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Provision of Services and Poverty Reduction

The Case of Botswana

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Introduction

Social services constitute an integral part of a country's welfare system. The Botswana Government has, since independence in 1966, delivered varying mixtures of infrastructure, goods and services to Batswana with a view to mitigating poverty and improving the quality of life. To this end, massive investments were made in education, health, housing, water and sanitation because it was believed that such spending would lift people out of poverty. There is ample evidence to suggest that most people benefited from social services referred to above. However, there have been concerns that social provision has generally been unable to make a significant impact on poverty reduction for the majority of Batswana, especially those living in rural and remote areas. Today, while some stakeholders argue extravagance in social expenditure, others point out that, relative to empowering the poor, the outcomes are not encouraging. There is a growing concern that, for the funds spent, not enough is gained in terms of enhancing overall quality of life by reducing levels of poverty.

This paper examines the link between provision of social services and poverty reduction. In particular, the paper seeks to provide some answers to the broad social development question: does investing in social services reduce poverty? The analysis will present evidence from Botswana, paying particular attention to issues relating to educational expenditure, quantity, quality, access and policy reforms in the social sector. An examination of these issues is useful in assessing the extent to which provision of social services have contributed to poverty reduction. Data for this paper were drawn from desk-top review of the literature on poverty and social services in Botswana, review of Government of Botswana official policy documents (i.e. National Development Plans-NDPs), and Census data. The review focused primarily on official documents on education, health, housing, water and sanitation. This was complemented by in-depth face-to-face interviews with key informants such as policy-makers, implementers and/or service providers and some beneficiaries.

This paper adopts a welfare regime approach in the analysis of the role social services provision in poverty reduction in Botswana. The paper consists of five (5) main parts. The first part focuses on provision of educational services. The second part of the paper is about provision of health services. Part three and four focuses on housing, water and sanitation respectively. Finally, the fifth part of this paper pulls together and summarizes salient issues (with implications for poverty reduction) in parts one, two, three and four. In particular, it examines key issues relating to equity, access, synergies between the different services and policy reforms. The paper concludes by reiterating the role of social services in poverty reduction, focusing on education, health, housing, water and sanitation.

Background and context

This paper has been written at a critical stage in the history of Botswana when the country is experiencing a period of rapid social, economic and political change. Forty years after Independence, Botswana has achieved most of its social and economic

development goals as well as some of the Millennium Development Goals (MDGs). While other countries in Africa (with the exception of South Africa and Mauritius) are still working towards achieving the Millennium Development Goal number 2 (MDG #2) i.e. achieving universal primary education – Botswana has long achieved it and is now working towards universal secondary education by 2016. As such, Botswana has found a place as a respected member of the international community.

Research over the past three decades has shown that Botswana has made tremendous efforts to reduce poverty. For example, the government has designed and implemented a wide range of social policies and programmes to reduce the incidence of poverty and mitigate its impact. Most have focused on creating opportunities for both wage and self-employment for citizens through provision of universal education. Major policies introduced include the Rural Development Policy, 1972 (revised, 2002) and the Education Policy (Education for Kagisano, 1977) revised 1994. In addition, social welfare services were provided to the needy through different policies and programmes such as the Destitute Persons Policy (1981) revised in 2002, the Remote Area Development Programme (1978) and the Orphan Care Programme (2001). These policies and programmes were designed to address socio-economic transformation of both the rural and urban sectors of the economy with a view to improving the overall quality of life for all Botswana citizens. A review of the different social policies reveals that their implementation has transformed the economy and contributed significantly to a general improvement in the quality of life. While government was able to make headway in this respect, there have been some challenges; including a more pronounced gap between rich and poor. This obviously has influenced the nature of social services provision and approaches to poverty reduction.

Social policy agenda in Botswana has been shaped, to a considerable extent, by both internal and external factors. External factors include: falling commodity prices, unfavorable trade relations and pressure to conform to international influence and expectations. The international community, represented by bodies such as UN agencies, international NGOs and donor agencies, has also dictated the tempo and character of social policy and provision of social services in Botswana. These bodies have directly or indirectly put pressure on the government of Botswana to institute certain reforms in some public policies consistent with global trends and expectations. For instance, since poverty has become a central feature of the international development agenda, international financial institutions and bilateral donors now require recipient's government in developing countries to develop strategies that will reduce the incidence of poverty in their societies. Internally, the development of social policy and subsequent provision of social services has been intrinsically linked with the development and adoption of different welfare regimes and ideological orientations used to guide broad socio-economic policies adopted by the state, at different points in the country's history, to address poverty. Understanding the above factors will help answer the following questions: What influences social provision? What institutional frameworks determine the nature of welfare regime and instruments for social provision and what effects do these have on poverty reduction?

Historical Background: Shifting welfare regime approaches, institutions and policy frameworks

This section adopted a historical perspective to explain the nature, evolution and structural shifts in the policy regime and provision of social services in Botswana. Provision of social services in Botswana has a history that is tied directly to the nation's history. In the pre-colonial and colonial period, response to need was situated within the traditional tribal framework, with the extended family playing a major role. The family, neighbors, community members and the chief played a pivotal role in this regard. Children, the poor, the aged and the disabled were cared for by various members of the family in a fixed order of responsibility. Provision of such essential services as education, health, housing, and water were the responsibility of household heads assisted by relatives, neighbors and other members of the community. Tswana societies then were relatively self-sufficient agricultural economies. Poverty was not widespread and, where it existed, was addressed by the welfare regime of the time or traditional welfare structures. However, since independence (and due to urbanization, migration and other social change factors), these forms of social security have been weakened or have disappeared. The Government is now faced with challenges to provide more formalized services and hence the need for statutory policies to inform and guide such programmes.

Botswana policy regime and provision of social services can be divided into two major historical epochs. Two major phases in terms of ideological direction which have impacted on the social policy agenda and provision of social services in the country's history can be discerned. The first phase constitutes the economic and social policies adopted during the first two decades after Botswana attained independence (the period between 1966-1980). This period is referred to as the Sir Seretse Khama regime (Seretse is the founder and first President of the Republic of Botswana. He died in 1980). The policies adopted during this period were mainly initiated and implemented by the Government with only limited community or private sector involvement. Highly centralized, state led government interventions promoted what is often referred to as the "trickle down" theory of development. The thrust of this theory was to promote capital investment in the mining and other productive sectors of the economy with a view to reinvesting the benefits accruing from such investment in social development. During this period, formulation of social policy and subsequent provision of social services was a preserve of the Government. To this end, the process of social policy formulation was dominated by the central government, particularly, the Ministry of Finance and Development Planning (MFDP). The ministry has overall jurisdiction over the formulation of national development plans. Input from other players such as district and village level institutions, non-governmental organizations and the private sector was minimal. The foundations of social policy and provision of social services was laid and the stage was set to provide services to all Batswana. This was made possible by a growing healthy economy. For example, economic growth more than doubled between 1966-1980 – growing from 7 % in 1966 to about 15 % at the end of the 1960s and thereafter maintaining a steady double digit for almost two decades.

During this period, social welfare was not associated with any particular class of people or specific communities, but with a polity and the nation as a whole because Botswana

was generally very poor. Social policy strategies tended to focus on how to get the country out of poverty and build a national economy that would grow rapidly and in a sustained manner to achieve a universal rise in the living standards of all citizens. In succeeding decades and in the context of rapid economic growth and widening income differentials, poverty (and hence the need for welfare provision), came to be perceived as a problem affecting certain classes of people. Such people were categorized in terms of their employment situation, sources of livelihood, resource capacity, gender and geographical location. The changes in perceptions were accompanied by changes in the welfare regimes to respond and deal with the challenges identified at different times in the history of Botswana, for example, the Remote Area Development Programme (RADP) in 1978 to improve the living conditions of the poverty stricken communities of remote area dwellers, the majority of whom were Basarwa, a marginalized ethnic minority in Botswana. They were provided with education, water supply, health care and other basic necessities such as food, shelter and clothing. Many are believed to have survived on government social provisions from the 1980s to date. The development of the RADP has been seen as a significant poverty reduction strategy.

The second phase (the period 1980 - 1990; 1990 -2007) was a period of transition and social transformation. The new President came into power – President Masire. He adopted similar policies to that of his predecessor with very slight structural changes to the economy. The status quo remained, except the move towards privatization and a change of responsibility by Government from being a provider to being a facilitator. Some major shifts occurred after Masire's term of office expired in 1998 and the coming in of the Mogae regime (President Mogae is the incumbent President of the Republic of Botswana. He will retire in March, 2008 to give way for his vice Ian Khama). This period involved the development of socio-economic policies guided to a large extent by market forces and "globalization of ideas". Notably, these changes have necessitated some shift in the socio-economic strategy of the day with a direct bearing on the development of social policy and resource allocation for public spending on such social services as education. The government has since openly embraced a private sector led open market strategy. It is important to point out that, prior to the 1990s, the Government had always been identified with a centralized, heavy handed approach. There is now an aggressive move towards decentralization, less government intervention and a more liberal approach that allows other players to participate actively in provision of essential social services. This approach has meant that the Government has now assigned the private sector and communities a considerable role in the initiation and provision of social services in a cost-effective manner. Government's role is to facilitate community and private sector efforts to provide social services in the area of education, health, housing and water. The extent to which the market approach is followed is becoming very clear. The government has introduced a number of reforms including the liberalization of exchange controls and reduction of company taxes consistent with IMF and World Bank prescriptions. In the arena of education, health, housing and water cost sharing measures such as the re-introduction of user fees and grant loan schemes in education and housing, have been introduced.

It is important to acknowledge that the impact of HIV and AIDS since 1985 is significant in the history of social services provision in Botswana. The advent of the epidemic necessitated a major shift in terms of policy on social spending. Prior to this, social expenditure, especially on education, had always accounted for the highest single percentage (about 45-55%) of total social spending, and a very large share of total public spending (around 17-18%). At present, and because of HIV and AIDS, an enormous amount of funds are being diverted to programmes dealing with prevention, treatment, mitigation, support and care of those infected and affected by the pandemic. For example, programmes such as Community Home Based-Care, Orphan Care and a focus on poor people with chronic illnesses as well as people with disabilities had to be put in place at phenomenal cost, compromising spending in education and other social service areas (Budget Speech, 2007). In addition, labor productivity is adversely affected by high levels of mortality among the workforce -a serious draw back for efforts aimed at poverty reduction.

In addition to the above challenges, it is important to point out that, Botswana is a drought prone country. Immediately after independence in the 1960s, the country was hit by what has been described in some quarters as " the worst drought in living memory". Livestock and crops were wiped out and many people impoverished. For example, drought was declared from 1966-1970; 1979-80; 1981-87; 1990-94; 2006-07. In response, the Government introduced "food for work" drought relief programmes to mitigate the impact of poverty. With each succeeding drought, these programmes became a permanent feature of the economy and have been credited with providing social security for the poor and vulnerable, hence a significant strategy for addressing the needs of the drought induced poor. However, research has shown that, although drought relief programmes have succeeded in keeping people alive, they have proved less successful at permanently reducing vulnerability to drought. Most beneficiaries return to a life of poverty when the drought ends and drought relief programmes are discontinued (Duncan et. al, 2000).

Educational development in Botswana 1966-1990

This section will focus on provision of educational services and examines principles that govern how they are provided (for example, universal coverage versus targeting). It will assess the extent to which educational services provided under the different welfare regimes protect and promote the wellbeing of the poor. By examining key issues relating to quantity, access and quality of services and linking them to such variables as spatial location, ethnic origin, and gender, this analysis will demonstrate the effects of education on poverty reduction. The most important question is – does investing in education reduce poverty? The critical issues which will be addressed are, the relevance of services provided; are they of good quality and able to satisfy the needs and aspirations of the poor? Do they address issues of equity and wider coverage? Are the services pro-poor and hence will they respond effectively to pervasive poverty and inequality amidst affluence? Also included will be an exploration of current educational policy reforms and their implication for enrolments and the quantity and quality of education. Answers to these questions are useful in assessing the extent to which provision of education in Botswana has contributed to poverty reduction in both quantitative and qualitative terms.

In Botswana formulation of policies is informed and guided by four national principles namely: democracy, unity, development and self reliance. These principles are rooted in the traditional culture of Botswana and, when applied together in practice, are supposed to achieve the national philosophy of KAGISANO which means "social harmony". Broadly speaking, KAGISANO embraces concepts of social justice, interdependence and mutual assistance. These principles have been emphasized and used in the various National Development Plans (NDPs) since independence. Through them, the Government of Botswana has committed itself to achieving four national planning objectives, namely: Rapid economic growth, Social justice, Economic independence and Sustained development.

The policies that have guided the field of education in Botswana derived their impetus from the above principles and development strategies. These principles have influenced all social and economic development planning since NDP 1 (1968-1973), and all subsequent development plans have been guided by these fundamental principles. The education system has also adopted the "letter and spirit" of the four guiding principles.

As a long tem strategy, the post-colonial government adopted the Transitional Plan for Social and Economic Development (1966-1969) which was aimed at making Botswana a financially viable entity within the shortest possible time. Government was very specific as to how the noble aims articulated in the transitional plan would be achieved. The first priority was to invest in mining so as to achieve rapid and large returns which could be ploughed back into improving the living standards of those who did not benefit directly from the mining sector.

It was anticipated that with the adoption of such a plan, the country will be able to address some of the major problems and challenges at the time. For example, at independence, Botswana was among the 25 poorest countries in the world with a per capita GNP of less that US$50. Education services were rudimentary and inadequate. Available schools, built mainly by missionaries and tribal regiments, were very few and crowded. There was no comprehensive education policy. The educational system inherited at independence was among the least developed in Africa. According to Duncan et al. (2000) in 1966, about 75 000 or half Botswana's children of primary school ages were enrolled at school. The quality of education was poor and most children did not complete primary school level. In 1966 there was only one government financed secondary school and most other educational and training institutions that existed were largely the result of initiatives by missionaries and through self-help. According to Hedenquist (1992) only 30% of the school going population was in primary school and about 1000 children were attending secondary schools. At independence Botswana had only 40 graduates.

Fortunately, the strategy referred to above worked in part in that, within seven years of Botswana's independence, the country achieved budgetary self-sufficiency. Economic growth more than doubled between 1966 and 1969 – growing from 7 % at independence to 15 % at the end of the 1960s. The stage was therefore set to undertake major policy initiatives to improve the quality of life for a majority of the people. The first all

embracing official government policy document on rural development was published in 1972 (National Policy on Rural Development - Government Paper No.1 /1972). The main aim of rural development was to increase basic social services and promote social justice. Given the exigencies of rural development, the 1972 policy was revised during the same year and an Accelerated Rural Development Policy was introduced in 1973. The Accelerated Rural Development Policy sought to expedite provision of basic social and economic infrastructure in the rural areas. In the area of education, the main focus was on provision of educational infrastructure such as schools, equipment and accelerated training of teachers. These efforts were continually reviewed in the light of the changing socio-economic environment which led to the formulation of the first National Policy on Education (NPE) in 1977.

Contextual and ideological issues

In addition to the national principles that guided Botswana's developmental path, it is important to recognize the influence from international organization such as UNESCO and the World Bank (WB). An interesting development in Botswana education is that the Transitional Plan adopted to guide Botswana's development immediately after independence did not put emphasis on primary education. The plan gave priority to secondary education. How is this preference to be explained? A review of records suggests that the plan was influenced by World Bank (WB) prescriptions. The plan recommendations reflected the view held by the WB – that general secondary education, vocational and technical education was more crucial to development than all other parts of the education sector (World Bank, 1963). The Bank's policy on reconstruction and development, which put more emphasis on construction of infrastructure, such as roads and irrigation schemes demand technical personnel such as technicians and engineers hence their focus on secondary education. This is evident in the Transitional Plan.

Given the pervasiveness of the Bank's thinking in both economic and educational development, it would not be surprising that the Bank had a hand in crafting the 1966 Transitional Plan. Major developments in Botswana at the time also appear to have greatly influenced the content of the plan with respect to preference in secondary education. For example, the opening of both Orapa and Selebi-Phikwe mines in the late 1960s increased both government and private sector employment, necessitating the need for post-secondary school employment. However, given the neglect of education by the colonial regime there were very few educated and trained Batswana to take up those job opportunities. The country had to rely on expatriate staff. More importantly perhaps was the fact that job opportunities that had just emerged required more than rudimentary education which primary education offered. It was felt that educating more people to the level of secondary education would help speed-up the localization process. Hence emphasis was placed on expanding secondary education. However, this is not to suggest that primary education was neglected completely. The need to improve access at all levels was acknowledged. It is for this reason that school fees at the primary education level were reduced by 50% in 1973. This acknowledgement, notwithstanding, primary education was not considered a priority area. Thus, though the human rights view of education was acknowledged, it was felt that given the economic imperatives, it was

defensible to neglect primary education and concentrate on secondary education, the level that was viewed as holding more promise for economic development.

But as the 1970s decade progressed, manpower planning models became obsolete and less favored. The Bank favor shifted to allocative decisions based on rates of return. By 1980, this shift has been concretized. Rates of return calculations favored investment in primary education. This was the climate in which the 1977 National Policy on Education was conceived. Interestingly, the shift moved WB closer to UNESCO human rights view of education which invariably favored universalization of basic primary education. The influence of international organization was obvious in the NPE, 1977 when the policy introduced the Basic Education Programme (BEP).

The National Policy on Education 1977

Influenced primarily by UNESCO and WB thinking, the Botswana Government crafted a National Policy on Education in 1977 that put more emphasis on provision of basic primary education. This was a major departure from the Transitional Plan (1966-1969) which placed more emphasis on secondary education. It is important to note that both UNESCO and the World Bank promoted basic primary education for different reasons. While UNESCO interest on sponsoring and financing basic education was informed and originated largely from the UN's Declaration of Human Rights of 1948 (the declaration recognized education as a fundamental human right), the WB was motivated by economic imperatives and the anticipated rates of return that primary education was likely to bring. Given their influence on developing countries and their financial muscle, poor countries had no choice but to succumb to the dictates of their thinking. The World Bank convinced developing countries that the society was likely to reap more from investing in primary education than from investing in the secondary and tertiary education sub-sectors. It was in order therefore that the Bank's strategy in investing in education throughout the 1970s and 80s would be that basic education should be provided for all children and adults (Psacharopoulos, 1985). Primary education was seen as a public good that all states had an obligation to provide to all its citizens. Ever since, the Bank has championed and funded basic education in developing countries, Botswana included. Clearly, the "new" thinking in the Bank resonated with that of UNESCO, where education had always been viewed as a basic human right. Thus, by the end of the 1970s both the Bank and UNESCO were calling for the universalization of basic primary education. It is not unreasonable therefore, to suggest that emerging from the 1970s, the 1977 National Policy on Education has been influenced by such thinking. For example, the Commissions report declared that primary education is the most important of all stages of education, thus echoing the sentiments of the Universal Declaration of Human Rights. and the World Bank. Primary education in Botswana was then declared a national priority. Note that this was a shift from the emphasis on secondary education which the Transitional Plan emphasized. The Bank's influence was further concretized when the Bank partially funded the Primary Education Improvement Project (PEIP) and the Junior Secondary Education Improvement Project (JSEIP) in the 1980s and 1990s. It is highly unlikely that the Bank would have funded these projects had the level of education to be funded not been basic education. The effects were that basic education attracted more funding and expanded phenomenally in the 1980s at the expense of both senior secondary

and tertiary education. To ensure that basic education becomes a reality school fees had to be abolished, this was done in 1980 for primary education and in 1989 for secondary education. For Botswana, basic primary education was found appealing because it was the level that anyone wishing to reach other levels had to pass through. It was therefore envisaged that universalizing basic education will address issues of access and equity. For this reason, and to give it weight, it has to be cast as a basic human right to which all children are entitled. Botswana's view, in particular, its commitment to promote the principle of social justice and democracy resonated with UNESCO's view of basic primary education described above.

It is against this background that the two major polices on education in Botswana, namely: the national Policy on Education, 1977 and the Revised National Policy on Education (RNEP, 1994) were crafted and implemented. Both policies emphasized promotion of primary education, and sought to promote the following objectives: (i) equal access to education (ii) greater equality in distribution of educational resources through-out Botswana and between institutions (iii) positive measures to help the less fortunate and (iv) closer links between the school and the community. The fast growing economy of Botswana made it possible to achieve some of these policy objectives as demonstrated below.

Financing education in Botswana: A human development approach

At independence, Botswana had a few schools or educated citizens as a result of the neglect of education by the colonial government. The few schools that existed had mainly been developed through local and missionary initiatives. Given this small human capital base, the government had to invest heavily in education. For many years (and even currently) both recurrent and development expenditures of the Ministries of Education and Local Government were given the biggest share of the government budget. Government has consistently maintained this deliberate bias towards education in terms of its expenditures. At independence government could not afford to pay all the education requirements since it was building new schools and having other budgetary constraints. For most of the late 1960s and early 1970s, students were required to pay school fees as well as other expenditures for education. In the late 1970s, government began to be increasingly aware of equity issues in education, as it was becoming evident that a number of children were unable to complete some levels of education due to financial constraints. The Botswana Government was also highly influenced by international practice and law, with such goals as "universal access to education for all". The effects were that government abolished school fees for primary education in 1980 and for secondary education in 1989. University education was also paid for by the government through a bursary sponsorship, which required the graduate to contribute 5% of their initial gross salary for each year of sponsorship. Apart from the fact that this contribution does not cover the full costs of training, a more serious problem has been that a majority of the graduates were not contributing since coordination between employers and the Bursaries Department has been very poor. This effectively left the government as the sole contributor-suggesting that quite a sizeable number of people did not pay for their university education.

All National Development Plans NDP 1- NDP 9 demonstrate the need for substantial financing of the education sector. One of the major reasons for investment in education is that, more than anything else, it is schooling that opens the door for the upward mobility of the poor and disadvantaged. The school provides equality of opportunities for everyone. People with more education tend to earn higher incomes and are less likely to be poor than those with less or no education at all. Certainly education provides opportunities for the poor to escape poverty. As demonstrated above, in Botswana educational facilities have been expanded and improved, all over the country, to ensure that all Batswana, irrespective of their birth, socio-economic status, gender, ethnic origin have equal access to education.

The National Development Plan (1976-81) stressed:

> All Batswana, wherever they live and whatever their social background, should have equal access to services that the Government provides such as education, health and water resources ……

Primary education

Since the early 1970s priority was given to primary education. The focus was on building more and more primary schools and increasing the number of enrolments. With considerable support from foreign donors, government undertook major primary school construction programmes during the 1970s and 1980s. Primary schooling was seen as the foundation on which further learning is based and an opener to a range of opportunities for further study and work generally closed to the uneducated. In 1975 there were only 166 primary schools with an enrolment of 29000. By 1985, there were as many as 500 primary schools and a total enrolment of 195 000. (Abosi & Kandjii-Murangi, 1996)

According to the Education Commission (1977:64) about 93% of the age cohort 7-13 year olds were in school in 1976. Enrolments nearly doubled with the decision to cut school fees by half in 1973 and then to abolish them in 1980. The following year (1981), intake rose by 16% from 27 550 to 32 065. By 1979 Botswana, like other developing countries, had joined the race towards meeting the goal of Universal Primary Education (UPE).

The National Development Plan 7 (1991-97), in reviewing the preceding plan period, notes such achievements but with concern thus:

> There was significant progress towards UPE but it is difficult to be certain of how many "missing children" did not enter the school system ….."

By the year 2000 Botswana had achieved UPE and surpassed its target of 80% by 14%. This is a remarkable achievement by developing country standards. As indicated above, exponential increase in school enrolment is partly attributed to abolition of school fees and an increase in the number of school buildings many of which were constructed by

government with help from the donor community. Key results for the period 1984-1989 are summarized in Table 1 below:

Table 1: Primary school enrolment 1964-1989

Year	Number of pupil enrolled
1964	62839
1974	124 265
1984	209 345
1986	235 941
1989	268 205

Source: Ministry of Education 1989

More recent studies show a large number of government funded primary schools. For example, there were 770 government funded primary school in 2007 as compared to only 250 in 1966 (MoE, 2007).

The question then is, why did Botswana embrace the policy discourse of basic education at that particular time in its history? It was obvious that the international influence, especially from UNESCO and World Bank played an important role in this policy choice. But these were mediated by local circumstances. For example, the dire human resource situation in the context of an expanding economy and the country chosen path to nation building and unity had great influence. It is a fact that the colonial power did very little to develop education in Botswana. After independence, with the discovery and opening of diamonds and copper/nickel, there was no local manpower to work in the mines. As employment increased dramatically for both the government and private sector there were very few educated and qualified Batswana to fill the posts. The need to expand educational provision became a priority. However, initially this did not favor basic primary education but the human resources shortages favored the expansion of secondary education. However, as the 1970s progressed and in the light of the World Bank thinking in favor of basic education, Government saw the need to expand basic education. What became clear in the 1970s and 1980s was that the inequitable distribution of educational chances in the country could in the long run become a source of national disunity. There was a need therefore to work out an education plan that would address the issue of equity. The latter therefore became a powerful guiding principle in the nation building project. Given the climate of limited resources, it was only logical to extend equality of opportunity to only one cycle of the education system and the most basic of them all – primary education. Expanding provision of primary education was viewed as important as nation building. The significance of nation building is underscored in the title of the 1975 Education's Commission's Report – Education for *Kagisano* (Social Harmony). Equity has important implications for building a nation in which harmony reins.

Universal coverage ensured that no one was left out irrespective of their socio-economic status. Children from poor households benefited a great deal from free education as demonstrated by the above figure. Enrolments increased substantially with the abolition

of school fees and that clearly demonstrate the role that provision of education play in poverty reduction

Although Botswana has been successful in achieving universal primary education, problems of access are still prevalent especially in the rural areas. Given existing settlement patterns (village, lands and cattle post) some parents prefer to stay in the lands or cattle post creating permanent settlements there as such, children have to walk long distances to and from school. This has a negative impact on their education. Some drop out of school while those who stay on perform poorly resulting in high repeat rates. This makes primary schooling ineffective. Broadly speaking, inefficiency of the system deprives some of the children the chance to benefit from free tuition provided by the state. If this situation is not attended to promptly, the country will fail to maintain its universal primary education status, thus failing to reduce poverty through education. Making primary schooling not only universal but accessible and compulsory for all might help in making parents take their children's education seriously which will assist in achieving Vision 2016's and MDGs poverty reduction objectives.

Secondary education

The rapid expansion in the 1970s of the mining and industrial sectors led to an increasing demand for highly skilled manpower. Education development which had hitherto focused on primary education shifted towards the expansion of secondary education during the early 1980s. Secondary education was needed to absorb a large number graduating from primary schools as well as to prepare those graduating from secondary to tertiary education and the job market. This was important because, until the early 1980s, almost all professional and technical post-secondary education had to be pursued outside Botswana. To accommodate an increased number graduating from primary schools *Boipelego* education project was started, which saw a tremendous increase in the number of Community Junior Secondary Schools. In addition, phenomenal increase in school enrolment rates was triggered by the abolition of secondary school fees in 1989. For example, in 1987, the entire form one enrolment stood at 12 904. With the introduction of free secondary education the following year, there was a surge to 16 719.

By 1991 the transition rate from primary to junior secondary school was about 65% and the country was on the path to attaining the objective of providing nine years of basic education for all children (seven years of primary and two years of secondary). The table below shows secondary school enrolments between 1990 and 1997.

Table 2: Secondary School Enrolment Targets 1990-1997

Year	1990	1991	1992	1993	1994	1995	1996	1997

Junior Secondary School								
Form 1	22 672	25 952	31 520	34 382	36 524	38 666	40 747	42 522
Form 2	18076	22 672	25 270	28 368	30 944	32 872	34 799	36 672
Total	40 748	48 624	56 790	62 750	67 468	71 538	75 546	79 194
Senior Secondary School								
Form 3	6 625	6 735	7 080	7 800	8 520	8 520	9 240	9 240
Form 4	6 330	6 559	6 668	7 009	7 722	8 435	8 435	9 146
Form 5	4 093	6 014	6 231	6 601	6 639	7 645	8 350	8 350
Total	17 048	19 308	19 978	21 410	23 181	24 600	26 025	26 738
TOTAL	57 796	67 932	76 768	84 160	90 649	96 137	101 572	105932

Source: Ministry of Education 1997

Table: 3 Secondary school enrolment projections for NDP 9 (2003/4 – 2008/09)

	2003	2004	2005	2006	2007	2008	2009
Form 1	40 674	41 081	41 492	41 907	42 326	42 749	43 176
Form 2	41 308	40 430	40 835	41 243	41 656	42 073	42 493
Form 3	40 454	41 061	40 187	40 590	40 996	41 407	41 821
CJSS Total (A)	122 436	122 572	122 514	123 740	124 987	126 229	127 490
Population projections (13-15 years)	115 022	115 966	117 204	118 479	121 049	123 871	127 334
Form 4	19 928	20 227	20 531	20 094	20 295	20 498	20 703
Form 5	18 326	19 789	19 938	20 387	19 953	20 153	20 354
SSS Total (B)	38 254	40 016	40 469	40 481	40 248	40 651	41 057
Grand total A +B	160 690	162 588	162 983	164 221	165 226	166 880	168 547

Source: Department of Secondary Education 2002

As can be seen from the above Table, there has been tremendous growth in the number of secondary school enrolment during NDP 9 plan period. In 2007, there were 239 government funded secondary schools compared to only 9 at independence in 1966. The total number of students enrolled in secondary schools in 2007 is estimated at 165 226 and projected to be 168 547 by the end of NDP 9 in 2009. With the current expansion of secondary education, in particular, the construction of community secondary schools and upgrading of senior secondary schools, both student enrolment figures and the number of trained secondary school teachers are bound to increase.

Tertiary Education

Growth is also experienced in the tertiary education sector. For example, Botswana had only 2 teacher training colleges in 1966, today the number has increased to 6. Vocational training institutions increased from only 1 at independence to 6 in 2007. The tree shade classrooms that were a common feature in the 1950s and 1960s have given way to modern classrooms. Botswana literacy rate have gone up from 10 % at independence to almost 90 % in 2007.

Given that secondary school teachers are usually graduates at the university, this has implications on university enrollments as well. In 1989/90, the total enrolment of the University of Botswana was 2, 856. Technical and vocational training was also being conducted outside the university at various institutions. The Botswana Polytechnic with an annual enrollment of about 1600 students in 2002 provided technical courses in engineering. The Botswana Agricultural College, setup in 1971, also provided courses in general agriculture. Furthermore, the Brigades also played an important role in the education of Batswana children. Established in the 1960s they provided vocational training mainly for those who could not make it into secondary schools. They offered artisan courses in areas such as bricklaying, welding, carpentry and auto mechanics.

However, it is important to point out that both secondary and tertiary education do not necessarily prepare school leavers for the world of work. Only a few manage to obtain employment, mainly in the government sector, since the private and parastatal sectors prefer candidates with specialized skills not just possession of a secondary or university certificate. This has serious implications for poverty reduction given the assumption that those with formal education are unable to get jobs and improve their quality of life. This obviously frustrates the role of education as a poverty reduction strategy since those who go to school do not necessarily find employment.

Table 4: University of Botswana student enrolment projections for NDP 9

Faculty	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Business and ICT	1 376	1 610	1 883	2 203	2 578	3 000
Science, Engineering Tech, Health science	3 010	3 191	3 382	3 585	3 800	4 050
Social Sciences and Humanities	4 109	4 191	4 275	4 360	4 447	4 500
Education	2 275	2 412	2 557	2 710	2 873	3 000
Graduate studies	352	369	388	407	427	450
Total	**11 121**	**11 772**	**12 484**	**13 266**	**14 125**	**15 000**

Source: University of Botswana 2002

An increase in enrolments at secondary school level means a corresponding increase at university and other tertiary institutions. As can be seen from table above, UB enrolment across faculties is increasing rapidly with a projected student population of around 15 000 by the end of NDP 9. The role of tertiary education is to ensure that young people are

provided with requisite academic training and technical skills development that meets the needs of local labor market and incorporates the latest development in technology. Education and training will ensure that young people are provided with the knowledge and skills they need to make a living and escape poverty. With respect to tertiary education, the main objective for NDP 9 is to increase access to technical and vocational education and training, through upgrading physical facilities and other means, while ensuring equity through appropriate admission policies and a range of programmes.

Many commentators on the Botswana economy have attributed the BDP longevity in power to its welfarist policies, especially in the area of education, health and water. According to Dr. O. Tsheko (Sunday Standard 11-17 March, 2007). in Manuel's and Gaolatlhe's Budget: Whose is Bigger? observes that Botswana runs a welfare state. If one puts together the per capita cost of all the social safety nets that the Government of Botswana has been providing over the years plus provision of social services such as free education, free health, free ARV drugs and water as well as subsidized electricity and housing, then Botswana tops South Africa as sub-Saharan Africa's leading welfare state.

Table 1 shows a breakdown of the total estimated capital budget for the Ministry of Education for the budget years 2003 – 2009 (i.e. the budget covers the entire plan period which include projections for 2007/08 and 2008/09). Note that figures presented are only for the Capital Budget. This does not include recurrent budget. If included the budget for the ministry goes up significantly.

Table 5: NDP 9 Budget for Ministry of Education

Selected Budget Items	Ministry of Education Budget from 2003 – 2009 in millions						
	2003/04	2004/05	2005/06	2006/07	20007/08	2008/09	Total
Educational Facilities	26 700	15 000	11 000	10 000	10 000	4 200	76 900
Special education	4 000	10 000	10 000	10 000	10 000	16 000	60 000
Secondary schools	10 200	207 000	200 000	200 000	200 000	192 800	1 100 000
University of Botswana	58 000	160 000	250 000	250 000	290 700	391 300	1 400 000
Colleges of Ed	83 400	185 900	130 500	149 800	125 000	55 400	730 000
Brigades dev	32 500	15 000	15 000	15 000	20 000	2 500	100 000
Out of school	9 700	15 000	15 000	15 000	10 000	16 300	81 000

Source: NDP 9 (2003/04 – 2008/09)

Table 1 above shows a significant increase in capital budget for secondary and tertiary education. The government engaged in a massive secondary school expansion project. This included building new junior and senior secondary schools, expanding the existing ones, introducing new practical subjects (design and technology, art, home economic, agriculture and computers) and equipments. The university also expanded significantly to include new development projects such as the construction of the new university of science and technology, medical school, academic support and laboratories.

The major objective of these new projects is to expand tertiary education in the country. The government has achieved universal primary education. The move now is to attain universal secondary education by 2016. The emphasis has now shifted to secondary and tertiary education. Education is now geared towards providing the much needed knowledge and skills required for the ever increasing industry. It is anticipated that those who acquire skills from the University, technical colleges and Brigades will be prepared enough to compete for scarce jobs opportunities in the market or set their own small industries with a view to creating employment for themselves and other Batswana. Realizing these ideals through education is a positive move towards poverty eradication. The emphasis it to ensure that all graduates has the necessary skills to enter into self-employment. This requires investing heavily on infrastructure for technical training to reduce the cost of the reliance on training provided outside Botswana.

Financing education in Botswana has led to exponential increase in the quantity and to some extent quality of education in Botswana. The following section provides a descriptive discussion of the growth in education in Botswana; at three levels, namely: primary, secondary and tertiary levels.

During NDP 8 & 9 a number of educational projects were funded including educational facilities, central resource centres for special education, expansion of tertiary institutions e.g. University of Botswana, colleges of education, technical colleges, brigades and out of school education.

Qualitative growth in education

There is no doubt that the Government of Botswana has invested heavily in education. Massive investment is demonstrated by abolition of school fees in primary, secondary and tertiary institutions; provision of school uniforms and other items for children of destitute persons and remote area dwellers; availability of school feeding programmes; supporting private and aided schools; and establishment of literacy and distance learning programmes such as BOCODOL. The result has been phenomenal growth in physical infrastructure and in enrolment rates at all levels of education. Above all, growth has made education accessible to all citizens of Botswana irrespective of their socio-economic status, gender, ethnicity and spatial distribution. By removing barriers to access, in particular school fees, Government was able to promote and address equity in education which is an essential ingredient for nation building.

Quantitative growth in education should keep pace with quality for it to be meaningful. Quality, in part, is usually demonstrated by the relevance and appropriateness of the type of education in a society. Our interest here is to assess the extent to which provision of education has contributed to poverty reduction. Clearly, an effective reduction in poverty requires provision of high quality education.

According to Mutumbuka (1985) education must be development oriented and, if designed properly, is the most effective tool through which a nation can bring about the necessary socio-economic transformation and achieve qualitative improvement in living

standards. Thus, education should prepare people to make a living and become self-reliant. The question is: Has the education system in Botswana succeeded in achieving these noble objectives?

Despite its successes (in quantitative terms) educational expansion has placed considerable strain on the capacity of the education system to pay attention to critical issues of quality. Problems with quality in the education system were the major focus of the 1993 National Commission for Education in Botswana. The Commission's mandate was, among others to:

> Review the current education system and its relevance; and identify problems and strategies for its further development in the context of Botswana's changing and complex economy (RNPE, 1994)

Against the backdrop of this review, some serious problems were identified in the implementation of education programmes which has adverse implications on quality and poverty reduction: These include: spatial distribution, gender, policy options and reforms, the dual system of education and curricula.

Spatial distribution

Available studies show that there is a disparity in terms of educational provision between the populated areas along the line of rail in the east and the sparsely populated areas in the central and western parts of the country. For example, the central and western parts were largely neglected with limited and poor educational facilities and equipment. Smith (1984) identified important reasons for non-enrolment in the west such as: boys being needed for herding cattle; greater distances to the nearest primary school and negative attitudes towards primary education by both parents and children. Basarwa children, in particular, were also left out given their remote conditions (Kann, 1989; BIDPA, 2003).

Lack of suitably qualified and experienced staff was also identified as a major problem. A study conducted by Campbell and Abbott (1977) on spatial distribution of primary schools revealed that 50% of the teachers in large and small village were untrained as opposed to 27% in large rural towns (district headquarters), and 2% in urban centres. However, over the years there has been improvement in the number of trained teachers, but, despite this improvement, most teachers sent to teach in rural and remote parts of the country have poor academic backgrounds with a large number only having attained Junior secondary education (NDP, 9: 2003/04-2008/09).

The dual system of education

The dual system of education (English vs Tswana medium schools) also works to the disadvantage of children with implications for quality. Evidence shows that English medium schools, which tend to be elitist and charge much higher fees, offer better quality education than Tswana medium schools. As a result children of the wealthier citizens attend English medium schools and those of the "poor" who cannot afford higher fees

receive their education in Tswana medium schools. As indicated earlier there is ample evidence to suggest that children who receive quality education have access to better paying jobs than those with inferior education, which attract "poverty wages" and remain forever poor.

Curriculum and employment

In view of the need to make education appropriate, since 1977 there was needed to change the curriculum to suit the manpower needs of the country. Unfortunately, the curriculum adopted over the years had prepared students for white collar jobs and emphasis had been on teaching for examinations and spoon feeding pupils. Lack of books and teaching materials in most schools also contributed significantly to lower standards of education. Quality education therefore became a privilege of those who could afford the fees and as a result, the poorer members of society remained disadvantaged with regard to employment opportunities and lifestyles. In this case educational provision had benefited some social group at the expense of others.

Policy options and policy reforms

In recent years the Ministry of Education has introduced a number of policy options and reforms with implications for poverty reduction. These include a scarce skills policy; grant-loan scheme and double shifts. The scarce skills policy and grant-loan scheme is reminiscent of a selective curriculum that privileges students according to their aptitudes at school. For example, students who excel in science and technology are highly regarded and given preferential treatment when they complete secondary school and enter tertiary institutions. They are granted free education under the guise of being trained for courses that require specialized skills commensurate with the critical manpower needs of the economy. Their counterparts, who happen to be less scientific or technology oriented, but obviously proficient in other subjects, do not enjoy similar benefits. They have to rely upon partial or full loans for their tertiary education in accordance with the grant-loan scheme. This division is reproduced and further entrenched by the scarce skills policy when the student enters the world of work. Those who possess science and technology degrees enter the public service pay structure at super scale level. Their counterparts enter the pay structure at comparatively lower levels. As if this was not enough they have to pay back to the government their student loans. In the final analysis, these policies promote discrimination and further entrench the already existing class divisions and poverty that characterize Botswana society.

Double shift is yet another policy option that has had negative consequences for the education system in Botswana. Introduced in 2006, the policy seeks to deal with a backlog resulting in a large number of students entering senior secondary schools. Instead of just teaching in the morning, afternoon classes were introduced. Although the policy is still in its pilot phase and has not been formally evaluated, an informal assessment reveals that it has created more problems than solutions. Double shifts have led to unmanageable teacher/student ratios, which mean larger teacher workloads. This has obviously impacted negatively on the quality of instruction leading to deterioration in student performance.

What do the above problems mean in terms of the relationship between provision of educational services and poverty reduction? An attempt to answer the question is provided below.

Reforms in education

Initiatives to introduce educational reforms were noticeable during NDP 7, which ran from 1991-1997, with the introduction of user fees and the intention to introduce school fees. Since then user fees has become part of government macro-economic policy. It was anticipated that revenues from minerals would grow slowly over the coming decades and hence other sources of revenue would have to be found. Cost recovery was identified as one of them. The plan declared that "there are no free goods or services. The question is rather, who benefits and who pays for government goods and services (P.96).

The statement above signaled a change in government economic policy. The introduction of school fees and medical fees is simply an implementation of what was put on the plan some years ago. Therefore it should have been clear decades ago that school and medical fees will be introduced at some point.

Cost recovery

To alleviate the problem of non-recovery and based on recommendations of the Revised National Policy on Education (1994), the government shifted its financing policy from a bursaries system to a loan/grant system. This was also in line with cost recovery measures, even though this policy primarily addressed a larger problem of attracting student to courses considered to be scarce. Such courses attracted 100 % grant, while those considered not to be scarce had a very low grant element. According to an official from the Ministry of Education, cost recovery measures are currently being implemented in both primary and secondary school education where parents are required to pay 5 % contribution to the cost of their children education. Payment of school fees was introduced in January, 2006.

While such a move may be desirable, it is important that such a policy should not exclude children from very poor families from the education system. There are already indications that some children of the very poor are unable to complete certain levels of education because of hidden costs and issues of access. Studies conducted in the past have shown that the background of parents matters in terms of both completion of and rates of returns from, education (Siphambe, 2000a, 2000b). It is argued that, it is possible to have cost sharing at upper secondary education and tertiary levels without reducing demand for education, since this demand was found to be elastic. Private rates to education are also found to be substantially high, making it acceptable to beneficiaries to share the costs with government (Siphambe 2000a; Atta et. Al 1996).

It is important to point out that the loan grant system has been implemented for more than 8 years now, and yet it has not improved the cost recovery agenda in a substantial way. There is lack of data on graduate employment, especially in the light of the fact that

graduate are not guaranteed employment by government as was the case in the past. Implementing the loan grant system is therefore proving to be a very difficult task. Evidently, there is need to have a through look at the loan grant system. Research is needed to guide education policy makers on the most appropriate cost sharing method. Some alternatives include graduate tax systems, which are assumed to be easier to administer as it works on the same principle as an income tax. A major problem with this system is that it assumes all graduates get employment, which is not the case for Botswana currently. With regard to applying cost recovery to secondary schools, there is need to have an appropriate structure that can identify students from poorer families for scholarship award. Cost recovery can become a very thorny issue without a proper mechanism for identifying students from needy families. It is perhaps for this reason that government is proceeding carefully in implementing its cost recovery policy in both primary and secondary schools.

Education and employment

Botswana, like most developing countries, is faced with problems of unemployment and poverty. Education is generally regarded as a means to formal employment and self-reliance. Riddell (1980) observed that the education system must take into account factors such as job opportunities, patterns of production and demand for skills in the wider society, hence the need for education that is relevant and appropriate. With specific reference to education as a precondition for formal employment, the Transitional Plan for Social and Economic Development (1966-69:20) states:

> The primary aim in the field of education is to create in the shortest possible time …… a stock of trained local manpower capable of servicing the country's economy.

The government set itself a target to achieve the above goal in 25 years (1966-1991). There is evidence to show that, through education, formal sector employment has grown. For example, in 1966, the total requirement for manpower within category 1 & 11 i.e. Diploma and Degree qualification, was 417 but the country could only produce 45 matriculants, a shortfall of 372 positions which were all filled by expatriates. With increased enrolment at secondary school level, the situation improved tremendously. For instance, in 1971, 1976 and 1981 the country managed to produce 100, 255 and 270 matriculants respectively to meet the manpower needs of the nation. Shortages were greatly reduced to 20 in 1981. By 1991, the total requirement for people with diploma and degree qualifications was 300 and it was attained as indicated in table 5 below. Thus, the country did not have any serious shortage of diploma and degree holders in most fields except technical areas.

Table 6: Demands for high level manpower

Year	Total requirements of categories 1 &11 manpower	Planned output of local matriculants	Shortfall to be met by recruitment of expatriates
1966	417	45	372
1971	300	100	200
1976	300	255	45

1981	290	270	20
1991	300	300	-

Source: Transitional Plan for Social and Economic Development (1966-69)

In comparison with 1966-1991 figures above, Table 7 below shows how, through schooling, formal sector employment has grown over the years to meet manpower needs of the country. Growth in formal sector employment has been credited with the socio-economic transformation of the country, reduction in poverty and general improvement in quality of life. As a result of this transformation, Botswana has experienced massive rural-urban migration as the search for job opportunities intensified. This resulted in a radical shift from a subsistence economy to a modern economy with declining poverty in urban centres and some rural areas.

Formal sector employment

The labor market represents a key arena for socio-economic empowerment. At independence, formal sector employment was estimated at about 25 000. It has grown tremendously over the years. Table 6 below shows employment in the formal sector for selected years.

TABLE 7: Formal sector employment in Botswana 1994-2000

Economic Sector/years	1994	1995	1996	1997	1998	1999	2000	% changing 1994-2000
Central government	66,438	69,425	70,077	71,448	81,799	84,856	85,690	29.4
Local government	15,433	15,921	16,341	16,555	18,217	19,073	18,847	22.1
parastatals	13,222	13,420	13,718	13,787	13,608	15,522	16,498	24.8
Private sector	136,231	132,621	133,980	135,760	125,877	137,615	143,320	5.2
Total (all sectors)	231,324	231,387	234,116	237,550	239,501	257,066	264,355	14.3

Source: Bank of Botswana Annual Report 2000. Table 2.8

A key feature of the employment situation in Botswana is the slow growth rate of the private sector. As indicated in Table 6, total formal sector employment increased from 231,324 in 1994 to 264,355 in 2000, showing an increase of 14.3% during the six-year period, and accounting for 46% of formal employment. However, during the same period, the private sector created an additional 7,089 jobs, implying an increase of only 5.2%; while employment in central and local government and parastatals grew by 29.4 percent, 22.1 percent and 24.8 percent, respectively. Available statistics show that total employment has increased by 5.4% per annum since 1998. The growth rate was above the growth of the labor force, which suggests that unemployment is falling. Despite its economic importance, the mining sector accounts for only 3.5% of the labor force, while informal sector employment accounts for between 10-15%. It is important to point out

that almost all employees in the formal sector possess higher educational qualifications – most are high school leavers and tertiary education graduates.

In terms of employment creation in the informal sector, it is acknowledged that the informal sector makes a significant contribution to the economy. For example, according to the 1995/96 Labor Force Survey and the 2000 Multi Indicators Survey, total employment opportunities in the economy grew from 345,400 in 1996 to 483,400 in 2000, an average annual growth rate of 8%. Much of that employment growth was due to increases in employment opportunities in the informal sector, which, as may be inferred from these figures, were about 226,334.

Table 8 below provides more recent data on trends in labor force and unemployment 1991-2003. It uses official data sources which have been quoted widely and are generally used for planning purposes.

Table 8: Trends in total labor force and unemployment 1991-2003

Data Source	Unemployed	Employed	Labor force	Unemployment rate (%)
1991 census	61 625	379 938	441 293	13.9
HIES 1993/94	107 723	391 804	499 527	21.6
1995/96 LFS	94 528	345 405	439 033	21.5
1998 DS	115 703	441 187	556 890	20.8
2000 MIS	90 729	483 432	574 161	15.8
2001 census	109 518	449 235	558 753	19.6
HIES 2002/03	144 424	462 401	606 825	23.8

Source: MFDP, Annual Economic report 2003. CSO, 2004

According to the 2001 census, the population of Botswana was estimated at 1.7 million people, of which, according to the Households Income and Expenditure Survey (HIES, 2003/04) 606 825 were economically active (labor force). However, out of those who were economically active, only 462 401 were employed and 144 424 unemployed representing only 23.8% unemployment rate at the time of the survey. For all locations i.e. towns, cities, urban villages and rural areas, unemployment was higher for females than for males. For example, in cities and towns, unemployment for females and males stood at 21.6% and 15.5 % respectively, while in urban village's unemployment for females and males stood at 30 % and 28.9 % respectively. In the rural areas, females and male unemployment was recorded at 26.7 % and 20.3 % respectively. Generally unemployment was highest in urban villages, followed by rural areas, and lowest for cities and towns. The disparity in unemployment rates is an outcome of the concentration of jobs in towns or cities, and the fact that those unemployed in cities and towns usually migrate back to rural and urban villages. In all regions, the age group 15-19 and 20-24 have the highest unemployment rates for both males and females, indicating that unemployment is a major problem for youth in Botswana. HIES data shows that most of the unemployed have secondary education and no other form of training (Citizen Economic Empowerment Consultancy Report 2007).

In recent years there are disturbing indicators that difficulties are beginning to be experienced by young people with tertiary qualifications. At certificate level, HIES 2002/03 reported an unemployment rate of 10.7 % falling to 1.3 % of people with Diploma and 0.5 % for graduates (note that the survey took place in 2002/03 and the data is now more than 4 years old). At present there is anecdotal evidence that unemployment rate among graduates is growing at an exponential rate. There seem to be little or no difference between those who obtained academic or technical qualifications. Under the circumstances, it would appear that provision of education has not translated into jobs. The phenomena of the unemployed graduate raise concerns on the extent to which acquiring education can lead to formal employment or at least self-employment. This obviously has implications for poverty reduction.

From the foregoing discussion, Botswana's spectacular growth in the first three decades after independence did not translate well in terms of employment creation. Recent figures presented in the UNDP-Human Development Report (2005) paint a bleak scenario. Whereas real GDP grew by 45% between 1991 and 1999, formal sector employment increased by only 13%, and was, in 1999, estimated at 257 066. This represents an average annual increase of 1.6% compared to 5% for GDP. However, between 1997 and 2001, formal sector employment grew at a rate of 4.9% per annum, before declining to 1.8% between 1999 and 2002. The report also notes that more than one in six job seekers could not find a job in 2000. The 1995/96 Labor Force Survey shows that 182,703 of the total labor force (or 34.6%) were unemployed. Of these, 48% or 88,175 were discouraged job seekers. Current unofficial estimates suggest a 40 percent unemployment rate. This figure includes mainly the youth aged 15-24 estimated at approximately 37%, and is almost double that for the adult unemployed. Clearly, unemployment is a serious problem, despite high rates of economic growth and many years of schooling. Thus rates of returns on education seem to be declining, a situation that may lead to increased poverty among those who have acquired education.

Historically, in Botswana, academic education has been the major escape route from poverty into formal employment. However, the overemphasis on academic education has over the years overshadowed the importance of other types of education. Academic education leads to white collar, higher paying jobs. Other types of education were therefore regarded as inferior and "second rate". Many people prefer to pursue academic education even if they can do better in vocational and technical education. This has led to a situation where high and tertiary school graduates are unemployed because the formal job market is unable to absorb them. This is a growing problem in Botswana and currently there are many unemployed college and university graduates (represented in the 37% referred to above). Today, the assumption that schooling will ensure employment is increasingly becoming a fallacy. The reality in Botswana is that education does not necessarily lead to employment for the majority of youth. There is need to re-think current strategies with a view to provision of education that is relevant to the needs of the country.

Equity and Access

Equity and access are important indicators that are often used to determine the extent to which social services such as health and education reach the intended beneficiaries. In many parts of the world, there have been concerns that girls are often disadvantaged in access to education. However, in Botswana this does not appear to be a problem. For example, the sex ratio for enrolment in primary and secondary schools is quite even or in some cases higher for girls than boys. The problem cited by officials from the Ministry of Education is that of inequality in access to education according to socio-economic background i.e. sometimes the poor do not send their children to school not because they are turned away from school by government but because of ignorant on the part of parents. Sometimes parents fail to pay user fees because they are not registered with social workers and as such are not exempted from paying.

However, it is important to point out that children from poor households are often disadvantaged not only by ignorance on the part of parents, payment of user fees and other related factors but also by the lower quality of education, both at primary and secondary level that they are able to access. The low reputation and poor quality education they receive from these schools (rural and remote) put them at a disadvantage in the job market once they have left school. Subsequently, they remain unemployed and poor.

Not withstanding the above, NB: The second national literacy survey jointly conducted by the Department of Non-Formal Education and Central Statistics Office in 2003 found that Botswana has achieved 81 % national literacy rate. This represents a 12 percent increase from the 1993 survey which recorded 68.9 %. However the challenge is to raise the literacy rate to 95% by 2015 in tandem with MDGs. National literacy rates are often referred to as good indicators of wellbeing and equitable provision of educational services.

Education and poverty reduction: A quandary?

It is clear that Botswana has, since the early 1970s, invested heavily in education as a poverty reduction strategy. The above challenges notwithstanding, there is evidence to suggest that levels of schooling among the population are highly correlated with decline in poverty levels (MDG Status Report, 2004). For example, studies on poverty in Botswana reveal that the proportion of people living in poverty declined from 59% in 1985/86 to 30% in 2002/2003 (NSPR, 2003). As the economy grows, more people are educated and absorbed into the labor force. Further, the role of education in poverty reduction is clear when comparisons are made between the educated and those who have never been to school. Illiterate, uneducated people find it difficult to enter the world of work or even self-employment. In this day and age of technological advances, they become poor and dependent on government for welfare thus contributing to an increase in social expenditure.

Clearly, quantitative growth of the education sector, in particular the basic education sub-sector, has been phenomenal and has produced spectacular results. Education and training

is generally recognized as being the critical pre-requisite for poverty reduction. One of the indicators of poverty reduction is the growth in the number of citizens who have benefited from the education system. With an annual recurrent expenditure on education approaching P4 billion, Botswana spends over 20 % of its recurrent budget on education- one of the highest expenditure rates in the world. As noted, Botswana has virtually attained universal access to primary education and transition rates from primary to secondary are close to 80 %. In the past 10 years however, there has been greater emphasis on tertiary education and the growth in tertiary education has been impressive. For example, the annual undergraduate output from the University of Botswana has tripled in the past 10 years. In addition, the number of post-graduates leaving the University with Masters Degrees has also risen dramatically from only 29 in 1994 to 123 in 2006 – an increase of over 300 % (University of Botswana Annual Report, 2006). Equally impressive has been the rapid growth of Batswana with vocational qualifications. At the artisan level, Botswana has accelerated its investment in vocationally trained employees through the growth of technical colleges. The annual output of national Craft Certificate holders has increased significantly. However, in the absence of demand statistics it is difficult to determine the extent to which artisan are getting absorbed in the job market. However, if non-citizens employed in the country can be used as a proxy indicator for the demand of vocational and higher level manpower, then it is clear that Botswana either have to double the output from tertiary education, particularly in the industrial, and engineering vocational and technical level or provide quality, employable personnel with more relevant technical qualifications to suit the needs of the industry and not half-baked technician who cannot be absorbed in the industry.

However, an in-depth analysis of the education system reveals that this massive expansion has created other problems which demand immediate attention. Quantitative expansion has taken place at the expense of quality. In the process, some of the major guiding principles within which the Botswana education system is premised such as social justice and Vision 2016 have not been followed and, in some cases, flouted with impunity. To determine whether education has made an impact on poverty reduction it has to be judged against the attainment or near attainment of these principles. Within the broader context of poverty reduction, the question is: How congruent is the education system with the long term vision of Botswana's Vision 2016 and the much acclaimed culture of democracy, social justice and social harmony? The answer should serve as a synthesis and overall conclusion of this section.

Vision 2016 has set itself an ambitious target of eradicating absolute poverty by 2016. In line with this objective, the target is to reduce the proportion of the population living below the PDL to 23%. To achieve this requires the adoption of social policy regimes that, in addition to growing the economy and thereby creating employment opportunities, will design appropriate educational policies that will ensure that all citizens benefit, irrespective of their socio-economic status, ethnic origin or gender.

However, it would appear that the country's education system has little respect for the principles of social harmony and social justice. For example, as already indicated above, the selective curriculum policies in senior secondary and university education promote

discrimination and entrench class divisions, perpetuating poverty among those already disadvantaged. While Vision 2016, advocates for the reduction and total removal of inequalities in educational access, income distribution, allocation of jobs and social solidarity and harmony, educational reforms and current policy options seem destined to reduce or erode the gains that the Government of Botswana made during the first two decades after independence (under the first welfare regime)**.** Under the current welfare regime education seem to be focused on empowering the already powerful and impoverishing further those who are already wallowing in poverty. Obviously, this is detrimental to and is at variance with the principle of social justice.

The current educational reforms seem to give with one hand and take a huge chunk with the other. For example, the re-introduction of school fees in January 2006 is likely to disadvantage poorer members of Botswana society despite Government promises that those who cannot afford to pay are not forced to do so and that children of destitute persons and other disadvantaged groups will be exempted from paying the 5% required as contribution by government. It is important to note that, while few countries in the developing world, except for Mauritius which introduced free secondary education in 1977 and free tertiary education in 1988, come close to Botswana benchmarks (even when we factor in cost sharing), many commentators believe that it may not be wise for Botswana to commoditize education, leaving it rather to market forces, when there are obvious inequalities within the current society. These reforms needs to be subjected to thorough scrutiny because carrying on with their implementation may disadvantage the poor – a far cry from the proclaimed Education for ***Kagisano.***

The question is, what do these reforms (cost-sharing) mean to education as a strategy for poverty reduction? What is the likely impact of this on enrolment levels? What are its implications for quality education?

The effects of the reforms are already being felt by many poor people. School fees have gone up, children who cannot afford to pay are being sent back home despite government promises to the contrary (this should not happen but does happen). This is going to impoverish many households and force children from poor backgrounds to leave school. Private education is likely to increase at a high price. The number of people who cannot afford quality education will increase and they will be forced to send their children to inferior schools. Thus, private services, which presumably provide quality services, will continue to benefit a handful of affluent people. Standards in the public sector are likely to deteriorate especially that government spending is likely to go down.

Further, it is important to point out that despite major achievements in educational provision; research reveals considerable disparities and imbalances in the education system. For instance, while over 95% of the children attain their first 10 years of basic education, only 40% are able to proceed to senior schools. Access to tertiary institutions is also limited due to the fact that there are few such institutions to absorb all form five school leavers. As a result, there is a high preponderance of unemployed out of school youth who have no employable skills this is a serious drawback for poverty reduction as

over 50% of school leavers roam the streets since they do not have experience or employable skills (Duncan at al 2000).

Conclusion

Botswana's quest for universal education is based on the premise that education transforms many aspects of life in the country. In Botswana, education has undoubtedly played a major role in economic development. Mass education provides many opportunities to the children of the poor, who traditionally were disadvantaged and living in the periphery of society. However, the gap in quality of education between the rural, remote and urban areas and in urban areas, between schools catering for the poor and wealthy, means that attainment of mass education does not necessarily mean equity in opportunities.

In order for education to continue to make a significant impact, and address all the problems cited above, it should be recognized and pronounced in national documents such as Vision 2016 as a fundamental human right which government is obliged to provide from nursery to university.

In Botswana education is not regarded as a right that one can claim, in a court of law, if denied. The current Education Act (1966) does not provide the legal basis for citizens to claim education as a right. Thus, there is no law that protects people who are denied education as a right. Given tremendous strides that Botswana has made in the area of education, the time has come for the country to introduce institutional and statutory frameworks that will guarantee and protect education as a social right. Social rights embody recognition by the government to provide legislation that protects the right to education (International Covenant on Social and Cultural Rights (UN, 2001).

Internationally and nationally recognized and legitimized social rights are seen as a means of strengthening the ability of the poor to claim social, economic and political resources to meet their educational needs. Social rights provide the means of strengthening the claims to education. Taken in totality social rights approaches could therefore be regarded as pro-poor, they contain elements that reasonably suggest that they are on the side of the poor and the vulnerable. They seek to provide legal protection to those who are disadvantaged and are therefore relevant strategies capable of making a positive contribution towards poverty reduction.

It is, therefore, not entirely unreasonable to suggest that, as currently packaged, our education system falls short of that which is needed i.e. to prepare people for the world of work, self-reliance and ultimately to keep them out of poverty. Education with production has been ignored and discouraged for a long time. Botswana needs to design an education system that will benefit the majority of the people and enable them to enter sectors that encourage education with production. This will help to reduce poverty.

It is also necessary for Botswana to review current educational reforms and policies and retool them to ensure that they combine to constitute an educational system that will make a significant contribution to poverty reduction, consistent with the long term vision

for the country. Education remains cardinal to the successful implementation of the long term vision of the country and other strategic documents such as NDP 9 and NSPR, 2003 which emphasize poverty reduction. If existing poverty levels are to be reduced, education must be made compliant and re-aligned to the country's guiding principles. The state, as the main player in educational provisioning should devise affirmative mechanisms to protect all citizens against exploitative practices that, when implemented, run counter to or frustrate government efforts to reduce poverty and achieve both Vision 2016 and MDG goal # 1: Eradicate Extreme Poverty and Hunger (MDGs) and An Educated, and Informed Nation (Vision 2016). The ultimate objective is to achieve a better quality of life for all citizens.

Health

Introduction

Health is seen as a basic need for the people of Botswana. This understanding is reflected in the philosophy of the Botswana Health Policy, which is based on the principles of Primary Health Care as contained in the Alma Ata declaration of 1978. The Health Policy (1995) states:

> The Government shall, when planning its activities, put health promotion and care, and disease prevention, among its priorities, the basic objectives of which shall be access by all citizens of Botswana to essential health care, whatever their own financial resources or place of domicile, and the assurance of an equitable distribution of health resources and utilization of health services (Pg. 7.).

The above policy statement provides a broader framework for health services provision in Botswana. Government commitment to live to the spirit and letter of the health policy is demonstrated by the amount of resources (both human and financial) that are allocated to health services. The Government of Botswana notes that while there are no direct economic benefits to improving the health status of the people, the indirect benefits are greatly recognized because for the country to develop economically, socially and politically there is need for a healthy population. To this end, the maintenance of a healthy population is fundamental for human survival and poverty reduction. Survival, maintenance of health and nutrition are contingent on the availability and quality of health services, and the utilization of those services by the population (GoB & UNDP, 1997).

This part focuses on provision of health services in Botswana. It addresses provision health service during the colonial and post-colonial era and the ideological underpinnings that informed and guided such provisions. This is followed by an overview of quantitative growth in health since independence, provision of health services and programmes and their impact on the overall quality of health care, health financing, access and equity as well as health sector reforms. An overall assessment of these will enable us to determine the link between provision of health services and poverty reduction.

Evolution of Health services in Botswana

Modern health services only got established in Botswana in the 1920s and 1930s and as such were influenced by the colonial administration. During this period, missionary churches such as Seventh Day Adventist Church, Dutch Reformed Church and London Missionary Society established hospitals in major villages such as Kanye, Mochudi and Molepolole. The only existing government hospitals then were the Athlone Hospital in Lobatse and Sekgoma Memorial Hospital in Serowe. The colonial government did not have any deliberate plan for promoting access to health care during this period. Hospitals were therefore established in a rather haphazard manner and not according to the health needs of the country. The colonial government philosophy at the time seems to have been that the tribes should finance their own health care (this was consistent with the colonizers policy of indirect rule) (Tlou and Campbell, 1984; Data & Murray, 1989). As a result missionary and colonial government hospitals were constructed primarily to cater for colonial officers (Europeans) and some few privileged African high ranking employees. There was no attempt to cover those living very far from health facilities by mobile stops or traveling dispensaries. Thus the majority of people did not have access to modern health services. It was only a few years before independence that some uncoordinated attempts were made to provide medical services to cater for the general population.

After Botswana attained its independence in 1966, in particular, in the early 1970s, the Government of Botswana adopted a policy of health care based on universal accessibility to basic health services. World bodies such as the World Bank and WHO played an important role in shaping the Botswana health agenda such that it is consistent with the global agenda. The only way to achieve this, to make sure that every citizen has acceptable access to essential health care, was to build a large number of basic health care facilities i.e. clinics and health posts in every village and settlement of a specified population size (See Population Policy, 1995), or a certain degree of remoteness. By the mid 1980's, more than 85% of the population of Botswana was within 15km radius of a health facility. According to an assessment made by Maganu (1993), most Batswana in the mid and late 1980s were within 8 km of the health facility. Those outside this radius were covered by mobile health stops. In those facilities, basic preventative and clinical care was available. For example, prenatal and delivery services, treatment of common conditions, growth monitoring, immunization and others.

To deliver the above services effectively, Botswana runs a referral public health system which comprise a network of health facilities through out the country. These comprise the mobile stops, health posts, clinics, primary hospitals and national referral hospitals. Each health category has a specific function to perform in the delivery of health care services in Botswana. All these are owned, run and maintained by the Government of Botswana. Clinics, health posts and mobile stops constitute primary health care delivery systems run by local authorities, while primary hospitals and national referral hospitals are run by the central government i.e. Ministry of Health.

In addition, the private and NGO sector are involved in the delivery of health services. These include: mine hospitals, Christian mission hospitals and private commercial

hospitals and a number of private medical and dental practitioners. Table 9 below is a summary of existing health facilities in the country, services provided and area of coverage.

Table 9: Health facilities in Botswana

Facility	Number NDP9 2003-2009	Services provided	description	Population coverage
Health Post	341	-Primary health care services i.e. health education, family planning, nutrition, environmental health, maternal child health, first aid and treatment of common diseases-	3 rooms and a toilet (pit latrine). Located mainly in remote settlements	500-1000 in rural and remote areas 4000-5000 in major areas
Clinic (with or without maternity ward)	261	-maternal child health and deliveries -diagnosis and treatment of common diseases -case finding and follow-ups	5 rooms, covered area, toilets, vehicle, 2 staff houses, maternity unit	500-10000 in rural areas -10000 or more in major villages and towns
Health Centre	16	-as a clinic -supervision of clinics and health posts -general in-patient care, lab examinations, x-ray and surgery	-a total of 20-70 beds -4-12 beds for delivery and observations -16-58 beds for curative care -out patient facility as a clinic	Located mainly in major villages and other urban centres with a population of over 10 000
District/Regional Hospital	6	-As a health centre -specialist services for serious and complicated health problems -basic curative, preventive and promotive services	- health centre on a large scale 70 – 400 beds	-Major villages, towns and cities -catchment population of 35,000 – 100,000
National Referral Hospital	3	-As a district hospital -specialist clinical services for serious and complicated health problems -more specialist equipment	- Over 400 beds	-National capital -referral services for the whole country.

Table 9 shows the types of health facilities in Botswana, type of services provided and areas of concentration. It is clear that the population size of a given area determine the type of facility to be constructed, facilities and equipments and services provided. For example, a rural remote settlement of population less than 500 people can only attract a health post and a family welfare educator or a junior nurse. While Government hospitals which provide care services that are mainly urban and regional based and emphasize curative care attract high quality facilities, equipments and more qualified staff. In line

with the ideology of the day, the emphasis is on universal coverage. The aim is to ensure that all Batswana get free and quality medical services. Statistics from the Ministry of Health show that during the 1980s and 1990s Botswana was one of those countries with the best health services in the developing world. This is an impressive record which the government of Botswana would like to maintain. To do so, Government has over the years committed massive financial resources to support local authorities. Local authorities are responsible for primary health care in both the urban and rural areas. Primary health care include all aspects of preventative and curative care such as family planning; environmental health; epidemic and endemic diseases control; health promotive and school health services. These are provided through clinics, health posts and mobile stops.

In addition to work done by local authorities, Christian mission also provide health services to the majority of people in the rural areas. The contribution of Christian mission hospitals is significant in both curative and preventative care. Although care in the rural areas were mainly in the care of the mission hospitals, government intervened by providing small grants to supplement donations from charity organizations overseas.

The private sector consists of both the traditional and modern health care practices. Traditional healers operate mainly in the rural areas, but also in some urban centres. While the practice of traditional health care is not promoted nor fully recognized by government and generally discouraged, most Batswana still visit them. The reality is that traditional medicine is widely practiced in Botswana i.e. most people still consult traditional healers as and when the need arises.

Secondly, since independence modern medical private practice was dominated by Whites, Indians and Black doctors from other African states. Only in the 1990s did we see a proliferation of Batswana into private health practice. They provide mainly curative care and are concentrated mainly in towns, cities and urban villages. Private doctors are preferred to general hospitals and clinics for the following reasons: (i) shorter queues; one will always be examined by a doctor; (ii) quality of care; (iii) drugs supplies at the local private pharmacy and there is no queue so safe time; (iv) supply of good drugs.

Quantitative Growth in Health Provision 1966-1980

The Transitional plan for Social and Economic Development (1966-1969) laid a foundation for provision of health services against the background of limited financial resources. Inadequate resources made it virtually impossible for the country to prioritize provision of health services at the time. The plan states:

> In health … it has not been possible to assign the priority truly wished. The government is aware of the widespread desire for better medical services, but the stringent financial situation necessitates reliance on foreign aid for any improvement in this field (p. 7).

The above statement captures government aspiration to provide better health services during the early years of independence. Unfortunately, Botswana was a very poor country with limited financial resources and many competing demands. However, this is not to

suggest that health was completely neglected, it was just not a priority at the time. With increased mineral revenues in the late 1960s, coupled with sound micro economic policies and state-led philosophy to re-invest proceeds from mining into the social sector, health was back in the priority list within a short space of time. The approval and subsequent implementation of the Rural Development Policy between 1972 - 1980 contributed significantly to the development and expansion of primary level health services. Subsequent adoption of the principle of Primary Health Care in the 1980s and 1990s paved way for rapid expansion of health services in Botswana. Through these policy initiatives, significant progress was achieved between 1973 and 1990. Impressive results were achieved through aggressive investment by the state on health between 1980 and 1990, guided by the overall World Health Organization (WHO) global objective of delivering "Health for All by the year 2000 (see UNDP report, April, 2002).

Through a system of decentralized health care services and the adoption of the Primary Health Care strategy, the health status of the nation has recorded positive trends in almost all the indices that are customarily used to measure progress in this sector. For example, it is estimated that 88% of Batswana are within 15 km of a health facility and 81% within a 10 km radius. As a result, health care indicators show that infant mortality has declined considerably (BFHS, 1988, 1996). The infant mortality rate declined from 100 in 1971 to 56 in 1991. Maternal mortality had declined to about 200 per 100 000 in 1991. Furthermore, the Family Health Survey 111 (BFHS, 1996) report infant mortality rate of 37.4 per 1000 in 1988 and 37.0 in 1996. It is important to point out that family surveys in Botswana are conducted every 10 years, the last survey was conducted in 1996, and the next survey will start in September, 2007.

In addition to a dramatic decline in disease and mortality rates, especially among the poor, other ailments such as small pox were eradicated. After the eradication of small pox, the occurrence of diphtheria, polio and whooping cough was reduced to insignificant levels and there was significant reduction of both the incidence of measles and its severity, resulting in low cases of fatality. Death due to acute respiratory infections and diarrhoeal diseases also dropped significantly. The result was a very rapid drop in death rates, especially among infants and children, and a significant increase in life expectancy. The infant mortality rate (IMR), the commonest indicator of health status, dropped from about 150 per 1000 in the 1950s to 98 in 1971, 71 in 1981 and 43.1 in 1992. This gives an indication of the combined impact of the different programmes, i.e. education, water, nutrition, sanitation and health care, on human development and their role in poverty reduction.

In 1995, the National Health Policy was approved. Its overall goals were; (i) health promotion and (ii) disease prevention. The main objectives of the policy were among others: (i) to provide access to essential health care to all citizens of Botswana; (ii) to promote health care and prevent disease and (iii) to assure and equitable distribution of health resources and health services. The National Health Policy is implemented through various additional policies and programmes. For example, provision and access to essential health care is catered for through the public health system, which comprises of primary health care facilities as well as referral hospitals. To achieve these noble

objectives, priority was given to the development of health services infrastructure with a view to increasing quantity, ensure equitable access to essential health services as well as improvement in the quality of health service delivery.

The primary health care component is managed by the districts, town and city councils and health teams. The referral hospitals consist of hospitals owned by the government, mining companies and churches. At the beginning of NDP 9 there was a network of 3 referral hospitals, 6 district hospitals, and 16 primary hospitals. Table 9 shows that at the primary care level, 243 clinics, 340 health posts and 810 mobile stops provided preventative and curative care within communities. The majority of Batswana lived within 15 km distance from a health facility (Ministry of Finance, 2003). Today, Botswana boasts of 34 hospitals (there were less than 5 in 1966); 261 clinics; 341 health posts; and 461 mobile clinics. While these may not be enough they represent remarkable achievements in just 41 years (The Mid Week Sun, Wednesday 7th March, 2007 – Four Decades of Diamonds and Economic Development).

Provision of health services was part of other public services that became widely available through government programmes such as provision of safe water, which became almost universal (100% in urban areas and 80% in rural areas). Sanitary disposal facilities also became more widely available, although in the rural areas the availability of proper latrines is still not universal. In addition, nutrition programmes with food aid for the underprivileged were also started. The motivation is to improve the health status of the people by focusing on such critical areas as (i) income (ii) education and (iii) provision of health services. For instance, income is generally influenced by education – the higher the education one attains, the more income one tends to earn. In turn, better income allows purchase of goods and services that are essential for good health (food, housing, and clothing, services like water, electricity and health care). Education opens up the mind to new ideas and therefore the higher the education, the more likely one is to attain knowledge and adopt practices that promote good health, such as the use of health care services, family planning and good hygiene practices in the home.

Table 10 is a summary of trends in provision of health services overtime. It shows the type of health services provided at different periods in the history of the country, the prevailing ideology informing and guiding such provisions as well as the status of health in the country.

Table 10: Provision of health services in Botswana during the pre and post independence period

Years (between)	Period/Phase	ideology	Mode of health service delivery	Health situation
Before independence in 1966	Colonial rule	-Colonial indirect rule -Care provided by family and tribal framework (households, relatives, neighbors responsible -informal tribal based care	-over reliance on traditional medicine -Christian mission hospital started playing limited role in the provision of modern health services	Very poor by modern standards

1966-1969	-post independence -transitional plan for social and economic development	-On-set of Seretse regime -State led and financed intervention; state planning and control -social justice and development Care provided by family and tribal framework (households, relatives, neighbors responsible	-traditional medicine - Christian mission hospital played a key role as mission hospitals were constructed in major villages through out the country -limited government provision -Provision of health services not a priority	very poor by modern standards
1968-1973	-First decade after Independence NDP 1& 2	-Heavy state intervention -family continue to provide informal care at home (extended family) -neighbors involved -government led and financed intervention/policy -emphasis on quantity and close access	-plan emphasized provision of social services, including health -traditional medicine - Christian mission hospital provided limited health services -government services expanded rapidly to the rural areas	Moderate improvement esp. with introduction of RDP 1972
1973-81	Post-independence NDP 3 & 4	-government rapid expansion of health services -Adoption of the principle of Primary Health Care strategy -emphasis on quantity	-emphasis on rural development – in order to improve livelihoods for the rural poor - traditional medicine - Christian mission hospital expanded their health services -government provision of health services	improved significantly
1980-1990	NDP 5 & 6	-Onset of Masire regime (status quo maintained) - State led and financed health services -Family continue (both nuclear and extended family) -primary health Care strategy - Non-governmental organizations and private sector became a major player in health provision -debate on the role of traditional medicine -emphasis on both quantity and quality	-traditional medicine -missionaries partnership with government -government -private sector became a major player -health insurers and medical aid schemes introduced - government assumed the role of facilitator	massive spending on health led to tremendous improvement in the nations health status
1990-2000	Independence Globalization NDP 6,7 & 8	-State led and financed approved Health Policy (1995) - private sector - creeping in of new liberal thinking -introduction of health reforms --encourage participation of private sector on health -government begins talk about	traditional medicine -Some missionary hospitals taken over by the government -rapid expansion of government health services -health insurance and medical aid schemes expanded - private hospital widen choices and reduce burden on govt. hospitals	Started experiencing reversals Decline due to HIV and AIDS

		playing a facilitatory role - demand for quality health care increased -recognition of the role played by traditional medicine in primary health care Mogae regime took over in 1998		
2000 and beyond	Independence Globalization NDP 9	-State led and financed -State begins to see private sector and NGOs as partners - NGOs and private sector played major role --encourage participation of private sector -government now play facilitatory role -neo-liberal ideology become more pronounced -implementation of health reforms (cost sharing) - emphasis on quality of health care since quantity has been achieved	traditional medicine -Christian mission hospitals continue to play a critical role but in partnership with government -government expanded its funding to Christian mission hospitals -health insurance and medical aid popularized - introduction of cost sharing measures	-continued decline of national health standards due to HIV and AIDS

From Table 10 above it is clear that the health situation during the first few years after independence was pathetic. Due to lack of funding, health services were crossly inadequate and of poor quality. According to the Transitional Plan, there was one registered doctor per 26,000 of the population, two hospital beds per 1000 patients, only 83 dispensaries, the majority of which did not have trained staff, and there were very few and in some cases no specialists such as dentists at all. In addition, people had to travel long distances to access health services. As a result many people did not receive better health services (Transitional Plan 1966-69). However, the health situation improved dramatically with massive investment in the health sector by the state as indicated above.

Unfortunately, the years between 1990s - 2000 and beyond have witnessed reversals in the health gains that accrued in the 1980s. Since the advent of HIV and AIDS, both infant and under-five mortality rates have been rising. From the 1990s, both infant and child mortality rates increased to levels experienced in the nineteen seventies, primarily because of the devastating impact of HIV and AIDS. For example, HIV prevalence among women attending antenatal clinics increased from 13.5% in 1992 to 35.4% in 2002. It is estimated that 40% of infants born to HIV positive mothers who do not enroll for PMTCT therapy are infected with HIV (Millennium Development Goals Report, 2004). Furthermore, the Multiple Indicator Survey (2000) recorded infant mortality and under-five mortality rates of 57 per 1000 and 75 per 1000 respectively.

Related to the above problem, is the prevalence of severe malnutrition rate which has increased from 0.5% in 1996 to about 2% in 2000. Figures recorded for 2000/01 showed that 7-9% of children aged 0-5 had a low weight for their age or suffered Protein Energy

Malnutrition (PEM). It is important to note that, inter and intra district variations exist in malnutrition prevalence rates. For instance, district with remote area dweller settlements notably (Kgalagadi North and Gantsi) have persistently shown the highest malnutrition prevalence levels. Nationally, PEM deficiency in children was about 26% in 1993, declining slightly to about 23% in 2000 (MoH, 2005). Children 0-5 years also suffer from Iron Deficiency Anemia (IDA). Reports from the Ministry of Health (MoH) show that IDA is increasingly becoming common and therefore deserve attention.

The national Development Plan 9 provides a broader framework and political commitment to address PEM and IDA. The plan states:

> Good nutrition is the foundation of survival, health, productivity and national development. The provision of food and nutrition services in the country has been among the priority strategies of Primary Health Care. …. Overall, there has been some improvement in the nutritional status of the under-fives. However, the HIV and AIDS pandemic had a negative impact on the health and household food security of the affected households.

Current Initiatives to address the PEM and IDA

Given the trends in prevalence and severity of children who suffer PEM, the government of Botswana has introduced several pieces of legislation, policies and schemes to safeguard and promote the welfare of children. Programmes introduced include the following: Baby and Mother Friendly Hospital Initiative; Maternal Protection Laws; promotion of Breast feeding; introduction of nutritionally fortified food for the vulnerable groups such as ***Tsa Bana.***

The policies and programmes that impact directly on infant and child health in Botswana include but are not limited to; Expanded Programme on Immunization 1980; Health Policy, 1995; PMTCT, 1998; Population, Policy, 1999; Baby and Mother Friendly Hospital Initiative; Vulnerable Feeding Programmes; HAART 2002. With the introduction of Anti-Retroviral Therapy and country-wide implementation of the Prevention-of-Mother-to-Child Transmission (PMTCT) programme, the situation has improved tremendously and is making positive impact in reversing the trend in both infant and child mortality (CSO, 1999).

All programmes referred to above are funded by the Government of Botswana and their overall objectives are to improve child survival and development by reducing mortality and morbidity rates.

The above policies have contributed significantly to health promotion and disease prevention in Botswana, especially among the poor who could not afford such health services on their own. To that extent, universal provision of health services have been essential in ensuring equity, access to and utilization by those afflicted by poverty. To this end, provision of health services has contributed significantly to the fight against poverty in Botswana.

Despite the above interventions, infant malnutrition continues to rise, mainly due the devastating impact of HIV and AIDS. Breast feeding, the long recommended source of nutrition and protection from disease for infants, is not an option for HIV positive mothers because of the risk of HIV transmission from mother to child. The public health system provides infant formula as a substitute for breast feeding to HIV positive mothers who enroll for PMTCT. However, this is not enough because artificial milk cannot replace the mother's natural milk hence the need for nutritionally sound foods to supplement children's diet. These limitations notwithstanding, Botswana has managed to dramatically reduce mother-to-child HIV transmission rates to fewer than 4 %, a rate more commonly seen in developed countries (Mmegi, the reporter 28th August, 2007).

Financing Health Services in Botswana

The provision of basic and affordable health care is an important aspect of poverty reduction. To that effect, Botswana's health care system is financed from the national budget. While the revenue from user fees is meant to contribute to the financing of the health care system, that contribution is not generally forthcoming. Most Batswana, especially in the rural areas, perceive health provision as the responsibility of the government.

As indicated earlier, health is the responsibility of two ministries – the Ministry of Health and Ministry of Local Government. The Ministry of Health is responsible for the overall policy direction, ideological direction, initiation and implementation of major national projects such as referral hospitals and monitoring and evaluation of health care in the country. The Ministry of Local Government is responsible for primary health care i.e. construction of clinics and health posts and their administration. The two work closely together to implement the health policy and ensure good health and welfare for all citizens.

Financing health like education has been the responsibility of the Government since independence. Budgets are prepared yearly and presented to parliament and then included in the 5 year national development plans. Tables 11 and 12 below show specific capital budget items for the ministries of Health and Local Government for the entire NDP 9 plan period. Recurrent budget estimates have also been included for the Ministry of Local Government.

Table 11: Capital budget: Ministry of Health 2003-2009

	2003/04	**2004/5**	**2005/06**	**2006/07**	**2007/08**	**2008/9**	**Total**
Institute of health	19 262	85 100	46 000	50 200	49 900	120 847	364 309
Improvement to hospitals	233 438	324 055	374 445	397 100	346 700	406 862	2064 600
Medical teaching hospital	0	88 245	100 000	161 755	120 000	102 000	572 000
Primary health care	2 500	12 500	15 500	20 300	3 500	1 700	56 000

programmes							
Improvement to technical support services	1 500	14 000	13 000	15 000	16 800	20 900	81 200

Source: NDP 9

With a capital budget on Health in excess of 3 billion (P3 138 109) for a five year plan period, Botswana is spending over 10 % of its budget on health – one of the highest in sub-Saharan Africa. As noted there is now virtually universal access to primary health care. In recent years, however, the emphasis has now shifted to upgrading of hospitals and training of medical personnel. Table 11 shows huge budget for improvement of hospitals, institute of health and a medical teaching hospital.

Table 12: Capital budget: Ministry of Health 2003-2009

	2003/04	2004/5	2005/06	2006/07	2007/08	2008/9	Total
Capital	29 000	45 400	52 300	57 900	49 300	40 900	274 800
Recurrent	6 000	6 900	5 700	4 200	3 300	3 900	30 000

Source: NDP 9

Table 12 shows the ministry of Local Government current budget and budget projections for the entire NDP 9. Table 12 reports available budget allocation for the different years in current prices. The figures reflect the amount received by the ministry for both capital and recurrent. Total budget for Primary Health Facilities was recorded as P274 800 million for the entire NDP 9. The budget has risen steadily from P29 000 million in 2003/04 to P57 900 million in 2006/07 and is projected to decline slightly between 2007-2009. The increase is mainly attributed to the construction of new health facilities in order to improve access and bring services closer to the people.

Note that recurrent expenditure show a steady decline from 2005 and is projected to go down until 2009. This is because maintenance costs for facilities are likely to be low, especially with newly constructed health facilities.

Health and HIV and AIDS

The first case of HIV and AIDS related illness was discovered in 1985. From that time on, the virus that causes AIDS spread rapidly from urban and peri-urban areas to rural areas, leaving no district spared by the epidemic. Sentinel survey among pregnant women carried out in all the 22 health districts of the country showed prevalence rates ranging from a minimum of 23.3% in Gantsi to a maximum of 51.1% in Tutume. The HIV trend during 1993-2001 for all age groups apart from those aged 19 and 20 to 24 years increased gradually and have reached in 2001 at least twice the prevalence in 1992.

Since 1992, Botswana has been monitoring the HIV/AIDS epidemic through annual sentinel surveillance of pregnant women attending antenatal clinics. The most current sentinel survey was conducted in 2003 in all 22 districts and a total of 7,251 pregnant

women participated in the survey. Overall, countrywide, a prevalence rate of 37.4% was recorded.

However, unlike the previous studies, the latest survey Botswana AIDS Impact Survey 11 (CSO, 2004) found that the overall HIV prevalence in the general population aged 18 months and older was estimated at 17.1 percent. The most affected age groups range from 25-44 with a prevalence rate of 30.5 to 40.7 percent respectively. This shows that HIV prevalence is very high at the prime of childbearing ages. In terms of the impact of the epidemic, the latest figures reveal that about 18% of all deaths were attributed to HIV/AIDS and these are concentrated in the prime ages (NACA, 2003). HIV/AIDS dramatically affects labor, setting back economic activity and social progress. There are a number of different prevention programmes in Botswana. These include among others, public education and awareness, condom distribution, PMTCT and Voluntary Counseling and Testing (VCT).

The following causes seem to be the major determining factors; biological and physiological factors, intergenerational sex, socio-cultural factors and gender inequality and discriminatory practices that put women at a social and economic disadvantage.

Notwithstanding the above, there appears to be a significant decline in the spread of HIV/AIDS. For example, BAIS 11 (CSO, 2004) estimates the national HIV prevalence to be 17.1% (19.8% for females and 13.9% for males). This figure is believed to be a more accurate figure than the previously quoted figure of 37.4% in 2003 (UNAIDS Report, 2005). This is because BIAS 11 was a population-based survey involving males and females 10-64 whereas the UNAIDS report was based only on pregnant women of childbearing ages who present themselves for antenatal care. The recent statistics indicates a reduction in the prevalence of HIV today compared to 10 years ago, in particular, among the younger age groups (Minister of Health-Mmegi, March, 14, 2006). For example, the 2005 Sentinel Surveillance, which tests pregnant women, aged between 15-49 years and attending government clinics, showed HIV prevalence had decreased from 37.4% in 2003 to 33.4% in 2005. The preliminary 2006 Sentinel Surveillance shows that HIV prevalence decreased to 32.4% in 2006, again the highest reduction being among the youth. The reduced prevalence rates suggest that the rate of new infections is declining. The decline suggests that the various interventions are beginning to yield some positive results. HIV prevalence rates for the various districts are summarized in Table 13 below:

Table 13: HIV Prevalence from BIAS 11 and 2003 ANC

District	15-49 (%)	18 months + (%)	ANC (2003) 15-49 (%)
Francistown	29.6	24.9	45.8
Selebi-Phikwe	33.9	23.7	52.2
Ngwaketse West	25.4	16.2	25.7
Central-Serowe	27.2	18.6	43.3
Ngamiland South	25.5	16.7	38.4

Chobe	49.7	29.8	47.0
Ghanzi	16.8	14.5	-
National	25.3	17.1	37.4

A reduction in HIV and AIDS prevalence is attributed to government commitment to assist all Batswana affected by the pandemic irrespective of their socio-economic status, ethnicity and gender. The Government of Botswana, in line with the principles of universal health care provision and the long term vision of Botswana – Vision 2016 seeks to promote health for all. With respect to HIV and AIDS Government main response to the pandemic has been through the National AIDS Council (NAC) and the National Coordinating Agency (NACA). NAC is chaired by the President of the country. NACA serves as the lead agency for coordinating all prevention, care and support, treatment and community mobilization programmes run by government ministries and departments, Private sector, NGOs, CBOs and communities. A multi-sectoral approach to bring all the coordinating structures together has been established since the early 1990s. Most HIV and AIDS services target everybody and are provided free of charge. These include: ART, PMTCT, IEC, IPT, and community home-based care, HIV counseling and testing. Government has also introduced "routine" and "voluntary" testing to encourage and facilitate the goal of having all citizens knows their HIV status. This remains a prerequisite for halting the spread of the pandemic (NSF, 2003/09; NDP 9).

Major achievements and successes on HIV and AIDS became noticeable after the introduction of free ARVs for all citizens of Botswana in 2002. Free ARVs were distributed through the Masa programme. In August 2006, there were 70 000 beneficiaries. The poor were the great beneficiaries since evidence show that before the introduction of ARVs, they were dying in large numbers since they could not afford the treatment on their own.

However, the greatest challenge faced by the Government of Botswana is to answer the following questions: (i) Do Batswana possess the necessary will to fight the pandemic given that there is still no known cure for AIDS? And (ii) given the link between poverty and HIV and AIDS what innovative strategies are being undertaken by the government to deal with poverty among those affected or infected by HIV and AIDS? These questions are not easy to answer. The difficulty arises from the fact that the war and ultimate defeat of the virus depends on individuals. Government cannot defeat the virus; neither can the civil society of organizations or international donors. In the end it is individuals who must assume personal responsibility (President Mogae, 2007).

Compounding the above problems, HIV and AIDS has emerged a major development challenge posing a great threat to continued economic growth and sustained educational provision, mostly because of its impact on the labor force, savings and investment. Thus, impressive gains in the economic and social sphere are being reversed by the ravaging effects of the epidemic. For example, the increase in sickness and mortality rates among the educated labor force, have impacted negatively on the capacity of households to provide for other members of the family leading to poverty (CSO, 2001). This has far reaching implications for education as a strategy for poverty reduction. More funds are

being diverted into HIV and AIDS programmes at the expense of the education sector forcing the government to institute reforms and leaving many disaffected people. Discontent breeds anger and frustration and may be a threat to democracy.

Private spending on health

Botswana Government is responsible for providing health services throughout the country. In addition, the private sector also plays a pivotal role in providing health services. Since the late 1990s, there are a significant number of private health care providers entering the market. For example, there are hospitals run by mining companies, a major private hospital in Gaborone, and numerous private medical and dental practitioners. Private sector contribution is important in that it; broadens choices of health facilities in the health sector, sharing costs of providing national health care, reducing pressure on the government health care budget and enable government to enhance the quality of its own services (Republic of Botswana, 1991:374).Although at present it is not possible to determine the magnitude of private health expenditure as data is not available (i.e. not centrally compiled). Estimates by Duncan et. al (1998) show that private expenditure on health care was approximately P60million in 1993. This is much smaller compared to total government expenditure of about P230million in 1993-4, but nevertheless a significant proportion representing approximately 20 percent of total health care spending in the country outside the government. This share is likely to increase overtime with rising real incomes and as more and more employees join private medical insurer such as BOMAID, BOPMAS as well as one for low income earners.

Health access and equity: Access to health services by the poor

Botswana has a health policy that promotes universal access to health services. Everyone irrespective of their gender, age, socio-economic status have equal access to health services. Those who are poor and cannot afford to pay user fees at hospitals and other medical centres are exempted from paying. Even for those who pay, they are highly subsidized by the government. Subsidy applies to both citizens and non-citizens. For example, until the 1st of September, 2007, to visit a doctor in any government medical facility cost a paltry P2.00 (about 40 US cents), which was only increased to P5.00 (about 85 US cents) the beginning of September. Prior to the figures above it used to cost only 40 thebe (about 6.5 US cents) to visit a doctor.

Other health services, in particular, services provided for HIV and AIDS patients such as ARV, PMTCT and others are offered virtually free of charge. All expenses are covered by the government with minimal assistance from international organizations.

Government commitment to provide free health services for the poor is further demonstrated by provisions in the Revised National Policy on Destitute Persons (2002) clearly specifies categories of people defined as destitute. All categories of destitute persons are exempted from payment of publicly provided health services. These include but are not exclusive to medical fees, school fees, water charges, service levy and electricity charges. Occasional taxi and bus fares are also paid for transport to and from school at start and finish of each school term for needy people. Also in recognition of the

difficulty circumstances under which needy student study, they student are given the opportunity to repeat in order to improve their grades and all expenses are paid for by the Ministry of Education.

In order to achieve the above, the emphasis was on equity, community involvement inter-sectoral collaboration and most importantly provision of health services which were appropriate, accessible and affordable. Successive national development plans have emphasized these commitments, in particular NDP 6, 7 & 8 have emphasized the need to promote social justice with a view to securing livelihoods and improvement of access to public services, in particular , by the poor living in the rural areas. The plans recognizes the problems of persistent poverty in the rural areas hence the need to provide public services such as health to improve quality of life.

It is also important to point out that in the quest for universal coverage and equity and in line with WHO declarations; the Government of Botswana (during NDP, 7) adopted the principle of Health for All by the year 2000. Health for All by the year 2000 sets a new and higher target for public health, seeking not merely to provide services but to assure every citizen of Botswana of the level of health that allows him/her to lead an economically and socially productive life (Republic of Botswana, 1991).

Health sector reform and its motivations

Since 2000, the government of Botswana has introduced the concept of health sector reforms as a guiding principle in the provision of health services in the country. According to NDP 9, health sector reforms were designed to improve the functioning a performance of the health sector and ultimately the health status of the population. However, it is important to point out that, reforms have been part of the government of Botswana broader policy agenda since the 1990s. The minister responsible for health noted in her numerous public speeches that, in the area of health, it was becoming clear that universal provision of health services could not be sustained in the long term and hence the need for citizens (i.e. those who can afford) to make a small contribution and assist the government in provision and maintenance of viable public health services. Health sector reforms were considered inevitable in the light of the light of international trends in health sector reforms. Worldwide there is a move towards greater participation of citizens in their own health. Increasing pressure is being put by the World Health Organization (WHO) on countries (member states) to provide sustainable curative, preventative and promotive medical care and to ensure equity in access to health services.

Cost recovery in the health sector

Studies undertaken by the Ministry of Health on user fees indicate that the user fee system is disorganized, weak and ineffective in providing cost recovery oriented revenue to government. The government has started the process of cost recovery on medical costs since June, 2002, with all foreigners being charged the full cost. While the intention is to eventually charge citizens full costs. Government is mindful that this may have implications for accessibility of health care to poorer sections of the population (NDP, 9).

Government expenditure on public health is aimed at providing health services to all Batswana. Health services in Botswana have been offered almost free of charge to all citizens since 1966 to date. A patient reporting at a health facility is only required to pay a small fee of P2.00 (an equivalent of 40 US cents). No one is denied access to and utilization of health services because of inability to pay the P2.00. In addition, ambulance services were offered completely free. However, this will no longer be the case. With effect from the 1st September, 2007, the Ministry of Health has announced increases in the cost of public health services. The general outpatient fees for citizens will be hiked from P2.00 to P5.00. Other fees that will be hiked include admission, medical examination, and ambulance services. According to officials from the Ministry of Health:

> The government decided to revise medical fees after they have been stagnant over 20 years, while major changes have continued to occur in the health services. The new charges are a result of the ongoing efforts of introducing cost sharing measures so that government can be able to improve and strengthen the delivery of quality health care to all its citizens.

The government of Botswana noted that over the years the volume of patients and types of services offered have expanded , becoming more complex and sophisticated, resulting in a drastic escalation in related costs.

However, despite all the above, citizen children below the age of 16 years and destitute persons registered with the Department of Social Welfare have been exempted from paying. Refugees living in refugee camp, prisoners in police custody pending trial have also been exempted. Furthermore, treatment of all diseases of public health importance such as tuberculosis, malaria, sexually transmitted infections and HIV and AIDS will be free but to citizens only. This initiative is meant to ensure that public health services are also provided for the benefit of the poor who are unable to contribute towards a public health insurance scheme or a private health insurance scheme.

Government and parastatal sector employees have an option to join a contributory medical aid scheme, in which the employer contributes 50% and the employee 50%. Private sector employees also have access to such schemes with varying employer contributions. Most government and private sector employees prefer to participate in contributory medical aid schemes because they are prestigious. They operate like a health insurance scheme and through them one is able to access the best private medical doctors and services at a private clinic or hospital within and outside the country, while government hospitals are overcrowded and perceived to provide poor quality medical services. Many of the clinics and health posts across the country do not have well trained staff or adequate equipment. Many people have had to travel long distances to obtain health care, especially in the remote settlements. This is a challenge that Botswana will have to meet by the year 2016.

Conclusion

One of the major challenges facing the health sector which has broad implications for delivery of health services in the country is that four decades of rapid economic growth

have not translated into a concomitant increase in the number of health workers to enable more rapid improvements in the quality of health services. Duncan (1998) observes that in many instances, it has proved easier to invest in expansion than to bring about the changes in peoples knowledge, attitudes and practices about health and hygiene services that are fundamental to the prevention of health problems and if people are to make good use of health services.

Housing

Housing is a universal basic human need, provision of which should be made by all countries. Peattie (1979) provide a broad conceptualization of the concept "House". He argues that, in the lives of the urban dwellers, housing encompasses numerous functional elements over and above that of physical shelter. Firstly, a house offers privacy; it is a form of shelter from the outside world that provides the family, irrespective of their socio-economic background a space for sleeping, eating and carrying out basic socio-economic functions. Secondly, a house is located within the wider community and in this sense it offers the owner linkages with places of work, community facilities (i.e. schools and clinics), shops, recreational facilities and social interaction. Thirdly, provides access to clean water, roads, electricity and sanitation. It is therefore an embodiment of and links an individual or the family to a network of other services offered in the community. Finally and most importantly, a house is a form of investment, it offers the family a means of establishing its social identity, financial security and social mobility. Given the above, the need for decent shelter cannot be over-emphasized.

In Botswana, the housing sector is a major contributor to national economic development. Botswana has over the years experienced a construction boom. Large scale housing development contributes to socio-economic development employment creation and investment. A large number of people are usually employed in housing construction. The housing sector therefore provides employment opportunities and therefore income for the family, which has a positive impact on poverty reduction. For example, the construction sector was a major contributor to employment during NDP 7, accounting for about 15% of formal employment in 1991.

Note that houses can reveal so much about the way of life and standard of living of their occupants. For the poor the home is merely a residence, while for the wealthy building a nice comfortable house is one way to demonstrate one's wealth in today's society. So building a house is very much dependent on the economic situation of the individual household. People with improved housing have been employed in cash paying jobs in both rural and urban areas. If housing is classified according to income we find that in general the traditional huts house the very poor households... The government of Botswana is attempting to assist the people in the rural areas to improve their housing as one way of improving living standards.

Historical Perspectives

Historically, Batswana lived in their villages in the rural homes. There was no shortage of housing as members of the family build their homes through self-help and shared the

household. Constructing a house was also cheaper in that natural materials such as mud, reeds and poles were easily available and in abundance. Housing was also a communal project because members of the family would come together to help each other build a home. No help was sought from the government and governance that existed at the time did not consider it their responsibility to provide housing for the people. Land was not sold but allocated for free to all citizens who needed. Every citizen enjoyed security of tenure. It is important to point out that, to date, citizens of Botswana still enjoy security of tenure.

The traditional system of housing development changed rapidly during the post-colonial era. After independence, new towns emerged. This necessitated the move from the rural to the urban centres in search for jobs. Gradually, many workers stayed longer in towns as more jobs became available and their needs for shelter increased under the influence of the cash economy. Some workers started bringing their families into town, hence the need for more space and shelter. As the urban population gradually increased, it put a lot of strain on the available un-serviced land in towns. An increase in industrial development since independence, an influx of people into towns leading to an exponential increase in urban population and the need for more land and shelter necessitated a response from the Government in terms of policy.

The first National Housing Policy was introduced in 1982 following the work of a Presidential Commission on Housing. The policy recognized and underscored the need for decent shelter and equitable provision of such. It called for the creation of institutions focusing on provision of housing for the Government and people of Botswana, strengthening of the private sector, provision of housing subsidies, and improvement of building standards and divestment of the Botswana Housing Corporation housing stock.

During the 1970s, 1980s and 1990s the majority of Batswana resident in towns could not afford, out of their wages to build houses nor even to rent. Botswana Government created two parastatals: the Botswana Housing Corporation (BHC) and the Btswana Building Society (BBS). The BHC was established in 1970 to build houses and provide rental accommodation for Batswana at highly subsidized rates (i.e. on a non-profit basis). Botswana Building Society was also created to provide housing loans or mortgaged schemes for those who could afford. This was followed by the introduction of a highly subsidized low-income home-ownership scheme in municipal townships through site and services area programme known as Self Help Housing Agency (SHHA). SHHA targeted low income poor people who could not afford to buy (through BBS mortgage loan, rent BHC houses or build themselves a house.

The policy recommended that housing become one of the national priorities. Since large sums of funding were required to construct houses, the government took the responsibility and initially injected huge sums of money to develop infrastructure. Given shortage of serviced land in towns, the focus was to provide serviced land. This led to the birth of Accelerated Land Servicing Programme (ALSP) in 1987.

Major achievements of the 1982 policy, which has implications on the welfare of the people include: the formation of the Presidential Commission on Land Tenure leading to land reforms in 1983; the launching of the Accelerated Land Servicing Programme; and a broad range of programmes that brought essential services to the rural population; improving and extending SHHA programme for the benefit of the urban low income and poor households. Given the political will and commitment from the leadership of the country, the Department of Housing was created in 1994. The creation of the department was a step forward to putting housing on the national priority list. Through the department, it was possible to mobilize financial resources hence large sums of money were invested into the housing sector through the Public Service Debt Fund. The outcome was large scale provision of shelter and associated services, increased home ownership and improved quality of life for citizens who, as a result of Government intervention are now enjoying decent shelter.

Government Policy and Housing Provision - Post Independence housing strategies

Since independence, the Government of Botswana has recognized provision of adequate and decent housing as a basic need and an essential element in improving social welfare. Housing is recognized as playing an important role in contributing towards the socio-economic development of the country by reducing poverty. The importance of providing decent housing for all is therefore appreciated by the government. This is clearly demonstrated by the amount of resources invested in housing development and most importantly, by the creation of institutional structures to support housing such as the creation of the Ministry of Lands and Housing, which was previously a division in the Ministry of Local Government. and later the creation of the Department of Housing in 1994.

Government policy on housing in Botswana is well spelt out in the National Policy on Housing Botswana (2000). The main goal of this policy is to provide decent and affordable housing for all within a safe and sanitary environment. The other policy document that addresses the issue of housing is the National Population Policy (1997), which recognizes that housing has far reaching implications on the health and productivity of the population. The policy therefore endeavors to ensure access to safe and sanitary housing as well as increasing the number of citizen owned housing. The policy sought to create a conducive environment to facilitate public, private and community participation in the provision of affordable quality housing.

The Botswana Vision 2016 envisages that by the year 2016, all Batswana will be able to obtain access to good quality basic shelter in both urban and rural areas, including; privacy, space, security, lightning and ventilation – basic infrastructure at a reasonable cost in relation to income. The goal of the National Policy on Housing is to facilitate the provision of decent and affordable housing for all within a safe and sanitary environment. This will contribute immensely towards achievement of Vision 2016 pillar of " A compassionate Just and Caring nation". According to Botswana Vision 2016, in order to have a healthy society by the year 2016, it is essential that shelter is provided in accordance with this vision (for those who cannot afford, Government has an obligation to provide subsides.

The National Policy on Housing emphasized the following:

- To change the emphasis of Government from home provision to facilitation in the various settlements in partnership with other stakeholders
- To channel more government resources to low and middle income housing in both rural and urban areas
- To promote housing as an instrument for economic empowerment and poverty alleviation
- To foster a partnership with the Private Sector and all major employers in home development and facilitating home ownership

Concerted efforts have been made in order to achieve the above strategies, including:

- Provision of serviced land in all urban areas and some major urban villages. Land could be serviced by BHC or the private sector. Where large areas of land are serviced, they will be required to provide for all income groups with preference given to lower and middle income households.
- Provision of financial and technical assistance to home owners both in the rural and urban centres
- Upgrading slum and high density areas in the urban areas
- Provision of self-help housing schemes with housing loan facilities and service infrastructure provision by the government

In order to finance the housing programme, government decided on the following strategies:

- Provide guarantee mortgage loan schemes for all income groups (high, middle and low). Guarantees vary according to the level of income.
- Government allocates funds directly to the SHHA scheme located in the local authorities at subsidized rates. Government recognized that the cost of housing has gone very high, far beyond the means of the poor.
- Expand the SHHA building material loans (BML) and increase the threshold from P20 000 to P40 000 in order to cover current costs of building a decent low-cost house
- SHHA beneficiaries who have cleared their previous loans should be allowed additional loans to extend or improve existing houses.

It is important to point out that as a result of the above efforts, the post-independence period also witnessed rapid development of the housing sector but, unlike education and health, this sector did not provide universal coverage, as housing was mainly concentrated in the urban areas to cater for the large numbers of people who migrated from rural areas to seek employment. In urban areas, entities such as the BHC and SHHA were established to respond to housing needs of Batswana. Because BHC could not cater for the low-income households living in urban centers, SHHA became the main instrument through which the poor gained access to affordable housing. Note that SHHA was only introduced in the rural areas in the late 1990s. Because of rural-urban migration, provision of land and adequate housing is a serious problem, resulting in the mushrooming of slum areas for people who cannot afford decent accommodation in areas built on serviced land. This has serious implications for the environment and provision of other social services because it often compromises the quality of life for slum dwellers.

Housing characteristics

The 1981 and 1991 census records show that the majority of the people in Botswana live in traditional huts. According to the 1991 census 64 % lived in traditional huts against 24 % who lived in "modern" housing. The remainder (about 9000) households lived in non-dwelling, the majority of these (65 %) live in the non-urban areas (see Tables 14 below).

Table 14: Types of Housing Units (# of h/holds, 1991 Census

Location	Modern %	Lolwapa %	Rooms %	Others/ns in %	All %
Urban Centres	52.05	16.71	27.11	4.13	76.11
Urban Villages	24.51	71.16	2.48	1.85	64.77
Rural	08.48	87.25	.86	3.41	135.326
All	24.24	64.04	8.47	3.25	276.209

Source: Living Conditions in Botswana: 1986-1994 CSO – 1996.

Modern house: Detached house; semi-detached house, flat or town house

Lolwapa: traditional huts (not compounds)

Others: commercial buildings, shacks, movables, rooms and not stated

Table 15: Types of Housing Units (# of h/holds, 1991 Census

Location	Commercial buildings	Shacks	moveables	Not stated	Total
Urban	35 1.1 %	1624 52 %	1095 35 %	365 11.9 %	3,119 100%
Major Villages	72 5.8 %	366 29 %	617 49 %	204 16.2 %	1 259 100%
Rural	95 2.0 %	1358 30 %	2510 55 %	621 13 %	4 584 100 %
All	203 2.3 %	3348 37 %	4222 47%	1 190 13.3 %	8 963 100 %

Source: 1991 population and Housing Census, CSO – 1991.

Table 15 shows that nearly 40% of Batswana lived in shacks in 1991. The majority (52%) were in urban areas, followed by 30% in rural areas and 295 in major villages. Interestingly, almost half (47%) lived in moveables i.e. makeshift structures. Indeed, these figures are a source of concern because overall they show that over 50% of Batswana in 1991 were living in sub-standard inhabitable conditions with serious implications on their quality of life.

Table 16: Housing units by type 1991 and 2001 census data

Type of housing	1991	2001

Traditional	176,881	89, 713
Mixed	-	75, 462
Detached	55, 409	137, 924
Semi-detached	7, 464	16, 312
Town house	2, 805	11, 475
Flats	1, 288	3, 449
Part of commercial building	203	811
Moveable	4, 222	5, 019
Shack	3, 348	6, 884
Rooms	20, 825	55, 895
Shared	-	806
Other	3, 764	21
Not stated	-	935
Total	276, 209	404, 706

Table 16 shows that an overwhelming majority of Batswana lived in traditional housing units in 1991, which they build themselves (176, 881). Interestingly, this number was reduced almost to half in 10 years as reported during the 2001 Census that only (89, 713) Batswana were living in traditional units. Data reveal that in 2001 a large number of Batswana now lived in modern detached housing units. This means with the introduction of government housing programmes and schemes, the housing situation has greatly improved and many people now live in decent housing.

Homeownership in Botswana

According to the 1993/94 Household Income and Expenditure Survey (HIES) estimates, SHHA housing accounted for 25 % of home ownership in urban centres. However, without SHHA programme the proportion of housing ownership drops to 8 % at national level. These figures are a clear demonstration on the impact of the SHHA scheme in housing provision in Botswana.

In urban centres the most common tenure ship is renting at almost 60 %, in rural areas, most people (84 %) own their houses. At a national level, the high percentage (60%) of home ownership is in spite of the very low proportion (7.2 %) of urban home owners (Table 17).

Table : 17 Type of dwelling unit and ownership

Location	Owned %	SHHA %	Rented %	Other %	All %
Urban	7.2	25.51	58.56	8.71	87, 419
Major Villages	75.70	0.29	19.11	4.89	67, 218
Rural	84.25	0.59	7.03	8.13	136, 97
All	59.19	7.99	25.26	7.56	291, 610

Sources: 1991 population and Housing Census, CSO – 1991.

From Table 17, it is clear that the majority of Batswana in both the rural and major villages own their houses 84% and 76% respectively. Only a few people own houses in urban areas. About a quarter (25%) lives in and some rent SHHA houses. The conclusion that can be reached from these statistics is that the majority of Batswana have security of tenure.

Table 18: Number of housing tenure classified by rural and urban areas

Housing	Rural	Urban
Purchased	3, 087	8, 800
Rent (BHC)	3	10, 779
Rent (Government)	3, 629	9, 207
Rent (Council)	2, 166	4, 974
Rent (Individual)	5, 780	72, 723
Rent (Company)	803	10, 772
Rent (VDC)	2, 650	849
Inherited (owner occupant)	5, 778	6, 188
Self-built (owner occupant)	130, 424	94, 401
Free job-related	14, 282	14, 754
Others	39, 683	213
Don't know	1, 189	1, 097
Total	209, 474	234, 544

Source: Analytic report 2001 Population and Housing Census – CSO, 2004

Living Conditions

According to Living Condition in Botswana Report 1986-1994, the number of households with one or two persons per room has decreased in the period of the survey. In addition the percentage of house holds with three or more persons per room has decreased over the same period. There is therefore a strong suggestion that there is less overcrowding at the national level than in the past.

Table 19 below is based on HIES data. It summarizes the number of households in the three locations and provides useful data on the number of persons in each household per room. On average, it shows approximately 50% of Batswana in 1993/94 lived in decent housing with at least acceptable 2-3 persons per room. Thus overcrowding was not a problem.

Table 19: Number of rooms per household (1991) census)

	H/Holds Total #						
		1 rm %	2 rms %	3 rms %	4 rms %	5 rms %	< 5 rms %	All
Urban	87 419	40.7	16.9	22.2	13.3	4.9	2.0	100
Urban village	67 218	23.9	29.4	23.0	13.0	5.5	5.1	100
Rural	136 97	21.7	28.5	25.6	12.6	6.5	5.2	100
All	291 610	27.9	25.2	24.0	12.9	5.8	4.2	100

Source: Households Income and Expenditure Survey: 1993/94 – CSO, 1995.

Table 20: Number of persons per room (No. of h/holds – 1993-94 HIES)

Location	1 – 2	3 - 4	5 -6	> 6	All %
Urban	77.16	18.16	4.02	0.66	87 , 419
Urban Villages	65.22	27.43	5.38	1.96	67, 218
Rural	63.78	28.56	6.31	1.35	136, 97
All	68.12	25.18	5.41	1.28	291, 610

Source: Living Conditions in Botswana 1986 – 1994, CSO – 1996.

According to the 1991 Census and the HIES 1993/94 the total number of rooms used for domestic accommodation were 690 125; and 60 017 in 1981 and 1994 respectively (see Table 21 below).

Table 21 Average number of Rooms per household

Location	Census 1991			HIES 1993/94		
	House holds	Rooms	Rms per H/hold	Households	Rooms	Rooms/ per H/hold
Urban	76, 111	198, 746	2.61	87, 419	204, 092	2.33
Urban Villages	64, 772	161, 930	2.50	67, 218	179, 751	2.67
Rural Areas	135, 326	329, 449	2.43	136, 937	376, 174	2.74
All	176, 209	690, 125	2.50	291, 610	760, 017	2.60

Sources: Household Income and Expenditure Survey, 1993/94: CSO – 1995.
1991 Population and Housing Census; CSO, 1991

The above Tables provide a summary of living conditions in Botswana as reflected by the characteristics of the houses people occupy, number of persons per room and average number of persons per room in terms of whether dwellings are owned or rented. The bulk of the data were obtained from the 1991 Census and some from the HIES 1993/94. From the above statistics it is clear that government interventions referred to earlier, in particular, the introduction of SHHA were bearing positive results. SHHA has made

tremendous impact in provision of low income housing to the poor, especially in the urban centres. While many people still occupy shacks and live in slums, a substantial number of people in urban areas either have their own shelter; live in a rented home and the average number of persons per room is at acceptable levels. This means that overcrowding has been reduced significantly. There seem to be a general move from typical traditional structures to more modern houses. The improvement is more visible in the quality of housing units. More houses are now constructed using durable materials when compared to traditional thatch roof and hand mould mud bricks wall.

Overcrowding

Overcrowding is a health hazard. It increases the risk of pollution and airborne infection like tuberculosis and other respiratory ailments. Sanitation problems increase and many people are exposed to health risks. Data from the 1991 Population and Housing Census indicate that about 18 % of urban population lives in overcrowding conditions. This is a huge chunk of the urban population with serious implications for the quality of life of many Batswana living in urban centres. The reason is simple: many people who migrate to the cities with the hope of getting jobs are unable to get jobs. They end up squatting with relatives or friends. Alternatively, they rent out small shacks together and live in squalid conditions.

In an attempt to reduce overcrowding, the Ministry of Local Government Lands and Housing (MLGL & H), has since 1989 made concerted efforts to ensure provision of decent and affordable housing, especially in the urban areas. For example, during the period under review 52 % of the houses were provided under the SHHA scheme, followed by BHC with 17 % of the total stock (one third of SHHA housing number). In 1995 BHC housing stock was 18 000 after sales compared to SHHA 27 000. The SHHA therefore remained the greatest single contributor. In fact since the allocation of Accelerated Land Serving Programme plots commenced, the opening had completed about 447 more houses (Review of the national Policy on Housing, 1997).

Housing and land Affordability

Affordability of housing is determined mainly by income. However, it is observed that even when income is available, supply and demand for housing is critical. In urban areas provision of serviced land is the major determinant of supply of housing, since housing cannot be developed until government services and allocates plots. Once serviced plots are available, the BHC and SHHA are the major players with the corporate sector, government and individuals playing a less significant role. According to the Director of Housing – Botswana Government Ministry of Land and Housing, the Government of Botswana has since the establishment of the Housing Department committed to assist the poor. The priority and focus of the Department is on the implementation of SHHA scheme and the Integrated Poverty Alleviation Housing Scheme. The Government is clearly biased towards the poor than other income groups who can be catered for by the market.

Developments in the SHHA were not encouraging during NDP 7. It is important to point out that NDP 7 coincided with the ALSP for which plot allocation did not commence before 1993/94. Also there was temporary freeze of SHHA plot allocation between 1990 and 1993 during which period, no plot was allocated. The freeze was meant to facilitate a review of SHHA programme.

The current housing problem in Botswana is that a large number of households cannot afford houses at current prices and with current income levels. For example, in 1997 a well constructed house of modern standards costs approximately P900 per m2. The current cost of residential land with services is generally P35 per square meter. Therefore a small ploy of 400 square meters would cost about P14 000. This figure does not include the cost for utilities such as water, electricity nor does it include taxes, insurance and maintenance. Using the conventional assumption that total housing expenses should not exceed 25 % of household income, one is led to the conclusion that a in 1997 (nearly 10 years ago) family would have to have a monthly income of P2264 to be able to afford full cost of new housing of even the modest type. Such a house would only be affordable to civil servants earning between 2500 – 3 500 per month. However, as modern housing is more expensive than the traditional one, accessibility of this type of housing depends on affordability by the household. The prevailing cost/pricing regime (i.e. for land, building and finance) means that only one household in five could afford even the basic 50m2 house.

From the above, it is clear that commercially constructed houses are economically inaccessible for a substantial portion of the population. According to the HIES 1993/94, the income needed to pay for such a loan is accessible to only around 19 % of urban households. Put differently, four out of five households cannot afford to purchase or build even a modest home of their own. Therefore reducing the cost of land, construction and finance is one of the most important issues to be addressed.

Given the above reality, the Government of Botswana, during NDP 8 introduced new initiatives to encourage and promote home ownership. The objectives of Government during NDP 8 were among others to: (i) integrate income generation with shelter provision as a strategy for poverty alleviation and (ii) to provide assistance to households who do not qualify for the SHHA programme, and cannot afford BHC houses.

Government commitment to address housing needs of the poor and other low income groups was further demonstrated by the introduction of the Poverty Alleviation and Housing Scheme during NDP 8. The scheme focuses on creating employment opportunities and empowering the poor households with capital to produce building materials, such as bricks. In the process, the scheme hopes to integrate skills acquisition, employment creation, income generation and shelter provision. The scheme target households who do not qualify for the SHHA scheme to establish income –generating ventures to enable them to generate enough money to construct houses. Already the scheme has been piloted in various towns and districts in Botswana such as Mahalapye, Ghanzi and Francistown. According to the Director of Housing, the scheme is showing signs of success, On the basis of these preliminary results, the intention of the

Department of Housing are to roll out the scheme to other districts during financial year 2006/07. The budget is available to undertake this mammoth task. It is anticipated that during the roll out, many poor people will benefit from both the shelter and income generated by the scheme...

Other related project initiatives which the Government has undertaken include: Water and Sewerage Reticulation in Old SHHA Areas; Block Survey of Old SHHA Areas, New SHHA loans and Housing Association Schemes. All these are efforts are efforts by the Botswana Government to provide decent and affordable housing to those on the lower echelons of society – the poor.

In addition, the Government through the Revised National Policy on Destitute Persons (2002) has made a special dispensation to provide shelter to the poor and the destitute. The destitute are entitled to basic shelter on assessment. The revised policy on destitute persons makes specific provisions for needy people or people defined as destitute. It provide shelter to destitute persons in line with the National Housing Policy (2000), which states that the district/town/city councils are to provide basic shelter for destitute persons and to budget accordingly. In addition district, town and city councils are charged with the responsibility to construct municipal shelters for destitute persons, and maintain them in order to accommodate the destitute persons together with their dependents who do not have anywhere to stay.

The National Housing Policy further provides that … where a destitute person has acquired a plot, but is unable to develop it, the council shall construct a "basic" structure which will be inherited by the dependents upon the death of the destitute person. Basic refers to a structurally sound dwelling with a roof that is weather proof and with a secure door, window fittings and lavatory. All costs for the building construction or improvements to the existing structure on a destitute persons plot, carried out to meet the basic standard are paid for by the District, Town or City council.

Taken together the above provisions underscore the Botswana Government commitment to provide decent housing for citizens. Government recognizes the importance of housing to the well being of the people. This is because poor housing environment pose serious health problems.

Financing Housing in Botswana

The Government of Botswana's commitment to provide resources for low cost housing is part of the broader strategy for poverty reduction. Government recognized that the poor, especially those residing in the cities and towns could not afford decent housing – hence the introduction of SHHA and the Integrated Poverty Alleviation and Housing Scheme (PAHS). To implement these schemes effectively require serviced land. To demonstrate its commitment, the Government of Botswana fast-tracked it's Accelerated Land Servicing Programme in order to ensure availability of serviced.

It is important to point out that Government intervention to provide affordable low income housing is in line with the principle of social justice - the principle that requires

every citizen of Botswana to benefit from the country's economic development. One such benefit is in the area of housing. Housing is a very expensive undertaking. The poor cannot afford to build or rent a decent house because of unemployment, low incomes and high construction costs. Furthermore, the poor cannot borrow money to build houses from commercial banks or any other financial institution. Given this reality government has undertaken to provide funding for low cost housing development. Firstly, through acquiring and servicing land and secondly, through provision of grant loan scheme (such as the SHHA loan scheme) to cater for the poor. Through this intervention, it is anticipated that the living conditions of the majority of citizens, in cities and towns, who are currently living in squalid and inhabitable situations will be improved. Under the circumstances and in line with the principle of social justice, Government had to come up with a low income and highly subsidized housing scheme to provide financial resources for the poor.

Table 22 below shows government capital budget for the entire NDP 9 period. The total budget for Self Help Housing Agency (SHHA) alone is P338 million. The total budget for district housing is 606 200 million while P100 million is budgeted for the purchase of freehold farms. Freehold farms were purchased especially, in areas with critical shortage of land but surrounded by Farms such the North-East district and Gaborone.

Table 22: Ministry of lands and Housing budget for NDP 9

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	Total
SHHA	60 000	23 600	30 00	30 000	94 400	100 000	338 000
District housing	50 000	32 957	30 000	113 600	177 600	202 043	606 200
Purchase of freehold farms	0	10 000	30 000	10 000	30 000	20 000	100 000

Source: NDP 9

The budget reported in the above Table is mixed. The mixture and fluctuation in budget allocation show variations in priorities given the different years. However, overall, there is indication that, at least from 2007 the budget for SHHA and the purchase of freehold farms will be increased. Through increased SHHA and purchase of freehold farms budget, Government is committed to assist the people in both the rural and urban centres to acquire land, build and improve their housing as one way of improving their standard of living.

Furthermore, in order to improve its operational efficiency and sustainability, the Self-Help Housing Agency (SHHA) is currently under review and the report is expected before the end of 2007. One of the terms of reference for the review is to investigate the feasibility of involving both the private sector and non-governmental organizations in the funding and management of the housing provision.

Housing material construction and quality housing

Availability of Government subsidies, mortgage loans and private developers have enabled Batswana to construct and own quality houses. The quality of the house is usually assessed by the type of material used in its construction i.e. floors, roof, walls and ventilation. Good quality material is essential for safety and safety of the occupants. Although the decision on which material to use may not be an option for the poor or low-income households, Government has come up with building regulations that specify the type of material to use in urban centres. As a result more and more houses in urban centres use the modern type of material. Among the materials regarded as good quality for housing are, corrugated iron, concrete, slates, tiles, wood and treated thatch.

The 2001 census reveals that out of the total of 404 706 housing units, 315, 918 (78.16 %) had cement floors; 72 903 (18.01 %) had mud and dung floors and 11, 150 (0.28 %) were made of wood. The proportions indicate that the floors of most housing units are durable, and there is a tendency to move away from the traditional type of floor made out of mud and dung.

Table 23 Construction material 1991 – 2001 Census

Construction material	1991	2001
Floor		
Cement	57.70	78.16
Mud	35.90	18.01
Others	6.40	3.83
Roof		
Corrugated Iron	49.60	68.88
Thatch	41.20	22.00
Others	9.20	9.12

Source: Computed from 2001 Census Data – Table A5

Table 23 presents the material used in house construction for 1991 and 2001. Regarding the type of housing the Table shows that there has been general improvement in the quality of material used especially for the floor and roof. More durable floors and walls are becoming common.

Housing Reforms

Like in education and health reforms have also been introduced in the area of housing. In recent times, the Botswana Government policy is to involve both the public and private sectors in housing development. The key players in the private and parastatal sector include: The BHC, BBS and NDB (parastatal), Time Projects; Phakalane Estates, Universal Builders and commercial Banks (private sector). This is in line with a call made in 1989 by the United Nations Commission for Human Settlements (Habitat) for adequate housing for all by the year 2000. The main focus was what came to be known as an *enabling approach*. The thrust of the enabling approach was to reduce the government's role as a direct provider of housing so as to become an "enabler" and "facilitator" of local authority, private and informal housing processes.

The country's approach to social services has been based on this philosophy since the early 1990s. Successive national development plans have always emphasized that the role of the state in provision of social services as that of a facilitator of economic growth and development rather than an active participant. In the area of housing, the government has since independence played a dominant role i.e. providing land, building, finance and subsidies (in particular, for BHC and SHHA). However, in the 1980s and 1990s as the demand for housing increases, and BHC and SHHA could not cope with increased demand, the government strategy gradually shifted from being provider and financier of housing to that of being a facilitator. To this end, housing has been seen increasingly as a commodity. The Public Service Debt Fund which provided housing subsidies for public corporations like BHC and BBS were discontinued. These corporations were required to restructure and rationalize their operations in order to make profit. Government could no longer afford to "baby sit" them. Hence BHC was required to move towards economic rentals. In terms of low and medium cost housing, Government provided loan guarantee schemes to its employees. Government guaranteed 25% to civil servants to borrow money from the Botswana Building Society to build their own houses or buy houses from the market. Borrowers are usually given 25 years to pay the loan. Financial institutions like banks also offer mortgage loans to those who can afford to pay.

As indicated earlier the bias of the government is to support low income and poor households. SHHA and the Integrated Poverty Alleviation Housing Scheme have been created to assist households who could not afford even the basic 50m2 house, especially in the SHHA areas.

In line with the objectives of the National Housing Policy (2000), Government encouraged private developers to enter the housing market and even buy or lease and service land. Land servicing will no longer be the responsibility of the Government alone but private developers were also encouraged to help Government develop and service the land. Already there are a number of private developers acquiring and servicing land. Usually the y targets the middle and upper income brackets. This process has reduced congestion in housing demand and complemented Governments efforts to provide housing for its people.

However, even through this liberal approach the Government is not expected to abdicate its responsibility but rather to assist mobilize the resources of other actors and facilitate their deployment for the effective provision of shelter. Government is expected to retreat gradually from direct involvement in housing provision and maintenance and leave the role to the other players. However, given acute shortage of housing and shortage of serviced land in Botswana, government direct involvement is still required.

Water and sanitation

Water is a basic need for development and investment, and as such a prerequisite for poverty alleviation and improved standard of living. It is a key resource in any plan for implementing sustainable development. To this end, water is an important basic need. It is a goal of the Botswana Government that every citizen should have access to safe and

clean water at all times. Vision 2016 recognizes this reality and states that by the year 2016, Botswana must have a national water development and distribution strategy that will make water affordable and accessible to all, including those who live in small and remote settlements.

Botswana is a very dry country with limited water supply. Given, its scarcity, water is a valuable resource for the economy and people of Botswana. At independence there was lack of hydrological information and limited capacity for drilling boreholes. No major boreholes were drilled and no major dams constructed. As a result water development was given a priority in national development planning. For example, Government has over the years initiated and funded major programmes for ground water drilling and dam construction. Since independence, major boreholes have been drilled throughout the country, dams constructed and water piped to the people. In order to improve the quality of life for all citizens of Botswana, provision of safe drinking water became a major priority of the Government.

In the early 1980s Government of Botswana committed itself to provide universal access to safe drinking water. Universal provision of water was regarded as a key concept underpinning social provision in Botswana such as education and health. By the early 1990s the task of providing universal access to safe water was almost complete. The task of pioneering new water resources was undertaken through District Councils, Department. of Water Affairs and Water Utilities Corporation. Funding was provided by the Government of Botswana for major infrastructure to facilitate adequate provision of safe drinking water. The National Water Master Plan was developed in 1991, which sets out the overall framework for the water sector. The framework specifies a number of institutions involved in the activities of the water sector, including: Departments of Water Affairs and Geological Survey, National Conservation Strategy, Water Utilities Corporation, Ministry of Local Government and Ministry of Agriculture. The Ministry of Mineral Resources and Water Affairs is responsible for the overall policy direction of the ministry.

Available data reveal that nearly all Batswana, regardless of economic status, have access to safe and clean water. For example, the 1981 Population and Housing Census reveals that 89% of the urban population had access to drinking water, all villages with a population of more than 5000 people, 90% and 50% of people living in village of between 1000-5000 had access to drinking water. The 1991 census revealed that 96% of the population (especially those living in urban centres) had such access. In the 2001 Census, 98% were reported to have access. In the rural areas, 77% of the population had access to standpipes or boreholes whereas this figure was 100% in the urban areas (CSO, 2001). An official from the Department of Water Affairs said that water supply is being made available to the rural people in their homes at a minimal cost of only P439 per connection. Water is provided virtually free of charge in the rural areas. In the urban communities, there is a standard fee for the low income groups and rates based on consumption for groups with higher incomes.

Financing water development

Like education, health and housing the Government of Botswana has committed large sums of money on water development throughout the country. Large-scale developments to improve the supply of water have been completed in major villages (MFDP, 2001). These include the construction of dams, water treatment plants and pipe connections to supply and distribution points. The budget for 2007 alone indicate yet another commitment by the Government to improve water supply resources country-wide. For example, in implementing the National Water Master Plan, Government has engaged in major dam construction throughout the country. Construction of the Ntimbale dam in the north east is complete and preparations are underway for the construction of the largest dam in Botswana during 2007/08 financial year at an estimated total cost of P2 billion. In addition, and in order to complement surface water, various under ground water projects have been initiated. These will be completed during NDP 9 at an estimated cost of about P100 million. The objective of these massive water projects is to provide water to all Batswana with a view to increasing the quality of their lives.

The Budget Speech delivered by the Minister of Finance and Development Planning in 2007 allocates to the Ministry of Minerals, Energy and Water Resources a total of P637 million, which is 9 % of the total development budget for the year. Major villages water supply and development projects takes the largest share of P230 million, followed by water planning and development with P183 million. The two projects constitute more than 50 percent of the Ministry's total development budget estimate (Budget Speech, 2007).

High spending in improving water supply and making it accessible and affordable to the majority of citizens in both urban and rural areas is demonstrated by the high number of private water connections. The demand for private water connection by ordinary Batswana have increased significantly towards the end of NDP 8 period. The increase reflects changes in economic activities, improved standard of living and level of development in the country, especially in towns, cities and major villages. A similar trend in increase of private connections and water consumption is expected during NDP 9.

Table 24 below shows the number of private water connections from 1996 to 2001.

Table 24: Number of private water connection

Year	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Total no. of connections	46,608	52,099	57,654	64,248	70,769	78,886
Difference from year before	-	5,491	5,555	6,594	6,521	8,097

Source: Department of Water Affairs

As can be observed from Table 24 above, the number of private water connections increased significantly from 1997 to 2002, from 5,491 to 8, 097. An increase of close to 3000 connections, within a period of 5 years. This data does not apply to the whole country but to only 17 major villages surveyed.

Water reforms

Since independence, the Government of Botswana has provided water to its citizens virtually for free of charge. However, since the beginning of the NDP 8 plan period, it was recognized that the practice was unsustainable and that citizens should also make a small contribution to water development. However, before water tariffs could be implemented the Ministry of Minerals, Energy and Water Resources through the Department of Water Affairs will undertake a water affordability and tariff study over the whole country with a view to ensuring that those who can afford to pay for water in Botswana should do so and at the right level of cost recovery. According to an official of the Department of Water Affairs, one of the terms of reference for the study was to come up with a water tariff policy, which ensures that the price that a customer pays for water is based economic considerations and not the name of or label of where one resides e.g. urban centre vs and village. Payment of water and anticipated tariffs increase during NDP 8 and NDP 9 are expected to recover about 70 % of the operating costs.

In addition to introducing water tariffs, during NDP 9 the Government was to gradually relinquish its role as a provider of water services to that of a facilitator in such provision. To this end, during NDP 8 and NDP 9 Government will stop participating in activities not considered "core" to its mandate. These activities will be contracted out to the private sector. It is anticipated that privatization will create employment opportunities and increase efficiency in service provision.

Sanitation

Sanitation refers to facilities or actions aimed at improving public health, including, in particular, proper disposal of human body waste e.g. pit latrines in low income areas (Ministry of Local Government, 2001). In 1976, the Urban Sanitation Research Project was introduced. This was followed in 1980 by the introduction of the Environmental Sanitation and Protection Pilot Project., the project was extended in 1984 under the Self-Help Environmental Sanitation Project. Through these initiatives, urban households were provided with pit latrines at subsidized costs by the government. To further demonstrate its commitment to provide decent sanitation facilities, the Botswana Government introduced a policy for Wastewater and Sanitation Management in 2001. The overall objective of the policy was to provide appropriate, affordable and sustainable sanitation facilities to the people of Botswana. The introduction of this policy led to numerous sanitation projects including: the national Rural Sanitation Program Strategy (1991); National Master Plan for Waste Water and Sanitation and numerous Technical Working Groups to guide the implementation of the sanitation programmes. Virtually, policy direction, all funding and provision of sanitation facilities have been provided by the government since independence. It is only recently that the private sector has been encouraged to participate in provision of sanitation and waste water management services. For example, during NDP 8 planning period the Ministry of Local Government through the Department of Sanitation and Waste Management provided funding for the construction of 22 000 VIP latrine sub-structures. The target for the provision of onsite sanitation facilities under NDP 9 is 7000 units.

Land (1991) study on Water Hygiene, Environmental Sanitation and Control of Diarrhoeal Diseases found that the availability of latrines was useful in reducing the incidence of diarrhoeal diseases. The study further found that household's reasons for erecting latrines had more to do with convenience and privacy than health and environmental issues, which goes to underlie the need for education about the health value of latrines.

Table 25 shows the pattern of access to sanitary excreta disposal facilities in rural Botswana for a period of 10 years 1980-1990

.Table 25: Proportion of HH with access to sanitary excreta disposal facilities

Year	Bush	Own latrine	Other latrine	Flush	Source of information
1980	78%	22%	-	-	Sanitation Campaign report, 1980
1986	64%	36%	-	-	DMT survey, 1986
1990	45%	41%	13%	1%	KAP study
2001	-	-	-	20.7 %	2001 Census report

Source: 1991 Census

Table 25 shows the proportion of households with access to sanitary excreta disposal facilities in Botswana over a period of 20 years. As observed from the figures obtained the bush is no longer the preferred method of disposing human waste. More people are adopting safer practices of disposing human waste such as the use of a latrine. The number of people who use the bush has declined significantly from 78% in 1980 to 45% in 1990 (a drop of about 33%) and the number of people who own latrines also increased by more than 20% from 22% in 1980 to 41% in 1990. These figures are an indication of significant improvement in quality of life (clean environment).

Furthermore, the 2001 Census revealed that there were 83, 887 (20.7%) of the households in Botswana used flush toilets. The irony is that a large proportion 91, 125 (22.5%) of all households in Botswana had no access to a constructed toilet in 2001.

Table 26: Method of human waste disposal by size of village

Size of village	Large	Medium	Small	Very small
Own latrine	63%	46%	17%	15%
Other latrine	22%	10%	9%	5%
Bush	15%	44%	74%	80%

Source: Land et al. 1991

It is clear from the above Table that the majority of people in small and very small settlements still use the bush to relieve themselves (80 to 74 % respectively. These are predominantly rural people, the majority of whom are very poor. Note that studies on

poverty in Botswana shows that poverty is concentrated in small rural and remote small settlements. It therefore not surprising that the majority of residents in these areas still use the bush to dispose human waste. However, the Ministry of Local Government, through the National Rural Sanitation Programme is currently working to improve the situation. According to the 1991 Census only about 40 % of households had access to safe sanitation, with less than 30 % in more remote areas and small settlements (CSO, 2001). In the light of this problem, the Ministry main objective is to reduce excreta related diseases by subsidizing Ventilated Improved Pit (VIP) latrines through self-help as well as providing facilities for the collection and disposal of solid and liquid waste in the rural areas.

In their analysis of the social sector, Duncan et. al (1989) concluded that in comparison with the water sector, access to adequate sanitation was started later and proved to be slower between 1981 and 1991, the proportion of households with access to sanitation rose from 36 percent to 55 percent, increasing from 79 to 91 per cent in urban areas and from 25 percent to 41 per cent in rural areas. The relatively high standards adopted for the new urban areas ensured virtually universal access to sanitation in urban areas.

Table 27 below shows the total number of households disaggregated by district and type of sanitation facility used to dispose human solid and water waste in 2001.

Table 27: Access to sanitation facilities: 2001 Population and Housing Census (Census District Summary of Percentage Household Accessibility to on-site sanitation facilities)

District	Total HH	Own Facility					Communal facility							
		Flush Toilet	Own VIP	Own Pit Latrine	Enviro-loo	Sub-total own facility	Flush toilet	VIP	Pit Latrine	Neigh/s toilet	Sub-total communal facility	none	Not known	total
Southern	**37202**	6.9	22.1	25.2	0.3	54.4	0.4	0.7	5.4	9.9	16.4	29.1	0.1	100
S/East	**14780**	28.7	25.2	30.8	1.4	86.1	0.6	0.5	2.5	3.9	7.5	6.5	0,02	100
Kweneng	**52578**	11.2	16.3	32.7	0.3	60.5	0.3	0.6	7.7	6.9	15.5	32.9	0.1	100
Kgatleng	**17054**	11.9	39.7	19.4	0.5	71.5	0.6	0.5	4.4	6.5	12	16.4	0.1	100
Central	**110287**	9	18.1	22.3	0.5	49.9	0.5	0.7	5.6	8.3	15.1	34.8	0.1	100
N/East	**10834**	10.4	1.7	42.1	0.9	55.1	0.9	0.3	13.8	5.3	20.3	24.3	0.3	100
N/West	**30913**	11.2	9.9	16.9	0.9	38.9	1.6	0.6	3.8	5.4	11.4	49.5	0.1	100
Ghanzi	**7776**	13.3	7.8	11.8	1.1	33.0	0.6	0.2	4.2	7.9	12.9	54.1	0.1	100
Kgalagadi	**9663**	11.9	18.2	15.3	0.6	47.0	0.9	2.7	5.7	11.4	20.7	32.2	0.04	100
F/Town	**23124**	32.6	15.3	44	2.8	94.7	0.6	0.3	2.5	1.7	5.1	0.2	0.1	100
Gaborone	**58476**	50.3	20.6	22.5	0.3	93.7	0.8	1.5	3.4	0.7	6.4	0.04	0.04	100
Jwaneng	**4681**	71.8	3.8	7.8	0.02	83.4	2.7	0.02	0.6	8	11.32	5.2	0.04	100
Lobatse	**8523**	37	31.4	26	0.2	94.6	1.3	0.4	0.6	2.9	5.2	0.1	0.1	100
Orapa	**2578**	87.4	0.1	0.12	0	87.6	12.4	0,04	0	0	12.44	0	0	100
S/Phikwe	**15258**	37.5	22.6	28.9	1.1	90.1	2.9	2.3	2.1	2.3	9.6	0.2	0.1	100
Sowa	**979**	99.6	0	0	0.4	100.0	0	0	0	0	0	0	0	100
Total	**404 706**	**20.7**	**18.5**	**25.1**	**0.7**	**65.0**	**0.8**	**0.8**	**4.9**	**5.9**	**12.4**	**22.5**	**0.1**	**100**

Source: 2001 Housing and Population Census

Table 28: Percentage household accessibility to adequate sanitation facilities

District	Total HH	Adequacy sanitation according to BPWSM definition				Inadequacy sanitation according to BPWSM definition								
		Flush Toilet	Own VIP	Enviro-loo	Sub-total BPWSM	Own Pit latrine	Com Flush toilet	Com VIP	Com Pit latrine	Neigh/s toilet	Sub-total WHO	none	Not known	total
Southern	**37202**	6.9	22.1	0.3	29.3	25.2	0.4	0.7	5.4	9.9	70.9	29.1	0.1	100
S/East	**14780**	28.7	25.2	1.4	55.3	30.8	0.6	0.5	2.5	3.9	93.6	6.5	0.0	100
Kweneng	**52578**	11.2	16.3	0.3	27.8	32.7	0.3	0.6	7.7	6.9	76.0	23.9	0.1	100
Kgatleng	**17054**	11.9	39.7	0.5	52.1	19.4	0.6	0.5	4.4	6.5	83.5	16.4	0.1	100
Central	**110287**	9.0	18.1	0.5	27.6	22.3	0.5	0.7	5.6	8.3	65.0	34.8	0.1	100
N/East	**10834**	10.4	1.7	0.9	13.0	42.1	0.9	0.3	13.8	5.3	75.4	24.3	0.3	100
N/West	**30913**	11.2	9.9	0.9	22.0	16.9	1.6	0.6	3.8	5.4	50.3	49.5	0.1	100
Ghanzi	**7776**	13.3	7.8	0.1	21.2	11.8	0.6	0.2	4.2	7.9	45.9	54.1	0.1	100
Kgalagadi	**9663**	11.9	18.2	1.6	31.7	15.3	0.9	2.7	5.7	11.4	67.7	32.2	0.0	100
F/Town	**23124**	32.6	15.3	2.8	50.7	44.0	0.6	0.3	2.5	1.7	99.8	0.2	0.1	100
Gaborone	**58476**	50.3	20.6	0.3	71.2	22.5	0.8	1.5	3.4	0.7	100.0	0.0	0.0	100
Jwaneng	**4681**	71.8	3.8	0.0	75.6	7.8	2.7	0.0	0.6	8.0	94.7	5.2	0.0	100
Lobatse	**8523**	37.0	31.4	0.2	68.6	26.0	1.3	0.4	0.6	2.9	99.8	0.1	0.1	100
Orapa	**2578**	87.4	0.1	-	87.5	0.1	2.4	0.0	0.0	0.0	100.0	0.0	0.0	100
S/Phikwe	**15258**	37.5	22.6	1.1	61.2	28.9	2.9	2.3	2.1	2.3	99.7	0.2	0.1	100
Sowa	**979**	99.6	0	0.4	100	-	-	-	-	-	100.0	-	-	100
Total	**404 706**	**20.7**	**18.5**	**0.7**	**39.9**	**25.1**	**0.8**	**0.8**	**4.9**	**5.9**	**77.4**	**22.5**	**0.1**	**100**

Source: 2001 Housing and Population Census

Data on Tables 27 & 28 above reveal that a total of 404 706 households were counted in the 2001 Census against a total of 276 209 households in 1991 Census. This represents the growth rate of about 3.9 % per annum. The 2001 Census generated meaningful data on provision of sanitation facilities. It indicates, according to the definition used by WHO for adequate sanitation, that overall 77.4 % of the households in Botswana have access to adequate sanitation. This is further divided into urban services at 95 % and rural at 51%. However, using standards set by BPWSM (2001), the figures are reduced significantly, with only 39.9% 0f the country having adequate sanitation, 53% in urban centres and only 18% in rural areas. This is because the BPWSM does not consider pit latrines as "adequate". Overall, a high proportion of people in Botswana do not have access to adequate sanitation. The remote parts of the country are generally worse off, where 2 out of 3 households are without adequate sanitation.

In addition, the data shows that 63.7% of all households who have access to adequate sanitation have their heads of households employed and paid in cash while 59.6% of those who have no access to any type of toilet facility have unemployed heads of households. This demonstrates the relationship between income and adequate sanitation facilities. Therefore poor households without any source of income are likely to have no adequate facilities than those employed with a reliable source of income (2001 Census).

The proportion of households in the country with access to flush toilets has increased from 8.6% in 1981 to 20.7% in 2001. An increase was also observed for the proportion of households with access to a communal flush toilet from 0% in 1981 to 0.8% in 2001. In the same period, proportions of households that have no access no access to any form of sanitation facility dropped from 64.1% to 22.5% nationally. It has not been possible to carry-out a comparison of the 2001 Census results with the results obtained in previous Censuses, or to compare the change in adequacy rating because the categories used in the two earlier Censuses were broader than those used in the 2001 Census. For example, in the 2001 Census, there were three categories of pit latrines i.e. unimproved pit latrine, Ventilated improved pit latrine and Envro-loo) while in the previous Censuses all those were classified simply as pit latrine.

A review of records from the Ministries of Local Government and Health show that programmes to develop and improve sanitation in the rural areas only started in the 1970s. The programmes focused on the construction of latrines of rural households on a subsidized, self-help basis. However, an evaluation of the programme shows that it has not been effective and that the initial emphasis on subsidies was a mistake. For example, the level of subsidy was high and there were various technical and organizational problems with taking direct government intervention to the level of construction at household level. Furthermore, subsidies did very little to motivate people to use latrines properly or to adopt the health and hygiene practices needed if latrines were to make a contribution to improved public health. Because of these problems, government had no choice but to re-visit and revise its strategy on rural sanitation. The focus now shifted to health education, to sensitize people to adopt sound health and hygiene practices and to encourage people to provide their own sanitation facilities with some technical advice from the government. This strategy was meant to ensure participation of the community

in their own health and sanitation. Government role was to facilitate that process, provide subsidies where necessary and health education.

Conclusion

The government embarked on the formulation of a National Water Master Plan in 1999. The plan which is an outcome of intensive and participatory consultation with all key stakeholders, committed the government to provide clean and affordable water to all citizens of Botswana. According to the plan, water is a basic need which must be provided by government free of charge. However, those who can afford should be allowed to pay a small fee just to help the government meet some of the costs for water. The challenges currently facing government is drying up of boreholes and hence the need to build more dams (at phenomenal costs) given that Botswana is a very dry country and prone to droughts. The bias is to provide water to the poor who cannot afford through improving the village water supply project.

In the area of sanitation concerted efforts are being made through the Botswana Policy for Wastewater and Sanitation management: Through this, many Batswana have access to adequate sanitation. However, a lot still remains to be done. The greatest challenge is to plan and develop positive strategies for sanitation technologies and accessibility in order to accomplish the Vision 2016 pillars.

The Role of Social Services in Poverty Reduction

The promotion of both economic growth and social development has been the focus of Botswana's development strategies since independence. The state-led social development strategy has ushered in an ideology emphasizing equality of all people, democracy, social justice, human rights, access to social services, opportunities and resources and more importantly, a concerted drive towards poverty reduction. The preceding discussion has focused on relentless efforts by the Botswana Government to provide social services, such as education, health, housing, water and sanitation to all its people irrespective of the their socio-economic status, gender, ethnic or tribal affiliation. From this discussion, it is clear that the government has, since independence, invested heavily in social development, the result of which has been phenomenal growth in provision of social service leading to an overall improvement in the quality of life for most Batswanaa. The Government of Botswana strongly believes that an improvement in the quality of life of the people through education, health, housing and provision of water is a pre-requisite for development and poverty reduction. Indeed, evidence gleaned from various studies on poverty in Botswana indicate that a combination of these social provisions have led to a reduction in poverty (NDP 9). Evidence presented so far reveal that provision of social services has played an important role in poverty reduction in Botswana.

The above notwithstanding, the pertinent question is: To what extent has massive growth in social service provision contributed to a reduction in poverty? Put differently, what is the role of social services provision in poverty reduction? To answer this question, this part will discuss issues relating to social services financing, gender, access and equity. Note that some of these issues have been discussed in detail with respect to each service

provided. Furthermore, this part will assess the extent to which interventions such as the introduction of policy reforms (cost cutting, cost sharing), and privatization of social services have impacted on poverty. That is, is there evidence of poverty reduction as a result of these interventions? Are the poor getting better is there any significant improvement in their livelihoods?

In order to shed some light into the above issues, it is important to re-state that, when Botswana attained independence a conscious decision was made to invest heavily on the productive sectors of the economy and reinvest proceeds into social development. This strategy has been followed for the past 41 years by the different social policy regimes that have guided and informed Botswana's social development agenda, albeit with minor variations. The strategy was simple, mineral revenue would be used to develop and finance social infrastructure, diversify the economy, and develop essential human capabilities. The main thrust of social development strategy was on the following:

- To improve the quality of life for all Batswana by reducing poverty through social spending, creation of employment and income generating activities based on generous government subsidy support e.g. through Citizen Entrepreneurial Development Agency (CEDA), micro credit Guarantee Schemes and other citizen empowerment initiatives
- Provision of education and health as long term responses to poverty reduction and joblessness
- Rural development – this entailed extension of basic services to rural areas and incentives for agriculture and small businesses
- Social safety nets for economically vulnerable groups who are destitute

As indicated elsewhere, Botswana's development success was state-driven and controlled. A combination of the strong state ideology and political will provided the basis for massive investment in the social sector and their priority in the country's social development agenda. Centralized planning through National Development Plans (NDPs) ensured smooth formulation and implementation of the government social policy agenda.

Commentators on the Botswana economy have argued that massive investment in the development of social services since independence has led to a significant decline in poverty. Evidence gleaned from various studies conducted on poverty in Botswana bears testimony to this assertion. For instance, the Rural Income Distribution Survey (1985/6) estimated that 59% of the people in Botswana were living below the Poverty Datum Line (PDL) in 1985/86, the House Hold Income and Expenditure Survey (HIES, 1993/94) recorded 47% of Batswana living below the PDL and HIES conducted in 2002/03 revealed that only 30.1 % were living below PDL. According to the Central Statistics Office (CSO) reports, in the 10 years since 1992, the magnitude of poverty has, in approximate terms, reduced from one in two people (47 %) to one in three (30 %) in 2002. The data also shows that on average, real incomes have risen over the last 40 years. According to the latest UNDP Human Development Report for 2005, in the two years between the 2002/03 survey and 2005, there had been another significant shift downwards in the incidence of poverty in Botswana to an estimated 23.5 % using UNDP standard of the percentage of the population living below US$ 1 a day. An analysis of poverty trends by UNDP in a report entitled: **Poverty Status Report for Botswana:**

Incidence, Trends, and Dynamics indicates that the proportion of people living in poverty declined from 46.1% in 1985-1986 to 30.2% in 2002-2003 (UNDP & BIDPA, 2005).

Furthermore, the Bank of Botswana Review of Current Economic Challenges in the Bank's 2006 Annual Report show the rate of decrease in the incidence of poverty in Botswana thus putting the country back on track towards eradicating absolute poverty by 2016. However, the Bank points out that the current levels of poverty are unacceptable and further reducing poverty must be seen as one of the major challenges facing the country.

While these figures may only be estimates and not the gospel truth, given methodological and conceptual limitations as well as measurements problems, a 17 percentage point decrease from (1992-2002) is not modest. It shows significant decrease. This, notwithstanding, available statistical evidence suggests that Botswana has made good progress in education, health, housing, water and sanitation. Increased social expenditure led to a significant improvement in the poverty situation in the 1980s, 1990s and 2000 and beyond, both households and individual poverty rates declined by 17 percent. Furthermore, the decline has mostly been among the very poor rural households, as this is the largest single poverty group in Botswana. In terms of numbers, this result is encouraging because it suggests that economic processes that resulted in social policies and programmes have been well targeted and as such has contributed to a decline in poverty (MDG Report, 2004)

However, an official from UNDP and the Ministry of Finance and Development Planning asserted that while the above statistics show a decline in the incidence of poverty, the figures are still very high for an upper middle income country. For example, many countries of comparable economic stature, such as Tunisia, have only 5% of its people living below the poverty datum line. Given this and other considerations, conclusions reached by various scholars are that current poverty levels are still considered too high in comparative terms.

Financing social development in Botswana

Botswana's achievement in the field of social development have been facilitated by strong state-led interventions with a rapidly growing revenue base over the past 40 years, which have enabled significant increases in public expenditure on social services. Table 29 was constructed from Budget speeches presented to Parliament annually. It shows the amount of money spent on social and economic services during the selected budget years, from 1982-1999 and 2006/2007. Budget allocations provide a good indicator of spending priorities for both the recurrent and development budget. The Table below shows the development budget only.

Table 29: Development Budget 1982/83 – 19998/99 (current prices)

Budget Year	Total development. budget	Ministry	Ministry allocation (in millions)
1982/83	219.8million	Works and Communications	68.4 m
		Local Government and Lands (MLGL)	P53.9m or 25% of total development budget
		Education (MoE)	20.8 m
		Ministry of Mineral Resources & Water Affairs (MMR&WA)	15.9m
1983/84	P206.2m	Works & Communications.	P62.9m or 30.5% of the development budget
		Ministry of Local Government & Lands	P44 m or 21% of the total development budget
		Ministry of Health (MoH)	shared the remaining P21.4m with other ministries
1985/86	272m	MLGL	P 60m third largest share 15% after Works and Water Affairs 27%
1990/91	1,286m	MLGL	P239m 2nd largest share of the development budget
		MoE	P147m or 11% of the development budget
		MoH	P46m
1991/92	1,185m	MLGL	received largest share P350m or 30% of the development budget
		MoE	3rd largest share after Works & Com
		MMRWAs	P103 or 4th Largest share of the development budget
		MoH	P46m or 5th largest of the development budget
1992/93	1,416m	Ministry of Local Government Lands &Housing (MLGL&H)	Largest share P419m or 30% of the development budget
		MMRWA	P118m or 8 % or 2nd largest share of the development budget
		MoE	P 112 or 8% of the development budget
		MoH	P 45m
1994/95	1,591m	MLG &H	largest share P 335m or 21% of the development budget
		MMRWA	P 228m or 14% of the development budget
		MoE	P 164m or 10% of the development budget
		MoH	P222m or 14% shared with other ministries
1995/96	1,735m	MLGL&H	P 376m or 21.7% or largest share of the development budget
		MMR&WA	311m or 17.9% 2nd largest share of the development budget

		MoE	P300 or 3rd largest share of the development budget
		MoH	share remaining 43% with other ministries
1998/99	3,086m	MLGL&H	P682m or 22% largest share of the development budget
		MoE	544 m or 18% 2nd largest share of the development budget
		MMRWAs	350m or 11% of the development budget
		MoH	share the remaining 345 m or 11% of the development budget with other ministries
2006/07	7.26 billion	Ministry of State President	P1.93 billion 27 % or largest share (P896 million goes to HIV/AIDS)
		Ministry of Local Government	P990 million or 2nd largest share (primary schools, village water supply, urban land servicing and sanitation
		Minerals, Energy and Water Resources	P P637 million or 9% of total development budget (major village water supply
		Ministry of health	P636 million or 9 % of total development budget (improvement of hospitals)
		Ministry of Education	P584 million or 8 % of the proposed development budget (secondary schools projects, and tertiary ed. development
		Ministry of Lands and Housing	P363 million or 5% of total development budget (district housing,, land servicing, BHC finances, SHHA and IPAHS

As already indicated, Table 29 above was constructed using data obtained from the Botswana Government annual Budget Speeches presented to Parliament by the Minister of Finance and Development Planning. To assess government spending on social services over the years, an analysis of the development budget allocations to the different ministries is necessary. Budget allocations are made to the different ministries ranked in the order of priority. It varies annually depending on the following factors: (i) economic and political ideology of the day (ii) the influence of the bureaucratic and technocratic elite (iii) international expectations, considerations and limited influence from interest groups and/or NGOs. These factors combine, to determine allocation priorities to the various sectors of the economy.

As can be observed from Table 29, during the 1982/83 budget speech, the Ministry of Works Transport and Telecommunications (MWTT) received the largest share of the development budget. This trend continued until the late 1980s. Throughout this period, the ministry consistently received over 30% of the total development budget allocations. Allocating the largest share of the development budget to this ministry was necessary and in line with the priorities of government at the time. For example, the focus during the first decade of independence was on infrastructural development hence the need to allocate large sums of funds to this sector, mainly for road and telecommunications construction. In the 1980s, the majority (over 70 %) of Batswana lived in the rural areas.

It was therefore defensible to give roads and telecommunications a priority. With good roads and telecommunication systems, it is easier to provide social services to all citizens regardless of where they stayed. In subsequent years (1985/86-1990/91), the Ministry of Mineral Resources and Water Affairs was given the highest priority followed by Works Transport and Telecommunications and then Local Government Lands and Housing. A shift in budget allocation priorities reflects the needs and priorities of the country. It was necessary to continue the development and expansion of infrastructure in the key sectors of the economy. Phenomenal achievements were made in these sectors in the 1980s and 1990s which necessitated a shift in government spending priorities.

The 1990s saw the Ministry of Local Government Lands and Housing (MLGL&H) attracting the largest share of the development budget. The ministry has now become a priority as indicated by the amount of financial resources allocated in the budget under review. This is a clear indication of government commitment to implement its overall development strategy which calls for re-investment of the returns from large mineral projects into social development. MLGL&H is a highly decentralized ministry responsible for provision of primary social services to all communities in Botswana, especially in the rural areas. The ministry is responsible for provision of primary education; primary health care; rural water supply; sanitation and housing as well as remote area development. Provision of social services was given a priority in line with the Government thinking at the time i.e. to plough back proceeds from the productive sector of the economy into social development to reduce poverty and improve quality of life for all the people of Botswana. To date, the Ministries of Local Government, Education and Mineral, Energy and Water Resources and Office of the President (through which HIV and AIDS funds are channeled) continued to receive the largest share of both the development and recurrent budgets. For example, during 2006/07 budget allocations, the Ministry of State President received the large share (27%) of the proposed total development budget. The bulk of the money (over P800 million) was going to be used for HIV and AIDS. This was followed by Ministry of Local Government, Health, Education and Lands and Housing in that order. These ministries received between 5 – 14 % of the total development budget as indicated in Table 29 for provision of the various social services. Recurrent budget allocations for 2006/07 also show massive allocations to the social sector. For example, the Ministry of Education is the largest beneficiary with P5.0 billion (28.2%); followed by Local Government with P2.8 billion or 15.9%; State President with 2.4 billion or 13.7%; and Health with P1.57 billion or 8.9% of the total recurrent budget.

The history of state-driven social spending in Botswana is very clear. A review of social expenditure by Duncan et. al (1998) between 1967 and 1971 shows that real expenditure on health was roughly constant and falling as a share of total government expenditure. However, from 1972 on, expenditure on health rose sharply in real terms from 10 to 22 percent in 1976. This trend has continued somewhat to date. Furthermore, an analysis of social development trends in Botswana by Duncan et. al (1998) show that since independence in 1966, Botswana's overall social expenditure rose between 30-40% of total public spending and has on average grown by 11 percent per year in real terms. In the 1990s, health has accounted for between 10 and 20 percent of social spending and

between 4 and 5 percent of total spending. By international standards this reflects a significant increase in social expenditure. Expenditure in health has continued to grow in the 1990s and beyond. Total spending on clinics and hospitals aimed at improving basic health which is essential in any fight against poverty and overall improvement in the quality of life.

Trends in social spending in Botswana

The Government of Botswana managed to fulfill its promises made in the 1970s. As more money was realized from the mining sector, in particular diamonds, the proceeds were wisely allocated to educate Batswana children. Between 1973 and 1990 Botswana's economic growth was ranked among the fastest and highest in the world, averaging an annual growth rate of 13%. The mineral sector contribution to GDP and national revenue increased substantially during the 1970s and 1980s. Real GDP per capita increased almost tenfold between independence and the 1990s. As a consequence, expenditure in all areas of social and economic infrastructure increased considerably (Hope, 1996). Given the status of social sector in the country, provision of social services to all citizens of Botswana was given priority.

Table 30 shows the trend in social spending for the period 1981/2-1991/2.

Table 30: Social expenditure as a percentage of public sector expenditure (pula million)

Year	Social sector expenditure	Public sector expenditure	Social sector expenditure %
1981/82	107.6	321.2	33.5
1982/3	129.8	386.7	33.6
1983/84	142.8	411.1	33.9
1984/85	172.3	551.9	31.2
1985/86	201.8	673.9	29.9
1986/87	311.4	977.5	31.8
1987/88	407.7	1,243.9	32.9
1988/89	513.2	1,693.6	30.3
1989/90	645.8	1,969.4	32.9
1990/91	828.0	2,506.3	33.0
1991/92	1,150.4	3,092.3	37.2

Source: Botswana in the 21st century

As can be observed from Table 30 above, for 10 years (1981-1991), Government has consistently allocated over 30% of its total expenditure on social services. Table 31 below further demonstrates Government commitment to the development and provision of social services during the period 1997/2003.

Table 31: Functional classification of government development and recurrent expenditures in 1997/98 and 2002/03 (pula million-current prices)

Functional category	1997/1998		2002/2003		Growth in total expenditure (%)
	Total Expenditure	Percentage share	Total Expenditure	Percentage share	
Education	1,787,80	24.14	3,820,80	21.95	133.6
Health	411.2	5.55	1,130.80	6.50	175.0
Food and Social Welfare Programmes	160.3	2.16	168.3	0.97	5.0
Housing, Urban & Regional development	430.2	5.81	1,269.90	7.30	195.2
Other community and social services	131.4	1.77	580.5	3.33	341.8
Economic Services	1,701.80	22.98	3,133.50	18.00	84.1
Local Authorities	887.2	11.98	2,341.68	17.85	163.9
Financial Assistance Policy (FAP) Grants	102	1.38	154	0.88	51.0

Source: Ministry of Finance and Development Planning: NDP 9

Table 31 provides current figures on social expenditure. It shows the functional breakdown of total recurrent and development expenditure for 1997/98 and 2002/03 along side the respective shares and percentage growth over the period of NDP 8 (1997-2003).This high allocation to the social sector has brought positive results. Poverty rates have declined and many Batswana are now enjoying better standards of living. Although poverty appear to have declined over the years, e.g. from 59 % in 1984/5; 47 % in 1993/4 and 30.1 % in 2002/3 (NSPR, 2003), older and more recent surveys have shown a disturbing disparity in the distribution of national assets and income, with the top 20 % of the population earning almost 24 times as much as the bottom 20 %. Given the level of economic growth, such poverty and disparities are not acceptable. Clearly, without decisive action, they will reproduce, setting up a vicious cycle of poverty which negates the objective of social services provision and human development. In the Botswana's context, they pose a threat to social justice, national unity, and the principles of democracy and development. It is ironic that after two decades of double digit GDP growth, and with real GDP per capita currently as high as P40.000.00 (US$ 6.700). The availability of financial resources should constitute less of a limitation on Botswana's capacity to ensure human development than is the case in almost any other African country (MFDP, 2007).

Significant spending is now observed in the area of HIV and AIDS. The Government of Botswana spends billions on HIV and AIDS yearly. The country spends approximately 6 % of the national budget on HIV and AIDS. For example, in 2005/2006, Botswana

Government spent almost 1.14 billion (P1, 138, 255, 518) or (USD 185.4 million) in fighting HIV and AIDS. Of this amount almost 900 million was directly funded by the Botswana Government. Various international donors accounted for another 228 million, while domestic private sector contribution totaled almost P11 million. In percentage terms, the Botswana government contributed about 79% of the total spending, with international donors providing another 20% and the private sector 1 % (Mid Week Sun 29th November, 2006; ECHO Newspaper, 30th November, 2006).

Figures quoted above shows the extent to which the Botswana Government is involved in the fight against HIV and AIDS. Government has committed massive financial resources into HIV and AIDS. This commitment is better appreciated if Botswana is compared to other countries in sub-Saharan Africa, for example, in Mozambique, 78 % of AIDS resources come from donors; Uganda, 73 % and Zambia, 62 %. The largest donor of international funding for HIV and AIDS in the three countries were PERPFAR and World Bank (Global HIV and AIDS News 12th October, 2007).

Tables 32 and 33 below shows the pattern of recurrent and development expenditure in Botswana for a 20 year period (1980-1990). It is evident that during the 1990s, social services accounted for the largest portion of the recurrent expenditure. This trend continues and is rising (see figures for the 2006/07 recurrent budget – Budget Speech 2007). Within this sector recurrent expenditure is mainly on education. Overall, education in the past two decades has accounted for the largest share of recurrent expenditure – about 25% of the Government budget. Table 32 shows the pattern of development expenditure in Botswana during 1980 -2000. In this case, it is clear that social services continue to receive a larger proportion of the development expenditure and this trend has been rising. Therefore from the tables 32 and 33, it is evident that in Botswana, Government expenditure is greatest on socio-economic services (Mupimpila, 2005).

Table 32: Recurrent expenditure (percentages)

	Years				
	1980	1985	1990	1995	2000
General services, including defense	37.3	35.4	32.6	31.8	29.8
Social services	34.3	31.0	34.9	40.2	45.5
Education	22.6	20.6	22.4	23.8	27.9
Health	6.1	5.2	5.8	6.4	6.3
Food and social welfare programmes	0.3	0.6	0.8	0.1	3.6
Housing, urban and regional development	3.8	3.2	4.0	7.9	5.5
Other community and social services	1.5	1.4	1.9	1.9	2.3

Source: Adapted from Mupimpila, C. 2005: Calculated from Bank of Botswana Annual Reports and CSO statistical Bulletins

Table 33: Development expenditure (percentages)

	Years				
	1980	1985	1990	1995	2000
General services, including defense	13.8	11.9	18.1	19.5	24.3
Social services	34.1	29.3	37.0	37.1	37.1
Education	14.5	8.4	10.9	19.7	15.9
Health	2.8	3.2	2.5	1.9	3.1
Food and social welfare programmes	-	5.2	0.2	7.5	3.8
Housing, urban and regional development	15.9	11.6	23.0	7.0	9.5
Other community and social services	0.9	0.9	0.4	0.9	4.8

Source: Adapted from Mupimpila, C. 2005: Calculated from Bank of Botswana Annual Reports and CSO statistical Bulletins

Based on data from Tables 32 and 33, the following observations can be made about recurrent expenditure in Botswana.

- Social services account for the largest and rising share of recurrent expenditure. They were 34.3% in 1980; 34.9% in 1990 and 45.5% in 2000
- Within the social services sector, education accounts for the largest and rising share of expenditure on social services. The proportion was 22.6% in 1980; 22.4% in 1990; and 27.9 in 2000. The rise in the share of education in total social services expenditure is most significant since the 1990s.

However, despite a programme of sustained public investment in the social sector development, resulting in public expenditure ratios between 32% and 45.5% in each of the past three decades, well over 30 % of the people in Botswana are still reported to be living below the Poverty Datum Line (HIES, 2002/2003).

Botswana Human Development Index (HDI) ratings

Expenditure in all areas of Botswana social development sector has continued to grow considerably since independence. According to indices that are customarily used to measure progress in the social development sector, Botswana's achievement is remarkable. Access to health, education, clean water and housing have improved rapidly over the years. There has been considerable increase in infrastructural development as evidenced by an increase in the number of schools and clinics constructed.

Botswana's relative good performance in the social sector can be further appreciated if the country's performance is compared with others. This is done using the United Nation Development Programme – Human Development Index. This is illustrated by Table 34 below:

Table 34: Botswana Human Development Index compared

Country	Human Development Index					
	1985	1990	1992	1994	1998	2001
Botswana	**0.611**	**0.651**	**0.763**	**0.673**	**0.613**	**0.577**
Mauritius	0.682	0.718	0.821	0.831	0.782	0.765
South Africa	0.678	0.705	0.05	0.716	0.718	0.702
Swaziland	0.564	0.613	0.522	0.582	0.672	0.596
Namibia	0.624	0.644	0.611	0.582	0.651	0.601
Lesotho	0.531	0.561	0.473	0.457	0.583	0.541
Zimbabwe	0.606	0.599	0.539	0.513	0.570	0.554
Zambia	0.470	0.451	0.425	0.369	0.429	0.427
Malawi	0.347	0.348	0.330	0.320	0.419	0.397

Source: SADC: Regional Human Development Report 2000
UNDP – Human Development Report 2001.

The Human Development Index is a composite measure of human welfare that aggregates income, education and health outcomes on a scale of zero to one. It is a much broader measure than per capita income on its own. However, despite excellent performance in all indices customarily used to measure quality of life, when compared to other countries, recent HDI ratings are not encouraging. Since the 1990s HDI measure suggests a deteriorating human welfare in Botswana. In 1994, Botswana had HDI of 0.673. It fell to 0.613 in 1998 and 0,577 in 2001 respectively. Recent figures quoted by UNDP indicate a further fall to 0.570 in 2004. In 2004, Botswana HDI rank was 131 out of 177 countries, 60 positions lower than it was in 1996 and 73 below the country's per capita GDP rank in 2004.

The critical question is – What have we learned from this? The lessons learned are that poverty is more than lack of income. Other dimensions of welfare matter too. Although available statistics reveal that Botswana has made good progress in other sector's such as education and water, it has not made much progress on health related targets. There has been a steady increase in infant mortality, child mortality, maternal mortality and HIV and AIDS. Since 1996, both infant and child mortality rates have risen, no doubt as a result of HIV and AIDS. However, it is important to point out that, although HIV and AIDS impact adversely on poverty, its effects have fallen short of stifling progress on human development as indicated by a decline in poverty over the years after the onset of HIV and AIDS (MDG Report, 2004).

Perhaps that explains why, despite all these setbacks, Batswana are better of now than they were 40 years ago. The majority have escaped from poverty, ignorance, inequality and lack of opportunities. Certainly, many are well-fed, adequately housed, have better education, clean water and sanitation and better health services and protected against preventable diseases such as malaria. Batswana who were born in the 1960s and grew up in the 1970 and 1980s have witnessed significant transformation in the physical evidence

of their villages. Batswana are today better provided for in terms of basic services such as water, sanitation, health, education, electricity and communications, than it was the case at independence 41 years ago.

So can we definitively say basic services are more extensively provided now than at any time in post independence Botswana -Yes. The critical question is, has the quality of life improved for the majority of citizens? The answer is No! and there is no inherent contradiction between the two responses. The reality is that, the majority of Batswana may be well-fed but they are a lot less healthy. A combination of achieving material outcomes and eroding health makes for interesting, even if sad, discourse. Whilst growth in incomes suggests rising material well-being, the HDI in Table 34 above depicts a different scenario.

However, the fact that the country's HDI is on a decline should not detract us from major achievement made in the social sector to date. Therefore on the basis of evidence provided it will not be unreasonable to conclude that provision of social services have made a positive impact on the lives of Batswana many of whom will be wallowing in poverty without proper education, health, housing, water and sanitation.

Introduction of policy reforms in education, health, housing, water and sanitation: Implications for poverty reduction

The Government of Botswana introduced policy reforms in the early 1970s, 1980s and 1990s to date. Earlier reforms, for example, in the education sector were influenced by international bodies such as UNESCO and the World Bank, which played a crucial role in shaping the global education agenda. UNESCO's 1964 mission report, for instance, advised that emphasis be placed on primary education. Given its history, it is not surprising that UNESCO would offer this advice. This was perfectly in line with its human rights view of education. They believed in universal access to education and that education is a basic human right. The assumption is that basic education open doors for further schooling and provide basic literacy for survival skills and ultimately a major onslaught on poverty.

In the 1990s and early 2000 a noticeable shift in ideological reforms became apparent. Government started introducing cost-recovery as a policy measure. The government position it that people must realize that for the various services provided by the government to be sustained and even improved in terms of coverage and quality, those already benefiting and who can afford must be prepared to pay a small proportion of the cost. Government sees cost recovery as a form of "*Ipelegeng"* or self-reliance and should be understood as such. "*Ipelegeng"* or self-reliance is one of the key principles that Botswana evoked in the early years of independence. Together with the values of unity, social harmony and democracy they form the bedrock of the country's development and social provision, that when applied together will enable Botswana to achieve its ambitious but realizable goals encapsulated in Vision 2016 and National Strategy for Poverty Reduction (NSPR, 2003).

Of immediate interest in this regard was the introduction of partial cost recovery in education with effect from January 2006. Furthermore, cost recovery was introduced in the health sector in September, 2007. In both instances, during implementation of cost recovery measures, no one will be turned away from school or a health centre if they do not have the means and cannot afford. Government has put in place adequate safeguards to ensure that those genuinely unable to pay are not denied access to and utilization of the services. One could call this practice, "cost-recovery" with a human face. This obviously protects the poorer members of society and cushions them against extreme poverty.

Similar measures were undertaken with respect to water and housing. For instance, water tariffs were introduced to encourage those who can afford to pay makes a contribution and thereby helps government meet the ever increasing costs and improve service delivery. In housing, Government was forced to remove subsidies save for those who are "truly" deserving and have been assessed by professionals as such. These include the poor and destitute. However, in all cases, safeguards were put in place to ensure that those who cannot afford any of the services are not duly disadvantages or denied access. It is still early to determine the extent to which the introduction of reforms have reduced poverty and contributed to the betterment of the poor. Some reforms were introduced about two years ago others as recent as 2 months ago. However, anecdotal evidence and/or preliminary observations suggest that some reforms are likely to hurt the poor. For example, the introduction of school fees after more than 25 years has been the subject of debate. Some argue that the hidden costs of education are already hurting the poor. The poor are also being stigmatized and their children sent back home for failing to pay. Some children never come back to school. The same is true for health. Many people have complained about the increase of consultation fee from P2.00 to P5.00 (an increase of over 100 percent. Given the level of income poverty, P5.00 which may appear very little to some people, may not be so for the poor.

Privatization of social services: Implication for poverty reduction.

I had indicated in the discussion on the global context of education that international influence had played a significant role in the crafting of education policies in Botswana. The same is also true for health and housing, with WHO and Habitat playing an important role in shaping both the formulation and implementation of policies.

In terms of privatization of services, it is clear that the WB has had more influence on provision of social services in general. In the field of education, the new human capital theory of the 1970s and 1980s was used to justify investment in education. The economic view of education became very strong and received strong support from the Bank. As a Breton Woods institution, the Banks thinking resonated with that of what has come to be known as "the Washington Consensus". Neo-Liberalism emerged as the new consensus ideology: the belief in free market, minimal state intervention, competitiveness, de-regulation and privatization. According to this thinking, investment in education, health and housing, had to be justified on economic grounds. Cost-benefit analysis in the form of rates of return became the Bank's preferred formula. The level (s) that promised highest private and social rates of return would be the one that the Bank would support.

While UNESCO and WB imprint in the social services field, in particular, education is very clear and is evident in both the NPE, 1977 and RNPE, 1994, it is important to note that such influence has always been mediated by local circumstances in order to give relevant shape to the resultant policies. Since the early 1990s, the Botswana Government has openly embraced a private-sector led market strategy. Government has introduced a number of reforms including introduction of school fees, health user fees, water tariffs and removal of housing subsidies and other reform s consistent with IMF and WB prescriptions.

The important question is- what does this mean in terms of poverty reduction? Is there evidence to suggest that as a result of privatization the poor are getting better? In the case of housing, the effects are already felt by many people. Botswana housing Corporation is retrenching employees as well as increasing rentals on its properties. This is likely to impoverish many households, who prior to the reforms could afford decent housing. The number of people who cannot afford decent accommodation has risen in recent years, and so is the number of people who will be completely without accommodation. In the area of education and health, it is too early to say how the recently introduced reforms will impact on the poor. However, people are already complaining that the poor are getting hurt and services provided by the government are poor and sub-standard.

Private services in health are already available as in the case with Gaborone Private Hospital and a proliferation of other private health services, especially in the urban and peri-urban centres. In education, private education facilities are likely to increase. These private services are known to provide better quality services than government and they benefit only a handful wealthy people. Standards in the public sector are likely to deteriorate further; especially that government spending is likely to go down with serious implications on poverty.

Despite the introduction of reforms, in particular privatization or contracting out of services, the Government of Botswana continues to provide social services at highly subsidized rates. For example, education is heavily subsidized or totally free for all Batswana from primary to secondary education. All deserving Batswana continue to get substantial assistance for their education even at tertiary level. These subsidies are a targeted investment by the Government, intended to provide Batswana with a springboard they could use to economically empower themselves. The recent expansion of the University of Botswana, the planned Botswana International University of Science and Technology, the medical school and medical training hospital are recent examples of projects in education aimed at further empowering more enterprising Batswana for employment and high caliber job creation. In early 2007 the Ministry of Education started to sponsor students at local private tertiary institutions for Diploma and Degree courses. Over 7000 are now so sponsored at a huge cot to the Government. Given that literacy and education have positive effect on household welfare, and that the likelihood of poverty diminishes with as the level of education increases, large investment in education may reduce poverty in Botswana now and in future.

There is, however, need to continuously review of Botswana's social reforms with a view to assess its impact on poverty reduction, and if need be, re-orient reforms such that they do not hurt the poor or they become pro-poor so as to effectively meet the differing needs and circumstances of the poor in both rural and urban communities of Botswana. To improve the sustainability and equity of social services, Government has committed to continue to review their design and implementation in order to target them better to specific needs of the disadvantaged members of the society. This approach may enable government to address problems of structural poverty more effectively and within a manageable budget.

Service delivery, gender and poverty reduction

Gender as a structural principle organizes other social and institutional relations. Although gender refers to both sexes, in this section, the focus shall be on women, since generally women suffer more than men in their quest for a decent education, health, housing and water. Gender therefore determines the extent to which males and females have access to and utilize resources and social services provided. Most importantly, gender may also determine access to employment opportunities. Note that in Botswana, the main causes of income poverty include among others, limited access to employment opportunities. To this end, access to employment is one of the pre-requisites for sustainable poverty reduction for both males and females. Social services should be provided in an equitable manner, the ultimate goal is to reduce gender disparity in education, employment, and in access to and control of productive resources, to reduce discrimination and violence against women and raise women participation in leadership and decision making positions.

Preliminary results from the Labor Force Survey 2005/6 suggest that overall unemployment has dropped to 17.6 %. This figure, however, disguises highly skewed unemployment rates between males and females as shown in Table 34 below:

Table 35: Unemployment by gender and age 2005/06

Age	Male	Female	Total
15-19	21.60 %	34.90 %	26.80 %
20-24	30.70 %	39.70 %	35.20 %
25-29	20.10 %	26.00 %	23.10 %
30-34	11.00 %	18.20 %	14.80 %
35-39	11.30 %	14.80 %	13.10 %
40-44	11.20 %	12.50 5	11.90 %
45-49	9.80 %	10.30 %	10.00 %
50-54	10.80 %	6.60 %	6.80 %
55-59	6.90 %	5.20 %	6.10 %
60-64	6.50 %	4.50 %	5.60 %
65+	3.30 %	2.00 %	2.80 %
Total	15.30 %	19.90 %	17.60 %

Source: MFDP, 2007 – Preliminary results of the consultancy report on Citizen Economic Empowerment.

Overall, the unemployment rate among women is almost 20 %, compared to just over 15 % for men. In the age cohort 15 – 30 years unemployment among women almost reaches 40 % compared to just over 30 % for men. Overall, youth unemployment rate is estimated at 27.4 %.

Although women compete quite effectively in school or in education in general and in most schools there are more females than males, when it comes to employment, women between the ages 15 years to 64 years have a 23 % chance of getting a job compared to 37 % for men (Tsa Badiri, CEE consultancy report, 2007). The pertinent question is – what does this mean for poverty reduction? Two conclusions can be reached. The first is that education for women does not necessarily eliminate gender stereotypes when it comes to work and job opportunities. Secondly, women are more likely to be poorer than men regardless of their educational attainment.

In the area of housing, the 1991 Census reported that female headed households comprised 33.2 % of the total in the urban areas and 51.9 % in rural areas. The majority of women were reported to be facing difficulties in their efforts to access decent housing for themselves and their families. In terms of affordability, many Batswana cannot afford to own even the most basic house, women are the most affected even more seriously because they are generally unemployed and poorer than men. Among the urban very poor people, female headed households constitute 42 % as opposed to 16 % for male headed households (BIDPA, 1997).

Several studies have been conducted on access to housing by women in Botswana (see Review of the National Policy on Housing 1997). Issues raised in these studies and anecdotal evidence suggests that:

- Women are often exposed to serious health hazard through strenuous domestic work, exposure to toxic chemicals and cleaning agents, lack of water, inadequate sanitation and domestic violence
- It is very difficult for women alone to get access to credit. Banks always ask for male guarantor
- Institutional housing is less accessible to women because they generally occupy junior positions and lack the power and influence to fight for a limited number of houses. The same situation obtains in the private sector, where the majority of women occupies lower positions and is therefore accorded lower status.

With respect to education, it is important to point out that, in 1966 when Botswana gained independence from Britain, like all other African states, the country inherited a gender stereotyped educational system. Subsequent commissions in 1977 and 1994 made attempts to address the gender imbalance in education. They both emphasized the importance of education for human development. However, due to an entrenched gender stereotyped educational system, the girl child still struggle to access education. These challenges must be addressed in order to close the gaps created by gender inequalities in education which militate against poverty reduction among girls.

Access and Quality

The National Commission on Education 1977 stresses that:

> True equality implies that schools will be as far as possible made geographically accessible to all, that they will be approximately equal in quality, and that scarce qualified teachers, books, materials and permanent buildings be distributed throughout the system so that Batswana children are treated equally in school.

The health system, housing, water and sanitation policies put a lot of emphasis on universal access and coverage. It is therefore not surprising that government social spending has focused primarily on ensuring that every citizen, irrespective of their socio-economic status benefits from these services. In all the policies, the bias has been towards the poor. This is essential for nation building promotion of social justice and equity. However, giving priority to quantitative growth and development of social services meant less attention to quality. This "neglect" characterized provision of social services in Botswana since the 1970s to date.

While most Batswana have access to almost all social services such as education, health, housing and water, some vulnerable groups such as the disabled, orphans and the girl child have limited access to social services. For example, most of the orphans have limited access to basic human needs such as food, health, clothing and shelter. Their opportunities for growth and development are also limited due to household poverty. Their access to education, health, housing and other services is also at stake as caregivers cannot afford hidden costs of these services. The implications of orphan hood on children have serious consequences. In education, the consequences manifest in various forms including; school drop outs, truancy, teenage pregnancy and poor school performance. To compound this, HIV and AIDS orphans are often stigmatized not only by other children at school but also by the teachers. As a result they undergo deep emotional stress which

drives them away from school into poverty. Generally, lack of access adversely affects the social development processes. Instead of getting people out of poverty, it perpetuates the legacy of poverty.

In terms of quality, it is important to note that the term "quality" in provision of social services is often used loosely. The problem with quality is that it is a concept without absolute meaning. It is largely un-quantified and therefore subjective as it is relative to some criterion or ideal. For example, in education, most people confuse quality education with pass rates, teacher qualifications and location. While quality in health is often associated with attractive health facilities or buildings and a clean environment. However, these attributes do not necessarily reflect quality of social services. The reality is that quality in education, health or any other social service can only be measured if judged against set goals and objectives. Thus it is important to be very clear about what is to be achieved through and with social service provision. That is to establish the purpose and role that provision of social services should serve. Then welfare regimes should be developed and concomitant institutional action and behavior promoted towards achieving those goals and objectives. For example, if education is about poverty reduction we have to be very clear and develop quality assurance mechanisms to measure the extent to which the stated goals and objectives of poverty reduction have been achieved. Without this we may never really know whether education leads to poverty reduction. The curriculum, teaching methods, job markets and other methods of assessment all need to be aligned to both the explicitly and implicitly stated purpose of education so that progress can be measured and controlled.

With respect to education, research has shown that the problems of quality cut across all levels of education (primary, secondary and tertiary) in Botswana (Duncan et. al 2000). The Revised National Policy on Education (1994) is making considerable efforts to address quality issues in education in Botswana. Other social services like health, housing and water are also faced with similar problems of quality. The quality of health services provided by the government has been the subject of scrutiny for many years. There are concerns that although health services are readily available and virtually provided free of charge, the quality of such services leaves a lot to be desired. By government own admission, the quality of health services in Botswana is very low and calls have been made in successive NDPs to improve service delivery and quality. Failure to deliver quality services is counter productive and undermines government development efforts, in particular, its relentless commitment towards poverty reduction.

Conclusion

The aim of this paper was to assess the role of social services in poverty reduction. Since independence Botswana has developed a very strong state. Provision of social services was state-led and controlled. Centralised planning is still evident even to date but with limited private sector and NGO sector involvement. This approach has enabled the state to invest heavily in provision of social services, the outcome of which was phenomenal quantitative growth in the social sector. It is important to point out that by any standard; Botswana has done extremely well in provision of decent and affordable social services, to the envy of many countries around the world. Unfortunately, quantitative growth was

not matched by qualitative improvements in social service standards. An analysis of whether massive investment in education leads to quality education with profound impact on poverty reduction leads to two conflicting conclusions (i) On the one hand, the majority of Batswana have benefited from provision of social services such as education and health and are now gainfully employed and not income poor (ii) on the other hand, several categories and groups of poor people did not derive maximum benefits from the education system and as such are not able to lift themselves out of poverty. For example, major problems identified in the education system, include, but are not limited, to the following areas: spatial distribution, gender, policy options, the dual system of education and curriculum. These have disadvantaged a substantial number of people especially in the rural and remote areas.

Introduction of policy reforms to address these problems have not been generally helpful. Instead, reforms and policy options contributed to discrimination in the social service provision system and a further entrenchment of the existing inequalities in the Botswana society. Taken together, this constitutes a recipe for embedding inequalities and ingraining poverty-a recipe that undermines the aspirations of the national Vision 2016, NSPR, 2003 and core values of the Botswana society such as democracy and social justice.

Compounding the above problems are fragmented and weak linkages between education and employment opportunities. Although it is through education that the country can produce an educated and skilled labour force capable of uplifting themselves from poverty, this has had limited results. The curriculum, teaching methods, assessment and quality assurance mechanisms are not clearly aligned with the purpose of education. Currently there is no relationship between the goals and objectives of education on the one hand and the curriculum, instruction and assessment on the other. Worse still, education for poverty reduction has not been clearly and consistently stated in all major policy documents such as RNPE (1994), Vision 2016 and Vision and Mission of the Ministry of Education. The section on education forms only a small component of important national documents and is hardly visible. Without a credible education system, the strategic role of education in poverty reduction is being eroded, leading to a poorer population not benefiting from the education system and declining overall quality of life.

The ripple effects of a poor education system are felt in other social services areas, notably in health and housing. In the area of health poorly educated people are unable to find jobs. Lack of income means they cannot afford decent accommodation and their access to health is severely limited. Their lower socio-economic status (poverty) forces them to live in squalid conditions with poor sanitary facilities with serious implications on their health status. As indicated elsewhere in this paper, provision of social services is a necessary but not sufficient condition for poverty reduction.

In the final analysis, it is not unreasonable to conclude that Botswana has great potential to reduce poverty through provision of social services. The country has a strong economic base and is democratic and politically stable. The social justice mandate of social services can be enhanced by recognizing all social services as fundamental human

rights. Currently, the wealth of the country has not sufficiently "trickled down" to benefit all the poor. Instead, like many capitalist states, the rich are becoming richer and the poor poorer. The role of social services is to ensure that the poor also benefit from economic development. This will ensure equity, political stability and sustained democracy. For any meaningful change to take place, the challenge for Botswana is to:

- Engage in a comprehensive review of the social policies in Education, health, housing, water and sanitation with a view to strengthening its poverty reduction components and mandates
- Expand and improve the quality of senior secondary schools and tertiary institutions to ensure that the majority of youth are prepared for the world of work
- Improve labour competitiveness through skills training for self-reliance among the poor
- Introduce radical reforms that argue for recognizing social services as a fundamental human right and thus provide a legal base for their provision.

If social services reforms work as envisaged, they will go a long way to ensuring that the ideals of Millennium Development Goals, Vision 2016 and NSPR, 2003 are realized. Furthermore, it may be possible that after forty-one years of independence, Botswana should, rather than simply declaring social justice as an intrinsic goal, practice it as an inherent social value, because all these factors combine to give Botswana a decent chance of meeting the objectives of poverty reduction. Successful poverty reduction strategies lead to improved quality of life, political stability and enhanced democracy.

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