Research Report

On

Privatisation of Education and Health Services in Southern Africa

Conducted by AFRODAD

Submitted to

OPEN SOCIETY INITIATIVE FOR SOUTHERN AFRICA (OSISA)

2018
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List of Key Acronyms

AAAA Addis Ababa Agenda for Action
AFRODAD African Forum and Network on Debt and Development
CESA Continental Education Strategy for Africa
<table>
<thead>
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<th>Abbreviation</th>
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<tr>
<td>CHAL</td>
<td>Christian Health Association of Lesotho</td>
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<td>Convention on the Rights of the Child</td>
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<td>DRC</td>
<td>Democratic Republic of Congo</td>
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<td>ESSP</td>
<td>Education Sector Strategic Plan</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>HIV / AIDS</td>
<td>Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<td>Regional indicative Strategic Development plan</td>
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<td>Sustainable Development Goals</td>
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<td>TEVETA</td>
<td>Technical Education, Vocational and Entrepreneurship Training Authority</td>
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<td>THE</td>
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Acknowledgements

Whilst the study on Privatisation of Education and Health in Southern Africa was carried out by the African Forum and Network on Debt and Development (AFRODAD), the organisation would like to recognise and appreciate the contributions made by a number of other individuals who made this research study a reality. The contributions are highlighted below; the acknowledgements, however, are not in order of importance.

- AFRODAD team: the Policy Analyst, Mr. Taurai Chiraerae for spending considerable time in writing this report.

- Civil Society partners, Jerry Moloko of BOCEFA, Allan Tshekedi (Botswana), Lehloholo Chefa of PARIL (Lesotho), Esther Sharara of CWGH, Janet Zhou of ZIMCODD (Zimbabwe), Victor Muyunga, Lewis Mwape, Dr. Francis Mupeta (Zambia), Harry Madukani of COWLHA (Malawi), Dr. Mukolongo Elema (DRC), Dlamini Dumezweni (Swaziland), Martin Matsuib (Namibia), and Dr. Jorge Matine (Mozambique), among many others, for the insights into this research.

- OSISA, for commissioning this research and organising a validation meeting that took place at its Johannesburg offices on the 22nd of November 2017.

- Tatenda Makoni for the editing and Fidélité Nshimiyimana for the overall revision of the report.

Looking forward to more such collaborations!
Executive Summary

The research report provides findings and recommendations on the impacts of privatisation in Botswana, Malawi, Mozambique, Swaziland, Lesotho, South Africa, Namibia, Democratic Republic of Congo (DRC), Zambia and Zimbabwe. Privatisation and its policy prescriptions were embraced in the Southern African Development Community (SADC) and other African countries in the early 1980s and 1990s largely as conditionalities for accessing balance of payments under the Economic Structural Adjustment programme (ESAP) and it has been on a rising trend as private sector spending and investment in the health and education sectors continues to increase. Private actors have taken over the role of governments in providing these two essential services.

Non-state provision (NSP) of education and health is delivered by a combination of Non-Governmental, faith-based, philanthropic and community organisations, as well as private providers. The NSP of education and health takes a myriad of forms including: low-fee private schools, hospitals and clinics; for-profit private schools and health centres, community schools, educational and health public-private partnerships, private tutoring, and religious based institutions in schools and hospitals. In modern statecraft, there is a trend to establish more private institutions as opposed to the traditional practice where central governments took responsibility for providing education and health care. The main drivers for this shift are contained within a neo-liberal agenda and a discourse of State failure. Central to the neo-liberal argument for greater engagement of the private sector in education and health are arguments of increased effectiveness, efficiency, competition and choice that altogether are alleged to drive better quality learning and health outcomes.

The state has an innate obligation to provide education and health services to its citizens as clearly stated in the various country constitutions, and as such these rights cannot be abrogated. They are part of socio-economic rights enshrined in a number of leading international human rights instruments and frameworks. These are inclusive of the Universal Declaration of Human Rights (1948), the International Covenant on Economic and Social Rights (1966), The African Charter on Human and People’s Rights (1986) and SADC Protocol on Education and Training (1997), Health (1999), The Dakar Framework for Action of 2000 and the SADC Protocol on Gender and Development (2008) which SADC countries subscribe to with an aim to promote socio-economic rights of their citizens.

More recently the Sustainable Development Goals (SDGs) for 2015-2030 have dedicated Goal number 3 to the provision of universal good health and well-being, whilst SDG 4 deals with ensuring inclusive and equitable quality education. The rapid shift towards privatisation is taking place despite States ratifying these human rights instruments and in the backdrop of deep-seated

1 http://unesdoc.unesco.org/images/0025/002593/259338e.pdf
concerns about efficiency and effectiveness through privatised education and health care. Some emergent concerns include that: (i) quality varies enormously across a range of private providers and in many cases, is only marginally better than public education and health centres, if at all; (2) access to better quality institutions is based on the ability to pay thereby further stratifying already unequal societies; and (3) governance of privatised education and health-care centres increasingly abdicates the role of national governments and locks out civil society. Associated concerns include the de-professionalization of teachers, nurses and doctors, plus the erosion of confidence in public education and health services.

However, the ability of governments to deliver optimum education and health care services is contingent upon a number of country-specific factors that include the socio-economic and political context as well as the legal and constitutional frameworks in place. The global recession over the last five years is further reducing the amount of capital being allocated in absolute terms to public education and health care through shrinking national budgets. At the same time, reduced overseas aid budgets for education and health are focusing more sharply on methods for greater private sector engagement in these sectors whilst there is need to enhance the capacities of national governments in the establishment of sector specific plans, regulatory bodies and financing for implementation of the plans. Resultantly, privatisation of education and health-care provision continues to rise, promoted by international financial institutions (IFIs), multi and bilateral organisations and private sector providers.

This study raises concerns of the private sector’s profit motive against the governments’ mandate to provide education and health services where services are provided mainly in the context of making profits whilst neglecting the human rights entitlement which these sectors are attached to yet everyone by reason of being human is entitled to enjoy rights to education and a healthy living. This study analyses privatisation of education and health in selected countries in Southern Africa, with a view to assess impacts and gaps of the Southern African countries accommodation of private sector players in the two sectors. The overall objective is to propose tangible recommendations to stakeholders working towards the effective and efficient privatisation of education and health-care, including the need for more radical reforms in revamping the public services delivery systems and tight monitoring of private sector activities in education and health. However, besides the legal frameworks that need improvements, especially around monitoring of private sector involvement, this study further recommends that the governments need to uphold the international human rights laws and be supported by civil society partners in positioning education and health as non-negotiable socio-economic rights.
Section One

INTRODUCTION AND BACKGROUND

1.1 Introduction

Access to education and health services has been recognised as a human right in international, continental and regional conventions and related protocols. The Universal Declaration of Human Rights (1948); the International Covenant on Economic; Social and Cultural Rights; the 1960 UNESCO Convention against Discrimination in Education; the 1981 Convention on the Elimination of All Forms of Discrimination Against Women and the 2006 Convention on the Rights of Persons with Disabilities reaffirm that education and health should be treated as a fundamental right of every human being. Education and health are also at the top of the global agenda as enunciated in the then Millennium Development Goals (MDGs) and the current Sustainable Development Goals (SDGs).

In particular, the SDG 3 speaks of universal good health and well-being whilst SDG 4 focuses on quality education. Southern African countries under review (Botswana, Malawi, Mozambique, Swaziland, Lesotho, South Africa, Namibia, DRC, Zambia and Zimbabwe) are members of the African Union and are therefore signatories to the African Charter on Human and Peoples’ Rights, the African Union Continental Education Strategy 2016-2025 and the African Union Health Strategy for Africa 2016-2030 which binds its member countries to the attainment of education and health for all. In addition, the Multi-sector HIV AIDS strategic framework, the SADC Regional Indicative Strategic Development Plan (RISDP) and New Partnership for Africa's Development (NEPAD) also provides insights on the right to education and health in Africa.

The extent to which SADC countries provide public services including education and health differs from one country to another, despite being signatories to the same protocols and conventions owing to lack of financial, human and institutional capacities. By and large, Sub-Saharan Africa has failed to meet its obligations to support the right to education and health. Resultantly, the region has the highest rates of child mortality, where 1 in 8 children die before the age of 5, more than 17 times the average for developed regions (1 in 143). On the other hand, out-of-school rates are highest in sub-Saharan Africa: 21% of primary school age children, 36% of lower secondary school age adolescents and 57% of upper secondary school age youth are not enrolled2.

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There was a rapid shift towards privatisation in Africa between the early 1980s and 1990s as part of the neoliberal agenda of the World Bank and the International Monetary Fund (IMF). The countries being reviewed also adopted the structural adjustment programmes (SAPs) and as part of the conditions either partially or fully privatised some public institutions. SAPs were adopted in Malawi and Mozambique in 1987, in Zambia in 1989 whilst Zimbabwe implemented SAPs from 1990.

Some countries started the process of restructuring and privatization way before the SAPs. For instance, Zambia reduced the civil service by 13% in 1983 as part of the IMF backed Austerity programme. The initiative meant restructuring of the development approaches towards reduction in public expenditure, currency devaluation, reduction of trade barriers and controls, removal of subsidies and privatisation. The immediate impact of structural adjustment policies has been the reduction of education and health budgets which negatively impacted on the enrolment, quality of education and widened inequality.

To date, SAPs and the privatisation drive in particular are blamed for negating the social and income conditions of the poor. If anything, the conditions of the poor have worsened. The consequences of austerity in South Africa, for instance, galvanized educational and health opposition, as the state tried to introduce exam and health fees, and was unable to meet demands for both expanded access and improved quality of education and health within the framework of apartheid and monetarist economic policy. Consequently, private actors are increasingly participating in the provision of education and health.

In the SADC region, Non-state provision (NSP) of education and health is delivered by a combination of NGOs, faith-based, philanthropic, community and private providers. It takes a myriad of forms including low-fee private schools, hospitals and clinics; for-profit private schools and health centres; community schools, public-private partnerships (PPPs); private tutoring and religious based institutions in schools and hospitals.

### 1.1.1 Understanding Privatisation

The definition of privatisation yields many results as scholars and countries have defined privatisation differently in line with their specific circumstances. Scholars such as Boris Crnković (2002) have defined privatisation of the economy as a process of transformation of a state-controlled and run economic system into a market system that is firmly and consistently based on the principles of private ownership. Lubienski & Lubienski (2006) referred to privatisation as policies that promote liberalisation and deregulation that leads to the establishment of a market in education or health, at least, to competition between public and private providers.

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3 SADC Initiative in Education Policy Development, Planning and Management, UNESCO Sub-regional Office for Southern Africa, 1998

4 SADC and UNESCO, SADC Initiative in Education Policy Development, Planning and Management, 1998
The private sector is generally dominated by the desire to attract profit and is driven by market forces and only engages in operations were there is a certainty of profit making. Some of the models of privatisation that are used in Southern Africa include:

i. Contracting out - The state enters into agreements with private vendors to provide services and the state pays contractors to provide the services;

ii. Public Private Partnerships - this is where the state relies on private sector resources for assistance in providing public services. Private firms may loan personnel, facilities, or equipment to state agencies;

iii. Deregulation - This model entails that the state removes its regulations from the service previously monopolized by government in favour of private provision of the service and competition against government agencies;

iv. Subsidies and Grant - in this model the state makes monetary contributions to help private vendors deliver a public service;

v. Asset Sale: In this model, the state sells or cashes out its assets to private providers to enlarge the tax base;

vi. Franchise - The state gives monopoly privileges to a private vendor to provide a service in a specific geographical area;

vii. Private donations - The state relies on private sector resources for assistance in providing public services. Private firms may loan personnel, facilities, or equipment to state agencies;

viii. Vouchers - The state allows eligible clients to purchase services available in the open market from private providers. As with contracting, the government pays for the services;

ix. Service Shedding - The state drastically reduces the level of a service or stops providing a service so that the private sector can assume the function with private sources;

x. Volunteerism - The state uses volunteers to provide public services.

The proponents of privatisation which are mainly World Bank and the International Monetary Fund (IMF) believe that this shift enhances efficiency and quality of services whilst reducing taxes and the size of government. Whilst this could yield results in developed countries where the citizenry has a high marginal propensity to spend and mainly in the bracket of middle to high income earners, citizens in developing countries tend to lose out more. The privatisation of basic services undermines the social contract between the state and its citizens which mandates the government to deliver accessible, equitable and affordable health and education using the tax revenue. In developing country contexts, privatisation is perpetuating inequalities in accessing health and education. The essential services are increasingly becoming unaffordable and unavailable to the majority poor, especially the rural poor who constitute about 70% of the poor population in the case of Zimbabwe. A profit-making entity has no provision for the marginalised African communities such as the poor and the disabled for instance, calling on the government to intervene, yet the service should have been provided by the government in the first instance. This is an issue of concern for human rights defenders, civil society and social

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5 ZIMCODD, 2016

6 ZimStats, Poverty Atlas, 2015
movements. These groups bemoan privatisation for its tendency to perpetuate social and economic inequality, selective accessibility to social services and fostering corruption.

The state remains the custodian to provide its citizens with education and health services. Therefore, the state has the mandate to regulate all private providers in health and education so that they remain a true alternative choice to quality public health and education.

1.2 Background

The SADC region has 15 countries with a total population of 327.2 million spread over the countries. It has high rates of child and maternal deaths, as well as communicable diseases such as HIV and AIDS, malaria and tuberculosis. The region has the highest levels of HIV prevalence globally. It is host to developmental challenges among them poverty, unemployment and poor health and living conditions. Despite registering steady increase in life expectancy from 51.8 years in 2007 to reach 60.1 years in 2016, the average life expectancy remains low. The government of Lesotho (45.5) and Swaziland (45.8) should therefore invest more resources towards the health sector particularly nutrition and sanitation in order to improve the life expectancy (refer to table below).

Botswana, Lesotho, Namibia, and South Africa have some of the highest levels of income inequality in the world. On a scale of 0 to 100, 0 represents total equality, South Africa scored 63, Botswana and Namibia followed closely with 61 each, Zambia scored 57 while Lesotho and Swaziland scored 54 and 52 respectively. Inequality in the region is mainly due to unequal distribution of social, economic and physical facilities such as roads, electricity, schools, hospitals, water and sanitation especially between rural and urban areas which exacerbates income disparities. As a result, the above-mentioned challenges are a major impediment for the realisation of Goal 3 and 4 of the SDGs on health and education respectively.

The major negative influencers among SADC member states include limitations in domestic resource mobilisation, corruption and poor governance, which are quintessential ingredients to unlocking inclusive growth and development. Continuous monitoring of the Millennium Development Goals 2, 4, 5 and 6 showed mixed progress on access to education and health, with other SADC countries scoring better than others.

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7 SADC Secretariat, SADC Selected Economic and Social Indicators, 2016

8 Southern Times, 13 April 2018
What is clear from the 2014 figures is that countries in SADC fell short of the 15% Health to total budget threshold agreed during the Abuja Declaration, neither are they meeting the global commitment of spending at least 4% of GDP nor allocate 15% of total government expenditure on education.¹

**Life Expectancy at birth (Total) in SADC, number of years, 2007 – 2016**

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**Source:** SADC Secretariat, 2016

In a number of SADC member countries there is proliferation of private actors in the provision of education and health services. This entails payment for basic public service which would have been provided by the respective governments. Very few people and households can afford private health and education. The public services will get little attention hence compromised quality, thereby perpetuating inequality between the rich and the poor (especially the rural poor) who cannot afford private education and health care.

### 1.3 Methodology

The study explored two hypotheses, one that noted that privatisation has positive effects while the other highlighted more of the negative effects of privatisation on education and health sectors. The stance on the positive effects of privatisation highlights views of market oriented service delivery where privatisation is commended for instituting competition, efficiency and high quality services through the introduction of user fees and the use of medical insurance schemes. This approach mainly serves citizens that have the financial capacity to pay for the services.

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¹ UNESCO, Global Education Monitoring Report, 2017/8
The hypothesis that speaks to the negativity of privatisation ascertains a view that in as much as privatisation of health and education may compliment government efforts, user fees are an instrument that creates inequality amongst societies as it disenfranchises those who cannot afford the services from accessing them. This also then contradicts the fundamental rights of the underprivileged of enjoying their entitlements to health and education as stipulated in the instruments such as the Universal Bill of Rights, Banjul Declaration, SADC Protocols on Health; Education and Training and as enshrined in the various constitutions of the SADC countries. The research was based on the analysis of privatisation as a development approach, highlighting the context and rationale for privatisation, motivation, external and internal factors, the process leading to privatisation, the format of privatisation adopted, implications and outcomes and evaluation of privatisation on education and health.

Using the qualitative research approach, AFRODAD engaged civil society organisations that work with ministries of education and health as well as the private sector. Quantitative data of the state of privatisation largely came from results of qualitative findings. Key informants were sourced from Civil Society Organisations (CSOs) that work on education and health rights in the specific countries. With regards to responses from the State, the study used official government documents to ascertain the position of the ten governments as interviewing government officials would have given the perspective of individual respondent not the exclusive government position. The study used the following methods:

- Desk research to get primary sources of data, statistics, literature review, laws and policies;
- Data collection through structured questionnaire to CSOs;
- Field trips to get clarity on forms of private sector involvement in education and health, impacts on human rights, and involvement of the State;
- Interviews via Skype as well as observations.

The study employed these methods to bring out research issues, research variables and conceptual framework. The research also consisted of selected country case studies and evaluations. Graphs and tables were used for analysing and synthesizing the report. The last stage of the study was a validation of the research findings in order to provide assurance that the methodology was reliable through peer review and cross-checking the form and substance of the research.

### 1.4 Structure of the Report

Following the introduction, study background and the methodology sections, the succeeding section will put to the fore a comparative analysis of the selected countries, showing the regulatory frameworks, trends, impacts and gaps in the privatisation in and of education and health. A discussion section has also been added to look at key considerations when privatising education and health services, and in particular the human rights, gender and sustainable development concerns.
The report sums up with a recommendations section that articulates how to manage privatisation in education and health as well as putting forth the selected mechanisms for best practices in education and health. The last section briefly highlights the conclusion of the research.

Section Two

COMPARATIVE ANALYSIS OF PRIVATISATION IN AND OF EDUCATION IN SOUTHERN AFRICA

2.1 Contextual Analysis

2.1.1 Regulatory and Institutional Frameworks for Education

Education in the region is governed by the SADC Protocol on Education and Training of 1997. This is an expansive framework which does not only limit education to primary and secondary education but considers all levels of education from pre-school through to intermediate education (certificates and diplomas) to tertiary education. This protocol recognises the need for privatising education as a sector. However, it is clear that SADC member states must develop and implement policies and strategies that promote participation and contribution of the private sector, non-governmental and other key stakeholders in the provision of education and training.

At the African Union level, The AU Continental Education Strategy for Africa 2016-2025 (CESA) also aims at enhancing private sector investment in education and training systems through developing enabling legislation and efficient policies and creating a conducive environment for public-private partnerships to contribute to the development of quality education and training in the service of social and economic transformation. When the private sector operates without proper regulation, the marginalised tend to lose out as private institutions tend to commercialise education service provision thus disenfranchising the poor as private education pricing would become unaffordable. More so, this also triggers education quality inequality and equity as human resources tend to flock where there are better salaries and conditions of service as compared to public education institutions that are characterised by poor equipped facilities and wages thus stricter regulation of private sector involvement is needed to ensure that profitability does not trump equity and quality.

Private tutoring, paid out of pocket, widens the education advantage gap between have and have-nots. When teachers serve as private tutors, conflicts of interest arise. Article 2 of the UN Human Rights Council (UN Doc, A/HRC/29/L.14/Rev.1, July 1, 2015) also urged all countries to ensure the right to education by monitoring private education providers and holding accountable those practices that have a negative impact on the enjoyment of the right.

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The policy instruments regulating private players to contribute to education improvements are paramount. With SADC countries providing fewer resources towards education, a number of private actors have entered the sector to provide these services. The table below illustrates the legal frameworks for private actors to engage in the education sector in the countries selected for this study.
### Table 1: Institutional and Legislative Frameworks Governing Education in the SADC Region

<table>
<thead>
<tr>
<th>Country</th>
<th>Institutions Governing Education</th>
<th>Education Legal Framework</th>
<th>Evidence State of facilities and enrolment</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRC</td>
<td>- Ministry of Primary, Secondary and Vocational Education.</td>
<td>- The education sector strategy 2016–2025 (“Stratégie sectorielle pour l’éducation et la formation” [SSEF]) - DRC Constitution ; Articles 43 and 44 (Constitution de la République Démocratique du Congo.)</td>
<td>- There are 48,147 primary schools; - 8722 are State Schools; - 32929 Confessional School; - 6496 Private Schools.</td>
<td>Privatisation in the DRC is not yielding better results as expected of private schools. Quality concerns are an issue as private schools are resourced with poor facilities and ill-equipped human resources, except</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-------------------------------</td>
<td></td>
</tr>
<tr>
<td>Lesotho</td>
<td>Ministry of Education and Training</td>
<td>- Chapter 2 of the Constitution of Lesotho;</td>
<td>Private education is varied across rural and urban areas, rural students fare poorly than their urban counterparts thus instituting inequality as both private and public urban schools are better equipped with material and human resources.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Education ACT NO. 10 OF 1995;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Education Act No.3 of 2010;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Education Sector Plan (ESP) 2016 – 2026;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- National ECCD Policy 201(3)5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malawi</td>
<td>Ministry of Education, Science and technology.</td>
<td>- Constitution of the Republic of Malawi (1998: Chapter III Article 13, Chapter IV Article 25; Article 211 of the 1994 constitution of Malawi, as revised in 1998; National Education Sector Plan (2008); Education Act (2010); National Education Policy 2013; National Education Sector Plan (NESP) 2008-2017.</td>
<td>Private schools are supplementing government efforts in education provision. 60% of students joining public universities come from private schools. This highlights that government Is lacking in its commitment to provide quality education thus limiting progression chances of poor and marginalised</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Private sector supply of education services: the cases of UNIMA and MZUNI; Private Schools Association in Malawi.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Mozambique

- National System of Education Act nº 6/92 of 6 May;
- Higher Education Act (1993);
- Law 27/2009 for Private Schools in Mozambique;
- Ministry of Education (Presidential Decree no. 7/2010);
- Constitution, arts. 88, 113 and 114);
- Law on Higher Education (Law no. 27/2009);\(^{13}\)
- (Decree no. 11/90, of 1 June, art. 5);
- Ministerial Decree no. 126/94, of 5 October).
- Decree no. 11/90, of 1 June, art. 5).

Various private schools throughout Mozambique. More than 27 registered as independent schools.

- The government has lost monopoly of administering education service delivery due to lack of efficient monitoring and implementation. This has left private players including not for profit INGOs to step in. In essence government has neglected its constitutional mandate leaving its citizens at the mercy of well-wishers to assist thus violating the former’s rights for accessing education.

### Namibia

- Ministry of Education, Arts and Culture.
- Article 15 and 20 of the Namibian Constitution, Provides for the establishment of private schools;
- Education Act 16 of 2001;
- Ministry of Education Strategic Plan (2012-2017);
- Education Sector Policy for Orphans and Vulnerable Children 2008;
- Top 10 performing private schools are St Boniface College (Kavango East), St Paul's College (Khomas), Canisianum Roman Catholic School (Omusati), Gobabis Gymnasium Private School (Omaheke), Oshigambo Secondary.

Private schools have more financial and other resources resulting in better grades than private schools. Moreover, public schools in urban and rural schools fare lower than their private counterparts as a result of less resourced facility thus creating inequality in service provision as those with capacity to

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<table>
<thead>
<tr>
<th>Country</th>
<th>National Policy.</th>
<th>School/Institutions</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swaziland</td>
<td>Ministry of Ed.</td>
<td>School (Oshikoto),</td>
<td>- Private schools are not effectively monitored thus they are lacking in terms of effectively empowering students.</td>
</tr>
<tr>
<td></td>
<td>and Training.</td>
<td>Elein Nkurenkuru</td>
<td>- 3,610 students in private/non state primary schools;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High School (Kavango West), Windhoek Gymnasium Private (Khomas), St George's Diocesan School (Khomas), Duneside Private School (Erongo) and Heroes Combined School (Oshikoto).</td>
<td>- 1,938 students in private non state secondary schools;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Kavango West)</td>
<td>- average of 5% penetration of private actors in education.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- 4,06% total private primary school enrolment;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- 4,18% total private secondary school enrolment;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- 35% of Black children</td>
</tr>
<tr>
<td>South Africa</td>
<td>Department of</td>
<td></td>
<td>- there is an influx of low fee independent primary and secondary schools. They are affordable albeit with compromised quality of education as they do not effectively empower students.</td>
</tr>
<tr>
<td></td>
<td>Higher Ed.</td>
<td></td>
<td>- The education system is still</td>
</tr>
<tr>
<td></td>
<td>and Training (DHET).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Zambia

- Ministry of General Education (MoGE).
- Ministry of Higher Education (MoHE).
- Education Act of 2011;
- 2013 Higher Education Act;
- Zambia’s Constitution (1964);
- National policy on education, Educating Our Future (1996);
- Education Sector Plan (2003 - 2007);
- Fifth National Development Plan Education Chapter (2006);
- Secondary Education National Implementation Plan (NIF II - 2008).
- 19 registered private universities.
- There is no clear strategy that takes into account the burgeoning private sector at every level of the education system to bring the sub-sector within a clear and notable regulatory framework.
- Many private schools and universities are competing for student enrolments but there is no monitoring of standards for this sector thus the negative impact of poor quality service.

### Zimbabwe

- Ministry of Primary and Secondary Education (MoPSE).
- Ministry of Higher and - Education Act 22/2001;
- Zimbabwe Council for Higher Education Act Chapter 25:27 of 2006;
- Education Act 25:04;
- Private University Charters;
- Manpower Planning and Development Act, Chapter 28:02;
- 57 Private Schools in Zimbabwe at Primary and Secondary level
- Pre-schools mostly dominated by private individuals.
- Private education facilities accessible to citizens that has the buying power due to high costs.
- Private providers in education at pre-school level filling the quality gap that government cannot provide as teacher- pupil ratio is unequal as the vices of the apartheid system have not been fully eroded. Schools with a majority attendance of white students are better equipped than those with more Black and Colored students.

Between 3-4 years old not attending pre-school: 49% for Coloured children, 53% for Indian/Asian and 29% for White children.
From Table 1 above, almost all the countries have legal provisions for private sector to engage in education. However, Article 28(a) of the United Nations Convention on the Rights of the Child, requires that all state parties ‘make primary education compulsory and available free for all’ and this is clearly missing in most national policies which do not avail free and compulsory education to citizens.

**Source:** AFRODAD Compilations
Some countries that previously implemented free primary education like Zimbabwe, Lesotho and Zambia have since abandoned the schemes as a result of the adoption of neo-liberal packages under the auspices of IMF Economic Structural Adjustment Programmes which advocated for the liberalisation of markets thus promoting the rise of private players role and the cutting down of government expenditure in the various economic sectors including education\textsuperscript{14}.

In addition, most national policy instruments do not assign conclusive roles for private schools to play but only gives room for private sector to contribute to issues like infrastructure as in Lesotho and Zimbabwe). This also has an unintended negative consequence when it comes to monitoring private schools. Monitoring is only done when private schools are applying to renew their operating contracts hence reviews might not be conclusive. For countries such as the DRC, monitoring is rarely done or non-existent as the government lacks commitment, will and capacity to do follow ups, monitor and ensure private schools are complying with set regulations. Also, when examination bodies are presenting their examination results they tend to lump up both public and private schools as in the case of Zimbabwe and Malawi making it difficult for performance comparison using results\textsuperscript{15}.

2.1.2 Privatisation Trends in the Education Sector

The study has noted that the complementarity brought about by the private sector has its positive and negative outcomes. In all countries under review, actors in privatisation have ranged from powerful high net worth individuals and companies to average citizens trying to get a piece of the cake that comes with providing these services. Governments across SADC tend to enjoy the presence of these private players as they bridge the gap that governments are failing to meet. A cross country analysis depicted that the budget allocation to these sectors is swallowed mostly in salaries and other administrative considerations with less resources being allocated to impact oriented activities that improve learning outcomes.

All countries under review have not invested much in pre-primary Education, thus leaving the private players to dominate at that level. This has serious ramifications on the regulatory role of the State. This is evident across the SADC region. Primary enrolment in the private sector is less than 10\% of total primary school enrolment in all countries under review. Secondary School enrolment by private schools is also below 30\% of total secondary school enrollment\textsuperscript{16}.


\textsuperscript{16}AFRODAD’s tabulation of the country’s National Statistical Offices
Legal frameworks are well elaborated in state laws but implementation and monitoring mechanisms are very weak. For example, the influx of private actors in DRC impacted heavily on the rights to education in that country’s education sector governance system. The institutional performance of the education system is impacted by DRC’s governance context. Whether it is measured through the Worldwide Governance Indicators, the Ibrahim Index of African Governance, or Transparency International’s corruption perception index—DRC’s governance performance ranks among the weakest in the world. This is especially true of government effectiveness, accountability and corruption.

Despite the country’s significant economic potential, and its mineral and natural resource wealth, DRC was ranked 176th out of 188 countries on the Human Development Index for the year 2016, this is further worsened by the country’s political fragility and conflict positionality. Like in any other country, private schools are only accessible to those who have the ability to pay, thus leaving the poor disenfranchised. This is evident in the poor performance of students in public schools compared to their counterparts in private schools.\(^\text{17}\) \(^\text{18}\)

![Figure 1](image1.png)

**Source:** The World Bank Development Report 2018

According to The World Bank’s Development Report of 2018, evidence from given countries depicts that the private sector contribution in terms of enrolling learners at primary schools has been less than 10% in all the years under review, with the exemption of Zimbabwe (88.84%) in 2012 and DRC (12.58%) in 2014.\(^\text{19}\) Though private institutions offering primary education have been increasing, the same cannot be said on enrolment.

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\(^\text{17}\) International Rescue Committee, 2015 - Improved Management and Accountability: Conditions for Better Access and Quality of Primary Education in the Democratic Republic of Congo?


In 2012 Zimbabwe had the highest enrolment figures of 77.41% followed by DRC in 2014 which had figures of 18.45%. South Africa and Lesotho had the least enrolment figures at secondary level of 4.1% (2012) and 1.3% (2013) respectively. Hence, the extent of privatisation has been minimal at both primary and secondary levels. Statistics relating to private actor participation in Botswana and Namibia were last updated in 2007 with the countries having a private institution penetration in the education sector of 7.03% and 4.9% respectively. Data for Zambia is unavailable.

Source: World Bank

Data on Botswana and Zambia was not available at the time of printing this report.
Table 2 Private Enrolment for Tertiary Education (as %) of total enrolment

<table>
<thead>
<tr>
<th>Country Name</th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
<th>2011</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>42.6</td>
<td>42.6</td>
<td>35.2</td>
<td>41</td>
<td></td>
</tr>
<tr>
<td>Lesotho</td>
<td>15.5</td>
<td>14.6</td>
<td>13.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congo, Dem. Rep.</td>
<td></td>
<td>28.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>33.3</td>
<td>24.3</td>
<td>34.1</td>
<td>29.5</td>
<td>28.7</td>
</tr>
<tr>
<td>Malawi</td>
<td></td>
<td></td>
<td>10.3</td>
<td>5.8</td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>5</td>
<td>5.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td></td>
<td></td>
<td>13</td>
<td>12.8</td>
<td></td>
</tr>
</tbody>
</table>

Source: World Data Atlas 2017

The world Data Atlas notes that other countries such as the United Kingdom have 100% private enrolment at tertiary level. This means that the UK government lets the private sector run tertiary education. Whereas, in the SADC, for countries under review, Botswana has a greater penetration of the private sector in tertiary education with evidence showing that for the years 2013 and 2014 there was 42.6% private enrolment in private tertiary institutions. Albeit scant information on statistics for the years 2014 to 2016, South Africa registered the least enrolment in private institutions at tertiary level with averages of 5% for 2013 and 5.2% for 2012. From the ten countries under review, only seven could be scoped for data for the years 2010 to 2015 as there was no data aggregated for the remaining three countries.

Privatisation has presented another avenue for universality in education though student opportunities remain unequally distributed. Without proper legislation inequalities and exclusion at all levels is inevitable. Pre-primary, technical and vocational and non-formal education is severely underdeveloped in spite of growing evidence showing their importance in all countries under review.

From the three illustrations, it is clear that privatisation in education is a phenomenon that is going to remain in place and that needs to be regulated and monitored earnestly. Taking lessons from other countries like Liberia and The United Kingdom that have given private sector exclusive rights to provide education at various levels, it becomes critical that a holistic approach to private schools be followed with systems put in place to ensure that all its operation are monitored in such a way that the right to education is preserved.
The region can adopt best practice in promoting the right to inclusive and affordable education by borrowing from the Rwandese model where the government of Rwanda instituted the 9 year and 12 year Basic Education Programs in 2007 and 2010 respectively in primary and secondary schools. The two initiatives have had a positive impact on inclusivity of education as evidenced by the dwindling space of private institutions. This was aided by some of the following decisive factors:

i. The government strongly supported the implementation of these two programs by allocating 19% of the national budget, US$260m to education and over 60% was invested into primary and secondary education. This amount of money was spent on the construction of 2,679 new classrooms for the 12YE program—increasing secondary school enrolment by 49% from 31,106 in 2013 to 46,236 in 2014;

ii. Hiring publishers to supply books to public schools across the country to ensure that every student in Primary and Secondary education is entitled to a book for every subject;

iii. Paying Capitation Grant - With the abolition of school fees, the Rwandan government introduced a capitation grant which in 2010 was equivalent to 6 USD per pupil for primary schools, but higher for lower secondary where it was 12 USD for day students and 23 USD for boarding students.

iv. Providing free laptops to public school children under the One Laptop per Child Program (OLPC). Over 250,000 free laptops, each costing $200, have so far been distributed to 450 public schools. Private schools via parents contributions have to buy them as needed;

v. Support to the school-feeding program in the 9 and 12-year basic education program.

23 http://campaignforeducationusa.org/blog/detail/reversing-privatization-of-education-case-study-of-rwanda
2.1.3 Education Financing in the Region

Table 3 SADC Regional Overview

<table>
<thead>
<tr>
<th>Country</th>
<th>Population</th>
<th>Education Budget % Total government expenditure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>2.02</td>
<td>22 (2015)</td>
<td></td>
</tr>
<tr>
<td>DRC</td>
<td>67.51</td>
<td>16.8 (2013)</td>
<td></td>
</tr>
<tr>
<td>Lesotho(^{24})</td>
<td>2.07</td>
<td>1.8 (2015)</td>
<td></td>
</tr>
<tr>
<td>Malawi(^{25})</td>
<td>16.36</td>
<td>12.3 (2017)</td>
<td></td>
</tr>
<tr>
<td>Mozambique(^{26})</td>
<td>25.83</td>
<td>18.6 (2015)</td>
<td></td>
</tr>
<tr>
<td>Namibia(^{27})</td>
<td>2.3</td>
<td>21 (2016)</td>
<td></td>
</tr>
<tr>
<td>South Africa(^{28})</td>
<td>52.78</td>
<td>17.5 (2017)</td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td>1.25</td>
<td>22.4 (2011)</td>
<td></td>
</tr>
<tr>
<td>Zambia</td>
<td>14.54</td>
<td>16.5 (2017)</td>
<td></td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>14.15</td>
<td>9.2 (2016)</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** World Bank and UNESCO, 2018


\(^{28}\) [https://equaleducation.org.za/2017/02/22/2284/](https://equaleducation.org.za/2017/02/22/2284/)
Section Three

COMPARATIVE ANALYSIS OF PRIVATISATION OF HEALTH IN SOUTHERN AFRICA

3.1 Contextual Analysis

3.1.1 Regulatory and Institutional Frameworks for Health

To demonstrate its commitment to health for all in the region, SADC came up with the SADC Protocol on Health 1999, Health Policy Framework 2003 and the Revised Regional Indicative Strategic Development Plan (RISDP) of 2015-2020. The RISDP in particular integrates health as a policy within the context of social and human development, poverty and food security. It notes the importance of private sector engagement and the establishment of Public Private Dialogues on the development of the sector.

The framework for health in the region has also been guided by the Multi-sectoral HIV and AIDS Strategic Framework and Programme of Action 2003-2007 and the HIV and AIDS Strategic Framework 2010. This was a response to the high prevalence of HIV/AIDS in the region whose adverse effects on social, political and economic development are devastating.

As a signatory to the African Union, SADC member states are also guided by continental instruments including the NEPAD health vision which is underpinned by the following key values; Health and access to quality affordable health care as a human right; Health as a developmental issue requiring a multi-sectoral response; Equity in health and health care is beneficial to countries as well as individuals and that evidence should be the basis of public health practice so that it is effective, efficient and of quality. The private sector is also recognised in the strategy as critical in providing innovation, material and co-financing inputs which contribute to the expanded financial, human, infrastructural and technological resource base needed to improve health sector performance in Africa.
<table>
<thead>
<tr>
<th>Country</th>
<th>Health Institutional Framework</th>
<th>Health Legal Framework</th>
<th>Evidence Penetration of facilities and expenditure</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>- Ministry of Health</td>
<td>- 2002 Public Health Act Chapter 63:01. - Medical, Dental and Pharmacy Act. - Nurses and Midwives - Vision 2030.</td>
<td>- Total spending in health by private sector was 42.9% in 2009. - 128 Private medical practices in 2016.</td>
<td>- Private health care in Botswana is well resourced but expensive and can only be accessed with those with financial capacity. Whilst Public facilities are in place, they lack adequate human resources thus having a negative implication on quality of services provided.</td>
</tr>
<tr>
<td>DRC</td>
<td>- Ministry of Public Health</td>
<td>- Health System Strengthening Strategy. - National Health Development Plan (PNDS) 2016–2020.</td>
<td>- An estimated 73% of total health expenditure is made to private facilities. This entails that DRC has a struggling health sector that cannot offer services to the majority of its citizens</td>
<td>- Unregulated fee-for-service payment for health services is widespread in DRC leading to the sale of counterfeit drugs, unaffordable health care and disenfranchised citizenry in the conflict ridden country.</td>
</tr>
<tr>
<td>Lesotho</td>
<td>- Ministry of Health.</td>
<td>- The Health Professions Act - Public Health Order of 1970 - Lesotho's National</td>
<td>- Registered hospitals: - 48 Private hospitals - 46 Private pharmacies - 66 private clinics. - Private registered schools at</td>
<td>- The second major source of financing health in Lesotho is private sources from international organisations such as the World Bank. The introduction of user fees</td>
</tr>
<tr>
<td>Country</td>
<td>Ministry of Health</td>
<td>Health Plan.</td>
<td>Health Services</td>
<td>Notes</td>
</tr>
<tr>
<td>----------</td>
<td>-------------------</td>
<td>--------------</td>
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<td>-------</td>
</tr>
<tr>
<td>Malawi</td>
<td>- Ministry of Health.</td>
<td>- Public Health Act 2020 National Health Policy</td>
<td>- 37% not-for-profit health services. - 4% individual private-for-profit health practitioners.</td>
<td>- The government subsidized health services through Churches Health Associations of Malawi (CHAM), however the services are mainly located in rural areas and inaccessibility as a result of distance is a major concern. The government heavily relies on CHAM as its facilities are better but now overwhelmed as government is faltering in the provision of adequate human resources.</td>
</tr>
<tr>
<td>Mozambique</td>
<td>- Ministry of Health</td>
<td>- National Health Policy (2007) - Law 24-2009 of 28 September - Approves the Law of the Exercise of Private Medicine - Mozambique Health Sector Strategic Plan</td>
<td>- More than 10 private hospitals in Maputo, Tete and Nampula &amp; Beira.</td>
<td>- Health services are subsidised by private sector are plugging the gap that government has been failing to meet. But this only applies for the less than 30% who can afford private health care. The majority of citizens still need to travel for more than 30 minutes to a facility that is ill-equipped, understaffed and weak in</td>
</tr>
<tr>
<td>Country</td>
<td>Ministry/Office</td>
<td>Monitoring Instruments/Acts/Policy</td>
<td>Private Facilities</td>
<td>Concerns</td>
</tr>
<tr>
<td>-----------</td>
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<tr>
<td>Namibia</td>
<td>Ministry of Health and Social Services.</td>
<td>Public and Environmental Health Act, 2015.</td>
<td>5 Private registered hospitals.</td>
<td>Private hospitals providing more services and public facilities are not adequately equipped. The concern of user fees is imminent as only those with medical insurance and the employed can afford services thus infringing on the rights of the underprivileged to access health care.</td>
</tr>
<tr>
<td>Swaziland</td>
<td>Ministry of Health and Social Welfare - Office of the Chief Pharmacist.</td>
<td>National Health Policy 2006. - National Pharmaceutical Policy, 2011. - Policy For Human Resources For Health 2012.</td>
<td>62 private clinics. - 22 industry-supported health centres and clinics.</td>
<td>Private health facilities are mostly offering services to those financially capable. For the poor, remedies including subsidies are still required for them to access health care.</td>
</tr>
<tr>
<td>South Africa</td>
<td>Department of Health.</td>
<td>Constitution of the Republic of South Africa, Act 108 of 1996.</td>
<td>(70.5%) households went to public clinics while 25.3% have access to private doctors, private clinics or hospitals. - private health care sector serves</td>
<td>Privatisation of health services is high, the government gets support from the donor community so that it provides health care to the poor and marginalised. Public facilities are ill-</td>
</tr>
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**Zambia**
- Ministry of Health
- National Health Insurance Bill, 2017
- Medical Services Act of 1985
- National Health Service Act 1995
- 10 private health posts.
- 75 private health centres.
- 4 private District Hospitals.
- 5 private provincial hospitals.

Out of pocket expenditure and private health expenditure is high in Zambia as the government only expends an estimated average of 11% on health. This financially burdens the citizens as they fund themselves since government is lacking on its commitment.

**Zimbabwe**
- Ministries of Education, Defence,
- Public Health Act 19 of 1924.
- Health Services Act.
- Health Professions Act [Chapter 27:19].
- Medical Services Act No. 27 of 1998.
- Public Health Act [Chapter. 15:09].
- 20th Amendment of the Zimbabwean
- Both private for profit (e.g. industrial clinics.
- private hospitals, maternity homes and general practitioners)
- Not-for-profit private sector (e.g. mission clinics and hospitals and Non-Governmental Organizations) health facilities.

Private health care is only accessible to citizens that have financial capacity and or medical aid cover. For the poor, public facilities, pharmaceutical needs are not adequately stocked and citizens have to buy from private pharmacies that charge high fees for the medication. This disenfranchises those unable to afford the services.
| Home Affairs and Prison services. | Constitution of 2013 |  |

**Source:** AFRODAD Compilations
Health is an intrinsic concern enshrined in the Bill of Rights at global level and in most countries it is covered in the respective national constitutions as can be evidenced in various constitutional instruments such as the Constitution of the Republic of South Africa, Act 108 of 1996 and the 20th Amendment of the Zimbabwean Constitution of 2013. The health sector is under the Ministry or Department of Health in the respective countries under review with other countries such as Zimbabwe having well detailed mandates for health services provisions under ministries that include Ministry of Local Government; Ministry of Defence and the Ministry of Home Affairs as shown in Table 4 above.

Whilst all countries endeavour to have inclusive and efficient health services systems, all the countries are found in the bottom 35 countries of the World Health Organisations ranking of the world’s health systems. Of the 190 countries scoped by the WHO, DRC is positioned at 188 out of the 190 countries, Zambia is 182, Lesotho 183 and Malawi at 184. Countries faring better than the rest are Namibia at rank 168 and Zimbabwe at 155. In essence, this implies that Zimbabwe has better health systems amongst the countries under review albeit having faltering service delivery within its institutions.

Countries in the region may borrow concepts from some of the structural mechanisms set in place by Zimbabwe. These include establishing health boards in line with legal statutes, however, effective implementation and financing to drive these boards is of importance. For example, the Health Professions Act Chapter 27:19 and the Medical Services Act No.27 of 1998 established for Zimbabwe’s health sector are instruments that recognise the role of the private sector. They however go further in setting the tone for the governance of the sector through establishing bodies such as the Health Professions Authority which oversees conduct of health services personnel in a bid to protect the consumers from harmful practices.

3.1.2 Privatisation Trends in the Health Sector

Just like in education, the right to health is guaranteed by the laws in the respective countries but the capacity and will to commit to the mandates of the legal instruments has been lacking. Public health provision is limited by financial, human and institutional capacities. Involving private players to compliment government effort is prudent only if the sentiments supporting private sector activity such as bringing efficiency to the system does not infringe on the citizens ability to access health care at affordable fees or even free through government subsiding private companies.


Moreover, inclusion of private actors could be commendable if there are robust monitoring systems that ensure that private players do not abuse government systems and facilities. Without these, the implications of such negligence or abuse of set systems are largely felt by the poor particularly the rural poor and unemployed as they mostly bear the burden of high user fees and out of pocket expenses should they even be in a position to afford. This is worrying as there is a significant trend where health provision in Namibia, Swaziland, Lesotho, the DRC is dominated by the private sector whilst in Zimbabwe, South Africa and DRC private health expenditure far exceeds public health expenditure. This has negative implications as it spells out that the governments are failing to offer and commit to their mandatory constitutional obligations of health services delivery. This exposes the citizens to the vices of commercialization and marketization of this fundamental basic human right thus affecting equality in access to service provision.

The continued collapse of public institutions has also undermined the role of the state in providing quality health care. This has been one of the factors leading to the influx of private sector players who are capitalizing on the state’s failure to provide health services in the region. Whilst constitutions of all the countries under review save for Botswana demonstrates that health is a basic human right, out of pocket contributions of most citizens in the SADC countries have been on the rise as governments have been inadequately financing respective ministries on health. Resultant from under-funding within public institutions, a trend of some aspects of health care such as drug dispensary and X-Ray being privatised has also emerged

Table 5 below shows that the contribution of the private sector to the total health expenditure is in the range of 40-50%. This entails that the government is not offering either service or quality health care to the citizenry thus they the latter is forced to seek private services. The downside is that typically the services are more expensive and are highly unlikely to be afforded by the marginalised, unemployed, poor and those in rural areas.


Denoting from Table 5 above, out of pocket expenditure due to the involvement of private providers has been highest in Lesotho and Zambia for the year 2014. This depicts the level of financial burden citizens are experiencing due to seeking services from private health providers. In the same year under review, only South Africa and Botswana had the lowest out of pocket expenditure as a percentage of private expenditure on health. In 2014 Malawi had the highest expenditure on health as a percentage of Gross National Product of 11.4%. These scenarios differ according to the positionality of the countries on the international especially with specific reference to countries such as Malawi and Lesotho whose health budgets are largely financed by the donor community.

For instance, Malawi's health budget has a 60% donor financing component which spells that out of pocket expenses will be relatively lower as the health system is subsidized by donor funds injected into the government budget. However, as for Lesotho, the privatization of some elements of health services and institutions such as the Queen Mamohato Memorial Hospital resulted in hiked up user fees as compared to the previous hospital.

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31 [http://apps.who.int/nha/database/Key_Indicators/Index/en](http://apps.who.int/nha/database/Key_Indicators/Index/en)
For a country like the DRC, out of pocket expenses are relatively high in the 60% range as a result of limited budgetary expenditure on health coupled by the fact that regulatory systems are weak with limited monitoring by the state’s apparatus resulting in the private sector taking advantage of these loopholes. These scenarios are tantamount to infringing on the universal rights to access to safe health care as concerns of counterfeit pharmaceutical have been reported in countries including the DRC. It also affects efforts toward achieving SDG 3.

**Figure 3 Total Health Expenditure in Selected Countries**

![Bar chart showing total health expenditure in selected countries with bars for public and private expenditure.](image)

*Source: AFRODAD Compilation*

As illustrated in Figure 3 above countries like DRC and Zimbabwe are in situations in which private expenditure is higher than public expenditure in health. This is a worrying trend considering that in Zimbabwe 90% of all health institutions are public. This means that 10% of private institutions is where 60% of the total health expenditure is being used. In the DRC private institutions constitute 41% yet use 61% of all health expenditure. This reflects the reality that most public institutions are underfunded.
Swaziland and Namibia have more private providers than public which is a worrying trend in the region as it reflex that the two States are negating their legal and moral obligation in service provision. From the Figure above Zambia has the least private health providers in the region whilst Zimbabwe and Mozambique have the highest public health providers which is a desirable indicator of the government’s commitment at ensuring that health as a public good is protected and upheld as it is the responsibility of the state in taking the lead in providing health services. Swaziland, Malawi, Lesotho and DRC depict a scenario were private providers are of big significance since private providers penetration in the health sectors of these countries is between 35% and 40% which is very significant and raises questions on affordability to access the 35%.

**Source:** AFRODAD Compilation
Private Sector Health Delivery in Lesotho

The Government of Lesotho has been innovative and inclusive in allowing other private providers to contribute to the health sector. Government still takes the bigger burden in providing health services. Forty two percent (42%) of the health centres and 58% of the hospitals are owned by the Ministry of Health. Thirty eight percent (38%) of the health centres and the same proportion (38%) of the hospitals are owned by Christian Health Association of Lesotho (CHAL).

90% of the private health facilities are situated in the four large districts of Maseru, Berea, Mafeteng, and Leribe. Healthcare facilities are distributed throughout the country, with Government administering 12 hospitals and 79 clinics. CHAL manages eight hospitals and 75 clinics, Lesotho Red Cross Society (LRCS) has four clinics and the Maseru City Council controls two clinics. Two hospitals and 33 clinics being privately owned.

CHAL and MoH have a Memorandum of Understanding in which CHAL removes fees at clinic level and applies uniform tariffs in CHAL hospitals. MoH in return pays CHAL salaries and compensates CHAL for basic healthcare services provided. Also, the MoH has developed the Human Resource Development Strategic Plan (2005-2025) for pre-service training and increasing the nursing cadres.

Whilst there are several legislative instruments and adherence to regulatory frameworks in the health sector within the 10 SADC countries scoped in this study, legislation that regulates requirements for practising as doctors, pharmacists, nurses and on medicines/medical equipment in the context of accommodating private actors also exists although characterised with weaknesses in monitoring compliance to the regulatory statutes.

For example, in Mozambique there has been demonstrated regulatory constrains regarding the validity of licences to private providers under the National Health Policy of 2007. Institutionally, Mozambique still faces a challenge on authorisation of private entities between the Ministry of Health and the Order of Doctors. However, in countries like Zimbabwe there has been a trend of dual practitioners working both in public and private institutions. This has resulted in conflict of interest where patients are referred to private clinic or surgeries of the very practitioners that would have referred them from a public facility. Whilst adequate and quality services are provided at the referral facilities, they are usually unaffordable. Most national policies allow for the operation of for-profit and not-for-profit private sector. Countries like Malawi demonstrated that private facilities are concentrated in the two major cities Lilongwe and Blantyre. This is also true for Namibia were most private providers are concentrated in Windhoek and Swakopmund. Of all the countries under review Namibia demonstrated the increasing significance of private providers in health that has grown bigger in magnitude than public institutions thus raising concerns over the need for the government to protect citizen’s rights to health as they may be negatively implicated by the ulterior profit motives of commercialization of health by the private sector.
Section Four

4.1 KEY CONSIDERATIONS/ DISCUSSION

Privatisation has been identified as a significant development issue. United Nations member states in September 2015 at the General Assembly, adopted the 2030 Agenda for Sustainable Development that pushes for greater public-private partnerships, under SDG 17. Education, health and gender have targets under the SDGs but more importantly human rights are mainstreamed across all the 17 globally selected Sustainable Development Goals and targets. This research provides a comprehensive look at the nexus of privatisation and these three themes. In spite of the push for the privatisation agenda in the development goals evidence on the impact of privatisation on human rights, gender and sustainable development has not been clearly documented.

In Southern Africa, more boys than girls are enrolled in school. Evidence shows that it is a problem that is worsened when education is privatised as private entities usually charge more fees and in some communities parents would rather pay for boys than for girls. In the area of health, private companies often introduce user fees and other charges that result in lower utilisation of reproductive health services by women who cannot afford them. As a result, those women are forced to give birth without professional medical assistance, increasing the risks of maternal and child mortality, which is already a serious developmental challenge in Southern Africa. This interplay of developmental issues, not only presents a dilemma of opportunity costs but grave human rights, gender and sustainable development concerns.

4.2 Impacts of Privatisation on Human Rights

Education and health are human rights and public goods. However, the growing privatisation in and of education and health represents the greatest threat to the achievement of quality free public education and health for all. Human rights norms and standards around the role of private actors in education are developing, notably through a series of concluding observations from human rights bodies and reports from the UN Special Rapporteur on the right to education.

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32 UN, SDGs Conceptual Framework, 2015

33 The Danish Institute for Human Rights, 2017

34 Counterview, 2014

35 Action Aid, 6 reasons why privatisation impacts women’s rights, 13 September 2016.

36 Human Rights Centre Clinic, 2017
In the Education sector, the selling of educational services such as standardized testing, teacher evaluation tools and curricula negatively impact the right to education by entrenching inequalities and excluding the marginalised. It also undermines working conditions and rights of teacher professionals and education workers while eroding democratic decision making and public accountability in relation to education governance. Notably, impacts of education's privatisation are felt with most intensity in developing countries, as user fees to for-profit schools further impoverish poor families and exclude the poorest.

International Conventions such as the Universal Declaration of Human Rights provide for rights of education and health. Governments should therefore not abrogate their obligation to ensure that every student has access to free, quality public education by facilitating growth in the privatisation of education. Instead, governments must increase domestic resource mobilisation for education to at least 6% of Gross Domestic Product, target resources to combat educational inequality, and strengthen regulations to guard against profit making in education that undermines the right to free, quality education. Where governments lack capacity and have not reached the target of education of all, a strong bond of international solidarity is needed to provide aid and assistance to achieve the internationally agreed SDGs.

The study notes that in all the countries save for Botswana, the right to education is enshrined in the country’s constitution. Only DRC, South Africa and Zimbabwe have two ministries overseeing education but the other countries under review have one ministry overseeing education. The legal frameworks for education in the SADC countries are guaranteed by Acts of Parliament and by the constitution.

For example, South Africa’s School Act of 1996 and the Constitution of South Africa Section 29 allows for registration of private schools. In Zambia private schools’ registration is guaranteed in the Education Act of 2011. In Namibia the Education Act of 2001 provides the establishment of private schools. In Zimbabwe the Education Act of 2001 also facilitates for registration of private schools.

In magnitude, private schools account for less than 30% of the school’s system thus contributing to the competitiveness of the whole school’s system. Through sending learners to private schools, parents allow commercial considerations of value for money to work. This demonstrates that parents appreciate the contribution of private schools to the whole school’s system. The existence of private schools has come with its myriad of challenges, with some concerns over high tuition fees they charge which in most cases fuel inequalities. The study put to the fore that the role of the state in providing quality education should continue to be sustained.

37 Education International, 2017

38 UNDHR, 1948
Recognising that private players play a complimentary role to State’s efforts in principle, privatisation is a threat to the access of health and education by the poor and marginalised whilst it serves an advantage to those with financial muscle by providing quality services. Accordingly, States should adhere to instruments such as the CESCR’s General Comment No. 14 on the right to health, which imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health. Whether privately or publicly provided, health care services must be affordable to all, including socially disadvantaged and poorer households.

It further stipulates that the obligation to protect requires that the privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability, and quality of health facilities. In the same vein, the General Recommendation on Health from the Committee on the Elimination of Discrimination against Women (CEDAW) specifies that “State parties cannot absolve themselves of responsibility in these areas [women’s ill-health] by delegating or transferring these powers to private sector agencies.” The Committee on the Rights of the Child (CRC) has also given the most attention to issues relating to private provision of health care.

The Sexual and Reproductive Health and Rights Continental Policy Framework and its extended Maputo Plan of Action (2016-2030), the Pharmaceutical Manufacturing Plan for Africa (PMPA), African Regional Nutrition Strategy 2015 - 2025 (ARNS), the various AU Abuja commitments, calls, declarations aimed at combating AIDS, tuberculosis and malaria in Africa, the Catalytic Framework to End AIDS, TB and Eliminate Malaria in Africa By 2030 as well as the Global Strategy for Women’s, Children’s and Adolescent Health 2016 – 2030 all call for a rights-based approach to health. This essential service is a human right that must be accessible to all and that equity is important in accessing health services and addressing the determinants of health.

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Evidence has shown that the growth of private actors in the delivery of essential social services such as education and health risks undermining States’ obligations to realise economic, social and cultural rights. Privatisation in essential social services, if not adequately monitored, regulated and controlled, could lead to violations of economic and social rights, particularly for those too poor to pay for or without the capacity to choose adequate services. Thus in an increasingly globalized world, where the role of private actors is growing, there is a need to reflect on and develop common principles based on human rights, regarding how States and private actors interact as well as their limitations, to ensure the full realisation of human rights in the changing landscape.

Ideally, privatisation of basic livelihood needs should not be left in the hands of private actors as they do not have a constitutional mandate to protect the rights of citizens at any costs. This therefore makes a position that governments should be urged to reposes their space and establish alternative ways of financing and administering education and health services in a way that protects and promotes these human rights entitlements in line with declarations and statutes ascribed to by these countries in the SADC region.

4.3 Impacts of Privatisation on Gender

Privatisation in the area of education and health in many cases exacerbates gender discrimination since as quality education becomes more costly, studies show that boys are often given priority over girls. In order for women and girls to be able to realize their right to education and health, as well as their rights to non-discrimination and equality more broadly, it is imperative that education and health be seen as a public good, and not as a commodity. This is in line with a human rights-based understanding of the right to education and health, and it also underscores not only a state’s obligation to protect, but also to fulfil the right to these two essential services.

41 Human Rights Centre Clinic, 2017

42 Counterview, 2014
The international policy framework for the right to education of girls and women and Article 10 of The United Nations Committee on the Elimination of Discrimination against Women (CEDAW) calls for state parties to provide the right to education and health for women and girls (Articles 10 and 12 respectively). These explicit rights to education and health are also recognised in many international legal instruments, including but not limited to the International Covenant on Economic, Social and Cultural Rights (Article 13), and the Convention on the Rights of the Child (Articles 24 and 28). The Maputo Protocol on Education & Training of Women in Africa calls upon States Parties to take all appropriate measures to eliminate all forms of discrimination against women and guarantee equal opportunity and access in the sphere of education and training.

The United Nations estimates that 123 million youth aged 15-24 lack basic reading and writing skills, and 61 per cent are young women and girls. UNESCO has stated that “Gender-based discrimination in education is both a cause and a consequence of deep-rooted disparities in society.” The OECD’s Social Institutions and Gender Index (SIGI) similarly shows that “[w]omen’s low status in the family is linked to reduced educational attainment and economic outcomes for women and girls.” Conversely, girls’ education also has well known benefits – it is empowering and valuable in and of itself, and it also leads to other social gains.

For example, UNFPA has highlighted that education of girls is closely related to improvements in family health and to falling fertility rates, and that girls who are educated grow up to have more healthy children themselves. The proposition that ‘private schools provide real choice for parents including the disadvantaged’ requires qualification. Although choice may indeed exist for the relatively affluent, it is counter-balanced by the seeming structural exclusion by private schools of the very poor, girls and marginalised groups. As a result, private schools risk entrenching economic divisions, deepening gender discrimination and institutionalising class inequalities. These are troubling trends which have specific gender impacts.

\[43\] Art.10 CEDAW,


\[45\] Bernhardt, A., and Dresser, L., 2002
Gender equity in health implies that men and women will be treated equally where they have common needs, and that their differences will be addressed in an equitable manner. In Southern Africa, well-functioning and wide-ranging public health services provide equitable and affordable services to the less privileged, many of whom are women. Thus, shifting to privatisation of health care where there are direct user fees may increase the burden of payment among economically less privileged groups mostly women, reduce access, and generate a serious poverty trap. Policy considerations are required to ensure that privatisation provides assurances that vulnerable and marginalized groups, including poor men and women, will be adequately covered.

4.4 Impacts of Privatisation on Sustainable Development

SDGs are defined by their broad and ambitious scope, universal application across all countries and sectors, and indivisibility from one another. Private capital and private-sector innovation are needed to achieve the SDGs agenda. The impact of privatisation on sustainable development, is however problematic to measure as it includes several complex and less understood transmission conduits. When privatisation is implemented successfully, it leads to efficiency in allocation of resources, higher productivity, innovation and entrepreneurship. Empirical experience from all parts of the developing and emerging countries has clearly demonstrated that State Owned Enterprises (SOEs) exhibit a significant lower productive efficiency in comparison with privately owned companies.

For the Education sector to position itself towards playing a meaningful role in sustainable development in the selected Southern African states, there is need for a balance on the extent to which the market model can be allowed to prevail. At the same time, the state will have to play a key role in terms of both setting up functional regulatory frameworks to safeguard quality, and to support school and university access through greater funding in order to strengthen equality of opportunity and equality of outcome.

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46 Conceição, Malloch-Brown, Nabarro, 2017

47 ibid
In Namibia, for example, the implementation of the Education policy has ensured that the country has high rate of enrolment. However, the magnitude of private schools in Namibia is small on coverage, and its small contributions if supported with a well-funded public education system would lead to positive impacts to the overall education system in the country.

Health is both a critical input and an outcome of development, and it is an integral part of the Sustainable Development Goals (SDGs) Agenda (Conceiço, Malloch-Brown, Nabarro, 2017).\(^{48}\) However, sustainable progress on health outcomes in Southern Africa requires both addressing the underlying causes of morbidity and mortality to achieve long-term improvements in health. These underlying causes, or determinants of health, cut across all areas of development such as education, gender equality, and employment. Private-public partnerships, for example in the areas of fighting malaria and HIV/AIDS, demonstrate the importance of inclusion of effective partnerships among multiple actors. One example is that most countries in Southern Africa have National Aids Councils that include both public and private actors to eradicate HIV/AIDS, and such broad partnerships has resulted in meeting key milestones towards redressing the impacts of the disease in the region.

While selected Southern African countries in this study are building and strengthening the education and health systems, it will be more important in the long-term to build and monitor partnerships in education and health, including those aimed at addressing shortfalls in the public domain. Results of this study can therefore assist governments in Southern Africa, private sector, civil society, and all those concerned to enhance their efforts to raise awareness on the political, socio-economic impacts of privatisation of education and health services and to strengthen the monitoring of non-state actors.

\(^{48}\) ibid
Section Five

RECOMMENDATIONS

Based on the findings of the study on Privatisation of Education and Health in Southern Africa, priority actions were developed. The study recommends a comprehensive, holistic and multi-sectoral set of priority responses, which emphasises working with actors operating in sectors of education and health at various levels—these may include international organisations; national NGOs, FBOs, the media, and communities.

5.1 Best Practices

5.1.1 Best Practices in Education

The study assessed 10 country regulatory frameworks for private providers in education. All the countries under review have demonstrated the existence of a legal framework to operate private schools, although archaic and in need of revision. In some countries this is a right provided for in its constitution. In most countries monitoring and evaluation in these private schools is done by two ministries. For example, in the DRC and Zimbabwe the ministries of Primary and Secondary Education issue licences to private schools at primary level. A major focus therefore, should be on the continued capacitating of ministries in charge of education and training in terms of their ability to formulate policy, plan and implement reforms that improve education outcomes in all the countries.

However, besides legal frameworks other indicators need assessment for improvements. Legal frameworks in all the countries under review only provides for registration and standards that private schools should have. Policy frameworks lack the statutes that remind the private providers that education is a fundamental right that they should not discriminate against.
A good starting point to correct this is to follow the Guide to Human Rights Guiding Principles on State Obligations Regarding Private Schools (2017). This is anchored on the understanding that private schools should be affixed by the rule of law, accountability, transparency and participation. The guiding principles recommend that private schools should:

- Not be a source of segregation, discrimination and inequalities;
- Provide an alternative to and not affect access to free, quality, publicly-supported education;
- Preserve the humanistic nature of education;
- Conform to minimum education standards established and adequately enforced by the State;
- Be regulated by norms that are developed following due process, including participation of all education stakeholders.

The private sector has a niche in providing education services since governments are failing to meet with the demand but should be commensurate with the national legislations. For best results, relevant ministries in education have to enhance private sector investment in the education through developing enabling legislation and efficient policies that support access to education as a fundamental human right. School fees charged by private schools should be offering services that demonstrate value for money vis-a-vis schools profiteering and marginalising other community members in instances were public schools are not present in those areas. The private sector is a major provider of pre-school education in most countries which clearly indicates the limited involvement of the public sector. There should be increased state funding towards provision of this service.

Data on public and private schools needs to be made available by relevant ministries. Most education ministries provide aggregate data on learning achievements of all schools making it difficult to compare and contrast performance of public and private schools. The analysis has hinted the preference of private schools to public schools but there is need to put a distinction of public to private when presenting results.

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49 Guide to Human Rights Guiding Principles on State Obligations Regarding Private Schools, 2017

The quality of education provided by public and private schools needs to be analysed annually. At university level private providers are playing an important role as they currently enrol about 25% of the students in the African continent. On world ranking of universities with the exception of South Africa, none of the Southern African universities appears in the top of these rankings. There is therefore need to work towards improving the quality of education at all levels.

For example, data on learning achievements point to more than two-thirds of the children failing to read competently at the grade levels they are in (Adams and Van der Gaag, 2013). Mozambique and Malawi face a huge task in ensuring high quality of education provided at primary school by public schools. Stakeholders have a role to advocate for better learning outcomes in both public and private schools. The demand for education is growing in all SADC countries yet the supply side of public education is less than the demanded level of education leading to stiff competition for the available opportunities in the private schools.

5.1.2 Best Practices in Health

Due to high limitations on health care resources, governments have to make choices for public financing and payment of health services by the communities. There is need to come up with guiding principles on state obligations regarding private health providers. Currently health privatisation is taking all different forms and only strict legislations exist for practitioners involved in health delivery. For best outcomes in engaging private sector in health care, there should be a review of health systems in all the SADC countries under study and ensure that:

- The cost of private health remains affordable based on market competitiveness and that privatised services should be regulated, monitored and evaluated just as public health;
- Where there is dissatisfaction due to poor management with the public services, private providers can be utilised to provide efficiency of services, however transaction costs associated with outsourcing should be regulated;
- Patient’s right is respected and presented with alternatives of quality health care providers. This is good for the overall performance of the health system as providers will continuously engage in self-assessments of their services as well as constantly compete to edge other providers, hence leading to better quality services and client satisfaction;
• The development of private health does not undermine the existence of public institutions;
• In national policy framework measurable privatisation of health goals needs to be established.

Health care should by and large remain a government responsibility and this function should not be completely left for private health providers to deliver. It is thus vital that the State provides legislation that ensures that citizens can access quality private health care at affordable costs. However, the state should create an enabling environment for private health providers to operate since they bridge the health gap that government is not able to satisfy.

5.2 Recommendations to Governments

• Increase education and health budgetary allocations to revive the two essential sectors in line with global standards;
• Review archaic national education and health policies, with inputs from other stakeholders inclusive of the private sector, academia and civil society organisations;
• Improve efficiency in both education and public health sectors by constantly monitoring outcomes from public institutions. In the health sector, government should ensure that public institutions remain public by not privatising aspects or departments within public institutions like hospitals;
• Ensure that there is clear rationale to engage private players in education and health. Governments should not negate their role to provide education and health services as what is currently transpiring at pre-primary level in most countries;
• In education, SADC countries can benefit from domesticating the ‘Guiding Principles on State Obligations Regarding Private Schools’;
• Domestic resource mobilisation remains key for governments to have resources to use in education and health. They can broaden their tax base by curbing illicit financial flows, increasing their revenue streams and advocating for private sector to invest in education and health as part of their corporate social responsibility;
• When engaging in PPPs government should ensure that they do due diligence to evaluate the merits and de-merit to such ventures. Besides financial costs, they should also assess the capacity of communities to pay for services that PPP projects will bring. Governments should develop clear policies on PPP project implementation.
• In education, privatisation has resulted in an encouraging teacher/ learner ratio. The ratio is way higher in public schools compared to private schools. There is need for government to ensure that the teacher pupil ratio in public schools be revised to ensure that learning outcomes are of high quality.
5.3 **Recommendations to Private Sector Actors**

The private sector can do more to ensure quality service provision besides conforming to the rule of law that mandates private actors to register and operate institutions in both education and health sectors. The study puts to the fore the following considerations:

- Private sector engagement in the two sectors should be strengthened by Memorandum of understanding (MOU) between the private sector players and the governments. MOUs will be linked to the vision and mission of respective governments with regards to provision of education and health. In the MOUs private sector should ensure that it mirrors government efforts to provide quality and affordable services;

- Private sector not directly engaging in education and health can contribute through meeting their tax obligation and through corporate social responsibility. At present over $138 billion a year is lost to the budgets of developing countries by what the IMF calls ‘harmful tax incentives.’ Estimates for revenue lost owing to aggressive tax avoidance in developing countries by private sector hoarding money in tax havens varies from $200 billion to $800 billion (Paradise Papers / Panama Papers).

5.4 **Recommendations to OSISA and Partners**

*Education:* OSISA and its partners in the Civil Society must amplify advocacy efforts towards high quality standards of both public and private schools. Although the Millennium Development Goals (MDGs) demonstrated improvements in education at primary level, much focus now should be on the quality of education basing on examination results at secondary level, plus ability to read and write at primary schools.
It has been noted that completion rates in many SADC countries is very low. On average, only 70% of children entering primary education in Sub-Saharan Africa complete it, this is against 95% completion rates in North Africa and the Middle East. Another policy consideration for education is advocacy around ensuring that governments increase their contribution to the education sector. The United Nations Special Rapporteur on the Right to Education, Kishore Singh notes that, “Education is not a privilege of the rich and well-to-do; it is an inalienable right of every child. Provisions of basic education free of costs is a core obligation of the state.”

Health: OSISA and partners can organise campaigns against the privatisation of essential health services resulting in the poor not having access to healthcare. As governments negate their obligations, CSOs should continue to advocate for governments to meet international and regional commitments, such as the Abuja Declaration, in which member states committed to allocate 15% towards health.

Also, the call for governments not to consider the use of Public Private Partnerships in health must be amplified, as examples of negative impact in Lesotho and Zimbabwe are well documented. OSISA should therefore dedicate more resources towards exploring the impact of public facilities that have privatised aspects of their health delivery and recommend to governments the need to continue providing free accessible health care. In addition, advocacy and technical assistance in revamping regulatory frameworks in both education and health sectors is required.

Further Research: There is need for more research on unpacking the actors in privatisation, their motivation and above all the impact of privatisation on women and children. A gap analysis can be conducted to ascertain the number of citizens who cannot access education and healthcare due to high costs at public and private institutions.

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