status of vulnerability for both rural and urban households and also generate current information on health sector/facilities preparedness to deal with COVID-19. Specific objectives include:

- Establish health facility capacity and resource needs to be able to deal with Covid-19;
- To establish the extent of markets and trade operations for food security and other basic household needs;
- To quantify the extent of food insecurity among urban and rural households;
- To identify suitable recommendations for response in affected households.

2.2 Assessment Scope

The assessment covered areas from both rural and urban areas of the Kingdom of Eswatini. For the rural households, the community leaders, Bucopho and Ward Counsellors, were used as entry points, from whom, cell phone numbers for potential participants in the data collection exercise were obtained. They were briefed on the new method and the importance of the assessment during the COVID-19 period. The duration of the interviews was carefully monitored and was kept short to enhance data quality during the data collection process.

Other than household data, the assessment further collected data from 25 health facilities which include: hospitals, health centres and clinics. A total of 25 health facilities were covered for the 2020 annual assessment. From the facilities, interest was on the capacity of each facility to handle the pressure during the COVID-19 period. Health and nutrition data of children under the ages of five was also collected.

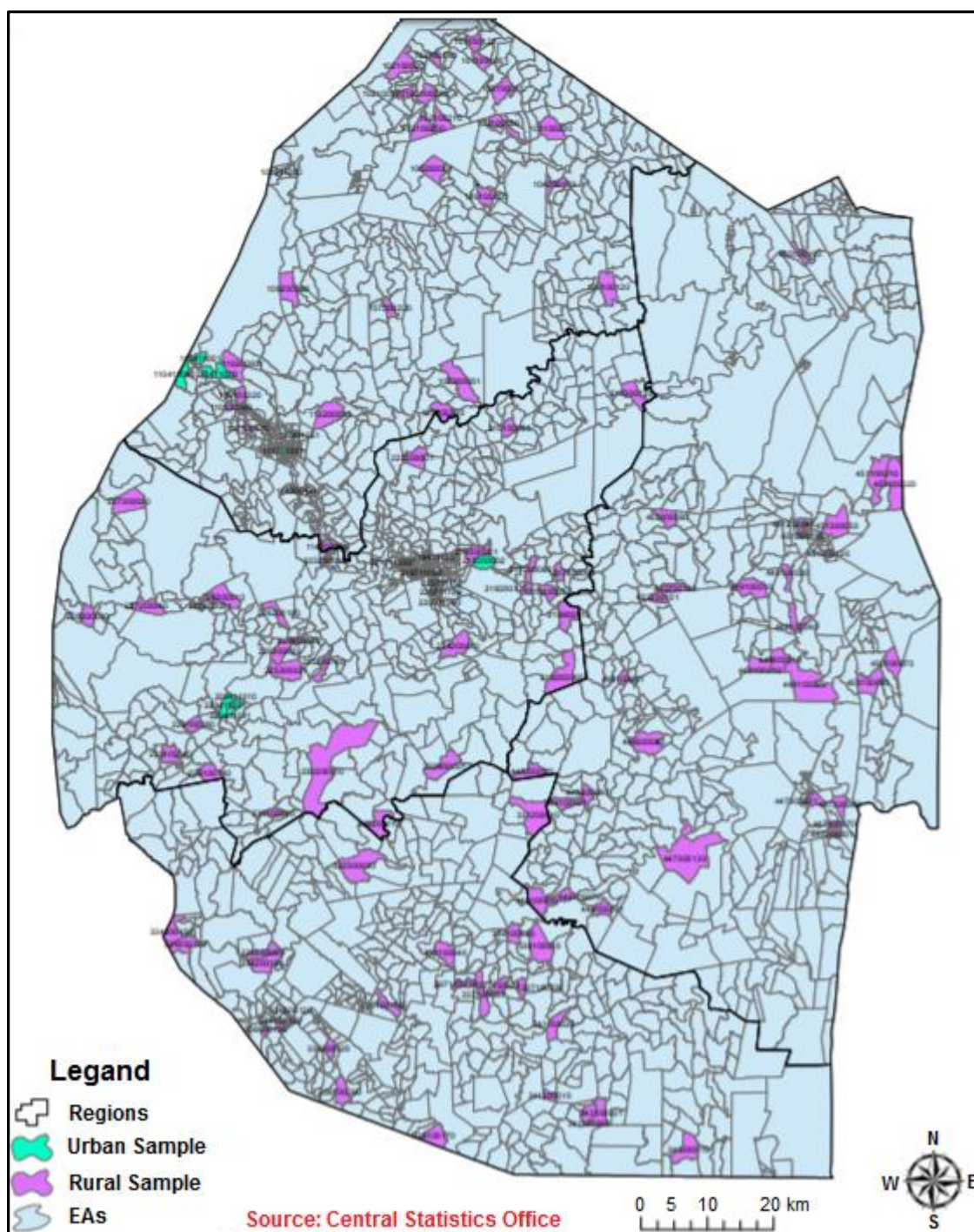
The assessment also made use of second data from various sources which include: the annual rapid assessment, macro-economic data, price data, livestock data, and market information from relevant sources, to mention but a few.

2.3 Sample Design

A two-stage-sampling procedure was used for the 2020 annual assessment. Firstly, **a total of 125 enumeration areas (EAs)** were randomly selected from the regions and livelihoods zones of the country, ensuring representativeness of all parts of the country (Map 1) Secondly, purposive sampling of households was carried out through the help of community leaders (Bucopho and Ward Counsellors). From each sampled area, 15 households were selected for inclusion in the sample. These households included poor, middle and better-off/wealth groups. **A total of 25 health facilities** were also covered in order to assess the health situations during the COVID-19 pandemic outbreak. Both rural and urban areas of the country were represented in this assessment.

Table 1: Sampled Rural EAs by Region

Region	Rural	Urban	Total
Hhohho	263	61	324
Manzini	277	109	386
Shiselweni	272	23	295
Lubombo	320	35	355
Total	1132	228	1360



Map 1: Sampled EAs by Region

2.4 The 2020 Assessment Tool

Unlike in face-to-face interview, the tool that was used for this year's assessment was short since it had to be chopped to accommodate telephone interviews. This came about in order to consider challenges regarding time spent during each interview. As expected, a number of different key stakeholders were consulted for inputs into the development of the tool.

Likewise, stakeholders were also consulted for inputs in the modification of the tool (removing of some sections) to accommodate the new methodology. Among the sections covered was the general information of the households, water, sanitation and hygiene, food consumption and sources, consumption-based coping strategies, livelihood based coping strategies, food insecurity experience scale, household hunger scale, humanitarian support and markets, among others.

2.5 Recruitment and Training of Field Staff

The 2020 VAA used mobile technology to collect data where data was downloaded daily and checked for inconsistencies. CSPro was used to develop application to collect data from the field using tablets, for both households and facilities. There were four teams deployed in all the four regions of Eswatini. Each team, in each region, covered both rural and urban households. The teams were residing in one place in order to ensure proper monitoring during data collection. Alongside primary data collection, secondary data was collated from various sources, which includes data on prices, economy performance, market and trade, employment, rainfall performance, among other important variables.

2.6 Recruitment of Households to the Assessment

The community leaders and ward counsellors were engaged to assist in the selection of the participants to be included in the survey. In both geographical locations, community leaders, Bucopho and ward counsellors were used as entry points. From the community leaders, the teams requested for a list of 10 household heads classified as poor, middle and better-off.

2.7 Data Analysis

Once the data was collected, it was then migrated to SPSS for cleaning and analysis. Data processing and tabulation followed shortly after completion of data collection and was mainly done by the Eswatini VAA core team. Tables were produced for both rural and urban areas. For comparison purposes, rural and urban areas were separated. An improvement in coverage for the 2020 VAA was noticeable since the urban was also covered, unlike in the past years which saw the country covering only rural areas.

2.8 IPC Training and Analysis

The 2020 Eswatini VAA, just like the previous years, presented their evidence through the IPC framework. The IPC analysis framework entails bringing together sector experts who worked together through the analysis. A training of one and a half days was conducted by the local IPC facilitators. The country has two level-2 IPC certified officials. They conducted the training in support of other level-1 certified IPC analysts.

After the training, evidence from various sources, mainly from the Eswatini 2020 VAA, was uploaded into the ISS. Other pieces of evidence came from secondary sources, which include: socio-economic status of the country, health data, education data as well as information on humanitarian support.

3 SEASONAL PERFORMANCE

3.1 Rainfall Performance

The Kingdom of Eswatini experienced a late onset of the rainfall seasons, with most rains received in the last week of October. November, December and February had total monthly rainfall exceeding the corresponding long-term average. There were periods in the season which had dry spells, particularly mid-December and end of January. This had an adverse impact on tasselling maize plants and thus significantly affecting crop productivity. The total seasonal rainfall accumulation reflects that the Central to Central Eastern Lubombo, South-Western Shiselweni and North-Western Hhohho received below normal rainfall. The rest of the country received normal rainfall with portions of areas in the Highveld receiving slightly above normal rainfall. Figure 2 below shows a summary of the comparison of the rainfall received in the 2019/20 farming season against the previous (2018/19) farming season and the national long term average.

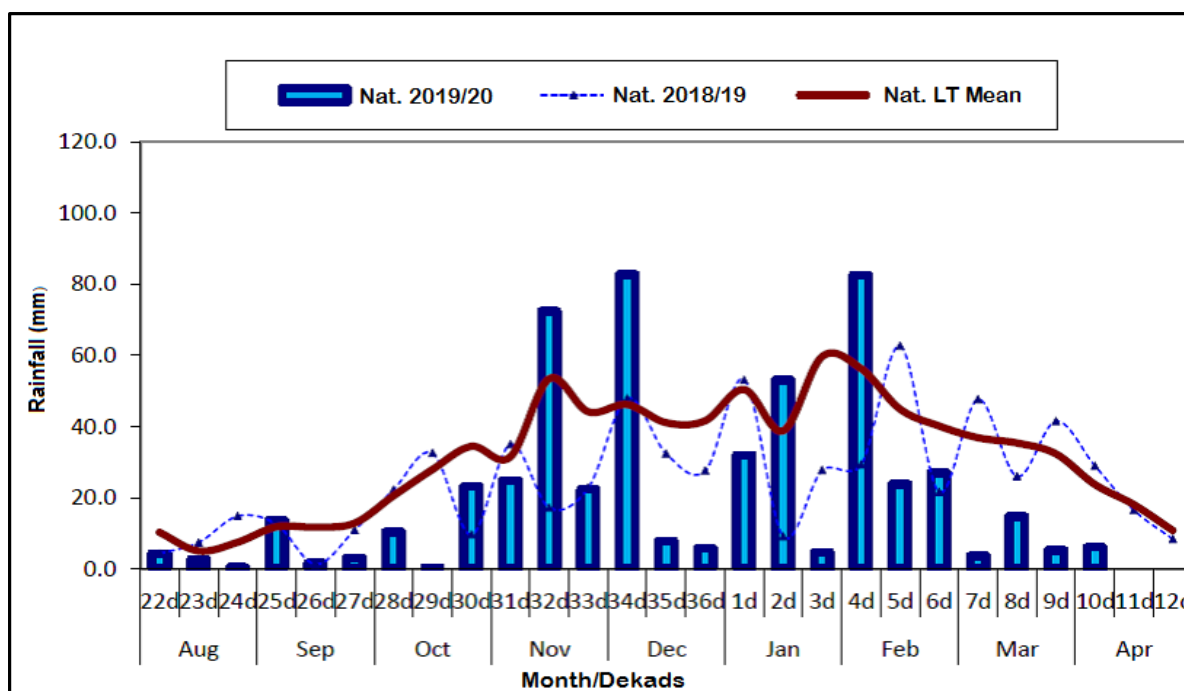


Figure 2: 2019/20 Rainfall Performance and Comparison to 2018/19 and long term average.

3.2 Agriculture Performance

The past agricultural season was characterized by delays in onset of rainfalls, resulting to a delay in the start of the harvesting season. The crop harvest was significant for maize, however, very low for other crops namely: legumes, sorghum and sweet potatoes which could potentially fail to sustain households until the next farming season. On livestock production, the rains had positive impacts. Pastures and water conditions were good in the wet season for livestock production to thrive.

The start of COVID 19 in March 2020 did not have much impact to the cropping season since it had already started. The effects of the partial lockdown resulted to a lot of households establishing backyard gardens in complementing their dietary needs and use of the free time that was a result of the break from work (working from home and restricted travel). The Ministry of Agriculture, through National Agricultural Marketing Board, had provided agricultural inputs, mainly seedlings and seeds, to individual farmers as a government intervention to improve the nutritional status in the country during the pandemic period.

In addition, the Ministry of Agriculture, through National Agricultural Marketing Board (NAMBOARD) and in collaboration with Food Agriculture Organization (FAO), had established a winter cropping programme to meet the maize deficit needs in the country. FAO had donated an amount of E1 million to support the winter cropping programme.

3.2.1 Maize Availability and Access in the country

The Ministry of Agriculture reported the current year's maize production quantities to be 86,547.90 MT at national level, while at regional level, the maize quantity harvested is 15,625 MT for Hhohho recorded, Lubombo recorded 3,993.1 MT, and Manzini was 45,497 MT while Shiselweni recorded 12,432.30 MT. The current year's maize production is 9% higher than the 5 years' averages (Figure 3).

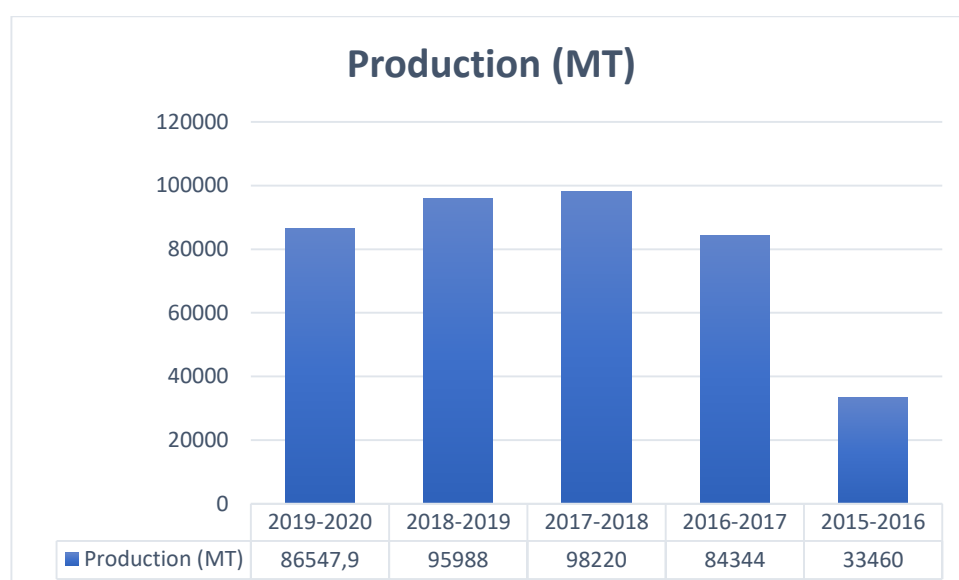


Figure 3: Maize production 5-year trend.

3.2.2 Cereal Availability

The overall country's requirement for cereals (maize, wheat and rice) is 252, 560 MT, while the domestic availability is 91, 390 MT (Table 2). This translates to a domestic shortfall of 161,170 MT which needs to be met through imports. Food imports are, therefore, estimated at 140,310 MT. Planned commercial imports stand at 121,970 MT and food aid is estimated at 18, 340 MT.

Table 2: The Cereal Food Balance Sheet 2019-20

Figures in '000 Metric Tonnes				
	Maize	Wheat	Rice	All
A. Domestic Availability	91.39	0	0	91.39
B. Gross Domestic Requirement	162.32	51.98	37.26	252.56
C. Domestic Shortfall/Surplus	71.93	51.98	37.26	161.17
D .Planned Imports	61.71	44.88	33.72	140.31
D1. Commercial	43.37	44.88	33.72	121.97
D2.Food Aid	18.34	0	0	18.34
Uncovered Gap/Unallocated Surplus	10.22	7.1	3.54	20.86

The cereal uncovered gap is 20860MT. Current food stocks in the country are sufficient for a period less than 6 months for most households. The new price increase of maize by NMC (E3100.00 per tones) will hike the price of mealie meal in the market before the next harvesting season when food stocks had been depleted.

The persistence of the pandemic threatens the coming planting season. The dependence of the country on South Africa for farming inputs makes prospects of the next planting season to be slim. As firms and markets are not operating to their full potential in South Africa, farming inputs may be limited in the country, resulting to higher input prices. Livestock drugs and animal care equipment may be in high demand in the coming season as livestock farmers undergo routine livestock vaccinations. Currently, there is an outcry of ear tags at dip tanks due to ear tags shortage in the market.

3.2.3 Livestock Production

After five years since the 2015/16 drought, livestock numbers are still struggling to reach their highest and farmers are still struggling with restocking. Livestock populations are increasing at a very slow rate, except for chickens which are rapidly increasing (Figure 4). This increase can be attributed to the good rains that we received in the past wet season.

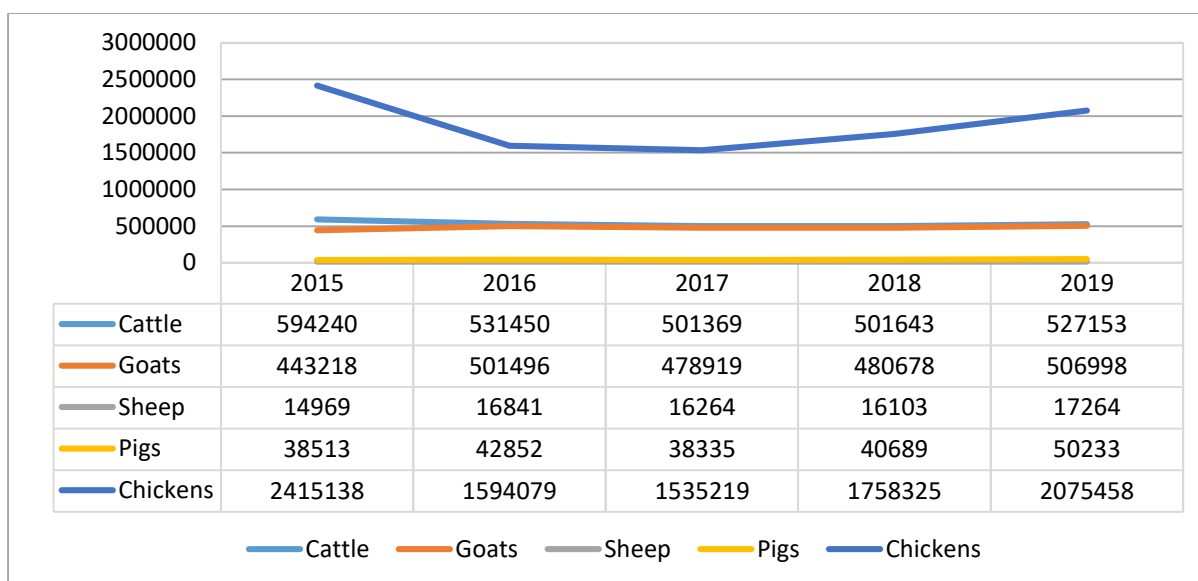


Figure 4: Livestock Statistics

Local pig production has been showing significant improvement, however, it was greatly affected by restrictions imposed as a result of the COVID-19 pandemic. Farmers are experiencing drug and vaccines shortages for their animals. There are also concerns with regards to marketing as local pig. Farmers are struggling to access and secure markets for pork. The establishment of free markets in all the country's urban areas provides a platform for marketing avenues for indigenous poultry farmers. However, due to the restrictions placed to avert the COVID-19 pandemic, indigenous poultry farmers have suffered a blow as free markets were also halted.

Most rangelands in the country, especially those that are in the Lowveld, lower Middleveld and Lubombo Plateau range from fair to good in condition. However, the rangelands under these zones have high bush encroachment and Alien Invasive Plant Species which decrease the grazing capacity and value of the rangelands, thus affecting livestock production and productivity. Majority of the earth dams have average water levels. Some earth dams are, however, dry hence there is already water scarcity for livestock, especially in areas around Lowveld. Rangelands from the Highveld and upper Middleveld range are fair in condition but are, however, dominated by less palatable grass species. Water availability is good under these zones given the good rainfall received during the latter part of the season. The late rains

have also resulted in the accumulation of high biomass in most Highveld areas which is a fire hazard that threatens fodder availability in these areas.

4 KEY FINDINGS

4.1 Demographics

The demographic characteristics of the households are one of the key variables in any assessment and in many instances, form part of the basic variables with which the rest of the variables are cross-tabulated. The ESVAC 2020 collected a number of demographic variables including sex of household head, age, education level, household size, and marital, among others. The demographic variables collected are presented below.

4.1.1 Sex of Household Heads

Figure 4 below indicates that in rural areas, male headed households were estimated at 56% while female headed households were at 43%. In the urban, male headed households were estimated at 36% against 63% female headed households. When comparing rural and urban areas, rural households are predominantly male-headed (56% vs 43%) compared to urban households where households' headship is female dominated (64% vs 43%) (Figure 5). A similar pattern is also observed between regions. These differences can be attributed to culture and/or traditional structures that tend to exist strong in rural areas in patriarchal societies and tend to weaken in the urban space.

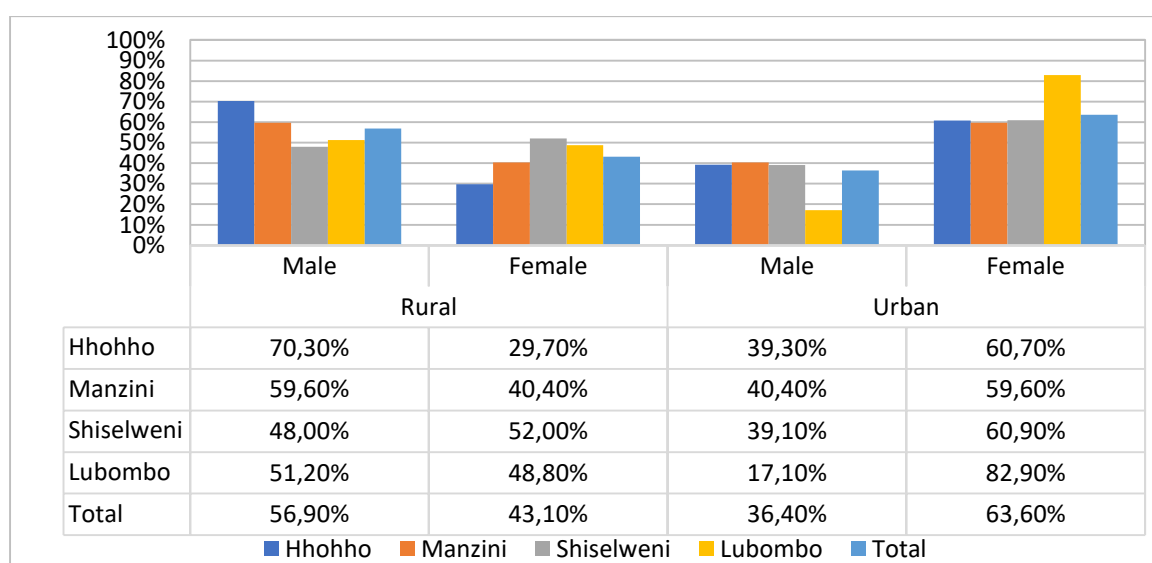


Figure 5: Household headship, both in rural and urban areas by administrative region

4.1.2 Sex of Household Heads

Age of the household head is another demographic variable that is useful, mainly in measuring households' level of vulnerability. Households headed by children are usually more vulnerable compared to those headed by adults. According to the 2020 VAA, only the rural areas reported households headed by children between the ages of 15 and 24 years, while the urban areas reported the youngest household head to be 25 years old. This highlights a higher exposure and vulnerability to food insecurity related issues in rural areas compared to urban areas in the country. Cultural, traditional and social dynamics play a significant role in household headship in both rural and urban areas.

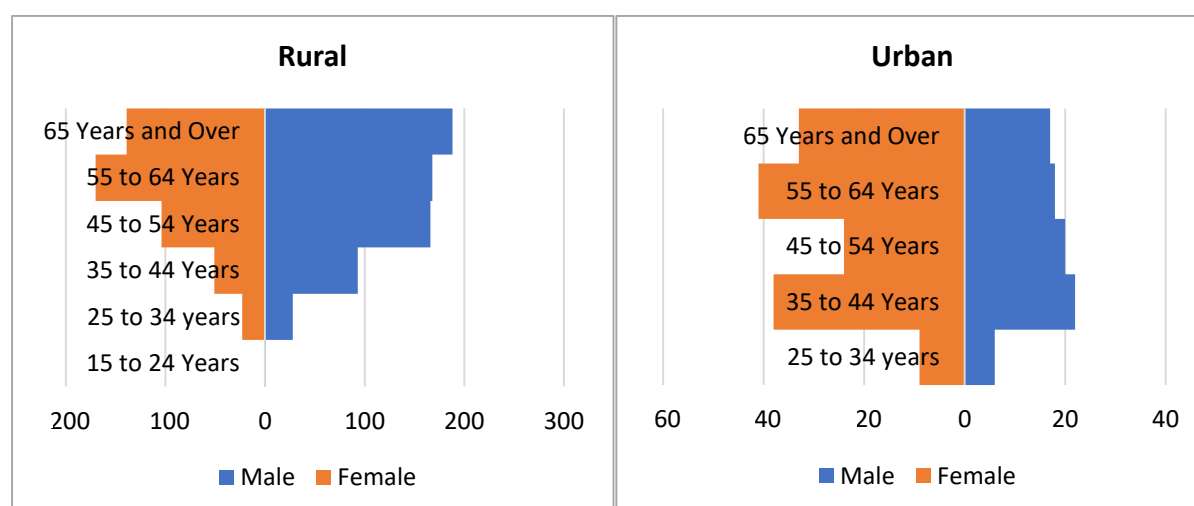


Figure 6: Household headship by sex and age

4.1.3 Household Size

Household size is one of the major determinants of food (in)security, hence it was necessary to capture this variable to measure households' vulnerability, stress and exposure to food insecurity. Food security studies show that the larger the household size, the more food is needed to sustain the household, hence the indicator was found to be important in this food security assessment. This year's assessment points to an average household size of eight (8) in rural areas, and six (6) in urban areas. As expected, urban areas are characterised by small household sizes compared to their rural counterparts as illustrated in Table 3 below and the Shiselweni and Lubombo regions have the largest household sizes.

Table 3: Household size in rural and urban areas by administrative region

Region	Rural	Urban
Hhohho	7	6
Manzini	7	5
Shiselweni	8	5
Lubombo	8	6
Total	8	6

4.1.4 Employment status of household head

The employment status of the household head is also an indicator that can be used in order to establish household's vulnerability. If the household head is employed, the vulnerability of that household is said to be low compared to those with unemployed household heads. The assumption is that most households consider paid employment as their main livelihood. According to the 2020 assessment, most household heads, in general, were found to be unemployed (53% in rural and 61% in urban). The employed few were mainly self-employed in both rural and urban areas where 22% and 18%, respectively, were found to be self-employed. The level of unemployment was found to be higher in urban areas (61%) than in rural areas (53%), by comparison. Employment status varied also with region with Shiselweni being home to 82% of the urban unemployed and Lubombo hosting 70% of unemployed rural population (Figure 7). This has an implication on food security, especially in urban areas where purchasing power is a key determinant for food access.

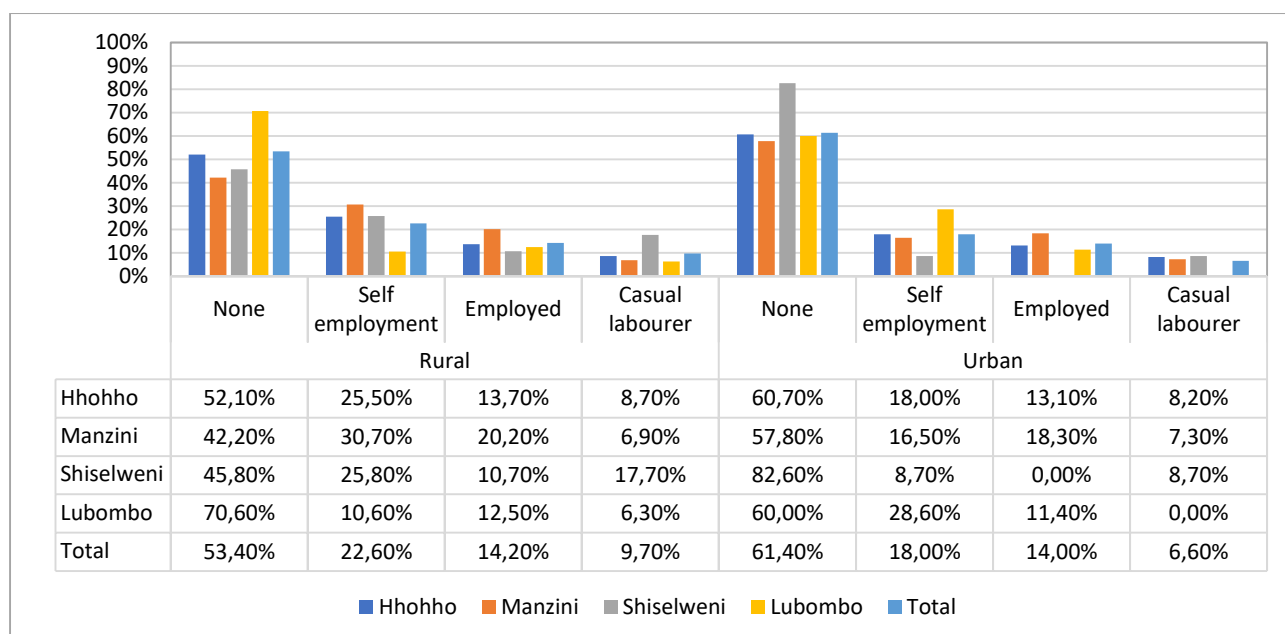


Figure 7: Employment status of household head in rural and urban areas by region

The high unemployment observed in urban areas in the country can be attributed to several factors, among which is the COVID-19 pandemic which has greatly affected household's livelihoods in many sectors. It was necessary, therefore, for this assessment to establish the impact of the pandemic on employment. First it was to establish if households reported members on employment in order to come with households faced with unemployment challenges as well as to investigate if household members lost a job or faced reduction in income due to the COVID-19 pandemic. The results revealed that about 30% households reported their members to have lost employment in rural areas and 46% reported the same in urban areas (Figure 8). It can be concluded that more households have reported to have lost jobs and/or employment in urban areas than in rural areas, with Manzini region reporting more job losses and/or reduction of income due to the COVID-19 pandemic. Otherwise, the pattern looks similar in all the regions, with the exception of Shiselweni region where more rural households (31% vs 13%) reported to have lost employment than urban areas (Figure 8).

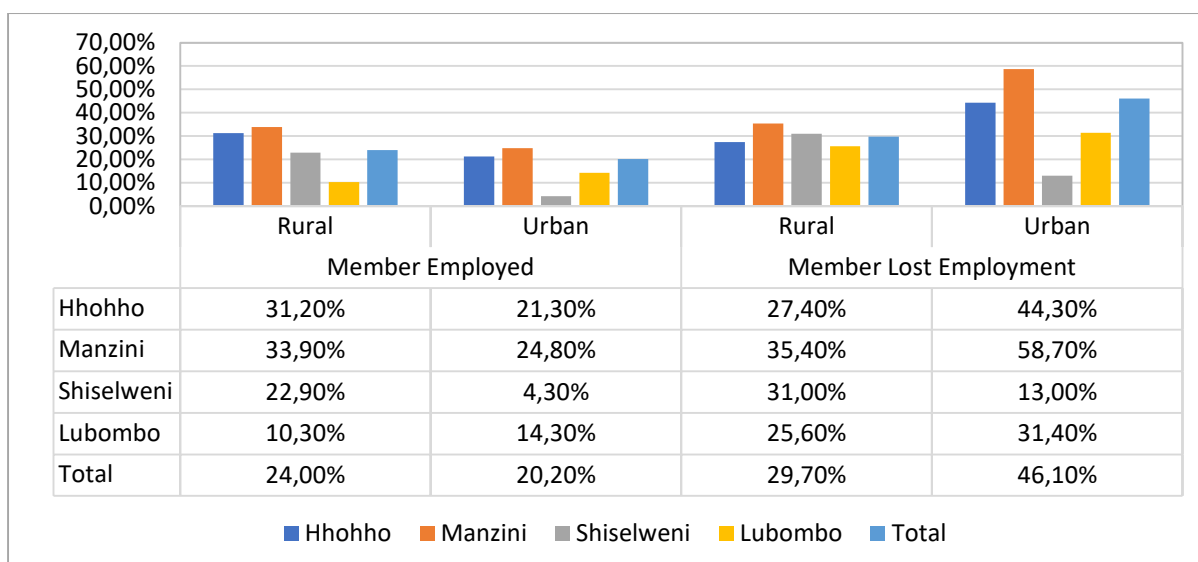


Figure 8: Household head that lost employment in rural and urban areas by region

The assessment further established sectors of the economy with which the job was lost, that is sectors where household members were working before job loss and these are captured in Table 4 below. The results reveal that household members working in the manufacturing sector, including the textile industry, were hit hard by the COVID-19 pandemic as 23% reported to have lost employment from this sector and the Shiselweni region was the most affected (33%). The next sector that was equally affected was the retail and wholesale sector (16%) with Manzini being the lead (Table 4).

Table 4: Sectors which experienced employment losses by administrative region

Sector	Hhohho	Manzini	Shiselweni	Lubombo	Total
Manufacturing	15.30%	22.40%	33.30%	23.20%	23.80%
Retail sales and wholesales	16.70%	25.50%	4.80%	15.90%	16.10%
Household and domestic chores	5.60%	5.10%	28.60%	13.40%	13.10%
Agriculture, forestry and fisheries	15.30%	12.20%	11.90%	12.20%	12.80%
Construction	20.80%	10.20%	3.60%	11.00%	11.00%
Transport	4.20%	0.00%	11.90%	9.80%	6.30%
Hotels, restaurants and Accommodation	5.60%	7.10%	1.20%	4.90%	4.80%
Mining and quarrying	8.30%	3.10%	0.00%	3.70%	3.60%

Education	4.20%	2.00%	1.20%	3.70%	2.70%
Health and personal care	0.00%	6.10%	0.00%	1.20%	2.10%
Public administration and defence	1.40%	5.10%	0.00%	0.00%	1.80%
Energy Sector: Electricity, Gas, water and Petroleum	1.40%	1.00%	2.40%	0.00%	1.20%
Financial and banking services	1.40%	0.00%	1.20%	1.20%	0.90%

4.2 Access to arable land

For this current year, the area planted was 77,189.20 hectares, which is 12% above the five-year average and 10% above last year's planted area. The results indicate that 81% of households, nationally, have access to arable land while the rest (19%) lack access to arable land. The Shiselweni region had the highest (91.9%) number of households with access to arable land, while Lubombo had the low (70%) proportion of households with access to cultivation land (Figure 8). Fewer females (75.8%) compared to males (84.9%) have access to arable land and this is true across the four regions, with the Lubombo region displaying a higher gender disparity (66% vs 73.8%) (Figure 9). This reflects the continued marginalization of women which is perpetuated by traditional structures that characterize most patriarchal societies.

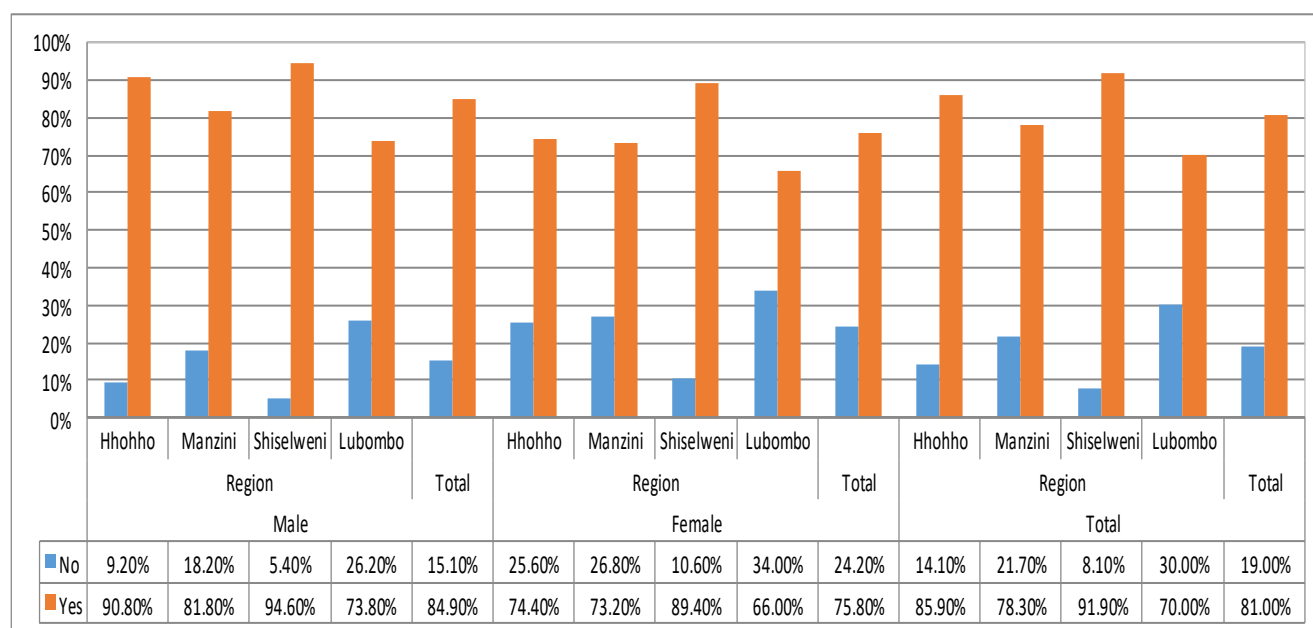


Figure 9: Percentage Households with Access to Arable Land by gender and Region

4.3 Household Food stocks

At national level, 34% of households reported to have harvested food stocks that would last for a period of 0-2 months, with most of these households found in the Lubombo region. The rest of the households reported to have food stocks that would last for a period of 3-5 months (28.3%), 6-8 months (16.3%), 9-11 months (9.1%) and 12 months and more (12.3%) (Figure 10). It is important to note that Lubombo region recorded the highest percentage (53%) of households with food stocks lasting for at most 2 months, with no household with food stocks that would sustain them for the whole year (12 months). Hhohho region, on the other hand, has a reasonable proportion (15.4%) of households who will have food stocks the year round. The gender disparity observed on access to arable land tends to filter into the food stocks. As such, more females (43.6%) compared to males (29.3%), nationally, have food stocks that would last 0-2 months. The opposite is true for households with stocks that would last for at least 12 months where a larger proportion of male-headed households (16.6%) compared to very few female-headed households (4.4%) who have food to sustain them for at least twelve months, which highlights an even more glaring gender disparity. Again, this is more pronounced in Lubombo region where more females compared to males (59.5% vs 48.9%) have food stocks to last them at most 2 months and none among females have food stocks to sustain them for at least 9 months while males do, although they are also few (2.1%) in this region (Figure 10).

Generally, many households in the country have low food stocks (food stocks lasting for 0-2 months), which suggests that most of the households in the country will quickly run out of food and would have to rely on purchases to supplement their food stocks until the next farming season. However, the situation is worse for female headed households who will have to survive on a much more limited food stock, which also highlight their vulnerability to food insecurity.

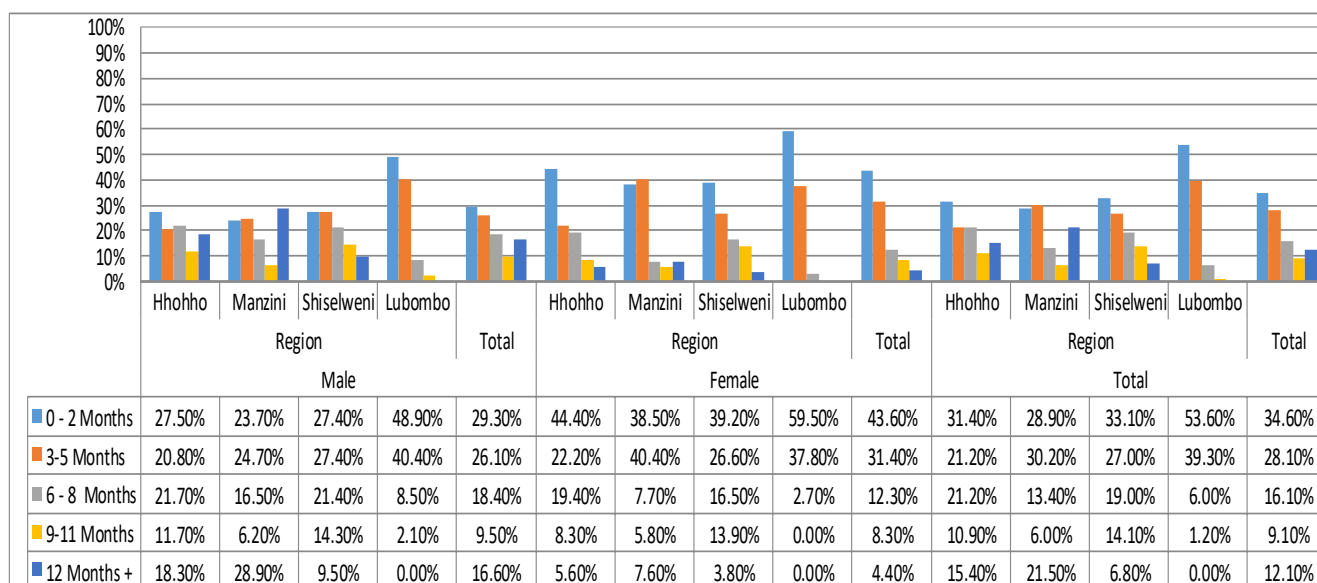


Figure 10: Duration harvested maize will last

Access to Markets

In terms of access to market and trade, the results point to an abnormal situation where half (50%) of the sampled households reported to have not been able to access consumption goods in the way they usually do, and this abnormality was attributed to the COVID-19 pandemic, following a three months lockdown dictated by the exponential growth in COVID-19 infections, hence the implementation of control measures to try and flatten the curve.

As a consequence of the lockdown, many businesses started-off by scaling down operations and cutting down on staff. On worse cases, some businesses had to shut down completely. The loss of income from employment became a new reality faced by households in most parts of the country. This was reported in most households (slightly over 50% households), however, there was no significant variation in the impact of the lockdown between male and female headed households.

The ability of households to cope with the non-access to basic commodities was mitigated, in most cases, by the availability of alternatives in the market, and to a very limited extent, by availability of reserves or employment and other coping mechanisms. Support from humanitarian agencies and Government has been received but not enough to cover all the needs that would otherwise be met through households' own survival means.

4.4 Household Shocks and Coping Strategies

Over the course of the year, households were faced with a number of shocks that had an impact on households' ability to meet their food and nutritional needs for the current and projected period. Overall, 80% of households reported to have experienced shocks over the past 12 months. Both urban and rural households reported to have been exposed to shocks, however, with the urban population being slightly more vulnerable to shocks than its rural counterparts (82% vs 80%). At national level, more females (82%) compared to males (79%) experienced shocks and this observation seems to hold also for both rural and urban settlements where more females compared to males reported to have experienced shocks in rural areas (81% vs 79%) and urban areas (85% vs 77%). It should be noted that although both rural and urban households experienced shocks, urban households tend to be more vulnerable to shocks (85% vs 81%) than rural households. Also important to note is that the level of vulnerability of the regions tends to vary, with Lubombo region being more vulnerable to shocks in both rural and urban settings, regardless of gender. The high level of vulnerability of female-headed households in Shiselweni (93% vs 76%) is also worrying (Figure 11). The high level of exposure of urban Shiselweni to shocks can be attributed to the COVID-19 lockdown and restrictions which led to business closure. The urban population, especially females, relies almost exclusively on wage employment in the firms in Nhlanguano. The closure of these firms, loss of and/or reduced employment could have led to their high exposure to shocks.

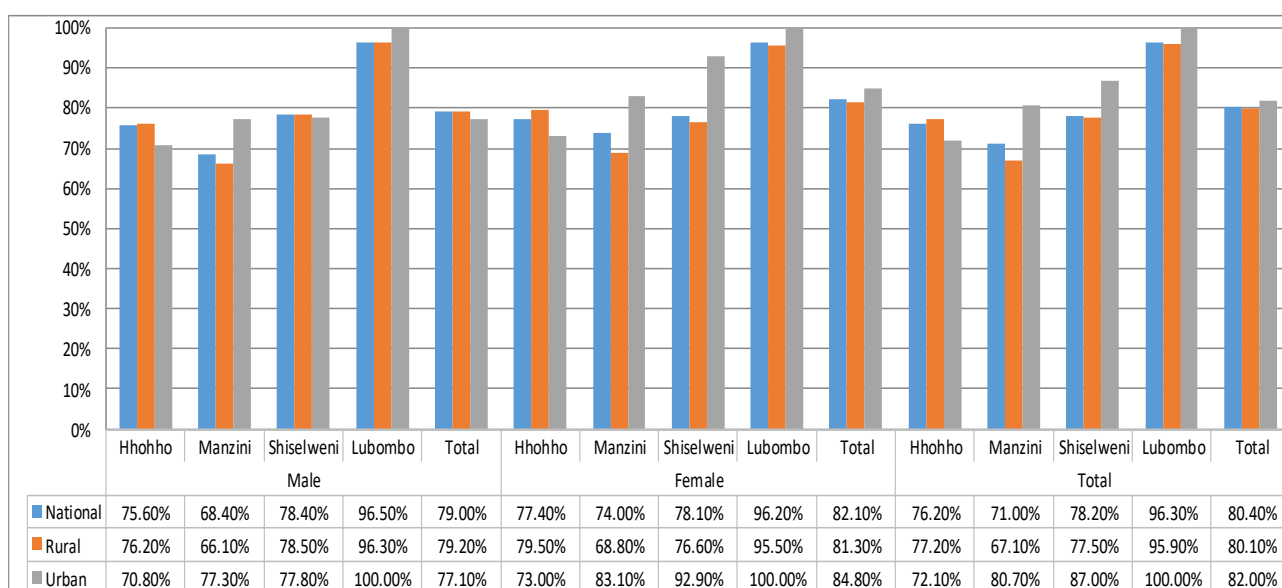


Figure 11: Households experiencing shocks in rural and urban areas by gender and region

The assessment further captured the different shocks faced by households in both urban and rural areas. Irregular rains (54%), reduced income (32.7%), loss of employment for household member (29.6%) and high food prices (16.1%) constitutes major shocks reported by rural households (Figure 12). The advent of the COVID-19 pandemic has magnified the severity and number of reported shocks, mainly impacting people's livelihood. This was more evident with urban households, mainly as a result of the COVID-19 prevention measures (i.e. the partial lockdown, loss of livelihood and reduced income for many households). Reduced income (56%) account for the major shock in urban areas, followed by loss of employment (39%) and high food prices (15.2%). Weather-related shocks, given the nature of urban livelihood, only accounts for 13% of the shocks reported (Figure 12).

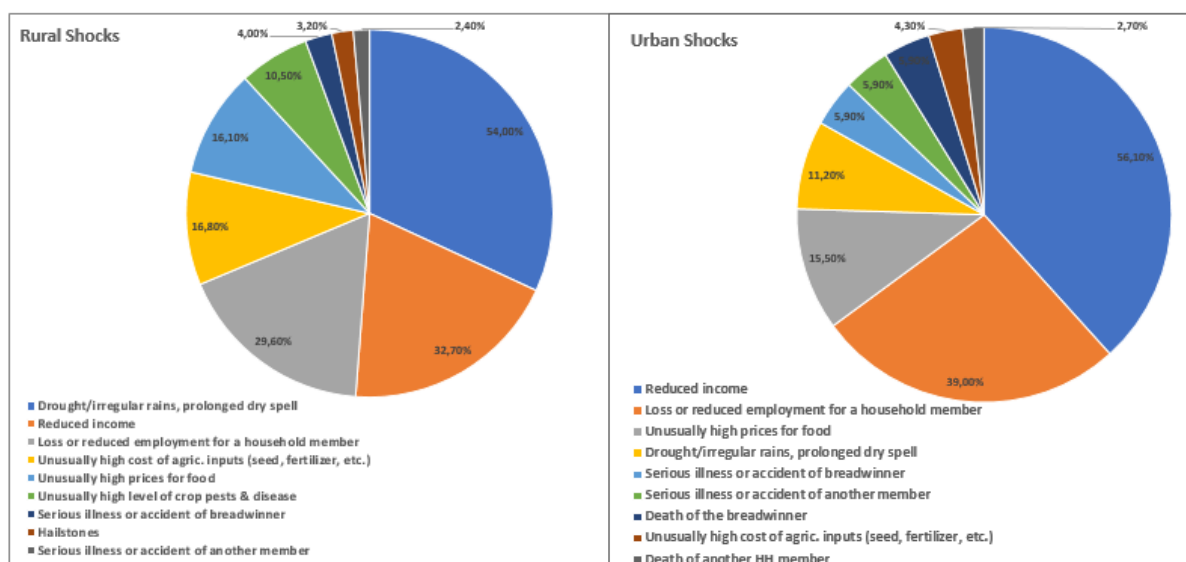


Figure 12: Shock faced by households by location

It was necessary to find out when the shocks were experienced (pre-COVID-19 or post COVID-19) to determine if the experienced shocks were related to the pandemic. Generally, shocks were experienced before and during COVID-19 outbreak, however, with some variations between regions (Figure 13). The Lubombo region has the highest proportion of households that have experienced shocks over the past 12 months with the Hhohho and Shiselweni following suit. Weather related shocks were key shocks reported in the rural areas, as more than 54 % of households reported drought and irregular rains as the main shocks faced during the year.

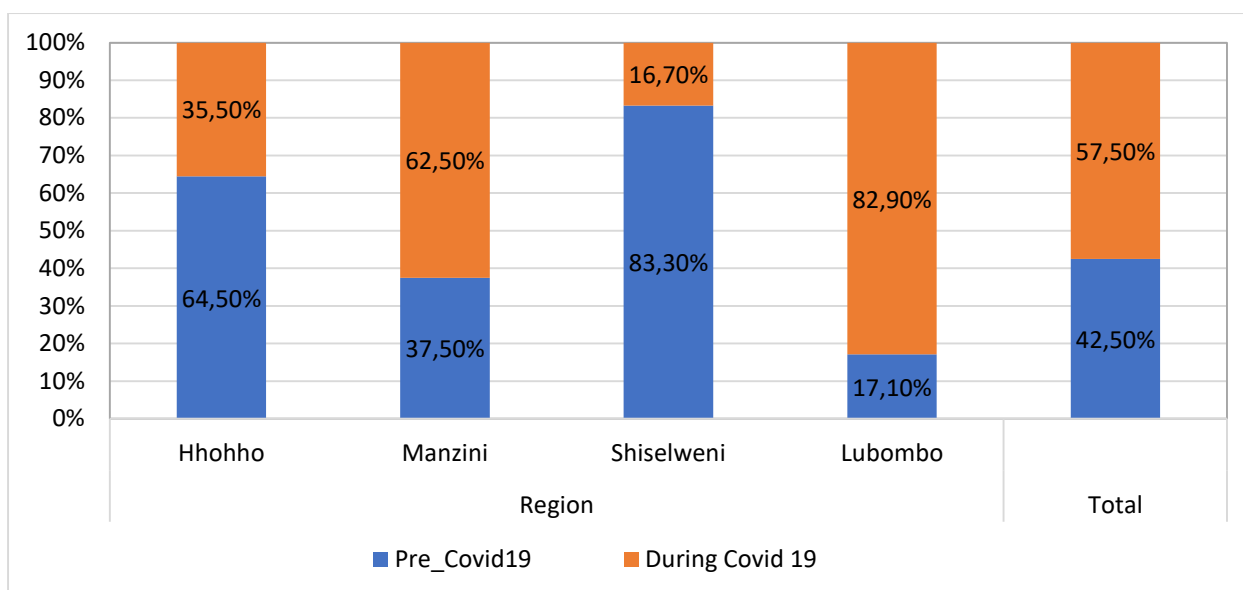


Figure 13: Time when shocks were experienced in the different regions

4.5 Food security indicators

4.5.1 Reduced Coping Strategies

When livelihoods are negatively affected by a shock/crisis, households adopt various mechanisms (strategies) which are not adopted in a normal day-to-day life, to cope with reduced or declining access to food. Based on a recall period of 7 days, the Reduced Coping Strategy Index (rCSI) measures food-based household's behaviors and strategies undertaken in periods of food shortages. rCSI combines: (i) the *frequency* of each strategy (how many times each strategy was adopted?); and (ii) their (*severity*) (how serious is each strategy?) for households reporting food consumption problems. Higher rCSI indicates a worse food security situation and vice versa. rCSI is a particularly powerful tool for monitoring the same households or population over time.

This current assessment indicates that the use of the food-based coping strategies has worsened over time in the country as 25% of rural households are reported to be engaged in severe coping strategies as a result of lack of food; with 51% engaged in moderate coping and 25% with little or no coping (Figure 14). The Shiselweni (51%) and Lubombo (30%) region have the highest proportion of households that are engaged in severe coping strategies in indication of high food insecurity in the regions. The Hhohho region has no household engaged in severe coping strategies. Given the upcoming consumption period, the situation

is expected to slightly improve for some households in rural area as food from own production is expected to improve. The picture for the urban areas (Figure 15) points to the same situation as a large proportion (26%), nationally, engaged in severe coping strategies, with 47% engaging in moderate coping strategies and 27 per cent with no coping mechanism.

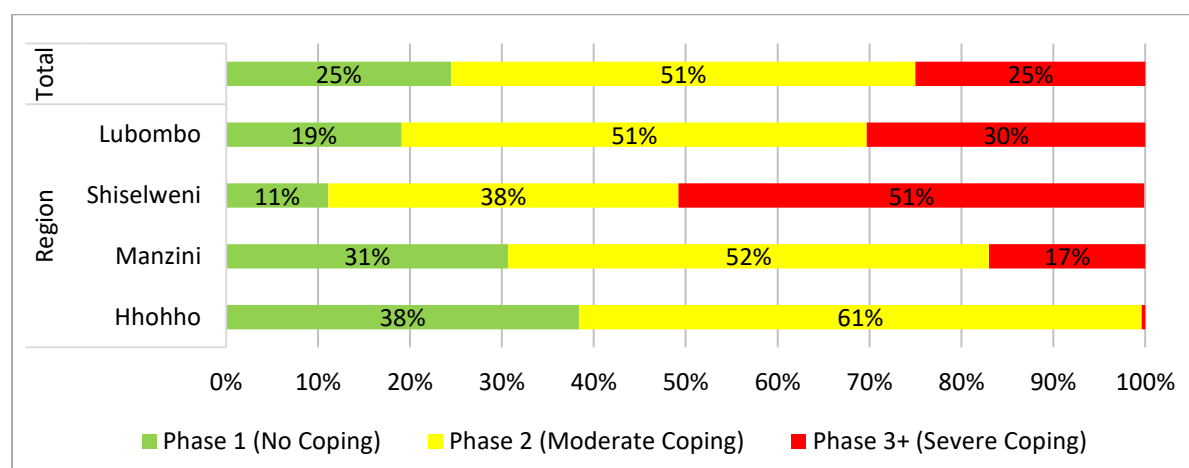


Figure 14: rCSI Categories by administration region – rural

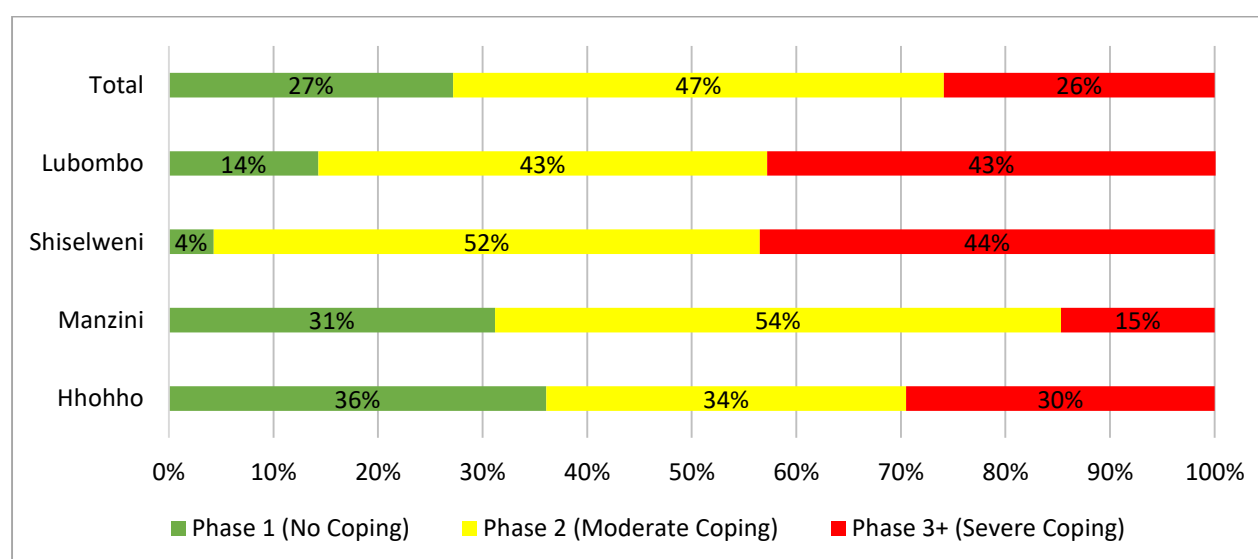


Figure 15: rCSI Categories by administration region - Urban

rCSI was further cross tabulated by gender. The results indicate that more females were found to be in Phase 3+ compared to males (31.8% vs 19.7%). Contrary, more males were found to be in Phase 1 compared to females found in the same Phase (30.9% vs 16.4%). This does not only highlight the vulnerability of women to shocks compared to their male counterparts, but

also indicate that females apply diverse strategies to cope with food shortages and other shocks.

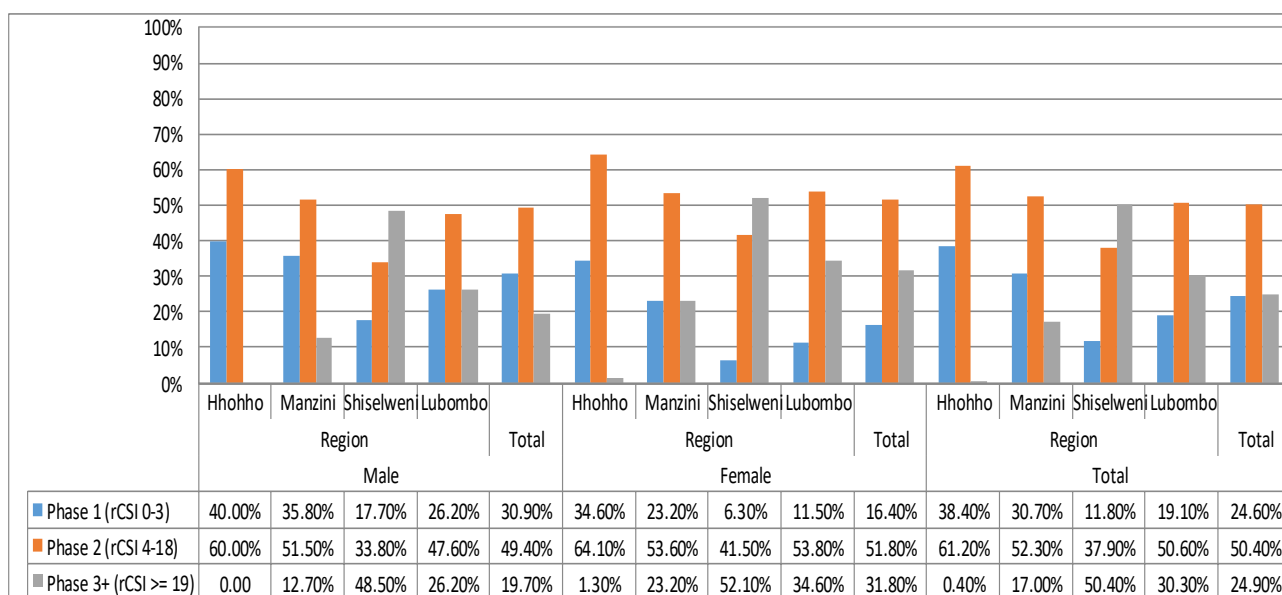


Figure 16: rCSI Categories by gender and administration region – rural

4.5.2 Livelihood coping strategies

The livelihood coping strategies are used to better understand longer-term coping capacity of households and are divided into 3 categories i.e. Stress, Crisis and Emergency. Responses are used to understand the stress and insecurity faced by households and describes their capacity regarding future productivity. Unlike the consumption-based coping strategies, the recall period is 30 days instead of 7, and it does not capture the number of times each strategy was undertaken. Households have also engaged in livelihood-based coping strategies as a result of the reported shocks. A majority of rural households (44.4%) are using crisis-based coping strategies (Figure 17). Households reported to be selling non-productive assets and reducing spending on health and education to meet their food needs. Households engaged in emergency coping strategies are at 8.5% per cent, where household are disposing their productive assets and engaging in risky behaviour as means to meet their food needs. Increased use of livelihood-based coping strategies will likely have a negative impact on households' ability to cope with future food security shocks which will, in turn, increase their vulnerability to food insecurity.

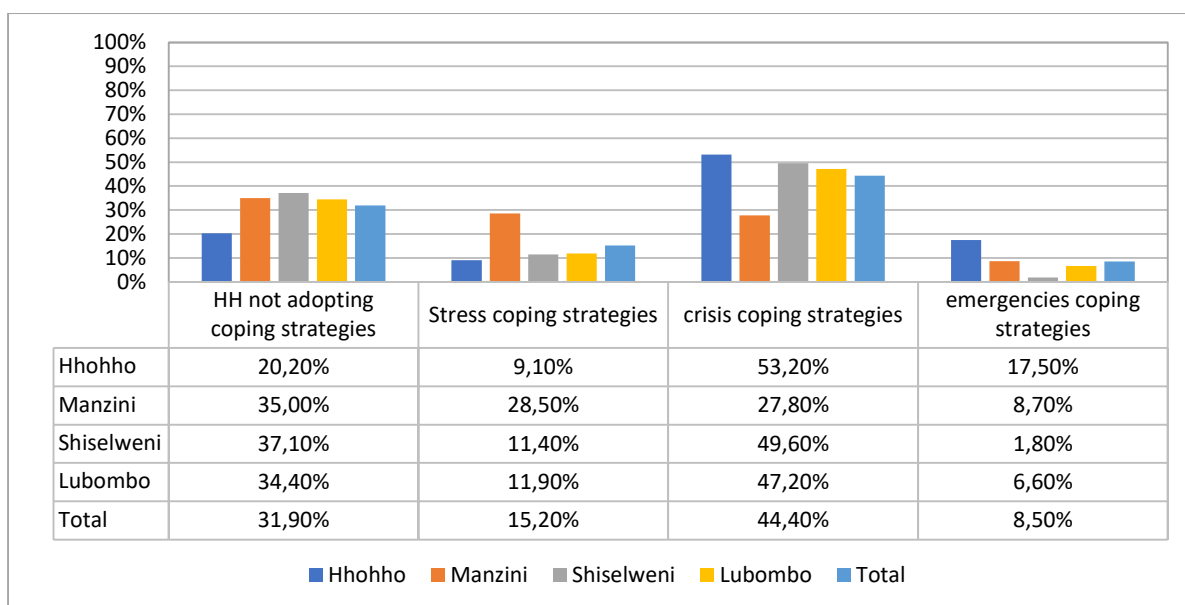


Figure 17: Households' livelihood coping strategies by administrative region - rural

In comparison to previous years, there is an increase in the use of coping strategies in all the regions (Figure 18). Households were faced with increased food insecurity shocks which resulted in increased means employed by households to meet their food needs. The National average is at 10 with the Lubombo region (18) having the highest proportion of households engaged in increased coping as a result of increased food insecurity in the current year.

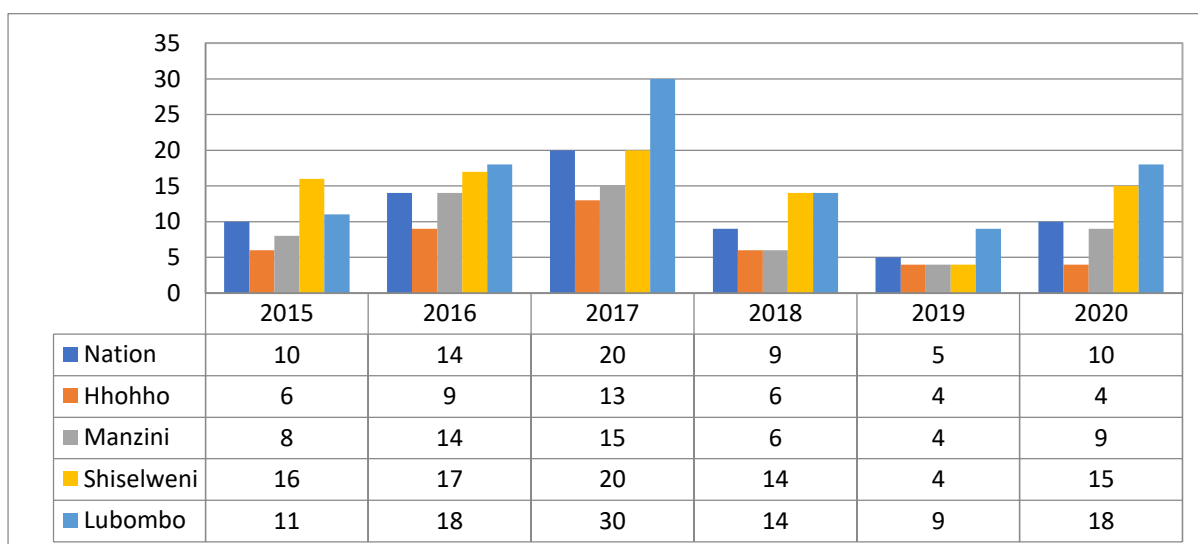


Figure 18: Households CSI by region from 2015-2020

4.5.3 Food Consumption Score

The household Food Consumption Score (FCS) module is used as a proxy indicator for household food security. The Food Consumption Score is a measure of dietary diversity, food frequency and the relative nutritional importance of the food consumed. The FCS is used to classify households into three groups: poor, borderline or acceptable food consumption and the households with acceptable food consumption are considered food secure, while those with borderline or poor food consumption are considered moderately or severely food insecure respectively. The results indicate that, slightly above half (53%) of the rural households have acceptable food consumption, 29 percent have borderline and few (18%) have poor consumption. A regional variation is noticeable, which indicates that Lubombo has the highest proportion of households (30%) with poor food consumption compared to the other regions, followed by Hhohho with 28 per cent. Manzini, by comparison, is better off in terms of food consumption where majority of the population (69%) have acceptable food consumption patterns with very few (3%) with poor consumption (Figure 19). Compared to the previous year the situation has worsened as the proportion of households with borderline or poor consumption has increased while those with acceptable consumption decreased. The impact of shocks and the COVID-19 pandemic had affected households access to adequate food.

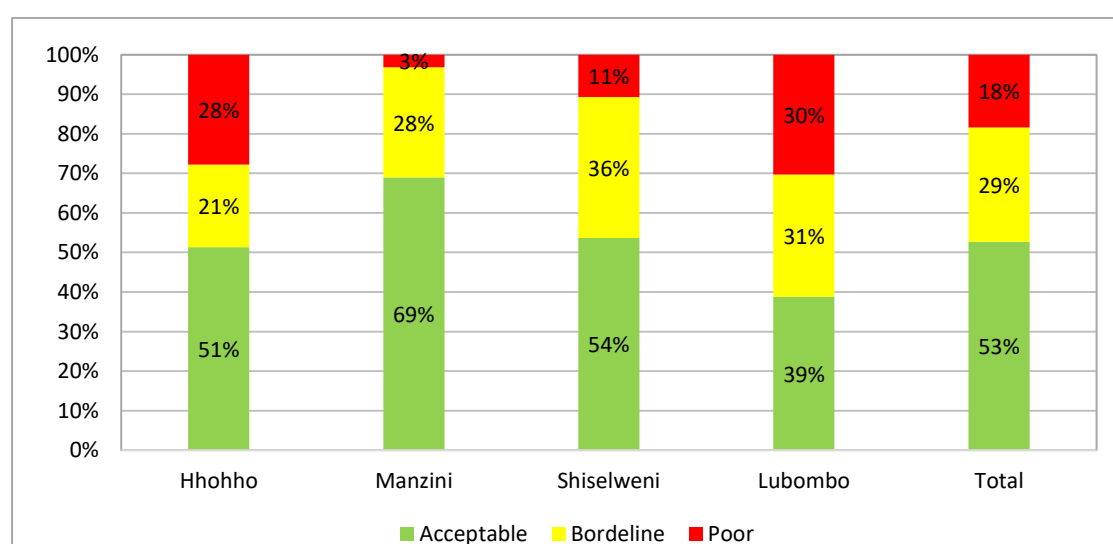


Figure 19: Food Consumption Score - rural

Hosting HIV patients tends to have a negative impact on food consumption, as overall food utilization is compromised and households tends to spend more resources on health. Fewer households among those hosting HIV patients compared to none hosting households had acceptable consumption behaviour (50% vs 55%). Likewise, more HIV hosting households compared to none hosting had borderline cases in food consumption (32% vs 26%) (Figure 20).

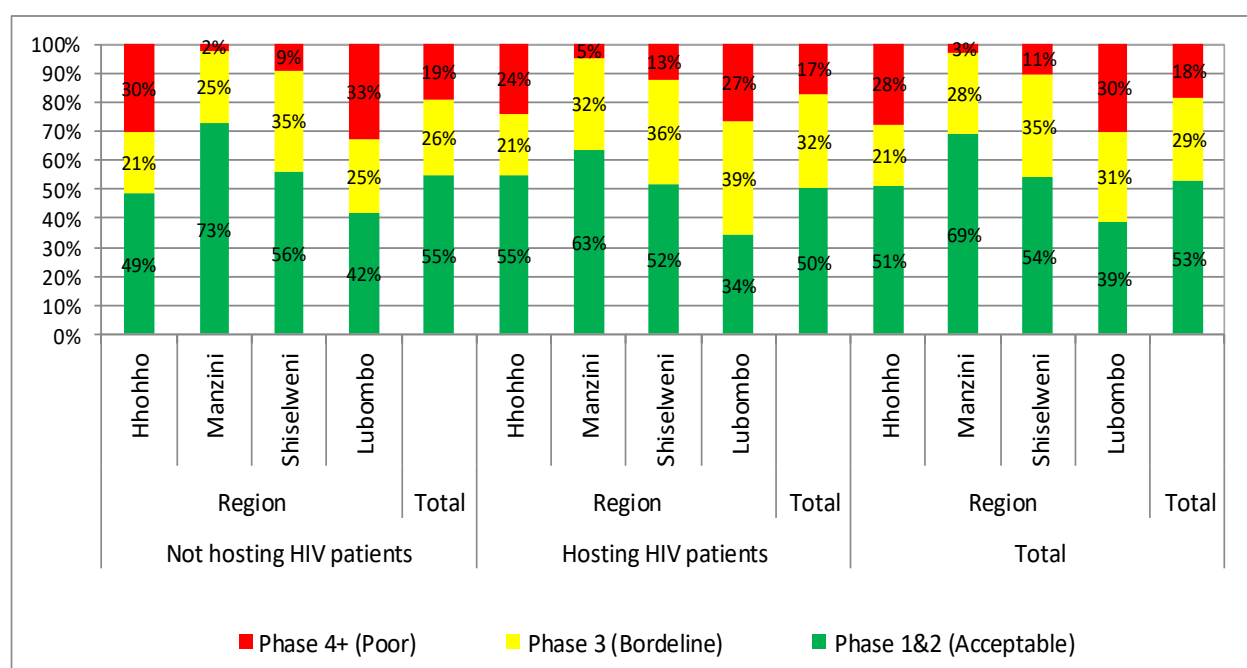


Figure 20: Food Consumption Score for households hosting HIV patients

Even though faced with a number of shocks, households in the urban households had a higher and acceptable level of consumption. Overall, the two regions under analysis for the urban areas indicate that 78% of households had acceptable consumption levels while 22% have borderline and poor consumption in urban Eswatini (Figure 21). Given that most of the households depend on markets to access their food, availability of food has been stable, such that access to food is possible for most households even though observed increases in prices and loss of livelihood will compromise poor households' ability to access adequate food leading to increased food insecurity.

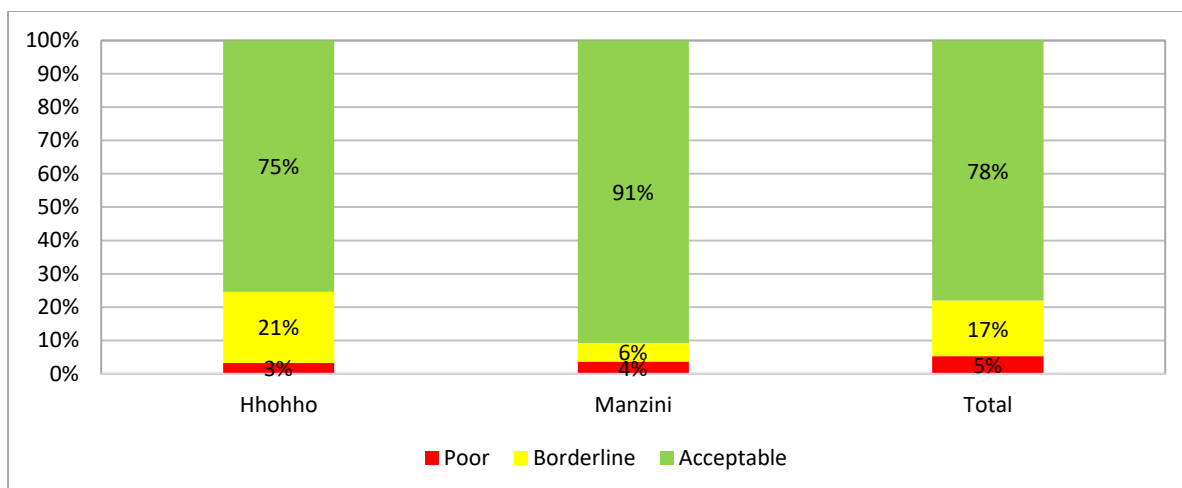


Figure 21: FCS for Hhohho and Manzini regions – Urban

4.5.4 Household Dietary Diversity Score

The Household Dietary Diversity Score (HDDS) is a qualitative measure of food consumption that reflects household access to a variety of foods. HDDS is, however, not meant to be used in accessing dietary diversity at individual level. An increase in the average number of different food groups consumed at household level provides a quantifiable measure of improved household food access. In general, any increase in household dietary diversity reflects an improvement in the household's diet.

The consumption of diversified food groups has improved in the country as 48 per cent of households have reported to be consuming 5 – 12 food groups (Figure 22). This is an improvement from 2019, where only 6 per cent of households had a high HDDS. Access to diversified food groups have improved, overall, indicating improved households' diet for the period as consumption. Hhohho and Manzini regions have the highest proportion of households with high food diversity, while Lubombo has the highest proportion of households with low HDDS (consuming few food groups 0 – 2).

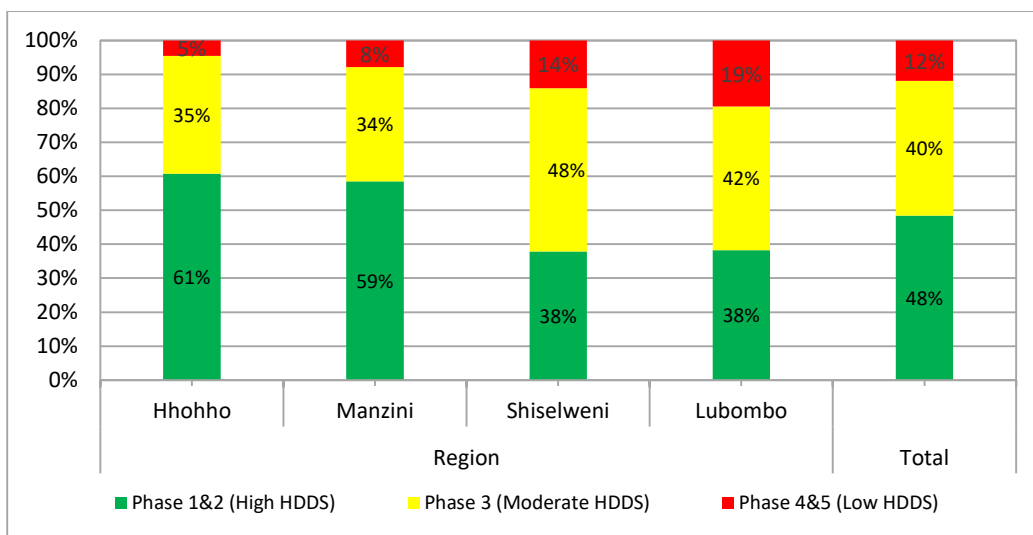


Figure 22: Households Dietary Diversity - Rural

Hosting HIV patients seems to impact negatively on household diet. Fewer households who host HIV patients compared to those who do not host HIV patients have a high HDDS (43% vs 52%). On the other hand, more households who host HIV patients compared to those who do not host them have a moderate HDDS (43 vs 38%) and poor HDDS (14 vs 10%) (Figure 23).

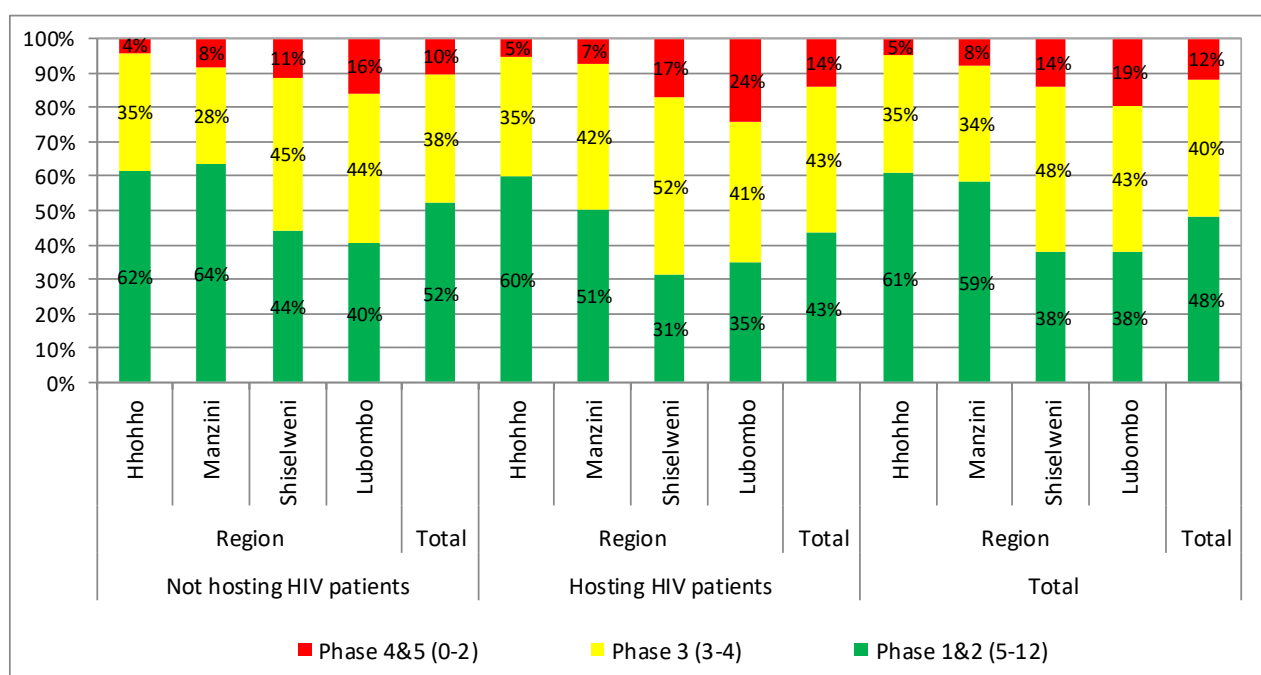


Figure 23: Household Dietary Diversity of HIV hosting households - Rural

Consumption of diversified food group in urban areas is also high as 50% reported to be consuming 5 – 12 food groups. Overall, 8% have low consumption diversity, consuming less than 2 food groups. Worth noting is that female-headed households tend to have a lower dietary diversity compared to male-headed households. Fewer females compared to males were found to have a higher HDDS (45% vs 60%). Instead, majority of females were found to either have a moderate (46%) or low (10%) HDDS compared to males where fewer, compared to females had moderate (36%) and low (4%) HDDS (Figure 24).

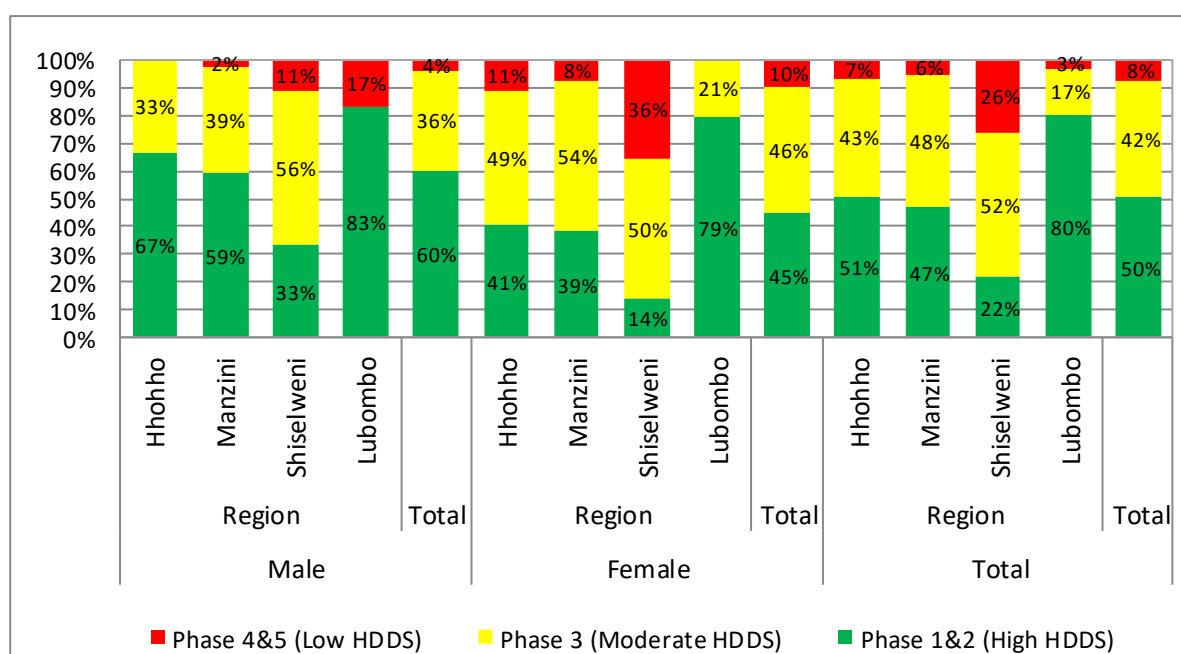


Figure 24: Household Dietary Diversity by gender - Urban

4.5.5 Household Hunger Score Categories

Household Hunger Score is a proxy of food access. The HHS is built around 3 questions about perceptions of a household on varying degrees of hunger by the number of times a household has experienced hunger within past 30 days prior to the survey. Overall, 10 percent of rural households have indicated to have been faced with severe hunger over the period, while 34 per cent faced with moderate hunger. The Lubombo region, has the highest proportion of households (17%) that have experienced severe hunger, followed by the Shiselweni region, where 11 per cent of households under this category. These are the regions that are normally characterised by high food insecurity challenges in the country. Manzini region (with 73 per cent) has the highest proportion of households facing little or no hunger of the reporting

period (Figure 25). Under the urban areas, the same proportions are observed as in the rural area where only 14 percent of household are faced with severe hunger, 25 per cent with moderate while 62 per cent faced with little or no hunger. under Manzini urban 14 per cent of households are faced with moderate (8%) or severe hunger (6%). Hhohho urban has 14 per cent experiencing severe hunger while 34 per cent faced moderate hunger (Figure 26).

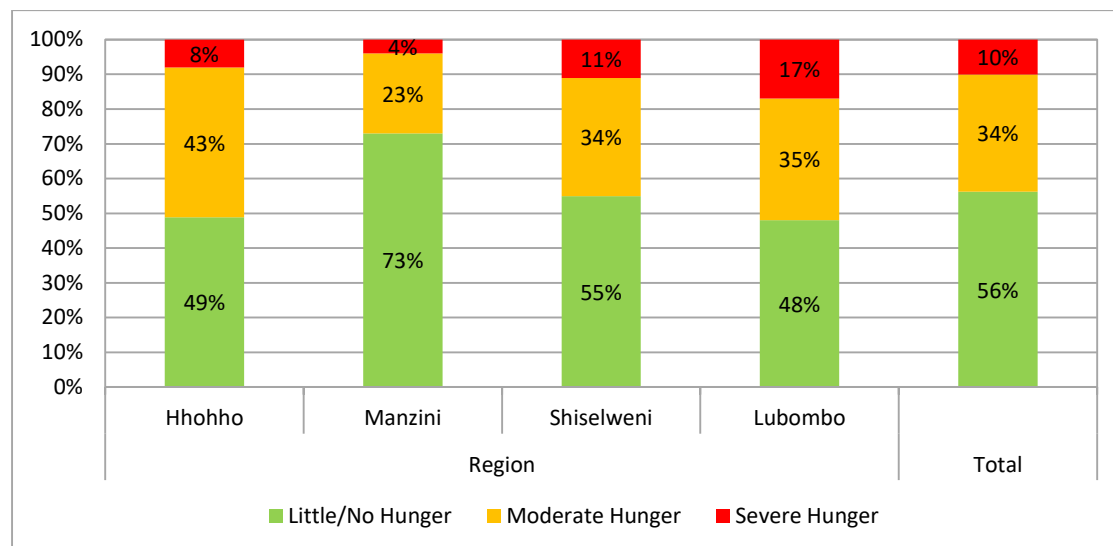


Figure 25: Household Hunger Score - Rural

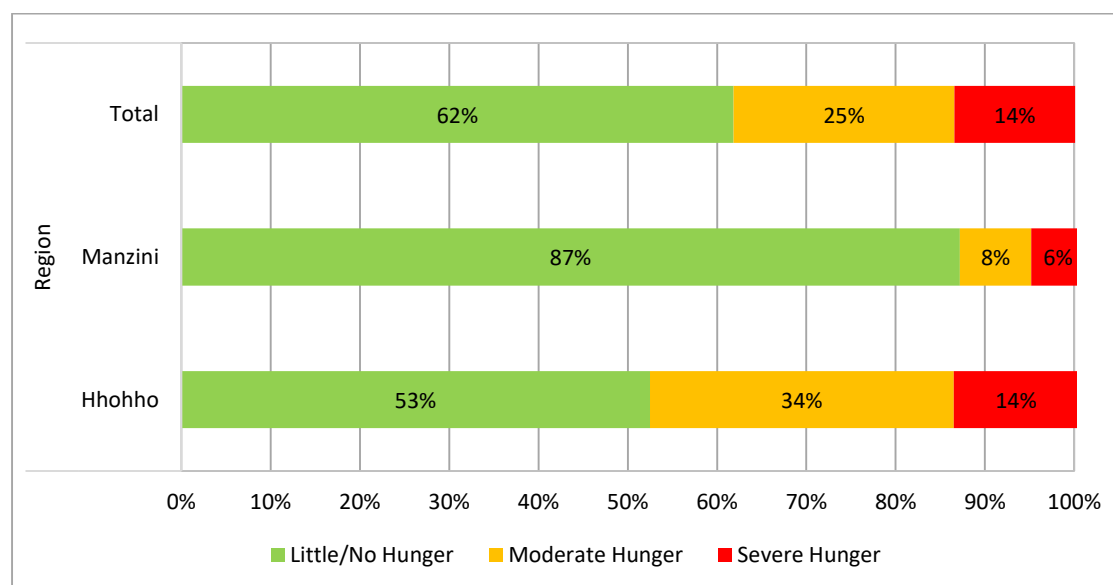


Figure 26: Household Hunger Score - Urban

Hosting an HIV patient tends to have an impact on the level of hunger, although to a lesser extent, with some variations between regions. More households who do not host HIV patients

are in Phase 1 compared to those that host HIV patients in the same Phase (58% vs 54). For regions such as Manzini, the impact of hosting HIV patients has been more pronounced where none HIV patients' hosting households had more people in Phase 1 compared to those who host HIV patients (79% vs 64%). The same was observed for Shiselweni where more none HIV hosting households made a majority of the population in Phase 1 compared to HIV patients hosting households (60% vs 49%). The other Phase follow a similar pattern, for instance, in Shiselweni, it was found that a larger proportion of people in Phase 3 were those hosting HIV patient compared to those who did not host HIV patients (32% vs 12%). The results point into a somewhat different picture for Hhohho and Lubombo regions (Figure 27).

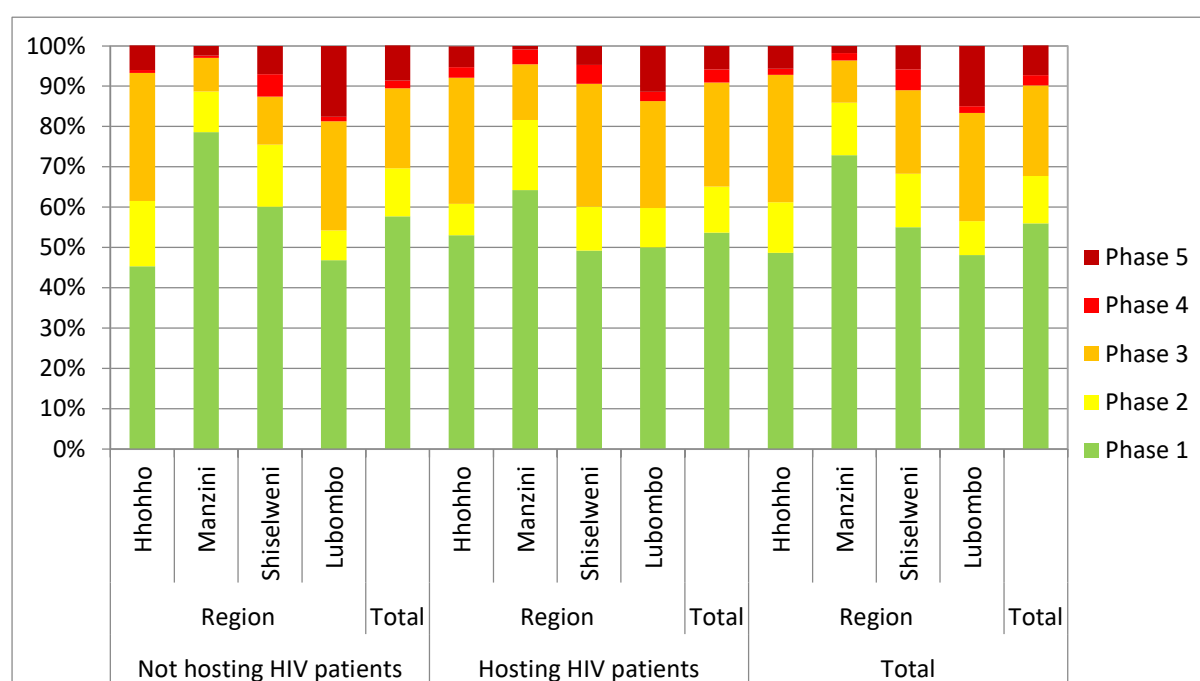


Figure 27: Household Hunger Score for members hosting HIV patients - rural

A further disaggregation of House Hunger Score by gender indicates that fewer females are found in Phase 1 compared to males in the same Phase (66% vs 77%). The pattern is observed across all the four regions and the. This highlight the vulnerability of women to hunger compared to their male counterparts, more particularly in urban areas (Figure 28).

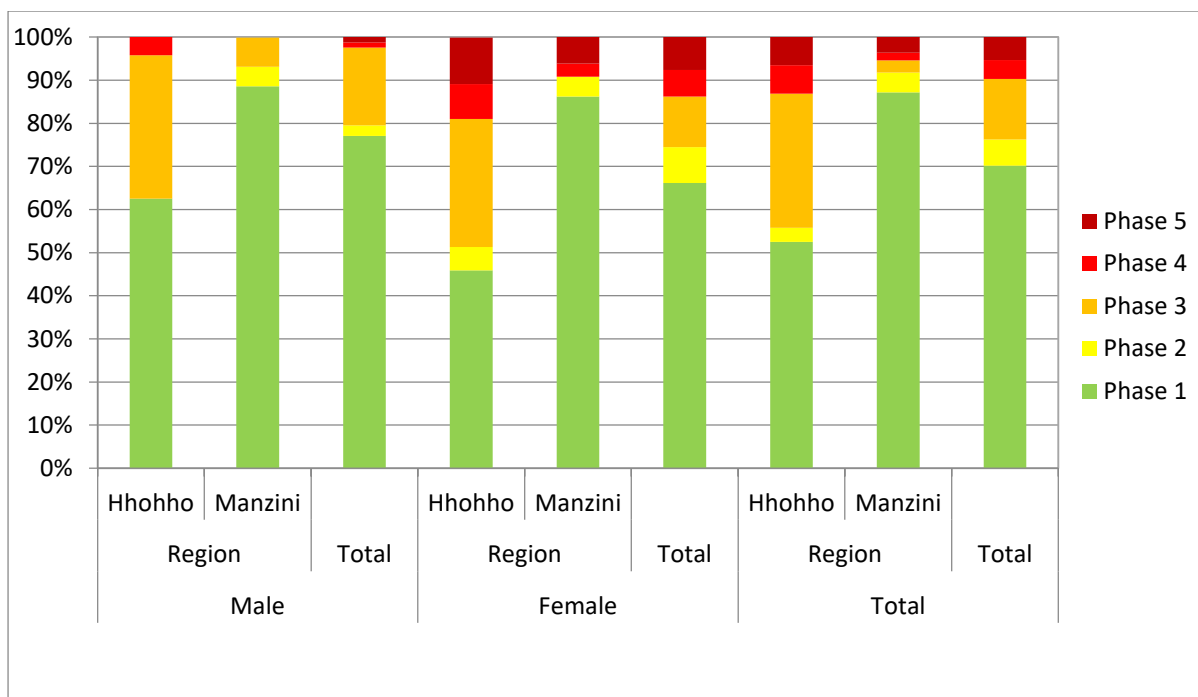


Figure 28: Household hunger score by gender of household head – urban

4.6 Health

Humanitarian crises due to natural disasters, disease outbreaks and other hazards are a major and growing contributor to ill-health and vulnerability. The persisting effects of crises on health and health systems can undermine decades of social development

4.6.1 Chronic Illnesses

Households are affected by chronic illnesses and the direct costs of HIV/AIDS can be measured in the lost income of those who die or who lose their jobs because of chronic illness. Household savings fall and consumption on items and expenditure patterns are distorted as households struggle to cope with the burden of illness. The assessment asked if households hosted HIV members in the last 12 months. The assessment results reveal that the Shiselweni region has the highest number of households hosting an HIV member (47.2%), followed by Hhohho region (43.7). About 22.4% of households reported hosting a member living with disability in the last 12 months (Figure 29).

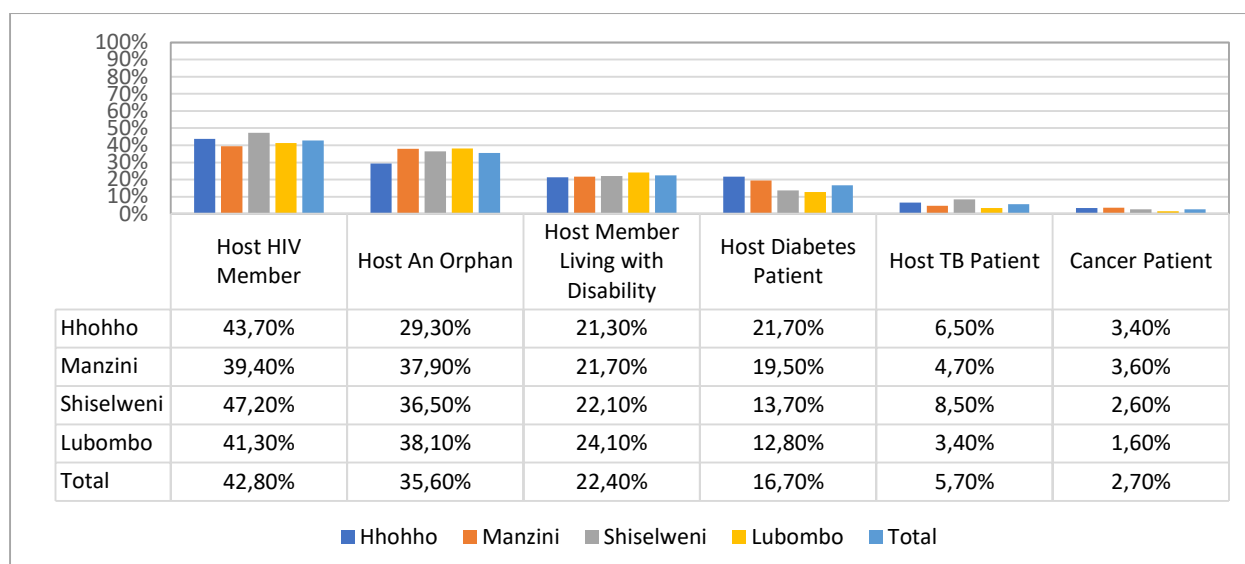


Figure 29: Rural Households hosting an HIV member

When looking at households hosting an HIV member in the last 12 months in urban areas, Hhohho urban has the highest number of households hosting an HIV Positive member (52.5%) and Manzini urban areas with 32.1% (Figure 30).

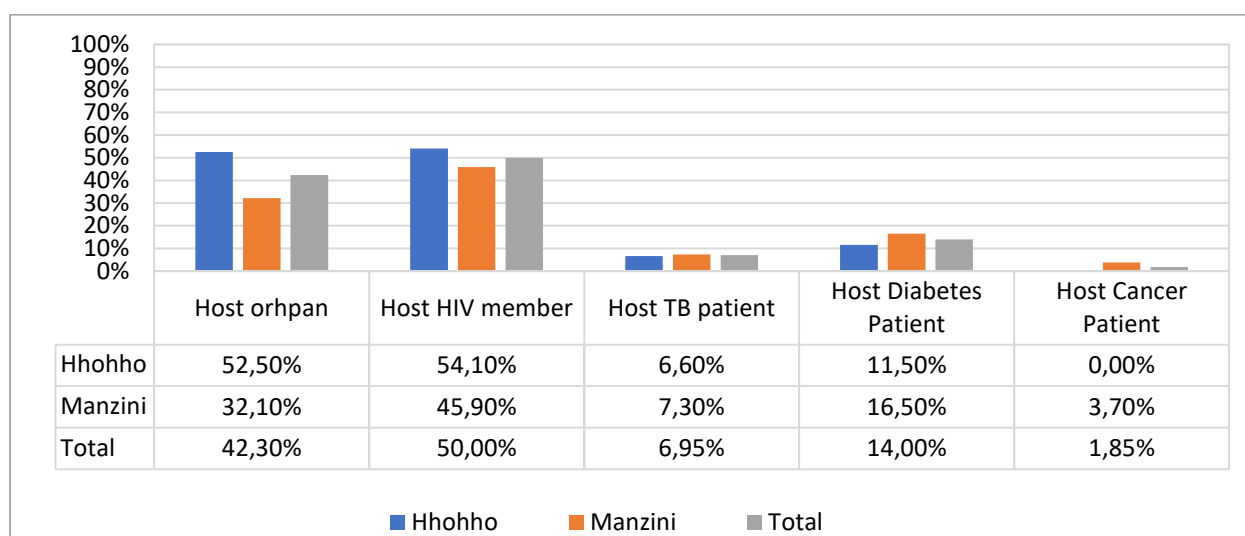


Figure 30: Urban Households hosting an HIV member

4.6.2 Households with Orphans

The results indicate that 64% of the sampled households in rural areas reported not to have orphans in their compounds while 36% reported to have orphans in compound in rural Eswatini. The urban picture is not different, where 37% of the urban households reported to host orphans against 63% who did not host any orphans. In general, there are more orphans

in urban areas than rural areas in Eswatini, with Hhohho region reporting more urban orphans (53%) than the other regions, while Lubombo recorded the highest number of orphans (38%) in rural areas (Figure 31).

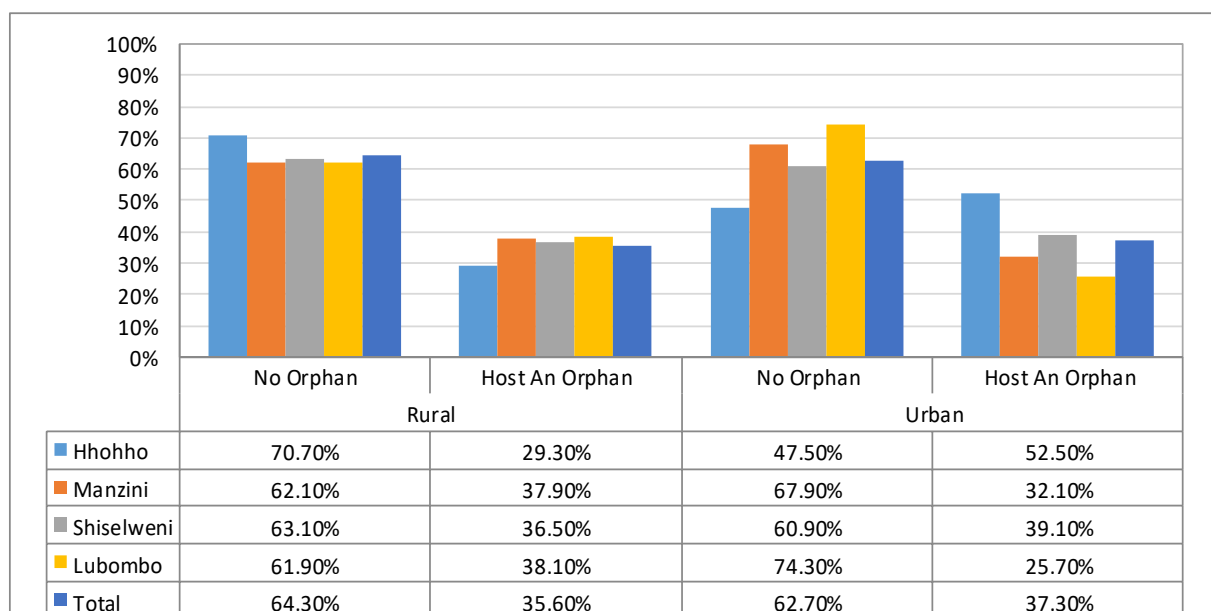


Figure 31: Households with Orphans in rural and urban areas by administrative region

4.6.3 Households' adherence to medicines

The assessment also looked at whether households have members who are not taking medicines regularly and reasons for household members for not taking their medicines regularly if they are on medication. The results show that there are members at household level who are not taking their medicines regularly. Manzini region has the highest number of households (15%) not taking their medicines regularly as expected (Figure 32). The reasons include: unavailability of medicines, no transport to facility, no money for medicines, side effects of medicines, long distances to the nearest health facility and lack of food for taking medicines.

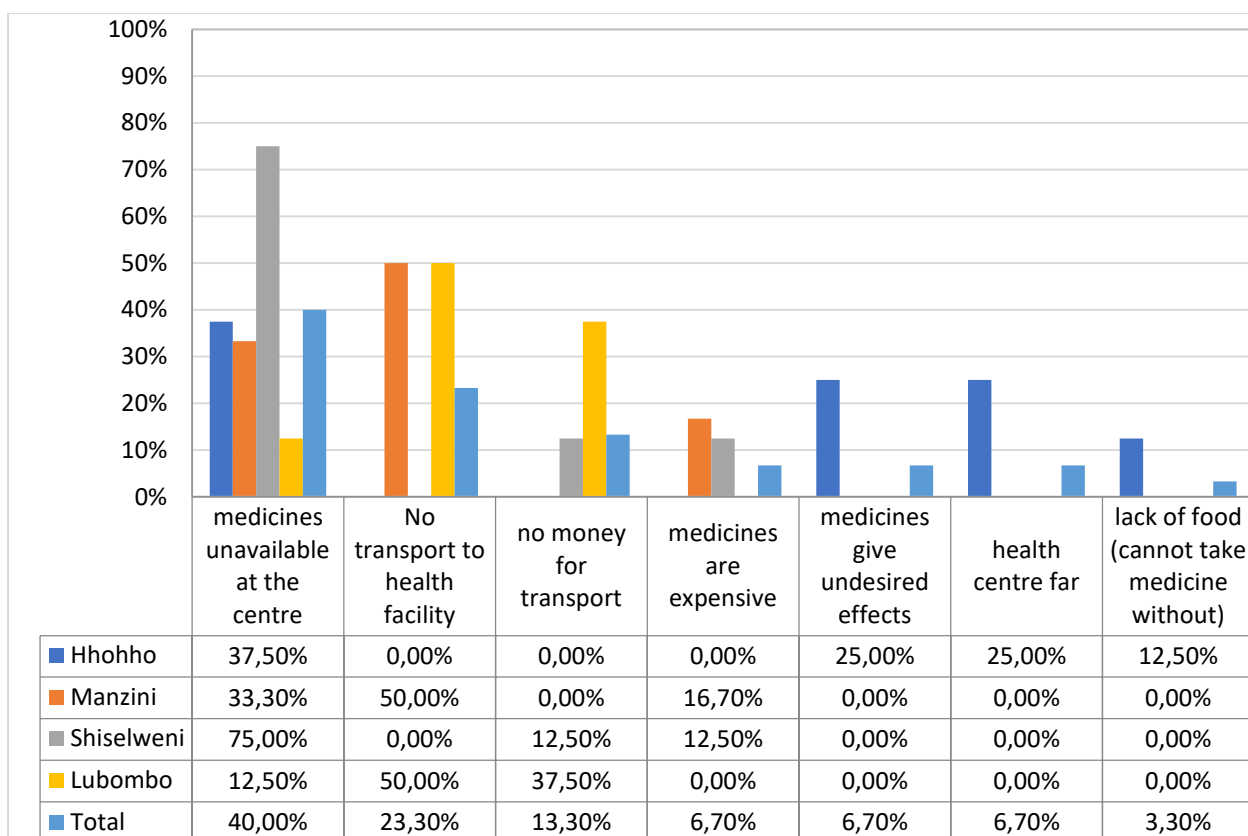


Figure 32: Households reasons for not taking medicines

4.7 Health Facility Readiness to Respond to COVID -19 and emerging health emergencies

The Government of the Kingdom of Eswatini declared the COVID-19 pandemic a National Emergency on the 17th of March 2020, thereby invoking Section 29 of the Disaster Management Act of 2006. The Ministry of Health activated its sectoral Emergency Operation Centre (Public Health Emergency Operation Centre). This further necessitated the EVAC to conduct an assessment of health facilities' readiness to respond to COVID -19 and emerging health emergencies. The building blocks of health facility's readiness to respond to emergencies include: emergency preparedness and response plans, functional emergency management committees, functional resuscitation unit/corner, healthcare workers trained on emergency management, emergency management support functions.

4.7.1 Emergency Preparedness Response Plan

When assessing health facilities' readiness to respond to emergencies with emergency preparedness and response plans, 54.5% of health facilities in the country have emergency preparedness and response plan whilst only 45.50% of facilities, nationally, do not have plans. The Hhohho and Manzini regions are leading in terms of facilities, with emergency preparedness and response plans as shown in Figure 33.

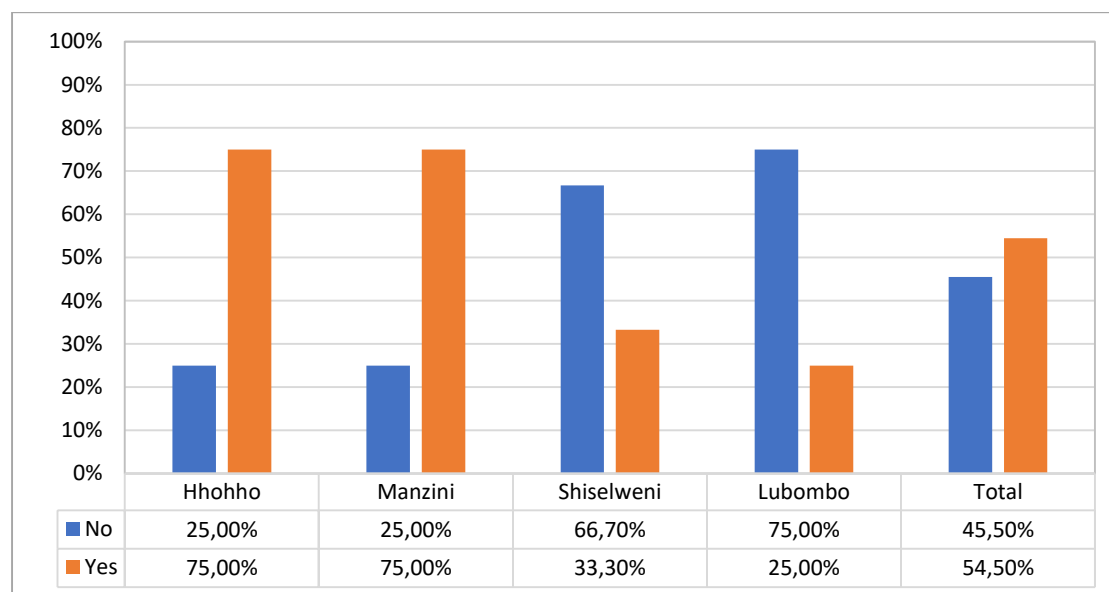


Figure 33: Facilities having an Emergency Preparedness Response Plans in Eswatini

Even though findings have shown that more facilities have emergency preparedness and response plans, 50% of health facilities do not have emergency management committees, with Manzini and Lubombo regions (75%), respectively having facilities with no emergency management committees as indicated in Figure 34.

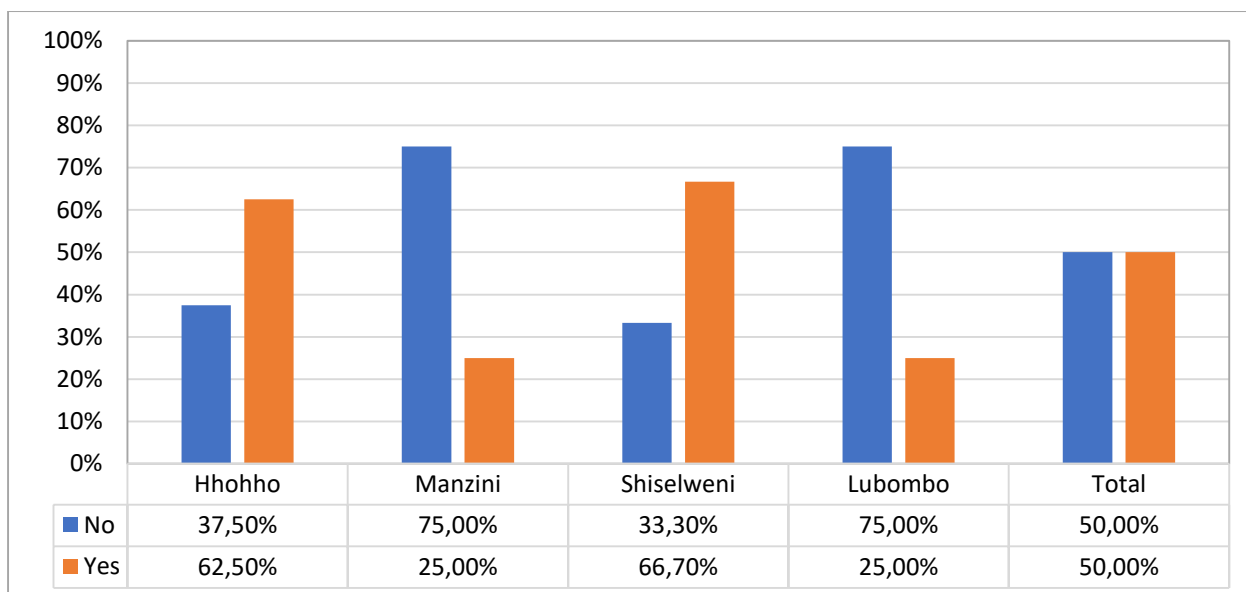


Figure 34: Facilities having an Emergency Management Committee in Eswatini

The findings have shown that some health facilities in the regions have emergency management committees, but some of them are not functional. It is only Manzini and Lubombo regions that have fully functional emergency management committees (100%) as indicated in Figure 35 below.

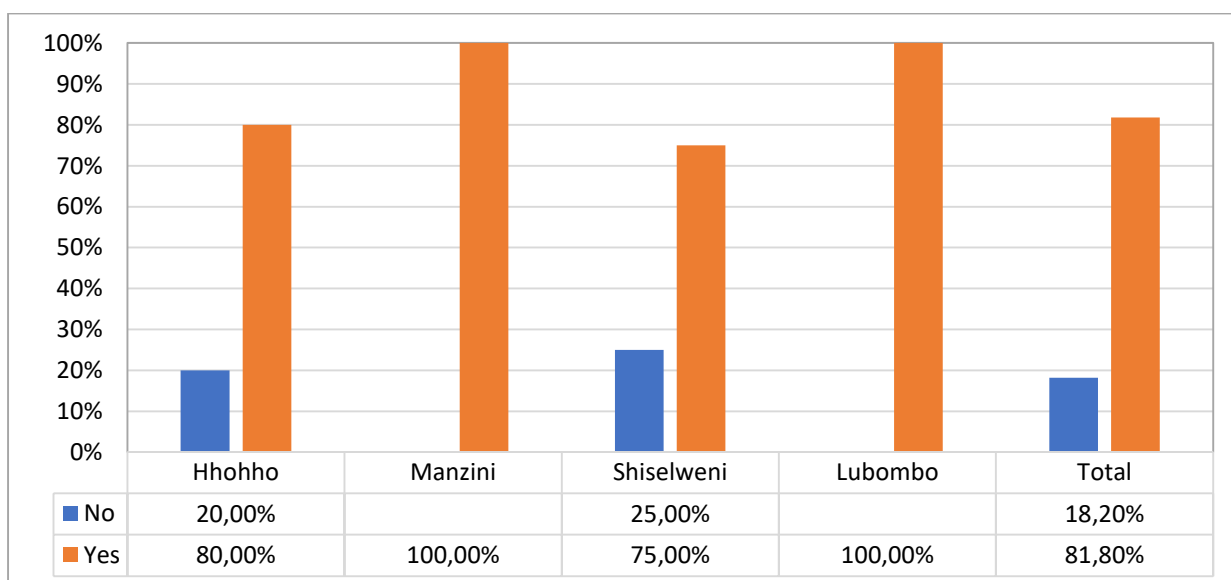


Figure 35: Functional Emergency Management Committee in Eswatini

4.7.2 Facilities with resuscitation unit

The resuscitation area is a key area in most departments. The most seriously ill or injured patients will be dealt with in this area, as it contains the equipment and staff required for

dealing with immediately life-threatening illnesses and injuries. About 27.3% of health facilities, nationally, do not have resuscitation units, and these include 12.5% in Hhohho region, 50% in Manzini region, 33.3% in Shiselweni region and 25% in Lubombo region as indicated in Figure 36 below.

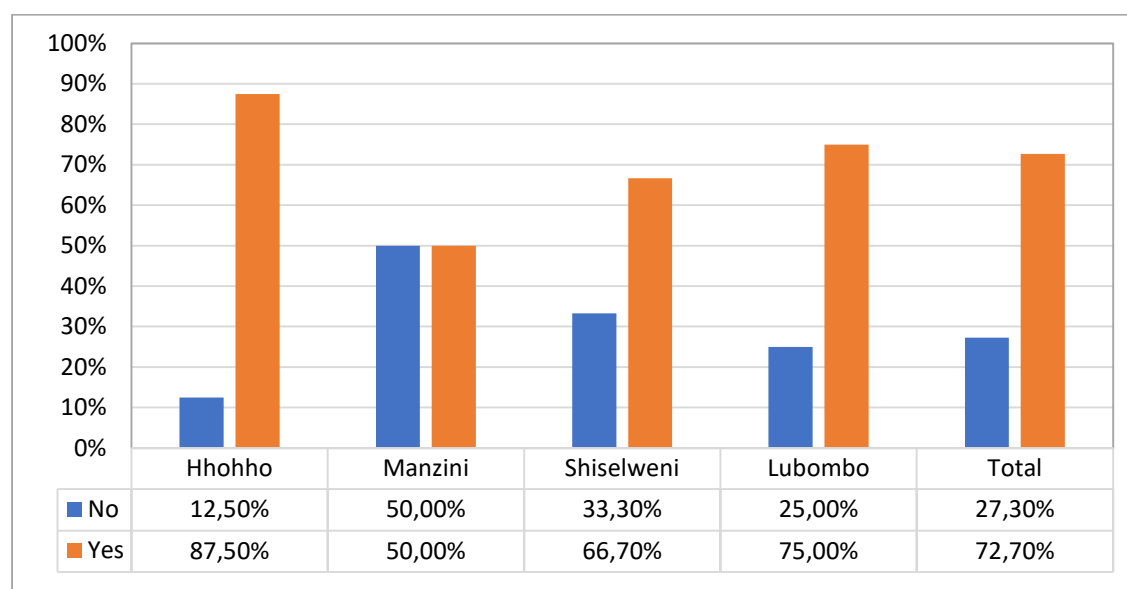


Figure 36: Facilities with a Resuscitation Unit/Corner in Eswatini

In terms of functionality of resuscitation units in facilities, all resuscitation units in the Lubombo region are fully functional (100%). Manzini region, however, has only half (50%) of health facilities with functional resuscitation units as indicated in Figure 37 below.

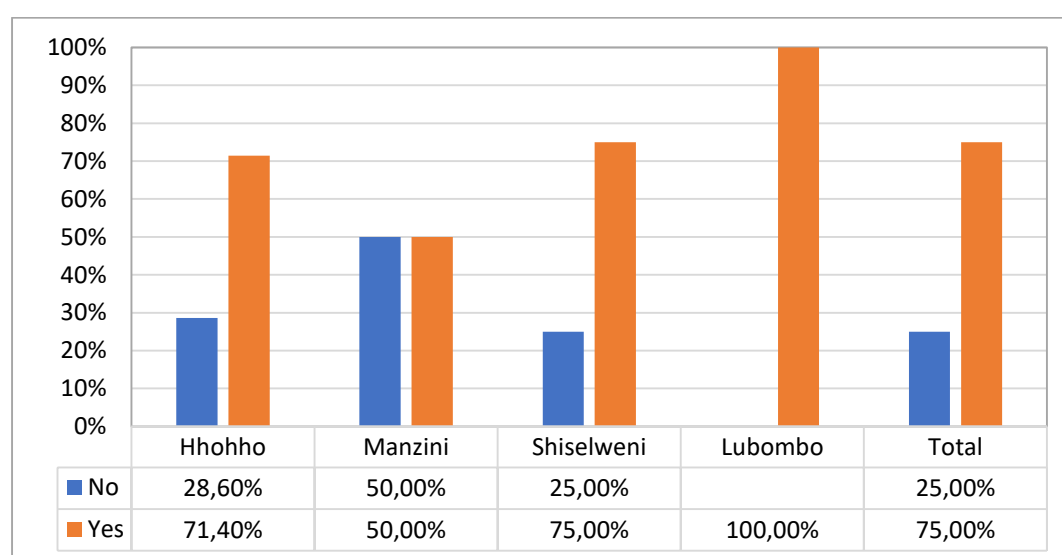


Figure 37: Functional Resuscitation Corner in Eswatini

4.7.3 Workers Trained on Emergency Management

Building critical mass of health workforce trained in emergency management for an effective response to an emergency is crucial. About 59.1% of health facilities in the regions have staff that has not been trained on emergency management, with 83.3% of health facilities in Shiselweni region reported that they have not been trained on emergency management, followed by Hhohho region with 75% of staff not trained on emergency management as indicated in Figure 38 below.

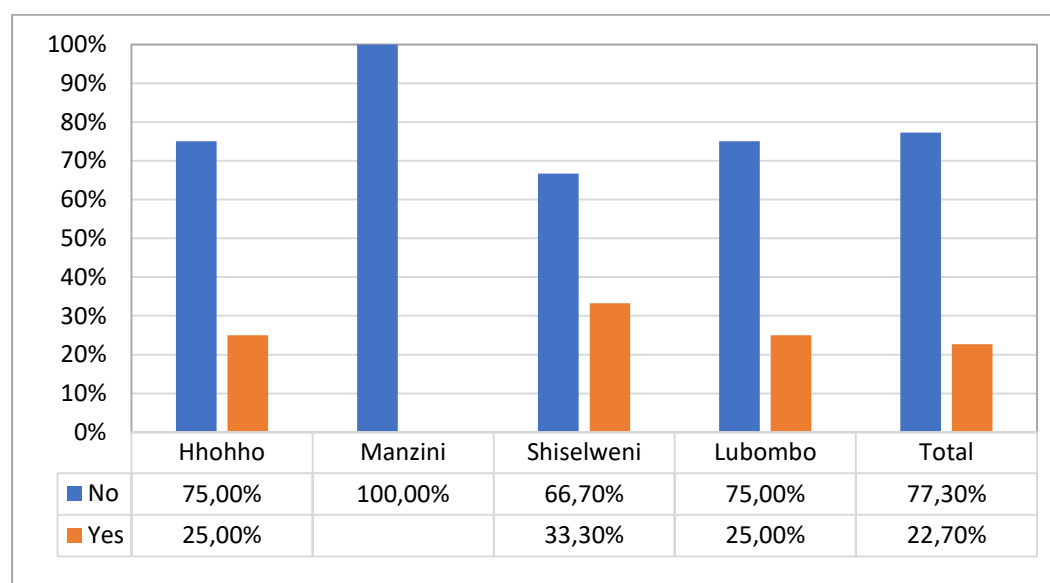


Figure 38: Workers trained on EM in Eswatini

Facilities have expressed need for support to strengthen emergency management systems at facility level. Facilities in Manzini and Lubombo regions (100%) reported a strong need for support to strengthen emergency management systems. About 75% of facilities in Hhohho region and 83.3% in Shiselweni region shared the same sentiment, highlighting the urgent need for support in strengthening emergency management systems at facility level as indicated in Figure 39 below.

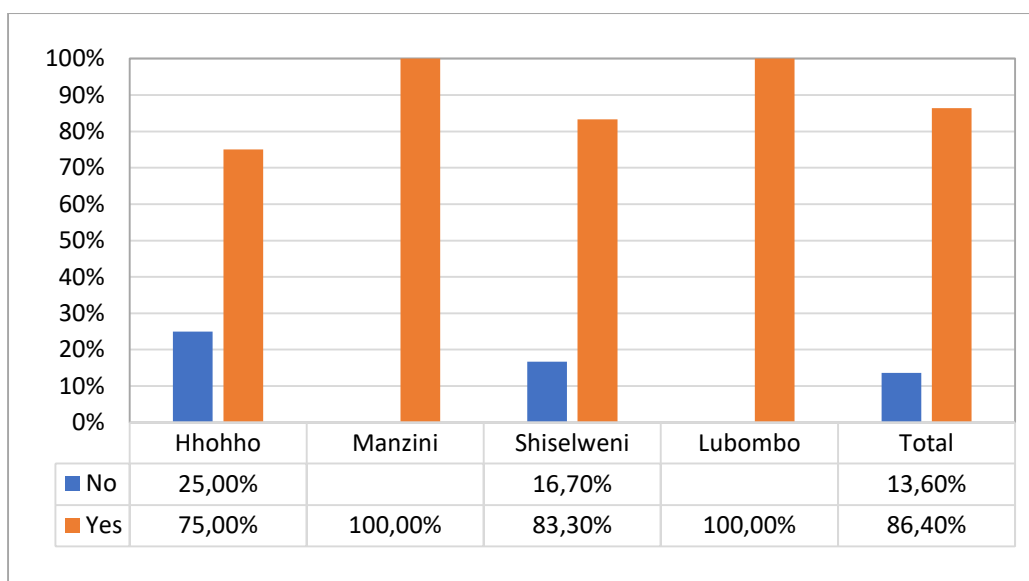


Figure 39: Facilities in need of support to strengthen Emergency Management Systems

4.7.4 Facilities in need of equipment

Majority (86.4%) of health facilities reported a need for equipment to support emergency management systems in the facilities as shown in Figure 40 below.

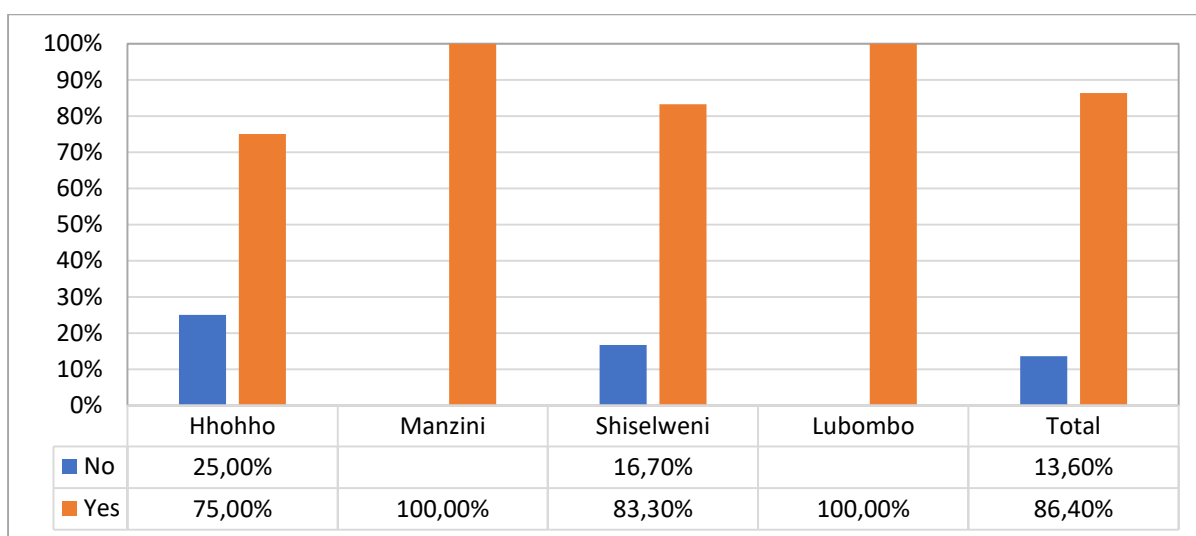


Figure 40: Facilities in need of equipment in Eswatini

4.7.5 Facilities in need of training on basic life support

Basic life support consists of a number of medical procedures provided to patients with life threatening conditions of the body, that cause pain or dysfunction to the person. All these techniques are focused on helping patients or sustain life until more precise medical treatment can begin. The findings have shown that 95.5% of health facilities in the region

require basic life support training in order to strengthen emergency management systems at facility level as indicated in Figure 41 below.

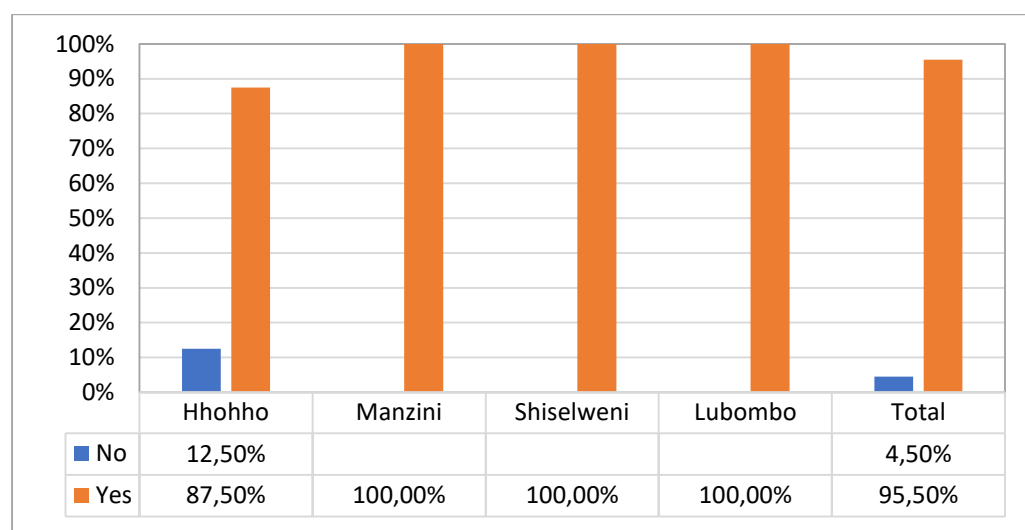


Figure 41: Facilities in need of training on basic life support in Eswatini

4.8 Nutrition

Due to the COVID – 19 pandemic, nutrition screening was not done at household level for this annual assessment, but information on malnutrition was collected from health facilities. The numbers below come from a routine system of data collection for the Integrated Management of Acute Malnutrition programme which provides treatment for malnourished children.

The graph below depicts the progress of moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) in a trend form from January to April 2020 (Figure 42). The number of children admitted for malnutrition shows a down ward trend. This might be due to the impact of COVID – 19 which resulted to restricted movement for most people, thus denying children access to health services like immunisation and community growth monitoring.

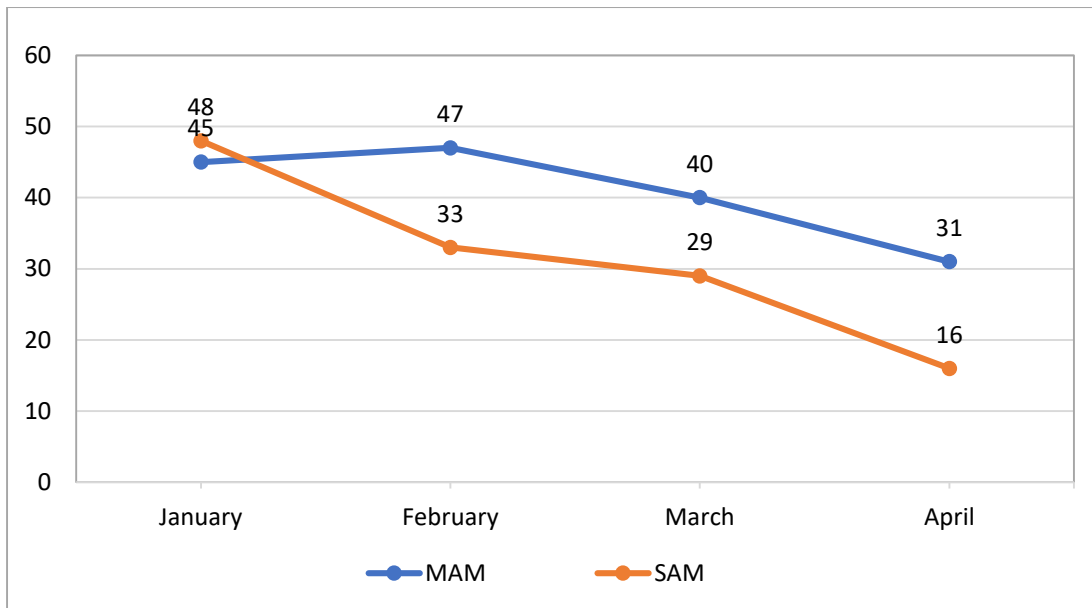


Figure 42: Integrated Management of Acute Malnutrition (IMAM) Indicators Performance

The graph above shows discharges in the IMAM programme which are in the form of cured and death rates. A steady increase in cured rate was observed between January and March followed by a steep decline in April. The death rate shows a constant rate across the months.

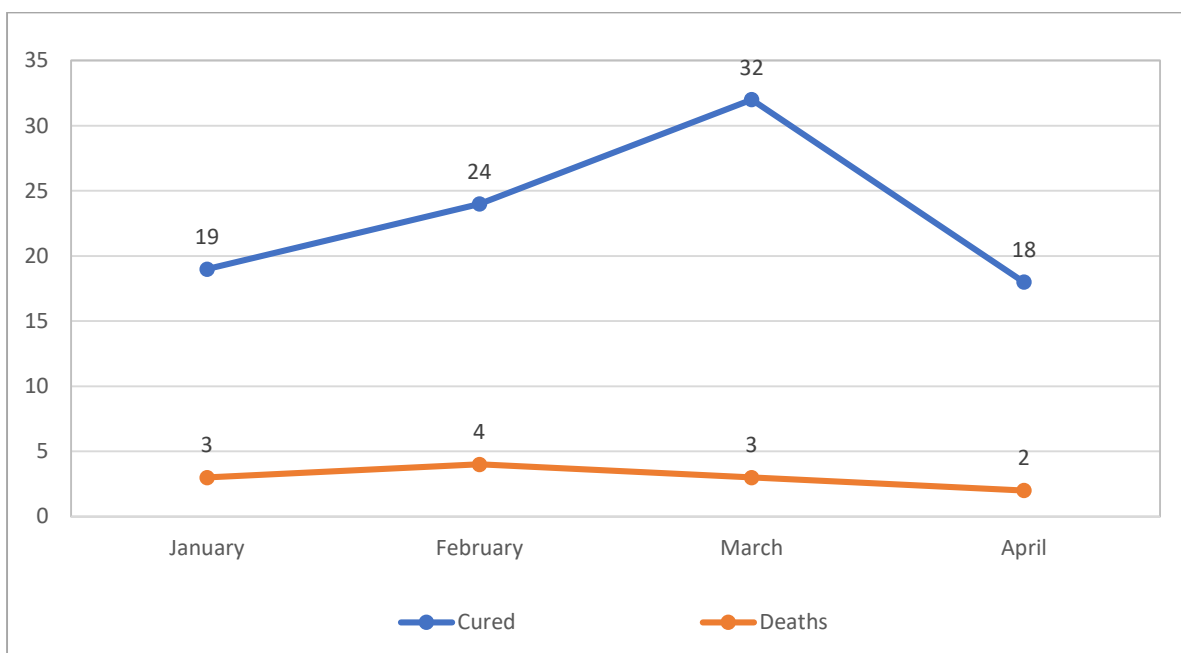


Figure 43: IMAM Discharges

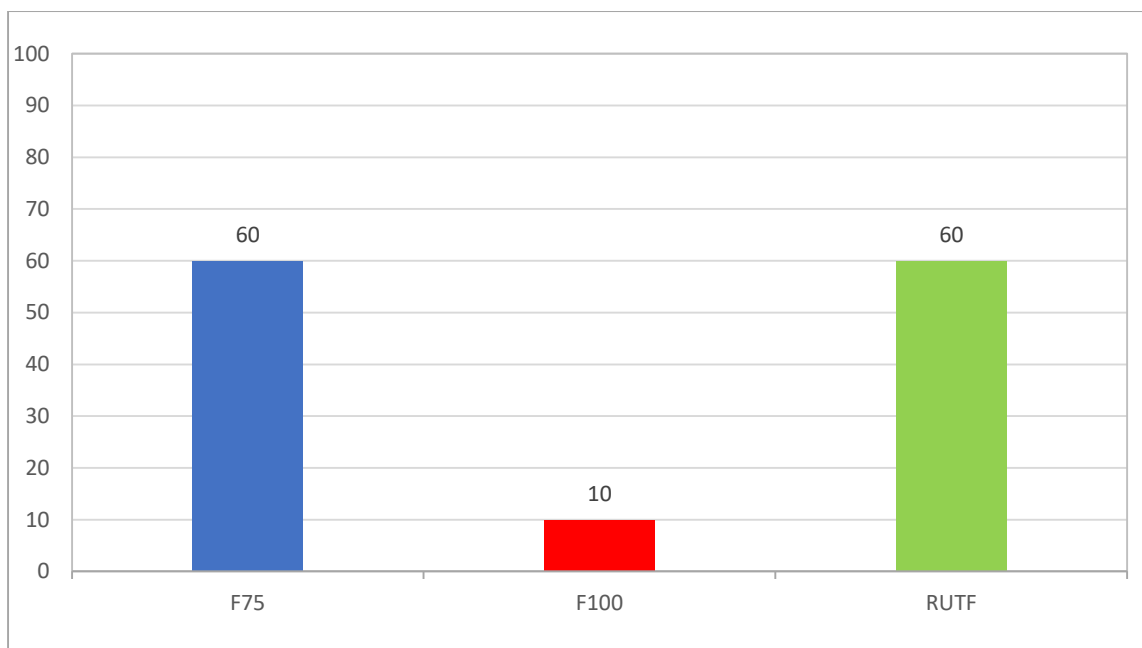


Figure 44: Availability of Stocks

The bar graph above shows the availability of basic commodities necessary for the management of malnutrition at both in and out patient. Only F75 and RUTF were available in the facilities, 60% respectively while 10% of the facilities reported availability of F100.

4.8.1 Feeding Practices

Overall, about 64% of the children under 6 months were exclusively breastfed, 20% mixed fed and 16% using replacement fed as shown in the graph above. It is observed that Lubombo and Shiselweni regions have the highest number of exclusively breastfed children at 86% and 71%, respectively while Hhohho region has more replacement fed children at about 46% with Manzini region having more mixed fed children at 38%.

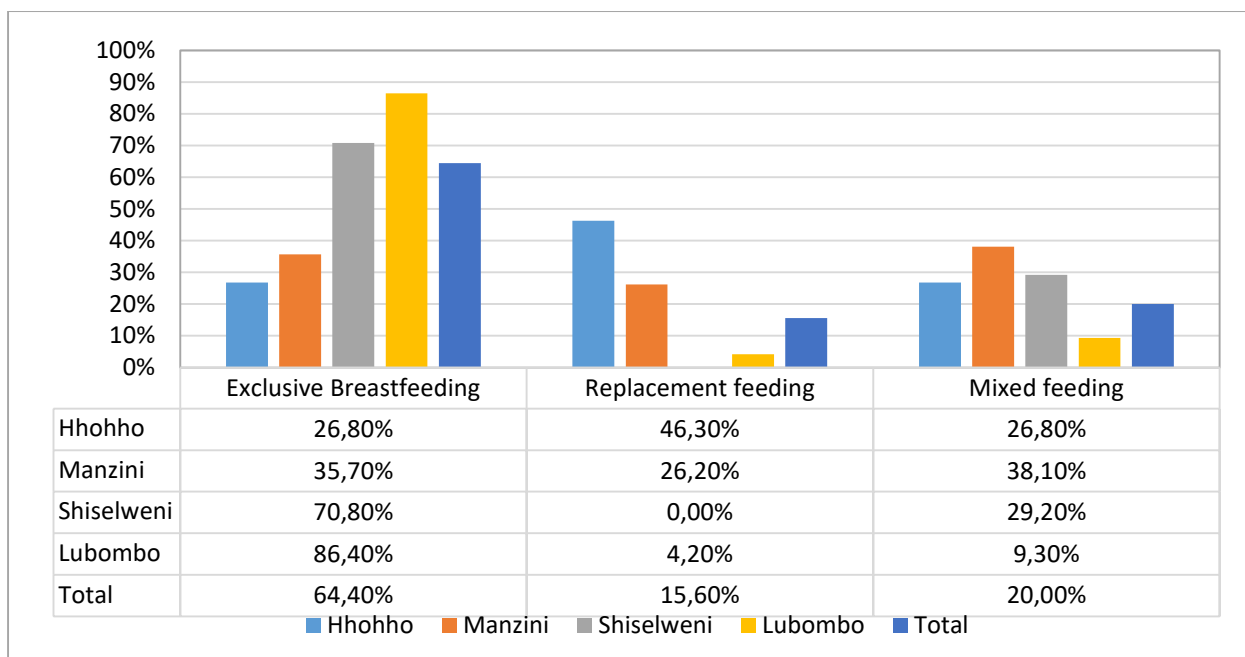


Figure 45: Feeding Practices

4.8.2 Number of meals per day

The graph below shows that both adults and children eat a minimum of 2 meals per day across all the regions. School going children usually get an extra meal at school but this is no longer the case as schools are closed due to the impact of COVID – 19. This is a course of concern as the nutritional status of the children might be compromised.

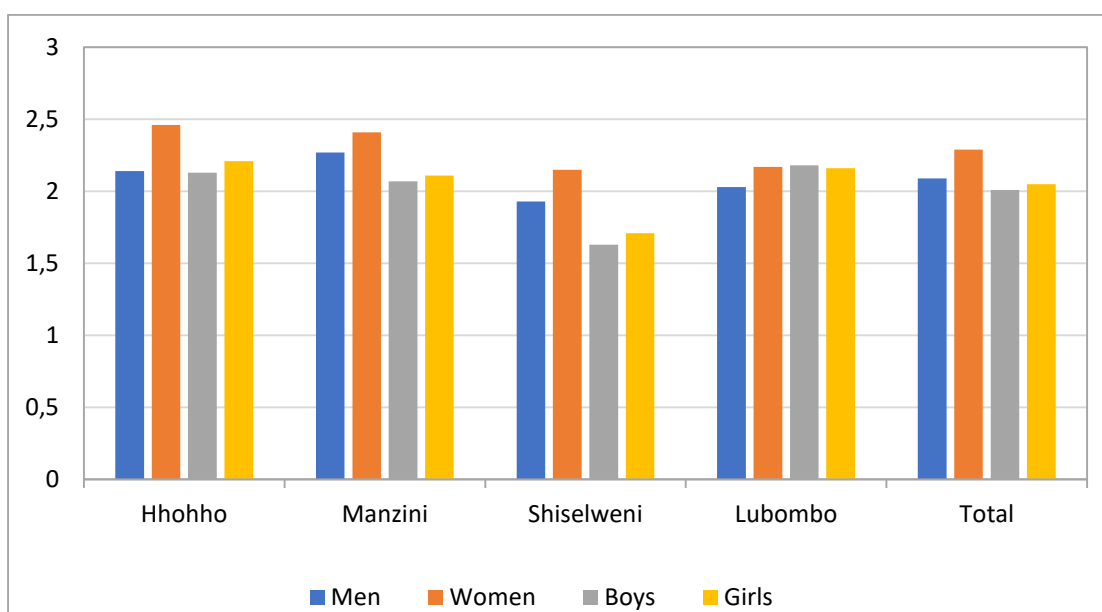


Figure 46: Number of meals per day

4.9 Water and sanitation

The lack of access to safe drinking water, basic sanitation and good hygiene practices is a significant risk factor for poor health with high mortality rates due to Diarrhoeal disease. In 2020, globally and in Eswatini, poor hygiene practices have led to the significant spread of COVID-19. National Epidemiological data continues to indicate high prevalence of diarrhoeal episodes among under 5 children as well as adults. Climate change is a pertinent risk factor for availability of water supply, especially for rural households who are highly dependent on ground water sources, experiencing receding water levels rendering water out of reach for existing infrastructure. This section focuses on the use of improved water sources, unimproved water sources, improved sanitation facilities and unimproved facilities in relation to the Household Characteristics.

4.9.1 Use of Improved Water Sources

Access to improved water sources currently stands at 62.5% as seen in Figure 47 below. Shiselweni has the lowest access (44%) to improved water, with all other regions having better access to improved water sources with Hhohho region (74%) on the lead in terms of access to improved water supply. In comparison with the 2019 assessment, Manzini has dropped from 74% to 63% access.

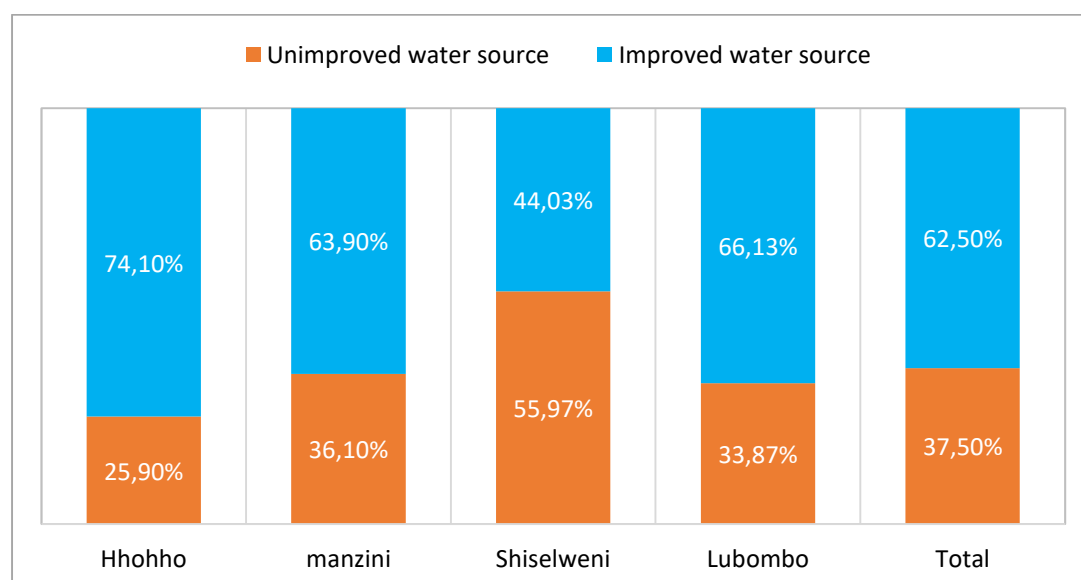


Figure 47: Use of improved water sources

Further analysis of the VAC Data shows that improved water access to Household with a person living with disability stands at 37%, nationally, with Shiselweni having the lowest access (50%). For Households who have orphans nationally, about 67% have access to improved water sources, with shiselweni having the lowest proportion (53.5%) of households with access to improved water sources. Lubombo and Hhohho regions are leading at 74% and 76%, respectively in the proportion of households with improved access to water sources. With a high burden of HIV and a need for safe water to take medication, 82% of the households with people living with HIV have access to an improved water source, with Manzini leading the regional distribution at 92.7% of the households having access and the region with the lowest proportion of households with access to improved water source among the HIV hosting members is Shiselweni (75%). Regarding the Household income potential based on employment status, the lowest proportion of households with access to an improved water source among casual labourers is 53%, whereas for the employed it is 75% who have access to improved water sources. Access to improved water for households with a pregnant or lactating woman at national level is 74.8%, with the regional lowest of 66% access for households in being the Lubombo region. Access to improved water sources by the elderly (65 years and older) is 94% at the national level, with all regions performing generally well above 90% in terms of elderly access to improved water sources.

4.9.2 Distance to improved water source

The Rural Water Supply Design manual indicates that each household should not travel more than 200m to the water point, with the preferred access being within the household yard. Results indicate that 42.5% of the households, nationally, have their water source within their premises and 21.8% travel Less than 500m to water sources. The results show that 6% of the households travel more than 2km to the nearest water source. For households with a person leaving with disabilities, 65% of the households have water source within their premises, with 24% of them travelling between 500m to 1 km.

The burden of water collection rests on women and children and the further the distance to the water source, the more time spent collecting water, with the recommended round trip

being 30min. The results show that 17% of the households travel between 30-60min round trip to collect water (Figure 47).

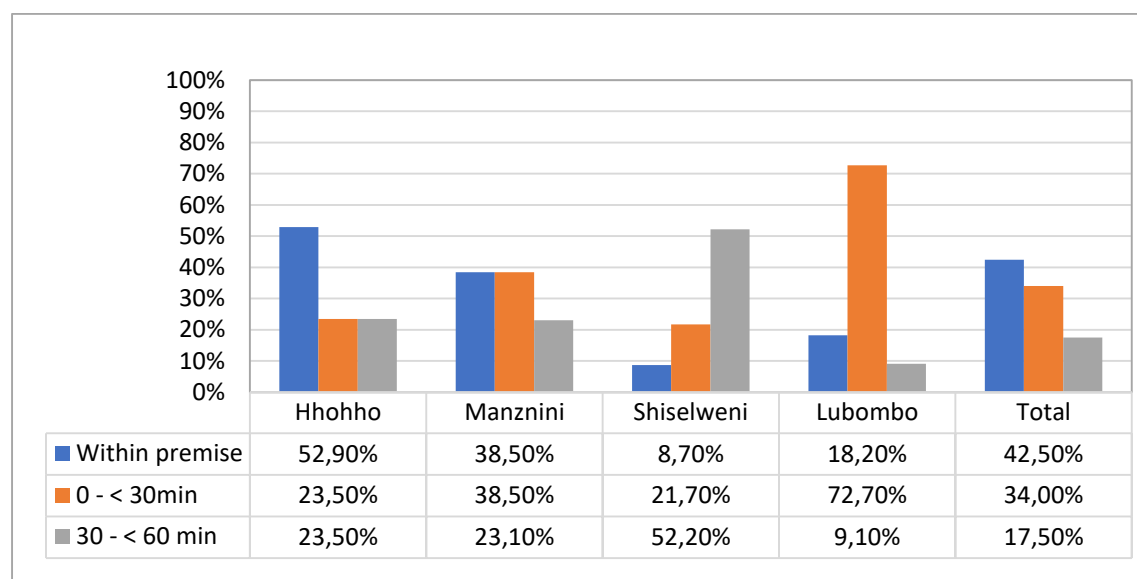


Figure 48: Distance to water sources in time

The results also show that 40% of households with an orphan have water access within their premises and 42% travel less than a 30min roundtrip. For households with a person living with HIV, the results show that 75% of them have water within their premises, with 21% of the households walking less than 30min round trip. Households with water on their premises for elderly people 65years and above is 44% with 34% of the households walking less than 30min round trip and 3% walk a round trip between 60-90mins. The results indicate that of the households with pregnant and lactating women, 35% have water sources within their premises and 42% accessing the water within a round trip of less than 30min.

4.9.3 Use of Improved Sanitation

Households' access to and use of improved sanitation facilities is fundamental in the prevention and reduction of the incidence of diarrhoea outbreak and in breaking the cyclical and synergistic relationship between malnutrition and diarrhoea. The results in Figure 48 show that 95.30% of the households had access to improved sanitation, however, Eswatini has set a standard for basic sanitation facility to be a Ventilated Improved Pit (VIP) Latrine with Slab. The results indicate that 27% of the households have access to a basic sanitation facility or better. The results further show that a majority of the households (55%) improved

sanitation through a Pit latrine with slab (non VIP) and 4% of the households, nationally, do not have access to a sanitation facility.

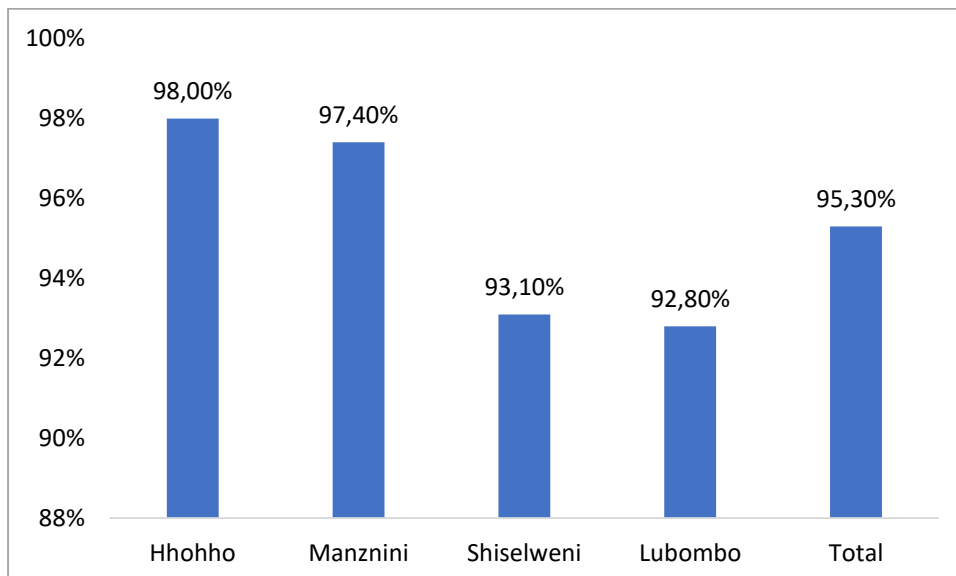


Figure 49: Access to improved sanitation by region

4.9.4 Handwashing

The practice of handwashing with soap and water is an effective practice against the spread of diarrheas and COVID-19. The results (Figure 50) indicates that a majority (75%) of the households have a handwashing station with running water, with most regions reflecting being above the national average with an exception of Manznini where only 49% of households in this region have handwashing stations with running water. The Result show that 5.3% of the households only use water to wash their hands and a majority (89%) use water and soap while 4.7% use water and other detergent.

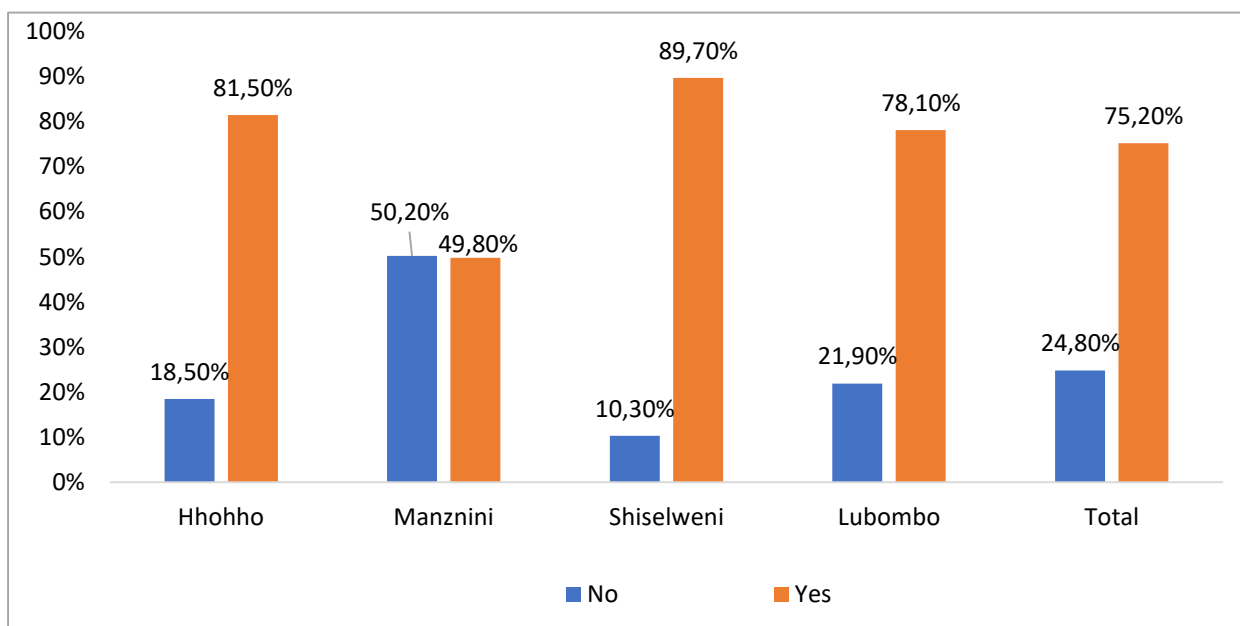


Figure 50: Designated handwashing station with running water in the household

4.10 Analysis of acute food insecurity situation

During this reporting period, the Integrated Food Security Phase Classification (IPC) protocols were employed to classify the nature and severity of food insecurity in the country. As usual, the acute food insecurity areas were classified into five Phases: Phase 1 (Minimal), Phase 2 (Stressed), Phase 3 (Crisis), Phase 4 (Emergency) and Phase 5 (Famine). The 2020 analysis managed to make two projections, including the current period (June – September 2020) and the projected time period (October 2020 – March 2021). Table 5 below, depicts the population classified under each phase.

The current production year, crippled by the increasing impact of COVID-19 on livelihoods and economic activities, as well as natural hazards affecting the already low levels of local crop production, had resulted in over 330,000 people (29% of the population) classified as phase 3 or worse. This has eroded the ability of households to cope with new and intensifying shocks.

The rural population (293, 000) makes the majority (27%) of the national population in IPC Phase 3 and 4 compared to the urban population (37,000) which accounts for only 2% of the

population in this situation. The rural population in crisis (Phase 3) is estimated at 263,500 people compared to 37,400 urban populations (Manzini and Hhohho). About 29,300 of the rural population are facing an emergency situation (Phase 4).

Table 5: Vulnerable Population classified by Regions for current projected period (June – October 2020)

Region	Population	Phase 1	Phase 2	Phase 3	Phase 4
Hhohho	253,814	101526 (40%)	88835 (35%)	63454 (25%)	
Hhohho Urban	88,361	39762 (45%)	30926 (35%)	17672 (20%)	
Lubombo	195260	39052 (20%)	68341(35%)	68341 (35%)	19526 (10%)
Manzini	261,790	91627 (35%)	117806(45%)	52358 (20%)	
Manzini Urban	131,679	72423 (55%)	39504 (30%)	19752 (15%)	
Shiselweni	198251	49563 (25%)	59475 (30%)	79300 (40%)	9815 (5%)
Average	1129155	393953 (35)	404887(36%)	300877(27%)	29341 (3%)

In the projected time period (October 2020 – March 2021), the population classified as phase 3 or worse will increase to around 32% (366261) of the total population. This is due to low food stocks gained from the 2019/20 harvest, and the economic impacts of COVID-19 which has resulted in significant loss in income for rural and urban households. Lubombo and Shiselweni regions will continue to be the worst affected regions in the country. The population proportion in crisis (Phase 3) in rural areas make up 42% of the affected population compared to 27% in urban areas. On the contrary, the stressed population proportion (Phase 2) make up 53% of the affected population in rural areas compared to 65% in urban areas in the same category, which reflects a somewhat mild situation in the urban context. Table 6 below shows the severity and magnitude of the food insecurity situation in the projected period.

Table 6: Population classification by Administrative Regions for projected period (October 2020 – March 2021)

Region	Population	Phase 1	Phase 2	Phase 3	Phase 4
Hhohho	253814	101526 (40%)	88835 (35%)	50763 (20%)	12691 (5%)
Hhohho Urban	88361	30926 (35%)	39762 (45%)	13254 (15%)	4418 (5%)
Lubombo	195260	39052 (20%)	48815 (25%)	87867 (45%)	19526 (10%)
Manzini	261790	78537 (30%)	117806 (45%)	52358 (20%)	13090 (5%)
Manzini Urban	131679	79007 (60%)	39504 (30%)	13168 (10%)	0
Shiselweni	198251	49563 (25%)	49563 (25%)	89213 (45%)	9913 (5%)
Average	1129155	378611 (33%)	384285 (34%)	306623 (27%)	59638 (5%)

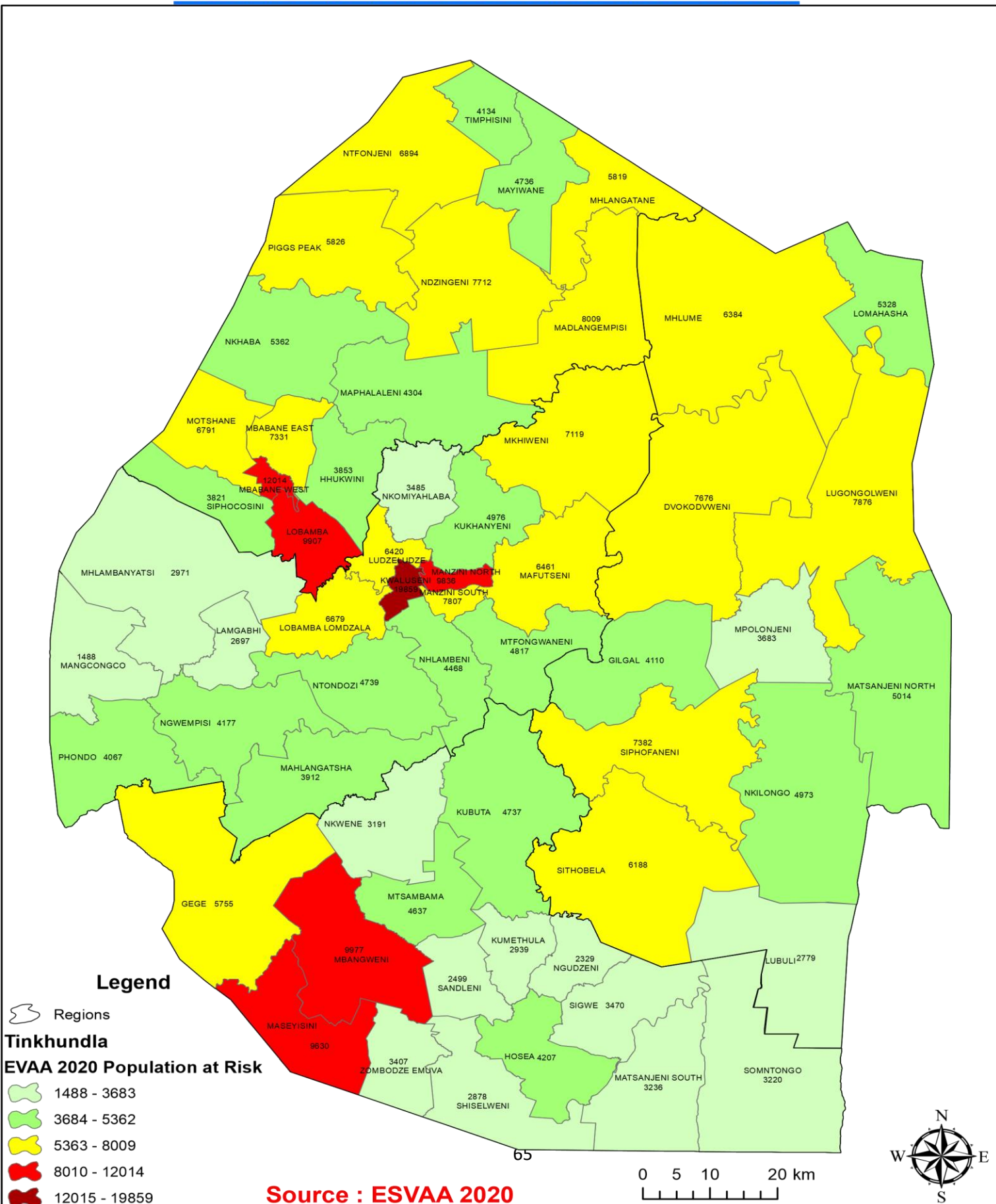
4.10.1 Response Priorities

1. Provision of continued and unobstructed direct food assistance to save lives and measures to protect livelihoods of populations estimated to be in IPC Phase 3 (Crisis) and IPC Phase 4 (Emergency). Primary focus should be given to COVID-19 affected households and fragile populations facing major food consumption gaps in priority regions such Lubombo and Shiselweni.
2. Provision of complimentary food assistance approach to protect livelihoods by reducing food consumption gaps of the populations estimated to be in IPC Phase 3 (Crisis), including, but not limited to:
 - Promoting the restoration and recovery of livelihoods of populations in IPC Phase 3 through the provision of agricultural inputs (seeds, plant material, tools, and irrigation system) and livestock, with particular focus on the areas affected by natural hazards such as Fall army worm and drought/long dry spells.

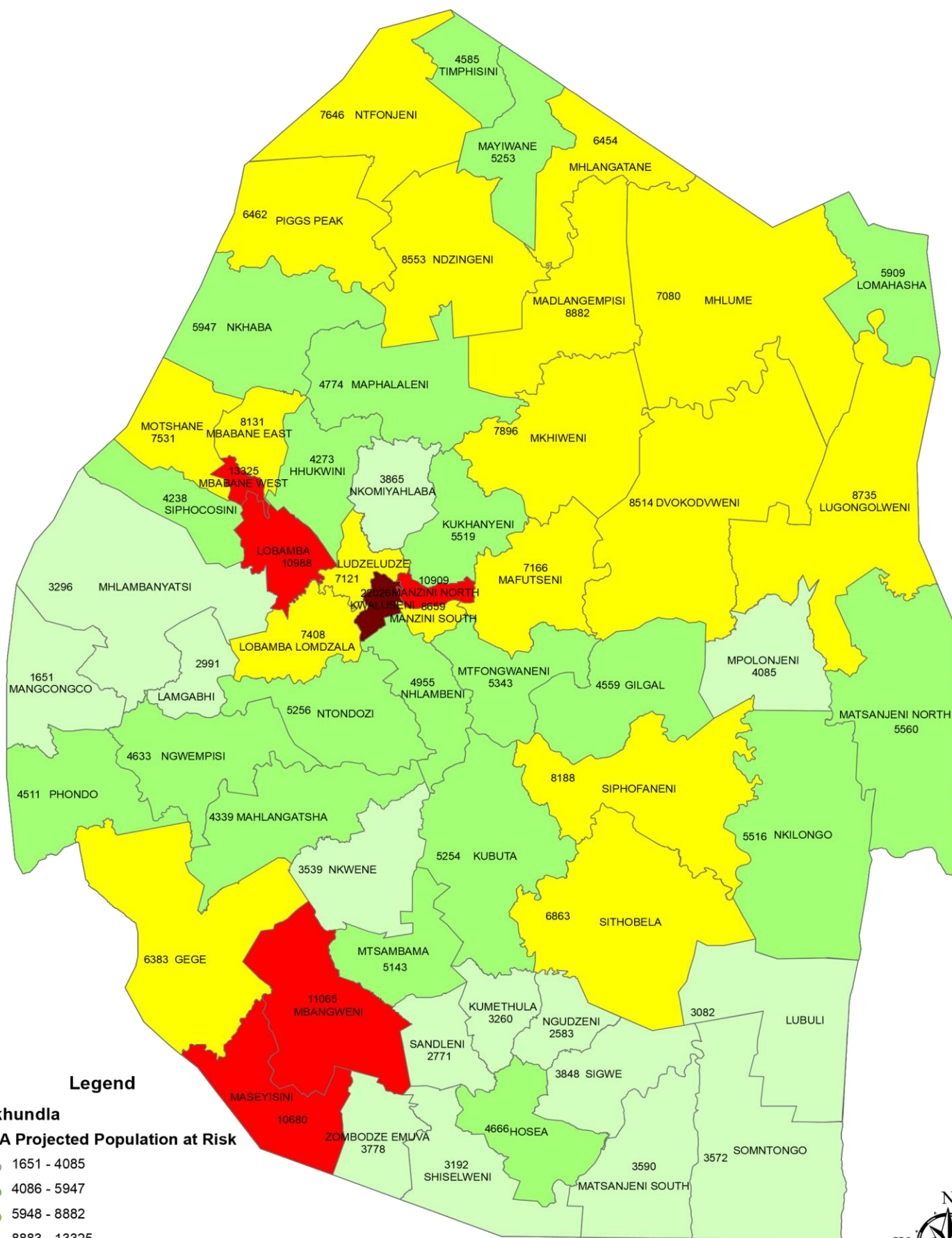
- Develop short to medium term interventions to support people with vulnerable urban livelihoods who suffer from COVID-19 mitigation measures and the loss of income opportunities.
 - Build and strengthen community resilience by providing safety nets; scale-up programmes for improved self-reliance, and social protection to vulnerable communities classified under IPC Phase 2 (Stressed) and above.
 - Support activities that promote the prevention of post-harvest losses
3. Promoting good nutritional practices at the household level through nutrition sensitive activities such as educational programmes on food management, water purification methods as well as backyard gardening.
 4. Strengthening early warning and food security monitoring systems to mitigate the negative impact of shocks.
 5. The Ministry of Agriculture, in collaboration with agro dealers, must ensure that farming inputs and livestock drugs are in stock in preparation for the next season.
 6. Need to conduct a nutrition survey on the impact of COVID-19.

ANNEX

ESVAA 2020 POPULATION AT RISK



ESVAA PROJECTED POPULATION AT RISK



Source : ESVAA 2020

0 5 10 20 km



