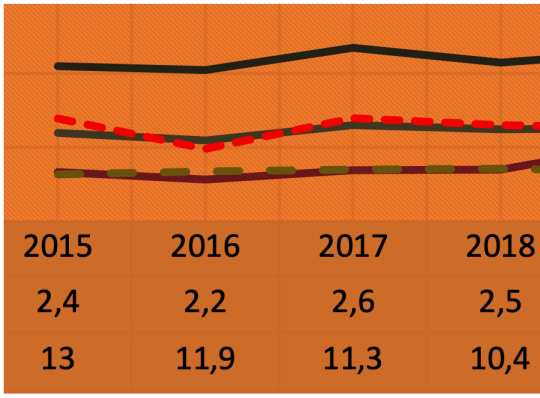
RATT
Eastern & Southern Africa
Regional Inter Agency Task Team on Children & AIDS

POLICY BRIEF ON CHILDREN'S FUNDING IN SADC



The budget is the skeleton of the state, stripped of all misleading ideologies…

Joseph Schumpeter – 1918

1. INTRODUCTION

The SADC region has a young population with 76 percent of its population below the age of 35 years.[1] Children below the age of 18 years comprise nearly half of the region's population. Tailoring programs, agendas and budgets to meet the developmental needs of this demographic group is imperative to achievement of sustainable development. A World Bank Report suggests that in 2050, Southern Africa will have a working-age population that is larger than its number of young dependents.[2] That demographic window of opportunity will reach its peak around 2050, when 68 percent of the people in the region will be of working age. This demographic bulge can be a double-edged sword. If the Eastern and Southern Africa (ESA) Member States do not deliberately invest in human capital, which is a conduit for transforming the demographic bulge into a dividend, then the productive potential will be lost. The repercussions of complacency will be dire for the region as a whole, hence RIATT-ESA's interest in ensuring that adequate funding is accorded to transforming the demographic bulge into a dividend.

2. WHY PUBLIC INVESTMENT IN CHILDREN'S RIGHTS MATTERS

Beyond the ratifications of international and regional child rights instruments, as well as promulgation of impeccable laws, realization of children's rights will not be actualized until adequate public resources are availed. It is the incumbency of the governments to increase their fiscal space so that adequate resources are accorded to children's rights. There is need for SADC Member States to act on the recognition that investing in children's rights is critical to achieving inclusive, equitable and sustainable development for present and future generations.[3]

The commitment to promote children's rights in the SADC region is expressed through efforts that have been made by countries in developing various national policies that speak to different aspects of child development and rights. Although SADC countries are at varying levels in child policy development there is evidence of efforts to develop policies that incorporate the minimum package of services for children that has been agreed at the regional level. The SADC Minimum Package of Services (2011) identifies the basic and complementing needs and services for children in the following areas: Education and vocational skills; Healthcare and sanitation; Food security and nutrition; Child and youth protection and safety; Psycho-social well-being; and social protection.

1 Corcoran, T. (2017). Are the kids alright? Relating to representations of youth. *International Journal of Adolescence and Youth*, 22(2), 151-164.

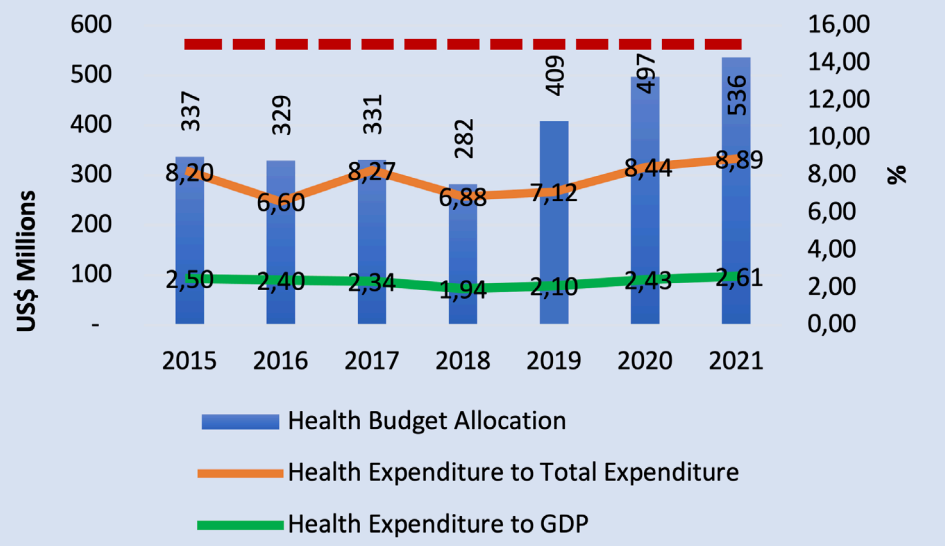
2 Bruni, L. M., Rigolini, J., & Troiano, S. (2016). *Forever Young? Social Policies for a Changing Population in Southern Africa*. World Bank.

3 Ibid.

Mobilization and effective use of domestic resources is needful to guarantee sustainable child rights outcomes for every child in each country. While there is an appreciation that international assistance plays a key role in financing children's issues, it should, however, not be the backbone of child rights financing of Member States, instead, it should only supplement domestic efforts. Such a situation can be reached when revenue collection and administration systems are enhanced through modernized, progressive tax systems, improved tax policies adapted to local contexts and more efficient tax collection. The next section provides trend analyses on children's financing in SADC, using data obtained through review of budget data of the Member States.

3. RIGHT TO HEALTH EXPENDITURE IN SADC

FIGURE 1: *Trends in Average Health Budget Allocations for SADC: 2015-2021*



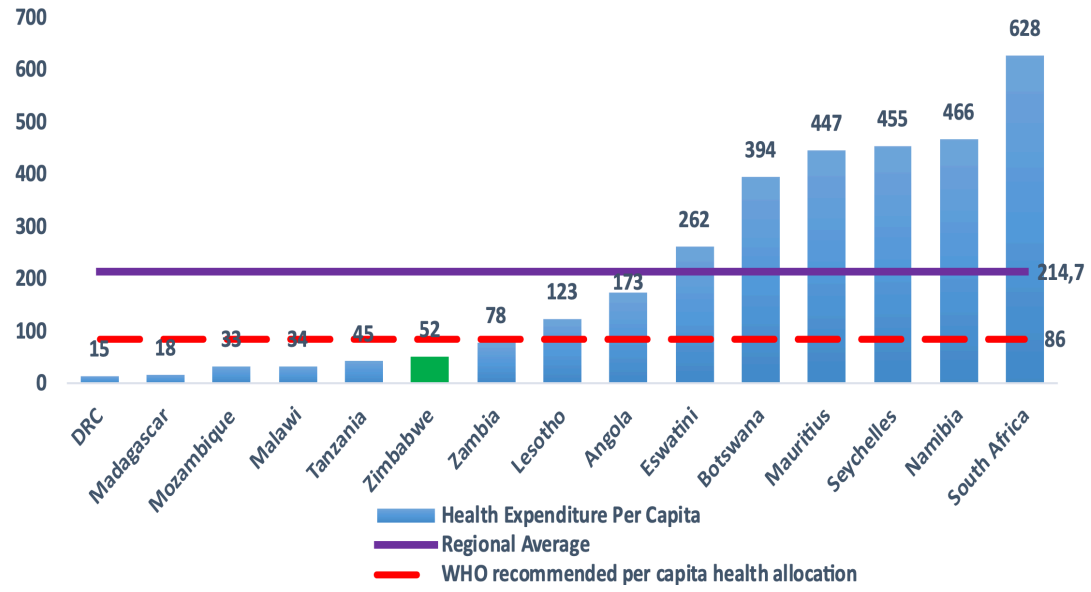
As can be deciphered from Figure 1, health budget allocations in SADC have increased between 2015 and 2021 in both absolute and relative terms, even though they are still below the Abuja Target. At 8.89 percent of the total budget, the 2021 average health care budget in the SADC region was 6.11 percent lower than the required Abuja benchmark of 15 percent.

The failure to reach the Abuja benchmark is the reliance by SADC countries on external aid to cover their expenditure requirements in several sectors, including health, education and social protection.[4] Governments in the region need to rework on their financing plans and this should be mainly through increased domestic resources mobilisation, as already mentioned. A classic example of functional domestic resource mobilisation is the AIDS Levy Fund in Zimbabwe. The Fund was established in 1999 and entails a three percent deduction for every employed individual and another three percent on profits of employers and trusts to finance the fight against HIV/AIDS. Figure 1 shows that the

4 SADC and the Abuja Declaration: Honouring the Pledge - SAIIA (Accessed 15 August 2022).

average health expenditure as a percentage of the Gross Domestic Product (GDP) for the period 2015 to 2021 was relatively low. The average share for the countries, for example, in 2021 translated to only 2.61 percent of GDP, up from 2.10 percent in the year 2019 which is way below the required 6.6 percent of GDP in SADC.[5] This shows the need for increasing the budget commitment to the health sector in SADC.

FIGURE 2: *Average per capita health spending in the SADC Region (2015-2021)*



In terms of health care spending per capita, Figure 2 shows that countries in the SADC region are failing to spend enough on public health. DRC, Madagascar, Mozambique, Malawi, Tanzania, Zimbabwe and Zambia's health spending falls short of the World Health Organisation's recommended target of US$86 per year. Compared with other regional countries, South Africa has the largest per capita allocation for the period with an average of US$628 followed by Namibia and Seychelles with US$466 and US$455 respectively. The regional average per capita share in SADC is US$214.70, however 9 of the SADC countries are way below the average. This therefore shows the need for governments in the SADC region to increase the level of funding so as to achieve health outcomes as well as making progress towards the Sustainable Development Goals.

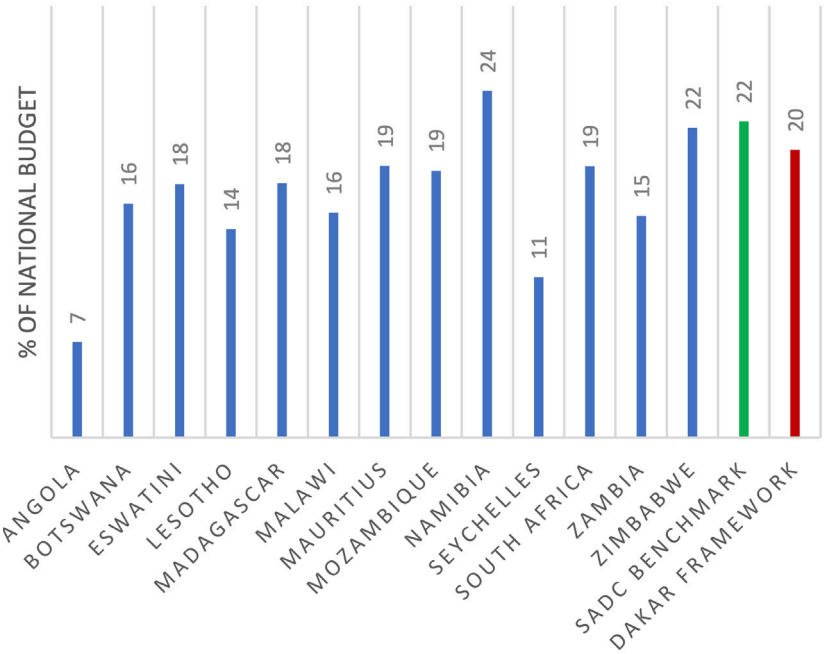
The low levels of per capita spending cannot guarantee adequate access and quality services for the population, including children in SADC. The implication of the inadequacy in public health spending is that the right to health for children will continue to significantly rely on out-of-pocket expenditures and donor assistance, which are both unsustainable. The COVID-19 pandemic and other natural disasters that have hit the SADC region show the need for an increase in per capita spending.

5 Health expenditure and growth dynamics in the SADC region: evidence from non-stationary panel data with cross section dependence and unobserved heterogeneity on JSTOR (Accessed 12 August 2022).

4. EDUCATION FUNDING IN SADC

Education falls among the key priorities of the SADC Minimum Package of Services for OVCY. The priority area covers the education needs of children at various stages of their development including: early childhood development, primary, secondary and tertiary education, non-formal education and vocational training opportunities for children, adolescents and youth. Allocation of resources towards meeting the education needs of children must take into account costs related to tuition fees, school uniforms, educational materials (stationery and instructional materials), skilled teachers and safe schools, psychosocial skills and support for all children and youth, and professional, entrepreneurial and livelihood training and income-earning skills for adolescents and youth. SADC countries, despite the macroeconomic challenges, have maintained allocations to the education sector averaging above 13 percent of the national budgets. The gradual increase trend towards the 20 percent benchmark is visible across the region due to priority towards human development. Figure 3 gives a snapshot of the percentage of the total national budget allocated by some SADC countries. Access to primary education in particular has been supported by policy and budget allocations, with some countries such as Eswatini and Tanzania adopting free access to primary education policies. The prioritisation of primary education has seen significant increases in allocations and spending by governments in order to meet their commitment to free primary education for all children. This has been responsible for the overall increase in the education budgets in countries such as Madagascar, Mozambique, Namibia and Zimbabwe.

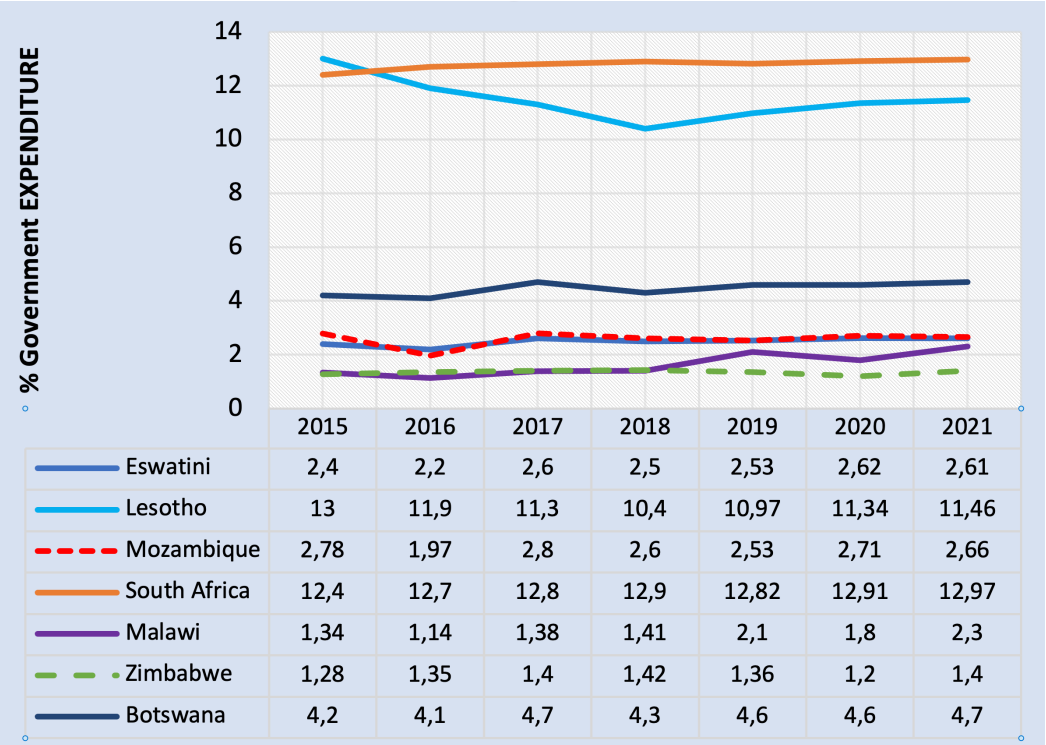
FIGURE 3: *Average spending on education (2014-2021)*



5. SOCIAL PROTECTION FUNDING IN SADC

While data on spending on specific social protection programmes for children, is unavailable for most countries, using overall public social protection expenditure is a useful proxy which provides an indication of the level of commitment that a nation has. The average spending on social protection in Africa is estimated at four percent of GDP and it is mainly used for social assistance. Some countries in the SADC region, such as Lesotho, Mauritius, Seychelles and South Africa, however, are spending way above the four percent average at about 16 percent, 9.8 percent, 7.5 percent and 10.1 percent respectively. The larger number of SADC countries spend between 4.4 percent and 7 percent except DRC, Malawi and Madagascar which have expenditures that are below the continental average at 3.5 percent, 1 percent and 0.7 percent respectively.

FIGURE 4: *Social Protection as percentage of total government expenditure (2015-2021)*



	2015	2016	2017	2018	2019	2020	2021
Eswatini	2,4	2,2	2,6	2,5	2,53	2,62	2,61
Lesotho	13	11,9	11,3	10,4	10,97	11,34	11,46
Mozambique	2,78	1,97	2,8	2,6	2,53	2,71	2,66
South Africa	12,4	12,7	12,8	12,9	12,82	12,91	12,97
Malawi	1,34	1,14	1,38	1,41	2,1	1,8	2,3
Zimbabwe	1,28	1,35	1,4	1,42	1,36	1,2	1,4
Botswana	4,2	4,1	4,7	4,3	4,6	4,6	4,7

The levels of expenditure on social protection are determined largely by the socio-economic contexts of each country. In South Africa and Lesotho, there are relatively high levels of expenditure on social protection. Countries that have been progressive in the development of social protection policies also reflect higher levels of expenditure in this sector. The national budget in Lesotho for instance now includes specific budget lines on the child grants programme.

6. IMPACT OF COVID-19 ON FUNDING IN SADC

The COVID-19 pandemic exposed capacity limitations of the health sector in SADC. This includes insufficient supplies of drugs and medicines, underinvestment in healthcare infrastructure and shortages of healthcare professionals. The pandemic worsened existing extreme inequalities in the region, pushing millions into poverty. Economic crises continue due to the obscene global vaccine inequality. As of end March 2022, a dismal 14 percent of SADC citizens had been fully vaccinated against COVID-19, compared with 65.5 percent in the United States and 73 percent in the European Union.[6] Recovering from the pandemic offers SADC governments a once-in-a-generation opportunity to boost public spending especially on healthcare.

FIGURE 5: *COVID-19 Response Spending (% GDP)*

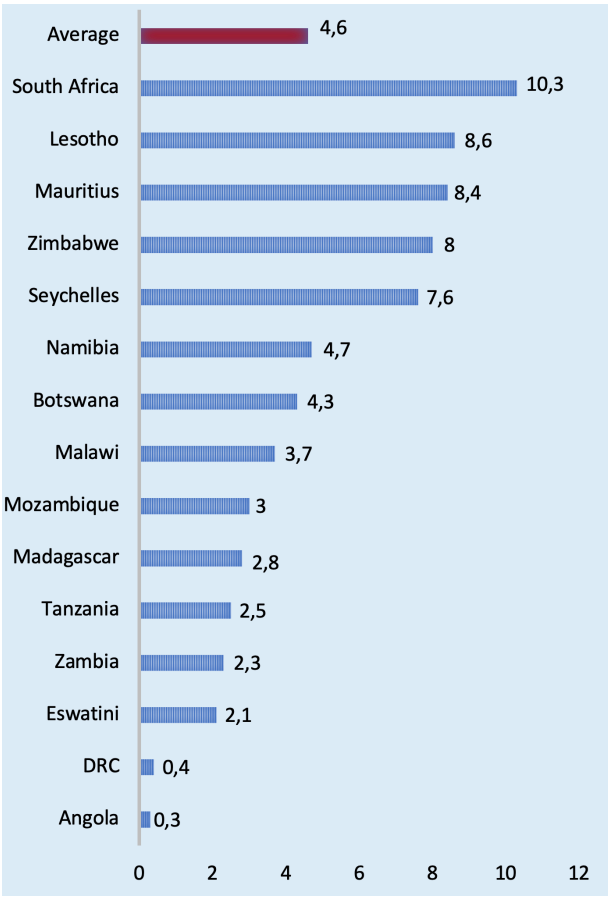


Figure 4 shows that countries in SADC responded to COVID-19 with fiscal support packages of very varied sizes. They average 4.6 percent of GDP due to some countries' limited ability to borrow additional funds. The figure shows the scale of states' responses, ranging from well below 1 percent in Angola and DRC (reflecting pre-COVID economic crises and very limited fiscal space) to 10.3 percent in South Africa. During COVID-19, disruptions to healthcare services were reported in all SADC states.

The reasons for disruption in healthcare services varied in each country. In some countries, services were disrupted due to overwhelmed healthcare systems, medicine stock outs and prioritisation of COVID-19 response. Many health workers were also unavailable because of restrictions on travel or re-deployment to COVID response duties as well as a lack of protective equipment. As a result, Lesotho, Malawi, Namibia, Zambia and Zimbabwe reported cases of declining access and utilization of essential services including preventive, curative and rehabilitation services. Out-patient care also drastically reduced in the same countries with an average drop rate of 38 percent.[7]

6 The crisis of extreme inequality in SADC: fighting austerity and the pandemic | Oxfam International (Accessed 13 August 2022).

7 Author's calculation of out- patient care drop-outs based on Country-level UNOCHA Situation Update Estimates.

On access to HIV services, there was a 45 percent decrease of the number of young people tested for HIV in 2020 (April-October) compared to the same period in 2019.[8] The stay-at-home orders that were implemented to contain the spread of the virus disrupted vaccination campaigns and immunization activities, which increased the risk of children contracting other infectious diseases.[9] Measles and polio immunization campaigns were delayed in some SADC countries leaving many children unvaccinated and at risk of contracting other infectious diseases. In Zimbabwe, the proportion of districts reporting at least 80 percent of routine immunizations declined from 90 percent in December 2019 to less than 60 percent at the end of June 2020, while there was a 45 percent decline in the number of women's fourth antenatal care visits when comparing the April to July periods in 2019 and 2020.[10]

7. KEY CHILD RIGHTS FUNDING ASKS FROM ESA MEMBER STATES

7.1 Budget allocation and expenditure data collection: In the spirit of tracking the level of investment into the demographic bulge to turn it into a dividend, ESA member states should improve collection, disaggregation and dissemination of budget allocation and expenditure data. This can be done through observance of the dictates of UNCRC General Comment No. 5 (2003) on General Measures of Implementation by collecting in real time and sharing budget allocation and utilization data amongst all relevant stakeholders covering areas such as education, healthcare, nutrition, child protection, psychosocial wellbeing, and social protection.

7.2 Domestic Resource Mobilisation: There is need for the governments in ESA to build sustainability for its programmes in education, healthcare, nutrition, child protection, psychosocial wellbeing, and social protection. Domestic resource mobilisation is critical as a sustainable way of ensuring sustainability in provision of resources for this sector. To promote domestic resource mobilisation, Member States will need to review their revenue collection mechanism as well adopt strategies that can enable revenue authorities to efficiently and effectively collect taxes from the huge informal sector in the region.

7.3 Public spending in children's rights: In the light of general comment No. 19 (2016) on public budgeting for the realization of children's rights, the ESA national governments are recommended to

8 Governder et al *Beyond the Disease: Contextualised Implications of the COVID-19 Pandemic for Children and Young People Living in Eastern and Southern Africa*

9 For detailed analysis of the impact of COVID-19 on children, please see ACERWC (2022), *Continental Assessment of the Impact of COVID-19 on the Rights and Welfare of Children in Africa* https://www.acerwc.africa/wp-content/uploads/2022/08/Continental-Covid-19-assessment_report_14_July_Final-Clean-Draft_En.pdf; and Govender, K., Cowden, R. G., Nyamaruze, P., Armstrong, R. M., & Hatane, L. (2020). *Beyond the disease: Contextualized implications of the COVID-19 pandemic for children and young people living in Eastern and Southern Africa*. Frontiers in Public Health, 8, 504.

10 UNOCHA Situation Report Zimbabwe National Covid-19 response (2020)

ensure that public spending on child focused sectors such as inter alia, such as education, healthcare, nutrition, child protection, psychosocial wellbeing, and social protection are adequate, equitable, efficient and effective and undertaken within transparent and inclusive public finance management processes. It is only through increased and improved quality of public spending that ESA member states can sustainably deliver the aforementioned essential services for children. The allocation of resources should take note of target 16.5 of the Sustainable Development Goals on substantially reducing corruption and bribery in all their forms, take immediate measures to combat corruption and strengthen institutional capacities to effectively detect and investigate cases of corruption and prosecute the perpetrators, including by strengthening the public financial management system in order to avoid diverting resources from the implementation of the rights of the child.

7.4 Recovering from COVID-19 and other disasters: ESA member states need to derive lessons from the COVID Pandemic so that the health systems are adequately prepared for any other such pandemics or epidemics and natural disasters. This will mean development of adequately financed early warning systems embedding child protection indicators with anticipatory action and early action, which must be risk-informed and target those who are most at risk, especially the children.

7.5 Consistency with budget benchmarks: With most ESA countries being unable to meet the political commitments they made at regional level, for example the Abuja Declaration on Health and the Dakar Framework for Action on Education for All, there is need for countries to ensure efficient use of existing resources for the child focused sectors.