PART B

Regional perspectives on the experience of chronic poverty

6 Understanding chronic poverty in sub-Saharan Africa

Sub-Saharan Africa is the poorest part of the world but also the region with the highest share of its population living in chronic poverty. The region as a whole has not experienced economic growth over the last two decades, and the opportunities available to the poor have been highly constrained. A high proportion of poverty is likely to be chronic. Best estimates are that between 30% and 40% of the absolute poor population in sub-Saharan Africa is chronically poor – between 90 and 120 million people. It is a gloomy picture, the human development results of which are summarised in Table 6.1. Chronic poverty in the region is most pronounced in areas that are remote, affected by protracted violent conflict, suffering economic stagnation or decline, and where HIV/AIDS and other diseases are endemic.

Poverty trends in sub-Saharan Africa

High rates of infant mortality and stunting, and low life expectancy, (exacerbated by the HIV/AIDS pandemic) occur across sub-Saharan Africa, despite differences in income poverty levels.

The most extreme, persistent, multi-dimensional poverty is 100% a sub-Saharan African – and particularly a Central and West African – problem

- All of the 16 countries flagged up as 'desperately deprived' are in sub-Saharan Africa, (see Chapter 1)
  - 12 are in Central or West Africa
  - Of the 23 'moderately deprived' countries, 15 are sub-Saharan African, and nine are East or Southern African
- Few sub-Saharan countries have low levels of deprivation on any one indicator. Exceptions include the middle income countries of Southern Africa, which nonetheless have extremely low life expectancy, perhaps reflecting the HIV/AIDS epidemic
- Among low income countries, Côte d'Ivoire has been doing relatively well in terms of proportion of people living on less than US$1/day, and, along with the Gambia, Senegal and Togo, it has had relatively low rates of stunting
  - Female literacy is high in Lesotho and Zimbabwe
  - Each of these six countries has at least three indicators that show extreme deprivation.

Over the past two decades, many indicators have worsened, for sub-Saharan Africa as a whole as well as for particular sub-regions and countries (see Table 6.2, and PART C for country-level detail). Due to HIV/AIDS and conflict, overall life expectancy has reduced, especially in southern Africa and among women. On average, household consumption has stagnated, and, in West Africa, declined.

Nevertheless, some positive signs are apparent:

- Generally reduced illiteracy rates, especially for women
- Reduced infant mortality rates (except where HIV/AIDS has led to an increase)
- Over the past two decades, a few countries including Cape Verde, Equatorial Guinea, Guinea, Mauritius, and possibly Sudan,[1] have registered significant improvements in human development as well as sustained positive growth
- A number of other countries, many of which are recovering from conflict or economic collapse, have begun to grow in the 1990s, supported by inflows of aid
- Benin, Burkina Faso, Ethiopia, Ghana, Mozambique and Uganda have all increased consumption per capita during the 1990s, the last two countries dramatically so, and most appear to be sustaining that growth into this decade.

Figure 6.1 Chronic poverty in sub-Saharan Africa

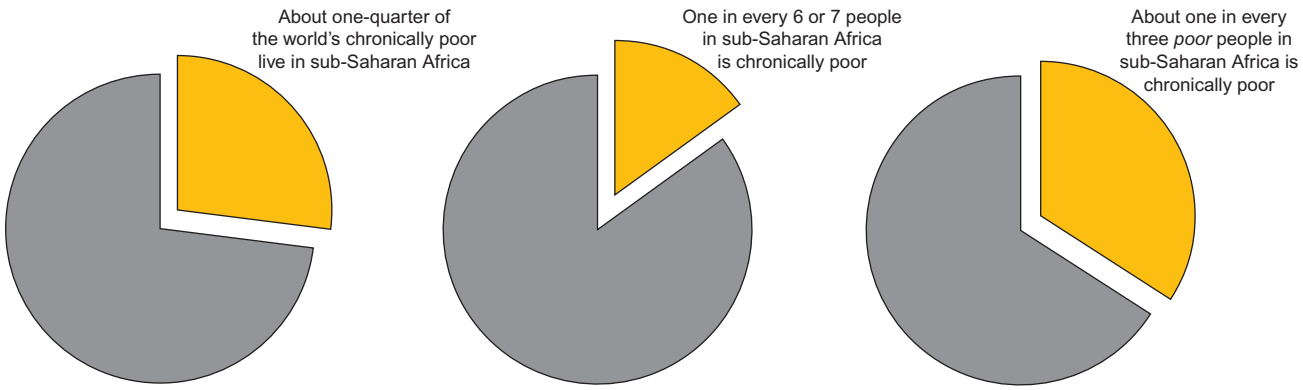

Table 6.1 Summary of poverty indicators for Africa*

	Percentage of people living on less than US$1/ day,1989–99[a]	Average shortfall of poor below US$1/day (%), 1989–99[a]	Under-5 mortality rate (per 1,000 live births), 2001	Infant mortality rate, 2000	Stunting <- 2 s.d., 1992–2000[a]	Life expectancy, female, 2000	Life expectancy, male, 2000	Adult illiteracy rate, female, 2000	Adult illiteracy rate, male, 2000
West Africa	58	45	185	111	37	51	50	52	35
Central Africa	50	36	196	121	44	50	47	49	28
Southern Africa	29	27	165	111	36	47	45	29	19
East Africa	30	27	155	100	44	49	47	47	31
All sub-Saharan Africa	**43**	**36**	**174**	**109**	**40**	**50**	**48**	**46**	**30**
North Africa	3	–	53	44	22	68	64	53	30
Sub-Saharan Africa + North Africa	*34*	–	*156*	*99*	*38*	*53*	*52*	*48*	*30*

Figures have been rounded.

Source: See Part C.

Table 6.2 The changing African picture, 1980–2000*

	Change in infant mortality rate (% points)	Change in female life expectancy (# years)	Change in male life expectancy (# years)	Change in female illiteracy rate (% points)	Change in male illiteracy rate (% points)	Average annual change in household consumption per capita (%)
West Africa	–18	1	2	–29	–25	–3.9
Central Africa	–5	–5	–2	–28	–23	–0.8
Southern Africa	–6	–8	–6	–15	–13	–0.3
East Africa	–17	–3	–1	–25	–18	–0.3
Sub-Saharan Africa	**–15**	**–3**	**–1**	**–25**	**–21**	**–2.3**
North Africa	*–56*	*11*	*10*	*–24*	*–19*	*1.2*
Sub-Saharan Africa + North Africa	*–21*	*0*	*2*	*–25*	*–20*	*–1.5*

Figures have been rounded.
West Africa = Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Côte d'Ivoire, Equatorial Guinea, Gabon, Gambia, The, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Sao Tome, Senegal, Sierra Leone, Togo
Central Africa = Burundi, Central African Rep., Dem. Rep. Congo, Rep. Congo, Rwanda
Southern Africa = Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zimbabwe
East Africa = Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Mauritius, Somalia, Tanzania, Uganda
North Africa = Algeria, Egypt, Libya, Morocco, Sudan, Tunisia

Source: See Part C.

* These tables contain a reconfiguration of the data provided in PART C based on a more detailed regional disaggregation (African Development Bank). Although further analysis is required, the data is broadly compatible with that in PART C, but highlights the extreme regional disparities discussed in the text.

However, even these 'turnaround' countries are often only growing in limited regions and sectors and progress is fragile. The dramatic reduction in poverty in post-conflict Uganda has enabled a large number of people who were poor – including some of the severely poor – in 1992 to escape poverty by 1996 or 1999. Uganda's infant mortality rate has seen an above-average decline, despite the HIV/AIDS epidemic. However, recently the infant mortality rate has stagnated. The reasons for this are both direct (disease – malaria, diarrhoea, HIV/AIDS, malnutrition, acute respiratory infection (ARI) and maternal conditions) and proximate (linked to maternal and household characteristics, utilisation of health services and socio-economic factors).[2] As a result of population growth, the absolute number of preventable infant deaths and illiterate adults in Uganda may actually be as great as it was in 1980.

Progress on poverty has excluded about 20% of Ugandans – the chronically poor – largely made up of large rural households: poor food crop farmers unable to benefit from periodic price increases for crops like cotton and coffee; people unable to diversify their livelihoods; severely poor people with limited or no education; and those in the poorest eastern regions and conflict-affected north. Indeed, while Uganda is commonly referred to as post-conflict, its northern region is still affected by chronic conflict. The household survey for 1999 indicated that 15% of households reported being affected by civil strife, compared to 7% in 1992, and civil strife was seen as being a greater cause of economic damage than theft or personal violence.

Unsurprisingly, escape is most difficult for the poorest; and in Uganda urban households emerged from poverty at a much higher rate than rural.[3] Ugandan panel data suggests that movement out of poverty favoured those households close to the poverty line: 68% of households within 5% of the poverty line in 1992 had moved out of poverty by 1996, compared to only 31% of those with expenditures less than 50% below the poverty line initially.[4] The extent to which sustained growth can facilitate an escape from poverty – even in the longer term – for those left behind is debatable.

Several states have seen improvements in human development despite little or no growth in consumption. The Gambia, Madagascar and Niger, for example, have seen large improvements in infant mortality rates, life expectancy and literacy, despite high proportions of the population living on less than US$1/day and declining consumption levels. The Gambia now has one of the lowest rates of infant mortality and stunting on the continent, and life expectancy in Madagascar is significantly above both East and sub-Saharan African averages.

How many people are chronically poor in sub-Saharan Africa?

There is a limited number of recent, high quality, representative and comparable panel surveys from which the extent of chronic poverty in sub-Saharan Africa can be determined. Based on panel data from Ethiopia, Côte d'Ivoire, Uganda, urban Madagascar and rural Zimbabwe, best estimates are that between 30% and 40% of the absolute poor population in sub-Saharan Africa is chronically poor – between 90 and 120 million people. Nearly one-third live in Nigeria, and over half live in West Africa in total. The rates of both absolute and chronic poverty are high in Western and Central Africa where one in every 5 or 6 is both absolutely and chronically poor.

There are 22 sub-Saharan countries for which there is both a US$1/day figure and sufficient data to undertake the cluster analysis detailed in Chapter One. Of these 22 countries, approximately 310 million people live in 12 desperately deprived countries, about 150 million of whom live on less than US$1/day; perhaps 45–60 million of these people are chronically poor. Almost 110 million people live in the 10 moderately deprived countries for which we have data, close to 40 million of whom are absolutely poor, and 10–15 million of whom are chronically poor. Several countries with insufficient data – including Angola, Guinea, Liberia, Mali, Somalia, Sudan and Zambia – make up the ranks of those countries with high proportions and numbers of absolute and chronically poor.

Middle income countries with high levels of inequality can still have significant populations of chronically poor people, even if this is not necessarily extreme poverty in a US$1/day sense. In sub-Saharan Africa, South Africa dominates, with other middle income countries (Botswana, Namibia and Swaziland) linked economically and politically to it. The major source of information on chronic poverty to date has been the KwaZulu-Natal Income Dynamics Survey. While it cannot be taken as representative of middle income southern Africa, primarily because of its geographical limitations, it is clearly indicative of the extent to which there can be large populations living in chronic, severe and multi-dimensional poverty in relatively wealthy countries (Box 6.1).

Above the Sahara, panel data is available for Egypt – where only about 3% live on less than US$1/day but over half the population, or close to 35 million people, lives on less than $2/day. This data suggests that the middle income countries of North Africa may also have significant numbers of people living in chronic poverty. Egyptian panel data suggests that about one-fifth of all households are chronically poor, and that, of the households that were poor at one time, 48% were always poor, so that the overall contribution of chronic poverty to total poverty is high.[5]

Who are the chronically poor in sub-Saharan Africa?

Chronically poor households tend to be larger and with high dependency ratios (Uganda,[6] South Africa's KwaZulu-Natal,[7] urban Madagascar[8]). In KwaZulu-Natal, it is particularly women-headed, older households, as well as larger, rural households who are chronically poor. Such households usually have low overall years of schooling, low levels of productive assets such as chickens, livestock (Uganda) and arable land (South Africa), and get low returns from their land (Rwanda).[9]

The chronically poor include those who have missed out on economic opportunity and have been unable to diversify or secure their livelihoods. Disabled people, older people, ethnic minorities are frequently marginalised or excluded from participating in what opportunities exist in, for example, education, health, employment, politics and community support. They are often unable to access limited livelihood options to help them

Box 6.1 Understanding chronic poverty in middle income South Africa

South Africa is a middle income country, with per capita GDP of $3,985 in 2000, comparable to countries in parts of East-Central Europe and Latin America. However, about half of all South Africa's 45 million people presently live in poverty, and about one quarter of all households are trapped in chronic poverty. Whilst many poor people manage to escape poverty for short periods (a couple of months or even a few years), they fail to do so in a more permanent way. These households may not be chronically poor at present, but they are very vulnerable to becoming chronically poor in the future. Five of the central aspects underlying chronic poverty in South Africa are:

1. **Historic asset depletion:** From the mid-17th century onwards, black workers were selectively incorporated into a severely repressive labour system, limiting their ability to accumulate and use their assets and skills. Today the effects are still evident, as the majority of poor black households continue to lack direct access to basic economic resources and household food production assets. It is unlikely that they will be able to escape inter-generational poverty through their own efforts.
2. **Post-1970s economic restructuring.** South Africa's economic restructuring is rooted in the economic decline between 1974 and 1994. During this time, the number of potential African workers increased from 6.9 to 9.3 million, but the number employed in the formal sector actually declined from 5.2 to 5.0 million, expanding African formal sector unemployment from 24% to 46%. Semi-skilled black workers became increasingly detached from the formal economy, rendering their households susceptible to chronic poverty. Since the end of apartheid, a further one million jobs were lost in the formal sector, and official unemployment of 16% in 1995 has since doubled. Moreover, many employed people do not earn enough to escape poverty.
3. **Rural poverty:** Nearly three-quarters of all rural people are poor, most of them chronically so. Poor rural households do not have the assets (land, finances, tools) to progress as agriculturalists, and land-based livelihood strategies fail to provide enough to accumulate, inhibiting incremental escape from chronic poverty over time.
4. **High inequalities:** South Africa has both very high income inequality (with the richest fifth of households receiving over 70% of income, and the poorest two fifths less than 4 percent), and highly racialised economic geographies due to apartheid spatial planning.
5. **HIV/AIDS epidemic:** HIV/AIDS incidence in South Africa is amongst the highest in the world. HIV/AIDS related deaths are now a major cause of chronic poverty. The causal relationship between AIDS and chronic poverty is complex and controversial, but there is some evidence that chronic poverty makes households more susceptible to HIV/AIDS exposure and thus infection.

Source: de Swardt, 2003.

diversify and improve their position.

In areas where the economy is largely agricultural, many, if not most, older people missed out on formal education in their youth, making it difficult for them to participate in less physically demanding, off-farm activities.[10] The poor and especially the poorest often depend only on their own labour. This capacity naturally declines with age, increasing the vulnerability of older people, particularly if they do not enjoy support from kin. They may have to resort to begging and charity to survive.

The chronically poor include large numbers of people displaced or disabled by persistent conflict, including refugees and internally displaced people – of whom there are more in sub-Saharan Africa than anywhere else in the world; abducted children, orphans, widows, people with impairments and illnesses. People affected by conflict spend long periods on the run from violence, with or without basic assets, which may have been left behind in the hurry to escape. This limits their ability to find food and shelter. Life within refugee camps may not be better – most are overcrowded with very poor living conditions, and access to key resources such as land and basic services are severely limited.

Older people (and their households), especially when they are responsible for the care of vulnerable children orphaned as a result of HIV/AIDS and conflict, are also particularly vulnerable to deepening and ongoing poverty.

The situation is made worse for older people and others who are excluded from decision making and for those who are physically unable to access services, such as food and health facilities, and are disadvantaged by the way services are provided and structured. This leaves people highly vulnerable to ill-health and disease, and dependent on fragile support systems. Loss of individuality and control, as well as the humiliation of dependency, often define their lives.

There are more HIV/AIDS sufferers in sub-Saharan Africa than anywhere else in the world, and their households have to bear the isolation associated with this as well as almost all the burden of care for this and other chronic illnesses (see Box 6.2). Many households have witnessed several deaths from AIDS, and most deaths are in the adult breadwinner and/or homemaker and carer category.

Women-headed households and AIDS widowhood

Often the product of AIDS deaths or conflict, but also of estrangement, abandonment and family breakdown, women-headed households are not in general more likely to be poor compared to male-headed households. There is much variety in the picture across the continent, as throughout the world. Male-headed polygamous households in Nigeria's rural areas, for example, are disproportionately poor, affecting a large number of women.[11] It is plausible, however, that women-headed households who are *poor* are more likely to be *chronically* poor, although this does not necessarily mean that women-headed households represent a disproportionate segment of the *absolute* poor.

In semi-arid Zimbabwe, women-headed households reported less recovery from the 1991/2 drought, and were more likely to not have recovered at all by 1998. They found entry into the critical non-farm occupations more difficult than did male-headed households.[12] Women-headed households were also more disadvantaged in urban Madagascar.[13] This may be the case in many

urban settings where education, health and nutritional status – assets that are often less common in women-headed households – make a large difference to the work and income available.

Widows commonly return to their parent's village and beg for a small parcel of land to cultivate. Some will seek a protector, often marrying again soon after their widowhood. This option is not available to AIDS widows however, who are often shunned.[14] AIDS widows make-up between 24% and 60% of all widows, and are commonly stigmatised, accused of being witches and bringing the disease into the family.[15]

Box 6.2 Voice from the field

Illness and marginalization among the working poor in South Africa

'They appreciated that I came to visit them because no one visits their house. What touched me is that four members of the family were sick. One had TB, one had HIV, one woman had a breast problem, and her baby had diarrhoea. They have never been treated because they could not pay (US$0.3 – 30 cents) for transport. The baby is fed on thin porridge diluted with water and breastfed on the healthy breast. I had to help them with money. There is no food at all, they depend on anyone who comes in and gives food . . . The family is tired of them, they do not want to assist them anymore, because they are always hungry. There are no blankets except one, which is shared between the baby with diarrhoea and the person with HIV. The roof is leaking during the rainy season and it gets flooded sometimes. This house belonged to a family member who died of TB. No-one in this family has an ID, and they have no money to apply for IDs, or even to come to town.'

Source: Mount Frere fieldworker, translated from Xhosa, in de Swardt (2002).

People with low and declining access to income, land and other assets

The poorest occupational groups are often non-cash crop farmers, whose agricultural productivity is low, assets minimal, and access to credit and output markets weak. This is widely true in West Africa. Cash crops can give good results from time to time, the benefits of which can be capitalised and used to expand enterprise, and provide access to state loans, extension and research often denied to others. However, tenants, sharecroppers and migrant labourers can remain poor for long periods. Poor households who are able to diversify out of farm activities into off- and non-farm activities are in many situations the lucky few. Many are only able to enter low cost and low return activities, often dependent on shrinking and heavily used common property resources. These are not escape routes from poverty.

The chronically poor are likely to have experienced a series of shocks of different sorts – health, drought, conflict, family breakdown – from which their low asset position hardly allows them to recover, or from which recovery is at best slow and erratic.

Landlessness is particularly important, as land has been the continent's prime safety net. There is an expanding group for whom this is no longer the case. Whether the 'negotiability' of access to land offers sufficient potential for social mobility for the disadvantaged is questionable.[16] Land adjudication processes in Kenya, for example, have ignored the claims of some, notably young men without clear inheritance rights such as sons of widows or divorcees, and women- and child-headed households.[17]

Those that are unable to access borrowing or rental systems either due to weak family connections, diminishing common lands (in some cases related to wildlife conservation projects), or inability to pay rent are more vulnerable to long-term poverty. Land has classically provided subsistence when the market or state has been hostile, and provides a basis for accumulation when conditions are propitious. Loss of land has occurred both on an individual basis, as for the AIDS widows and abandoned women discussed above, and on a collective basis, as a result of conflict.

Where are the chronically poor in sub-Saharan Africa?

The African chronically poor tend to live in countries with large numbers of poor people, and a history of low economic growth, such that the prospects of remaining poor are strong. Poverty is more prevalent in rural than urban areas across the whole of sub-Saharan Africa, despite regional differences in income and levels of urbanisation.

There are pronounced regional differences in the incidence of poverty throughout Africa, and chronic poverty tends to follow similar distribution patterns across remote, less-favoured, weakly-integrated regions. There are many regional poverty traps in sub-Saharan Africa, where people are generally highly dependent on food crops and livestock farming (or agro-pastoralism), and these are often inhabited by minority ethnic groups, both in rural and urban areas.

Chronic poverty in remote rural sub-Saharan Africa

Chronic rural poverty in Africa is characterised by topography and remoteness. In remote areas such as semi-arid, coastal, deep forests, borders and mountainous areas, poor people are likely to experience poverty along several dimensions, including low incomes, low rates of literacy, and political marginality. They are likely to have underdeveloped and highly imperfect markets, limited non-farm livelihood opportunities, poor social and physical infrastructure, and weak social and political institutions. Quality basic services tend not to reach deep into rural areas. Towns in these regions are more likely to have stagnant economies than urban centres elsewhere.

Extreme poverty in the Gambia is highly concentrated in the rural areas, with about 35% of the rural community living in absolute poverty, compared to 15% in urban areas. Low agricultural productivity and an inability to accumulate capital and other assets are key, with livelihoods being constrained by a lack of tools and equipment, inadequate storage facilities, difficult to access markets and credit.

In Uganda, while 61% of the urban households that were poor in 1992 were able to move out of poverty by 1996, only 39% of rural households moved out of poverty over the same period, leaving a large proportion of the rural poor in a state of chronic poverty. Within rural areas, this was strongly regionally differentiated, with mobility much higher in the more rapidly growing coffee producing regions than elsewhere.

Urban chronic poverty in sub-Saharan Africa

In countries experiencing sustained growth, the chronically poor are mainly located in regions, sectors or sub-sectors which are not contributing to and benefiting from that growth. There is some evidence that urban Africa – at least in the large cities – seems to respond to growth with significant and fairly rapid urban poverty reduction. However, some groups of urban chronically poor people may not benefit from growth. In smaller towns, particularly in more remote and less economically dynamic regions, it may be that the urban poor are more likely to remain absolutely poor.

In urban Côte d'Ivoire poverty unambiguously rose between 1985 and 1995 at both the $1/day and $2/day level but was accompanied by rising poverty severity and worsening inequality. High rates of urban poverty began to decline (although not to below 1985 rates) after economic recovery began in 1995, such that by 1998 poverty incidence ($1/day) fell to 1.2% in Abidjan, 10% for other urban centres, and 5.9% for all urban areas. Today, however, urban as well as rural Côte d'Ivoire is in a very different situation after a succession of shocks, combined with the current political and economic collapse which has propelled many into chronic poverty.

Not all urban centres are responsive to growth. Madagascar followed neo-liberal prescriptions during the late 1980s and 1990s, but economic growth did not materialise until 1997. Poverty remained high, slightly worse in rural areas, and far worse than it was in the 1970s. Although there was rapid growth in average household incomes in the capital city (50% between 1995 and 2000 compared to an overall GDP increase of only 2.3%), 65% of the urban population were poor in both 1997 and 1999. Few had access to electricity and running water. Most chronically poor households lived in poor neighbourhoods, and their jobs were largely low quality and in the informal, low wage sector.

Between 1994 and 1997, 26% of urban Ethiopians remained poor, compared to 24% in transitory poverty and 51% non-poor.[18] Despite economic recovery associated with post-conflict stability, good weather and improved macro-economic management, urban household welfare declined during this period. That one-quarter of urban households remained poor reflects the long-term impacts of the serious agro-ecological and conflict-related shocks that affected Ethiopia before 1994 (and have done again since 1997). Chronic poverty in urban Ethiopia is associated with low asset ownership, low levels of education, as well as age and ethnicity (the Gurage being more likely to be chronically poor than the Tigre), and, to a certain degree, with women-headedness.

Under- and unemployment are significant problems of the urban Ethiopian chronically poor. Over one-quarter of chronically poor household heads work as casual labourers or in 'women's business activities', compared to 8% among the never poor. These occupations are insecure and give low returns, so it is not surprising that the chronically poor are disproportionately represented. Similarly, in urban Uganda the main livelihood activity of 47% of the 'always poor' is in agricultural subsistence.

Notes

1. Data is questionable for Sudan.
2. Government of Uganda 2002.
3. Deininger and Okidi 2003.
4. Lwanga-Ntale and McClean 2003.
5. Haddad and Ahmed 2003.
6. Lawson, McKay and Okidi 2003.
7. Aliber 2003.
8. Herrera and Roubaud (2003).
9. Muller (2000).
10. Najjumba-Mulindwa, I 2003.
11. Oduro (2003).
12. Bird and Shepherd 2003: 603–4.
13. Herrera and Roubaud (2003).
14. Bird and Shinyekwa 2003.
15. UNDP 2002:49–50.
16. Woodhouse (2003:6).
17. Hunt (1994).
18. Kadir & McKay 2003.