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**Effects of Economic Growth on Poverty Reduction: Experiences
from Botswana, Kenya and Namibia**

A paper presented at the ABCDE Conference in Cape Town, 09 June 2008

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List of abbreviations

ABCDE	Annual Bank Conference on Development Economics
AIDS	Human Immunodeficiency Syndrome
ASAL	Small and Medium Enterprises Arid and Semi-arid Land
BIDPA	Botswana Institute for Development Policy Analysis
CDF	Constituency Development Fund
EFA	Education for All
ERS	Economic Recovery Strategy for Wealth and Employment Creation
EU	European Union
FHHS	Female-Headed Households
GDP	Gross Domestic Product
HDI	Human Development Index
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
I-PRSP	Interim Poverty Reduction Strategy Paper
KDHS	Kenya Demographic Household Survey
KNALS	Kenya National Adult Literacy Survey
LATF	Local Authorities Transfer Fund
MDGs.	Millennium Development Goals
MFDP	Ministry of Planning and Development Planning
MTEF	Medium Term Expenditure Framework
NDHS	Namibia Demographic and Health Survey
NDP	National Development Plans
NEPRU	Namibian Economic Policy Research Unit
NHIES	Household Income and Expenditure Survey
NPEP	National Poverty Eradication Plan
NSPR	National Strategy for Poverty Reduction
PETS	Public Expenditure Tracking Survey
PHC	Primary Health Care
PRSP	Poverty Reduction Strategy Paper
QSDS	Quantitative Service Delivery Survey
RAD	Remote Area Dwellers
SADC	Southern Africa Development Community
TB	Tuberculosis
UNDP	United Nations Development Programme
UNAIDS	United Nations Programme on HIV/AIDS
UPE	Universal Primary Education
USD	United States Dollar
WFP	World Food Programme
WSSD	World Summit for Social Development

1. Introduction

This is a comparative study that involves three non-highly indebted poor countries (non-HIPC), namely: Botswana, Kenya and Namibia. These countries exhibit diverse geographical characteristics. Botswana is a landlocked country in Southern Africa which shares borders with South Africa to the south and southeast, Namibia to the northwest and west, and with Zambia and Zimbabwe to the northeast. Kenya is located in East Africa, with the equator almost bisecting it, and borders on Tanzania to the south, Uganda to the west, Ethiopia and Sudan to the north, Somalia to the northeast and the Indian Ocean to the southeast. Namibia is located in the south-west of Africa bordering South Africa to the south, Angola and Zambia to the north and Botswana to the east. The surface area of Botswana is 582,000 km² with the Kalahari Desert constituting 77 per cent of the total area (Central Statistical Office 2006). Kenya occupies a total surface area of 582,646 km², of which 571,466 km² form the land area. Approximately 80 per cent of the land area of the country is arid or semi-arid and only 20 per cent is arable (Republic of Kenya 2000a). Namibia covers some 824,000 km², spanning 1,440 km at its widest point and 1,320 at its longest (Office of the President, National Planning Commission 2004). Namibia is regarded as one of the most arid countries South of the Sahara with only 2 per cent of the land classified as arable land.

The climate for Botswana is sub-tropical, with summer temperatures ranging from 19° to 33° C and in the winter from 0° to 23° C. Average annual rainfall in the northeast is about 650 mm, decreasing to less than 250 mm in the extreme southwest. In Namibia, rainfall varies between 700mm in the north-east to less than 10mm on average in the Namib Desert in the west of the country (Ministry of Environment and Tourism, Republic of Namibia 2002).

The population of Botswana is 1.7 million which is perceived as small (Central Statistical Office 2006). A small population provides a small market base, which makes it difficult to foster a diversified and stable economy. Its advantage is in spreading resources over a small number of people, which may result in adequately meeting the needs of everyone. Botswana's population growth rate was at 3.5 per cent in the 1980s and 2.5 per cent in 2001 and ultimately -0.04 per cent by 2006. Life expectancy at birth declined from 65.2 years in 1993 to 56 years in 2007 with male life expectancy being 53 years and 59 years for females (Population Census 2001). By 2002 the population distribution between urban and rural was even but by 2006 it had changed to 60 per cent urban and 40 per cent rural. This complete shift in population settlement pattern primarily reflected the influx of migrants from the rural areas rather than a natural increase in the existing urban population. Rural-urban migrants are attracted by job opportunities in urban centres or pushed out by the hardships in the rural areas, or both.

The Namibian population is estimated at two million (2007), with a population growth rate of 2.6 per cent. Characteristical of most developing countries, two-thirds of the Namibian population resides in the rural areas (Republic of Namibia 2003). The Kenyan population is estimated to have increased from 10.9 million in 1969 to 28.7 million in 1999 and further to 33.5 million in 2005 (Republic of Kenya 1994, 2001 and 2006), with a population growth rate of 2.9 per cent per annum for the period 1989-1999, down from the 3.4 per cent estimated for both the 1969-1979 and 1979-1989 inter-censal periods (Republic of Kenya 2000a).

2. Economic Growth and Poverty

Growth is regarded as key to poverty reduction. Poverty is a widely defined term, and most definitions take its multidimensional aspects into consideration. According to the World Bank (2000), poverty is a lack of power to command resources. Its multidimensional phenomenon makes the poor face multiple deprivations due to the interaction of economic, political and social processes. Beyond the lack of income, the multidimensional concept of poverty refers to disadvantages that those afflicted are subjected to when trying to access productive resources such as land, credit and services (e. g. health and education), to vulnerability (to violence, external economic shocks, natural disasters) and powerlessness as well as social exclusion. The poor lack adequate food, shelter, education and health, deprivations that keep them from leading the kind of life valued by everyone. They are also often exposed to ill treatment at institutions when seeking services and are powerless when trying to influence key decisions.

Although growth is a prerequisite to poverty reduction, poverty may also hamper sustained growth. According to Perry *et al.* (2006), a 10 percentage points drop in poverty levels, other things being equal, can increase economic growth by one per cent. In turn, a 10 percentage points increase in poverty levels will lower the growth rate by one per cent and reduce investment by up to eight per cent of GDP. This is so because the poor are in no position to engage in many of the profitable activities that stimulate investment and growth, thus creating a vicious circle in which low growth results in high poverty and high poverty, in turn, results in low growth. As attested by poverty levels and country growth rates, presented below, reduction in poverty rates has been lower than anticipated, even when countries registered relatively high growth rates.

Botswana has experienced four decades of high real per capita income growth in the last decade - more than 7 per cent per annum on average. Sound macroeconomic policies and prudent use of diamond revenues have made Botswana one of the fastest-growing economies in the world over the three last decades and it has now achieved middle-income status, making it globally the best economic performer over that period. Botswana is often hailed as one of Africa's success stories of sustained economic growth, which is grounded in good governance, political stability and prudent macroeconomic management. From humble beginnings as one of the poorest countries in the world at the time of attaining independence in 1966, Botswana harnessed diamond rents in the 1970s as an engine of growth and the economy dramatically progressed to its classification in the late 1990s as a "middle income country" by the World Bank. GDP growth has averaged 6 per cent per annum in real terms over the post-independence period and per capita GDP has grown six-fold. This impressive performance record continues to earn the country high international ratings.

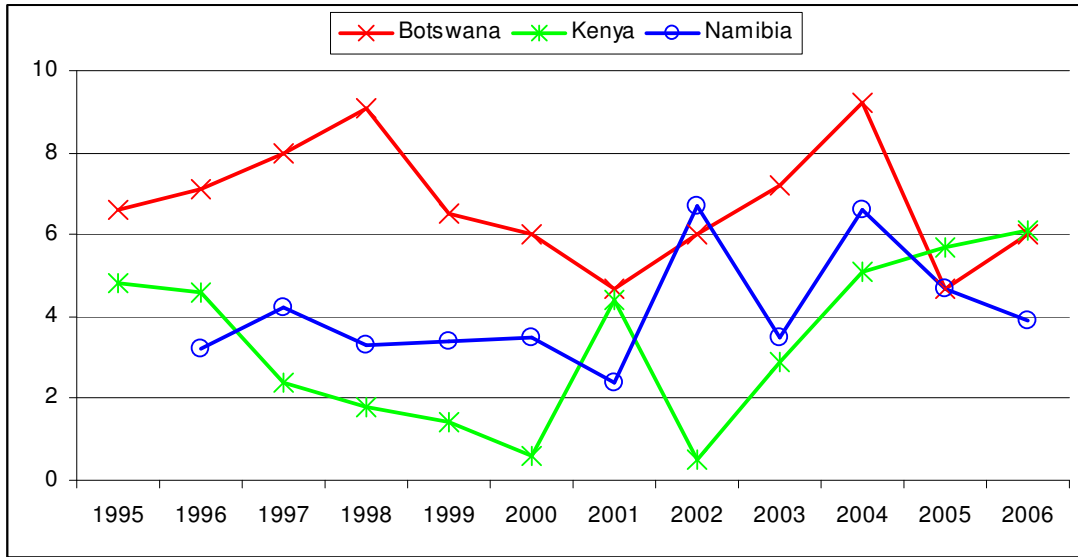
The Kenyan economy is predominantly agricultural, yet with a comparatively strong industrial base. The performance of the economy since independence has been mixed. In the post-independence era (1964-2006), Kenya transited from a high economic growth path in the 1960s (6.6 per cent average annual growth over 1964-72) to a declining path (5.2 per cent over 1974-79, 4.0 per cent over 1980-1989, 2.4 per cent over 1990-2002). As a result of a change of the political regime in 2002 and subsequent implementation of prudent

macroeconomic policies, Kenya has been on a recovery path, achieving a high economic growth rates in 2004 (5.1 per cent), 2005 (5.7 per cent) and 2006 (6.1 per cent) (Republic of Kenya 2007a). Rapid economic growth has been given prominence by the Kenyan government as a means of alleviating poverty and creating employment opportunities.

The rapid growth of the economy has been regarded in Kenya as a key solution not only to poverty, but also to unemployment, poor health, economic exploitation and inequality. For these reasons the government's stated economic policy reflected in various Sessional Papers and the five-year Development Plans tended to place emphasis on the promotion of rapid economic growth, equality in the sharing of economic growth benefits and the reduction of extreme imbalances and inequalities in the economy as the main goals of economic development. This policy stance has been maintained throughout the last four decades with slight variations. The first two development plans focused emphasis on rapid growth to alleviate poverty and reduce unemployment. However, in the early years after independence, the two problems of poverty and unemployment persisted and income inequality widened despite the economy achieving high rates of economic growth (Republic of Kenya 1994). The government's strategy of promoting growth as a means of poverty alleviation was based on an implicit assumption that a "trickle down" process would take place to spread the benefits of growth from some of the more dynamic modern sectors to the rest of the economy and sections of the population (Ikiara 1998). The trickle down did not work as by the mid-1970s, unemployment and income disparities were more apparent than they had been in 1963. The failure of economic growth to solve the problems continued to be observed in the 1980s and 1990s. This necessitated shifting resources towards rural and labour-intensive production activities and the provision of social services by the government.

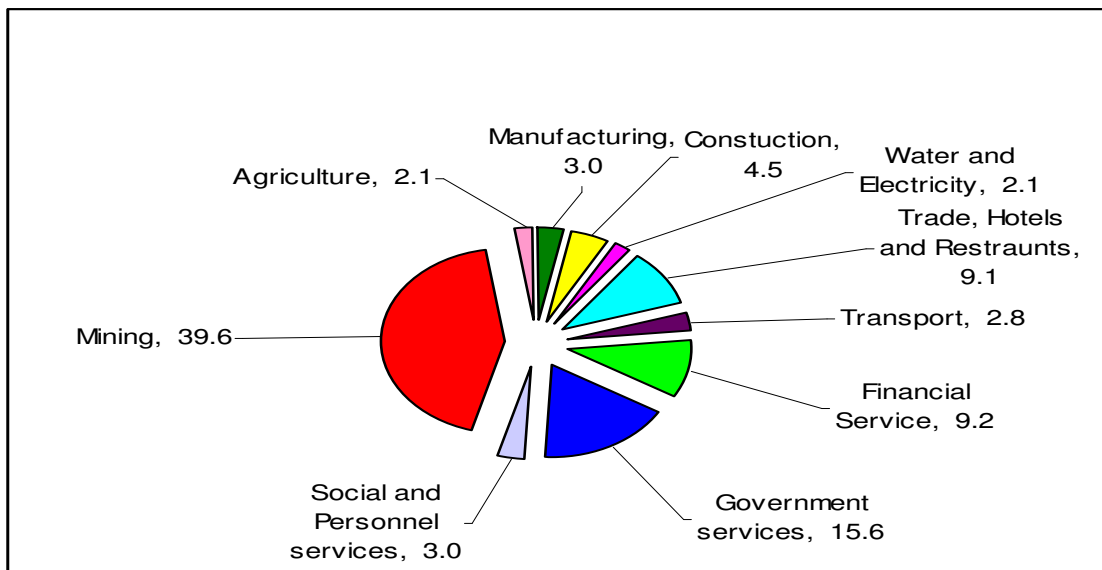
Like Kenya and Botswana, Namibia's economic growth has been volatile (figure 1). Growth during the pre-independence (between 1982 and 1989) period averaged 0.9 per cent. After independence in 1990, Namibia recorded a Gross Domestic Product (GDP) growth rate of 3.5 per cent during the first eight years. While the economy grew strongly immediately after independence, growth rates declined steadily during the following years. With some major investments in the mining and textile sectors, growth picked up after 2000, reaching on average 4.4 per cent. Namibia is rich in natural resources. Nonetheless, it is classified as a lower middle-income country, which is characterised by a much skewed income distribution. The inequitable income distribution in Namibia is to a large extent the result of a long period of racial segregation under the apartheid regime, which eventually ended with independence in 1990. The Namibian government identified the reduction of poverty and of income inequality as two of its four main national development objectives in its national development plans. However, the government realised that it was necessary to design a more profound strategy to reduce poverty and prepared a Poverty Reduction Strategy in 1997 and subsequently a Poverty Reduction Action Programme as well as a Poverty Monitoring Strategy.

Figure 1 Growth of Gross Domestic Product



All three countries have dominant sectors driving their growth. The economy of Botswana has undergone structural change from primarily an agricultural subsistence one in 1966 when agriculture accounted for 40 per cent of the country's Gross Domestic Product (GDP) to one that is predominantly dependent on mineral revenue, specifically diamonds. Over the years the contribution of the minerals industry to GDP has burgeoned from virtually zero in 1966 to almost 45 per cent in 2004/05 (Figure 2). Apart from being the world's leading diamond producer, the country produces copper, nickel, cobalt, coal, gold and soda ash, albeit not on the scale of its diamond industry. Other sectors such as tourism grew by 4 per cent, which is a potential source of growth and employment, especially in rural areas.

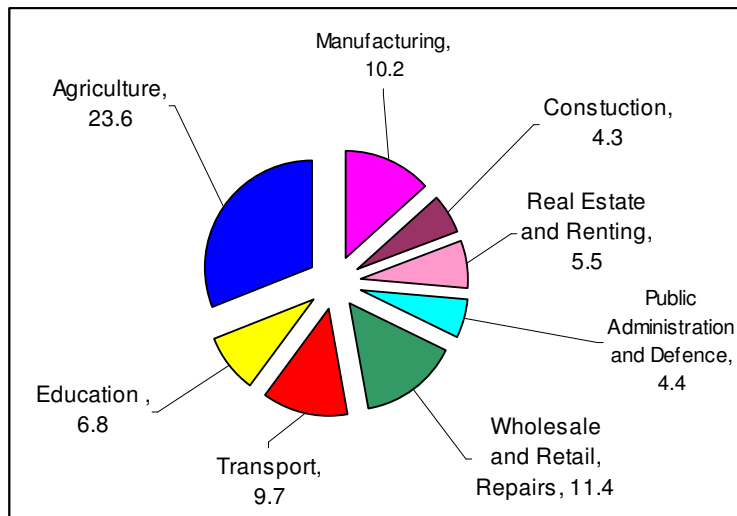
Figure 2 Sectoral Share of GDP 2004/05 for Botswana



The Kenyan economy is predominantly agricultural. Agricultural production contributes more than 23 per cent to the country GDP. Since independence, rain fed agriculture has remained

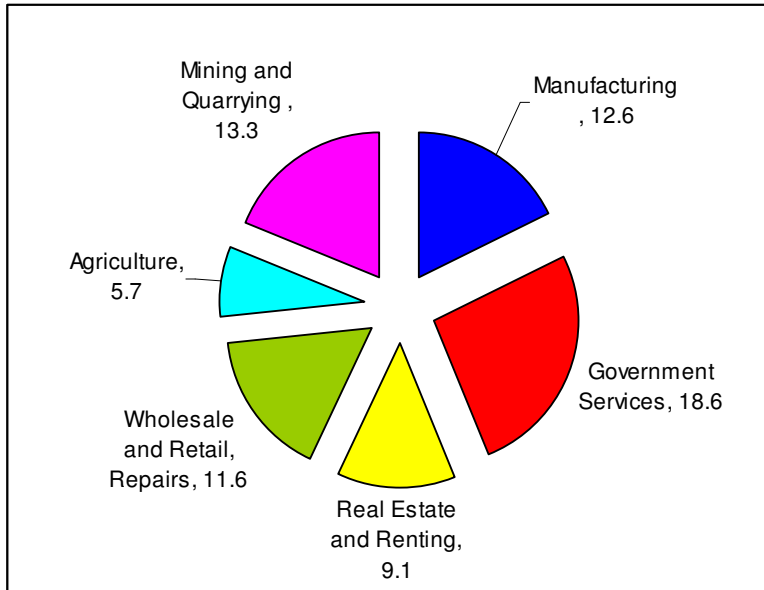
the main stay of the economy, serving more than two thirds of the population. Besides, the informal sector in Kenya generates more than 80 per cent of total employment (Republic of Kenya 2007a). Though the country is said to have a strong industrial base, sectoral contribution from the manufacturing sector has remained static at about 10 per cent for the last five years, having slowed down from an average of 13 per cent in the 1990s. The dependence of the economy on the rain fed agricultural sector explains the volatility in GDP growth depicted in figure 1. The main sectors and their contribution to GDP are shown in figure 3.

Figure 3 Selected sectoral contribution to GDP in Kenya in 2006



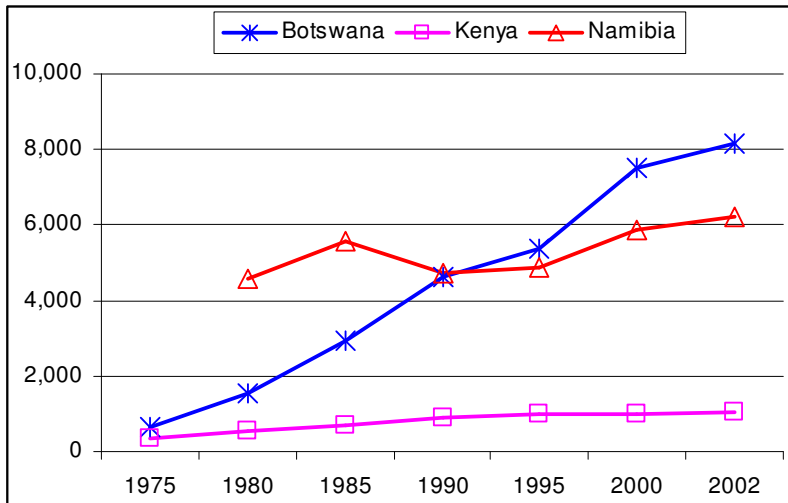
Unlike Botswana that is heavily dependent on mining, and Kenya which is heavily dependent on rain-fed agriculture, the Namibian economy is dependent on both renewable resources, which are in turn dependent on climatic conditions and non-renewable resources. The economy continues to rely on its traditional outputs such as minerals, fish, livestock and crops. However, a diversification process is slowly taking place at the micro level: non-traditional agricultural products such as grapes and horticultural products are produced domestically and new investments have been made in the dairy and pasta industries. Figure 4 depicts sectoral contribution to overall GDP for Namibia.

Figure 4 Selected sectoral share of GDP in Namibia in 2006



These countries have achieved modest development since their independences. Growth in GDP per capita shows upward trends. For instance, data from the UNDP human development indicators reveal that in 1975, Botswana had a per capita GDP of USD 640. Over the years it increased more than twelve-fold to USD 8,170 by 2002. In 1975, Kenya's GDP per capita was equal to half of that of Botswana. However, as of 2002, Kenya's GDP per capita stands at one-eighth of that of Botswana and one-sixth that of Namibia. The changes in GDP per capita over time are shown in the figure 5 below.

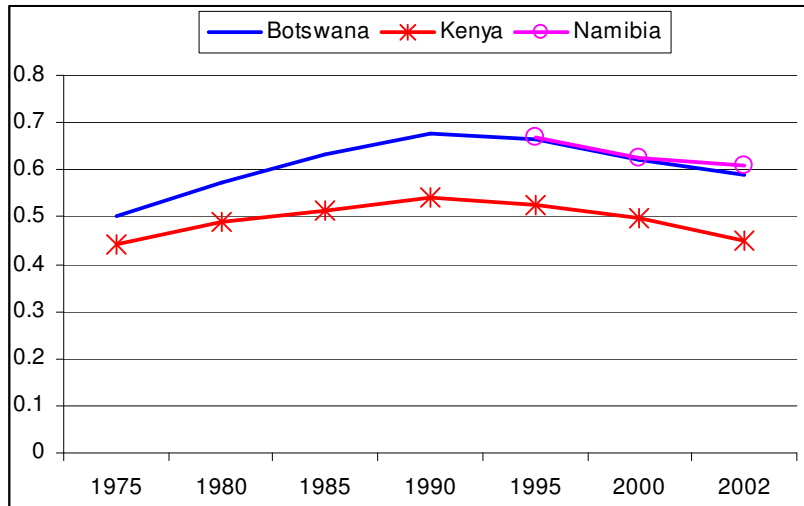
Figure 5 Gross Domestic Product per capita



Though GDP per capita has been on the increase and specifically high for Botswana and Namibia, this may not have translated into high welfare improvement for the individual citizens of the various countries, especially after mid 1990. As captured by the Human Development Index (HDI) which measures the average achievements based on measures of long and healthy life, knowledge and a decent standard of living, countries seem to have

done well between 1975 and 1995 (Botswana and Kenya) but deteriorated in 2000 and even further in 2002. Available figure for Namibia are for 1995 to 2002, which also depict a declining trend in the HDI index. The HDI for Botswana is particularly important to note. It rose from 0.5 in 1975 to almost 0.7 in 1990, placing it among the few top countries in the developing world. However, this score has been declining over time due to the impact of HIV and AIDS. The decline in Botswana's HDI has been dramatic, from 0.675 in 1990 to 0.589 in 2002, placing it among only four countries (the others being the Russian Federation, Moldova and Lesotho) to witness such a marked fall (Institute for Security Studies 2005). This is shown in the figure 6 below.

Figure 6 Human Development Index



3. Poverty Status

Poverty is said to be on the decline in all three countries. Nonetheless, its current level is still unacceptably high. The figures on incidence of poverty are not necessarily comparable on a one to one across the three countries because of the differences underlying the sampling frame, collection, collation and analysis of data. Nonetheless, they are indicative of poverty progression in the different countries. One common characteristic across the three countries is that poverty is predominantly a rural problem. In Botswana, a study on Poverty and Poverty Alleviation, undertaken by the Botswana Institute for Development Policy Analysis (BIDPA) in 1997, reported that the national poverty rate had declined sharply from 59 per cent in 1985 to 47 per cent in 1994. In 2002/03 national income poverty was estimated at 32.89 per cent, and subsequently in 2005/06 at 30.2 per cent (Central Statistical Office 2006). While poverty reduction was rapid between 1985/86 and 1993/94, it significantly slowed down between 1993/94 and 2005/06. Another feature is the highly skewed income distribution with a Gini coefficient of almost 0.6, implying that the benefits of growth are not equitably distributed (Central Statistical Office 2004). The HIV/AIDS epidemic presents another challenge for poverty reduction by eroding achievements in socio-economic development. The most recent sentinel survey shows that HIV prevalence in Botswana is 32.4 per cent.

In Kenya, the number of people living in absolute poverty is estimated to have risen from 11 million in 1990, representing 48 per cent of the population, to 17 million in 1997, representing 52.3 per cent of the population (Republic of Kenya 2001). This trend was halted and results of the Kenya integrated household budget survey conducted in 2005/06 indicates that absolute poverty declined to 45.9 per cent of the population in 2006. The survey further indicates that for rural areas, the Gini coefficient of expenditure per adult equivalent declined from 0.417 in 1997 to 0.380 in 2005/06, while the urban Gini coefficient rose from 0.426 in 1997 to 0.447 in 2005/06. The decline in the rural Gini coefficient indicates that income disparities in rural areas have on average gone down while the disparities in urban areas have increased substantially (Republic of Kenya 2007a).

In Namibia, an estimated 6.1 per cent and 36 per cent of rural households are classified as severely poor or poor households based on the food consumption ratio, while the levels in urban areas are significantly lower – 0.6 per cent and 6.0 per cent, respectively. Overall, 27.8 per cent of households in the country are poor; 3.9 per cent are severely poor and 23.9 per cent are poor (Central Bureau of Statistics 2006). Further, Namibia's history of colonialism and racial segregation resulted in a dual society and economy and, hence, strikingly divergent standards of living within its population. While Namibia enjoys on average a relatively high GDP per capita, its income distribution is highly skewed. Namibia recorded one of the highest Gini coefficients in the world in 1993/94 of 0.7, based on the Household Income and Expenditure Survey (NHIES). According to the latest data from the NHIES conducted in 2003/04 the Gini coefficient stood at 0.6 - remaining one of the highest in the world.

There are disparities in poverty incidence by geography, gender and ethnicity. In some parts of Botswana, poverty is endemic and many depend on destitution payments by the state for their livelihoods. This situation persists mostly in the smallest settlements inhabited mainly by people referred to as remote area dwellers (RADs), who reside in settlements and cattle posts, as well as villages. The RAD households are still highly dependent for their survival on rapidly depleting natural resources. The BIDPA report in 1997 estimated that at least 62 per cent of the poor or the very poor lived in rural areas. Overall, 48 per cent of rural households were estimated to be poor or very poor. Botswana is divided into administrative districts. The most severe poverty is recorded in the rural southwest (Ghanzi and Kgalahadi Districts), and in western parts of Kweneng and Southern Districts, where most of the Basarwa and other ethnic minorities live. There, some 71 per cent of the population were found to be poor in 1997, and 59 per cent were classified as very poor. By 2002/03, the poverty headcount had declined to 51.5 per cent in Kgalagadi and 44.23 per cent in Southern and 33.97 per cent in Kweneng Districts. The incidence of poverty is also high in other districts, such as Ngamiland (43.29 per cent), Chobe (43.29 per cent) and Central (43.14 per cent). Poverty is highly concentrated in the districts in the northwest of Botswana and less in urban districts, especially in Jwaneng, which has the lowest poverty incidence of 3.16 per cent only.

In Kenya, by the mid-1970s national absolute poverty was estimated at 42 per cent while food poverty was 39 per cent with considerable regional variation (Greer and Thorbecke 1986a, 1986b; Republic of Kenya 1998; Mwabu and Mullei 1998; Mwabu *et al.* 1999). Absolute poverty rates for 1982, 1992, and 1994 were estimated at 47 per cent while food

poverty rates were estimated at 67 per cent in 1982, 72 per cent in 1992, and 47 per cent in 1994 (Republic of Kenya 1998). Analysis of survey data from the first and second welfare monitoring surveys revealed that 47 per cent of the rural population was food poor in 1994 compared to 72 per cent in 1992 (Republic of Kenya 1998). Absolute poverty was estimated at 47 per cent for 1999 and 1994. In urban areas, food and absolute poverty was estimated at 29 per cent. Absolute and food poverty rates were highest in North Eastern and Eastern Provinces at 56 and 58 per cent of the population respectively. Central Province had the lowest absolute and food poverty rates of around 32 per cent whereas Kisumu was the poorest of the urban areas with absolute and food poverty rates of 46 per cent and 44 per cent, respectively, and Nairobi had the lowest rates of 27 per cent and 26 per cent for food and absolute poverty, respectively. The districts with the highest levels of food poverty in 1994 were Marsabit (86 per cent), Turkana (81 per cent), Isiolo (81 per cent), Samburu (79 per cent) Tana River (71 per cent), Makueni (70 per cent), Machakos (66 per cent), Kilifi (65 per cent) and Kitui (64 per cent). From the 1999 population and housing census and the 1997 welfare monitoring survey data, it was estimated that of the 56 per cent of the total population in Kenya that live below the poverty line, about 52.9 per cent are in the rural areas and 49.2 per cent in the urban areas (Republic of Kenya 2003). It was also estimated that about 34.8 per cent of the rural population and 7.6 per cent of the urban live in extreme poverty and therefore cannot meet dietary needs even with their total spending devoted to food.

Poverty estimates in Kenya have further been disaggregated by region. The geographical dimensions of poverty (Republic of Kenya (2003, 2005) show that the level of poverty differs across regions. Over time, Central Province has always registered lower levels of poverty whereas North Eastern, Nyanza and Coast Provinces have the highest levels of poverty. Poverty estimates for the year 2000 indicate that Central Province had the lowest level of poverty, estimated at 35.3 per cent, while North Eastern Province had the highest level of poverty at 73.1 per cent. The latest household budget survey conducted in Kenya in 2005/06 indicate that absolute poverty in Kenya declined from 56.8 per cent in 2000 to 45.9 per cent in 2006 and that still poverty is lowest in Central province, estimated at 30.4 per cent and highest in North Eastern, estimated at 73.9 per cent. Among the rural population, 49.1 per cent of the rural population were found to be absolutely poor, with the highest level of 73.9 per cent recorded for North Eastern province and the lowest level of 30.4 per cent recorded for Central province. The survey measured the incidence of poverty in urban areas to be lowest for Nairobi city at 21 per cent and the highest for Nakuru municipality at 50 per cent (Republic of Kenya 2007b).

Like Kenya, poverty in Namibia is predominantly a rural phenomenon despite widespread informal settlements in urban areas. About 6.1 per cent and 36 per cent of rural households are classified as severely poor or poor households based on the food consumption ratio, while the levels in urban areas are significantly lower at 0.6 per cent and 6.0 per cent, respectively. Overall, 27.8 per cent of households in the country are poor; 3.9 per cent are severely poor and 23.9 per cent are poor (Central Bureau of Statistics 2006). As is the case with the Gini coefficient, the level of poverty has dropped substantially since the NHIES of 1993/94 (Central Bureau of Statistics 2006). Poverty is rampant in regions based on subsistence farming or with a large share of subsistence farmers. Some 50 per cent of

households in Kavango in the northeast of the country are classified as poor, followed by Omusati and Oshikoto in north-central Namibia with a poverty ratio of 47 per cent. The industrialised and more developed regions, in particular Khomas (with the capital Windhoek), as well as Erongo and Karas, both characterised by mining, fishing and tourism activities, display poverty levels far below average, namely 3.6 per cent, 5.7 per cent and 18.5 per cent, respectively (Central Bureau of Statistics 2006).

Poverty has also a gender dimension as men and women are often poor for different reasons, experience poverty differently and have differing capacities to withstand and/or escape poverty. Gender inequalities and gender power relations interact with other inequalities and power relations to produce these differences. Studies have shown that female-headed households (FHHs) are poorer than male-headed ones. In Botswana, an estimated 50 per cent of FHHs are poor, compared with 44 per cent of male-headed households (BIDPA 2000). In rural areas, both male and female-headed households experience the same poverty rate. This is also true for Kenya. The 2005/06 Kenya integrated household budget survey indicates that the incidence of poverty in rural areas for male-headed households is estimated at 48.8 per cent and that of female-headed households of 50 per cent. The difference in poverty incidence, poverty gap and severity of poverty in the rural areas between male and female is not statistically significant. In urban areas, the poverty incidence in Kenya for male-headed households is estimated at 30 per cent and that of female at 46.2 per cent. Unlike the rural areas, the difference between the male-headed and female-headed household in urban areas is significant (Republic of Kenya 2007b). Though poverty literature, and indeed the experience of Botswana and Kenya indicate that poverty has a gender bias especially in urban areas, data for Namibia does not reveal any significant correlation between gender and the incidence of poverty (Naimhwaka 2007).

4. Poverty Reduction Strategies

Poverty reduction has been the focus of government policies for many years, prior to the call by the Bretton Woods institutions to HIPC countries to formulate Poverty Reduction Strategy Papers (PRSP). The preparation and implementation of deliberate poverty reduction strategies in Botswana, Kenya and Namibia marked the start of a policy shift from just pursuing high economic growth to pursuing high and sustainable growth with redistribution. As alluded to above, the high growth registered by these countries soon after independence did not reduce poverty. Poverty increased amidst high economic growth due to high inequality experienced by these countries at independence and even to date.

Kenya identified poverty, disease and ignorance as major constraints to human development that needed to be addressed by the post-independence government with the preparation of Sessional Paper No. 10 of 1965 (Republic of Kenya 1965). However attempts at addressing poverty in the first three decades after independence in 1963 remained macro. Major initiatives in Kenya as articulated in various Sessional Papers and five-year development plans include the following: land resettlement schemes in the 1960s after independence; provision of free basic needs (education and health) in the 1960s; promotion of rapid growth and creation of employment opportunities in the 1960 and 1970s; District Focus for Rural Development in the 1980s to open up rural areas to markets; and promotion of the informal

economy in the late 1980s which were regarded as having a high potential for alleviating poverty through the creation of employment opportunities. The government assumed that the benefits of growth from high performing sectors and regions could trickle down to benefit everybody. These assumption and belief in the “trickle down” process proved ineffective (Ikiara 1998). This was the basis of “redistribution with growth”, which became a popular slogan with the authorities. However, by the mid-1970s it was realised that the strategy was not producing the desired effects as the problems associated with a rapidly growing population, unemployment and income disparities were more apparent than they had been in 1963. The failure of economic growth to solve the problems continued to be observed in the 1980s and 1990s. In effect, although economic growth is no doubt a necessary condition for meeting basic human needs, it is not in itself sufficient to address poverty. With this realisation, the government shifted focus to pursuing sectoral policies, in addition to maintaining a stable macroeconomic framework. The failure of economic growth to solve the poverty problems necessitated a shift of policy focus to equity and resource distribution.

In 1999, Kenya prepared a National Poverty Eradication Plan (NPEP) for the period 1999 to 2015 as a government’s deliberate initiative to give prominence to poverty reduction efforts. The plan signalled the government’s resolve to address the poverty challenge not only as a political necessity and moral obligation, but also on grounds of sound economic principles that recognised the critical role and potential contribution of the poor to national development. In line with the goals and commitments of the 1995 Copenhagen Summit set out in the declaration of the World Summit for Social Development (WSSD), the government committed itself to the eradication of poverty, the achievement of universal primary education, various aspects of health for all, and the social integration of disadvantaged people. The NPEP has three major components: (i) a charter for social integration; (ii) improved access to essential services by low income households that lack basic health, education and safe drinking water; and (iii) a strategy for broad economic growth, with each setting out a framework for further action by government, civil society, the private sector and donor partners.

To implement the NPEP, the government prepared the Interim Poverty Reduction Strategy Paper (I-PRSP 2000-2003) in 2000 (Republic of Kenya 2000b). The I-PRSP outlined measures to improve economic performance and actions to reduce poverty by deliberately shifting the composition of budgetary expenditures towards priority poverty reduction programmes and empowering the poor by providing them with means to help themselves through income-earning opportunities, ready access to means of production, the provision of affordable basic services and the protection of the law. To mainstream the poor into the development process, the government, through a participatory process, prepared a poverty reduction strategy paper (PRSP) for the period (2001–2004). The PRSP informed the development of a pro-poor and pro-growth Medium Term Expenditure Framework (MTEF) budget that linked policy planning and budgeting, thereby ensuring harmonised financing of growth and poverty reduction (Republic of Kenya 2001). In 2003, the government prepared the Economic Recovery Strategy for Wealth and Employment Creation (ERS) 2003–2007. The ERS identified rapid economic growth; strengthening institutions of governance; rehabilitation and expansion of physical infrastructure; and investment in human capital as key policy actions to spur economic growth. To reduce poverty, the ERS focused on the

provision of Universal Primary Education (UPE), improved access to basic health, development of traditional overlooked arid and semi-arid areas, and upgrading of the living conditions of the urban poor (Republic of Kenya 2003). In 2007, Kenya prepared its Vision 2030 which aims at making Kenya a “newly industrialised middle income country providing a high quality life for all its citizens by the year 2030” (Republic of Kenya 2007b)

Like Kenya, the government of Botswana commitment to poverty alleviation is demonstrated by its endorsement of a series of United Nations global declarations for the improvement of human conditions. Most notably, Botswana is a signatory to the Millennium Declaration of 2000, and to the Copenhagen Declaration and Programme of Action for Social Development (1995), whose central goal has been the elimination of poverty through the enhancement of productive employment and fostering of social integration. Botswana is also signatory to the International Convention on the Rights of the Child (1990); the International Convention on the Elimination of all Forms of Discrimination Against Women (1979); the SADC Gender and Development Declaration; the International Conference on Population and Development (1994); and the World Food Summit (Rome 1996).

Botswana’s policy to eliminate poverty has been articulated, directly or indirectly, in a number of policy documents, including, but not limited to, National Development Plans, Vision 2016, the National Policy on Rural Development, and recently the National Poverty Reduction Strategy. The government of Botswana has adopted a three-pronged strategy towards poverty reduction: stimulation of economic growth through economic diversification, employment creation, income generation, citizen economic empowerment, and citizen entrepreneurship development; investment in infrastructural development and social services to enhance health and education outcomes as well as to stimulate economic growth; and the adoption of a system of social safety nets as direct measures to assist the ultra poor and vulnerable groups. These strategies are similar to those pursued in Kenya through the ERS namely: rapid economic growth; strengthening institutions of governance; rehabilitation and expansion of physical infrastructure; and investment in human capital. Like Kenya, the government of Botswana also prepared a National Strategy for Poverty Reduction (NPRS) in April 2003. The Botswana NPRS is not a “Poverty Reduction Strategy Paper” (PRSP) in its usual meaning and bearing. Botswana is actually one of the only two African countries that are net creditors of the Bretton Woods institutions and hence external assistance is playing a very limited role in the development efforts of Botswana. The strategy is home-grown without reference to IMF and World Bank conditionalities. Through the NSPR, the government underscores the importance of broad-based economic growth as a means to promote sustained poverty reduction. The key areas of development under the NSPR include: enhancement of sustainable livelihoods; human capabilities and participation in programmes by beneficiaries; strengthening of local government institutions; and creation of an environment conducive for investment.

The Namibian government was confronted with a dual society at independence in 1990. The well-off part of society living in towns and industrial centres in central and southern Namibia enjoyed a standard of living not much different from that of other parts of the developed world. The majority, mainly rural population has been deprived of the same benefits. In order to change this pattern, the government identified the following four main national development objectives, which are also similar to those pursued by Botswana and Kenya,

namely: poverty alleviation; reduction of income inequality; employment creation; sustainable economic growth. These priorities have not changed throughout the successive five-year National Development Plans (NDP) so far, starting with the Transitional National Development Plan, NDP1 (1995/96 to 1999/2000) and NDP2 (2001/02 to 2005/06). However, further objectives were added in NDP2, such as the reduction of regional disparities, the promotion of gender equality, the promotion of economic empowerment, and combating the further spread of HIV and AIDS. Besides the NDPs Namibia also prepared a coherent poverty reduction strategy, with technical assistance from the World Bank and financial assistance from the UNDP. Because of its status as a non-HIPC country Namibia was not bound to a prescribed PRSP format. The PRS identified long- and short-term measures to alleviate poverty and pointed out three main issues to be addressed: equitable and efficient delivery of public services for poverty reduction countrywide; equitable agricultural expansion, including consideration of food security and other crop development options; promotion of non-agricultural economic empowerment, including an emphasis on the informal sector and self-employment opportunities (Republic of Namibia 1998).

In addition to the NDPS, Namibia has also prepared its Vision 2030. The overarching objective of Vision 2030 is to lift Namibia up to the level of an industrialised, developed country by 2030. It is envisaged that Namibia at that time will be a prosperous, harmonious, peaceful and politically stable country; a country that has graduated from a natural resource-dependent economy to a producer of manufactured goods as well as of services. A constituent feature is that poverty would be reduced to a minimum, the existing pattern of income distribution equitable and disparity at a minimum (Office of the President 2004). Vision 2030 follows the topics identified in the PRS, namely becoming a transport hub for Southern and Central Africa, investing in people to achieve the transition from a resource-based economy to a producer of manufactured goods and services. While this is the long-term goal, expanding the social safety net and supporting income-generating activities through SMEs, tourism and smallholder crop cultivation are the means (Office of the President 2004). Vision 2030 for Namibia acknowledges that growth alone would not be sufficient to reduce poverty; it needs to be translated into a redistribution of wealth to create a more equal society and equal local purchasing power in order to increase the contribution of local demand to economic growth.

Efforts to address poverty in these countries centre on economic growth and economic empowerment of the people. The rapid growth of the economy is not only regarded as a key solution for poverty, but also to unemployment, poor health, economic exploitation and inequality. For this reason the governments' stated economic policy tended to place emphasis on the promotion of rapid economic growth, equality in the sharing of economic growth benefits and the reduction of extreme imbalances and inequalities in the economy as the main goals of economic development. However, experience of countries has shown that growth alone could not address the problem of poverty. For growth to benefit all, there is always need for a deliberate policy to redistribute its benefits. This is because, although economic growth is a necessary condition for meeting basic human needs, it is not in itself sufficient, due to high levels of inequality which ensures that only a few individuals reap a disproportionate part of the gains from the high economic growth, while the majority languish in poverty. The failure of economic growth to solve the poverty problems necessitated a shift

of policy focus to equity and resource distribution. As a result of high level of inequality, the rich have no doubt reaped more benefits associated with high economic growth. Nonetheless, the average citizen has also benefited from the phenomenal economic growth through provision of social services in the form of health facilities, free education, clean water and other welfare services. Efforts to reduce poverty in Botswana, Kenya and Namibia through provision of these social services are articulated below.

4.1. Education and Literacy

Education plays an important role in human development by empowering people to improve their well-being through increasing their productivity and potential to achieve higher standards of living. Education has been a priority for Botswana since independence. Remarkable achievements have been made in primary and junior secondary schools alike. At both levels enrolment rates are close to 100 per cent, with girl pupils outnumbering boys. Adult illiteracy has fallen below 20 per cent for both males and females. It is estimated that in 2003, 81.2 per cent of the population were literate, with a larger percentage of females (81.5 per cent) than males (76.1 per cent) being literate. Literacy levels in urban areas tend to be higher than in rural areas: in 2000, 83.3 per cent of those in urban areas were literate compared with 64.1 per cent in rural areas (UNDP 2005). Further, literacy rates for adults (15 to 65+) increased from 68.9 per cent in 1993 to 81 per cent in 2003 and reached almost 90 per cent in 2006. The 2004 Status Report of the Millennium Goals concludes that Botswana has achieved universal access to primary education, which currently consists of a ten-year basic education system (Government of Botswana /United Nations 2004).

Like Botswana, education policy has remained central in Kenya's development process. Kenya considers education a basic right and basic need because of its importance for human development. Kenya has pursued mixed policies in education: Immediately after independence, Kenya offered free education which was however reversed and cost-sharing strategies in education were introduced in 1986. Cost sharing limited the access of children from poor households to schools thereby forcing children to drop out of school, especially the girl child. Other factors that affected education include: Inadequate schools and facilities; an inadequately designed education system, which is particularly unsuitable for those engaging in a pastoralist or nomadic lifestyle; low level of awareness among pastoralist communities on the importance of education; and discrimination against the girl child in education, particularly as a result of negative cultural norms and taboos, and also the excessive work load that is placed on women in general. In addressing the above problems, the government has given autonomy to the schools and districts in the recruitment of teachers. Under the WFP lead Emergency Operations (EMOP) programme in the drought-affected ASAL area there has been an expansion of the school feeding programme. Its coverage grew from 350,000 to over 1.1 million students. In 2003, the government reintroduced free primary education and started to provide for books and since 1993/94, the government has been providing bursaries and loans to poor and needy students, both of which are meant to reducing the cost of education to the poorest. The policies implemented by the government of Kenya are geared towards the attainment of Universal Primary Education (UPE) and Education for All (EFA), both of which are in line with the MDGs.

Overall public expenditure in Kenya on education as a share of GDP increased from 5.9 per cent in 2002/03, to 6.2 per cent in 2005/06 which translates to an average expenditure of 25 per cent of total government expenditure (Republic of Kenya 2006c). Over time, literacy levels have improved in Kenya but below the levels so far achieved by Botswana and Namibia. Results of the Kenya National Adult Literacy Survey (KNALS) conducted in 2006 indicate that the national level literacy rate is 61 per cent and the numeracy rate is 64.6 per cent. Males have a higher literacy rate than female estimated at 64.2 per cent to that of female estimated at 58.9 per cent. Similarly, male numeracy is higher at 67.9 per cent compared to that of females, at 61.4 per cent. The figures reveal that as of 2006, an estimated 7.8 million Kenyans adult population (15 years +) was illiterate. There exists wide regional differential with Nairobi province having the highest literacy and numeracy rates of 87.1 per cent and 86.6 per cent, respectively and North Eastern, which also happens to be the poorest province, with the lowest literacy and numeracy rates of 8.1 per cent and 9.1 per cent, respectively (Republic of Kenya 2007a). In terms of dealing with the quality of facilities and physical access to education, the Ministry of Local Government through the Local Authorities Transfer Fund (LATF) and members of parliament through the Constituency Development Fund (CDF) have significantly contributed to the expansion of school facilities and made it possible for children from poor families to access education through provision of bursaries.

Namibia also identified the social sectors as a priority after independence. Investment in education has resulted in increased literacy and enrolment rates and a drop in the share of people who never attended school. However, there are still some worrying signs. Net enrolment rates declined in the late 1990s. Drop-out and repetition rates remain high and subsequently the transition rates from junior secondary to senior secondary and further to tertiary education are low. In addition, the proportion of Namibian learners that could not read with any level of proficiency increased from 69 per cent to 76 per cent between 1995 and 2000. The private sector has repeatedly expressed concern about the adequacy for the labour market of the skills and knowledge acquired at school. These are challenges the government is going to address with the support of international cooperation partners over the next 15 years through its Education and Training Sector Improvement Programme. The first five-year phase of the programme covers the period 2006/07 to 2010/11 and is meant to run concurrently with the National Development Plan III (NDP3). Education commands and still continues to command one of the largest shares of the budget, estimated at 19.4 per cent of the total national budget is allocated to education, including school hostels. Excluding school hostels, the share stood at 17.5 per cent (Schade and Naimhwaka 2004).

4.2. Health Care

There is a two-way relationship between health care and poverty - poverty means an increase in health care costs due to disease prevalence caused by lack of education on preventable diseases as well as nutritional habits; on the other side sick people will not be economically productive hence intensifying poverty. Therefore, good health is seen as reducing poor families' economic and social vulnerability, thereby providing a healthy and productive labour force for the nation to create broad-based economic growth. Good health enhances productivity and self reliance. Botswana has achieved remarkable advances in the

health status of its population since 1966. There has been expansion of health services through government investment in health infrastructure and in the training of health personnel. Health expenditure in the past two decades has averaged 5-8 per cent of the national budget. Given the need to serve a sparsely distributed population, most of the investment in physical health infrastructure has gone into developing an extensive primary health care outreach system.

The steady increase in health spending reflects the commitment of the government to providing improved health services and fighting HIV/AIDS. Botswana's health care services were hospital-based until 1973, when the government accepted primary health care (PHC) as the most appropriate strategy for the attainment of health for all. The concept PHC is based on promotive, preventive, curative and rehabilitative health care services. This strategy has been followed in the past in national development plans as well as in the current NDP 9 (2003/04-2008/09). Access to health care is generally good, with almost 90 per cent of the rural population now living within 15 kilometres of a primary health clinic (EU 2006). There is a standard Botswana Pula 2 (USD 0.40) charge for outpatient treatment and first-line hospital care, but many sections of the population are exempted from payment: pregnant women, TB patients, HIV/AIDS patients and children under 12 are entitled to free treatment. Botswana faces one of the highest rates of HIV/AIDS, which increases the incidence of poverty due to the inability of the sick to work or to the demanding care for the sick, as well as to the loss of breadwinners for many households. The most recent sentinel survey shows that HIV prevalence had decreased from 37.4 per cent in 2003 to 32.4 per cent in 2006. HIV prevalence is below average among the group aged 15-19 years, and decreased from 22.8 per cent in 2003 to 17.8 per cent in 2005. The Prevention of Mother to Child Transmission Programme provides drugs to 73 per cent of pregnant HIV-positive women. Patients enrolled for anti-retroviral drug (ARV) treatment in 2005 increased to 54,378 compared to 32,835 in 2004. In 2004, there were an estimated 260,000 people living with HIV. The 2004 Botswana AIDS Impact Survey showed the overall HIV prevalence rate to be 17.3 per cent (population-based rate). There are some 60,000 registered orphans and about 200,000 orphans are projected for 2010 (Central Statistical Office 2004; UNAIDS 2006). The share of HIV/AIDS budget allocations in Botswana as a percentage of the total budget was almost two per cent in 2002/03 and has since hovered around one per cent of the total budget.

There has been a significant improvement in health and survival indicators in Botswana. Infant mortality fell from 95 to 56 deaths per thousand between 1970 and 1995. However, this figure subsequently rose to 80 deaths per thousand, as a direct consequence of HIV/AIDS. The infant mortality rate has been reduced from 80 per 1,000 births in 2000 to 54 per 1000 births in 2006 while under-five mortality increased from 58 per 1,000 births to 101 per 1,000 births. One of the factors influencing the indicators is the fact that some 99 per cent of births are attended by a trained health worker. Maternal mortality, however, which stands at 330 per 100,000 live births, is still relatively high for a middle income country. Health care services tend to be more easily accessible in urban areas than in rural areas. These disparities reflect, in part, the long distances which people have to travel in remote areas to reach health facilities. This fact reinforces household poverty.

The provision of primary health care to all citizens has been one of the goals of the Government of Kenya. Like education policy at independence, the government provided for

free medical services until 1989 when cost sharing was introduced. The health sector objective is to enhance the accessibility and affordability of quality basic services for all Kenyans, with special emphasis on the poor and vulnerable. To achieve these, the health budgetary provision continues to increase and is estimated at seven per cent of total government expenditure; the government is implementing the 2005-2010 health strategic plan which aims at reducing health inequalities across the country, strengthen capacity of district and provincial hospitals and restructure the Kenya medical supplies agency. Nonetheless, reforms in the health sector have not been as effective in Kenya as those in Botswana and Namibia. This is because infant mortality rate has increased to 77 per 1,000 in 2003 from 62 in 1993, the under-five mortality rate increased to 115 per 1,000 in 2003, full immunisation coverage declined to 60 per cent from 65 per cent in 1998 and the children receiving no vaccination increased from three per cent to six per cent in 2003. The only positive indicator in this category of mortality indicators in Kenya is the maternal mortality rate which declined to 414 in 2003 from 590 maternal deaths per 100,000 in 1998 (Republic of Kenya 2006b). Compared to Botswana and Namibia, the mortality rates in Kenya are unacceptably high, especially taking into account that Kenya's population is more than seventeen times that of Botswana and Namibia. Equity and efficient principles are the main drivers of the government of Kenya's policy on public spending. The key spending and resource allocation objectives include increased allocation of resources to rural health services, increase spending on drugs and non-pharmaceuticals, reduced spending on curative services and tertiary-care facilities.

The HIV and AIDS pandemic has further constrained the achievement of accessible and affordable health care as it is a drain on public and private resources. Since the first case was diagnosed in 1984, HIV and AIDS spread rapidly in Kenya during the 1990's reaching prevalence rates of 20-30 per cent in some areas of the country. It is further estimated that over 1.5 million people have died due to AIDS-related illnesses, resulting in 1.8 million children left as orphans. It is estimated that a total of 1.4 million Kenyans are infected with HIV, of whom about two thirds are women. The gender difference is most pronounced among young people. In the 15-24 age range, female prevalence is nearly five times higher than male prevalence. AIDS is impacting disproportionately the young people (aged between 15- 24). Already, life expectancy has dropped from 60 years in 1993 to about 47 years in 2004 mainly due to AIDS. Overall, average urban prevalence is estimated at 10 per cent, which is almost twice that in rural areas estimated at 5.5 per cent (Republic of Kenya 2005). With the realisation that AIDS affects health, lifespan, and productive capacity of the individual and severely constrains the accumulation of human capital and its transfer between generations, Kenya declared AIDS as a National Disaster in late 1999. Increased awareness campaigns have seen trends in HIV and AIDS reversed. Estimates from the Kenya Demographic Household Survey (KDHS) conducted in 2003 and sentinel surveillance data reveal that national prevalence has declined significantly to seven per cent (Republic of Kenya 2005).

The government of Namibia has implemented various programmes to curb the spread of HIV infection, ranging from awareness creation to provision of treatment to prevent the transmission of the virus from mother to child, as well as the provision of anti-retroviral treatment. New health clinics and health centres have also been constructed, especially in

rural areas to improve access to health facilities, while the number of hospitals was reduced in line with government's emphasis on primary health care rather than the provision of specialised treatment. Overall expenditure on health accounted for about 10 per cent of the national budget (Schade and Ashipala 2004). The 2002 Namibia Demographic and Health Survey (NDHS) revealed that infant mortality per 1,000 improved from 57 in 1992 to 38 in 2000; under-five mortality per 1,000 improved from 83 to 62; child mortality per 1,000 also improved slightly from 28 to 25 and immunisation coverage improved from 58 per cent to 65 per cent. Further, the same survey revealed that maternal mortality per 100,000 live births worsened from 225 to 271 (Ministry of Health and Social Services 2003).

The achievements in Namibia between 1992 and 2002 have however been eroded by the HIV and AIDS epidemic resulting in a substantial drop in life expectancy. The HIV prevalence rate was on a steady increase until 2002, but dropped in 2004 to 19.7 per cent compared to 22.0 per cent in 2002. This was however short-lived as the Sentinel Survey for 2006 recorded a slight increase in the prevalence rate to 19.9 per cent. Besides HIV and AIDS awareness campaigns, the government started a pilot project in two state hospitals to prevent the transmission of HIV from mother to child. The treatment has subsequently been scaled up to include all state hospitals. In addition, all state hospitals provide anti-retroviral therapy for HIV positive patients in need. In 2006 more than 20,000 patients are receiving such treatment and the proportion of pregnant women visiting antenatal clinics who agree to be tested for HIV has increased from 10 per cent five years ago to 90 per cent. Furthermore, over 75 per cent of women who deliver babies know their HIV status (*The Namibian*, 13 April 2007). This indicates a remarkable change in attitude towards HIV and the stigma attached to it.

4.3. Water and Sanitation

Access to water and good sanitation are central to reducing poverty. In Botswana, almost 100 per cent of the population is said to be currently enjoying access to safe drinking water. In 1983, almost 84 per cent of urban dwellers had access to safe drinking water, rising to 100 per cent by 1988. Similar progress has been made in rural areas. In 1983, only 46 per cent of the rural population had access to safe drinking water. By 2000, however, the coverage had reached 90 per cent and 97 per cent by 2006. Equally impressive achievements have also been registered in the expansion of sanitation and other social and economic infrastructures. The government of Botswana provides sanitation services with the aim of improving the general public health conditions of the Botswana. A major step in that direction has been the passage of the Waste Management Bill of 1998, in terms of which a sanitation and waste management department was established. In 1983 only 51 per cent of the population were using adequate sanitation facilities. By 2006, almost 80 per cent of households were using adequate sanitation facilities. Though there are disparities between rural and urban areas, access to sanitation in rural areas has been improving over time through the government's intervention programmes under which rural households were subsidised to build latrines.

Kenya is below Botswana and Namibia in achievements in water and sanitation. Kenya failed to realise its policy of 'water for all by the year 2000' as had been envisaged in

government policy documents prior to year 2000. Nonetheless, the policy still remains central in current government policy. This is because water and sanitation affect agriculture, livestock and health sectors. In an effort to fulfil the water for all policy, the government of Kenya acting on the Water Act 2000 has established a number of institutions to include: the water services board; the water services regulatory board, the water service trust fund, resources management authority, among others. Besides, the government has, as of 2005, commercialised water services in Nairobi, Nyeri, Kisumu, Nakuru, Eldoret and Meru; its has rehabilitated 45 hydrological and quality water monitoring stations and rehabilitated and augmented water and sanitation schemes - 32 water supply and 44 sanitation schemes. In rural areas and Arid and Semi-arid (ASALs) the government completed rehabilitation of 83 rural water supply schemes and 150 small dams and water bans in 44 districts of ASALs; it drilled 39 boreholes and completed rehabilitation and construction of flood dykes in Nyando and river Nzoia as well as rehabilitation and augmentation of Yatta irrigation canal. Overall, 53 per cent of the rural population and 75 per cent of the urban population have access to safe and reliable water (Republic of Kenya 2006 b). In terms of sanitation, the government through LATF and CDF and development partner has constructed latrines in slums areas, markets places and bus stops.

In Namibia, the communal areas were particularly neglected in terms of basic infrastructure during the apartheid era. Hence, the government has focused on providing water, and proper sanitation to these areas. Households' access to safe drinking water and toilet facilities has increased over the years. Estimates for 2003/04 indicate that 87 per cent of the population have access to safe water, up from 65 per cent in 1991 and that households with no access to toilet facilities declined from 61 per cent in 1991 to 53 per cent in 2003/04 (Republic of Namibia 2003; Central Bureau of Statistics 2006).

5. Conclusions

The previous sections spell out the strategies that governments have undertaken to reduce poverty. Growth is regarded as key to poverty reduction. However, as experience of Botswana, Kenya and Namibia have shown economic growth on its own failed to trickle down to benefit all and effectively reduce poverty. This is attested by the high poverty levels in Botswana in spite of high and sustained economic growth rates of seven per cent. High inequality levels registered in Botswana, Kenya and Namibia is one of the many reasons why growth has not been effective in poverty reduction.

Growth is no doubt a prerequisite to poverty reduction. However, poverty has been found to hamper economic growth. This is so because the poor are in no position to engage in many of the profitable activities that stimulate investment and growth, thus creating a vicious circle in which low growth results in high poverty and high poverty, in turn, results in low growth. As attested by poverty levels and country growth rates, discussed above, reduction in poverty rates has been lower than anticipated, even when countries registered relatively high growth rates.

Realisation by governments have that growth alone could not address poverty, made them change focus and design targeted programmes to provide social services as a means of

reducing poverty. Government embarked on programmes to provide social services (targeted programmes are in education, health and HIV and AIDS, water and sanitation) as a means of reducing poverty by improving the capacities of the poor to increase their income-earning capacity and to protect their own health. The provision of education directly alleviates human capacity poverty and indirectly alleviates income poverty and broadens individuals' range of choices. Education plays an important role in human development by empowering people to improve their well-being through increasing their productivity and potential to achieve higher standards of living. Health has been found to exhibit a two-way relationship between health care and poverty - poverty means an increase in health care costs due to disease prevalence caused by lack of education on preventable diseases as well as nutritional habits; on the other side sick people will not be economically productive hence intensifying poverty. Therefore, good health is seen as reducing poor families' economic and social vulnerability, thereby providing a healthy and productive labour force for the nation to create broad-based economic growth. Good health enhances productivity and self reliance. These programmes are linked to growth of the economies in terms of budgetary provisions and are aimed at empowering the poor to be economically active in the long run. Provision of water and sanitation has forward and backward linkages with the provision of education and health.

Data from household surveys indicate that with the introduction of targeted programmes, poverty is substantially reduced across countries, albeit slowly. Literacy levels are on the increase; inequality within and between regions is on the decline; modalities have been put in place to address HIV and AIDS pandemic, and child mortality, under-five mortality and maternal mortality are on the decrease; and government having been providing water and sanitation infrastructure. As envisaged in countries long-term strategic plans (Vision 2016 for Botswana and Vision 2030 for Kenya and Namibia) that endeavour to transform countries into newly industrialising status by the end of the plans, poverty might be reduced to societal acceptable levels if the objectives of the plans are realised. That is, if countries achieve high sustainable economic growth rate and implement effectively modalities to redistribute the growth to other sectors that economically empower the poor.

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Appendix – SEAPREN Publications as per 23 October 2008

Publication ID	Title	Authors	No. of Pages	Year Published
SEAP11	Growth and Poverty focus of the PRSPs in HIPC Countries: the Case of Tanzania, Uganda and Zambia	Thomson Kalinda		2008
SEAP10	Effects of Economic Growth on Poverty Reduction: Experiences from Botswana, Kenya and Namibia	Lineth N.Oyugi	23	2008
SEAP9	Development of Budget Systems and Practices in sub-Saharan Africa	Oswald Mashindano		2008
SEAP8	Budget Processes and Transparency in Southern and Eastern African Countries	Charity K. Kerapeletswe Rehabeam Shilimela	43	2008
SEAP7	Experiences with Medium-Term Expenditure Frameworks in Selected Southern and Eastern African Countries	Lineth N.Oyugi	18	2008
SEAP6	Access to Financial Services and Poverty Reduction in Rural Kenya	John M. Mutua, Lineth N. Oyugi	37	2006
SEAP5	Poverty Alleviation in Rural Namibia through Improved Access to Financial Services	Jonathan Andongo, Mariama Deen-Swarray	42	2006
SEAP4	The Budgetary Process and Economic Governance in Namibia: Literature Review	Rehabeam Shilimela, Erwin Naimhwaka	32	2005
SEAP3	The Budgetary Process and Economic Governance in Zambia: Literature Review	Dale Mudenda, Manenga Ndulo, Mukata Wamulume	42	2005
SEAP2	The Budgetary Process and Economic Governance in Kenya: Literature Review	Lineth Nyabokey Oyugi	26	2005
SEAP1	The Budgetary Process and Economic Governance in Southern and Eastern Africa: Literature Review	Odd-Helge Fjeldstad, Dirk Hansohm, Jan Isaksen Erwin Naimhwaka	44	2004