This report summarizes the findings of the 2006-07 Swaziland Demographic and Health Survey (SDHS), carried out by the Central Statistical Office (CSO) at the request of the Ministry of Health and Social Welfare. Macro International Inc. provided technical assistance in the design, implementation, and analysis of the survey as part of the Demographic and Health Surveys project (MEASURE DHS). The Human Sciences Research Council (HSRC) of South Africa assisted in the design of the survey and the Global Clinical and Viral Laboratory (GCVL) of South Africa assisted with the training and laboratory processing for the HIV testing. Funding for the survey was provided by the Government of the Kingdom of Swaziland, the United States Agency for International Development (USAID), the CDC-Global AIDS Programme under the United States President’s Emergency Plan for AIDS Relief (PEPFAR), the National Emergency Response Council on HIV/AIDS (NERCHA), HIV/AIDS Prevention and Care (HAPAC), UNAIDS, UNFPA, UNICEF, WHO, Italian Cooperation, and Population Services International (PSI).

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Additional information about the 2006-07 SDHS may be obtained from the Central Statistical Office (CSO), Ministry of Economic Planning and Development, P.O. Box 456, Mbanane Swaziland H100; Telephone: 268-404-2151, Fax: 268-404-3300.

Additional information about the DHS project may be obtained from Macro International, 11785 Beltsville Drive, Calverton, MD 20705, USA; Telephone: 301-572-0200, Fax: 301-572-0999, Internet: www.measuredhs.com.

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ABOUT THE 2006-07 SDHS

The 2006-07 Swaziland Demographic and Health Survey (SDHS) was designed to provide data for monitoring the population and health situation in Swaziland. The 2006-07 SDHS is the first Demographic and Health Survey conducted in Swaziland. The objective of the survey was to provide up-to-date information on fertility, family planning, childhood mortality, infant and child feeding practices, maternal and child health, maternal mortality, and HIV/AIDS-related knowledge and behavior. The survey also included testing for anemia and HIV.

Who participated in the survey?
A nationally representative sample of 4,987 women age 15-49 and 4,156 men age 15-49 were interviewed. This represents a response rate of 94 percent for women and 89 percent for men. Unlike most Demographic and Health Surveys, the SDHS also included interviews with younger teens and older adults. Over 900 young women and men age 12-14 were interviewed, as well as women and men age 50 and over. HIV testing was carried out for all household members age 2 and over. This sample provides estimates for Swaziland as a whole, for urban and rural areas, and, for most indicators, an estimate for each of the four regions.
Ownership of Goods

Currently three-quarters of Swazi households own a radio and one-third own a television. Sixty percent of households own a mobile phone, and one-third have a refrigerator.

About one-quarter of urban households own a car or truck, compared to 16 percent of rural households. Rural households, however, are far more likely to own agricultural land or farm animals. More than half of all households include a household member who has a bank account.

Housing Conditions

Housing conditions vary greatly based on residence. Almost two in three urban households have electricity, compared with only two in five households in rural areas. More than two-thirds of households have access to an improved water source, and three in four households are within 15 minutes of their drinking water supply. Most urban households have water piped into their dwelling or yard (73 percent), while only 23 percent of rural households have directly piped water. Rural households also rely on public taps (19 percent), surface water (22 percent), and unprotected dug wells (12 percent) for their drinking water. Half of households nationwide have an improved (and not shared) toilet facility.

Education of Survey Respondents

The majority of Swazis have received some education, and more than half have attended secondary school or higher. Only about 8 percent of men and women age 15-49 have had no education at all. Urban residents and those living in Hhohho and Manzini are more educated than those living in rural areas or Shiselweni and Lubombo.

<table>
<thead>
<tr>
<th>Education</th>
<th>Percent distribution of women and men age 15-49 by highest level of education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>8 7 25 34 18 7</td>
</tr>
<tr>
<td>No education</td>
<td>Lower primary</td>
</tr>
<tr>
<td>Men</td>
<td>8 11 24 29 21 8</td>
</tr>
</tbody>
</table>
FERTILITY AND ITS DETERMINANTS

Total Fertility Rate (TFR)

Fertility in Swaziland has decreased dramatically since 1986 according to past surveys and censuses. Currently, women in Swaziland have an average of 3.8 children, down from 4.5 in 1997 and 5.6 in 1991.

Fertility varies by residence and by region. Women in urban areas have 3.0 children on average, compared with 4.2 children per woman in rural areas. Fertility is highest in Shiselweni, where women have an average of 4.3 children, and lowest in Hhohho, where women have an average of 3.6 children.

Fertility also varies with mother’s education and economic status. Women who have tertiary education have an average of 2.4 children, while women with no education have twice as many children. Fertility increases as the wealth of the respondent’s household* decreases. The poorest women, in general, have more than twice as many children as women who live in the wealthiest households (5.5 versus 2.6 children per woman).

Fertility by Education and Wealth

* Wealth of families is calculated through household assets collected from DHS surveys—i.e., type of flooring; source of water; availability of electricity; possession of durable consumer goods. These are combined into a single wealth index. They are then divided into five groups of equal size, or quintiles, based on individuals’ relative standing on the household index.
Desired Family Size
Swazi women report a mean ideal family size of 2.5 children. Ideal family size is slightly higher among women in rural areas than urban areas (2.6 versus 2.3). Women with tertiary education want one less child than women with no education (2.3 versus 3.3).

Age at First Marriage
Women get married at a relatively late age in Swaziland. Only one-quarter of women (26 percent) are married by their twentieth birthday. The median age at first marriage is 24.3 for women age 30-49, while men get married even later, at a median age of 27.7. Women in urban areas tend to marry later (median age of 27.9) than their counterparts in rural areas (median age of 22.8). Age at marriage also greatly increases with education; women with tertiary education get married more than 5 years later than those with no education (26.8 years versus 21.6 for women age 30-49).

Age at First Sexual Intercourse
Half of women and three in ten men (age 25-49) were sexually active by the age of 18. Eleven percent of women and 3 percent of men had had sex by the age of 15. Women age 25-49 had their first sexual intercourse at a median age of 18, while men had their first sex later, at a median age of 19.5. Women living in rural areas have their first sex almost a year earlier than those living in urban areas. Women with higher levels of education are more likely to wait to initiate sexual activity than those with no education (median age at first sex of 21.0 versus 16.6).

Age at First Birth
On average, young women are waiting longer than their mothers to begin childbearing. Only 28 percent of 20 to 24 year-old women surveyed had given birth by the age of 18. In contrast, 40 percent of women age 45-49 had given birth by age 18. The median age at first birth for all women age 25-49 is 19.2. Women in urban areas have their first births more than one year later than women in rural areas. Age at first birth also increases with education and wealth. Women with no education have their first birth at a median age of 17.8 compared to 23.1 among women with tertiary education.

Teenage Fertility
Almost one quarter of young women age 15-19 have already begun childbearing: 19 percent are mothers and an additional 4 percent are pregnant with their first child. Young motherhood is more common in rural areas than in urban areas, and young women with lower primary education are more than twice as likely to have started childbearing by age 19 than those who have attended high school (36 versus 15 percent).
FAMILY PLANNING

Knowledge of Family Planning

Knowledge of family planning methods in Swaziland is universal; practically all women age 15-49 know at least one modern method of family planning. The most commonly known methods are the male condom (99 percent), injectable (96 percent), pill (95 percent), and female condom (91 percent).

Current Use of Family Planning

Almost half of married women (48 percent) currently use a modern method of family planning. Another 3 percent are using a traditional method. Injectables (17 percent) and male condoms (12 percent) are the most commonly used. Unmarried, sexually active women are most likely to use family planning—almost two-thirds (63 percent) are using a modern method, with 34 percent using male condoms and 17 percent using injectables.

Use of modern family planning varies by residence and region. Modern methods are used by 56 percent of married women in urban areas, compared with 45 percent in rural areas. Modern contraceptive use ranges from a low of 42 percent of married women in Shiselweni to a high of 51 percent in Hhohho.

Modern contraceptive use increases dramatically with women's education. Almost three-quarters of married women with tertiary education use modern methods, compared with only 27 percent of women with no education.

Source of Family Planning Methods

Public sources such as government hospitals, health centres, and clinics currently provide contraceptives to about 45 percent of current users, while private hospitals and clinics provide methods to only 14 percent of users and NGOs provide methods to 24 percent of users. Pills and injectables are most frequently obtained from public sources, while most male condoms are obtained from sources such as shops and friends or relatives.
NEED FOR FAMILY PLANNING

Intention to Use Family Planning
Six in ten (62 percent) currently married non-users intend to use family planning in the future. Half of them report that they would want to use injectables.

Desire to Delay or Stop Childbearing
Two-thirds of Swazi women want no more children. Another 15 percent want to wait at least two years before their next birth. These women are potential users of family planning. In addition, 6 percent of Swazi women are already sterilised.

Unmet Need for Family Planning
Unmet need for family planning is defined as the percentage of married women who want to space their next birth or stop childbearing entirely but are not using contraception. The 2006-07 SDHS reveals that 24 percent of married women have an unmet need for family planning—7 percent for spacing and 17 percent for limiting. Unmet need is highest in rural areas and among the least educated and poorest women.

Missed Opportunities
Many young people are not hearing family planning messages in the media. Almost 40 percent of women age 15-19 and 46 percent of men age 15-19 had not heard about family planning on the radio, television, or in newspapers.

Among all women who are not currently using family planning, only 7 percent were visited by a field worker who discussed family planning, and only 12 percent of women who visited a health facility discussed family planning with a health worker. Overall, more than 4 in 5 non-users did not discuss family planning with any health worker.

Informed Choice
Family planning clients should be informed about the side effects of the method used, what to do if they experience side effects, and told about other methods that could be used. Unfortunately, about one-third of Swazi women did not get this information the last time they began using a new method of contraception. Only 58 percent were informed about possible side effects of their method, and 67 percent were informed about other methods that could be used.
INFANT AND CHILD MORTALITY

Levels and Trends

Childhood mortality is increasing in Swaziland, most probably due to the HIV/AIDS epidemic. Currently, one in every eight children in Swaziland dies before his or her fifth birthday.

The infant mortality rate for the five years before the survey (2001-2006) is 85 deaths per 1,000 live births and the under-five mortality rate is 120 deaths per 1,000 live births. For the period from 1997-2001, infant mortality was 67 and under-five mortality was 90.

Mortality rates do not differ too dramatically throughout Swaziland. Urban and rural rates are almost identical, and the under-five mortality rate ranges very slightly, from 96 in Hhohho to 115 in Lubombo.

Birth Intervals

Spacing children at least 36 months apart reduces risk of infant death. In Swaziland, the average birth interval is 38 months. Infants born less than 2 years after a previous birth have particularly high infant mortality rates (90 deaths per 1,000 live births compared to only 57 deaths per 1,000 live births for infants born 3 years after the previous birth). One in six infants in Swaziland is born less than 2 years after a previous birth.
CHILD HEALTH

Vaccination Coverage
According to the 2006-07, 82 percent of Swazi children age 12-23 months had received all recommended vaccines— one dose of BCG, three doses each of DPT and polio, and one dose of measles. Only 3 percent of children had not received any of the recommended vaccines.

Vaccination coverage is slightly higher in rural areas than urban areas (83 versus 78 percent). There is slight variation in vaccination coverage by region, ranging from only 76 percent fully vaccinated in Lubombo to 84 percent in Hhohho and Shiselweni. Coverage is fairly high across educational levels, with 77 percent of children of uneducated mothers fully vaccinated.

Childhood Illnesses
In the two weeks before the survey, 8 percent of children under five had symptoms of an acute respiratory infection (ARI), and 28 percent had a fever.

During the two weeks before the survey, 13 percent of Swazi children under five had diarrhoea. The rate was highest (27 percent) among children 6 to 11 months old. Almost three-quarters of children with diarrhoea were taken to a health provider. Children with diarrhoea should drink more fluids, particularly through oral rehydration salts (ORS). Almost all (98 percent) mothers with children born in the last five years know about ORS packets, and in the two weeks before the survey, 86 percent of children with diarrhoea were treated with ORS. One-quarter of children with diarrhoea were offered increased fluids and 6 percent received no treatment (from a medical professional or at home) at all.

Prevention of Malaria
Overall, 6 percent of households have at least one mosquito net, and most of these households (4 percent) have an insecticide-treated net (ITN). Ownership of nets ranges from only 2 to 3 percent in Hhohho, Manzini, and Shiselweni, but is 13 percent in Lubombo. Use of nets is quite low—less than 1 percent of children under age 5 slept under a net the night before the survey.

Management of Malaria in Children
In the two weeks before the survey, 28 percent of children under age 5 had fever, the primary symptom of malaria. Of these children, less than 1 percent took an antimalarial drug. SP/Fansidar was the most frequently used antimalarial drug. Chloroquine, the first-line drug, was rarely given to children.
FEEDING PRACTICES AND THE NUTRITIONAL STATUS OF WOMEN AND CHILDREN

Breastfeeding and the Introduction of Complementary Foods

Breastfeeding is very common in Swaziland, with 87 percent of children breastfed. WHO recommends that children receive nothing but breastmilk (exclusive breastfeeding) for the first six months of life. About one-third of children under 6 months of age are being exclusively breastfed. Infants should not be given water, juices, other milks, or complementary foods until six months of age, yet about half of Swazi children under 6 months receive these. On average, children breastfeed until the age of 17 months.

Complementary foods should be introduced when a child is six months old to reduce the risk of malnutrition. In Swaziland, 76 percent of children ages 6-8 months are eating complementary foods.

The Infant and Young Child Feeding (IYCF) practices recommend that breastfed children age 6-23 months also be fed three or more other food groups. Three-quarters of breastfed children in Swaziland meet this recommendation. It is also recommended that non-breastfed children be fed milk or milk products, and four or more food groups. Two-thirds of non-breastfed Swazi children receive milk or milk products, and 60 percent were fed four or more food groups.

Vitamin A and Iron Supplementation

Micronutrients are essential vitamins and minerals required for good health.

Vitamin A, which prevents blindness and infection, is particularly important for children and new mothers. In the 24 hours before the survey, 79 percent of children age 6-35 months ate fruits and vegetables rich in vitamin A. Four in five children (81 percent) age 6-59 months received a vitamin A supplement in the 6 months prior to the survey. Only 44 percent of women received a vitamin A supplement postpartum, however.

Pregnant women should take iron tablets or syrup for at least 90 days during pregnancy to prevent anemia and other complications. Only one-third of women took iron tablets or syrup for at least 90 days during their last pregnancy. Adequate iron supplementation during pregnancy was highest in Manzini, where 46 percent of pregnant women took iron tablets for 90+ days.
Children’s Nutritional Status

The SDHS measures children’s nutritional status by comparing height and weight measurements against an international reference standard. According to the 2006-07 SDHS, 29 percent of children under 5 are stunted, or too short for their age. This indicates chronic malnutrition. Stunting is more common in rural areas (30 percent) than urban areas (23 percent). Stunting is least common among children of more educated mothers and those from wealthier families. Wasting (thin for height) and underweight are far less common than stunting. (3 and 5 percent, respectively).

Women’s Nutritional Status

Swazi women also face nutritional challenges. Very few women, however, are too thin, but over half (51 percent) are overweight or obese. Overweight increases with age, with education, and with wealth.

Anemia

Two in five (42 percent) children age 6-59 months have some degree of anemia, and 20 percent have moderate or severe cases of anemia. Anemia is more common in urban areas than rural areas (50 percent compared to 40 percent of children 5). The SDHS also included anemia testing of children age 5-14. Results show that 18 percent of 5-14 year-olds are anemic.

Thirty percent of women age 15-49 are anemic, but most (23 percent) have mild anemia. Pregnant women are most likely to be anemic (40 percent). Anemia is less common among older women—only 21 percent of women over 50 are anemic. Anemia among men is even less common—only 13 percent of men age 15-49 are anemic, and most of them have mild cases.
MATERNAL HEALTH

Antenatal Care
Almost all (97 percent) Swazi women receive some antenatal care from a medical professional, most commonly from a nurse/midwife (76 percent). Only 26 percent of women, however, had an antenatal care visit by their fourth month of pregnancy, as recommended. Although almost all Swazi women receive some antenatal care, they may not be receiving all the recommended components of care. According to the 2006-07 SDHS, only 54 percent of women were informed of signs of pregnancy complications during antenatal care, and only 78 percent were physically examined. Almost all women who received antenatal care received iron tablets, were weighed, and had their blood pressure measured. Urine and blood samples were taken from over 90 percent of pregnant women receiving antenatal care. Three-quarters of women's most recent births was protected against neonatal tetanus.

Antimalarial Drug Use During Pregnancy
Malaria during pregnancy contributes to low birth weight, infant mortality and other complications. At the time of the survey, it was recommended that pregnant women receive two doses of the antimalarial drug SP/Fansidar as intermittent preventive treatment (IPT). Only 7 percent of pregnant woman took any antimalarial drug during their last pregnancy, and fewer than 1 percent took the two recommended doses of SP during pregnancy. Only about 1 percent of pregnant women slept under a net the night before the survey.

Delivery and Postnatal Care
Three-quarters of Swaziland’s births occur in health facilities, 43 percent in the public sector and 27 percent in Mission/private sector facilities. One quarter of births occur at home. Home births are more common in rural areas (29 percent) than urban areas (11 percent). Three-quarters of births are assisted by a skilled provider (doctor, nurse/midwife, or nursing assistant). Another 5 percent are assisted by a traditional birth attendant and 16 percent by untrained relatives or friends.

Postnatal care helps prevent complications after childbirth. The majority (75 percent) of women did not have a postnatal checkup.

Maternal Mortality
The SHDS asked women about deaths of their sisters to determine maternal mortality—deaths associated with pregnancy and childbearing. The 2006-07 maternal mortality rate for Swaziland is 482.
## HIV/AIDS Knowledge and Attitudes

### Knowledge

According to the 2006-07 SDHS, almost all Swazi adults have heard of AIDS, but knowledge of HIV prevention measures is lower. Only 87 percent of women and 83 percent of men age 15-49 know that the risk of getting HIV can be reduced by using condoms and limiting sex to one faithful partner. Prevention knowledge is higher in urban areas and among those with higher levels of education. Adults age 50 and over are less likely to know about HIV prevention than those age 15-49. Only about 70 percent of older adults know that HIV can be prevented by using condoms. Most men and women know that HIV can be transmitted by breastfeeding, and about three-quarters know that the risk of mother-to-child transmission can be reduced by taking drugs during pregnancy.

Almost 90 percent of adults age 15-49 know where to get male condoms, but only half of women and one quarter of men know where to get a female condom.

Many Swazis still have misconceptions about HIV/AIDS. Only two-thirds of women and men, for example, know that AIDS cannot be transmitted by mosquito bites.

### Attitudes

There is still a lot of stigma associated with HIV in Swaziland. While most men and women say they are willing to take care of a family member with the AIDS virus, only about 60 percent say that they would not want to keep secret that a family member got infected with the AIDS virus. Three in four say that they would buy fresh vegetables from a shopkeeper who has the AIDS virus. Adults 50 and over are less accepting of those living with AIDS—only half would buy vegetables from a shopkeeper who had the AIDS virus.

HIV prevention education is a fairly controversial subject in Swaziland. Fewer than three-quarters of men and women agree that children age 12-14 should be taught about using a condom to avoid AIDS.

### Negotiating Safer Sex

Most men and women say that women can negotiate with their husbands to have safer sex. Two-thirds of women and three-quarters of men believe that women can refuse sex if the husband has a sexually transmitted infection (STI). More than 90 percent of women and men believe that the woman can propose condom use if the husband has an STI.

<table>
<thead>
<tr>
<th>Knowledge of HIV Prevention</th>
<th>Knowledge of Maternal to Child Transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent that know that HIV can be prevented by:</td>
<td>Percent that know that HIV can be transmitted by breastfeeding:</td>
</tr>
<tr>
<td>Using condoms</td>
<td>Transmission can be reduced by mother taking drugs during pregnancy:</td>
</tr>
<tr>
<td>Limiting sex to one uninfected partner</td>
<td></td>
</tr>
</tbody>
</table>

### Percent of men and women age 15-49

<table>
<thead>
<tr>
<th>Action</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using condoms</td>
<td>91</td>
<td>87</td>
</tr>
<tr>
<td>Limiting sex to one uninfected partner</td>
<td>93</td>
<td>91</td>
</tr>
<tr>
<td>Using condoms AND limiting sex to one uninfected partner</td>
<td>87</td>
<td>83</td>
</tr>
<tr>
<td>HIV can be transmitted by breastfeeding</td>
<td>85</td>
<td>76</td>
</tr>
<tr>
<td>Transmission can be reduced by mother taking drugs during pregnancy</td>
<td>85</td>
<td>79</td>
</tr>
</tbody>
</table>
HIV/AIDS-Related Behavior

HIV Testing
Most Swazis have never been tested for HIV. Almost all women age 15-49 know where to get an HIV test, compared to only about three in four men. Women are far more likely to have been tested for HIV - 36 percent of women have ever been tested and received results compared to only 17 percent of men. In the 12 months before the survey, 22 percent of women and only 9 percent of men had taken an HIV test and received the results. Forty-two percent of women who were pregnant in the two years before the survey were offered and received HIV testing during antenatal care. HIV testing during antenatal care is much more common in urban areas (53 percent) than rural areas (39 percent) and is highest among women with tertiary education (54 percent).

Prior HIV Testing

<table>
<thead>
<tr>
<th></th>
<th>Women 15-49</th>
<th>Men 15-49</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never tested</td>
<td>59%</td>
<td>81%</td>
</tr>
<tr>
<td>Ever tested and received results</td>
<td>36%</td>
<td>17%</td>
</tr>
<tr>
<td>Tested, did not receive results</td>
<td>5%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Higher-Risk Sex and Condom Use
In the 2006-07 SDHS, higher-risk sex is defined as sex with a partner who is neither a spouse or lived with the respondent in the 12 months preceding the survey. Overall, 44 percent of women engaged in higher-risk sex in the year before the survey, as did 58 percent of men. About half of these women and two-thirds of these men used a condom at their most recent higher-risk sex.

Condom Use
The majority of men age 15-49 who used a condom in the 12 months before the survey used either Government condoms (37 percent) or Trust brand condom (43 percent). Condoms were most frequently obtained at shops (44 percent) and hospitals/health centres/clinics (16 percent).
HIV PREVALENCE

HIV Prevalence

The 2006-07 SDHS included HIV testing of over 15,000 men, women, and children. Eighty-seven percent of women aged 15-49 and 78 percent of men 15-49 agreed to be tested for HIV.

More than one in four adults age 15-49 is HIV-positive. Women are much likely to be infected than men, and those living in urban areas are at higher risk of infection than those living in rural areas.

Swaziland is the only DHS survey to test for HIV in children age 2-14 and adults age 50 and over. Four percent of children age 2-14 are infected with HN. HIV prevalence is highest in young adults; one in two women age 25-29 are HN-positive. Twelve percent of women age 50 and over are infected compared to 18 percent of men over age 50.

HN prevalence is high in all four regions of Swaziland, ranging from 23 percent of 15-49 year-olds in Shiselweni to 29 percent in Hhohho.

HIV prevalence is particularly high among widows and those who are divorced or separated—56 percent of widowed women and 68 percent of widowed men are HIV-positive.
Orphanhood

Less than one-quarter of children under 18 lives with both of their parents. One-third of children under 18 are not living with either biological parent. One in four children have one or both parents dead, while one in three are considered orphans and/or vulnerable. Almost 30 percent of orphans do not live with all their siblings.

Orphans and vulnerable children (OVC) are less likely than non-OVC to possess the three basic needs—shoes, two sets of clothes, and at least one meal per day. OVC are also more likely to be underweight than their non-OVC peers. Although about one-third of OVCs receive school-related assistance, most households with OVCs (59 percent) received no external support in the year before the survey.

Caregivers of children should plan for succession in case of illness. Only one in four caregivers have made succession arrangements.

Five year-old Mfan'fikile Mkhanya, who lost both parents to AIDS, sits at the cold hearth of the empty cooking hut at his grandparents' homestead in Mavukutfu, Swaziland. (c) 2004 Tjekisa James Hall, Courtesy of Photoshare
**WOMEN’S EMPOWERMENT**

**Employment**
About half of women age 15-49 interviewed in the SDHS are employed compared to 86 percent of men. Among those who are employed, men are slightly more likely to earn cash, while women are more likely than men to be unpaid. Women who earn cash generally earn less than their husbands.

**Participation in household decisions**
Many Swazi women do not have the power to make household decisions. Women are most likely to have control over daily household purchases, while husbands often have final say over visits to family or relatives and larger household purchases. Ten percent of women do not participate at all in any of the four decisions.

**Attitudes towards wife beating and refusing sex**
More than one-third of women and 40 percent of men agree that a husband is justified in beating his wife for certain reasons. About two-thirds of women and men agree that women are justified in refusing sexual intercourse with her husband for certain reasons.

**Women’s empowerment and health outcomes**
Empowered women often have better health outcomes than women who are less empowered. For example, women who participate in more household decisions and those who find no reasons to justify wife beating are more likely to use contraception. Women who participate in more household decisions are also more likely to receive assistance from health personnel during delivery than those who have no say in decision making. Seventy-seven percent of women who participate in 3 or 4 household decisions received assistance from health personnel during delivery compared to only 67 percent of those who participated in no decisions.
**YOUTH**

In order to identify factors that put young people at risk for contracting HIV/AIDS, the 2006-07 SDHS included interviews with over 800 children age 12-14.

**Caregivers and Supervision**

More than half of young people age 12-14 have only one caregiver at home. Mothers and fathers are the most common caregivers; grandmothers were identified as caregivers for over one-quarter of children. Most youth report regular supervision at school, both in and out of the classroom.

**Knowledge of sex and HIV/AIDS**

About six in ten youth know the meaning of sex. Females and those living in urban areas are more likely to know the meaning of sex. Almost half of girls and one-quarter of boys report that parents talked with them about sex. Girls were also more likely to have talked with their parents about sexual abuse than boys.

Almost all 12-14 year-olds have heard of AIDS. Most also know that it is possible to avoid or reduce the chances of getting AIDS, and that a healthy-looking person can have AIDS. About three in four youth have heard about the male condom, while less than half have heard of the female condom. Only about one-third of youth believe that children their age should be taught to use condoms to avoid AIDS, while more than 60 percent believe that they should be taught to wait until they are married to have sex.

**HIV/AIDS information**

The radio is the most common source of HIV/AIDS information for young people age 12-14 — 70 percent have heard an HIV message on the radio. About one-third of youth report hearing these messages through television, newspapers, leaflets, posters, and billboards. Exposure to these messages is much more common in urban than rural areas. More than two-thirds of youth have also seen these messages on clothing and red ribbon badges. Eighteen percent know about an HIV/AIDS help line, and about half of youth know a place to be tested for the AIDS virus.

School is the most frequent source of HIV information for 12-14 year olds. Eighty-three percent of these youth received information on HIV from school, 45 percent received information from health facilities, and 37 percent from religious meetings.

Three in five youth who know about sex said that the HIV/AIDS information they received had too much focus on abstinence. Half felt there was too much focus on sex. Very few, however, believed that the information encouraged young people to have sex, or implied that it is OK for children to have sex if it is safe.

About one in three youth have ever discussed HIV/AIDS with parents or caregivers. However, among the youth who discussed HIV/AIDS in the month before the survey, friends were the most frequent discussion partner. Fifty-nine percent of youth talked with a friend about HIV/AIDS in the month before the survey, while 30 percent talked with a teacher, and only 14 percent talked with a parent. One-quarter of youth do report, however, that they would like to talk to their parent about HIV/AIDS.
### Key Indicators

#### Fertility
- Total fertility rate (number of children per woman)
- Women age 15–19 who are mothers or now pregnant (%)
- Median age at first marriage for women age 30-49 (years)
- Median age at first intercourse for women age 25-49 (years)
- Median age at first birth for women age 25-49 (years)
- Married women (age 15–49) wanting no more children (%)

#### Family Planning (married women, age 15-49)
- Current use:
  - Any method (%)
  - Any modern method (%)
  - Currently married women with an unmet need for family planning(%)

#### Maternal and Child Health
- Maternity care:
  - Women giving birth who received antenatal care from a health professional (%)
  - Births assisted by a health professional (%)
  - Births delivered in a health facility (%)
- Child immunisation:
  - Children 12-23 months fully vaccinated (%)

#### Nutrition in Children
- Children under 5 years who are stunted (moderate or severe) (%)
- Children under 5 years who are wasted (moderate or severe) (%)
- Children under 5 years who are underweight (%)
- Median duration of any breastfeeding (months)
- Median duration of exclusive breastfeeding (months)

#### Childhood Mortality
(Figures are for the ten-year period before the survey, except for the national rate, in italics, which represents the five-year period before the survey)
- Number of deaths per 1,000 births:
  - Infant mortality (between birth and first birthday)
  - Under-five mortality (between birth and fifth birthday)

#### AIDS-related Knowledge
- Knows ways to avoid AIDS:
  - Having one sex partner (women age 15–49/men age 15-49) (%)
  - Using condoms (women age 15–49/ men age 15-49) (%)
- Knows HIV can be transmitted by breastfeeding (women age 15–49/ men age 15-49) (%)
- Knows risk of MTCT can be reduced by mother taking special drugs during pregnancy (women)

#### HIV Prevalence
- HIV prevalence (women/men age 15-49) (%)
- HIV prevalence older adults (women/men age 50 and over) (%)
- HIV prevalence children age 2-14 (girls/boys) (%)

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1 Currently married women who do not want any more children or want to wait at least 2 years before their next birth but are not currently using a method of family planning.
2 Fully vaccinated includes BCG, measles, and three doses each of DPT and polio)
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