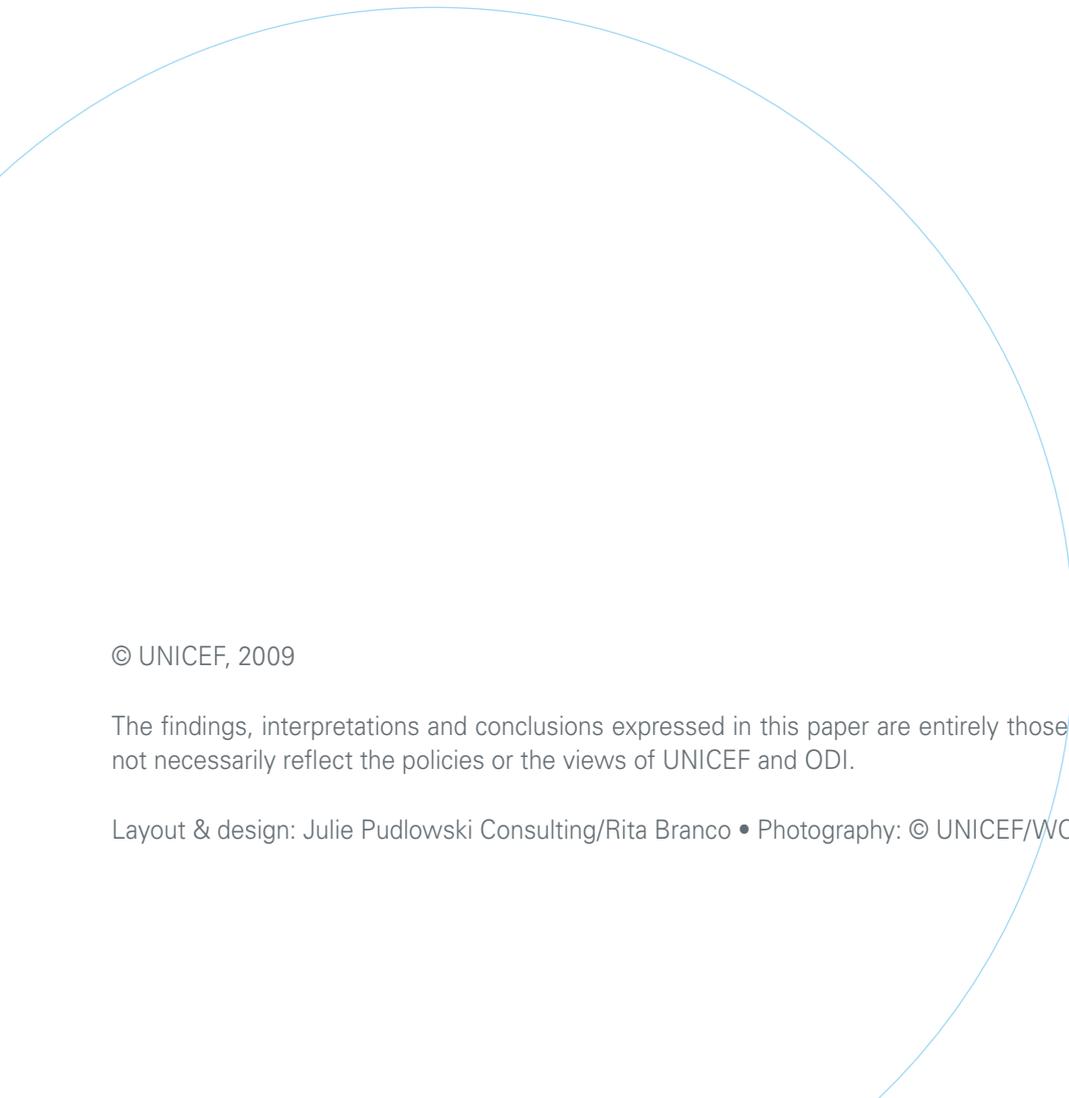




# STRENGTHENING SOCIAL PROTECTION FOR CHILDREN

WEST AND CENTRAL AFRICA





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FOR CHILDREN **WEST AND CENTRAL AFRICA**



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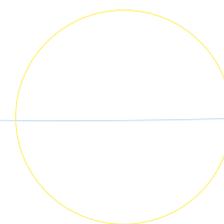
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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome	MDG	Millennium Development Goal
AMO	Compulsory Health Insurance Programme (Mali)	MICS	Multiple Indicator Cluster Survey
ASCA	Accumulating Savings and Credit Association	MMR	Maternal Mortality Rate
AU	African Union	MHO	Mutual Health Organisation
CHO	Community Health Organisation	NAPEP	National Poverty Eradication Programme (Nigeria)
COPE	In Care of the Poor (Nigeria)	NASSIT	National Social Security and Insurance Trust (Sierra Leone)
CSO	Civil Society Organisation	NDPC	National Development Planning Commission (Ghana)
CSS	Social Security Fund (Senegal)	NGO	Non-governmental Organisation
DALY	Disability Adjusted Life Year	NHIS	National Health Insurance Scheme (Ghana)
DFID	UK Department for International Development	ODI	Overseas Development Institute
DHS	Demographic and Health Survey	OVC	Orphans and Vulnerable Children
DPT3	Diphtheria–Pertussis–Tetanus	PRSP	Poverty Reduction Strategy Paper
ECPAT	End Child Prostitution, Child Pornography, and Trafficking in Children for Sexual Purposes	PYLL	Potential Years of Life Lost
FAM	Medical Assistance Fund (Mali)	RoSCA	Rotating Savings and Credit Association
FCPN	Food Crises Prevention Network	SSN	Social Safety Net (Sierra Leone)
FGC	Female Genital Mutilation	SSNIT	Social Security and National Insurance Trust (Ghana)
FGM	Female Genital Cutting	U5MR	Under-five Mortality Rate
FNR	National Retirement Fund (Senegal)	UN	United Nations
GDP	Gross Domestic Product	UNFPA	UN Population Fund
GJAS	Ghana Joint Assistance Strategy	UNICEF	UN Children’s Fund
HIPC	Heavily Indebted Poor Countries Initiative	UNRISD	UN Research Institute for Social Development
HIV	Human Immunodeficiency Virus	USAID	US Agency for International Development
IFAD	International Fund for Agricultural Development	WCARO	West and Central Africa Regional Office (UNICEF)
ILO	International Labour Organization	WHO	World Health Organization
IMF	International Monetary Fund	WFP	World Food Programme
IPM	Health Insurance Institute (Senegal)	YLD	Years Lost to Disability
IPRES	Institute for Retirement Planning of Senegal	YLL	Years of Life Lost
LEAP	Livelihood Empowerment Against Poverty (Ghana)		



## PREFACE AND ACKNOWLEDGEMENTS

This is one of a series of reports produced by a regional study on social protection and children in West and Central Africa, commissioned by the United Nations Children's Fund (UNICEF) West and Central Africa Regional Office (WCARO) and carried out by the Overseas Development Institute (ODI) in London between November 2007 and November 2008, in partnership with local researchers in the region.

Social protection is now widely seen as an important component of poverty reduction strategies and efforts to reduce vulnerability to economic, social, natural and other shocks and stresses. It is particularly important for children, in view of their heightened vulnerability relative to adults, and the role that social protection can play in ensuring adequate nutrition, utilisation of basic services (education, health, water and sanitation) and access to social services by the poorest. It is understood not only as being protective (by, for example, protecting a household's level of income and/or consumption), but also as providing a means of preventing households from resorting to negative coping strategies that are harmful to children (such as pulling them out of school), as well as a way of promoting household productivity, increasing household income and supporting children's development (through investments in their schooling and health), which can help break the cycle of poverty and contribute to growth.

The study's objective was to provide UNICEF with an improved understanding of existing social protection mechanisms in the region and the opportunities and challenges in developing more effective social protection programmes that reach the poorest and most vulnerable. The ultimate aim was to strengthen UNICEF's capacity to contribute to policy and programme development in this important field. More generally, however, the study has generated a body of knowledge that we are hopeful will be of wide interest to policymakers, programme practitioners and researchers, both in West and Central Africa and internationally.

Specifically, the study was intended to provide:

- A situation analysis of the current situation of social protection systems and programmes in West and Central Africa and their impact on children;
- An assessment of the priority needs for strengthening social protection systems to reduce poverty and vulnerability among children in the region;
- Preliminary recommendations to inform UNICEF's strategy development in the region.

The study combined a broad desk review of available literature, official documents and data covering the region as a whole on five key dimensions of social protection systems, with in-depth case studies in five countries, resulting in 11 reports produced overall. These are as follows<sup>1</sup>:

Five regional thematic reports:

- R. Holmes and T. Braunholtz-Speight (2009) 'Strengthening Social Protection for Children in West and Central Africa';
- G. Handley (2009) 'Fiscal Space for Strengthened Social Protection in West and Central Africa';

<sup>1</sup> Full titles are listed in the references.



- R. Holmes and A. Barrientos (2009) 'Child Poverty: A role for cash transfers?';
- C. Walsh, with N. Jones (2009) 'Maternal and Child Health: the Social Protection Dividend'; and
- N. Jones (2009) 'Promoting synergies between Child Protection and Social Protection'.

Five country case study reports:

- E. Villar and B. Makosso with R. Holmes, N. Jones and P. Perezniето (2009) 'Social Protection and Children in West and Central Africa: Case Study Republic of Congo';
- R. Holmes and E. Villar (2009) 'Social Protection and Children in West and Central Africa: Case Study Equatorial Guinea';
- N. Jones, W. Ahadzie and D. Doh (2009) 'Social Protection and Children in West and Central Africa: Opportunities and Challenges in Ghana';
- P. Perezniето and V. Diallo (2009) 'Social Protection and Children in West and Central Africa: Case Study Mali'; and
- P. Perezniето and A. Fall (2009) 'Social Protection and Children in West and Central Africa: Case Study Senegal'.

A final synthesis report:

- R. Holmes and N. Jones (2009) 'Child-sensitive Social Protection in West and Central Africa: Opportunities and Challenges'.

For this current report on child protection and broader social protection linkages, valuable research assistance was provided by Hannah Marsden, Jessica Espey and Emma Broadbent and is gratefully acknowledged. Similarly, helpful comments were provided by Anthony Hodges and Joachim Theis of UNICEF WCARO and Alexandra Yuster of UNICEF New York.

We would also like to thank Carol Watson for her valuable editorial support. While we have done our best to reflect the valuable insights and suggestions they provided, we alone are responsible for the final text, which does not necessarily reflect the official views of either UNICEF or ODI. Finally, we would like to thank Roo Griffiths of [www.griffiths-saat.org.uk](http://www.griffiths-saat.org.uk) for copyediting all of the papers.





## EXECUTIVE SUMMARY

This report, the first in a series of regional thematic reports produced for a study on social protection and children in West and Central Africa, seeks to provide an overview of existing social protection policy and programming initiatives in the region and to assess the extent to which these address the particular manifestations of childhood poverty and vulnerability that characterise different countries in the region. It highlights challenges in the design and implementation of child-sensitive social protection and offers a number of policy recommendations based on the analysis and lessons learned.

Increasingly, social protection is conceptualised as a set of public actions that address poverty, vulnerability and risk throughout the lifecycle. Such actions may potentially be conducted in tandem with private initiatives – either formal private sector or informal individual or community initiatives. Children’s experience of risk, vulnerability and deprivation is shaped by four broad characteristics of childhood poverty and vulnerability: **multidimensionality**, embracing both monetary and non-monetary aspects of poverty; **changes over the course of the lifecycle**; the **relational nature of childhood** derived from the situation of dependence on adults; and the particular **voicelessness** that characterises children’s status in society.

In view of the particularly severe, multiple and intersecting deprivations, vulnerabilities and risks faced by children and their caregivers in the West and Central Africa region, a transformative social protection framework is adopted for an analytical view that encompasses **protective, preventative, promotive and transformative** social protection measures (Devereux and Sabates-Wheeler, 2004). Operationally, this framework refers to social protection as the set of all initiatives, both formal and informal, that provide **social assistance, social services, social insurance and social equity measures** in an integrated manner that addresses all aspects of poverty and vulnerability as experienced by children.

Household and childhood poverty are both extremely high in West and Central Africa; in many of the countries, more than half the population lives below the officially defined absolute poverty line. Children constitute about half of the total population in the region and face a range of economic and social risks because of their age and dependency. Moreover, children are overrepresented among the poor and extreme poor owing to the relatively higher fertility rates among the poor. Deprivations in childhood can have lifecourse consequences, trapping individuals in poverty and contributing to the intergenerational transmission of poverty. This throws into relief the centrality of children in strategies for the reduction of poverty and vulnerability – and thus social protection programming.

Because vulnerability is not exclusively economic in nature, social and cultural factors also play a role, and at the micro (household) level vulnerability is often a complex interplay of different factors, including gender relations, discrimination and power imbalances. Children, again because of their age and their dependence on adults, can be vulnerable to adverse intra-household dynamics, including abuse, as well as one of the greatest risks of all – the disintegration or loss of the family environment, the basic social unit for the care and upbringing of children. This is a particularly important in the context of the HIV and AIDS crisis and in certain war-affected countries

Risk, vulnerability and poverty are closely related. Key factors identified as contributing to risks for children and households in the region include: **economic shocks and stresses; environmental fragility**; heightened vulnerability to **disease and ill health**; discriminatory **social norms and belief systems**; weaknesses in **governance and government capacity**; and situations of **political instability and armed conflict** and



their aftermath. From a multidimensional child poverty perspective, the particular manifestations of these risk factors for children include the highest regional **child mortality** rates in the world; **low school enrolment**, attendance and achievement rates; and evidence of multiple and widespread **problems of abuse, violence and neglect**, including the worst forms of child labour, trafficking and commercial sexual exploitation, involvement in war and harmful traditional practices.

The intersecting nature of these manifestations is clear from a multidimensional child poverty perspective: children brought up in income-poor households are more likely to suffer nutritional deficiencies, as well as poor housing conditions, poor sanitation and lack of access to potable water – all of which put their health at risk and compromise their well-being and development. They are less likely to receive medical care when they are sick and more likely to drop out of school early or in some cases never to be enrolled at all. Furthermore, they are more exposed to the risks of exploitation, including child labour and trafficking. Significant variations in such indicators (by wealth, urban/rural location, gender) highlight the need for disaggregated data analysis to inform policy and programme design to address these issues.

Although the countries of West and Central Africa have diverse economic, social, political and environmental conditions, which have specific implications for the design of social protection programmes, the analysis highlights a number of common characteristics that pose important challenges for social protection and its implementation across the region. These characteristics include the **extensive nature of poverty**, the **erosion of informal social protection mechanisms** as a result of rapid urbanisation and migration, national **fiscal resource constraints** and **institutional and governance challenges**.

Some countries in the region have developed national social protection plans and policies; in others, the political commitment to social protection has yet to be established. Even for countries with national social protection policies, their operationalisation and the commitment of resources remain a challenge. National social protection programming is still mainly small scale, uncoordinated and with limited monitoring and evaluation systems in place. The majority of social protection programmes – outside the formal contributory social security systems, which rarely reach more than a small fraction of the population in the formal sector of the economy – are implemented with significant support from donors and international organisations.

In many of the countries in the region where social protection has not been on the policy agenda, child-sensitive social protection that addresses both the economic and social risks and vulnerabilities that children face still has a long road ahead, especially given broader political and institutional governance challenges and fiscal constraints. In countries with existing social protection policies and programmes, the challenges centre on the need to build and support existing capacity to deliver social protection, and in particular to support inter-sectoral coordination to deliver child-sensitive social protection programming.

Ideally, an integrated approach to social protection would address the multiple dimensions of child vulnerability through cushioning the impacts of shocks and stresses on households and reducing chronic poverty, as well as ensuring that child-specific risks are addressed through specialised social welfare services and through linkages with complementary activities such as birth registration. The design of social protection policies aimed at reaching all members of the household – and in particular children – also needs to consider the gendered distribution of power, resources and decision making within households; how women's empowerment can influence and support children's well-being; and how women's time and the double burden of reproduction and production affect childcare responsibilities.



An integrated approach means developing comprehensive national social protection strategies rather than adopting piecemeal initiatives: this underscores the critical importance of capacity building, especially in ministries that have responsibility for a range of social protection and complementary programmes and services. An effective social protection system that can address childhood poverty should be built on strong linkages between ministries (such as health, education, social welfare, justice).

Recommendations for support to emerging social protection initiatives include: **assistance in the scale-up and refinement** of social protection programmes where they exist; support for the **operationalisation of national social protection strategies** where these have been prepared or adopted; and encouragement and support to **help translate the general commitments to social protection** that appear in many poverty reduction strategy papers (PRSPs) into social protection strategies and costed implementation plans for eventual programme design, operationalisation, monitoring and evaluation.

More broadly, the analysis concludes that governments and international development partners can take the following steps to develop and implement **child-sensitive** social protection: (i) review existing social protection policies and programmes to ensure that they are child sensitive; (ii) support priority setting and sequencing of policy development and implementation for the **progressive realisation** of a basic social protection package accessible to all those in need; (iii) improve fiscal space so as to **increase available resources**; (iv) enhance **capacity and coordination at all levels**, building awareness, political will, capacity and inter-sectoral synergies among a broad array of actors; (v) ensure **balance and synergies between social protection and complementary services**; and (vi) continue to build the **evidence base on child-sensitive social protection** through strengthened research, data disaggregation, monitoring and evaluation and knowledge management systems.





# 1. INTRODUCTION AND ANALYTICAL FRAMEWORK

This report is the first in a series of regional thematic reports produced for a study on social protection and children in West and Central Africa. It seeks to provide an overview of existing social protection policy and programming initiatives in the region and to assess in particular the extent to which these address childhood poverty and vulnerability. The report is based on a desk review of available documents and sources for the region as well as case study material from the Republic of Congo (hereafter Congo), Senegal, Mali, Ghana and Equatorial Guinea.

This introductory **Section 1** sets out the analytical framework and approach adopted for the study as a whole, focusing on the multidimensionality of issues to consider in relation to children and social protection. It is followed, in **Section 2**, by an analysis of the dominant factors contributing to poverty and vulnerability in the region, outlining key country characteristics and examining the principal sources of poverty and vulnerability and their manifestations at the household level as well as specifically for children. **Section 3** reviews existing social protection systems and initiatives in different countries in the region, identifying key social protection strategies and plans and touching on both traditional forms of social solidarity as well as formal sector programmes for social security, social insurance, social assistance and social service provision. **Section 4** highlights some of the key challenges in the design and implementation of social protection within a region characterised by extensive poverty, 'top inequity', limited fiscal space and weak governance and administrative capacity. **Section 5** draws a number of policy implications for child-sensitive social protection policy and programming and offers specific recommendations for the design, operationalisation and scale-up of national policies, plans and programmes. An overview of social protection issues included in selected poverty reduction strategy papers (PRSPs) in countries in the region is provided in **Annex 1**.

Increasingly, social protection is conceptualised as a set of public actions that address poverty, vulnerability and risk throughout the lifecycle. Such actions may potentially be conducted in tandem with private initiatives – either formal private sector or informal individual or community initiatives. Building on the recognition that poverty has both monetary and non-monetary dimensions, vulnerability and risk are now also recognised as being multidimensional, including natural and environmental, economic, health, social and lifecycle axes. The distribution and intensity of these vulnerabilities are likely to be experienced differently, depending on the stage in the lifecourse (infant, child, youth, adult, aged), social group positioning (gender, ethnicity, class) and geographic location (for example urban/rural), among other factors.

For children, the experience of risk, vulnerability and deprivation is shaped by four broad characteristics of childhood poverty and vulnerability:

- **Multidimensionality** – related to risks to children's survival, development, protection and participation in decisions that affect their lives;
- **Changes over the course of childhood** – in terms of vulnerabilities and coping capacities (e.g. young infants have much lower capacities than teenagers to cope with shocks without adult care and support);
- **Relational nature** – given the dependence of children on the care, support and protection of adults, especially in the earlier parts of childhood, the individual vulnerabilities of children are often compounded by the vulnerabilities and risks experienced by their caregivers (owing to their gender, ethnicity, spatial location, etc.);
- **Voicelessness** – although marginalised groups often lack voice and opportunities for participation in society, voicelessness in childhood has a particular quality, owing to legal and cultural systems that reinforce their marginalisation (Jones and Sumner, 2007).

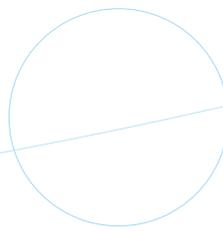


The diversity and relational nature of childhood risks are mapped out in Table 1. Health, lifecycle and social vulnerabilities have clearly identifiable child-specific manifestations. Natural/environmental and economic shocks impact children largely owing to the relational nature of childhood poverty and vulnerability. There is, however, also an argument to be made that, as a result of children’s physical and psychological immaturity and their dependence on adult care and protection, especially in early childhood, risks in general affect children more profoundly than they do adults. This suggests both that all types of vulnerability and risk should be assessed through the lens of children’s ‘evolving capacities’ and that it is likely that the most detrimental effects of any shock will therefore be concentrated in infancy and early childhood.

In view of the particularly severe, multiple and intersecting deprivations, vulnerabilities and risks faced by children and their caregivers in the West and Central Africa region, we draw on Devereux and Sabates-Wheeler’s (2004) transformative social protection framework for an analytical view that encompasses protective, preventative,

**Table 1: Vulnerabilities - Lifecycle and childhood manifestations**

Type of vulnerability	Indicators	Child-specific manifestation
<b>Natural/ environmental</b>	Natural disasters/phenomena/ environmental (human-generated environmental degradation, e.g. pollution, deforestation)	Children more vulnerable owing to physical and psychological, and also possible spill-over economic vulnerabilities, as natural disasters may destroy family livelihoods
<b>Economic</b>	<ul style="list-style-type: none"> <li>Income (low returns to labour, unemployment, irregular salaries, no access to credit)</li> <li>Inter-household inequality in access to land, rights and duties related to social standing, gender discrimination (access to productive assets)</li> </ul>	As above + child labour, child trafficking, child sexual exploitation owing to conceptualisation of children as economic assets
<b>Lifecycle</b>	Age-dependent requirements for care and support (infancy through to old age)	Physical/psychological vulnerabilities compounded by political voicelessness
<b>Social</b>	<ul style="list-style-type: none"> <li>Family composition (high dependency, intra-household inequality, household break-up, family violence, family break-up)</li> <li>Extra-family violence, social upheaval, social exclusion and discrimination</li> <li>Gender discrimination (unequal access to productive assets, access to information, capacity-building opportunities)</li> <li>Social capital (access to networks both within one’s community and beyond (bonding and bridging social capital), access to community support and inclusion)</li> <li>Education/information/literacy</li> </ul>	Family and school/community violence, diminished quantity and quality of adult care, discrimination
<b>Health</b>	Age-specific health vulnerabilities (e.g. infancy, early childhood, adolescence, childbearing, old age), illness and disability	Under three years especially vulnerable, access to immunisation, malnutrition, adolescence and child bearing



promotive and transformative social protection measures. A transformative perspective relates to power imbalances in society that encourage, create and sustain vulnerabilities – extending social protection to arenas such as equity, empowerment and economic, social and cultural rights. This may include, for example, sensitisation and awareness-raising campaigns to transform public attitudes and behaviour along with efforts to change the regulatory framework to protect marginalised groups from discrimination and abuse.

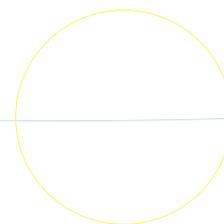
Operationally, this framework refers to social protection as the set of all initiatives, both formal and informal, that provide:

- **Social assistance** to extremely poor individuals and households. This typically involves regular, predictable transfers (cash or in kind, including fee waivers) from governments and non-governmental entities to individuals or households, with the aim of reducing poverty and vulnerability, increasing access to basic services and promoting asset accumulation.
- **Social services** to marginalised groups that need special care or would otherwise be denied access to basic services based on particular social (rather than economic) characteristics. Such services are normally targeted at those who have experienced illness, the death of a family breadwinner/caregiver, an accident or natural disaster; those who suffer from a disability, familial or extra-familial violence, family breakdown; or war veterans or refugees.
- **Social insurance** to protect people against the risks and consequences of livelihood, health and other shocks. Social insurance supports access to services in times of need, and typically takes the form of subsidised risk-pooling mechanisms, with potential contribution payment exemptions for the poor.
- **Social equity measures** to protect people against social risks such as discrimination or abuse. These can include anti-discrimination legislation (in terms of access to property, credit, assets, services) as well as affirmative action measures to attempt to redress past patterns of discrimination.

These social protection instruments are used to address the vulnerabilities of the population in general, but can also be adapted to address the specific risks faced by children as mapped out in Table 2 below. Given the close actual and potential linkages between women’s empowerment and child well-being (in what has been referred to as the ‘double dividend’ in the UNICEF State of the World’s Children Report 2007), each of the general social protection measures could also usefully be assessed through a gender-sensitive lens. Namely, to what extent is each social protection addressing gender-specific risks and vulnerabilities and gender barriers to services, supporting women’s care responsibilities and ensuring their inclusion in programme design and evaluation?

We also apply analytical elements of both Hickey’s (2007) politics of social protection framework and work by the United Nations Research Institute for Social Development (UNRISD) on the political economy of care (Razavi, 2007) in order to better understand the political and institutional context of social protection in the West and Central Africa region. The uptake of general and child-specific social protection instruments will be refracted through existing political institutions, political discourses about poverty and care and possibly path-dependent national social protection systems. Here, we consider factors such as political will on the part of the state to address poverty and vulnerability; the extent to which the intersection between poverty and social exclusion is recognised by the government officials responsible for designing and implementing social protection programmes; and the composition of the labour market, with the differential integration/positioning of men, women and children within it.

Such an analysis aims to identify appropriate policy entry points for engagement with social protection in the region, as well as to identify the processes and opportunities in which social protection can be politically sustainable as a basis for the development (and operationalisation) of a state–citizen contract that has citizenship rights at its centre.



**Table 2: Types of social protection and household and child-specific measures**

Type of social protection	General household-level measures	Specific measures for children
<p><b>Protective</b> Social assistance</p> <p>Social services</p>	<p>Cash transfers (conditional and unconditional), food aid, fee waivers, school subsidies, etc.</p> <p>Distinct from basic services as people can be vulnerable regardless of poverty status – includes social welfare services focused on those needing protection from violence and neglect – e.g. shelters for women, rehabilitation services, etc.</p>	<p>Scholarships, school feeding, cash transfers with child-related conditionalities, fee waivers for school, fee waivers for childcare</p> <p>Case management, alternative care, child foster systems, child-focused domestic and community violence prevention and protection services, rehabilitation services, reintegration services, basic alternative education for child labourers, etc.</p>
<p><b>Preventative</b> Social insurance</p>	<p>Health insurance, subsidised risk-pooling mechanisms – disaster insurance, unemployment insurance, etc.</p>	<p>Fee waivers for health insurance for children</p>
<p><b>Promotive</b> Productive transfers</p>	<p>Agricultural inputs, fertiliser subsidies, asset transfers, microfinance</p>	<p>Indirect spill-over effects (positive and negative)</p>
<p><b>Transformative</b> Social equity measures</p>	<p>Equal rights/social justice legislation, affirmative action policies, asset protection</p>	<p>Legislation and its implementation to promote child rights as victims (e.g. of violence, trafficking, early child marriage, etc.) and as perpetrators (special treatment and rehabilitation services for young offenders), efforts to promote children’s voice and agency</p>
<p><b>Complementary measures</b> Complementary basic services</p> <p>Complementary pro-poor or growth with equity macroeconomic policy frameworks</p>	<p>Health, education, economic/financial, agricultural extension</p> <p>Policies that support growth plus distribution</p>	<p>Child-focused health care services; pre-, primary and secondary school; childcare services</p> <p>Policies that support progressive realisation of children’s rights in line with macroeconomic growth indicators</p>



## 2. POVERTY AND VULNERABILITY IN WEST AND CENTRAL AFRICA

In many of the countries of West and Central Africa, more than half of the population lives below the officially defined absolute poverty line; often, 20-25% of people live in extreme (food) poverty, meaning that their standard of living is inadequate even for meeting basic nutritional needs. The poor are caught up in a web of deprivations and limited opportunities that mutually reinforce one another and make it difficult to climb out of poverty.

The poor are also highly vulnerable to a wide range of risks. These include natural disasters (droughts, floods, locusts and failed harvests); economic shocks (such as the global food price crisis); civil wars and political instability; and health shocks, including HIV and AIDS. The poor are deprived of the resources and opportunities (assets, savings, insurance, access to credit or new livelihood opportunities) needed to cope with such risks and shocks. In short, poverty and vulnerability are inextricably interlinked. Not only do external shocks tend to worsen the situation of the poor in the short term, but also they often force the poor to resort to adverse coping strategies, such as the sale of livestock or the withdrawal of children from school, which undermine their capacity to improve their situation in the long term.

### 2.1 COUNTRY CONTEXTS

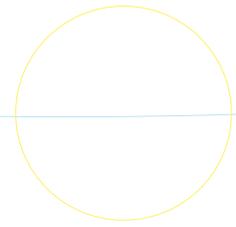
#### 2.1.1 ECONOMY

There is a wide variation of country contexts within West and Central Africa. Most of the region's countries are classed as 'low income' by the World Bank (2007a) and are among the very poorest in the world. The only 'middle-income' countries are among the Central African Gulf of Guinea countries, and Cape Verde. The landlocked countries in particular have lower gross domestic product (GDP), higher poverty rates, higher proportions of children within their population and higher household dependency ratios. These features also tend to characterise the more arid, subsistence farming regions within multi-zone countries (e.g. northern Ghana and Nigeria) bordering the Sahelian countries.

#### 2.1.2 DEMOGRAPHY

Across the region, population growth rates are high by global standards. According to the UN Population Fund (UNFPA, 2007), 'Middle Africa' (at 2.7%) and 'Western Africa' (at 2.3%) have the two highest population growth rates in the world; Niger (at 3.3%) has the highest population growth rate of any country. The population of West and Central Africa is young – a product of the twin forces of these high birth rates and low life expectancy. Children under 18 generally comprise about half of the population of each country.

Although predominantly rural in many countries, the region is marked by rapid urbanisation, such that, in around half of the countries, a majority of the population now lives in urban areas. Most coastal countries record 40-50% of the population in urban areas, compared with landlocked countries at 20-40%. Gabon, Congo, Cameroon, Liberia and the Gambia all have a clear majority of their population in urban areas (with



Gabon reporting an 85% urbanisation rate). Burkina Faso and Niger both have over 80% of the population in rural areas (UNFPA, 2007). Migration – rural–rural, rural–urban and within and between countries – is also a significant phenomenon in the region, one which impacts on children directly through, for example, household practices of sending older children away for seasonal agricultural work or to work or study in cities.

### 2.1.3 GOVERNMENT CAPACITY

The World Bank’s Worldwide Governance Indicators measure government effectiveness through an index of ‘the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government’s commitment to such policies’ (Kaufmann et al., 2007). Aggregate indicators collected from 1996-2006 show that:

- Ghana has the best governance ratings compared with the other countries in the region. It is the only country in West and Central Africa that is rated in the middle percentile (50th-75th percentile)<sup>2</sup> in the global comparison.
- The Sahelian West African countries and Benin are rated poorly but are among the better performers in the region.
- With the exception of Gabon, all the Central African countries are rated as having particularly ineffective states.
- The conflict-affected countries of Liberia, Sierra Leone (recently improved slightly) and Côte d’Ivoire, along with neighbouring Guinea and Guinea-Bissau, also score very poorly.

### 2.1.4 POLITICS AND VIOLENT CONFLICT

Several countries in the region have suffered serious political instability or violent conflicts in the past 20 years. There have been major conflicts in Liberia, Sierra Leone, Côte d’Ivoire, Congo and the Democratic Republic of Congo, and more localised conflicts in the Central African Republic and Chad, as well as sporadically in northern Niger, northern Mali and the Niger Delta region of Nigeria. However, progress has been achieved over the past few years, notably as a result of the restoration of peace and general elections in Liberia, Sierra Leone, Côte d’Ivoire and the Democratic Republic of Congo. Violence still continues in eastern parts of the Democratic Republic of Congo, as well as in eastern Chad, northern Central African Republic and northern Niger, causing serious humanitarian crises and large-scale human rights violations. The political situation also remains tense in Guinea.

Many countries in the region have made progress in establishing more stable multiparty political systems in recent years, with successful transitions from military to civilian rule or between rival political parties following elections. Benin, Cape Verde, Ghana, Mali, São Tomé and Príncipe and Sierra Leone are notable among these countries. Nigeria has been under civilian rule for a decade, although regionalised insecurity and conflict persist, notably in the Niger Delta. In 2007, Togo emerged from a long period of political crisis with an agreement between the government and the opposition that led to successful general elections and the lifting of international sanctions.

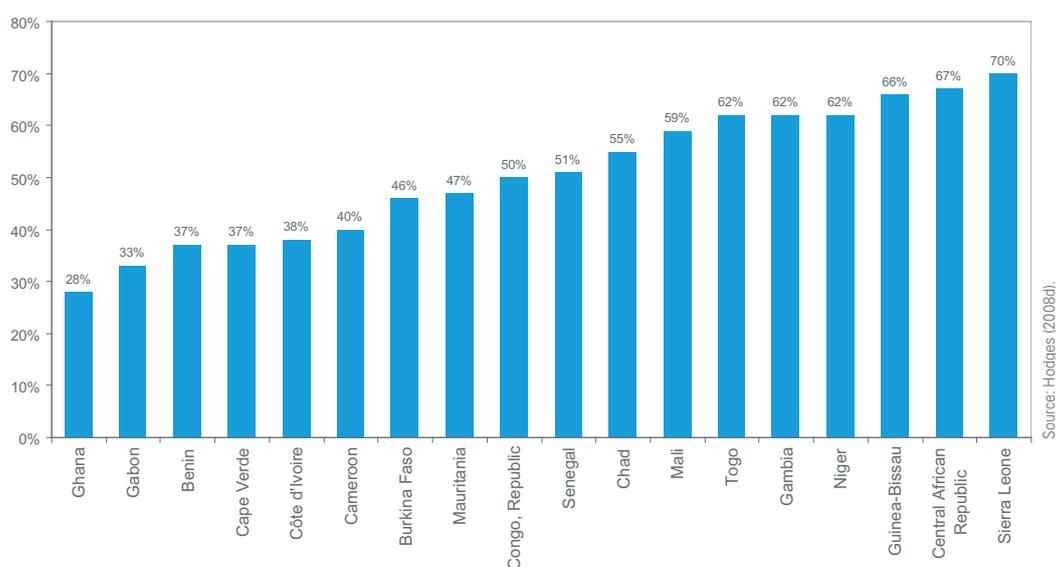
<sup>2</sup> Percentile ranks indicate the percentage of countries worldwide that score below each country. For example, a country with a percentile rank of 70 has 70% of countries scoring worse than it and 30% of countries scoring better.



## 2.2 HOUSEHOLD POVERTY AND VULNERABILITY

Countries in the West and Central Africa region are characterised by some of the lowest levels of human development in the world. Every country has a significant proportion of its population living in poverty. In some countries, the majority of the population lives below the poverty line and almost everywhere a substantial proportion of the population is highly vulnerable to livelihood shocks and stresses. Figure 1 shows that, in many countries, the national poverty headcounts, based on absolute poverty lines and consumption expenditure measures, are above 50%. In some countries (Togo, Gambia, Niger, Guinea-Bissau and the Central African Republic), poverty incidence is higher than 60%. In Sierra Leone, it is as high as 70% (Hodges, 2008d).

**Figure 1: Poverty rates in West and Central Africa**



In many countries, there is a strong rural–urban divide, with rural populations generally suffering a higher rate of poverty than urban ones. This is particularly so where the population is mostly rural, and so the urban population is disproportionately made up of wealthier and educated formal sector workers living in national or regional capitals. However, within the more widely urbanised countries, there is much more urban poverty: urban and rural poverty rates are almost the same in Nigeria, whereas urban poverty rates are reported to be higher than rural ones in Cameroon (IFAD, 2001). Particular social groups also suffer poverty more than others. Most notably, poverty is correlated with lack of formal education, and with participation in the informal sector – especially subsistence agriculture.

With a few exceptions in the case of the wealthiest groups in some of the middle-income countries, a large proportion of the population in each country in the region has inadequate access to social services such as education, health, water and sanitation, and has poor housing conditions. Such deprivations result in high levels of illiteracy, low levels of formal skills, widespread and severe ill health and low life expectancy (discussed in more detail below).



Furthermore, risk, vulnerability and poverty are closely related. People are vulnerable to impoverishment from a range of risks, with the type of risk and the vulnerability varying according to household location, occupation, income and social group. Here, we identify some of the particular sources of risk, or patterns affecting vulnerability, for poor households in the region.

### 2.2.1 ECONOMIC SHOCKS AND STRESSES

Recent rises in regional food prices (linked to both international and regional market conditions) have highlighted the complex patterns of risk and vulnerability produced by market economies. People who are dependent on buying food to meet their nutritional needs are vulnerable to malnutrition and/or poverty from higher food prices. This includes not only urban populations but also those living in rural areas who are net food buyers – often the poorest ‘below subsistence’ farmers, or those who do not work in agriculture. At country level, those countries that import substantial quantities of rice and wheat (such as Mauritania, Cape Verde, Senegal and Guinea-Bissau) face substantial challenges in the face of the food crisis (FCPN, 2008). On the other hand, the livelihoods of food and other commodity exporters across the region have suffered from falling prices over recent decades: current increases in world prices of many raw materials may offer them an opportunity to obtain higher incomes, accumulate assets and lessen their vulnerability to poverty.

### 2.2.2 ENVIRONMENTAL RISKS

Where livelihoods are directly dependent on environmental factors, environmental stresses have direct economic impacts – for example, the seasonal cycles of drought and ‘hungry seasons’ which deplete rural household resources year after year in the semi-arid zones of the region. A spatial analysis of the region reveals particular patterns of vulnerability and risk. Macroeconomic shocks in the Sahelian zone affect agricultural and pastoral populations – with crises brought on notably by drought and locusts, but with an element of recurring ‘shocks’, such that ‘hungry seasons’ are an annual phenomenon. These zones are also providers of child migrant labour to the more prosperous, urbanised and less seasonally cyclical economies of the West African coast and cities, generally found within the Gulf of Guinea countries. The forested regions of the Atlantic coast and central African inland areas tend to be dominated by subsistence livelihoods, with accompanying high levels of poverty; at the same time, their lucrative natural resource sectors are widely believed to be a significant factor in the devastating conflicts that have occurred with much greater frequency in these countries than elsewhere in the region.

Another potentially significant environmental variable is climate change. While the future impacts are still uncertain, they are likely to be complex and to affect many countries in the region, not just those Sahelian areas whose economies are the most environmentally fragile at present. Across Africa, declines in arable yields and cultivatable land area feature as products of climate change in many projections (Prowse and Braunholtz-Speight, 2007; Scott, 2008). Thus, one projection for Ghana suggests higher temperatures increasing the demand for irrigation and decreasing cereal yields, reduced rainfall leading to decreased hydroelectricity output and coastal sea level rises displacing over 100,000 people. This reminds us that environmental factors not only are related to economic risks, but also may affect shelter (e.g. through flooding) and health (poor sanitation and disease epidemics, e.g. in urban slums).



### 2.2.3 ILL HEALTH

Ill health is a risk faced by all people, but vulnerability to sickness, disease and disability can be increased through engaging in hazardous occupations (e.g. children doing 'heavy' manual labour), malnutrition, environmental factors (e.g. living in an urban slum with poor sanitation) or particular social practices and beliefs (e.g. female genital cutting/mutilation – FGC/M), all of which increase the chance of getting ill. Lack of access to quality health care, whether as a result of physical, economic or social barriers (e.g. distance to health centre, cost of health care or social norms that restrict decision making over health care), increases the negative consequences of becoming ill. Poor households and certain social groups (notably women) are likely to be particularly vulnerable to ill health.

### 2.2.4 SOCIAL FACTORS

Social norms, beliefs and systems structure vulnerability to various risks. People's ability to manage risks and protect themselves may be compromised by social norms that stigmatise them or restrict their behaviour, for example when women feel unable to access health services owing to fear of social discrimination or shame. Social norms may also justify or 'naturalise' exposure to risk, e.g. of women or children to domestic violence or dangerous work.

### 2.2.5 GOVERNANCE AND POLITICS

The state may be thought of as an institution whose function is to enable its citizens to better manage risk, but in some cases state action is itself a risk to people. An example might be government destruction of slums and informal settlements and clampdowns on the informal economy – actions to which the urban poor and informal sector workers are particularly vulnerable. Public policy may also create or reinforce social divisions and accentuate inequalities in vulnerability to other forms of risk, for example when migrants (international or internal) are barred from access to local public services and assistance.

### 2.2.6 CONFLICT AND RISK

Many countries in the region have suffered violent conflicts resulting in severe negative consequences, in particular for poor households. Children (and women, the elderly and people suffering ill health or impairment) are often the particular victims of violence in times of conflict. In several conflicts in the region, children have been recruited as fighters, which exposes them to a host of risks – violence, psychological trauma, drug addiction (sometimes used to control child combatants) and social stigma. Conflict can also heighten conditions of poverty in many ways: by destroying assets, disrupting livelihoods and cutting people off from access to markets. It diverts household resources away from saving and long-term investments to short-term survival needs – that is, if such resources are not looted by armed forces.

Conflict has a devastating and long-lasting effect on public services and infrastructure, both through the direct destruction of service structures and through diversion of resources from development and services to the funding of armies. This may, for example, contribute to the effects of ill health by reducing spending on health services and/or increasing vulnerability to poverty of the next generation by destroying the educational opportunities for children growing up in conflict.



## 2.3 CHILDHOOD POVERTY AND VULNERABILITY

Because of high fertility and birth rates, the region's population is extremely young. Children (under 18) account for just over half (51%) of the population, and one-third of these children are less than five years old (UNICEF, 2007). While there are high levels of income poverty among households across the region, children are overrepresented among the poor and extreme poor owing to the higher fertility rates among the poor. In Congo, for example, 54% of children live in income-poor households, compared with 47% of adults (Notten et al., 2008).

From a multidimensional child poverty perspective, the incidence of child deprivation is also high in this region (see Table 3). Children brought up in income-poor households are more likely to suffer nutritional deficiencies, as well as poor housing conditions, poor sanitation and lack of access to potable water – all of which put their health at risk and compromise their well-being and development. They are less likely to receive medical care when they are sick and more likely to drop out of school early or in some cases never to be enrolled at all. Furthermore, they are more exposed to the risks of exploitation, including child labour and trafficking.

**Table 3: Comparative indicators on multidimensional poverty in sub-Saharan Africa**

Indicator	Eastern/Southern Africa	West/Central Africa
Underweight prevalence – moderate and severe (%) (2000-2006)	28	28
Wasting – moderate and severe (%) (2000-2006)	7	10
Stunting – moderate and severe (%) (2000-2006)	41	36
Primary school net enrolment/attendance ratio (%) (2000-2006)	70	62
Male %	66	62
Female %	67	55
Gender parity	1	0.88
Under-5 mortality rate (1990)	165	208
Under-5 mortality rate (2006)	131	186
Infant mortality rate (under 1) (1990)	102	119
Infant mortality rate (under 1) (2006)	83	107
Maternal mortality ratio (2005, adjusted)	760	1100
% of population using improved drinking water sources	56	55
% of population using adequate sanitation facilities	38	36

Source: UNICEF (2007).

Nevertheless, although children in the poorest households (in income or consumption expenditure terms) usually suffer the most chronic and severe deprivations, there is often only a slight difference in the incidence of child deprivation among households in the bottom 40-60% of the income distribution (see Table 4). In some countries, children in only the top few percentiles have significantly better standards of living and security from risk and, while rates of survival are significantly better among richer households, they are still shockingly low, worse than the mean of 16% for sub-Saharan Africa as a whole (UNICEF, 2007).

A pattern emerges from household survey data of the characteristics of the adults of those households whose children suffer particularly from chronic malnutrition, severe health shocks, little formal education and other burdens affecting their nurture and development. The heads of these households tend to have low



levels of formal education, be subsistence farmers, live in conflict-affected areas and/or live in rural areas (demographic and health survey (DHS) country reports)<sup>3</sup>.

The degree of disparity between these groups and others varies from one country to another, but the pattern holds to some extent at least almost everywhere in the region. Thus, while in the more urbanised countries there is significant urban poverty (particularly in slums and in peri-urban areas) and a greater proportion of the highly vulnerable population is found in urban areas, rural areas remain worse off by most indicators of childhood deprivation. Taking child stunting as an example, the mean rural-urban ratio of child stunting is 36% to 23% (across 14 countries for which DHS data are available for the past decade), although the gap varies from seven percentage points (Congo, rural 28% to urban 21%) to 22 percentage points (Niger, rural 53% to urban 31%) (DHS country reports).

Children are especially vulnerable because of their age and the risks to their survival and their physiological and emotional development. Deprivations and lost opportunities in childhood have lifetime consequences, increasing the likelihood of poverty in adulthood and the transmission of poverty to the next generation. This throws into relief the centrality of children in strategies for reduction of poverty and vulnerability – and thus social protection programming.

**Table 4: Child poverty and vulnerability indicators by household wealth in case study countries**

Country	Wealth quintile	Under-5 mortality rate	Child stunting (%)	Primary/secondary school gross attendance (%) <sup>4</sup>	Child labour - working, not in school (%)
<b>Congo, Republic</b>	Poorest	135	32	N/A by household wealth. Overall figures are 123/65	19
	Second	130	27		21
	Middle	130	25		18
	Fourth	124	24		10
	Richest	85	20		5
<b>Equatorial Guinea</b> (data disaggregated by wealth unavailable)	Poorest	205	38%	Net attendance: 61/23	N/A (28% child labour in general)
	Second	-	-		
	Middle	-	-		
	Fourth	-	-		
	Richest	-	-		
<b>Ghana</b>	Poorest	128	42	70/20	9
	Second	105	32	95/28	3
	Middle	111	30	105/39	2
	Fourth	108	24	105/49	1
	Richest	88	13	107/63	1
<b>Mali</b>	Poorest	233	44	44/11	N/A by household wealth. Overall figure is 39%
	Second	241	43	48/16	
	Middle	226	43	49/15	
	Fourth	227	35	61/24	
	Richest	124	22	107/64	
<b>Senegal</b>	Poorest	183	26	62/4	27
	Second	164	19	76/10	26
	Middle	136	16	80/23	21
	Fourth	92	9	93/34	14
	Richest	64	6	109/57	9

Sources: DHS country reports; ILO et al. (2005).

<sup>3</sup> See references section for more.

<sup>4</sup> Although some primary completion data are available, these are generally not disaggregated by wealth for these case study countries. DHS secondary attendance data are shown as the best disaggregated indicator of numbers completing primary school and carrying on with formal schooling.



Because vulnerability is not exclusively economic in nature, social and cultural factors also play a role and, at the micro (household) level, vulnerability is often a complex interplay of different factors, including gender relations, discrimination and power imbalances. Children, again because of their age and their dependence on adults, can be vulnerable to adverse intra-household dynamics, including abuse, as well as one of the greatest risks of all – the disintegration or loss of the family environment, the basic social unit for the care and upbringing of children. This is particularly important in the context of the HIV and AIDS crisis and in certain war-affected countries. We turn to these issues in more detail in the sub-sections below.

### 2.3.1 CHILD SURVIVAL

The West and Central Africa region currently has the highest regional under-five mortality rate (U5MR) in the world at 186 (as measured by the U5MR per 1000 live births), compared with 160 for sub-Saharan Africa as a whole and 131 for Eastern and Southern Africa (see Table 3 above).

Three of the five middle-income countries of the region are among the best regional performers in child survival (Cape Verde, Gabon and Congo), with Cameroon around the regional median and Equatorial Guinea one of the worst performers, despite the highest per capita income of any country in the region. In a few countries – Cameroon, Central African Republic, Chad and Equatorial Guinea – the U5MR rate has increased since 1990. The first three have all suffered violent conflict. In two other conflict-affected countries – the Democratic Republic of Congo and Liberia – the U5MR in 2006 was unchanged from 1990. The U5MR also varies considerably within countries, notably between urban and rural areas and between different geographical regions. Progressing upwards from the lowest wealth quintile, there is often not a large decline in U5MR until the top one or two quintiles. In Congo, for example, only children in households in the top wealth quintile show any great advantage in child mortality, as was the case for stunting (see Table 4) (DHS country reports).

Respiratory and diarrhoeal diseases, both of which are highly preventable and of low cost to treat, represent leading causes of child mortality, with a further 20% of under-five childhood mortality owing to deaths resulting from malaria (World Health Organization – WHO – Statistical Information System, cited in Walsh, 2009). At a regional average, only 55% of the population has access to improved sources of drinking water, and only 36% of the population uses adequate sanitation facilities (UNICEF, 2007).

Antenatal care provision across the region is 67%: only 46% of births have a skilled attendant at delivery and 39% of births are institutional deliveries. Only 29% of children under-five in the region with diarrhoea receive oral rehydration therapy and continued feeding. Immunisation rates across the region, as measured by completion of DPT3 in the vaccination schedule<sup>5</sup>, are at 67%. However, a number of countries have rates of immunisation below 60%. Those countries that are the worst performers on the U5MR also fall on the lower end of maternal health care service utilisation and rehydration therapy for children, underpinning the recognised connection between basic maternal and child health services and U5MR rates (Walsh, 2009).

Maternal and child undernutrition are in turn estimated to be the underlying cause for 35% of under-five child mortality, amounting to 3.5 million deaths, and 11% of global disability adjusted life years (DALYs)

<sup>5</sup> DPT3 (diphtheria–pertussis–tetanus) is commonly used as a proxy for access to basic child health services, given current patterns of immunisation scheduling. However, recent evidence suggests that girls who receive DPT3 as their last vaccination have higher mortality rates than girls who receive the measles vaccine as their last vaccination. Further research is necessary to clarify these observations, but one potential implication is that ‘complete’ vaccination should be measured by measles vaccination rates (for girls) rather than DPT3 (Aaby et al., 2006).



(Black et al., 2008)<sup>6</sup>. In West and Central Africa, the percentage of children under-five stunted in growth for their age ranges from 20.1% in Senegal to 54.8% in Niger (WHO Statistical Information System, cited in Jones, 2009). Equatorial Guinea stands out as having a child stunting rate of 39% – equal to that of Mali – but with a GDP per capita seven times as high.

Within countries, a rich/poor, urban/rural and educated/uneducated spectrum is generally discernible, with children in the latter categories more likely to suffer chronic malnutrition in each case. Boys consistently suffered stunting slightly more often than girls, except in Senegal, where the rates were almost equal (16.5% of boys to 16.15% of girls). In terms of household composition, children in households where their mothers were absent were consistently more likely to be stunted. In some countries, it was only the children from the top wealth quintile households who seemed significantly better nourished, suggesting that vulnerability to livelihood shocks and stresses is widespread (e.g. Congo and Mali), whereas in others stunting seems more concentrated among the very poorest (e.g. Ghana and Senegal).

Across the region, DHS surveys often find that between 50% and 80% of women report significant problems accessing health care – with cost and transport/distance to health facilities top of the list. These obstacles are most often encountered by women in rural areas, without formal education, in the lower wealth bands – and those without a cash income (typically those not economically active or engaged in subsistence agriculture).

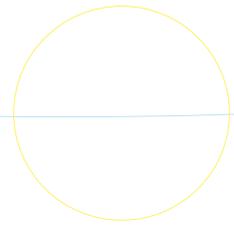
The regional gender gap in education is one of the widest, and the maternal mortality rate (MMR), at 1100 per 100,000 live births, is far higher than in any other region, including Eastern and Southern Africa, where MMR is 760 per 100,000 live births (UNICEF, 2007). Girls grow up vulnerable to male violence, ill health, maternal death, poor work opportunities and persistent poverty owing to lack of education. So, while the status of women varies from one country to another within the region, nowhere can gender equality or the fulfilment of women's human rights be said to have been achieved.

### 2.3.2 EDUCATION

School enrolment, attendance and achievement rates vary widely across the region, with net primary school attendance ratios (2000-2007) between 75% and 95% in São Tomé and Príncipe and Ghana but less than 45% in Chad and Mali (UNICEF, 2008). Secondary attendance (2000-2007) is uniformly lower than primary across the case study countries, at around 45% of children in Ghana but less than 20% in Mali and Senegal (ibid). The gender gap also varies widely at both primary and secondary levels – with the percentage of females relatively consistent for primary and secondary in Congo, but with a significant gap in Mali, where girls accounted for over half the class in primary school, falling to below 25% in secondary education (UNICEF, 2008).

Wealth, parental education and urban location appear to be almost uniformly strongly positively correlated with greater educational achievement: children in households that are poor, in rural areas and with uneducated parents are all less likely to go to school (see Table 4).

<sup>6</sup> DALYs for a disease are the sum of the years of life lost owing to premature mortality (YLL) in the population and the years lost owing to disability (YLD) for incident cases of the health condition. The DALY is a health gap measure that extends the concept of potential years of life lost owing to premature death (PYLL) to include equivalent years of 'healthy' life lost in states of less than full health, broadly termed disability. One DALY represents the loss of one year of equivalent full health ([www.who.int/healthinfo/bodddaly/en/](http://www.who.int/healthinfo/bodddaly/en/)).



The principal reasons given for children not attending school are the cost, difficulty of access (particularly for secondary schooling in rural areas) and low expectations of the utility of education. There is some evidence that this is related in part to concerns over the low quality of schooling available. In Congo, survey data are available on children's perceptions of education: the majority were dissatisfied, citing inadequate books, equipment and buildings, absent teachers and overcrowded classes as problems (World Bank, 2007b). It may also relate to perceptions of the labour market value of education, especially in geographical regions where subsistence agriculture predominates and the formal sector is little represented – which also tend to have low school attendance rates.

### 2.3.3 ABUSE, VIOLENCE AND NEGLECT <sup>7</sup>

There is a dearth of evidence on violence and abuse against children in the region; where it does exist, the available data are often small scale (Burton, 2005; Ebigbo, 2003) and/or based on anecdotal accounts such as Save the Children UK's 2006 study of sexual exploitation in Liberia's displaced persons camps. These limitations notwithstanding, the evidence that is available indicates that the risk factors underlying children's vulnerabilities to abuse, violence and neglect are multiple and widespread (Human Rights Watch, 2003; ILO, 2006; Jones and Espey, 2008).

Economic poverty and experience of household and community-level shocks appear to be major drivers of protection violations. The regional proportion of children engaged in child labour is 34% – roughly the same as the sub-Saharan African figure of 35%. Girls tend to be engaged in domestic work, agriculture and vending; boys tend to work fewer hours and engage in more specific economic activity in sectors such as agriculture, vending and low-skilled jobs. Children in the region are also involved in potentially dangerous work, including mining, waste collection and begging (UN, 2006). In particular, children's school attendance and achievement may be negatively affected by working (Canagarajah and Nielson, 1999), particularly in households with low maternal education levels (Blunch and Verner, 2001; Ray, 2002) and for girls in contexts where there is a preference for educational achievement for sons rather than daughters.

Rapid urbanisation as well as economic globalisation have fuelled extensive rural to urban migration and also cross-border migration in many West and Central African countries, often resulting in family separation and/or child migration to support household labour needs (e.g. Black et al., 2004). Trafficking and commercial sexual exploitation have also been identified as a major problem in a number of countries, including Ghana (ECPAT, 2008), Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Gabon, Ghana, Mali, Nigeria and Togo (ILO, 2001) and Nigeria (Ogunyemi, 2000), involving an estimated 200,000 children annually (Human Rights Watch, 2003)<sup>8</sup>. The demand for children varies, including the recruitment of soldiers in areas such as Guinea, Sierra Leone and Liberia (Tiefenbrun, 2007) and general labour and domestic work in places such as Togo (Human Rights Watch, 2003). In many cases, trafficking is also linked to sexual exploitation.

Harmful traditional practices remain an important and deeply entrenched driver of child vulnerability in the region. These value and belief systems may in turn be exacerbated, though not exclusively, by low levels

<sup>7</sup> This section is drawn from Jones (2009).

<sup>8</sup> This is distinct from children who often move from their parental home to that of relatives for reasons of economic scarcity or better educational opportunities. Some of these children do end up, however, being treated as quasi domestic servants and/or subject to other forms of abuse (Human Rights Watch, 2007a).



of education. A diverse array of harmful traditional practices has been identified in West and Central Africa, but because of the cultural sensitivity of many of these issues, reliable evidence is limited. In the case of FGC/M, the prevalence of the practice varies widely, ranging from as high as 96% among 15-46-year-old women in Guinea to just 2% in Niger.

Finally, armed conflict has been and continues to be a major driver of child vulnerability in the region. Although a number of peace settlements have been resolved in the past five years, addressing protection-related violations and associated traumas remains a major challenge. Conflict situations often undermine the social fabric at both family and community levels and erode governance and accountability mechanisms, leaving children particularly vulnerable to various forms of abuse. Girls appear to be especially vulnerable to sexual abuse (e.g. Human Rights Watch, 2007b; Save the Children UK, 2006), and boys to recruitment as child combatants, although a sizeable number of girls have also been recruited in the region (Machel, 2007).

In terms of impact, Jones (2009) argues that these vulnerabilities have both immediate and longer-term educational, physical, psychological development and well-being impacts. These include psycho-social trauma and higher suicide risks (Behrendt and Mor Mbaye, 2008); social stigma and possible rejection by families and communities, especially in the case of sexual violence because of the high cultural value often attached to sexual purity (Ogunyemi, 2000); diminished returns to education (endangering achievement of Millennium Development Goals – MDGs – 2 (universal primary education) and 3 (educational parity), through underperformance or school dropouts (ActionAid, 2004); and reproductive health risks through unwanted pregnancy, unsafe abortion and sexually transmitted infections, including HIV and AIDS (Jewkes et al., 2002; Kim and Bailey, 2003). Beyond these more immediate effects, experience of violence and abuse may also set the stage for future adult and intergenerational interactions, in what is described as the cycle of violence (Save the Children UK, 2006) and lifecourse and intergenerational transfers of poverty (Harper et al., 2003).

### 2.3.4 BIRTH REGISTRATION

Lack of birth registration has far-ranging consequences for children. Birth registration provides children with their fundamental right to an identity and is often essential for securing access to services and resources later in life (Jones, 2009). Birth registration rates in West and Central Africa range from 9% in Chad to 89% in Gabon. There is often a gap between registration rates for the poor and the rich, and between rural and urban areas. This may be linked to both the cost of registration and lack of awareness of the procedure (cited, for example, as frequent obstacles by respondents in the 2006 Ghana Multiple Indicator Cluster Survey – MICS – (Government of Ghana et al., 2006) both of which might be expected to hit harder the children of poor households (possibly with illiterate parents) in rural areas with little state presence. However, it is also the case that registration rates in rural areas in the better-performing states are often higher than those in urban areas in worse performers, suggesting that some states maintain little effective presence even in urban areas. In general, all of these registration rates need improvement if the state is to effectively provide social protection to reduce children's poverty and vulnerability.





## 3. EXISTING SOCIAL PROTECTION IN WEST AND CENTRAL AFRICA

### 3.1 TRADITIONAL AND INFORMAL SOCIAL PROTECTION MECHANISMS

Traditional and informal safety nets exist all over the world – most communities and extended families draw on different types of coping mechanisms during difficult times and/or in the absence of public interventions. Coping mechanisms range from the informal exchange of transfers and loans to more structured institutions that enable an entire community to provide protection to its neediest members (Murdoch and Sharma, 2002).

In West and Central Africa, households and communities use a variety of traditional and/or informal mechanisms (see Box 1 on the mechanisms that exist in Ghana), yet there are few studies on the importance and impacts of these mechanisms on poverty in general (Lourenço-Lindell, 2002)<sup>9</sup> and little attention has been drawn to how these might alleviate child poverty in particular. Nonetheless, data from household surveys do confirm the importance of inter-household private transfers in West and Central Africa as a mechanism of solidarity that contributes significantly to risk mitigation and the reduction of income poverty. In Mali, for example, 18% of the revenue of poor households comes from private inter-household transfers (Ministry of Social Development, Solidarity and the Elderly et al., 2008). In Congo, 38% of households are net beneficiaries of private inter-household transfers. These account for 8% of total household income and 15% of the income of net beneficiary households. The World Bank has calculated that, without these transfers, income poverty in Congo would be 2.2 percentage points higher (World Bank, 2007a).

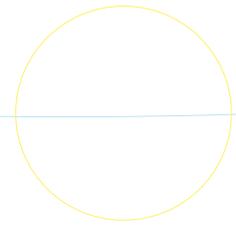
#### Box 1: Informal social protection mechanisms in Ghana

Five main sources of informal social protection have been identified in Ghana, all of them based on principles of reciprocity and mutual exchange:

- **Kin-based support systems:** In times of need, such as hunger, disease and old age, individuals have traditionally depended on family or clan members for assistance in cash or in kind (Nukunya, 1998). Such groups are not necessarily location based, as they have formed so-called hometown-based groups in urban areas and also in the Ghanaian diaspora.
- **Remittances:** The proliferation of money transfer institutions in Ghana attests to the rapid growth in the volume of migrant remittances – an estimated US\$1.5 billion in 2005 (GJAS Partners, 2007).
- **Trade associations:** These are non-kin-based groups formed around a common professional identity, which provide important support functions. They are estimated to involve about 9% of the population (SSNIT, nd).
- **Faith-based support networks:** These constitute one of the fastest social security systems in Ghana among both Christian and Muslim populations, with an estimated 51% of the population holding membership in a religious organisation. Faith-based groups provide support during key lifecycle events (birth, marriage, death) and in some groups payment levels are formalised.
- **Credit societies:** Termed *susu*, these are groups that serve to mobilise mutual funds in the informal sector, and are estimated to involve about one-third of the population.

Source: Bortei-Doku and Doh (2007).

<sup>9</sup> In general, there are few recent studies on this, but for example studies from Southern Africa see Devereux (1999).



It is also noteworthy that migration has resulted in rising remittances, particularly in some West African countries, from family members living and working abroad. Remittances in West and Central Africa, for example, were estimated at US\$10.4 billion and US\$2.7 billion, respectively, in 2006 (IFAD, 2008), with the amount of remittances steadily increasing since 2000 (Ratha et al., 2007). In Ghana, remittances to relatives back home are largely used to cover 'family maintenance' costs, such as school fees, social activities (especially funeral costs) and living expenses (Quartey, 2005, cited in GJAS Partners, 2007).

It is widely believed, however, that modernisation and urbanisation are eroding extended family obligations to assist poorer relatives<sup>10</sup>. It is also important to note that traditional solidarity mechanisms are of limited value when shocks, such as natural disasters, affect whole communities. After the drought in the Sahel in the early 1980s, for example, private transfers made up just 3% of average losses faced by poor households (Murdoch and Sharma, 2002).

Direct assistance is just one form of traditional, informal social protection. Rotating savings and credit associations (RoSCAs) and accumulating savings and credit associations (ASCAs) are also important traditional social protection mechanisms across West and Central Africa. These savings and credit clubs – called tontines in many countries (susu in Ghana) – are run by poor people, most often women, who mobilise the resources they need for business and personal reasons. RoSCAs are an informal means of mobilising savings whereby members of the association put in equal amounts of money that is pooled and rotated equally in turn to each person. ASCAs are similar to RoSCAs except that the pooled savings are not automatically rotated. Some members take the pooled money out as a loan that is paid back with interest. The interest allows the pooled funds to accumulate. A RoSCA is simpler to manage, but cannot always meet its users' needs for lump sums of cash; an ASCA offers a way for users to build up more money, but is riskier and demands more skill and management ability than the RoSCA.

There is some debate over whether the savings and credit clubs tend to exclude the poorest. Murdoch and Sharma (2002) challenge this notion, drawing on the experience of susu collectors in West Africa who go from household to household taking small deposits on a regular basis. According to Bortei-Doku and Doh (2007), susu groups are estimated to involve about one-third of the population. Murdoch and Sharma (2002) argue that, when safe and convenient ways to make savings deposits are established, the poor can and do save. In Congo, the existence of community support and collective initiatives through tontines reinforces the lines of solidarity in order to mitigate social risk (Villar and Makosso, 2009).

Faith-based organisations, both Muslim and Christian, also play a role in assisting the neediest households. Villar and Makosso (2009) in their case study of Congo indicate that churches are an important source of assistance for the most vulnerable populations. However, given the extent of poverty, faith-based organisations cannot assist all needy families. Research in Guinea-Bissau has shown that, while the local evangelical church provides some modest relief to some of its weakest members, it is incapable of assisting all who are in need (Lourenço-Lindell, 2002).

Informal social protection mechanisms remain important across the region, reducing to some extent the overall poverty headcount and poverty gap and making it slightly easier for poor households to cope with risk. However, overall high levels of poverty and economic hardship limit the impact of these informal mechanisms, which appear to have been eroding over time owing to limited economic opportunities for the poor, growing urbanisation, modernisation and changes in the nature of the family and cultural values of solidarity.

<sup>10</sup> Lourenço-Lindell (2002) draws attention to the differential degree to which the poorest households can continue to expect transfers. Evidence from urban Bissau, in Guinea-Bissau, shows that 'widespread economic hardship is undermining collaborative efforts among the poor. Some people could count on wide and diversified networks of support comprising resilient ties and egalitarian relations, whilst others were isolated, unable to enforce their perceived rights to support and were in subordinate positions in their support systems. Among relatives, norms of assistance were changing in a way that left a share of people to fend for themselves, which increased the burden particularly of women, including elderly women.'



## 3.2 FORMAL SECTOR SOCIAL SECURITY SCHEMES

Formal social protection systems in West and Central Africa mainly take the form of contributory social security schemes that provide, for example, sickness benefits, retirement pensions, maternity benefits or disability benefits and the like to salaried employees, mainly in the public sector and the formal private sector, and to some extent to their family dependents (Social Security Worldwide, 2007). The fact that these schemes benefit mostly those in formal sector employment, which is almost entirely limited to the urban areas and in most countries does not involve more than 10-20% of households, excludes the vast majority of the population, including the poorest and most vulnerable. Most households generate their livelihoods in the agricultural and informal sectors, which are characterised by low and irregular income, making it difficult for them to make regular contributions to formal social security schemes.

The high levels of exclusion are highlighted by these country examples:

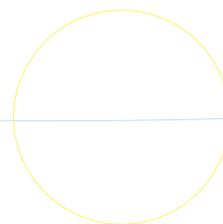
- In **Guinea**, the National Social Security Fund covers only 2% of the population (Government of Guinea, 2008);
- In **Cameroon**, the National Social Providence Fund and the 'civil service plan' cover approximately 10% of the population, and benefits do not include health insurance (Ministry of Social Affairs, 2008);
- Coverage of the two similar schemes in **Côte d'Ivoire** is also approximately 10% (Hodges, 2008d);
- In **Congo**, the National Social Security Fund and the Civil Service Pension Fund reach 15% of the population, but the benefits are low and irregular (Ondaye, 2008);
- In **Togo**, the National Social Security Fund covers less than 20% of the population (Assoumatine et al., 2008);
- The social security systems in **Senegal** (IPRES, CSS and FNR, see below) cover about 20% of the population (Hodges 2008d).

The following illustration from Senegal (Box 2) gives a further sense of the magnitude of the challenges remaining in ensuring social protection coverage for the majority of the population currently left out of the formal system.

## 3.3 SOCIAL INSURANCE

Social insurance mechanisms outside of the formal social security system are limited in the region. One of the most notable exceptions to this is Ghana. In 2003, the government enacted legislation to set up the Ghana National Health Insurance Scheme (NHIS), which aims to provide universal access to health insurance. By 2008, it had enrolled 42% of the population (Sultan and Schrofer, 2008). There are continuing concerns that this scheme will not reach the poorest, however, owing to the requirement to pay a premium of approximately US\$8 a year.

Smaller-scale mutual health organisations (MHOs) and community health organisation (CHOs) have been gaining momentum in West and Central Africa as a way for communities to provide their own health insurance. In West and Central Africa, the number of MHOs grew from 76 in 1997 to more than 800 by 2004 (Gamble-Kelley et al., 2006, cited in Chankova et al., 2008), but levels of enrolment, especially among the poor, remain low. For example, Mali and Senegal have comparatively high coverage rates for the region and still cover only 3.92% and 2.46% of their respective populations (Walsh, 2009). Evidence that MHOs are an effective tool for protecting households from catastrophic expenditures associated with health care in the region has in part encouraged the development of MHO-based health insurance as part of the national health financing strategy in countries including Benin and Senegal (Chankova et al., 2008).



## Box 2: Social security system and extent of coverage in Senegal

The social security system in Senegal covers only salaried workers in the formal public and private sectors. Under joint supervision by the Ministry of Civil Service, Employment and Professional Organisations and the Ministry of Health and Medical Prevention, benefits are extended through the following autonomous public institutions:

- The **National Retirement Fund (FNR)** provides social insurance to public sector employees financed by state contributions;
- The **Institute for Retirement Planning of Senegal (IPRES)** provides social insurance benefits to salaried workers in the private sector financed by contributions by employers and employees;
- The **Social Security Fund (CSS)** provides family and health benefits to private sector employees;
- **Health insurance institutes (IPMs)** are specific to particular firms or groups of firms.

Coverage of the above, however, remains limited, and the system is fragile – even in the formal sector, where employers often refuse to make contributions

on behalf of their employees. According to a recent ILO report (Annycke, 2008), only 16.6% of people over the age of 65 benefit from a retirement fund or pension; 5.5% of workers are covered by work-related health and accident insurance; 13.3% of children under 15 (10.5% of children under 18) are covered by family benefits; and fewer than one in five people (20%) benefit from health care coverage. Social protection coverage is minimal for those outside the formal sector and particularly for the poorest segments of the population, whose only recourse to health insurance is through voluntary contributions to mutual associations. This clearly underscores the importance of such associations and other alternative social assistance mechanisms to cover the majority of the population currently left out of the system – estimated at over 80% (Sow, 2008). One of the current objectives of Senegal's National Social Protection Strategy is to expand adequate social protection coverage to the poorest population groups, including in particular children, in view of their greater vulnerability.

Source: Perezniето and Fall (2009).

Some groups are very small, but are able to negotiate with local clinics for a better price for health care and to link into health plans offering members an array of health services. By nature of the contribution, there are continued debates over whether these organisations exclude the poorest. Chankova et al. (2008) find that in Benin, Ghana and Senegal the collection of MHO premiums on a monthly basis, rather than once a year, can promote enrolment by poorer households. Other evidence suggests that payment plans can be even more flexible, with some payments being made during harvest periods (Carrin et al., 2005). Including outpatient care provided at primary health care facilities in the MHO benefits package may also increase enrolment among the poor (Chankova et al., 2008).

In Benin, Ghana and Senegal, education of the household head is a strong determinant of MHO enrolment and there is a higher propensity of MHO enrolment for households headed by women, compared with those headed by men. This has important implications for the empowerment of women in the health sector (Chankova et al., 2008). Geographic location also influences the success of MHOs – the availability of a health facility in the community is associated with higher likelihood of enrolment, indicating that MHOs may have a limited role in improving access to affordable health services for populations that live far from health facilities (ibid).

While MHOs may offer an important complementary strategy for broader social protection for rural, informal



sector populations in the short run, the limited coverage of the poor and their potential exclusion from such contributory mechanisms remains a key area of concern<sup>11</sup>.

### 3.4 SOCIAL ASSISTANCE

In recent years, the growing interest in, and commitment to, social protection as a response to poverty has led some national governments to consider setting up cash-based safety net programmes targeted at the poorest. Cash-based social assistance already exists in some countries in the region (for example in Congo, Senegal and Mali), but many of these programmes provide demand-led assistance and have limited impact on the poorest (Perezniето and Diallo, 2009; Perezniето and Fall, 2009; Villar and Makosso, 2009). Other cash-based social transfer schemes targeted to the poorest (rather than being demand led) are still in their infancy in West and Central Africa and at present are limited to small-scale programmes, of which the most significant are shown in Box 3.

Both Ghana's LEAP and Nigeria's COPE (see Box 3) initiatives explicitly aim to reduce childhood poverty and vulnerability through their programme design. Both programmes also view cash transfers as part of broader poverty reduction package. In Ghana, this is done by linking up the beneficiaries to complementary services, such as free national health insurance and training and ensuring compliance with the conditions of the transfer, including birth registration and non-participation in child labour (Jones et al., 2009). In Nigeria, broader links are made through encouraging use of basic social services and attendance by adult members in various training sessions.

#### Box 3: Cash transfer programmes in West and Central Africa

##### **Ghana's Livelihood Empowerment Against Poverty (LEAP) programme**

Launched in March 2008, rollout was accelerated in response to the food price crisis and is due to reach 53,000 households with orphans and vulnerable children (OVC) and elderly and disabled persons by the end of 2008 (Asante-Asare, 2008). At its planned enrolment of 164,000 households within five years, LEAP will reach one-fifth of those below the extreme (food) poverty line (Sultan and Schrofer, 2008).

##### **Sierra Leone's Social Safety Net (SSN) programme**

Launched in 2007, this aims to reach 16,000 extremely vulnerable households, in particular households with elderly people with no other means of support (Scott, 2008).

##### **Cape Verde's 'Minimum Social Protection' and 'Social Solidarity Pensions'**

These were established in 1995 and 1992, respectively, providing transfers and free access to basic social services to about 17,000 extremely poor elderly, chronically ill and persons with disabilities (Ministry of Labour and Solidarity, 2006).

##### **Nigeria's In Care of the Poor (COPE)**

Implemented by the National Poverty Eradication Programme (NAPEP), this programme is funded by Heavily Indebted Poor Country (HIPC) Initiative debt relief funds. It provides cash to extremely poor and vulnerable households, on condition that adult members attend training sessions, keep their children in school and utilise health services. It has started operations with 12,500 beneficiary households in 12 states and the Federal Capital Territory (Hodges, 2008b).

<sup>11</sup> MHOs and other forms of health insurance and health financing are discussed in more detail in Regional Thematic Report 4 on 'Social Protection to Promote Maternal and Child Health in West and Central Africa' (Walsh, 2009).



As cash-based transfers are still relatively new in the region, other forms of social assistance continue to form a large part of social protection programming, often implemented or supported by international organisations. These programmes benefit children directly and indirectly. For example, some of the most popular forms include the distribution of nutritional supplements, bed nets and vaccinations for children; fee exemptions and abolition of user fees for specific target groups (which often include children under five); and school feeding programmes. Food aid, in particular, is still the largest form of social assistance in many of the countries in the region. Run by the World Food Programme (WFP), these programmes have a much larger budget and reach a much higher number of beneficiaries than the cash-based social transfers mentioned above.

For example, in Sierra Leone, the WFP aims to target up to 170,000 beneficiaries per year at a cost of US\$11 million over three years (WFP, 2007a). In comparison, the SSN aims to reach 16,000 people. In Burkina Faso, the WFP in collaboration with a number of partners, including the Ministry of Social Action and National Solidarity, is finalising a large social transfer scheme that will provide vouchers to 30,000 households in the two main cities (Ouagadougou and Bobo Dioulasso) in response to the food price crisis (Hodges, 2008c).

Many of the WFP interventions in the region respond to acute and chronic food crises as a result of shocks such as droughts and floods or of conflict and displacement. WFP expenditure on relief has been consistently high in comparison with its development expenditure in Chad, Congo, the Democratic Republic of Congo, Côte d'Ivoire, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger and Sierra Leone (WFP, 2007b). This raises important questions about the role of social protection in contexts with ongoing humanitarian needs. The design of social protection, the financing mechanisms and the role of actors implementing social protection are likely to be different in contexts recovering from conflict and moving into development (e.g. Sierra Leone, Liberia, Côte d'Ivoire) compared with countries experiencing recurrent and cyclical shocks (such as the Sahelian countries)<sup>12</sup>.

### 3.5 SOCIAL SERVICES

Social service provision for vulnerable children in West and Central Africa includes both governmental and non-governmental actions to ensure that children's right to live a life protected from violence, abuse and neglect is met. Overall, the findings from Jones (2009) highlight the fragmented nature of existing services in the region; the severe under-resourcing of these services both financially and in terms of human resources; the very high levels of reliance on international agencies and non-governmental organisations (NGOs) to fill gaps in services in a sometimes ad hoc manner; and the limited degree of coordination across agencies. A key concern is therefore how to integrate social protection programming with social service delivery in a holistic manner that strengthens both. This is discussed further in Section 5 below.

<sup>12</sup> These issues are discussed more fully in the country case studies: Holmes and Villar (2009); Jones et al. (2009); Perezniето and Diallo (2009); Perezniето and Fall (2009); and Villar and Makosso (2009).



## 3.6 SOCIAL PROTECTION STRATEGIES AND POLICIES

Some countries in the region have made attempts to consolidate the social protection programmes currently being implemented (by the state and by non-governmental actors) and to coordinate programmes through social protection policy frameworks. For a number of countries, this has been done through the PRSP, whereas a few have developed national social protection strategies.

An analysis of poverty reduction strategies in the region demonstrates some degree of policy commitment to social protection, but in most cases this has not yet led to the implementation of operational programmes or allocations of resources<sup>13</sup>. Many countries' PRSPs mention social protection or safety nets, but commitments are much more developed in some PRSPs than others. The conceptualisation, objectives and components of social protection are relatively well developed, for example, in the PRSPs in Burkina Faso (2004), Cape Verde (2004 and 2008), Chad (2003), Democratic Republic of Congo (2006), Ghana (2005), Mauritania (2006) and Senegal (2006). In general, however, there is little discussion in these documents on planning, implementation and/or financing strategies.

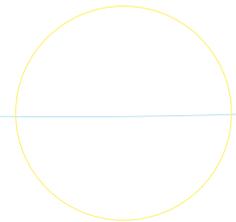
Although social protection is a component in a growing number of PRSPs across the region, only a few countries have prepared national social protection strategies or policies (Box 4).

### Box 4: National social protection strategies and plans - Examples in West and Central Africa

- **Burkina Faso** adopted its National Plan of Social Action in April 2007 and is now drafting a three-year implementation plan.
- **Cape Verde** adopted a National Social Protection Strategy and is about to prepare an operational plan for its implementation. Several components, such as Cape Verde's social pension, predate the strategy.
- The **Democratic Republic of Congo** has adopted a National Strategy for the Social Protection of Vulnerable Groups.
- **Ghana's** National Social Protection Strategy, though not yet formally adopted at the time of writing, has served as the basis for the launch of the LEAP, described above. As already noted, Ghana has also launched the NHIS, which aims to extend insurance coverage to the entire population.
- **Mali's** National Social Protection Policy aims to 'serve as a framework for the realisation of plans, programmes, projects and strategies to guarantee coverage to different categories of population from exposure to a range of risks'. This policy frames the National Health and Social Development Programme, now in its second stage, and includes a strong focus on extending health insurance coverage through the new Compulsory Health Insurance Programme (AMO) and the Medical Assistance Fund (FAM), which support access to health insurance by the poor.
- **Senegal's** National Social Protection Policy aims to extend health insurance to 50% of the population by 2015 and to establish a system to insure rural populations against the risks of natural disasters. The Sesame programme, launched in 2006 with co-financing from IPRES and the government, aims to provide free medical services to all elderly persons over the age of 60.

Sources: Information compiled from national PRSPs (see references for more details).

<sup>13</sup> Annex 1 summarises some of the salient features of the social protection components included in PRSPs. Not all countries are shown in the annex – those without much discussion of social protection have been excluded.



The range and scope of social protection identified in the PRSPs and national social protection strategies and the emphasis on the types of risks and vulnerability (although not often clearly defined) vary significantly across countries. For example, Ghana, Sierra Leone, Burkina Faso, Cameroon and Mali emphasise the importance of addressing social risks, such as social inclusion and exclusion and social marginalisation. Senegal takes a lifecycle approach to risk and vulnerability. Cameroon, the Democratic Republic of Congo, Ghana and Senegal focus on extending social protection to populations engaged in the informal economy. Chad, Senegal and Guinea specifically address the risk of natural disasters. Some countries, such as Senegal, Mali and Ghana, also focus on reducing health-related risks, including the risks associated with HIV and AIDS.

Children are mainly visible in the PRSPs and social protection strategies as part of the 'vulnerable group' category. It is clearly recognised in most countries that children face particularly devastating effects of poverty through lack of access to quality health and education. Importantly, many of the PRSPs focus on the potential for social protection programming to reduce childhood poverty and vulnerability through nutrition, health and education interventions. These programmes form an important part of a child-sensitive social protection strategy. Less well-developed are other potential avenues for social protection to address child-specific risks and vulnerabilities (for example to abuse and exploitation) or to consider the importance of intra-household decision making, resource allocation and power relations for children's well-being.

Many of the PRSPs and social protection strategies themselves offer limited discussion of or commitment to the different types of programmes to be implemented under social protection. In most cases, these fall under the category of social services and to some extent social assistance (such as school feeding programmes) or social insurance, of which health insurance schemes are most prominent. There are few explicit linkages made with social equity measures, such as anti-discrimination legislation. Moreover, as discussed further below, implementation constraints, low funding and low coverage are all challenges to the effective rollout of these programmes.



## 4. REGIONAL AND INTERNATIONAL SUPPORT TO SOCIAL PROTECTION

Renewed attention and commitment to social protection in West and Central Africa at the regional level has recently been spearheaded by support from regional bodies such as the African Union (AU), as well as by some development partners and NGOs.

In 2006, an intergovernmental conference in Livingstone, Zambia, involving 13 African governments, resulted in a commitment (the Livingstone Call for Action) to put social protection on national poverty reduction agendas and in particular to develop costed social transfer plans within three years. In September 2006, the Yaoundé Call for Action was issued at an Africa-wide workshop hosted by the government of Cameroon and supported by the AU. This called on governments to implement the Livingstone Call for Action and to adopt comprehensive social protection programmes for older people with particular emphasis on universal social pensions and the strengthening of national coordination frameworks (AU, 2008).

The AU has followed up both calls for action, notably by sponsoring a series of sub-regional experts meetings on Investing in Social Protection in Africa during 2008 to prepare for the AU's first-ever conference of social development ministers, in Windhoek, Namibia, in October 2008. One of the preparatory sub-regional experts meetings was held in Senegal, Dakar, in June 2008 for West and Central Africa. At the Windhoek meeting, a specific section on social protection was incorporated as a theme into the Social Policy Framework and formally adopted by the ministers. This provides significant leverage to advance the social protection agenda at national level, as AU member states will be called upon to develop financial plans of action for the design and rollout of a minimum package of social protection measures<sup>14</sup>.

Several development partners are also providing support for the formulation of social protection policy and programmes in the region. The World Bank has been assisting several governments in the region to draft national social protection strategies, and has also made social protection a key part of its global response to the recent food price crisis (World Bank, 2008), including in Ghana, where it has provided resources to accelerate the rollout of LEAP. Three UN agencies are also active in this field in the region: UNICEF, which supported the development of the National Social Protection Strategy and the LEAP programme in Ghana; the International Labour Organization (ILO), which has been working with several governments to expand social security coverage; and the WFP, which has begun to experiment with social transfers (particularly in some West African cities) as part of an emergency response to the food price crisis.

Among bilateral donors, the UK government made a commitment to increase resources for social protection in a 2006 White Paper on development aid (DFID, 2006) and has provided support for programme design and capacity building for social protection in Ghana. A number of international NGOs, including Save the Children UK and HelpAge International, have also been supporting pilot cash transfer projects and/or advocating for strengthened social protection systems in some countries.

<sup>14</sup> Personal communication with Anthony Hodges, October 2008





## 5. DESIGN AND IMPLEMENTATION CHALLENGES

While many of the countries in the region have a formal social security system in place, it is clear that these systems benefit only a small percentage of the population and are often only accessible in urban areas where administrative services and banks are mainly located. The challenge in West and Central Africa is to extend social protection coverage to the poor and marginalised through enhanced political commitment, implementation capacity and financial resources.

This section of the paper identifies particular characteristics of the situation in West and Central Africa that have far-reaching implications for the potential scale and nature of social protection programmes in the region. Although conditions across countries are not homogeneous, and in some respects differ widely, the following general contextual factors are particularly important for the design and implementation of social protection programmes: (i) the extensive nature of poverty; (ii) the phenomenon of 'top inequity'; (iii) constraints on fiscal space (with the exception of the oil producers); and (iv) weak governance and administrative capacity, especially in the particularly 'fragile' states.

### 5.1 IMPLICATIONS OF THE EXTENSIVE NATURE OF INCOME POVERTY<sup>15</sup>

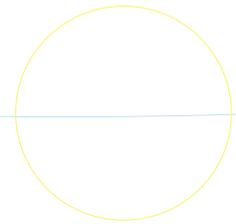
As Hodges (2008d) demonstrates (and as discussed above), one of the most distinctive characteristics of the majority of West and Central African countries is the widespread scale of monetary poverty. National poverty data, based on consumption expenditure measures of absolute poverty (a basket of food and non-food items required for basic survival), show that poverty is not concentrated in a small, marginalised or 'left-behind' part of the population, but is a broad phenomenon, often encompassing the majority of the population. This has clear implications for the design of social protection programmes. The poverty profile is completely different from that in Latin America, for example, where cash transfers have been targeted to reach excluded minorities of poor people. The extent of poverty in West and Central Africa suggests two options:

**Adopting a universal approach:** It makes little sense trying to target 40-70% of the population, especially given administrative weaknesses, exclusion risks and the costs of targeting, so a universal approach would appear to be more appropriate. However, this raises a key question regarding whether a universal approach is politically feasible or affordable.

**Targeting the ultra-poor/destitute:** This is the approach that the small pilot cash transfer programmes have adopted, not only in Ghana and Sierra Leone, but also elsewhere in low-income African countries, including Kenya, Malawi and Zambia. Given tight resource constraints and limited political support for programmes that may be seen as providing 'handouts', all these programmes focus on transferring resources to small numbers of ultra-poor households.

In Ghana, for example, LEAP specifically targets caregivers of OVC (in particular AIDS-related orphans and children with disabilities), persons with severe disabilities (with no productive capacity) and elderly people with no other

<sup>15</sup> This section draws on Hodges (2008a).



means of subsistence support. Sierra Leone's SSN has provided transfers to the aged in particularly difficult circumstances and will be extended to other specific groups, such as separated children (Scott, 2008).

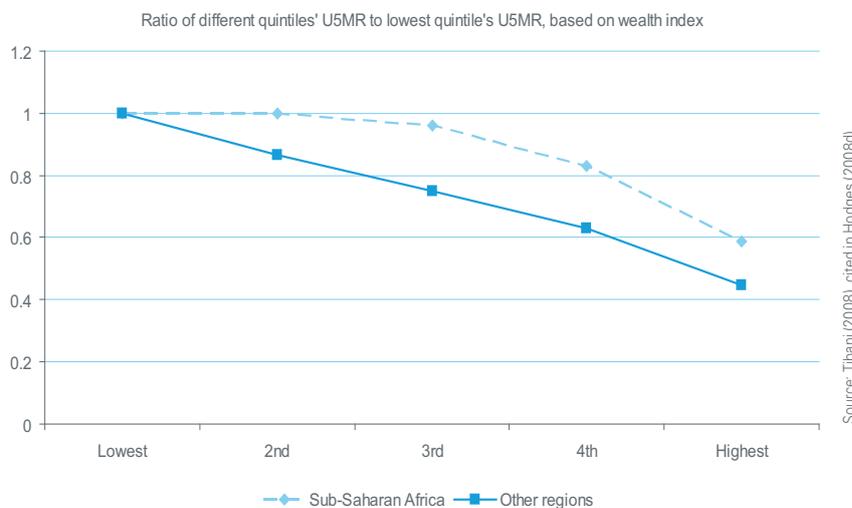
These programmes employ a mix of categorical targeting (to the elderly, disabled and/or OVC) and community-based targeting to identify those meeting the categorical criteria who have no other means of support. Both schemes have also been launched in limited geographical areas. Because they are so new, little is yet known about the effectiveness or efficiency of these new programmes, or in particular about the quality of their targeting methods, which will be an important priority for future research (Hodges, 2008a)<sup>16</sup>.

## 5.2 IMPLICATIONS OF THE PHENOMENON OF 'TOP INEQUITY'<sup>17</sup>

'Top inequity', which is closely related to the extensive nature of poverty, refers to a situation where a small minority is much better off than the broad mass of the population (Hodges, 2008d). This contrasts with a situation of 'bottom inequity' where a small minority is much worse off than the rest of the population. Broadly speaking, West and Central African countries demonstrate top inequity in many key deprivation indicators, since only individuals in the top quintile (based on a wealth or asset index) or at best in the top two quintiles are appreciably better off, while the differences in deprivation are fairly similar for those in the bottom three or four quintiles. This contrasts with the situation in most other regions of the world, as can be seen from Figures 2 and 3.

Figure 2 on child mortality shows the ratio of U5MR in each wealth quintile with the U5MR for the lowest quintile, contrasting sub-Saharan Africa with other regions of the world. As can be seen from the figure, the U5MR in sub-Saharan Africa is almost as high in the second and third quintiles as it is in the lowest quintile – a stark contrast with the situation elsewhere in the world.

**Figure 2: Child mortality by wealth quintile - Africa and the rest of the world**



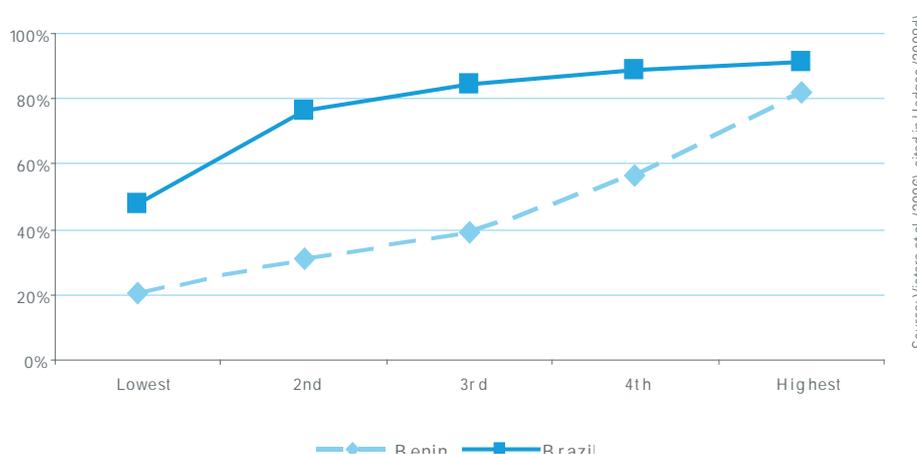
<sup>16</sup> These targeting issues are further explored in the third in this series of regional thematic reports: 'The Potential Role of Cash Transfers in Addressing Childhood Poverty and Vulnerability in West and Central Africa' (Holmes and Barrientos, 2009).

<sup>17</sup> This section draws on Hodges (2008d).



Figure 3 contrasts access of children under five to key health interventions between Benin, a typical West African country, and Brazil. As can be seen, the curve is almost flat in Brazil above the first quintile, where health service deprivations are much worse, whereas in Benin deprivations diminish only gradually between the first and third quintiles and then rise more steeply, especially in the fifth quintile.

**Figure 3: Percentage of under-five children receiving six or more health interventions - Benin and Brazil**



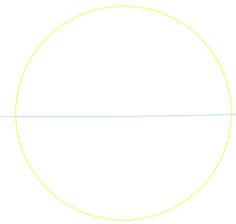
The 'shape of the curve' matters in each of the figures, as it suggests that large proportions of the populations need support in accessing health care and implies that to have a significant impact on children's access to health services and child mortality, it is necessary to focus across the first three to four quintiles. A narrower, more finely targeted approach therefore may not make much sense.

In light of this, there are two main options for countries: first, national health insurance, on the model of Ghana's NHIS; second, tax-based public provision of free or heavily subsidised services. The main concern with the health insurance approach is the equity risk, namely that those in the lower deciles of the population will have difficulty affording the premiums required to participate. This has already led to modifications in Ghana, with an announcement in May 2008 that all children under 18 and all expectant mothers will have access to free medical services, irrespective of whether or not their families are enrolled in the NHIS. Other West and Central African countries have introduced more limited free services, either for children under five or for specific interventions (malaria treatment, caesarean operations, insecticide-treated bed nets, etc)<sup>18</sup>.

### 5.3 FISCAL SPACE FOR SOCIAL PROTECTION

Government expenditure on social protection is extremely low in sub-Saharan Africa in general: an estimated 0.3% of GDP in the case of social assistance programmes, which is far lower than in any other region of the world (World Bank, 2005, cited in Hodges, 2008d). Although data are not readily available, the percentage is probably even lower in West and Central Africa. In Sierra Leone, for example, an estimated 0.1% of GDP was

<sup>18</sup> These issues are discussed in greater depth in Regional Thematic Report 4: 'Social Protection to Promote Maternal and Child Health in West and Central Africa' (Walsh, 2009).



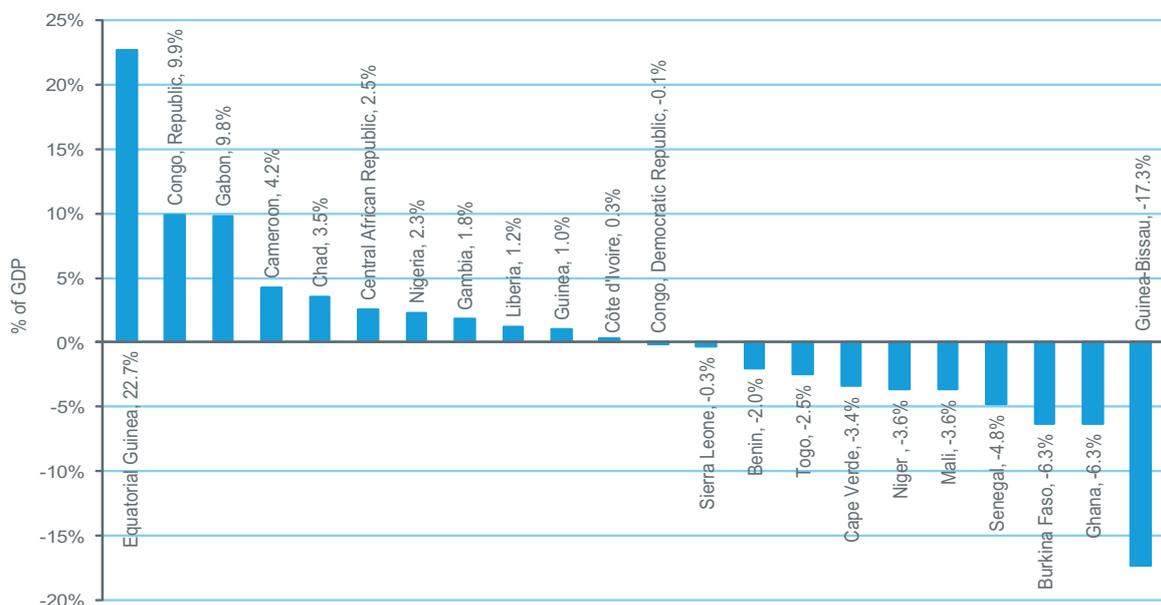
spent on social protection in 2006 (Holmes and Jackson, 2007). Some analysts have argued that targeted cash transfer programmes rarely need cost more than 0.5% of GDP (see, for example, Stewart and Handa, 2008), yet these estimates rarely include the associated costs of cash transfers such as investment in basic services or in infrastructure. Others have argued that a range of basic programmes could be provided for 1.5% to 2.0% of GDP and suggest that this is by and large affordable (Hodges, 2008d).

Such estimates, however, raise a number of questions about affordability. First: how much budgetary room is there to expand or to start spending on social protection in these countries; and second: what is the political commitment to spending on social protection?

When discussing the affordability of social protection it is not always useful to compare expenditure as a percentage of GDP. As Hodges (2008d) notes, levels of GDP (and GDP per capita) vary considerably within a region like West and Central Africa, which has a mix of oil-rich and resource-poor countries. Many countries run persistent overall fiscal deficits and remain heavily aid dependent, whereas a handful of oil-rich countries are enjoying unparalleled surpluses because of soaring world oil prices. Many countries have competing priorities, not just between social protection and basic social services, but with infrastructure and other pressing needs for economic growth, creating difficult choices about trade-offs.

Overall, as Figure 4 shows, there is a big difference between the handful of large oil producers, such as Equatorial Guinea (sub-Saharan Africa's first high-income country) and Congo and Gabon (both middle-income countries) and the rest, such as Burkina Faso, Ghana and Guinea-Bissau (Hodges, 2008d). Oil-rich countries with large populations like Nigeria and Cameroon fall in between.

**Figure 4: Overall fiscal balance in West and Central African countries, including grants, 2007**



Source: IMF (2008), cited in Hodges 2008d



Equatorial Guinea and Congo had overall fiscal surpluses of 23% and 10%, respectively, in 2007 (IMF, 2008, cited in Hodges, 2008d) and therefore appear to have the fiscal space for introducing social protection programmes (Handley, 2009). Indeed, they could afford to introduce quite generous social protection programmes, even considering the risks of future oil revenue downturns and the need to build up reserves for the future and avoid boom-bust cycles (Hodges, 2008d). Social transfer programmes in particular could be particularly attractive as a means of income redistribution (and improved social cohesion) in countries that, because of the capture of oil rents by elites, are especially unequal (ibid). However, the limited political commitment to social expenditure in both countries, but particularly Equatorial Guinea, raises concerns over the political acceptability of committing long-term expenditure to social protection programming.

Ghana, Senegal and Mali, on the other hand, are low-income countries running permanent fiscal deficits and it is much more difficult for them to embark on major new spending programmes, especially as these countries often have competing priorities for basic social service delivery, infrastructure and support to agriculture and other productive sectors. Interestingly, however, it is in these three countries that the political commitment to social protection is highest – and although there are fiscal constraints, all three countries have embarked on national social protection strategies to roll out over the next few years<sup>19</sup>.

## 5.4 GOVERNANCE AND ADMINISTRATIVE CAPACITY

Many countries in the region are characterised by a poor governance environment and low administrative capacity. Out of the 24 countries in the region, 14 are classified as ‘fragile states’ by the World Bank. Corruption is pervasive in many countries, and most score poorly on Transparency International’s Transparency Perceptions Index in 2008: out of 180 countries overall, all but four West and Central African countries are in the bottom 80 and 13 are in the bottom 40<sup>20</sup>.

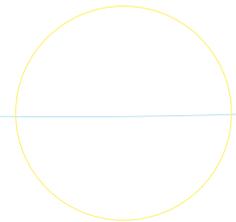
In terms of administrative capacity, the ministries often responsible for social protection are among the weakest, with low levels of funding and relatively little influence vis-à-vis ministries of finance. Social protection programmes are often dispersed across different ministries, such as those responsible for social affairs, social development, social security or the family, women and children, and coordination between and among them is usually weak (Temin, 2008). Moreover, throughout the region, there is a dearth of qualified and experienced social workers for delivering programmes. In short, there are serious capacity constraints for the implementation and scaling-up of social protection programmes in West and Central African countries, as well as institutional risks that could lead to the diversion of resources or the manipulation of eligibility criteria in targeted programmes.

This situation has two major implications. First, it is important to minimise the administrative burden of social protection programmes by avoiding complex programme designs and eligibility processes. Where affordable, universal approaches are more practical and less risky than programmes requiring heavy investments in systems and skilled staff for complex targeting procedures or for monitoring of conditionality.

Second, it is not enough to design and roll out individual programmes without giving due attention to systemic capacity building, including, where necessary, the clarification or rationalisation of organisational mandates,

<sup>19</sup> These issues are discussed more fully in Regional Thematic Report 2: ‘Fiscal Space for Strengthened Social Protection for Children in West and Central Africa’ (Handley, 2009).

<sup>20</sup> [www.transparency.org/policy\\_research/surveys\\_indices/cpi/2008](http://www.transparency.org/policy_research/surveys_indices/cpi/2008)



the strengthening of coordination mechanisms to achieve effective complementarity and synergies, investments in management information and monitoring and evaluation systems and the training, recruitment and motivation of social workers and other necessary staff.

New social protection initiatives in the region are mostly small in scale or pilots. The need for expanded coverage raises important questions about whether the existing formal social security systems can be broadened to reach the poorest, or whether new institutional roles and responsibilities are needed across government to develop new types of social protection programmes. In some countries, ministries responsible for social affairs, gender and children are taking on leading roles in developing new approaches to social protection parallel to the institutions responsible for the existing formal social security systems, which are normally autonomous public bodies, such as the National Social Security and Insurance Trust (NASSIT) in Sierra Leone. Clearly defining and identifying the roles and responsibilities of the ministries involved in social protection would contribute to the effective implementation of social protection systems (Temin, 2008), especially since child-specific risks and vulnerabilities are best addressed through an integrated approach (UNICEF et al., 2008).

These challenges are all the greater because of the multi-sectoral nature of social protection. Several of the PRSPs and national social protection strategies highlight this multi-sectorality. Ghana's PRSP for 2006-2009, for example, states that several government ministries, departments and agencies, as well as civil society organisations (CSOs), will be encouraged to play a strategic role in complementing government's social protection efforts (NDPC, 2005), yet weak interagency linkages, including within government, are one of the most pressing challenges to be tackled as LEAP is scaled up and the National Social Protection Strategy is implemented (see Perezniето and Fall, 2009).

Strong multi-sectoral coordination is critical for expanding child-sensitive social protection, which requires singular leadership, coordinated financing and donor harmonisation. Programming in narrowly defined areas, such as child labour, disability, trafficking or school feeding, without linkages to other sectors is not an effective way to address protection problems (Temin, 2008). Scaling up social protection will need a more comprehensive approach, where different actors work together towards shared objectives.



## 6. CONCLUSIONS

### IMPLICATIONS FOR CHILD-SENSITIVE SOCIAL PROTECTION POLICY AND PROGRAMMING

This paper has sought to provide an overview of existing social protection policy and programming in West and Central Africa in general and to assess in particular the extent to which these address childhood poverty and vulnerability.

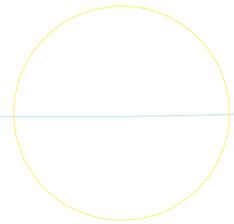
Household and childhood poverty are both extremely high in many of the countries in the region. Children constitute about half of the total population of West and Central Africa and face a range of economic and social risks because of their age and dependency. Deprivations in childhood can have lifecourse consequences, trapping individuals in poverty and contributing to the intergenerational transmission of poverty.

While the region includes a diverse range of economies, politics and environments which have specific implications for the design of social protection programmes, our analysis has identified a number of common characteristics, which pose important challenges for social protection and its implementation. These characteristics include the extensive nature of poverty, the erosion of informal social protection mechanisms as a result of rapid urbanisation and migration, national fiscal resource constraints and institutional and governance challenges.

Some countries in the region have developed national social protection plans and policies; for others, the political commitment to social protection has yet to be established. Even for countries with national social protection policies, the commitment of resources to roll out implementation plans remains a challenge. National social protection programming is still mainly small scale, uncoordinated and with limited monitoring and evaluation systems in place. The majority of social protection programmes – outside the formal contributory social security system – are implemented with significant support from donors and international organisations, including the WFP and international NGOs. In many countries, there is a focus on social protection mechanisms such as health insurance and social assistance in particular. These mechanisms rarely reach more than a fraction of the population, with the important exception of Ghana's national social health insurance scheme.

In many of the countries in the region where social protection has not been on the policy agenda, child-sensitive social protection that addresses both the economic and social risks and vulnerabilities that children face still has a long road ahead, especially given broader political and institutional governance challenges (Jones, 2009). In countries with existing social protection policies and programmes, such as Ghana, Burkina Faso and Senegal, the challenges are around the need to build and support existing capacity to deliver social protection, and in particular to support inter-sectoral coordination to deliver child-sensitive social protection programming.

Ideally, an integrated approach to social protection would address the multiple dimensions of child vulnerability through cushioning the impacts of shocks and stresses on households and reducing chronic poverty, as well as ensuring that child-specific risks are addressed through specialised social welfare services or through linkages with complementary activities such as birth registration. The design of social protection policies aimed at reaching all members of the household – and in particular children – also needs to consider the gendered distribution of power, resources and decision making within households; how women's empowerment can influence and support children's well-being; and how women's time poverty and double burden of reproduction and production affect childcare responsibilities.



An integrated approach means developing comprehensive national social protection strategies rather than piecemeal initiatives, with the subsequent need to support capacity building, especially in ministries that have responsibility for a range of social protection and complementary programmes and services (Hodges, 2008d). Given that institutional capacity is low across the region, an effective social protection system that can address childhood poverty should be built on strong linkages between ministries (such as health, education, social welfare, justice). Institutional capacity constraints and the fragmentation and/or segmentation of programmes in particular ministries present key challenges across the countries in the region. As more and more regional and donor initiatives support commitment to social protection, better coordination between institutions and organisations is needed.

Recommendations for support to emerging social protection initiatives include:

- Assistance in the scale-up and refinement of social protection programmes where they exist, e.g. LEAP in Ghana and the social pensions in Cape Verde;
- Support for the operationalisation of national social protection strategies where these have been prepared or adopted; and
- Encouragement and support to help translate the general commitments to social protection that appear in many PRSPs into a social protection strategy and costed implementation plan for eventual programme design, operationalisation, monitoring and evaluation.

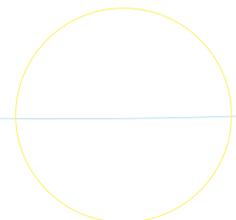
More specifically, our analysis supports the recommendations of UNICEF et al. (2008) which suggest that governments and international development partners can take the following steps to further development and implementation of child-sensitive social protection:

- **Ensure existing social protection policies and programmes are child sensitive:** Review the design and implementation of existing social protection policies and programmes to ensure they are child sensitive.
- **Support progressive realisation:** Set priorities and sequence policy development and implementation to progressively realise a basic social protection package that is accessible to all those in need and is fully child sensitive.
- **Increase available resources:** Governments and development partners alike should seek to improve fiscal space and increase available resources for child-sensitive social protection programmes.
- **Enhance capacity and coordination at all levels:** The design, implementation and evaluation of child-sensitive social protection involve a wide range of development actors. Accordingly, broad efforts are needed to build awareness, political will, capacity and inter-sectoral coordination.
- **Ensure balance and synergies between social protection and complementary services:** Important lessons can be drawn upon from Latin America and South Africa.
- **Continue to build the evidence base on child-sensitive social protection:** Ongoing research, data disaggregation and monitoring and evaluation are needed to enhance understanding of effective programme design and implementation for maximum impact on children (particularly in low-income countries), as well as to document how child-sensitive approaches benefit the wider community and national development.



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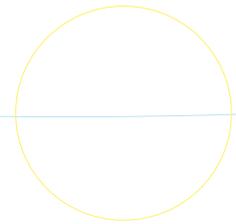
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# ANNEX 1. OVERVIEW OF SOCIAL PROTECTION IN SELECTED PRSPS

## Burkina Faso (2004)

**Objectives:** Pillar 2 - Promoting access to basic social services and social protection by the poor. Social protection is needed to address social risks (including social exclusion) and vulnerability.

**Target groups:** The government is concerned with improving social protection for the whole population, including the poorest citizens. Additional efforts will primarily target safety nets at groups that are marginalised and at risk.

**Programmes/strategies:** Includes health insurance.

## Cameroon (2003)

**Objectives:** Social protection strategy aims to create an institutional, legal and regulatory framework guaranteeing rights and social protection to vulnerable groups to mitigate inequalities and exclusion.

**Target groups:** Extension of social protection to the informal sector, rural dwellers and self-employed professionals, tradesmen and artisans.

**Programmes/strategies:** Activities include: (i) finalise the draft law relative to the social protection of children; (ii) help cover the cost of treatments by instituting a health risk-sharing system through the development of health mutual benefit associations; (iii) improve existing benefits, notably pensions, family allowances and professional risks.

## Cape Verde (2004)

**Objectives:** Pillar 4 - Income distribution and social protection policy. Aim is to contribute to the protection and improvement of living conditions of the poor and the excluded. Social protection is an income redistribution tool to guarantee social equity, justice and cohesion. Strategic objectives include formulating a strategy of social protection with a new approach based on the management of social risk.

**Target groups:** To include support to families, mainly women heads of households; the elderly; the disabled; children; and pre-school children.

**Programmes/strategies:** Includes school feeding programmes, subsidies.

## Chad (2003)

**Objectives:** Aim of social protection is to lessen vulnerability, to reduce excessive inequality and disparities between social strata and to mitigate possible negative impact of social and economic policy decisions and choices or of social unrest. Vulnerable groups at greater risk than others have insufficient capacity to cope with life's hazards, income shocks or a sharp decline in living standards.

**Target groups:** Vulnerable groups including widows, divorcees, single mothers and children needing special protection.

**Programmes/strategies:** Social protection may be institutional (laws, regulations) and/or programmes and projects. A comprehensive strategy should be based on three types of interventions: prevention, foresight and interventions.

## Congo, Democratic Republic (2007)

**Objectives:** National Social Protection Support Programme was developed in October 2005. Key policy objectives in the social protection sector are to: (i) improve the social standing of vulnerable persons; (ii) facilitate access of all to basic social services; (iii) implement wealth creation programmes adapted to the situations of the various target groups; and (iv) promote development at the grassroots level.

**Target groups:** Vulnerable groups, including women and children.

**Programmes/strategies:** In particular, social protection actions for vulnerable women and children include: (i) protection of child victims of the conflict and HIV/AIDS; (ii) reintegration of vulnerable children into formal or non-formal education channels; (iii) support for the food and nutritional needs of families with vulnerable children; (iv) targeted support for children with life-threatening disabilities and for their education.



### **Congo, Republic (2005)**

**Objectives:** The third pillar of the Interim PRSP is to improve access to basic services and social protection.

**Target groups:** Women, victims of the conflict, disabled persons and minorities.

**Programmes/strategies:** Legal and socioeconomic protection of women and unwed mothers; socioeconomic rehabilitation of victims, displaced persons and former combatants; socioeconomic rehabilitation of disabled persons and minorities; communities and families to care for vulnerable groups; pension reforms.

### **Côte d'Ivoire (2002)**

**Objectives:** To improve the living conditions of disabled and vulnerable people (women, elderly) and to ensure integrated coverage of infants in disadvantaged districts.

**Target groups:** Coverage of vulnerable groups – women, children, disabled, elderly, notably the poorest.

**Programmes/strategies:** Strategies include: (i) intensifying information, education and communication in order to prevent and avoid the worsening of marginalisation of the disabled and children in difficult situations; (ii) the creation of a fund for training of young people over 18 and their establishment in informal sector activities; (iii) insertion and reintegration programme for street children, orphans and babies in families; (iv) reintegration programme for former prisoners; (v) promotion and development of community activities; (vi) promotion of universal health insurance so that all may have access to health care, notably the poor.

### **Ghana (2005)**

**Objectives:** Social protection aim is to empower the vulnerable and excluded, especially women, to contribute to and share in the benefits of growth of the economy, thus ensuring sustained poverty reduction and growth.

**Target groups:** Children, unemployed youth, women, persons with disabilities and the elderly.

**Programmes/strategies:** Social protection will promote conditional and unconditional cash transfer systems and other support to displaced workers while they seek employment and pregnant and lactating women, and provide target subsidies to the elderly, pensioners, smallholder farmers and people with disabilities. The strategy will also expand coverage of the school feeding programme and facilitate access to microcredit for small-scale informal operators. NHIS (fee waivers).

### **Guinea (2007)**

**Objectives:** The national policy on population includes progressively expanding social protection for all. Rapid growth also requires an adequate supply of basic services.

**Target groups:** Vulnerable individuals – the disabled, displaced, women, children and the elderly.

**Programmes/strategies:** Extend social protection to the entire population and to all workers in particular; promote mutual associations; establish social funds for vulnerable groups.

### **Guinea-Bissau (2006)**

**Objectives:** Improve the social protection of vulnerable groups.

**Target groups:** War veterans and senior citizens.

**Programmes/strategies:** Promote the socioeconomic integration of vulnerable groups.

### **Mali (2002)**

**Objectives:** Pillar 2 - Human development and strengthening access to basic social services, includes access to social protection.

**Target groups:** Includes street children, the elderly and female-headed households.

**Programmes/strategies:** Priorities include improving the information system; strengthening risk prevention; developing welfare benefits in light of risks; strengthening appeals procedures and rationalising the advocacy system; specific initiatives aimed at target groups.



### **Mauritania (2006)**

**Objectives:** National Social Protection Strategy that fully takes into account the multidimensional nature of poverty and combats social marginalisation.

**Target groups:** Includes persons who are not necessarily poor, but whose income level does not enable them to cope with exceptional situations (accidents, serious health problems, job loss, etc.) or even foreseeable circumstances (retirement, old age, etc.), e.g. the disabled, children at risk, female heads of household, the elderly.

**Programmes/strategies:** Main strategies include (i) improve medical care and education for vulnerable groups and offer them an environment conducive to their integration and socioeconomic development; (ii) evaluate and revise the existing legal framework in order to orient it more towards the promotion and protection of the rights of all these vulnerable groups; (iii) develop suitably adapted decentralised infrastructures; (iv) strengthen coordination between the various sectors involved in social action; (v) enhance the capacities of the de-concentrated social action units; (vi) strengthen and supplement experiments aimed at creating mutual associations for medical coverage.

### **Nigeria (2004)**

**Objectives:** Social protection consists of interventions aimed at safeguarding the poor from becoming poorer and the non-poor from becoming poor.

**Target groups:** Vulnerable groups, including children.

**Programmes/strategies:** Providing safety nets for vulnerable groups, including children. Creation of a national health insurance scheme.

### **Senegal (2006)**

**Objectives:** Pillar 3 - 'Social protection, risk and disaster prevention and management' aims to support management of (natural and economic) risks and disasters.

**Target groups:** Vulnerable groups, including the disabled, women in vulnerable situations, children at risk, youths, non-traditional workers, refugees and repatriated persons, the elderly, persons living with chronic diseases and displaced persons.

**Programmes/strategies:** (i) Reform and strengthening of the formal social security systems; (ii) extension of social protection; (iii) prevention and management of major risks and disasters; and (iv) social protection of vulnerable groups. Establish a health risk protection system for vulnerable persons and social insurance systems for persons engaged in agriculture and the informal sector.

### **Sierra Leone (2005)**

**Objectives:** Formulation and implementation of a national social protection policy for vulnerable citizens.

**Target groups:** Vulnerable citizens.

**Programmes/strategies:** Expansion of school feeding and food-for-work programmes.



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