DETERMINING BETTER INVESTMENTS FOR CHILDREN IN SWAZILAND

Study supported by the African Capacity Building Foundation

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Executive Summary

The Coordinating Assembly of NGOs commissioned a desktop research to determine better investments for children in Swaziland. The research aimed to bring to the fore the size and extent of government expenditure on children and the existence policies supporting such expenditures.

Since the research was mainly a desk review, several government budget and expenditure documents were reviewed including national policies and strategic frameworks. Peer reviewed literature and international publications on children were also reviewed to give perspective on practice elsewhere and enable comparisons between Swaziland and other countries in the region as well as the rest of the world.

The investment analysis focused on health, education and social protection since these have a direct bearing on child development. The analysis of government expenditure was limited to recurrent spending as this information was easily available compared to capital spending. The results of the analysis revealed that substantial investments have been made in education and health in the past five years and these have been on a gradual increase over the years. As such, Swaziland compares favourably with other countries in the region and the rest of the world.

The Ministry of Education's share of the total national budget has averaged 20% over the past five years. Actually, in 2011 government expenditure on education as a percentage of total government expenditure was 24, 5%, and as such higher than that of South Africa which was 18, 9% (World Bank, 2015). Investments in education for children have risen from E1, 5 billion in 2011 to E2 billion in 2015. At the same time, in Swaziland, government expenditure per student at primary (also expressed as percentage of GDP per capita) was 18% in 2013 whilst that of South Africa and France and was 18% and 18, 4% respectively. These investments have positively contributed increase of the primary net enrolment rate which is estimated at 93% in 2011. Despite the positive trends in primary enrolment rates there are several issues that the government needs to attend to and key amongst them is the poor quality of education especially in rural areas due to factors such as unqualified teachers and lack of teaching materials, facilities and infrastructure. There is also an alarmingly high percentage of children of the appropriate age not enrolled in junior and senior education, at 74% and 88%, respectively.

In the SADC region Swaziland (US$256) comes after Botswana (US$397), Mauritius (US$463), Seychelles (US$551) and South Africa (US$593) in terms of per capita spending on health. Nonetheless, Health expenditure in Swaziland is still way above the WHO recommendation of US$38 per capita. In order to ascertain level of investments in children, the research considered five key programmes contributing to child related indicators, namely, Integrated management of Childhood illnesses

(IMCI), Sexual and Reproductive Health (SRH), Nutrition, Expanded Programme on Immunization (EPI) and HIV/AIDS. Total government recurrent expenditure across the 5 programmes has increased from E278 million in 2011 to E404 million in 2015 with HIV/AIDS and EPI claiming significant proportions at 40% and 29% respectively. Increased investments also have to be made towards IMCI, Nutrition and SRH to combat other childhood illnesses as well as positively influence behaviours amongst the youth.

According to the Social Policy Framework for Africa (2008), it is recommended that investments in social protection should comprise 4.5% of a country's GDP. In Sub-Saharan Africa including Swaziland, overall spending in social protection is estimated to be 2.81% of GDP. An analysis of the social welfare budget revealed that almost the entire budget allocated to the Department of Social Welfare is directed to the OVC education fund comprising 98% of the total budget.

There appears to be significant investments made in health and education and there has been an improvement in most child development indicators. On the other hand, despite the introduction of the OVC education fund, public investments in social protection have been very low. A positive development though has been the enactment of child protection laws and policies but what remains now is ensuring that there are resources availed to operationalize these laws and policies.

It is recommended that government needs to focus on; achieving value for money, effectiveness in implementation, strengthening multi-sectoral collaboration, increasing civil society and public participation in national planning and budgeting, restructuring and expanding the Department of Social Welfare and establishing a Social Work council.

In terms of advocacy, five areas are recommended; Increasing the enrolment of out of school children; Construction of additional secondary schools; Inclusion of all children in difficult circumstances (e.g children in correctional facilities); Increasing allocations to Nutrition, IMCI and SRH; and Increasing public participation in national planning and budgeting.

1.0 Introduction

The Coordinating Assembly for NGOs (CANGO) undertook a research for determining better Investment for Children in Swaziland. The assignment essentially reviewed of existing information (secondary data) focusing mainly on local efforts (from a financial and policy perspective) to improve the welfare status of children in the country.

The scope of research covered the following key areas;

i. Review the country annual budget from 2010 to 2014 and identify if Swaziland has been investing enough in children
ii. Cite the actual expenditures for each year on the key priority areas on children's issues for the different government ministries
iii. Review the policy framework ensuring that budget allocations can meet the needs of children in Swaziland
iv. Identify key gaps and challenges and recommend areas of advocacy for the Children's Consortium under the Coordinating Assembly of Non Governmental Organisations in Swaziland.

2.0 Background

Due to the prevalence of HIV/AIDS, poverty and rising unemployment in the country, the vulnerability of children is increasing. The efforts of the government, donors, and NGOs to improve the status of children have been undermined by the emergent problems of HIV/AIDS and poverty. Poverty amongst children is estimated at 70% and this is higher than in the general population which is 63% (UNICEF 2012)

HIV/AIDS remains one of the main causes of orphanhood and vulnerability amongst children. The Demographic Health Survey (2006) estimated the national HIV prevalence rate to be 26% amongst 15-49 age group. Recent 2014 UNAIDS estimates put the prevalence rate at 27.4% for the same age group. By end of 2012 there were 210 000 adults and 22 000 children living with HIV in Swaziland. Prevalence is more pronounced amongst adults aged 15 years and over (35%) and this comprises children in their late teens (15-18). The number of orphans is projected to further increase in the future due to the relatively high prevalence rate of pregnant women attending ante-natal clinic which was estimated to be 41% in 2010 having decreased slightly from 42% in 2008. (Swaziland HIV Estimates and Projections report, 2013). In fact the UNICEF study on Child Poverty and Disparities in Swaziland (2009) noted that the number of OVCs is projected to reach 250 000 in 2015 from 200 000 in 2010. It is worth noting though that there are ongoing efforts to enrol pregnant women on ART. In 2009 an estimated 40% of eligible pregnant women received ART and this percentage has gradually increased over the years to reach 72% in 2013 (MOH Annual HIV Programs Report 2013).

Also, the enrolment of more patients on ART has meant that parents can live longer and as such continue to participate in economic activities and thus take care of their children. According to the MOH Annual Program Report (2013), 101, 730 patients were actively on ART by end of 2013 and children constituted 7.8% of the population currently on ART. Also, the high coverage of PMTCT services (89%) is expected to significantly decrease the numbers of children living with HIV/AIDS in the future.

The UNICEF study on Child Poverty and Disparities further notes that safety nets such as the OVC education grants have increased access to basic services and significantly reduced the vulnerability of OVCs effectively closing the gap between OVCs and non OVCs. The recent piloting of the EU funded OVC cash transfer program is expected to further provide means of increasing household income levels consequently reducing deprivation levels.

It is without doubt that children are the future and no country can attain sustainable levels of growth and development unless it invests in the younger generation. Investing in children is bound to yield positive social and economic results in the longer term. According to UNICEF, 70% of the Copenhagen Consensus Initiative's most productive priority investments relate to children. Further UNICEF also states that resources required for scaling up interventions for children are minimal yet the impact could be significant and far reaching e.g immunization. Also minimal investments in basic/primary education usually results in longer term benefits whereby children are able to exercise choice and participate in economic activities at the later stages of their lives.

3.0 Legislation and Policy framework

The legal and policy environmental context in the country has improved with the adoption of policies and enactment of several pieces of legislation in recent years. This has contributed to Swaziland improving in the Child Friendliness Index within a period of 5 years moving up 36 places to become the ninth most child-friendly country out of 52 countries in Africa as reported by the African Child Policy Forum.

Swaziland domesticated the UNCRC and the African Charter on the Rights of the Child. There is also the Constitution that provides a "strong basis for children's rights through a progressive bill of rights" (section 29) and further protects the inheritance, maintenance and citizenship and family rights of children.

There are other laws that have been enacted to provide comprehensive protection to the child. These laws and policies are as follows;

- Child Protection and Welfare Act of 2012
- Social Development Policy (2010)
- National Children's Policy (2009)
- Youth Policy (2010)
- National Plan of Action for Children 2011-2015
- Child Care Services Order (1977),
- Maintenance Act no.35 (1970),
- Adoption of Children Act no.64 (1952)
- Girls and Women's Protection act no.39 of 1920
- Sexual Offences and Domestic Violence Bill (2009).

These policies and laws need to be harmonized with the constitution. The report on the 'Literature Review on the child rights situation analysis in Swaziland (2009), notes several gaps in the local laws and policies. Some of these gaps include fragmentation and inaccessibility of laws making implementation difficult, absence of a legal framework for child headed households, absence of legal mechanisms to cater for neglected abused or abandoned children and no laws to ensure access to basic services for OVCs.

There should also be increased effort on raising awareness on the existence of these laws and policies so that the target group and caregivers are aware of their rights.

4.0 National Development strategies

The National Development Strategy (NDS), Programme of Action 2013-2018, National Development Plan 2014-2017 and Poverty Reduction Strategy and Action Plan (2007) are key developmental frameworks guiding the national strategic vision. In 1992, government undertook to prepare a long-term development strategy namely the National Development Strategy (NDS). The Strategy documents a Vision 2022, which spells out the key macro, and sectoral strategies in the overall perspective plan of the government identifying the country's development sectoral strategies.

The underlying focus is on the quality of life; the critical dimensions of which are poverty eradication and employment creation. These dimensions are in turn crucially linked to education, health, and other aspects of human resource development. A number of policies to operationalise the NDS have been formulated, such as the Population policy, Education policy, Health policy and Children's policy. The National Development Plan which is a 3 year rolling development plan aims to accelerate inclusive economic growth and sustainable development. The key areas targeting children development issues within each of the aforementioned national frameworks are presented in the table below;

Table 1: Actions on investing for Children

Programme of Action 2013-2018

- Transfer of the OVC grant to individual schools will be effected no more than 24 hours after the funds are made available from the Treasury
- A residential facility for vulnerable groups will be constructed in Mankayane by 2015
- Government's commitment to the Nation's children having access to all the basic rights - shelter, food, education, health and security - will be sustained
- Sustain the Neighbourhood Care Points and revive the indlunkhulu scheme out in the communities.
- Maintaining the ongoing process of monitoring and protecting the welfare of OVC in alternative care institutions. No such institution will be permitted to operate without registration through Government. Inspection visits programme will be increased by 60% to ensure adherence to guidelines and standards among the 45 registered institutions as well as carrying out a programme to eliminate the existence of non-registered institutions.
- Promoting systems of rehabilitation for children and seeking to integrate these children back into their families and communities
- Increase the number of children accessing social protection services and receiving OVC grants and also put in place operational guidelines for the Child Protection and welfare Act (2012)

National Development Plan 2014-2017

- Construction of additional halfway houses
- Strengthening communities to effectively respond to the psychosocial needs of children
- Building capacity of partners on PSS programming
- Training of caregivers on children's health programmes (IMCI, SRH, Nutrition)
- Mobilizing community involvement in foster parenting

It will be imperative to monitor the inclusion of the above-mentioned actions in governments budgeting cycle over the indicated plan period.

4.0 Economic and budget analysis

a. Economic Overview

Swaziland has a relatively high GDP per capita income of US$2,415. Despite this, about 69 per cent of the country's 1.018 million people live below the national poverty line. Income distribution is skewed in Swaziland. According to the Swaziland Household Income and Expenditure Survey (SHIES) of 2001, 56 percent of wealth is held by the richest 20 percent while the poorest 20 percent own less than 4.3 percent. The country has recorded a Gini Coefficient (measure of income inequality) of 51 percent, which is considered great inequality according to the international standard. Income inequality of this magnitude is one of the major contributory factors to the high poverty level in the country. Swaziland's target under the MDGs is to reduce the income inequality – from 51 percent in 2001 to 25 percent in 2015.

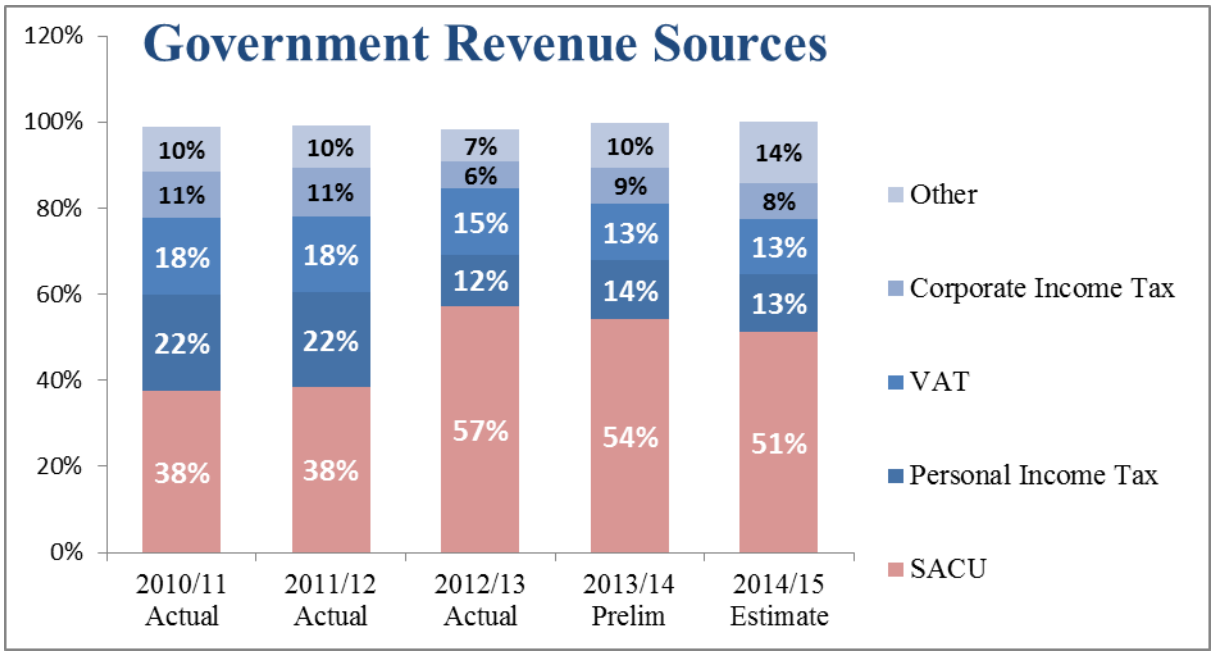
Since the 1990s, Swaziland's economic growth has significantly weakened, reversing positive prior made at a time when the country recorded significant Foreign Direct Investment (FDI) flows due, in part, to Southern Africa's military and political turmoil, particularly in Namibia, Mozambique and South Africa. The country's GDP growth rate has been declining in the last two decades, a state of affairs that has been worsened by recurrent droughts, declining export receipts, volatile exchange rates, the erosion of preferences, the country's loss of textile quotas on the EU market in 2005, and more recently, the loss of AGOA. The net result of the slow economic growth over the years has translated into significant adverse effects on social sector expenditures that have contributed to the worsening poverty levels.

The country witnessed a reversal of its human development achievements in the last decade as evidenced by a decline in the Human Development Index (HDI). Decelerating population, weak educational and training systems and frail health systems continue to hamper human development and access to quality, basic social services, which are inequitably accessed by the population owing to weak human resource capacity for the provision of such social services. The country also faces significant systemic challenges, with the increased burden of communicable, non-communicable and epidemic diseases. Consequently, the infant and maternal mortality ratios have increased by 26 percent and 160 percent, respectively, within the last decade.

With an HIV prevalence of 26 percent and estimated TB incidence of 1,198/100,000, the country has the highest burden of both diseases in the world. About 40 percent of the population, especially in rural areas, has no access to potable water, while 55 percent lacks proper sanitation. Similarly, the educational system remains generally weak despite improvements in enrolment and the roll out of free primary school education and is characterized by inadequate capacity of institutions, high drop-out and repetition rates and inadequate access, quality and oversight.

As depicted in Figure 1 below, government's main source of revenue is SACU receipts which amounted to approximately E7, 5 billion in 2014/15 financial year accounting for 51% of total revenue and grants. Tax revenues comprised approximately 40% of total revenue and grants and the remainder was generated from non-tax revenues and grants[1].

Figure 1: Government Revenue Sources.



Source: Ministry of Finance, 2015

Even though tax revenues are showing a healthy growth and targets could be surpassed by end of FY 2014/15 this may not necessarily translate to growth in children investments despite the fact that government as prioritized health and education

SACU receipts are projected to decrease significantly in FY2015/206 which could lead to cuts in public spending. However, government has reiterated its commitment to prioritize the education and health sector, in particular OVC grants, FPE and HIV/AIDS.

Swaziland's economy is also heavily dependent and intertwined with that of South Africa with 90% of imports coming from our neighbour whilst 60% of all exports go to South Africa. This makes Swaziland vulnerable to any shocks that may be experienced by South Africa.

[1] The Government of the Kingdom of Swaziland Estimates for the year from 1st April 2014 to 31st March 2017

Government faces efficiency challenges due to weak systems and strategy (implementation of programs not aligned to existing national plans), high labour costs and high fixed costs per head (MOF, 2014).

b. Government Planning and Budgeting Process

Government's budgeting process is to a great extent top-down since it hardly takes into account citizen and civil society participation. Budget priorities are captured in the Budget Outlook paper prepared by Central Agencies (MOPS, MOF and MOEPD) and approved by Cabinet on a yearly basis. The approval of the Outlook paper is then followed by the setting of budget ceilings for each Ministry followed by the budget preparation process which normally commences in August-September of every year. Each Ministry is expected to prepare a comprehensive budget clearly outlining priorities in the medium term in compliance with the budget ceilings. Some Ministries make an attempt to consult stakeholders within their sectors but this is usually not structured in a way to bring about effective participation. In some instances, other Ministries and departments utilize their sectoral strategic plans to undertake the budgeting process but it remains to be seen if activities taken from the plans are eventually funded. The Ministerial budgets are then presented to the Planning and Budgeting Committee (PBC) in or around December/January of every year and approvals are subject to the deliberations of the PBC, Cabinet and subsequently Parliament.

The involvement of civil society and engagement of the general public within the current planning and budgeting cycle would require a complete overhaul of the process. It is worth noting though that at the turn of the 21st century government recognized the need for –bottom-up development planning so as to reflect the aspirations of the poor and the marginalized in the national budget and ensure that development interventions are responsive to the needs of the people. Sometime in 2008, The Ministry of Regional development an Youth Affairs developed a Regional Development Planning Model in following the realization that planning was " haphazard, disintegrated, and lacks evidence as a basis for public resources allocation". The model is aligned to national frameworks including the decentralization policy and it aims to identify local needs and solutions through the involvement of the people at the local level and ensuring that all regional plans are linked to the national strategy. However, almost ten years after the model was developed, there has still be no progress towards ensuring that it is fully implemented.

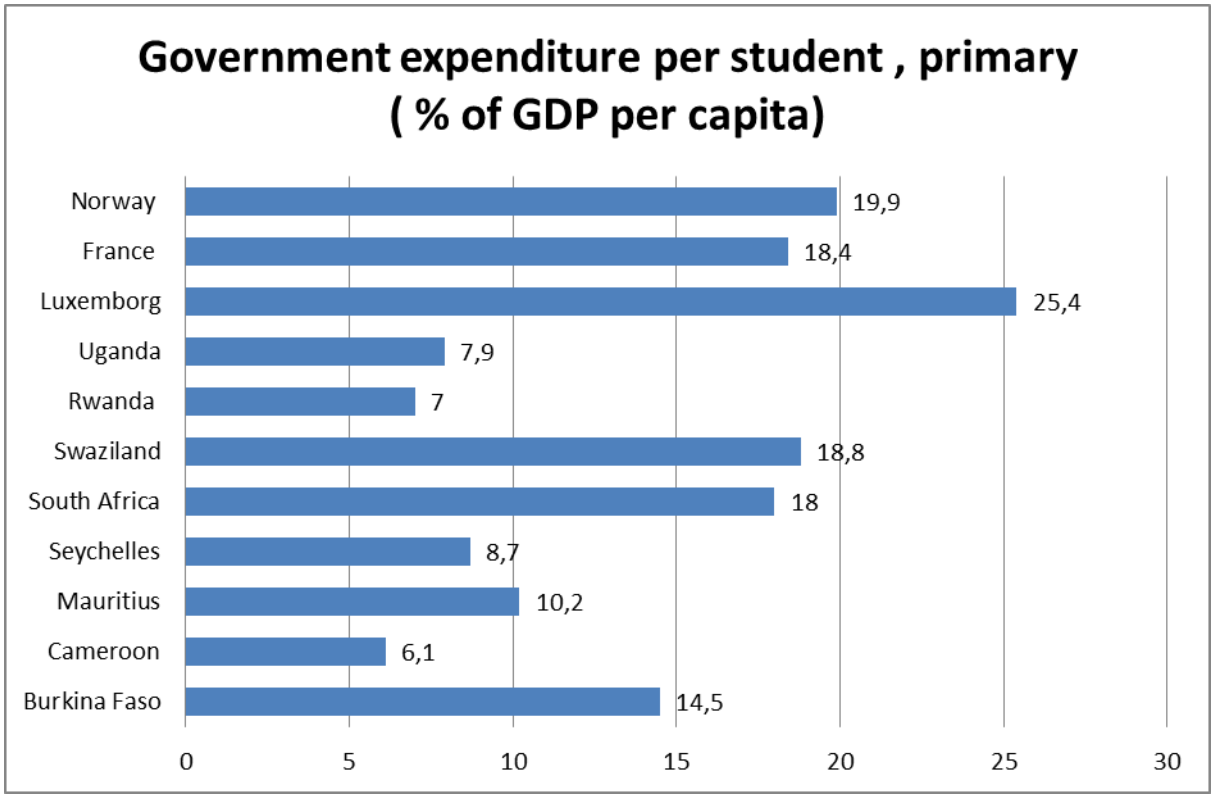
c. Analysing Investments in Children

i. Investments in Education

In 2000, 25 governments (including Swaziland) signed the Education for All Fast Track Initiative (EFA-FTI) at the World Education Forum in Dakar, Senegal. Governments agreed to increase allocations to education to at least 20% of government expenditure. In Swaziland, the Ministry of Education receives the lion's share of the budget which has averaged 20% of the total national budget over the past five years. Actually, in 2011 government expenditure on education as a percentage of total government expenditure was 24, 5%, higher than that of South Africa which was 18, 9%. (World Bank, 2015)

At the same time, in Swaziland, government expenditure per student (primary) also expressed as percentage of GDP per capita, compares favourably with those of other counties both LDCs and developed countries as depicted in the graph below;

Figure 2: Government Expenditure per student, primary (% of GDP per capita)



Source of data: World Bank (2015), www. data.worldbank.org/indicator

Generally, expenditures are guided by the National Education Policy (1999) which outlines the following portfolios and responsibilities;

- Early Childhood Care and Development
- Primary Education
- Junior and Senior Secondary Education
- Vocational Education
- Tertiary Education
- Bursary and Scholarship Administration
- Special Education
- Adult and Non-formal Education
- Distance Education
- In-service Education and Training
- Inspectorate and Advisory Services
- Science, Technology and Research
- Library Services

An analysis of the budget estimates book reveals that the aforementioned portfolios have been allocated budgets with primary education claiming a significant portion.

In terms of the expenditures the focus has been on Preschool, primary and secondary education given the scope of the research. The table below describes the nature of support provided by government in the aforementioned areas;

Table 2: Description of support (Education)

Type of support	**Description of support**	**Activities for Plan period**
Pre-school education - ECCD	providing custodial care for the children (i.e. promotion of children's health, nutrition and psychosocial and mental development	Equipping ECCD centres; build capacity of Pre-school teachers through the provision of training opportunities and educational tours, and reviewing the ECCD Application Forms.
Primary Education	providing the foundation for a life-long education, ensuring that the essential skills of literacy and numeracy are acquired and children discover their innate abilities	Reducing the costs of education through • Free Primary School Textbooks and Stationary (commenced in 2002) • Primary Schools Capitation Grant –payment of grants to schools on, among other conditions, the condition that they will retain OVC in school and prepare a School Development Plan) • School Bursary (OVC) Fund - ensuring that no child is denied access to education due to socio-economic circumstances • Primary School Infrastructure- provision of additional classrooms, administration blocks and toilets and assisting in providing water to schools School feeding – 264,676 children benefiting in primary and secondary level
Secondary Education	Equipping pupils with skills and knowledge to enable them to gain entry into tertiary education, training and formal employment	Improving secondary education to ensure that it is geared towards producing graduates capable of entering the work force or take up self-employment upon 'O'level certification.
Special Education	Improving access to	

	education for all learners with special educational needs

*Government is assisted by the EU in providing FPE and the Global fund on HIV/AIDS, TB and Malaria for the school feeding programme. JICA assists with construction of schools. There is also heavy reliance on communities with regard to the construction of primary schools.

The primary net enrolment rate in Swaziland is fairly high at 93% in 2014 which implies that 7% of children aged 6-12 years are not in the school system (Update on the situation analysis of children and women in Swaziland, UNICEF, 2013). This could have been a result if the introduction of Free Primary Education (FPE) as per the 2005 Constitution and the Free Primary Education Act (2010). However, government was already providing free textbooks in 2002 and free stationery in 2003. The high enrolment rates are undermined by the number of pupils who drop out at primary which is reflected in the 50% reduction of students enrolled in secondary schools.

School fees, family characteristics and pregnancy are some of the factors contributing to the students dropping out of school. 2011 data on primary and secondary school enrolment showed that there were approximately 15% more boys than girls in Grade 1-3.

It is estimated that children between the ages of 3 and 6 receiving Early Childhood Care and Education (ECCE) are 1 in 3. Only 26% of orphaned children attend preschool education and most pre-schools are informal and thus do not comply with the pre-primary curriculum. Approximately 50% of ECCE centres do not cater for children with special needs and most centres are underfunded lacking necessary materials and equipment (NDP 2014).

The table below reflects the expenditure over five years in the aforementioned areas;

Table 3: Five Year expenditure in Education 2011-2015

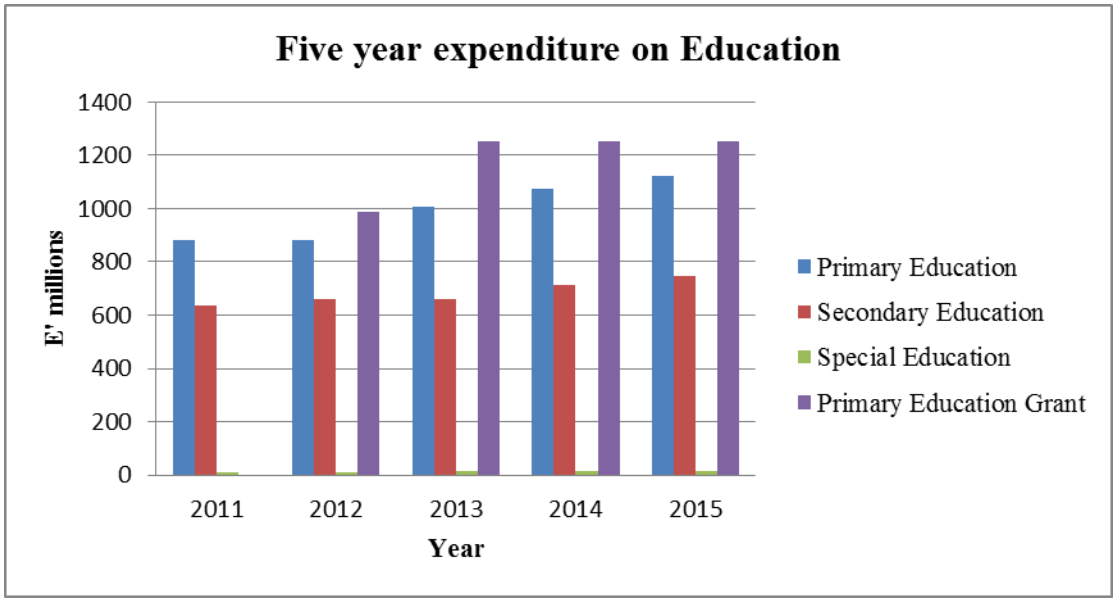
	2011	2012	2013	2014	2
Primary Education	881153188	884016330	1006366616	1074023424	1
Secondary Education	636423186	658361317	658868348	711536700	7
Special Education	10824518	12218737	13053454	13974134	1
Pre-School Education	3767551	3182856	3591373	3863020	4
Primary Education Grant		98703959	125403959	125403959	1

Sub Total	**1532168443**	**1656483199**	**1807283750**	**1928801237**	**2**

Source: The Government of the Kingdom of Swaziland Estimates for the years 1st April 2014 to 31st March 2017

Investments in education for children have risen from E1, 5 billion in 2011 to E2 billion in 2015. Primary education claims a significant proportion of this budget. According to the 2015 budget speech an additional E52 million has been allocated to implement the Free Primary Education program to Grade 7. The trends in expenditure can also be illustrated graphically as per the figure below;

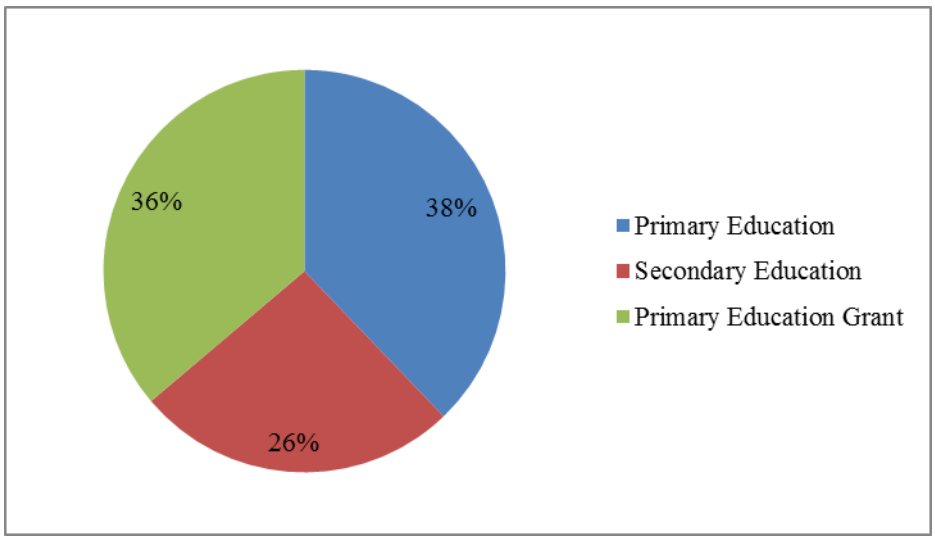
Figure3: Graphical trends in education expenditure



With the exception of special education, expenditure has steadily increased over the five years. There was a sharp increase in the primary education grant between 2012 and 2013. Notably this is the same period when the country experienced challenges with cash flows due to the effects of the global recession. It would then appear that government maintained its stance to sustain the levels of funding for education since it had been identified as a priority. However, there needs to be more investments directed towards special education to make it more equitable and accessible.

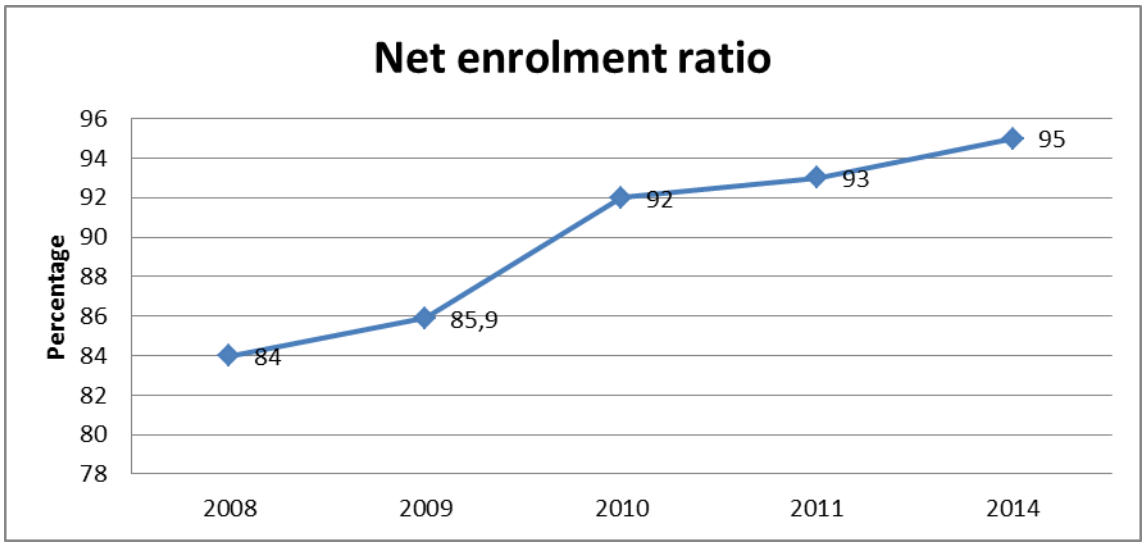
A significant proportion the budget has consistently been allocated to primary education of this amount has been allocated to primary education as depicted in the figure below.

Figure 4: Share of total investments in education (recurrent)



The introduction of FPE led to increased primary school net enrolment rates from 84% in 2008 to 93% in 2011 (NDP 2014-2017). As such, Swaziland is on track towards achieving the MDG target of 100% enrolment rate by 2015. The figure below depicts the trends in the primary enrolment rate.

Figure 5: Primary Net Enrolment Rate



Source of data: National Development Plan 2014/15 -2016/17 & Budget Speech, 2015

Even though the increased enrolment rate in primary education can be attributed to the increased expenditures, it should be acknowledged that there could have been other factors that have led to this positive phenomenon e.g changing attitudes of society towards education

Despite the positive trends in primary enrolment rates there are several issues that the government needs to attend to and key amongst them is the poor quality of education especially in rural areas due to factors such as unqualified teachers and lack of teaching materials, facilities and infrastructure. The percentage of qualified teachers nationally is 73% and Lubombo has the lowest percentage at 69.6% whilst Shiselweni has the highest percentage at 75.2% (NDP, 2014). Drop-out, repetition and teacher attrition are other issues that need to be attended to.

A discussion paper by Khumalo (2013), notes that 16% of children who are of primary school going age are not enrolled in primary education and there is an alarmingly high percentage of children of the appropriate age not enrolled in junior and senior education, at 74% and 88%, respectively. The paper further notes that education fees tend to be very high hence beyond the reach of most households leading to low participation in education especially of children from low income households.

There are still many children who walk long distances (17km on average) to school despite government's policy of at least 5km walking distance. The physical capacity of the schooling system is still low resulting in many children not being absorbed in secondary schools.

It has also been observed that the OVC grant is not sufficient to cater for moderate subsistence of beneficiaries as it does not cater for other basic needs for e.g. uniform, school shoes, winter jerseys etc. this may have caused an increase in numbers of school dropouts in the country. In addition, the top up of E300 required by the Head Teachers may force a child to drop out due to the fact that most parents and children cannot afford.

ii. Investments in Health

The implementation of interventions in the Ministry of Health and the health sectors as a whole is guided by the National Health Policy and the National Health sector Strategic Plan (2014-2018). Generally, according to the two aforementioned key frameworks, the MOH's focus is on improving the health of Swazi families and attaining universal health coverage. The NHSSP's strategic focus is on individuals' health from birth to early childhood, during the school age and teen years, through young adulthood and the childbearing years including pregnancy and ultimately to adulthood.

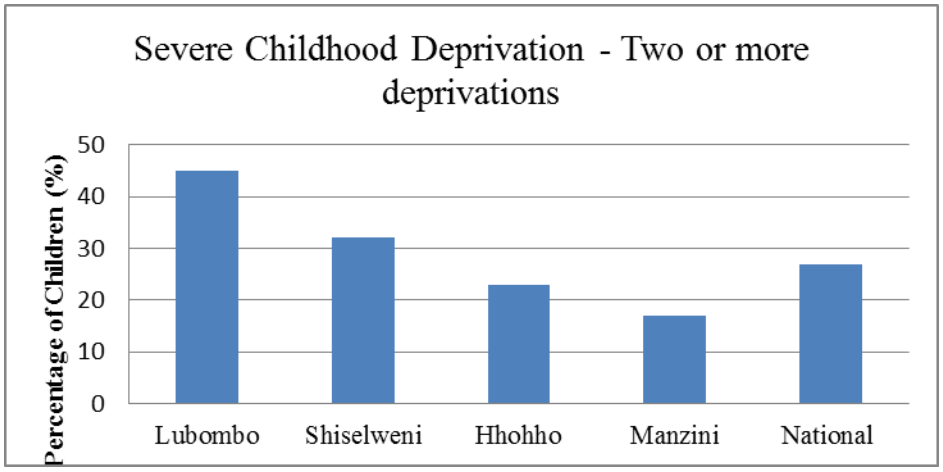
There are several programmes implemented at national, regional and facility level encompassing clinical and public health. All healthcare facilities whether public or private offer a component of child-related services (e.g immunization, treatment of minor and major ailments, antenatal and postnatal care) and most public health programmes are implemented at a national level.

In order to determine the level of investments in children, the study considered 5 public health programmes which contribute to child survival as measured through the following indicators; infant Mortality rate; under 5 mortality rate; prevalence of underweight and stunted children under 5 years and proportion of 1 year olds immunized against measles.

According to UNICEF (2013), a decrease in under five mortality has been observed in the past 11 years. In 2000, U5MR was 114.2/1000 live births and it decreased to 103.6/1000 live births in 2011. However, compared to other countries in the region with similar socioeconomic status, it is still higher than the average of 96/1000 live births.

Nationally, 28% of children suffer from two or more deprivations (water, sanitation, shelter, education, nutrition, healthcare and information). Again, there are more children suffering from two or more deprivations in the Lubombo and Shiselweni regions as reflected in the figure below;

Figure 6: Severe Childhood Deprivation



There are more stunted and underweight children in Shiselweni compared to the other regions as reflected in the table below;

Table 4: Stunted and Underweight children

Region	Underweight	Stunted
Hhohho	6.4	28.2
Manzini	5.0	28.1
Shiselweni	6.8	37.7
Lubombo	5.2	30.1
National	5.8	30.9

At national level, orphans have been found to have the worst nutritional status, even exceeding that of vulnerable children. For instance 11.8% of orphans were found to be underweight compared to 8.3 vulnerable children whilst stunting was found to affect 42.2% of orphans compared to 37.9% vulnerable children.

Despite the seemingly difficult situation in Lubombo and Shiselweni, in 2011 both regions recorded higher percentage of women testing for HIV during ANC visits at 96% and 95%, respectively whilst Manzini and Shiselweni recorded 85% and 92%, respectively. Notably, Lubombo has the highest concentration of health facilities at 33.3/100000 whilst Shiselweni has the lowest at 17.3/100000. In Manzini region the concentration of health facilities is 31.7/100000 whilst in Hhohho region it is 24.5/100000.

One of the significant successes in HIV prevention programs is the coverage of PMTCT services. According to the Service Availability Mapping report (2013), 162 facilities provide PMTCT services out of the 183 facilities that provide antenatal care. Shiselweni has the highest number of facilities providing PMTCT at 93% followed by Lubombo at 92% and the least is Manzini with 84% of ANC points offering PMTCT.

According to the Annual HIV program report (2013) only 2% of children born to HIV positive mother are infected with HIV at ages 6-8 weeks putting the country on the right track towards the elimination of MTCT.

According to MICS 2010 83% of children received all recommended vaccinations before they reach their 5th birthday and this is higher than the 65% rate reported during 2000 MICS survey. However, government still has to put more effort to reach the MDG target of 100% by 2015.

It would appear that strategies being proposed at sector level aim to address some of the challenges discussed above. The table below summarizes the type of support under each programme and the strategies/activities proposed for the plan period.

Table 5: Description of support (Health)

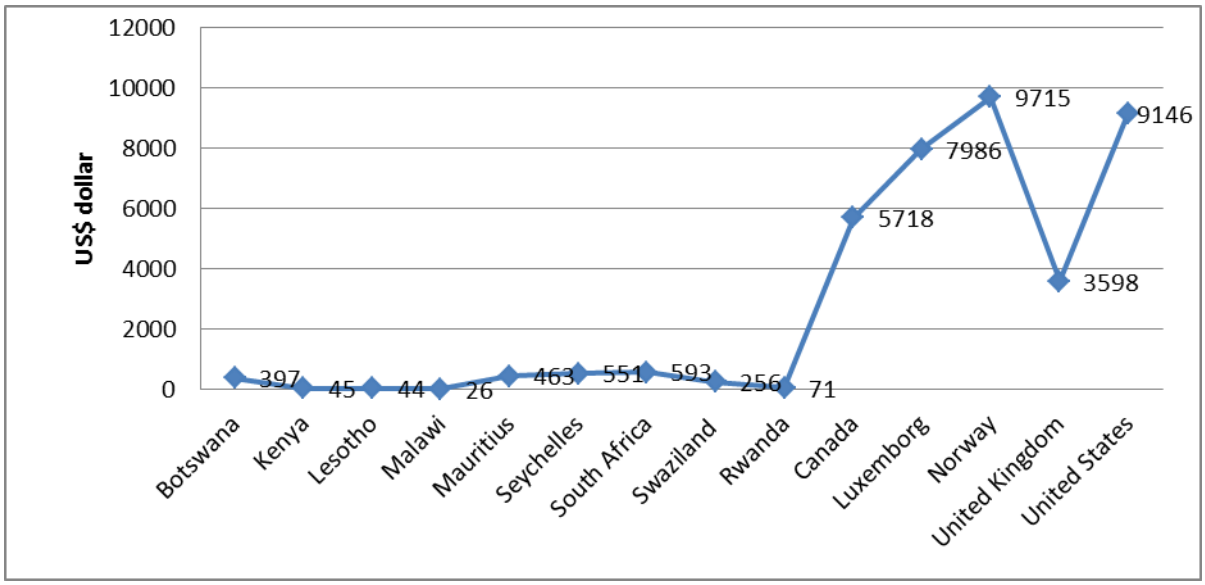
Key Programmes	Description of support	Strategies/Activities for Plan period
Integrated Management of Childhood Illnesses	Improving the quality of health care provided to children in order to significantly reduce morbidity and mortality due to common childhood diseases among children under the age of five years and improve their survival, growth and development.	• Improve accountability on integrated family and child health services at all levels of care • Improve access to family and child health services at strategic service delivery points – all levels of care • Strengthen capacity for integrated EMOC at all levels • Promote family and child health information services at all levels (individual, family, community, health service delivery points, national)
Nutrition	Reducing the prevalence of micronutrient deficiencies among women and children and improve the quality of life of people affected and living with HIV/AIDS by providing nutritional support, treatment and counseling	• Promote, protect and support appropriate infant and young child feeding practices and behaviours with focus on the first 1000 critical days • Develop, implement and monitor action plans based on the maternal, infant and young child nutrition comprehensive implementation plan • Adapt and implement norms and standards on maternal, infant and young child

		nutrition, population dietary goals, and breastfeeding and policy options for effective nutrition actions against stunting, wasting and anaemia **NHSSP 2014-2018**
Reproductive, maternal and neonatal health	Promoting the sexual and reproductive health status of children, adolescents and youth, women and men	• Reducing MNCH deaths by 50% in 2017 • Reducing teenage pregnancies • Reducing unintended pregnancies amongst women of reproductive age group especially among adolescents and HIV positive women • Increased STI, HIV and TB screening among children, women and men • Reducing mother to child transmission of HIV during pregnancy, childbirth and breast-feeding ***SRH Strategic Plan (2014-2018)***
Child Health	Providing universal immunization to all children and improving the quality of health care provided to children in order to significantly reduce morbidity and mortality due to common childhood diseases among children under the age of five years and improve their survival, growth and development.	• Implement and monitor the global vaccine action plan as part of the Decade of Vaccines Collaboration • Promote family and child health information services at all levels • Improve access to family and child health services at strategic service delivery points – all levels of care • Improve accountability on integrated family and child health services at all levels of care ***NHSSP 2014-2018***
HIV/AIDS	Contributing to the reduction of the incidence of HIV and mitigation of the impact of AIDS on individuals, families and communities through the provision of health services	• Reducing new infections by 50% in 2018 and mortality amongst PLHIV through • Social and behaviour change • HIV testing and counseling • Condom promotion and distribution

	for prevention of HIV transmission and care of infected and affected individuals.	• Eliminating new infections in children and keeping mothers alive • Male circumcision • Key populations at higher risks of HIV infection • Treatment, care and support • Care and support for specialized populations (OVC and people living with disabilities) **eNSF**

Health spending (THE) in the country is estimated to be E2 065 per capita (World Bank 2013). This is way above the WHO recommendation of US$38 per capita (approximately E380 per capita). As depicted in the figure below, Swaziland compares favorably with other countries in the SADC region and the rest of the word regarding per capita spending in health.

Figure 7: Health expenditure per capita (current US$)



Source of data: World Bank, 2015, www.data.worldbank.org/indicators

In the SADC region Swaziland (US$256) comes after Botswana (US$397), Mauritius (US$463), Seychelles (US$551) and South Africa (US$593) in terms of per capita spending on health. Countries is Africa cannot compare with developed economies as their per capita expenditure on health is very high reaching US$9715 in Norway from a low of US$3598 in the United Kingdom. It should be noted though that some of the African countries with low per capita expenditure in health, have better indicators on health compared to Swaziland.

An examination of trends over the past five years shows that the health sector's expenditure as a proportion of total government expenditure increased from 10.7% in FY2010/11 to 12.3% in FY 2011/12 but declined again to 11.4 % in FY 2013/14. However, current estimations indicate government contributions to health have again increased to 12.2%. Nonetheless, the government allocation to the health sector remains short of meeting the Abuja Declaration commitment of at least 15 %.

Government remains the main funder providing over 70% of total health expenditure whilst the remainder is shared between the donors and the private sector. Even though current financial data shows that there is less dependency on donor resources for health, most donor activities are not reported in Budget Estimates book implying that the share of donor spending is most probably understated. Donor spending on health as a percentage of THE in 2011 was estimated to be 19.36 (WHO Global Health Observatory 2013).

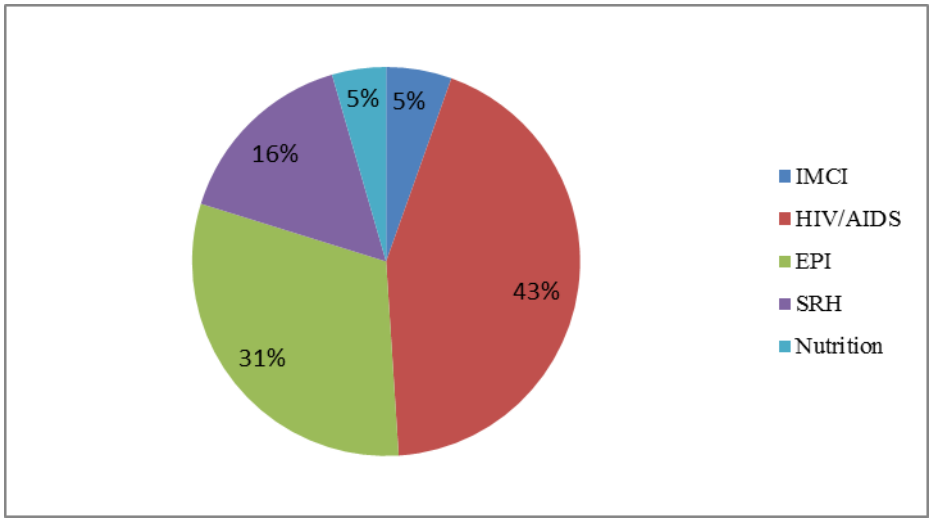
The table below depicts recurrent expenditure on the five key health programmes used proxies for investments in children.

Table 6: Five year expenditure in Health, 2011-2015

	2011	**2012**	**2013**	**2014**	**2015**
IMCI	1271739	1338306	1839445	2077269	2077269
HIV/AIDS	14234070	13081381	11140260	12442278	16772863
EPI	6880785	7099349	10048697	10180324	13710535
SRH	4222019	3764115	4415261	5871712	6138186
Nutrition	1151012	943344	1567986	1602680	1746898
TOTAL	**27759625**	**26226495**	**29011649**	**32174263**	**40445751**

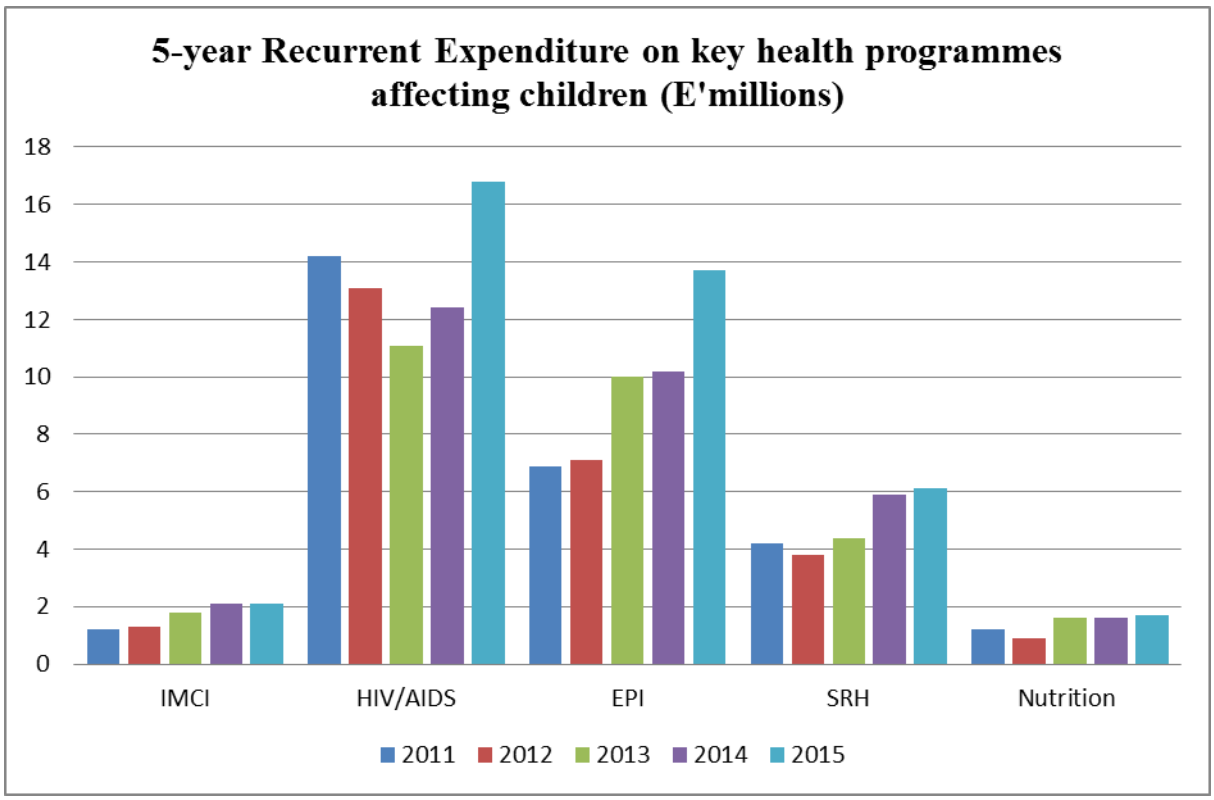
It can be observed that total expenditure across the 5 programmes has increased from E278 million in 2011 to E404 million in 2015 with HIV/AIDS and EPI claiming significant proportions of total expenditure at 40% and 29%, respectively, as depicted in the figure below;

Figure 8: Total investments in health (recurrent)



The graphical trend of investments in the five health programmes over the past five years is presented in the figure below;

Figure 9: Five year expenditure on key health programmes affecting children



Notably, expenditures have been steadily rising across all the programmes over the years. It is clear that significant investments have been made in HIV/AIDS and EPI programmes. However, nutrition which is an important aspect of child development is underfunded and expenditures are yet to reach at least E2 million on an annual basis. Increased investments also have to be made towards IMCI and SRH to combat other childhood illnesses as well as positively influence behaviours amongst the youth.

In as much as this study has not analyzed capital investments due to the lack of data, it would appear that government has in the past 5 years made means to increase accessibility to healthcare at primary level through the construction of rural clinics. According to the 2015 budget speech. Nine clinics have been constructed in Nkhaba, Bhudla, Mkhitsini, Nhlambeni, Vusweni, Nsalitje, Ebholi (maternity ward), Manyeveni, and Khuphuka. Nonetheless, a clear capital program with input from all stakeholders on construction of health facilities especially in riral areas needs to be in place and properly funded.

iii. Investments in Social Protection

The UN Social Protection Floor initiative "promotes universal access to social transfers and social services, including housing, health, water and sanitation" (Hagen-Zanker & McCord, 2014). According to the Social Policy Framework for Africa (SPFA), it is recommended that investments in social protection should comprise 4.5% of a country's GDP. The SPFA recommends a provision of a minimum package consisting of child grants, elderly grants, informal workers and unemployed person's grants, disability grants with the inclusion of healthcare.

In Sub-Saharan Africa including Swaziland, overall spending in social protection is estimated to be 2.81% of GDP. This of courses masks the higher levels of spending in South Africa and Seychelles which are 8% and 12 % of GDP, respectively (World Bank, 2012).

In Swaziland, the rise in poverty, food insecurity, and HIV/AIDS prevalence over the past several years has rendered a large part of the population of the country vulnerable. The vulnerability has manifested in various forms with a very profound impact on the lives and livelihood of children, the elderly and the disabled. HIV/AIDS has led to the death of not only the most economically productive section of society, but also the adult age group otherwise responsible for raising young children and supporting families. Many orphaned children are left in the care of their grandparents, increasing the burden and responsibility on the elderly, who no longer work, do not have the strength and know how nor receive any form of support.

There is increasing evidence that extended families and community networks are overstretched and unable to absorb the rising number of orphaned and vulnerable children (OVC), and the number of child headed households and street children is on the rise. This calls for enhanced measures to provide social protection for the elderly and children who are expected to become productive members of society. As traditional safety nets give way, the Government is increasingly faced with the challenge of a growing number of vulnerable people and diverse forms of vulnerability. It is therefore critical that the Government identifies these vulnerable groups and their needs as well as build capacity in all its institutions to deal will this emerging challenge.

To date, most of the orphans largely remain under the care of their grandparents and other traditional support systems. In most instances these traditional systems are not economically empowered to provide for the orphans. As a result these children remain unattended and suffer from malnutrition and other diseases**.**

Role of the Department of Social Welfare:

The goal of the Department of Social Welfare under the Deputy Prime Minister's Office " to enhance the well-being of the most vulnerable individuals, groups and communities in Swaziland, in collaboration with stakeholders, through the provision of relevant, appropriate and high quality social development services and programs that are accessible to all" (National Social Development Policy 2009) .

Over the years, the DSW has undergone a number of transformations. At the core of the department's mandate are services addressing child Welfare & child protection, alternative care- adoption, foster care/child welfare grant, residential care facilities, family services, elderly grants, ex-servicemen pensions, disability program, juvenile justice & young offenders and victims of disaster

Government acknowledges the fact that the DSW is under-resourced and lacks the required capacity to effectively deal with the many social problems engulfing the Swazi society. This is seen in the number of reviews have been undertaken in previous years to consider means of improving the functioning of the department.

These reviews include the Preliminary Capacity Gap Assessment report (2010) into the social welfare, Social Welfare Systems Strengthening Assessment Report (2012) and the Organizational Review of the Department of Social Welfare (2014). Generally, all the reviews have recommended the restructuring of the department, decentralization of service and professionalizing the social workers cadre. However, it remains unclear why the recommendations of these reviews have not been implemented to date. It would appear though that most of the services being provided are in line with international declarations (with the exception of providing for the unemployed and those in the informal sector).

1) Social Protection Expenditure

The analysis of investments for children under social protection only focused on budgets/expenditure that was strictly allocated for children.

Expenditure in social protection targeting children is very low. Previously budgets for children activities were all included under "social welfare department" and this were only separated in 2014.

Table 7: Five year expenditure on social protection

	2011	2012	2013	2014	2015
Recurrent Expenditure					
Department of Children	0	0	0	3460000	3675400
Grants and subsidies					
Child Welfare Foster Children	0	102200	102200	102200	102200
Handicapped Children	0	51900	51900	51900	51900
OVC Education Fund	0	170500000	170500000	170500000	170500000
Total		**170654100**	**170654100**	**174114100**	**1743295(**

As seen from the table above, almost the entire budget is allocated for the OVC education fund comprising 98% of the total budget. It is also only in 2014 that a recurrent budget was allocated for the department of children. The abolishment of the National Children's Coordinating Unit (NCCU) is also a huge setback towards ensuring increased investments for children.

The school feeding programme comprises a key social protection measure which the government (Ministry of Education) is implementing together with stakeholders including UNICEF and Save the Children Fund. This programme has been scaled up and it now covers 94 percent of all public primary schools (Budget Speech, 2015). It will be crucial for government to allocate additional resources for the sustenance of this programme especially in the Lubombo and Shiselweni regions which are more poverty stricken.

The Government of Swaziland with support from the EU is also presently piloting the cash transfer program. OVC cash grants will be provided to "beneficiaries to strengthen the ability of vulnerable households to care for OVC and meet their basic needs" (Project Appraisal document, Health, HIV/AIDS and TB Project (World Bank/EU, 2011). This is a step in the right direction given that cash transfer

programmes have been largely successful in countries like Kenya, Ghana, Burkina Faso, Malawi, Tanzania, Liberia and Nigeria. In Southern Africa, Botswana and South Africa have run significant cash transfer programmes for 10-15 years. (Background Paper for the 6th International Policy Conference on the African Child, 2014).

There are also in-kind transfers from which children benefit such as the Phalala Fund, Neighbourhood Care Points, food distribution, supplementary feeding and health fee waivers. It is estimated that in FY2010/11 expenditures on in-kind transfers were E403.8 million much higher than the spending on cash transfers (World Bank, 2012).

6.0 Observations and Recommendations

There appears to be significant investments made in health and education and there has been an improvement in most child development indicators. On the other hand, despite the introduction of the OVC education fund, public investments in social protection have been very low. A positive development though has been the enactment of child protection laws and policies but what remains now is ensuring that there are resources availed to operationalize these laws and policies.

The following observations can be made from the forgoing analysis on investment in education, health and social protection;

a) **Achieving Value for Money** – with the comparatively high expenditures (health expenditure locally higher than in most SADC countries) but poor indicators (even though improving) more needs to be done to ensure efficiency in spending i.e. achieving more for less.
b) **Effectiveness of implementation** - in as much as national strategies exist, most government departments lack frameworks for operationalizing the strategies. Modalities for implementing strategies are also usually lacking with no clear delineation of roles and responsibilities. As such there needs to be measures put in place to ensure that implementation of activities/programmes/interventions are done in a more structured way. Such measures should focus for example on improving teacher-pupil ratios, expanding the school feeding programmes, putting in place a clear programme for construction of primary schools, secondary schools, health facilities schools to increase coverage and accessibility. Also, where implementation frameworks exist, these need to be adhered to including the recommendations of several studies that have been carried out.
c) **Strengthening multi-sectoral collaboration** - In as much as increased funding is required for areas like nutrition, IMCI and SRH, there needs to be more effort exerted towards working collaboratively with other sectors given that illness and disease is also caused by environmental factors and other factors outside the health sector. Issues of water and sanitation, agriculture and housing (social determinants of health) need to be taken into account when addressing health issues and should also receive equal consideration.
d) **Increasing civil society and public participation in national planning and budgeting** – implementation of the regional development planning model would be a first step towards ensuring that the budget is; a) responsive to the needs of the population especially those at the grassroots level and the marginalized and b) addresses agreed national priorities especially those that aim at reducing poverty and creating employment. The

public and civil society must be in a position to influence budget allocations so that they match priorities to the letter.

e) **Restructuring and expanding the Department of Social Welfare** - this department plays a critical role in addressing the issues of children in the country. However, as previously noted, it still lacks the required capacity to effectively execute its mandate. Government needs to expedite the process of implementing the recommendations of studies that have been carried out over the years which include creating more posts and decentralizing services to lower levels.

f) **Establishing the Social Work Council** to provide practice standards and guidelines to regulate social services and practitioners in the Kingdom of Swaziland. The social workers cadre needs to be professionalized to ensure that services provided are of good quality and acceptable standards.

Efforts have to be made to ensure that the issues mentioned above are captured in the national development frameworks (e.g Programme of Action and national development plan) and form part of the agenda of the health, education and social welfare sectors.

With the desired goal of seeing increased investments for children, several advocacy actions are proposed and presented in the table below;

Table 8: Advocacy Action Plan

Advocacy Action	Tactics	Target Audience	Indicator
1. Increasing the enrolment of out of school children	• Lobbying policymakers • Building relationships with key government officials (PS, Directors and Sectoral Planning Officers)	Ministry of education – PS, Director of Education DPM's office - PS DSW - Director UNICEF	50% of out of school children enrolled in primary school by end of 2016
2. Construction of additional secondary schools	• Lobbying policymakers • Building relationships with key government officials (PS, Directors and Sectoral	Ministry of education – PS, Director of Education DPM's office - PS DSW - Director	Budget allocated for the construction of secondary schools in FY 2016/17

Advocacy Action	Tactics	Target Audience	Indicator
	Planning Officers)	UNICEF	
3. Inclusion of all children in difficult circumstances (e.g children in correctional facilities)	• Policy issue and research paper • Lobbying policymakers • Sensitizing g relevant stakeholders	Ministry of Justice and Constitutional Affairs Department of Social Welfare Department of Correctional Facilities	Appropriate regulations, procedures and policies for the treatment of young offenders in place ensuring protection of their rights and access to basic services
4. Increasing allocations to Nutrition, IMCI and SRH	• Networking with national public health programme managers at the MOH • Lobbying decision makers	Ministry of Health - PS , Directorate and Public Health programme managers	Budget for Nutrition, IMCI and SRH increased by at least 20% in FY 2016/17
5. Increasing public participation in national planning and budgeting	• Lobbying policymakers • Grassroots mobilizing • Partnering with media	Central Government Ministries (PSs, Directors, Planning and Finance Officers) Ministry of Tinkhundla and Regional Administration (PS, REOs Planning Officers	Percentage of Approved activities and budgets in FY 2016/17 influenced through public participation and civil society engagement

8.0 Conclusion

There is a potential for the government to increase and sustain investments in education, health and social protection. The fact that Swaziland compares favourably with other countries in the region especially concerning investments in health and education is encouraging. More gains could be realised if efficiency and effectiveness of spending is improved. There should be more stringent controls on expenditures as well as ensuring accountability.

The participation of the public in the national planning and budgeting processes could go a long way towards ensuring that expenditures address priorities and are responsive to the needs of the people.

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