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Government Expenditures on Social Services: How far has the Poor Benefited in Swaziland?

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Abstract: The conventional wisdom in both the public finance and development literature seems to suggest that one of the major roles of government in any society is to enhance social welfare through its fiscal policy actions. An important way through which the government could achieve this would be by spending on things of value to people that they will not otherwise be able to provide for themselves. In this regard, the conjecture is that public spending should be directed, not just at promoting efficiency by correcting for market failure in the economy, but also promoting equity and reducing poverty through the distribution of the gains from economic growth. In this paper we have shown that despite substantial increases in government expenditures on health, education and other social services in Swaziland, poverty continues to be endemic and the poor continue to be under-served in terms of access to basic education, primary health care and better living conditions. The level of poverty remains quite high; 70 per cent of the population continue to live in the rural areas; a small proportion of the population continue to hold a large portion of income; and land remains largely in the hands of the minority. For the objective of poverty reduction and equity to become achievable in Swaziland, fiscal policy actions of the government swill need to be more targeted at the currently underserved and the poor in the society, particularly the rural dwellers. In this way the access of the poor people to health, education and other infrastructure such as housing, safe water and other safety benefits could be guaranteed and sustained.

Key words: Public finance, government expenditure, social services, education

Introduction

The conventional wisdom in both the public finance and development literature seems to suggest that one of the major roles of government in any society is to enhance social welfare through its fiscal policy actions. An important way through which the government could achieve this would be by spending on things of value to people that they will not otherwise be able to provide for themselves. In this regard, the conjecture is that public spending should be directed, not just at promoting efficiency by correcting for market failure in the economy, but also promoting equity and reducing poverty through the distribution of the gains from economic growth. However, in the last two or three decades, and particularly so in most developing countries of the world, economists have continued to ponder over the question as to whether this redistributive goals of public spending are actually been achieved by current practices. According to Dominique Van de Walle (1995), these worries have stemmed out of three noticeable factors. These he identified as (i) the dissatisfaction with distributional outcomes in the absence of intervention, since market failures such as lack of access to credits may leave many households to face acute poverty for a very long time; (ii) the lack of alternative policy instruments since in most developing countries, and unlike what happens in the developed countries, comprehensive income taxes are not viable options for income redistribution; (iii) the need for fiscal restraint in many developing countries as occasioned by serious fiscal imbalances and debt problems. The immediate effect of the third factor is that governments in developing countries are forced to face hard and largely unpopular policy choices particularly with regards to the provision of essential public services such as basic schooling and health giving the need to service external debts and implement on structural adjustment programmes.

In response to the growing inability of governments in developing countries to meet distributional goals with fiscal policy actions, there emerged a paradigm shift from the early 1990s. Thus the idea as to how to effectively redirect strategy and actions towards poverty-reducing public spending began to assume a center-stage in international funding and assistance programmes (the World Bank 1990, 1991; UNDP 1990; the Asian Development Bank 1992; IFAD 1992). The case been made is that the development of human capital needed to be encouraged and expanded through primary education and basic health care, largely provided (though not necessarily produced) publicly. Additionally, that there should be a need for well-targeted social safety nets, provided by the state, to guard the poor and vulnerable against food and other insecurities. Thus while there may have been differences in terms of emphasis in the past, there now appears to be broad agreement on the basic elements of a poverty reduction strategy.

This paper is an attempt at examining the distributive effects of government expenditure on poverty and inequality. Its focus is on public spending in Swaziland for education, health (human capital development) and other social services. The paper coincides with the increasing interest in poverty alleviation, not just in Swaziland, but in most

of sub-Saharan African countries, and the strategies that can best be adopted towards achieving the desired objectives. Since the expenditures examined in this paper are some of those that can be used to meet the demands of the poor majority in any society, the paper can therefore be described as an attempt at analyzing why the situation has or has not improved over the years.

Swaziland: A Brief Overview of the Economy: Swaziland is a middle-income (lower) developing country with a human development index of 0.655 and a per capita gross national product of US $ 1,360 (UNDP Human Development Report, 2000). With an estimated population of about 1,018,000 (1999) and an area of 17,364 square kilometres, Swaziland has a population density of about 58.6 people per sq.km. The country is divided into four physiographic regions: highveld, lowveld, middleveld and lubombo plateau; and four administrative regions: Hhohho, Manzini, Shiselweni and Lubombo. According to the 1997 census, about 53 per cent of the total population is female and 47 per cent male, while the proportion of those under 15 years is about 44.4 per cent. Furthermore, over 70 per cent of the people live in rural areas. These are supported only by subsistence farming on Swazi Nation Land (SNL) that is held in trust by the King and administered by appointed chiefs. About 25 per cent of the land is Title Deed Land (TDL), which comprises mainly large-scale capital-intensive commercial farms. The Swaziland economy is small, open and reasonably well diversified and vulnerable to exogenous external economic shocks and influences. At independence in 1968 it was highly dependent on agriculture and has continued to maintain strong linkages with the South African economy. Currently, the main linkages with South Africa include trade, transport, communication, investments, energy and finance. About 80 per cent of imports of goods and non-factor services derive from there, while about 50 per cent of exports are destined there. The Common Monetary Area (CMA) consisting of Namibia, Lesotho, South Africa and Swaziland has over the years guaranteed her a reasonable degree of monetary sector stability. Under the CMA agreements, the Swaziland currency, the Lilangeni (plural, Emalangeni "E") is tied to the South African Rand on a one-one basis and currently exchanges at about E11.5 to the Unites States Dollar. This means too that the Swaziland currency is exposed to fluctuations as whatever happens to the Rand in the international currency market is automatically transmitted to the Lilangeni. Similarly, the Southern African Customs Union (SACU), established in 1910 and consisting of Swaziland, Lesotho, Botswana, Namibia and South Africa, provides the country with about 50 per cent of her annual fiscal revenue. Although Swaziland is an active member of the Southern Africa Development Community (SADC) and the Common Market for eastern and Southern Africa (COMESA), the country's economic dependence on the membership of these two organisations has, over the years, been heavily outweighed by the strength of its economic links with South Africa. However, new trade opportunities seem to be opening up with the changes taking place in regional and international economic scenes (Magagula and Faki, 1999).

Trend in Public Spending on Education, Health Care and Other Social Services: As highlighted above, the ability of the poor majority in most developing countries to improve their standard of living depends largely on the extent to which public expenditure enables them to obtain affordable health care and good quality education. The analysis that follows in the next two sections therefore attempts to highlight the allocative and/or distributive effects of public expenditure on education, health and other social services. Trends in public spending on these sub-sectors are examined below and the equity and poverty situation in Swaziland is then highlighted.

Public Expenditure on Education: As Table 1 indicates, substantial increases in budgetary allocation to the education sector have been achieved in Swaziland over the years. In response to the appreciable performance of government in this regard and going by available statistics, outcome indicators in the education sector in general have improved over time. The share of the population that had no education declined for both males and females

Table 1: Government Recurrent Expenditure on Social Services (1969/70 - 1999/00)

Sector	69/70	79/80	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00
Education	3.85	14.62	92.5	138.4	163.2	198.4	239.7	276.7	310.9	323.6	389.8	452.1	454.0
Health	1.12	5.33	33.4	47.7	48.2	61.3	82.5	91.4	109.3	109.7	150.3	161.0	172.0
Others	0.24	0.46	14.5	17.2	25.2	23.8	4.0	48.3	23.3	58.2	39.7	44.0	63.0
				AS	%	of	Total	current	Expd,				
Education	27.84	21.92	28.1	30.61	31.6	27.9	22.8	24.67	24.6	22.1	25.9	26.1	22.0
Health	8.10	7.99	10.17	10.54	9.33	8.6	7.8	8.15	8.6	7.5	9.9	9.3	8.3
Others	1.73	0.68	4.42	3.8	4.8	3.35	0.38	4.3	1.8	3.9	2.6	2.5	3.1
				AS	%	of	GDP	in	current	Market	Prices		
Education	5.11	4.22	4.87	6.02	6.63	7.24	7.83	7.32	7.47	6.31	6.44	7.27	7.04
Health	1.48	1.54	1.76	2.07	1.96	2.24	2.69	2.42	2.62	2.14	2.48	2.59	2.66
Others	0.32	0.13	0.76	0.75	1.02	0.87	0.13	1.30	0.56	1.13	0.65	0.71	0.97
Total	6.9	5.89	7.39	8.84	9.61	10.35	10.65	11.04	10.65	9.58	9.57	10.57	10.67

Sources: i) CBS, Annual Report, various years
ii) GOS, Budget Estimates, various years.
* Totals may not add up due to rounding errors

Table 2: Sources of Finance to the Education System (E' Million) Actual 1999

Source	Primary Ed.	(%)	Secondary/High School Ed.	(%)	Tertiary, Ed	(%)
Government	123.02	(47.4)	99.36	(42.7)	95.42	(82.8)
Families	136.61	(52.6)	132.68	(57.1)	0.45	(0.30)
NGOS	0.098	(0.04)	0.077	(0.03)	0.081	(0.07)
Corporations	-		0.40	(0.2)	0.60	(0.52)
Others	-		-		18.63	(16.2)

Source: Akinkugbe, O. (2000), pp. 1081

between 1985 and 1995. In rural areas the gains in educational attainment have been at every level, whereas in urban areas - which started with a stronger primary education base - the gains have been in secondary and tertiary education. The primary education gross enrolment ratio (total number enrolled as a percentage of school-going age group) climbed from 101 per cent in 1986 to 128 per cent a decade later (GOS) Ministry of Education, 1996). This is higher than the sub-Saharan Africa average of 73 per cent.

However, in terms of intra-sectoral congruence, the story is different. Although schools are well distributed throughout the country, some children are denied access because of lack of fees. This means that participation is limited by the ability of families to pay in order to maintain their children in schools. As shown in Table 2, the financing of primary and secondary education is borne largely by parents (53% and 57% respectively), while the government is mainly responsible for the funding of tertiary education. Families finance the education of their children from primary to secondary, but pay almost nothing for tertiary education. The fact that there is no school fee structure imposed by the Ministry of Education means that each school charges its own rate, thus creating resentment by parents. The justification for this structure of public subsidies in the education system is that of equity of access, according to which tertiary education - the most expensive level of the system - is thereby made affordable to all, while Swazi households are made to share the costs of the cheaper primary and secondary education levels.

The strong bias against primary education in the allocation of public resources within the sector is evident if we compare the per student subsidy at each level of education. Under the current structure of spending in the sector, the public cost to educate one university student in 1998/99 would have been sufficient to cover the cost of educating 55 primary or 20 secondary school students (Akinkugbe, 2000). These ratios are high enough to place Swaziland in the range of SSA countries that spend a disproportionate amount at the tertiary level. There is thus the need for a major restructuring of spending in order to increase the ability of the poor to obtain (i) quality education (ii) at an affordable cost; and (iii) within limited fiscal resources.

Furthermore, according to the 1997 census figures, the urban population is consistently better educated than the rural, especially in having a smaller share of people with no formal education and a larger share at higher education attainment levels. Similarly, even though gender disparities are small at the earlier levels of education, at the tertiary level, a differential seems to emerge in favour of men. This seems to suggest that a smaller proportion of women than men move on from the secondary to the tertiary level.

Public Expenditure on Health: In the health sector, there is evidence that the public budget is inefficient and biased against the poor. As Table 1 shows, public recurrent expenditure on health has been on the increase since 1970. Thus, at an annual average of 7 to 9 per cent, the share of Swaziland's public budget accruing to the health sector is comparable to that of other lower middle-income developing countries. The key indicators in the health sector have recorded significant improvement over the years, but for the HIV/AIDS pandemic, which has exerted its toll in recent times. Though driven primarily driven by the private sector, especially the missions, Swaziland's health facility and personnel-to-population ratios have improved considerably over the years. For example, the population-to-physician ratio has almost halved from 18,700 people to one physician in 1985 to 9,500 in 1993 (Health Sector Study, 1998). The gains in the population-to-nurse ratio now mean that Swaziland has one of the best ratios (232 people per nurse in 1993) in the continent. However, as the HIV/AIDS continues to take its toll especially among skilled personnel, maintaining the staffing ratios of the sector may prove to be difficult. The magnitude of the HIV infection in the country is already rolling back many of the health gains of the past three decades. Health indicators are thus declining rather than improving.

Despite much of the country's disease burden being preventable, health expenditures are skewed toward curative care (Health Sector Study, op. Cit.). Curative medicine accounted for 70 to 80 per cent of the total health spending during the mid-1990s. This implies that, only about 20 to 30 per cent of the budget were allocated to primary/preventive care, which is likely to be used mostly by the poor. Curative medical services tend to cater for the well to do in Swaziland because the user-fee scheme is not designed to cater for household's ability to pay. A strong urban bias is also evident in the distribution of health services and facilities. The gains in health personnel

and infrastructure achieved over the years have been inequitably distributed, with the rural poor being the least served. Although only 30 per cent of the country's population is urban, over 90 per cent of inpatient beds are located in urban areas (Health Sector Study, op. Cit.). Doctors are primarily based in the hospitals and central administration, and so are the majority of nurses and all health sector employees. This results in rural clinics - to which the poor have greater access - being relatively under served. Compared to the regional population distribution, health facilities are disproportionately concentrated in the urban areas of Manzini and Hhohho. These two regions account for about 55 per cent of the population, yet maintain about two-thirds of the country's health facilities, mostly in the big towns and cities. As the HIV/AIDS epidemic matures public expenditure in the health sector will come under severe pressure. There will be increased demand to provide home-based care as well as programmes targeting the poor.

Public Expenditure on Other Social Services (Housing): As previously stated over 70 per cent of the Swazi population still reside in rural areas where housing structures range from mud and grass thatched to corrugated iron roofs. Of the 30 per cent who live in urban areas over 60 per cent live in unplanned townships, without safe water supply and sewerage, and where solid waste disposal and sanitation are serious problems (UNDP, Swaziland Human Development Report 2000, draft). The majority of people living in peri-urban areas are often not employed in the formal sector, and lack capital, land and infrastructure to provide decent housing. The demand for urban housing is therefore very high, and people often resort to sharing rooms and building sub-standard and temporary buildings on unsurveyed plots.

In contrast with other social sectors like education and health, it appears the government of Swaziland spends little directly on housing. As a percentage of GDP, both government recurrent and capital allocations to housing and community amenities have been consistently less than 1 per cent over the years (Tables 1 and 3). The activities of the government have mainly been through financial institutions such as the Swaziland Building Society and the Swaziland Development and Savings Bank. These institutions finance the purchase and construction of dwellings and other amenities to facilitate the construction of new houses. Similarly the various commercial banks in the country provide limited mortgage for the upper and middle-income segments of the society, thus reinforcing inequality by their operations. Their high interest rates make it virtually impossible for the poor to access credit. Consequently, the poor cannot participate in the housing market using these avenues.

Recently, the government launched a housing co-operative programme to improve access to housing finance by the under-privileged. The co-operatives are to enable members, in mutually beneficial ventures, to collectively save money, procure land and build houses. Although the scope of the co-operatives has not been sufficient to date, the idea constitutes a step towards servicing the needs of the larger lower income strata.

The Social Welfare System: Even though there are Ministries of Enterprise and Employment, and of Health and Social Welfare, very little has been achieved in terms of the structure and performance of the social security system in Swaziland. The social welfare system is operated under a very limited budget and payments by the state to the destitute, elderly and disabled are meagre. There is, on average, one social worker per 50,000 individuals and no effective welfare policy (UNICEF, GOS, 1998). There appears therefore to be some reluctance on the part of the government to institutionalise care programmes because of the high cost. According to the 1997 Census figures elderly people aged 65 years and above represents about 3.5 per cent of the population. Majority of them has no pension income and relies on savings and assistance of family members. Furthermore the youth (children up to 15 years) represents 44.4 per cent of the population, all pointing to the fact that a great deal of effort and resources are required for social services and welfare protection in Swaziland.

The implication of the current situation is that much of the population's social security needs are being provided by the extended family. However, changes in lifestyle, migrant labour and mobility lead to considerable erosion of the family structure, which is currently not compensated for by any robust social security system. The destitute, elderly, disadvantaged and marginalised groups are, to some extent, helped by Non-governmental organisations (NGOs), Community based organisations (CBOs), religious associations, development agencies and self-help groups. There are about one hundred national and grass-root NGOs, some of which provide shelter, food, clothing, and basic life skills programmes. However, the current demand for social welfare services exceeds the capacity of all these welfare organisations. So far, the government has not been able to fulfil its role in providing essential social welfare services to the population.

Materials and Methods

Poverty in Swaziland: According to Lipton and Ravallion (1995), poverty is said to exist when one or more persons fall short of a level of economic welfare deemed to constitute a reasonable minimum either in some absolute sense or by the standards of a specific society. The level of "economic welfare" implied here refers to a person's consumption of goods and services and "reasonable minimum" is defined to mean a pre-determined basic

consumption needs. In this way, the existence of poverty may be assumed synonymous with inadequate command over commodities. Based on a food poverty line of E47.70 per capita per month (the level of income assumed sufficient to buy 2100 calories per capita per day), and a higher poverty line of E71.07 per capita per month (which includes allowance for non food expenditures), the incidence, depth and severity of poverty by administrative region and rural/urban distribution were computed for Swaziland as shown in Tables 4 and 5. The two tables reveal that the head count ratio or incidence of poverty (proportion of individuals in the population whose income or consumption expenditure falls below the poverty line) is 66 per cent for the higher poverty line, and 48 per cent for the food poverty line. The tables also show wide differences between the regions and between the rural and urban areas. The proportion of the poor in the urban areas is about half that of the rural areas, no matter what poverty line is used. Furthermore, the tables show that the poverty gap index or depth of poverty (mean standardised distance between the poverty line and the mean consumption of the poor) is very high compared to the percentage of the poor in Swaziland. This is a very strong indication of inequality in the distribution of consumption in Swaziland.

Tables 4 and 5 also show the severity of poverty in the squared poverty gap in Swaziland. This index gives more weight to those far from the poverty line and is higher if there are many very poor in a certain group. The tables reveal that there is no significant difference between the urban and rural areas. The fraction of very poor is the same though slightly higher in the Shiselweni and Lubombo regions.

Table 3: Government Capital Expenditure on Social Services (1969/70 - 1999/00)

Sector	69/70	79/80	89/90	90/91	91/92	92/93	93/94	94/95	95/96	96/97	97/98	98/99	99/00
Education	0.57	6.13	12.1	20.8	23.7	27.3	31.5	30.6	21.5	26.1	20.9	97.6	12.8
Health	0.07	0.78	1.8	3.9	10.4	9.8	10.1	5.8	8.9	4.6	6.6	9.1	15.9
Others	0.15	3.61	8.0	8.9	26.3	30.8	32.2	29.6	19.8	36.5	51.9	68.9	31.5
				AS	%	of	Total	current	Expd,				
Education	24.36	8.36	12.23	16.05	8.99	8.65	11.85	8.67	7.41	8.90	6.47	20.2	2.38
Health	3.00	1.06	1.82	3.01	3.95	3.11	3.80	1.66	3.07	1.57	2.04	1.88	2.96
Others	6.41	4.92	8.08	6.79	9.98	9.98	12.12	8.48	6.82	12.45	16.08	14.26	5.87
				AS	%	of	GDP	in	current	Market	Prices		
Education	0.75	1.77	0.64	0.90	0.96	0.99	1.03	0.81	0.51	0.51	0.34	1.6	0.19
Health	0.09	0.22	0.09	0.17	0.42	0.36	0.33	0.15	0.21	0.08	0.11	0.15	0.24
Others	0.20	1.04	0.42	0.38	1.07	1.12	1.05	0.78	0.47	0.71	0.86	1.14	0.48
Total*	0.57	3.03	1.15	1.45	2.45	2.47	2.41	1.74	1.19	1.30	1.31	2.89	0.91

Sources: i) CBS, Annual Reports, various years
ii) GOS, Budget Estimates, various years.
* Totals might not add up due to rounding errors.

Table 4: Incidence, Depth and Severity of Poverty in Swaziland, (Higher poverty line)

Region	Higher Poverty Line								
	Head Count Ratio			Poverty Gap Index			Poverty Gap (squared)		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Hhohho	0.650	0.442	0.595	0.300	0.199	0.277	0.169	0.117	0.160
Manzini	0.640	0.481	0.594	0.288	0.218	0.271	0.162	0.129	0.157
Shiselweni	0.790	0.454	0.787	0.409	0.224	0.416	0.256	0.126	0.263
Lubombo	0.725	0.405	0.659	0.378	0.201	0.340	0.236	0.123	0.214
All	0.706	0.454	0.655	0.346	0.210	0.322	0.207	0.124	0.195

Source: Computed from, Swaziland Government/CSO, Poverty Profile of Swaziland 1995.

Table 5: Incidence, Depth and Severity of Poverty in Swaziland, (lower poverty line)

Region	Lower Poverty Line								
	Head Count Ratio			Poverty Gap Index			Poverty Gap (squared)		
	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban	Total
Hhohho	0.488	0.279	0.416	0.186	0.114	0.161	0.09	0.062	0.081
Manzini	0.473	0.294	0.404	0.175	0.124	0.155	0.089	0.071	0.083
Shiselweni	0.640	0.410	0.625	0.283	0.119	0.272	0.160	0.054	0.153
Lubombo	0.580	0.299	0.499	0.259	0.122	0.22	0.148	0.067	0.125
All	0.549	0.297	0.479	0.227	0.120	0.198	0.123	0.067	0.107

Source: Computed from, Swaziland Government/CSO, Poverty Profile of Swaziland 1995.

Table 6: Distribution of Poverty between the rural and urban areas of Swaziland

Region	Population Share (%)	Share of core Poor	Share of Poor
Urban	21	18.1	15.7
Rural	79.0	81.9	84.3
National	100	100	100

Source: Computed from, SHIES, 1995 and World Bank, 2000.

Table 7: Distribution of Income or Consumption Expenditure in SADC Countries

			Percentage share of income or consumption						
Country	Survey Year	Gini Index	Lowest 10%	Lowest 20%	Second quintile	Third quintile	Fourth quintile	Highest 20%	Highest 10%
Tanzania	1993	38.1	2.9	6.9	10.9	15.3	21.5	45.4	30.2
Malawi	N/A								
Zambia	1993	46.2	1.5	3.9	8.0	13.8	23.8	50.4	31.3
Angola	N/A								
Zimbabwe	1990	56.8	1.8	4.0	6.3	10.0	17.4	62.3	46.9
Lesotho	1986/87	56.0	0.9	2.8	6.5	11.2	19.4	60.1	43.4
Namibia	N/A								
Botswana	N/A	54.21							
South Africa	1993	58.4	1.4	3.3	5.8	9.8	17.7	63.3	47.3
Mauritius	N/A	40.67							
Mozambique	N/A								
Swaziland	1994/95	50.7	1.4	3.9	3.3	4.2	5.1	58.3	42.9
SSA	1993	44.41							

Sources: i) World Bank Economic Review 1996
ii) African Development Indicators 2000
iii) UNDP Development Report 1997
iv) CSO, Poverty Profile of Swaziland 1996

Finally, Table 6 summarises the distribution of poverty between the urban and rural areas of Swaziland and shows that the rural areas have a greater share of the poor (84 per cent). This is an indication that not only is a rural Swazi more likely to be poor, and in deeper poverty, than a Swazi living in town, but the majority of poor people reside in rural Swaziland and on Swazi National Land.

Income Inequality in Swaziland and other SADC Countries: A Comparison: As shown in Table 7 out of the eight SADC countries for which the Gini indices are available, only Zimbabwe, South Africa, Lesotho and Botswana have a more inequitable pattern of income distribution than Swaziland. With a Gini coefficient of 0.507, Table 7 reveals that income inequality in Swaziland is higher than the SSA average of 0.444.
With respect to the percentage share of income, Table 8 similarly shows that the richest 20 per cent hold 64.4 per cent of the total income; while the poorest 20 per cent hold just 2.7 per cent. This shows that Swaziland only compares with South Africa in SADC in terms of the proportion of income held by the richest 20 per cent of the population. With respect to the ratio of the richest 20 per cent to poorest 20 per cent of the population, only Mozambique (with a ratio of 6.5%) has a higher ratio than Swaziland (24%). The average for the whole of SSA is 11.61 per cent. Furthermore, Table 9 shows that in the rural areas of Swaziland, 70 per cent of the population has a mean per capita income that is below two-thirds of the national average.

Other Social Indicators of Poverty and Inequality
Access to Safe Water and Sanitation Facilities: Available data show that the percentage of Swazi population with access to sanitation facilities increased from 63 in 1980 to 80 in 1998. For the urban area the ratio decreased slightly from 100 per cent in 1985 to 97 per cent in 1998 (Table 10), but increased in the rural areas from 25 per cent in 1985 to 71 per cent in 1998. In terms of access to safe water however, not much seems to have changed in Swaziland. As at 1998 the percentage of the population with access to safe water stood at 56 per cent for the country as a whole, 37 per cent in the rural areas, and 91per cent for the urban area (Table 11). This once again confirms the inequality situation in Swaziland.

Table 8: Share of income or consumption expenditure held by population groups

Country	Ratio of richest 20% to poorest 20% (1987-98)	Richest 20% (1987-98)	Poorest 20% (1987-98)
Tanzania	6.7	45.5	6.8
Malawi	N/A		
Zambia	13.0	54.8	4.2
Angola	N/A		
Zimbabwe	15.6	62.3	4.0
Lesotho	21.5	60.1	2.8
Namibia	N/A		
Botswana	42.9	58.9	3.6
South Africa	22.3	64.8	2.9
Mauritius	N/A		
Mozambique	46.5	7.2	6.5
Swaziland	23.9	64.4	2.7
SSA	11.61		

Source: African Development Indicators 2000

Table 9: Social indicators of poverty in SADC countries

Country	GDP per capita based on PPP 1997 (US$)	% of Population living under US$ 1 a day, 87-98	National poverty headcount as % of Population	% of Population below 2/3 of National mean per/capita income, 1991-97		Gini Coefficients		Percentage of Household Income spent on food 1991-97
				Urban	Rural	Urban	Rural	
Tanzania	522	19.9	51	20	51	-	-	70
Malawi	707	-	54	-	-	-	57	-
Zambia	976	85	68	28	70	40	46	64
Angola	1461	-	-	-	-	-	-	-
Zimbabwe	2385	36	26	-	-	-	-	-
Lesotho	1976	49	49	-	-	-	-	-
Namibia	5087	-	-	-	-	-	-	-
Botswana	8393	33	-	-	-	-	-	-
South Africa	7466	11.5	-	40	86	-	-	56
Mauritius	9424	-	11	-	-	-	-	-
Mozambique	877	-	-	-	-	-	-	-
Swaziland	3427	-	-	36	70	53.5	44.9	65
SSA	1566			22	37			

Source: African Development Indicators 2000

Table 10: Population with access to Sanitation Facilities (Percentages)

1985			1998		
Total	Urban	Rural	Total	Urban	Rural
63	100	25	80	97	71

Source: World Bank, African Development Indicators 2000

Table 11: Population with access to Safe Water (Percentages)

1993-96			1998		
Total	Urban	Rural	Total	Urban	Rural
60	80	46	56	91	37

Source: World Bank, African Development Indicators 2000

Conclusion

In this paper we have shown that despite substantial increases in government expenditures on health, education and other social services in Swaziland, poverty continues to be endemic and the poor continue to be under-served

in terms of access to basic education, primary health care and better living conditions. The level of poverty remains quite high; 70 per cent of the population continue to live in the rural areas; a small proportion of the population continue to hold a large portion of income; and land remains largely in the hands of the minority.

For the objective of poverty reduction and equity to become achievable in Swaziland, fiscal policy actions of the government swill need to be more targeted at the currently underserved and the poor in the society, particularly the rural dwellers. In this way the access of the poor people to health, education and other infrastructure such as housing, safe water and other safety benefits could be guaranteed and sustained.

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