Rapid appraisal of social inclusion policies in selected sub-Saharan African countries

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
AU	African Union
BEAM	Basic Education Assistance Programme (Zimbabwe)
CAP	Capacity Acquisition Programme (Nigeria)
CBO	community-based organisation
CCT	conditional cash transfer
CEDC	children in especially difficult circumstances
CJSS	Community Junior Secondary School
CODESRIA	Council for the Development of Education and Social Research in Africa
CSDH	Commission on Social Determinants of Health
CSG	Child Support Grant
CSO	civil society organisation
DfID	Department for International Development (United Kingdom)
DOH	Department of Health
DSD	Department of Social Development
DS	direct support
DSS	direct support services
EDMS	essential drugs and medical supplies
EFA	Education for All (Botswana)
EP1	EnsinoPrimário do Primeiro Grau (Grades 1 through 5, Mozambique)
EP2	EnsinoPrimário do Primeiro Grau (Grades 6 through 7, Mozambique)
ESPP	Enhanced Social Protection Project
EU	European Union
FCT	Federal Capital Territory
FSP	Food Security Programme
GAPVU	Gabinete de Apoio a População Vulnerável (Mozambique)
GDP	gross domestic product
GNP	gross national product
GPG	Gauteng Provincial Government (South Africa)
HDI	Human Development Index
HDR	Human Development Report
HIV	Human Immuno-deficiency Virus
HSRC	Human Sciences Research Council (South Africa)
HST	Health Systems Trust
ID	identity document
IILS	International Institute for Labour Studies
ILO	International Labour Organisation
IMF	International Monetary Fund
INAS	Instituto Nacional de Acção Social (Mozambique)
INE	Instituto Nacional de Estatistica (Mozambique)
IPC	International Poverty Centre
IRIF	Inter-Regional Inequality Facility
KN	knowledge network
KRA	key responsibility area
LEDCs	less economically developed countries
MDG(s)	Millennium Development Goals
MMCAS	Ministry of the Coordination of Social Action, including Women Affairs (Mozambique)
MoARD	Ministry of Agriculture and Rural Development (Ethiopia)
MoE	Ministry of Education

MoH	Ministry of Health
NAPEC	National Poverty Eradication Council Nigeria
NAPEP	National Poverty Eradication Programme Nigeria
NEPAD	New Economic Partnership for Africa's Development
NGO	non-governmental organisation
NRDCS	National Resources Development and Conservation Scheme
OAU	Organisation for African Unity
PARPA	Mozambique Action Plan for the Reduction of Absolute Poverty
PHC	primary healthcare
PLWHA	people living with HIV and AIDS
PRSP	Poverty Reduction Strategy Process
PSIA	Poverty and Social Impact Analysis
PSNP	Productive Safety Net Programme (Ethiopia)
PW	public works
RHVP	Regional Hunger and Vulnerability Programme.
RIDS	Rural Infrastructure Development Scheme
RSA	Republic of South Africa
SADC	Southern African Development Community
SADHS	South African Demographic and Health Survey
SASSA	South African Social Security Agency
SD	social determinants
SDH	social determinants of health
SEKN	Social Exclusion Knowledge Network
SIPO	Strategic Indicative Plan for the Organ on Politics, Defence and Security Cooperation
SON	State of the Nation
SOWESS	Social Welfare Services Scheme
SPS	Social Protection Strategy
SSA	sub-Saharan Africa
StatsSA	Statistics South Africa
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
WDR	World Development Report
WHO	World Health Organization
YES	Youth Empowerment Scheme

EXECUTIVE SUMMARY

The World Health Organization (WHO) has established a Commission on Social Determinants of Health (CSDH) to support countries and global health partners in addressing the social factors leading to ill-health and health inequities. The Commission's most important objective is to leverage policy change by turning existing social determinants of health (SDH) public health knowledge into actionable global and national agendas. The Social Exclusion Knowledge Network (SEKN) was established as part of the work of the Commission. Its scope is to identify and examine the relational processes excluding particular groups of people in different contexts from engaging fully in community and social life.

The work of the SEKN in the sub-regional hub has consisted of the following strands:

- A literature review on social exclusion and proxy concepts of marginalisation, vulnerability and poverty, and the associations between exclusionary processes and health and social disadvantage. The literature included published and unpublished documents, with a particular focus on sub-Saharan Africa (SSA).
- Analysis of key documents of the African Union (AU), the Southern African Development Community (SADC) and the South African president's State of the Nation (SON) addresses 1994–2007.
- Contacting more than 30 key informants in African countries, requesting assistance with the project and information on social exclusion/inclusion.
- An appraisal of policies and actions aimed at addressing the relational processes generating social exclusion, and health and social disadvantage. These include action by international agencies, national and local governments, non-governmental organisations (NGOs), civil society in general, and excluded groups in particular.
- A South African country case study to: assess the current impact of exclusionary social processes on key social determinants of health; describe the nature and impact of policies, programmes and/or institutional arrangements aimed at addressing exclusionary processes; and provide a systems-level analysis at national level of processes and factors enabling and/or constraining the implementation and scaling up of policies, programmes and/or institutional arrangements that have the potential to reduce social exclusion and ultimately reduce health inequalities.

This document summarises policy and action appraisals conducted as part of the work of the SEKN in the SSA regional hub. The aim of this component was to identify and appraise examples of policies, programmes, actions and institutional arrangements that have the potential to address exclusionary processes and reduce health inequalities.

The report is divided into the following chapters:

Chapter 1 summarises the social exclusion debates, based on a limited review in SSA, and makes reference to the global debates on social exclusion. The review shows that much of the social exclusion literature is concerned with more developed countries, and that in SSA the discourse has been about poverty, marginalisation and vulnerability. The social exclusion discourse and concept has spread from the north to the south, mainly through the efforts of United Nations (UN) agencies such as the International Labour Organisation (ILO) and United Nations Development Programme (UNDP). The application of the North American and Western European concepts of exclusion in SSA is problematic for several reasons. Poverty affects the majority of people in SSA, and if 'the excluded' is used as a synonym for the poor, or those outside the formal economy, the majority in SSA are 'excluded'. Given Africa's colonial past, the dominant analytical

concepts used have been diametrically opposed to any notion of exclusion and the major aim of African liberation and nationalism was to end this exclusion.

Despite these limitations, the notion of social exclusion appears increasingly in declarations on the 'developmental state' and in action programmes to address poverty. Similarly, in post-apartheid South Africa, redress and a focus on poverty has occupied the agenda of policy-makers in government. Nevertheless, there is an increasing academic focus on social exclusion and the notion of adverse inclusion. These concepts are applied in studies on poverty, livelihoods, the education sector, spatial dynamics in large cities such as Johannesburg, HIV and AIDS stigma, and the analysis of social movements.

Chapter 2 gives a synopsis of SSA and summarises available baseline indicators of the scale of inequality. Africa is rich in mineral resources. Its people and cultures are as diverse as its geography. Although nearly 70 per cent of Africa's people still live in rural areas and urbanisation in African countries continues to grow, more so than on any other continent. SSA is the world's poorest region, with half its people living on less than $1 per day. New global poverty estimates produced by the International Poverty Centre (IPC) show that during the 1990s, both the average income of the SSA region and the percentage of the people living below the $1 poverty line scarcely changed over the decade. A combination of economic and social policies is needed to reach the millennium development goals (MDGs) by 2015. We show the human development index (HDI) and other key indicators for a selection of SSA countries that constitute the focus of the policy appraisal.

Chapters 3 and 4 present an appraisal of selected policies and actions identified for the following countries:

- Southern Africa: Botswana, Mozambique and South Africa;
- East Africa: Ethiopia; and
- West Africa: Nigeria.

The focus of the rapid policy appraisal was on a donor-initiated project designed to reduce teenage pregnancies (Botswana); the provision of free health and education services (Mozambique, South Africa and Zimbabwe); cash transfers (Mozambique, South Africa and Ethiopia); and two policies focused on integrating and coordinating government activities for maximum impact (South African provincial government and Nigeria).

Botswana

Reducing social exclusion of teenage mothers

The Botswana Diphalana project, which aimed to reduce teen pregnancies and reduce the social exclusion suffered by teenage mothers, was only partially implemented. The five-year waiver, which allowed pregnant girls to remain at school until late in their pregnancy, and return to the same school soon after the end of pregnancy, was enacted for a pilot school. Available information suggests that most girls with babies returned to school and their achievement was approximately at the level they would have attained without their pregnancy leave. Although a community day care centre was established in conjunction with the pilot school, students' babies were not enrolled in the community day care centre. The school guidance and counselling component, dealing with student reproductive health needs and related sensitisation efforts of students, teachers, parents, and the community, was judged by the Botswana Ministry of Education (MoE) to be inappropriate, and was stopped.

The programme was hampered by the fact that it was seen as a donor-driven initiative, with insufficient buy-in from the Ministry and the local community. In addition, cultural aspects were not taken into account in programme design and implementation.

Mozambique

Targeted cash transfer

In Mozambique, various studies have demonstrated the effectiveness of the Targeted Cash Transfer programme in addressing the needs of poor urban people, and in reaching the majority of those targeted by the programme. It was also found that there was rapid growth in the number of beneficiaries, an important safety net for urban Mozambicans, as well as good general coverage. However, rural coverage and the impact of cash programmes on the rural poor remain critical outstanding questions. In addition, uneven regional implementation of the programme, uneven administrative capacity across regions, leakage to the non-poor and the substantial latent costs of enforcing means testing were some of the challenges experienced.

Free primary schooling

Primary school education fees were abolished in Mozambique in 2005. The study on the impact of school fees provided empirical input to the MoE Strategic Plan 2005–2009 policies and budgets and was used to revise the gender strategy of the Ministry. It also facilitated gender discussions and led to a request for a similar study in secondary schools. It is not clear, however, whether additional budgetary allocations to cover the shortfall in school-generated revenue, which was previously financed by households, will be covered by other means. The same is true for school supplies, textbooks, school uniforms and other miscellaneous items. The initial impact of the abolition of primary school fees has not been formally evaluated. The extent to which students will remain in the system until completion will also depend on households' ability to meet additional expenses to cover school supplies, uniforms and textbooks; or on an extraordinary effort from the government to increase public expenditure to cover these expenses. A follow-up study is needed to evaluate the impact of the policy change, and to determine its impact in eliminating school fees without providing additional financing to offset forgone school revenue.

South Africa

Free healthcare

The Free Health Care Policy in South Africa – health services rendered free at the point of contact at public sector clinics, community health centres and hospitals – commenced in 1994, and remains in force. Free healthcare services include primary healthcare (PHC) to children under 14 years, pregnant women, pensioners, the formally unemployed, those receiving social grants and people with disabilities. Poor people are less likely to have private health insurance or to be able to afford the costs of ill-health. The Free Health Care Policy has been effective in removing barriers to access and has resulted in increased service utilisation. There is general support by health-service users for the policy and access to healthcare has improved, especially for people living in rural areas, informal settlements and on white-owned farms. While many gains have been made in improving the quality of and access to healthcare for children, gaps remain in the delivery of health promotion and disease prevention for children. Implementation challenges include an inability to cope with the extra demand at health facilities and the aggravation of a number of existing problems within the health services, such as poor working conditions, low pay, shortage of medicine,

overcrowding and poor staff morale. A review has also found inappropriate use of hospital services by patients bypassing clinics, and health-worker dissatisfaction due to inadequate involvement by health authorities.

Support grants

The provision of social grants is the South African government's biggest poverty relief programme, with annual cash transfers in the region of R62 billion ($8.85 billion) to almost 11 million South Africans. These include old-age pensions and war-veteran pensions, and child support, disability, care dependency and foster care grants. The policy appraisal focuses on the following three types of grants: the child support grant (CSG), the foster care grant and the care dependency grant. The grants themselves are either paid in cash at specified pay points, or deposited directly into a beneficiary's bank account.

The number of beneficiaries of the CSG has been rising rapidly. In 2006, the number of recipients had increased to almost seven million children. According to research conducted, South Africa's social assistance programme is helping to reduce poverty, contributing to social cohesion and having a positive impact on the economic opportunities of households. In addition, social grants provide households with income, and support second-order effects that further reduce poverty. In particular, households that receive social grants are more likely to send young children to school, provide better nutrition for children, and have members looking for work more intensively, extensively and successfully than do workers in comparable households without social grants.

It was also found that the provision of grants contributes to an increase in the number of children enrolling at schools; while living in a household that receives grants is correlated with a higher success rate in finding employment. At the macro-economic level, the social grants programme tends to increase domestic employment while promoting a more equal distribution of wealth.

The implementation and administration of social grants was initially devolved to the provinces, but a government review identified a number of problems, including fraudulent grants, delays in approving and paying grant applications, and difficulties in accessing payment, with great inequity across provinces. Consequently, in 2004 the South African Social Security Agency (SASSA) was established to implement and administer social grants. There have also been allegations that the CSG has perverse incentives, one of which is to encourage women to have more children, especially teenagers. The findings on this matter are inconclusive and a formal study has been commissioned. Studies have demonstrated the effectiveness of the various types of grants addressing the needs of vulnerable children and reducing poverty. Relatively little is known, however, about the link between government social grants and the private social safety net, or about the differential impacts of social grants by gender and by geographical areas, or their effects on health or labour migration. The use of a means test may act as a significant barrier to a greater take-up of social grants among poor households. This is particularly true in the poorest rural areas, where the poor have the least access to the official identification documents necessary to access social grants.

A pro-poor children's policy

The review of the Bana Pele (children first) policy appraisal in Gauteng province, South Africa, found that the programme is conceptualised as a pro-poor, comprehensive and integrated package of free services aimed at vulnerable children. It includes access to the

various child support grants, free PHC services at clinics and hospitals, free school uniforms for school-fee exemptions and the school feeding scheme and scholar transport. Almost two million children are benefiting from the Bana Pele programme. Implementation is the major challenge, and relates to a lack of capacity, insufficient resources, the duplication of effort and insufficient funding. The intention of the programme was to develop a uniform electronic information system that would enable seamless referral across social sector departments (social assistance, education and health). To a large extent, implementation has been paper-based. At the time of appraisal, a formal impact assessment of the programme had not been done. Many of the indicators are output-focused (number of beneficiaries), rather than impact-focused (reduction in vulnerability).

Zimbabwe

Basic Education Assistance Programme (BEAM)

Zimbabwe's BEAM was launched in January 2001 as one component of the Enhanced Social Protection Project (ESPP). BEAM's main development objective is to prevent irreversible welfare losses for poor households who resort to extreme coping mechanisms, like withdrawing children from school, in response to increasing poverty. It is a national school-fee assistance programme targeting vulnerable children of school-going age. In 2005, BEAM assisted close to one million pupils, representing 27 per cent of enrolments. In 2006 the budget was Z$414 billion to assist an estimated 905 724 pupils. Some weaknesses include the facts that children could not be sponsored or supported at mid-year when there was a rampant increase of school fees, and the targeting or selection of children.

Ethiopia

Productive Safety Nets Programme (PSNP)

The development objective of Ethiopia's PSNP is to move from a relief-oriented to a development-oriented safety net by providing predictable, multi-annual resources, replacing food with cash transfers as the grant's primary medium, and making resources available for critical capital, technical assistance and administrative costs.

The PSNP consists of labour-intensive public works, in the form of grants to households whose adults participate in public works sub-projects, as well as direct support grants to households who are labour-poor and cannot undertake public works. Beneficiaries include, but are not limited to, orphans, pregnant and lactating mothers, elderly households, other labour-poor, high-risk households with sick individuals (such as people living with HIV and AIDS), and the majority of female-headed households with young children. In a review of the programme, it was found that several important changes have taken place in study areas in terms of nutrition. PSNP is also playing a key role in allowing people to feel secure enough in their income to take productive loans, which they previously found too risky. This indirectly enhances the asset-building role of the PSNP.

The challenges relate to programme design, improving gender aspects of the programme, including women's participation, revising the implementation guidelines and improving monitoring and supervision.

Nigeria

National Poverty Eradication Programme (NAPEP)

NAPEP is not a sector project implementation agency, but a coordination facility to ensure that the core poverty eradication ministries are effective. It commenced in 2002. NAPEP's overall aim was to spearhead the government's ambitious programme for eradicating absolute poverty in Nigeria. Absolute poverty was defined as a condition in which a person or group of persons are unable to satisfy their most basic requirements for survival in terms of food, clothing, shelter, health, transport, education and recreation. NAPEP has established structures at all levels nationwide and has trained 140 000 unemployed youth. A total of 50 000 unemployed graduates have also benefited from NAPEP's Mandatory Attachment Programme. Some reviews have noted that the impact of various programmes has not contributed significantly to the well-being of the poor, that community participation was inadequate and that the awareness of the programme was much higher among the educated elite than among illiterate people.

The concluding chapter summarises the main lessons from the rapid policy appraisal. Overall, the factors enabling policy implementation include international, national and local action. Among these factors are research evidence; political and economic support; community support; advocacy and lobbying; public consultation and debate about policy and programmes; the ability to enforce policies through legislation; and a functioning accountability system.

The main barriers identified to policy implementation were wide-ranging, and included political and fiscal constraints, a lack of skills and human resources, the attitudes of public servants, vested interests, misuse or default by consumers and an inadequate policy communication strategy.

In general, there is inadequate monitoring of policy implementation, either because of a lack of baseline data or because of problems with indicators and the measurement of input, process, output and impact. There has, however, been increasing emphasis on improving governmental monitoring and evaluation capacity and defining indicators upfront (as in the case of the Ethiopian programme).

Recommendations

The main recommendations emanating from the policy appraisal are summarised below.

- Initiate a process to measure health inequalities and advocate the revival of a strong global movement to address health inequalities, with a focus on poor and vulnerable people.
- Build strong public service systems that guarantee universal access to social services (e.g. healthcare and education). Such public services must support and empower women and girls and build an ethos where staff are involved and encouraged to take pride in their contribution.
- Facilitate the participation of civil society in local and national planning, budget and implementation processes, and ensure that they have oversight of service delivery.
- Strengthen monitoring and evaluation of programmes and services, identify outcome indicators and ensure that baseline indicators are measured.

Figure 1: African countries included in the appraisal of social inclusion policies

CHAPTER 1

Social exclusion

Background

In 2005, the WHO established the Commission on Social Determinants of Health (CSDH) to draw attention to and stimulate action around the social factors leading to ill-health and health inequities at global, regional, national, and local levels (WHO 2006). Various knowledge networks (KNs) have been established as part of the work of the Commission to synthesise and consolidate existing knowledge on the social determinants of health and to inform the CSDH and decision-makers of opportunities for improved action.

The SEKN is one of nine such networks set up by the Commission in 2006. The scope of the SEKN was to identify and examine the relational processes excluding particular groups of people in different contexts from engaging fully in community and social life (Popay et al. 2006). These processes may operate at the macro level (access to affordable education, equal employment opportunity, legislation, cultural and gender norms) and/or micro levels (income, occupational status and social networks).

The work of the SEKN in the sub-regional hub has consisted of the following strands:

- A literature review on social exclusion and proxy concepts of marginalisation, vulnerability and poverty, and the associations between exclusionary processes and health and social disadvantage. The literature included published and unpublished documents, with a particular focus on SSA.
- Analysis of key documents of the AU, SADC and the South African President's State of the Nation (SON) addresses 1994–2007.
- Contacting more than 30 key informants in African countries, requesting assistance with the project and information of social exclusion/inclusion.
- An appraisal of policies and actions aimed at addressing the relational processes generating social exclusion, and health and social disadvantage. These include action by international agencies, national and local governments, NGOs, civil society in general and excluded groups in particular.
- A South African country case study to: assess the current impact of exclusionary social processes on key social determinants of health; describe the nature and impact of policies, programmes and/or institutional arrangements aimed at addressing exclusionary processes; and provide a systems-level analysis at national level of processes and factors enabling and/or constraining the implementation and scaling up of policies, programmes and/or institutional arrangements that have the potential to reduce social exclusion and ultimately reduce health inequalities.

This publication summarises policy and action appraisals conducted as part of the work done for the SEKN. The project was constrained by time limitations and numerous competing priorities. The appraisal of policies in countries other than South Africa and Mozambique was done through a literature review. In South Africa and Mozambique the policy appraisal was complemented by interviews with key informants and the authors' personal knowledge of the countries. Hence, the review shows a bias towards policies and actions in southern Africa.

The review shows that the social exclusion discourse has been debated much more extensively in the north and an alternative discourse of poverty, marginalisation and

vulnerability appears to be more relevant or to have received much more attention in SSA. There was insufficient time to explore these alternative discourses. These limitations should be borne in mind when reading this report.

This chapter continues with a summary of the social exclusion debates, based on a limited review in SSA, with reference to the global debates on social exclusion, while Chapter 2 gives a synopsis of SSA, and summarises available baseline indicators of the scale of inequality. Chapters 3 and 4 present an appraisal of selected policies and actions identified for the following countries:

- Southern Africa: Botswana, Mozambique, South Africa and Zimbabwe.
- East Africa: Ethiopia.
- West Africa: Nigeria.

The concluding chapter highlights key lessons arising from the policy appraisal, and includes some recommendations.

Social exclusion discourse

There is a substantial body of literature from diverse disciplines, at times representing conflicting paradigms, exploring the discourse on social exclusion since it was popularised by Rene Lenoir, the French Secretary of State for Social Action in 1974 (Carr & Chen 2004; Clert 1999; De Haan 2000; Estivill 2003; Gore 1994; Sayed et al. 2003; Sen 2000). Processes of exclusion have also been used to analyse changes in post-industrial societies, while Myrdal's concept of the 'underclass' in North America has received renewed attention through the work of Wilson (Silver quoted in Gore 1994: 3–4).

Much of the social exclusion literature is concerned with more developed countries. Despite the voluminous research-based literature on social exclusion in the last two decades, the concept remains problematic and contested (Popay et al. 2006). Furthermore, social exclusion research and policies to address social exclusion often fail to define these meanings explicitly (Mathieson & Popay 2007). De Haan (2000) has argued that understandings of social exclusion or inclusion are socially constructed and rooted in specific contexts.

Silver's proposed paradigm classification schema of solidarity, specialisation and monopoly is one way of highlighting the contrasting approaches to, and different interpretations of, social exclusion (Silver 1994: 539). The solidarity paradigm is rooted in French thinking about the relationship between members of society and the nation-state, and is influenced by the discourse on social policy and assistance. Exclusion is seen as 'the rupture of social bonds between the individual and society' (De Haan 2000 quoted in Sayed et al. 2003: 235). The specialisation paradigm is informed by individual liberalism, dominant in the USA, and here exclusion reflects 'discrimination, the drawing of group distinctions that denies individuals' full access to, or participation in, exchange or interaction' (De Haan in Sayed et al. 2003: 235). The monopoly paradigm is influenced by the Weberian notion of 'social closure': a 'process by which social collectives seek to maximise rewards by restricting access to a limited number of eligibles' (Parkin in Gore 1994: 12). This social closure process aims to monopolise opportunities and involves the use of social or physical attributes, such as race, language, ethnicity and religion, as the justification for exclusion (Parkin in Gore 1994: 12).

The most common definitions of social exclusion include 'indiscriminate' lists of problems and processes describing the groups of people at risk of being excluded; the resources and/or opportunities people are excluded from; the resultant range of social, economic, political and health-related problems; different levels at which exclusion processes operate; and – perhaps less frequently – the types of processes excluding groups of people in different contexts (Popay et al. 2006). Silver suggests that, by 1994, the list of things people might be excluded from included:

> …a livelihood; secure, permanent employment; earnings; property, credit, or land; housing; minimal or prevailing consumption levels; education, skills, and cultural capital; the welfare state; citizenship and legal equality; democratic participation; public goods; the nation or the dominant race; family and sociability; humanity, respect, fulfilment and understanding. (Silver 1994: 541)

Sen (2000) has argued that the concept of social exclusion is potentially useful to our understanding of poverty and deprivation by placing it within the context of the extensive and long-standing literature on 'capability deprivation'; that is, poverty seen as the lack of capability to live a minimally decent life. Others have argued for the recognition of social exclusion as a multidimensional, dynamic and relational concept, depriving individuals, families, groups and neighbourhoods of the resources required for participation in the social, economic and political activity of society as a whole (Estivill 2003; Mathieson & Popay 2007). The importance of social and economic inclusion as a way of thinking and planning in Canada has led to the production of *An Inclusion Lens*, a workbook that describes elements of inclusion and exclusion along eight dimensions; namely cultural, economic, functional, participatory, physical, political, structural and relational (Shookner 2002).

In the last two decades, the idea of social exclusion has been taken up enthusiastically across the European Union (EU) and in North America. In the UK, the term was first adopted by the Conservative government in a political climate where 'poverty' was not officially recognised, and since 1997 has become integral to New Labour Party's political discourse (Mathieson & Popay 2007). In Canada, the Laidlaw Foundation papers stimulated interest in adapting social and economic inclusion in Canada, leading to two significant initiatives: Closing the Distance, a project of the Social Planning Network of Ontario, and Inclusive Cities Canada, a project of the Federation of Canadian Municipalities (Ontario Prevention Clearinghouse et al. 2007).

The UNDP and the ILO have made a major contribution to understanding social exclusion in both developed and less economically developed countries (LEDC) through several conceptual and empirical studies and policy forums. Country case studies funded by the UNDP point to the significance of fundamental civil and social rights, as well as to political rights (Gore & Figueiredo 1997). The UNDP continues to advocate a human-rights-based approach to the eradication of social exclusion (UNDP 2006a).

The political use of the term 'social exclusion' beyond the European context was discussed at a policy forum on social exclusion organised by the ILO's International Institute for Labour Studies (IILS) in 1996. The meeting noted the importance of not using social exclusion as a label for blaming poor people, but harnessing on the potential of using the concept to enhance our understanding of the politics of growth (Gore & Figueiredo 1997: 44).

Various reasons have been advanced for the ascendancy of the social exclusion concept in political, policy and academic discourse (Mathieson & Popay 2007). Silver notes: 'In symbolic politics, the power to name a social problem has vast implications for the policies considered suitable to address it' (1994: 533). Further, 'the discourse of exclusion may serve as a window through which to view political cultures' (Silver 1994: 536). Some have pointed out that the concept of social exclusion in Europe has had great value in improving the conceptual framework, which earlier concentrated on a static description of income shortages.

Estivill has argued that, in contrast to political responses to fighting poverty and combating wealth, countering exclusion and striving for an inclusive society is less threatening and appeals to a wide range of political views (Estivill 2003). This is aptly illustrated in the Canadian *Primer to Action: Social Determinants of Health* in the chapter on inclusion:

> Belonging to a family, a community, a society is one of the most important things in life. It makes us feel good. It makes us healthy. It makes us want to reach out to others. Belonging makes our communities healthy, too. We need to promote the feeling and reality of belonging. (Ontario Prevention Clearinghouse et al. 2007: 32)

Estivill also points out that there is less stigma attached to social exclusion than to poverty, and the concept is therefore more acceptable to public opinion and to those primarily affected (Estivill 2003). Loury (1999) has noted that the use of the term arose in Europe in the wake of prolonged and large-scale unemployment that provoked criticisms of the welfare systems for failing to prevent poverty and for hindering economic development. Others have adopted a more critical standpoint, interpreting the adoption of social exclusion in both Europe and the UK as a way of avoiding debate on wider inequities (Veit-Wilson 1998; Byrne 1999).

Sayed et al. (2003) have criticised social exclusion as becoming contentious shorthand for the inequities of class, race, gender, ethnicity and poverty. In the context of the educational exclusion/inclusion debate, they also note that the use of the concept comes with a strong normative stance that inclusion is by definition good, and exclusion bad. Furthermore, the authors note that the discourse ignores the existing and complex social relations in society, which give rise to and perpetuate inequalities, and how these inter-relate with one another (Sayed et al. 2003).

Despite these shortcomings, Popay et al. (2006) have argued that the concept of social exclusion has global relevance, particularly when a relational lens is applied. Byrne (1999) has made the distinction explicit between internal exclusion, within post-industrial societies, and external exclusion, which keeps other people out of a particular nation or block. As Castells puts it: 'globalization proceeds selectively, including and excluding segments of economies and societies in and out of networks of information, wealth and power that characterise the new dominant systems' (Castells 1998: 162). Sen, noting that globalisation is both a potential threat and an opportunity, has argued:

> The ability of people to use the positive prospects depends on their not being excluded from the effective opportunities that globalisation offers. If people are excluded…the overall impact of globalisation may be exclusion from older facilities of economic survival without being immediately included in newer ways of earning and living. (Sen 2000: 28)

Beall, using examples from the cities of Faisalabad in Pakistan and Johannesburg in South Africa, argues that a social exclusion perspective

> …provides us with a useful tool for understanding both persistent and mutating patterns of social disadvantage. It provides a way of understanding the relational and institutional dynamics that serve to include some and keep others out in a connected but polarised global economic context. As such, it is an analytical construct compatible with the study of global economic processes and the poverty and inequality to which they increasingly give rise. (Beall 2002a: 50)

Social exclusion literature: sub-Saharan Africa

The social exclusion discourse and concept has spread from the north to the south mainly through the efforts of UN agencies such as the ILO, UNDP, UNESCO and WHO (Saith 1999; Clert 1999). In SSA the discourse has been much more about poverty, marginalisation and vulnerability.

The application of the North American and Western European concepts of exclusion in SSA is problematic for several reasons. Poverty affects the majority of people in SSA, and if 'the excluded' is used as a synonym for 'the poor', or those outside the formal economy, the majority in SSA are 'excluded' (Gore 1994). Given Africa's colonial past and the social and economic exclusion of the African population during colonialism, the dominant analytical concepts have been diametrically opposed to any notion of exclusion (Gore 1994).

In a 1994 review done for the ILO's International Institute of Labour Studies, Gore noted that applications of recent concepts of exclusion have been limited. However, the relationship between social identity and entitlement to resources and other social goods formed the subject of his literature review on social exclusion. Four important dimensions of exclusion were examined: from agricultural land, from agricultural livelihood, from formal and informal employment, and from organisation and representation (Gore 1994). The review excluded material on apartheid South Africa.

There is a growing body of work exploring the utility of the concept to LEDCs. Saith has noted that the concept of social exclusion has led to the expansion of research on a multi-dimensional set of living conditions, and the dynamics and processes leading to poverty (Saith 1999). Related but different concepts from that of social exclusion have emerged, such as basic needs, entitlements, capabilities, vulnerability and human development. These have had the impact of widening the scope of assessing poverty and poverty alleviation policies in developing countries beyond a static approach and narrow monetary base (Saith 1999). It is beyond the scope of this work to explore the literature on these alternative discourses.

Gore's categorisation of the literature on exclusion processes in SSA is presented in terms of both international/national social relations and national/local social relations (Gore 1994).

Gore's classification locates the Western European notion of exclusion linked to citizenship rights, immigration and racism within a wider context, pointing towards the idea that SSA is becoming marginalised in international relations, with the region becoming a 'global underclass' within the international system. Gore notes that literature on exclusion processes has been poorly developed, with material focusing either on elites and the rich or on the marginal and the poor, despite the fact that social exclusion processes involve both groups (Gore 1994: 13).

Table 1.1: Conceptual map of the social exclusion literature in SSA, 1994

	Exclusion and elite formation	Exclusion and marginalisation
International		
• Monopoly of resources by powerful elites • Restricted rights and periodic expulsions of international migrant workers	• Indigenisation • Gate-keeping • Migrant workers	• SSA as a global ghetto • Refugees • Aliens
National		
• Monopoly of opportunities by bureaucratic or business elites • Multiple disadvantages of particular marginal groups	• Administrative elites • Long distance traders • Urban landlords	• Women • Female-headed households • Pastoralists • Hunter-gatherers • The internally displaced • The rural poor • Minorities

Source: Gore (1994: 13)

An important contribution has been made by feminist theorists who emphasise the shift from a focus on women to a focus on gender relations (Gore 1994: 14). In addition, within the Weberian model of social closure, strategies of the more powerful are accompanied by countervailing action from excluded groups who seek to break down the established monopoly of resources. Elliot's poverty study on patterns of access and exclusion notes that the exclusion of disfavoured groups cannot be total, in order to preserve confidence and legitimacy in the system (Elliot quoted in Gore 1994: 14).

The aspect of social agency is a highly contested issue in the literature on social exclusion, with attention having been directed at the causal role of a wide range of 'agents' ranging from globalisation, multinationals and international agencies such as the World Bank and International Monetary Fund (IMF), through nation states and their institutions to excluded individuals/groups themselves (Popay et al. 2006). Although social exclusion arises because of the practice of more powerful groups being denied access to particular resources, this does not completely block any possibility of agency on the part of excluded groups. Rather, exclusion structures their field of action. A key methodological insight in the literature, suggesting a way to avoid one-sided analysis, is that social exclusion processes can be usefully analysed through a focus on social institutions (Gore 1994).

Analysis of key AU, SADC and State of the Nation (SON) documents for a social exclusion discourse showed that poverty has been the dominant discourse. The concept 'social exclusion' appears for the first time in the AU strategic framework for 2004–2007, under Area 5 on social development, where it is listed as item 21: 'fight poverty and social exclusion' (AU 2004a: 74). Social inclusion appears in the Plan of Action for 2004–2007. Poverty is the dominant discourse, appearing 44 times in policy documents since 1963 (OAU 1963; AU 2004a; AU 2004b; Chissano 2003; Chissano 2007). Similarly, poverty appears 187 times in the SADC regional indicative strategic development plan, and more than 100 times in South African presidential addresses since 1994 (SADC n.d.; SON 1994–2007). Neither social exclusion nor inclusion has appeared in SADC policy documents or a single South African presidential address since democracy (SADC n.d.; SON 1994–2007).

However, the notion of social exclusion appears increasingly in declarations on the 'developmental state' and in African governments' action programmes to address poverty. In the Declaration on Africa's Development: Challenges and Reflections of the New Economic Partnership for Africa's Development (NEPAD), adopted in Accra, Ghana, in 2002, a call was made for action at national, continental and international levels to implement measures requiring the reconstruction of the developmental state in order to address developmental problems. A developmental state was defined as:

> …a state for which social equity, social inclusion, national unity and respect for human rights form the basis of economic policy; a state which actively promotes, and nurtures the productive sectors of the economy; actively engages appropriately in the equitable and balanced allocation and distribution of resources among sectors and people; and most importantly a state that is democratic and which integrates people's control over decision-making at all levels in the management, equitable use and distribution of social resources. (CODESRIA 2002)

Reports from international agencies also reveal a growing interest in the relational nature of social exclusion as applied to LEDCs. This literature represents a valuable body of experiential evidence to be drawn on to describe the nature and scale of social exclusion, and to describe and assess a range of policy responses at local, national and international levels. A policy paper was produced by the UK's Department for International Development (DfID) in 2005, to assist with existing efforts to tackle social exclusion in developing countries (DfID 2005). In the introduction to the document, it is noted that:

> For DfID, social exclusion matters because it denies some people the same rights and opportunities as are afforded to others in their society. Simply because of *who they are*, certain groups cannot fulfill their potential, nor can they participate equally in society. (DfID 2005: 5)

A review of the Government of Mozambique's Action Plan for the Reduction of Absolute Poverty for 2006–2009 (PARPA II) shows a key shift in the definition of poverty from that of the first document. With regard to the definition of poverty, the document notes:

> Poverty was initially considered as the lack of income – money or negotiable goods – necessary to satisfy basic needs. Because this monetarist definition did not cover all the manifestations of poverty, the definition was broadened over time to cover such aspects as a lack of access to education, health care, water, and sanitation, etc. At present, the definition of poverty has also come to include aspects such as isolation, exclusion from society, powerlessness, vulnerability, and others. The definition used for PARPA II is the impossibility, owing to inability and/or lack of opportunity for individuals, families, and communities to have access to the minimum basic conditions, according to the society's basic standards. (Republic of Mozambique 2006: 8)

A mapping study by civil society organisations (CSOs) in Tanzania has recorded multiple deprivations facing people working in marginal urban activities such as stone-crushing and begging, and persons in rural areas without access to land or the resources required to make it productive (CSO n.d.). The study has also explored factors that influence patterns of deprivation; including resources, social networks, age, family history and regional affiliation (CSO n.d.). The Tanzanian CSO report notes that there is social

exclusion of individuals and groups from sources of livelihood and that social exclusion has become a central national issue that has resulted in the formulation of several policies (CSO n.d.).

In South Africa, the post-apartheid era (since 1994) has provided social scientists with rich material to explore colonial ambiguities and post-colonial legacies, explore development possibilities within the context of globalisation, and examine shifting geographies of social inclusion and exclusion (Padayachee 2006). It is not surprising that there is a growing body of literature that explores the economic and multi-dimensional elements of poverty, unemployment, informal sector employment, inadequate income for basic needs, inequality, income disparities, deprivation, insecurity and lack of educational access (Klaasen 1997; Leibrandt & Woolard 1999; Beall 2002a; Sayed et al. 2003; Du Toit 2004; Greenberg 2004; Murray 2004; Lemon 2005; Hall et al. 2005; Adato et al. 2007).

In recent years, the concept of the 'ambivalence of exclusion' – the way inclusion is related to exploitation, first described by Wolfe – has been further developed (Wolfe quoted in Gore 1994: 16). Du Toit has coined the term 'adverse incorporation' and has been particularly critical of 'the export of "social exclusion" discourse to the field of development and poverty studies' in South Africa (Du Toit 2004: 1003–1005). His ongoing research into chronic poverty in the Western Cape and into informal economic activities has illustrated the negative terms of inclusion for poor black people (Du Toit 2004). In a study on the deciduous fruit export industry in the Western Cape, South Africa, Du Toit (2004) explores the links between the livelihood options of poor people and processes of global integration, agro-food restructuring and the modernisation of farming styles. In terms of livelihoods and employment, research findings have shown high levels of integration between the formal and informal sectors. He has argued that while the concept of 'social exclusion' has the potential to focus attention on the disabling effects of poverty, its most common usage in this context is of limited value and often fails to capture the way poverty can flow from processes of (adverse) integration into broader economic and social networks (Du Toit 2004).

There is also a significant body of literature in South Africa exploring the ambivalence of social exclusion and inclusion in the education sector. Education was a central ideological apparatus of the apartheid state in South Africa, and an instrument of both exclusion and social control (Mabokela & King 2001). Inferior education was provided to South Africans of colour to the extent that it legitimised the repressive regimes and provided the minimal knowledge and skills for an exploitable workforce. While there have been significant changes, authors caution against a simplistic and potentially misdirected association between inclusion as 'good' and exclusion as 'bad' (Sayed et al. 2003; Lemon 2005).

Lemon (2005) has examined the extent and nature of desegregation and redistribution in secondary schools in Pietermaritzburg, KwaZulu-Natal. The study has demonstrated that, although considerable desegregation has occurred, especially in the state sector, this has only happened at the upper end of the traditional racial hierarchy – black children have been admitted to white schools, and not the other way round (Lemon 2005). The study also shows that provincial resources allow for minimal capital spending and limited non-salary expenditure, while differential fees in state schools preserve apartheid inequalities of provision. Sayed et al. have argued that educational exclusion

> …operates in a sea of social exclusionary processes which affect access to basic rights in a number of domains: adequate or quality food, shelter, social security, employment, education, etc. It usually occurs in the guise and context of the

> acceptance of unproblematised identities within broader society. (Sayed et al. 2003: 242)

The spatial dynamics of exclusion in regionally significant cities such as Johannesburg has been explored by some through specific and comparative case studies (Beall 2002b; Murray 2004). Murray (2004) has argued that the spatial dynamics of Johannesburg both reproduce social inequalities and legitimate class privilege as well as various kinds of social exclusion. Beall et al. (2002b) point out that a key challenge for local government is spatial exclusion, which rests increasingly in the hands of private citizens rather than the state.

Stigmatisation and discrimination cut across several dimensions of exclusion. HIV and AIDS is perhaps one of the most stigmatised medical conditions in the world, and South Africa has one of the highest numbers of people living with HIV. Stigma interferes with HIV prevention, diagnosis, and treatment, and can become internalised by people living with HIV and AIDS (UNAIDS 2006). Numerous authors have explored the links between HIV infection, stigma, the social construction of sexual moralities and the resultant social exclusion, particularly of women and young people in South Africa, who are most affected (Johnston 2001; Achmat 2001; Simbayi 2002; Preston-Whyte & Stein 2003; Cloete et al. 2006; Campbell et al. 2006). A recent large survey conducted among 1 054 people living with HIV and AIDS (PLWHA) in Cape Town found high levels of internalised stigma, with a large number of PLWHA not disclosing their HIV-positive status for fear of stigma and discrimination (Simbayi et al. 2007).

Ballard et al. (2005) have reviewed social movements in post-apartheid South Africa in the light of increasing globalisation. They argue that one of the key effects of this has been massive job losses and resultant increases in poverty, and show that these social movements are driven by worsening poverty, with struggles addressing both labour and consumption issues (Ballard et al. 2005). In addition, some movements confront questions of social exclusion in terms of gender, sexuality and citizenship, lying at the intersection of recognition and redistribution. They conclude that social movements provide a vital counterbalance to promote the needs of the poor in political agendas (Ballard et al. 2005).

Conclusion

Chapter 1 has provided a brief overview of the global context of the social exclusion debates, followed by a brief review of the literature in SSA and South Africa. The review shows that much of the social exclusion literature is concerned with more developed countries, and that in SSA the discourse has been about poverty, marginalisation and vulnerability. Increasingly, the notion of social exclusion appears in declarations on the 'developmental state' and in action programmes to address poverty. Similarly, in post-apartheid South Africa, redress and a focus on poverty have occupied the agenda of policy-makers in government. Nevertheless, there is increasing academic focus on social exclusion and the notion of adverse inclusion. These concepts are applied in studies on poverty, livelihoods, the education sector, spatial dynamics in large cities such as Johannesburg, HIV and AIDS stigma, and the analysis of social movements.

The next chapter gives a high-level overview of SSA and the scale of inequalities prior to the policy appraisal.

CHAPTER 2

Sub-Saharan Africa

Region of diversity and contrast

In this chapter we provide a high-level overview of Africa as background to the policy appraisals that follow. Figure 1 on page xiv illustrates a map of Africa, showing the countries that form the focus of the policy appraisal.

The African continent consists of more than 50 independent countries on the mainland and on the islands off its coasts. With an estimated population of more than 721 million, African countries make up more than one-third of the membership of the UN (Infoplease n.d.). After the conclusion of World War II, countries gained their independence from the European countries that had controlled most of the continent since the 19th century. In 1994, South Africa's white minority rule also came to an end with the country's first democratic elections.

Many of the world's essential minerals, including copper, gold and uranium, are mined in Africa, and African countries have developed political and economic relations with nations throughout the world. The continent's extensive river system represents one of the world's major potential sources of hydroelectric power. Africa is the home of some of the largest and most varied wildlife populations in the world, from the rare mountain gorillas in the highlands of Rwanda and Zaire to the lemurs of Madagascar (Infoplease n.d.). The people and cultures of Africa are as diverse as its geography: north of the Sahara the inhabitants are mainly Arab, whereas the rest of the continent is dominated by black people of various ethnic groups. Anthropologists have identified almost 3 000 different ethnic groups or peoples in Africa, speaking approximately 1 000 languages (Infoplease n.d.).

Although nearly 70 per cent of the people of Africa still live in rural areas, African cities and towns are growing more rapidly than those of any other continent. More than in any other continent, urbanisation in African countries continues to grow. From 1950 to 1990, as much as 15 to 20 per cent of some rural populations moved to cities and towns (Infoplease n.d.).

The sub-Saharan development landscape

In Chapter 1, we have shown that poverty has been the dominant discourse in SSA, both in official documents of the AU and in those of the SADC. One of the seven objectives set by the AU is to 'address the structural causes of poverty and under-development' (AU 2007: 13). This is not surprising, given that SSA is the world's poorest region, with half its people living on less than $1 per day (USAID 2006). New global poverty estimates produced by the International Poverty Centre (IPC) show that during the 1990s, both the average income of the SSA region and the percentage of the people living below the $1 poverty line scarcely changed over the decade (Kakwani et al. 2005). The IPC also shows that the number of poor people rose substantially over the decade, in part because the population is still growing fairly rapidly in the SSA region (Kakwani et al. 2005). The IPC notes that the MDG of halving poverty between 1990 and 2015 would require most countries in SSA to reduce poverty by over three per cent per annum in the 2000s to reach the poverty reduction goal in 2015 (Kakwani et al. 2005). A combination of economic and social policies is needed to reach the MDGs by 2015.

Table 2.1: Indicators for selected countries in sub-Saharan Africa, 2006

Indicator[a]	Botswana	Mozam-bique	South Africa	Zimbabwe	Ethiopia	Nigeria
Income classification[b]	Middle income	Low income	Middle income	Low income	Low income	Low income
HDI	0.570	0.390	0.653	0.491	0.371	0.448
Human poverty index (%)	48.3	48.9	30.9	46.0	55.3	40.6
Probability at birth of not surviving to age of 40	69.1	50.9	43.3	65.9	39.5	46.0
Adult literacy rate (%)	81.2	Not avail.	82.4	Not avail.	Not avail.	Not avail.
Percentage population without sustainable access to improved water source	5.0	57.0	12.0	19.0	78.0	52.0
Percentage children under five underweight for age	13.0	24.0	12.0	13.0	47.0	29.0
Percentage population below poverty line ($1 per day)	23.5	37.8	10.7	56.1	23.0	70.8
Percentage population below poverty line ($2 per day)	50.1	78.4	34.1	83.0	77.8	92.4
Life expectancy	36.6	41.9	49.0	37.2	47.6	43.3
Infant mortality rate (per 1 000 live births)	84.0	104.0	54.0	79.0	110.0	101.0
Under-five mortality rate (deaths per 1 000)	116.0	152.0	67.0	129.0	166.0	197.0
Percentage HIV sero-prevalence (15 to 49-year-olds) (CI)	24.1	16.1	18.8	20.1	0.9–3.5	3.9
Public health expenditure as per cent of GDP	3.3	2.9	3.2	2.8	3.4	1.3
Private health expenditure as per cent of GDP	2.3	1.8	5.2	5.1	2.5	3.7
Share of income or expenditure (poorest 20%)	2.2	6.5	3.5	4.6	9.1	5.0
Share of income or expenditure (richest 20%)	70.3	46.5	62.2	55.7	39.4	49.2
Gini Index[c]	63.0	46.5	57.8	50.1	39.4	49.2

Source: UNDP 2006b

a See UNDP (2006b) for data sources and an explanation of computation of each index.

b Middle: (GNI $826–10 065 per capita per annum), Low: under $826 per capita per annum.

c Gini Index measures the extent to which the distribution of income (or consumption) among individuals or households within a country deviates from a perfectly equal distribution. A value of zero represents perfect equality, a value of 100 perfect inequality.

Poor people regard their health as one of their most valuable assets, as it means they are able to work in order to survive. Ill-health is one of the most important triggers that propel the near-poor into poverty (Bloom & Canning 2000). Compelling econometric simulations covering 30 countries (3.1 billion people) have provided evidence that more health equals less poverty, and have shown that a ten per cent improvement in life

expectancy in 1990 would have lifted 30 million people out of absolute poverty by 2015 (Bloom & Canning 2000). The link between poverty and health also works in the opposite direction: less poverty means more health.

Table 2.1 shows trends in the HDI and other key indicators for a selection of SSA countries (UNDP 2006b). The HDI is a composite index measuring average achievement in three basic dimensions of human development — a long and healthy life, knowledge and a decent standard of living (ibid.). The countries in Table 2.1 constitute the focus of the policy appraisal. The policies selected for appraisal are shown in Table 2.2.

Table 2.2: Policies and actions selected for appraisal

Country	Policy/action selected	Brief description
Botswana	Policy to retain teenage girls in schools	Diphalana project in Botswana focused on pregnant girls and fathers-to-be who would typically drop out of school. The project provided free day care for the children of teenage girls and boys, and parenting classes for young parents. Seen as part of national policies directed at improving the situation of pregnant girls
Mozambique	*O Instituto Nacional De Acção Social* (INAS) (predecessor was GAPVU)	An urban cash transfer programme to households/ individuals meeting certain eligibility criteria. Known as a 'food subsidy', it is a monthly cash transfer to extremely poor citizens to ease the combined negative effects of war, natural disasters and the structural adjustment programme
	Free education policy	A policy to exempt certain categories of families from paying fees
South Africa	Free healthcare	No user fees in PHC facilities and for certain categories in order to increase access to care
	Child support grants	Poverty relief for vulnerable (poor, fostered, disabled) children
	Bana Pele (children first)	Integrated and comprehensive pro-poor social services to children
Zimbabwe	The Basic Education Assistance Module (BEAM)	One component of the Enhanced social protection project (ESPP). BEAM's main development objective is to prevent irreversible welfare losses for poor households who resort to extreme coping mechanisms, like withdrawing children from school due to increasing poverty
Ethiopia	Productive Safety Nets Programme (PSNP)	Consists of cash or food resource transfers to meet basic needs. Both labour-based public works programme and direct support
Nigeria	National Poverty Eradication Programme (NAPEP)	Aims to streamline and rationalise the functions of core poverty alleviation institutions and agencies to enhance performance and improve coordination

CHAPTER 3

Policy appraisals: southern Africa

Botswana

Botswana is a sparsely populated southern African country which gained independence from the UK in 1966. It had an estimated population of 1.8 million people in 2004, the majority of which (56.6 per cent) were living in urban areas (UNDP 2006b). Almost 38 per cent of the population is under the age of 15 years; life expectancy at birth is under 40 years (36.6), mainly due to the HIV and AIDS epidemic, and the infant mortality rate is 84 per 1 000 live births (ibid.). There are huge inequalities, with a Gini index of 63.0 (ibid.).

Botswana has managed its natural resources efficiently and can now afford the second-highest public expenditure on education in the world, 8.6 per cent of its gross national product (GNP) (Challender 2004). Education is free for all children, and primary school attendance is 84 per cent of the age cohort. The country has achieved gender parity at primary school level, with the ratio of girls to boys at 0.993 (Challender 2004). There are also a high proportion of female teachers – approximately 82 per cent of those based in primary schools (Chapman et al. 2003: 1).

Teenage pregnancy

In the last decade, Botswana, like many other SADC countries, experienced high rates of teenage pregnancy and high prevalence rates of sexually transmitted diseases, including HIV and AIDS (ILO 2003).

In terms of the 1978 education legislation, pregnant girls were required to withdraw from school upon knowledge of the pregnancy. Re-entry was allowed one year after the pregnancy, subject to the written approval of the Minister (Botswana 1978: 58–68). Pregnant schoolgirls were not allowed to write examinations until at least six months after the end of the pregnancy. The law also required schoolboys fathering these children to withdraw from school for an unspecified period, but, unlike the mothers, the teenage fathers did not have to attend a different school upon their return. The rationale for these prohibitions was to act as a deterrent to pregnancy, to promote the mothers' health and to ensure that the babies were cared for (Unterhalter et al. 2004). However, Unterhalter has questioned whether the needs of young mothers and their children were addressed by this legislation. Those returning to school were likely to attend school much further away from home, knowing fewer people and more likely to be cut off from their babies. On the other hand, failing to return to school and taking the exams meant diminished prospects of employment (Unterhalter et al. 2004).

Teenage pregnancy leading to school dropout, with its concomitant educational impact, was one of the critical issues affecting equality in economic development between men and women (ILO 2003). Unmarried pregnant schoolgirls were either expelled from school or coerced into leaving for up to a year after giving birth. Only a small and insignificant proportion ever managed to return and complete their schooling.

Unmarried pregnant girls in Botswana bear a burden of stigma and sometimes 'cultural discrimination'. They are often ill-treated and given derogatory labels such as *tshenyo*, meaning 'defiled, spoilt or damaged', and a child born out of wedlock is often referred to as *letlaleanya*, meaning the 'one who comes feeding' or 'illegitimate' (Unterhalter et al. 2004: 21).

These negative assumptions have a detrimental impact on the girls' emotional and psychological well-being, distort their social life and further impair their sense of self-worth; this cultural dimension of exclusion can subsequently have negative repercussions with regard to the retention of these girls in school and possibly their children (Chilisa in Unterhalter et al. 2004).

Expanding educational opportunities for girls

The national policy on education in Botswana has undergone rigorous reform over the past decade, especially with regard to girls' education and more specifically in addressing the educational needs of pregnant schoolgirls. The 1994 Revised National Policy on Education outlined the strategy for the development of more responsive education and training (ILO 2003).

Pregnant teenagers and teenage mothers, rural dwellers and the rural destitute are classified as disadvantaged groups in Botswana. Historically, these distinct groups of people have often received the least support from government social services, particularly from the education sector. The provision of education for special population groups has historically been a concern of NGOs and other multilateral organisations (World Education Forum 2000).

However, there have been numerous initiatives towards the goal of Education for All (EFA) in Botswana. Since the mid-nineties, the combined government and NGO approach has consisted of the following initiatives:

- Strengthening government's capacity to implement an integrated programme.
- Enhancing teenage girls' scientific and technical education and training opportunities.
- Enhancing teenage girls' employment prospects.
- Increasing the number of girls gaining entry to university.
- Promoting girls' reproductive health and their survival.
- Postponing the age of first pregnancy.
- Capacity building to empower and motivate girls to refuse unwanted sexual advances and to negotiate safer sexual practices.

Diphalana: reducing exclusion of teenage mothers

Structure and components

Diphalana, a UNICEF initiative, is an example of an integrated programme to address schoolgirl pregnancy across a range of social sectors – health, education and social welfare (Unterhalter et al. 2004). The project started in 1996 and was intended to:

- Provide uninterrupted basic education for targeted girls by helping to reduce first and repeated pregnancies.
- Ensure that students who do become pregnant complete school.
- Improve the scholastic performance of teenage mothers.

In support of the project, the MoE provided a five-year waiver of the legislative mandate for girls taking part in this project. Through this waiver, pregnant girls were allowed to remain at school longer after announcing their pregnancy, and could return sooner after its culmination. While the waiver set the post-pregnancy exclusion at three months, some girls were allowed to return sooner (Chapman et al. 2003).

The pilot Diphalana project, implemented in Pekenene Community Junior Secondary School in Mahalapye, was intended to have four main elements:

- Longer retention and earlier return of pregnant girls.
- Instructional modules pregnant students could use while on pregnancy leave.
- On-site day care for their babies to allow them to return to school.
- Guidance and counselling of all girls about sex and pregnancy.

Achievements and impact

Only one component of Diphalana – the policy change which allowed for longer retention and earlier return of pregnant girls – was fully implemented as intended. From 1996 to 1999, pregnancies in Pekenene School were reduced from 8 to 3 (Chapman et al. 2003).

Table 3.1 highlights the outputs, outcomes and impact of the pilot project.

Table 3.1: Outputs, outcomes and impact of the Diphalana pilot project

Outputs	Outcomes	Impact
Five-year waiver, allowing pregnant girls to remain at school until late in their pregnancy and return to same school soon after the end of pregnancy, was enacted for one school (pilot project)	Informal data suggests that most girls with babies returned to school; their achievement was approximately at the level that would have occurred without their pregnancy leave	Positive impact on the pregnant girls in the one pilot school. Wider adoption limited
Community day care centre established in conjunction with pilot school	No babies from students who had been pregnant were enrolled in community day care centre; only used for children of community members	None anticipated
Instructional materials were developed for use by pregnant girls while out of school for delivery of child, but never used	None, due to non-use of materials	None anticipated
Child care classes were not designed or delivered	None, due to lack of Implementation	None anticipated
Aim was to strengthen school guidance and counselling functions through programme development around student reproductive health needs and related sensitisation efforts of students, teachers, parents, and the community	None	Activity was judged by the MoE to be inappropriate, and was stopped

Source: Chapman et al. 2003

Programme challenges and constraints

- The programme was only partially implemented. The instructional modules for pregnant students to use while on pregnancy leave were developed but never used (in part because some students returned to school quickly). The community-sponsored day-care centre was established and served the community, but none of the student mothers put their babies in day care, preferring to have family care for their children. The guidance and counselling component was judged by the MoE to be inappropriate, and stopped.
- The programme was seen as a donor-driven initiative, with insufficient buy-in from the ministry and the local community. Senior MoE staff raised doubts regarding Diphalana's sustainability and upscaling, for example, and expected the community to keep it going. Diphalana community members, on the other hand, saw this pilot as largely a UNICEF-sponsored activity (Tswapong Management Services 2003).
- Cultural aspects were not taken into account in the design and implementation of the programme. Ministry staff were of the opinion that national policy had already been liberalised to allow for the return of teenage mothers after just six months, at the headmaster's discretion, and that this was adequate to address the problem.

Mozambique

Mozambique stretches along more than 2 500 km of the eastern coastline of southern Africa, and is bordered by South Africa, Zimbabwe, Zambia and Malawi. The 2007 total population is estimated at 20.4 million (INE 2004); of whom 52 per cent are women, 44.3 per cent are younger than 15 years, 53 per cent are aged 15 to 65, and only 2.7 per cent are over 65 years (INE 2004). In terms of geographical distribution, 32.6 per cent of the population lives in the northern region, 41.9 per cent in the central region and 25.5 per cent in the southern region. The most populated provinces are Zambézia (central region) and Nampula (northern region), with 19.2 per cent and 19.0 per cent of the total population respectively. The majority of the population is rural (69 per cent), with an estimated population growth rate of 2.4 per cent per annum and a dependency ratio of approximately 90 per cent. The average population density of 24 inhabitants per square kilometre varies between 35 in Nampula province to six in Niassa province.

About 17 languages are reportedly in use; 40 per cent of the population speak Portuguese (50 per cent of men and 30 per cent of women) and nine per cent report its use at home.

Healthcare and well-being

Mozambique gained independence in June 1975, and inherited urban-based healthcare (mainly hospital), education and social welfare systems, designed to meet the needs of the Portuguese colonisers. A nationalised public healthcare service was established, based on the PHC approach, with a referral system consisting of secondary and tertiary levels in towns and cities and a quaternary level in Nampula, Beira and Maputo. In the late 1980s, private practice became legal again, and private healthcare expenditure now constitutes 1.8 per cent of GDP and is practised in major cities and towns. Universal coverage of the population with essential services, particularly in rural areas, remains a problem. Although the Ministry of Health (MoH) acknowledges the role of the traditional healthcare sector in caring for people, there are tensions.

Mozambique's economy and infrastructure were decimated by years of civil war throughout the 1980s (UNICEF 2006). Following the signing of peace accords in 1992, the country has experienced political stability, but it still faces a number of challenges. Almost one in five children dies before reaching age five; about 40 per cent of children under five suffer from chronic malnutrition and one in two children does not complete primary education (UNICEF 2006). In addition to malaria and acute respiratory infections, diarrhoea and vaccine-preventable diseases are the main causes of mortality, particularly for children under five. Cholera also remains a threat with repeated outbreaks (UNICEF 2006). Life expectancy at birth is 41.9 years, while the IMR is 104/1000 (UNDP 2006b).

The GAPVU/INAS cash transfer programme

Structure and components

In Mozambique, social assistance was located initially in the MoH, but was separated and run by a Secretariat of State and post-1994 by a Ministry of the Coordination of Social Action, including Women Affairs (MMCAS). The Instituto Nacional De Acção Social (INAS) was created by Decree 28/97 and is a public institution within MMCAS. Its mandate is to implement programmes of assistance, promotion and development aiming at the reduction of absolute poverty in Mozambique (INAS 2007). INAS succeeded the urban cash transfer programme, called Gabinete de Apoio (Support) a População Vulnerável (GAPVU), because of various organisational and management problems with GAPVU.

INAS implements direct social and economic assistance programmes, including a food subsidy, to needy individuals or groups of individuals and those unable to provide for their basic needs. The package of interventions consists of social benefits through work, direct social support, community development and income generation specially designed to benefit women (Government of Mozambique 2005).

INAS targets the most vulnerable among the poor and is decentralised to the provincial level. The processes of identifying beneficiaries differ for the main groups of beneficiaries: elderly and disabled individuals, and malnourished women and children (Rogers 1994). For the elderly and the disabled group, the households are informed of the GAPVU programme through group meetings organised by the neighbourhood chief or the secretary, and eligible persons then apply to the *bairro* (living quarter) secretary, who is responsible for screening elderly and disabled applicants. There may be verification of eligibility. The application form with the appropriate certification is sent to the programme office in the city (Datt et al. 1997).

The outreach for malnourished children and pregnant women is limited to the neighbourhood clinics. The nutritional status of children and pregnant women is verified by nurses in maternal and child health clinics, which monitor the health of pregnant women and the growth of children under four years of age. For all categories of beneficiary households except pregnant women, benefits are granted for one year (payable on a monthly basis), after which the eligibility of the household is re-evaluated and payments may or may be not renewed. If a child continues to be malnourished, payments continue up to a maximum age of five years. Pregnant women receive benefits from the time they are approved up to six months after the birth of the child (Datt et al. 1997). The target groups for INAS are listed in Table 3.2.

Table 3.2: INAS' values, target groups and eligibility criteria

Values of INAS	Target groups	Eligibility criteria
• Respect for the human person • Solidarity • Social justice • Work • Honesty • Initiative	• Women-headed households with five or more children and no other person of working age living in the same household • Persons with disabilities • Elderly persons • Children under difficult conditions (such as orphans, street children) • Victims of natural disasters • Persons socially	• Age • Residence: must live in the respective city for more than one year • Income criterion: households whose income is so low that the under-consumption of food reaches a level that endangers the health and lives of household members. Household income is less than Mt32 000 per person per month and there must be proof of no income from remittances • Clinical criterion: children less than five years old or pregnant women with nutritional problems associated with risk factors

Source: Adapted from INAS 2007

Achievements, impact and challenges

An assessment conducted by Datt et al. in 1997 found that the GAPVU cash transfer programme is an important safety net for urban Mozambique (Datt et al. 1997). The programme reached about 16 per cent of all urban households, and represented about 13 per cent of the beneficiaries' per capita consumption. Despite limited enforcement of means testing, nearly two-thirds of the beneficiary population is deemed to be absolutely poor by a modest poverty line. Without GAPVU transfers, the proportion in poverty would have been above 70 per cent. Limited evidence on nutritional and other non-consumption indicators is suggestive of the GAPVU beneficiary households being more deprived than urban households in general. GAPVU transfer benefits are progressive among the beneficiary households, and are not confined to those near the poverty line (Datt et al. 1997). Table 3.3 summarises the overall benefits of the programme, and some of the challenges experienced.

As indicated, the cash transfer support through GAPVU (supporting urban vulnerable persons) was integrated into INAS in 1997 and a Policy for Social Action was enacted in 1998. In addition to the cash transfer programme, INAS focuses on other development programmes to empower and integrate vulnerable persons and communities. Reaching the poor and vulnerable in rural areas remains a major challenge.

Conclusion

In Mozambique, various studies have demonstrated the effectiveness of the cash transfer programme in Mozambique in addressing the needs of poor urban people, and in reaching the majority of those targeted by the programme (Rogers 1994; Schubert 1995; Datt et al. 1997; Low et al. 1998). However, rural coverage and the impact of cash programmes on rural poor people remain critical outstanding questions.

Furthermore, the extent to which these cash transfer programmes impact on health and well-being is not well known. Recent decomposition analysis using data from Mozambique has shown that the four biggest contributors to poor growth in children (defined as height for age falling two standard deviations below the median of the reference population), stratified by household wealth are: source of drinking water, household wealth, geographical differences and mother's occupation (WHO 2007). The critical factors

determining the success of cash-transfer programmes include appropriate design, strong multi-sectoral political support and adequate administrative capacity (Low et al. 1998).

Table 3.3: Benefits of the cash transfer programme and challenges experienced

Benefits and achievements	Challenges/weaknesses
• Fully functioning social programme • Rapid growth in the number of beneficiaries (more than 2.5 times over the two-and-a-half-year period between the end of 1992 and mid-1995) • An important safety net for urban Mozambique • Generally good coverage • Good targeting of the poor with about 70 per cent of beneficiaries absolutely poor in terms of per capita consumption levels • Has contributed to the reduction of poverty among the beneficiaries	• Uneven regional implementation of the programme • Uneven administrative capacity across regions • 'Leakage' to the non-poor • Substantial latent costs of enforcing means testing • Very low income threshold (about one-fourth of reference poverty line) rendering it unenforceable • Lax enforcement of some of the eligibility criteria • Limited to the urban sector, despite majority of people being in rural areas

Sources: Rogers 1994; Schubert 1995; Datt et al. 1997

Working towards free education

School fees, primary school enrolment and retention

> But what truly characterizes exclusion in these (developing) countries is lack of access to a great many material goods, to social, educational and health services, to social protection and to participation in the decisions on which their people's lives depend. (Estivill 2003: 15)

Education has been a priority since Mozambican independence, in view of the high illiteracy rate (over 90 per cent in 1975) and the paucity of schools in the country at the time. Significant strides have been made, despite the destruction of social infrastructure (schools, health centres, etc.) during the war. The illiteracy rate is currently 53.6 per cent, and more common among women, in spite of adult literacy classes. Girls' dropout rate from school is higher than that of boys, and early marriage is seen as an important reason, hence a male bias in education persists. People in remote and poor areas have less access to education. Recently, priority and vulnerable children (orphans and street children) have been included in social protection policies articulated by MMCAS in agreements with the MoE.

An analysis by age indicates that, of 100 pupils who gain access to Grade 1, only 37 make it to Grade 5. By Grade 7, only 15 pupils remain in the system, and by Grade 12 only a single pupil remains. The most frequently cited reasons for the low retention rates are direct and opportunity costs (on the demand side); the poor quality of education and physical infrastructure (on the supply side); contextual factors, such as socio-economic conditions, food insecurity and chronic illness (HIV and AIDS); and traditional practices (mostly affecting girls).

It is important to note that primary education in Mozambique is neither compulsory nor free. School fees are payable and rules and regulations including fee exemption procedures are stipulated in the Ministerial Decree (No. 6 of 1986). These were still

in force in 2003. Fees account for up to 18 per cent and 23 per cent of recurrent expenses in EPI (Grades 1–5) and EP2 (Grades 6–7), respectively.

The recent gross admission rate to Grade 1 grew from 59 per cent to 123 per cent, and those in EP1 from 60 per cent to 112.7 per cent, while EP1 school numbers rose from 2 800 to 8 000 between 1992 and 2003. Yet the number of pupils per class and the number of unqualified teachers also rose, with a concomitant deterioration in pupil–teacher ratios and more use of open-air classrooms.

Completion rates were lower than those in neighbouring countries, and girls were disadvantaged when compared with boys, particularly in central and northern Mozambique.

Policy-making: removing the school-fee barrier

There is little information available on the extent to which various costs (formal and informal school fees) have an impact on school enrolments and pupil retention rates (Valerio et al. 2004). Since primary education in Mozambique is neither compulsory nor free, the policy alternative that was analysed is the elimination of school fees for primary education (Valerio et al. 2004).

Table 3.4: Poverty and social impact analysis of school fees

Policy level	School/operational level	Household level
• A discrepancy was found between official government policy on fees and what actually happened in practice • Direct budgetary allocations from MoE for routine expenses were rare • Direct support helped meet school financial needs. Its guidelines and mechanisms for accountability were clear and were followed. Staff in rural schools believed enrolments and attendance were increasing with the programme • Infrastructural constraints included crowded rooms, a lack of school furniture and poor quality of education (curriculum relevance) • Fees had no effect on enrolments in EP1 and EP2. Distance to school was the key variable in enrolment into EP1 • Age, gender and unusual vulnerability affected enrolment and the probability of dropout	• The majority of EP1 schools relied on funds generated for operational expenses • Fees collected well above the amounts fixed in government policy documents • Officials perceived funds as essential for the EP1 expansion • The application of the government policy on fees varied across provinces and districts • Fees tended to increase with the level of consumption in urban areas, less so in rural areas • The control of and accountability for fees was found wanting. Abuses could lead to high costs to households • There was a lack of women teachers to cater for girls, and to help them avoid sexual harassment by young, recent secondary-school graduates, often male, recruited as unqualified teachers	• Households struggled to pay school fees and expenses • Costs to families included direct expenses and also the cost of the income that is not earned when a child goes to school instead of to work. These costs, when taken together, can make it very difficult for all the children in a family to attend school • The need to buy school uniforms added to cost burden • Girls often dropped out to care for a younger brother or sick adults • Carers of AIDS orphans were often ignorant of the fee exemption • AIDS orphans and other vulnerable children were not well identified and not receiving special attention at school • Early marriage among girls and initiation rites (boys and girls) were contextual constraints

Source: Valerio et al. 2004

During 2004, a Poverty and Social Impact Analysis (PSIA) was undertaken to fill the information gap on the impact of direct costs (formal and informal school fees and related schooling expenses) and opportunity costs on enrolment and pupil retention in primary education, particularly among the poorest children who are more likely to be out of school. To the extent possible, it was agreed that the study would be complemented with analyses on the role of supply-side constraints and contextual factors to allow for a more informed comparison among policy reform alternatives (Valerio et al. 2004). The key findings of the study are summarised in Table 3.4.

Recommendations and impact

A consultative process was undertaken with policy-makers, technical officers, teachers, and key stakeholders from provinces to discuss results and emergent interpretations, and to ensure the acceptance and feasibility of recommendations (for the demand and supply sides, and for easing contextual constraints). Table 3.5 highlights the key recommendations, and the follow-up action since the PSIA was undertaken.

Table 3.5: Key recommendations and progress resulting from the poverty and social impact analysis of school fees

Recommendation	Action
Revise school-fees policy and clarify type (if any), purpose and frequency of fee contributions, payment mechanisms and accountability of funds. Make exemptions at local school councils (no certificate)	• All other primary education fees abolished since 2005 academic year • Not clear whether additional budgetary allocations will cover the shortfall in school-generated revenue • Unclear whether school supplies, textbooks, school uniforms and other miscellaneous items, which were financed by households, will be covered by other means
Increase school resources through DSS to ease schooling burden on households	• Empirical input on donor commitment provided for MoE Strategic Plan 2005–2009, policies and budgets • Plan to double the grant size of the DSS and include an additional, earmarked grant to finance small-scale civil works activities, whether upgrading or adding classrooms • An additional financial incentive mechanism needed to increase the completion rate of girls and vulnerable children in rural areas, as is also envisioned under the programme
Initiate a campaign on children's rights to attend primary school irrespective of economic considerations, benefits of schooling, and the need to start school at an appropriate age	• The study was used to revise the gender strategy of the MoE and facilitate gender discussions, and led to a request for a similar study in secondary schools
Deploy qualified teachers and women teachers for equitable distribution, especially in rural areas	No information available on progress
Build schools closer to the communities and consolidate EP1 and EP2 in the same physical area	No information available

Source: Valerio et al. 2004

Conclusion

The initial impact of the abolition of primary-school fees has not been formally evaluated. The removal of fees is likely to increase the absolute number of students, especially in upper-primary schools, in which only slightly more than ten per cent of the eligible school-age population is currently enrolled and where the social pressure to expand is greatest (Valerio et al. 2004). The extent to which students will remain in the system until completion will also depend on the household's ability to meet additional expenses to cover school supplies, uniforms and textbooks, or on an extraordinary effort from the government to increase public expenditure to cover school supplies and schooling expenses for the majority of EP1 and EP2 pupils. The study has informed the development of the second Education Sector Strategic Plan (2005–2009) and changes to direct support services (DSS). A follow-up study is needed to evaluate the impact of the policy change to eliminate school fees without providing additional financing to offset forgone school revenue.

South Africa

The Republic of South Africa (RSA), located at the southern tip of the African continent, is bound by Namibia to the north-west, Botswana to the north, Zimbabwe, Mozambique and Swaziland to the north-east, the Indian Ocean to the east and south-east and the Atlantic Ocean to the south-west and west. The country is divided into nine provinces. The first democratic, post-apartheid South African government was elected in 1994.

The estimated 2006 mid-year South African population was approximately 47.4 million (StatsSA 2006a). These estimates account explicitly for HIV and AIDS (StatsSA 2006a). Fifty-one per cent (approximately 24.1 million) of the population is female, with KwaZulu-Natal province having the largest share of the South African population (just over 20 per cent of the population). In 2006, life expectancy at birth was estimated at approximately 49 years for males and 53 years for females (StatsSA 2006a). The bulk of the population (close to 60 per cent) lives in urban areas.

Free healthcare policy

In the first five years of democracy access to healthcare in South Africa was extended, especially to those without prior access (ANC 1994a). The emphasis on increasing access to healthcare in the first term of governance was underlined in the Presidential address to parliament on 24 May 1994, when Mr Mandela declared that healthcare for children under the age of six and for pregnant women would be free (McCoy 1996). The free healthcare policy was implemented within the first 100 days in the context of social justice, equity and a better life for all (ANC 1994b).

The objective of this policy was to improve access to healthcare for women and children by removing the barrier of user fees for children from birth to six years, for pregnant women, and for women during the post-natal care period. The free healthcare policy was subsequently extended to include free PHC services obtained at clinics. The policy is also informed by the Constitutional provision which stipulates children's rights to basic nutrition, shelter, basic healthcare services and social services (RSA Constitution 1996).

Free healthcare services are currently provided in 3 500 public clinics and community health centres as well as 400 public hospitals (DoH 2006).

Structure and components

Free healthcare refers to health services that are rendered free at the point of contact at public-sector clinics, community health centres and hospitals (Leatt et al. 2006: 51). The policy was implemented in 1994, and remains in force. Free healthcare services include the following categories:

- PHC services, including free healthcare services to children under 14 years, pregnant women, pensioners, persons receiving social grants and the formally unemployed.
- Tuberculosis services.
- Voluntary counselling and testing for HIV.
- Prevention of mother-to-child transmission of HIV.
- Cervical screening at PHC services.
- Medico-legal services for survivors of sexual assault.
- Employee assistance programme.
- Free healthcare for people with disabilities, comprising the following three categories:
  1. People with a permanent, moderate or severe disability, those who cannot take care of themselves, or who cannot walk between 10 m and 200 m on their own continuously.
  2. People who have been diagnosed with a chronic, irreversible psychiatric disability, irrespective of fluctuations in their mental status.
  3. Frail older people and long-term institutionalised state-subsidised patients.

Pregnant women and children covered by private medical insurance and/or living in households with an income of more than R100 000 (about $14 000) per year are not eligible for free healthcare.

Achievements and impact

The South African MDG country report indicated that the free healthcare policy has resulted in an increase in the number of outpatient departmental visits since the inception of the programme and noted increased utilisation rates. It concluded that the previous system of user fees was a deterrent to people using healthcare services (DoH 2005: 5).

A formal evaluation of the Free Health Care Policy one year after its commencement revealed that:

- The policy has had an effect on service utilisation, such that there has been an increase in the attendance of patients at most public-sector health facilities, including increased attendance at antenatal clinics, and the number of women booking for antenatal care.
- Family planning attendances have also increased at most facilities, with no evidence of a rise in the number of deliveries. The number of referrals has also increased.
- Fee revenue prior to the implementation of the policy amounted to less than five per cent of the total public health budget. Following the introduction of the free healthcare policy, revenue from user fees was estimated to have dropped by about 30 per cent (approximately 1.5 per cent of the total public health budget). The bulk of this loss occurred at large referral hospitals.
- An increase in drug expenditure attributable to the free healthcare policy was estimated to be less than one per cent of the total public-sector health budget.
- There is general support by health-service users for the policy. People generally felt that access to healthcare had improved, especially for people living in rural areas, informal settlements and on white-owned farms (McCoy 1996).

Challenges and constraints

- The majority of public-health professionals were of the opinion that free healthcare had aggravated existing health service problems such as poor working conditions, a shortage of medicines, overcrowding and poor staff morale. Health workers were also dissatisfied, due to inadequate consultation with them regarding the design and implementation of the policy.
- Implementation challenges remain, including an inability to cope with the extra demand at health facilities.
- Hospital services are still used inappropriately with people bypassing clinics to seek basic healthcare from hospitals.
- Health workers perceive some patient misuse and alleged abuse of the policy, while patients complained about the attitudes of some health workers.
- While many gains have been made in improving the access to and quality of healthcare for children, gaps remain in the delivery of key health promotion and disease prevention for children (King et al. 2006). Many children still fall ill and die from preventable and treatable conditions. Child mortality has also increased, fuelled largely by HIV, which is reversing gains made in child survival over the last decade.
- The policy has not impacted positively on the maternal mortality rate, which has not declined in South Africa over the last 10 years. Infant and under-five mortality rates have increased since 1998, with child mortality slightly higher in rural areas than in urban areas (King et al. 2006).

Conclusion

Poor people are less likely to have private health insurance or to be able to afford the costs of ill-health. The free healthcare policy has been effective in removing barriers to access. Positive effects include an increased utilisation of PHC services and of preventive services such as antenatal care and family planning. The policy has not had an impact on health status, but that was not its primary intention. However, there have been unintended consequences, the most important of which has been negative health-worker attitudes, as they were not intimately involved in policy design and discussions on implementation, and because of inadequate communication. The Department of Health (DoH) has pointed out that the effect of the policy may be diluted over time, given other access barriers like health-worker attitudes. Some key informants have argued that the negative health-worker attitudes may lead to an unintended consequence of social exclusion.

Child support grants policy

Historically, social security in South Africa has been directed at meeting the needs of the white minority (IRIF 2006). There were racially differentiated grant benefit levels, with blacks receiving a small fraction of grant benefits, despite being in the majority. In 1994, the first democratically elected government in South Africa inherited a fragmented social security system. One of the key challenges was to give effect to constitutional provisions, while at the same time ensuring long-term affordability and sustainability (IRIF 2006).

The South African government has embarked on a comprehensive social security and assistance programme (IRIF 2006). The provision of social grants, governed by the Social Assistance Act, is the government's biggest poverty relief programme, with annual cash transfers in the region of R62 billion ($8.85 billion) per annum to almost 11 million South Africans (Pauw & Mcncube 2007). These include old-age pensions, contributions to war veterans, and child support, disability, care dependency and foster care grants.

Structure and components

Social assistance refers to 'non-contributory and income-tested benefits provided by the state to vulnerable groups unable to provide for their own minimum needs, such as the disabled, the elderly and young children in poor households' (Woolard 2003: 2). The social assistance system in South Africa makes provision for various groups of vulnerable people in the country. This policy appraisal will focus on the child support grants, available in three forms: the child support grant (CSG); foster care grant; and the care dependency grant. The grants themselves are either paid in cash at specified pay points, or deposited directly into a beneficiary's bank account. In practice, given the high costs of personal banking and low rates of bank access for the poor, most grants are paid out directly in cash (IRIF 2006). Table 3.6 summarises the different types of grants and the eligibility criteria.

Achievements and impact

The number of beneficiaries of the CSG has been rising rapidly. In 1999/2000, there were 321 906 beneficiaries, rising to 2 116 325 by October 2003 (Woolard 2003: 5). In 2006, the recipients had increased to 6.8 million (Pauw & Mncube 2007: 13).

Table 3.6: Types of child support grants and eligibility criteria

Type of grant	Focus	Eligibility criteria
Child support grant	• Payable to a primary care giver or any person who takes primary responsibility for the daily needs of the child • Children from birth to 14 years of age	• Child and primary caregiver must be a South African citizen and resident in South Africa • Applicant must be the primary caregiver • Child/children must be under the age of 14 years • The applicant and spouse must meet the requirements of the means test • ID documents of caregiver • Birth certificate of the child • Cannot apply for more than six non-biological children
Dependency care grant	• Payable to parent/s or foster parent/s of a child who is between one and 18 years old who requires and receives permanent home care due to his or her severe mental and/or physical disability	• Must be South African citizen/s • Applicant and child must be resident in South Africa • Children must be one to 18 years of age • Medical or assessment report confirming disability • Applicant, spouse and child must meet means test requirements • Care-dependant children must not be permanently cared for in a state institution • ID document of applicant • Birth certificate of child
Foster care grant	• Made in respect of a foster child who has been placed in custody in terms of the Child Care Act • Children under the age of 18 years	• Applicant/child must be resident in South Africa at the time of application • ID document of applicant • Court order indicating foster-care status • Foster child must pass the means test

Source: www.sassa.gov.za

The number of foster care grants paid per month increased from 42 917 in 1997 to almost 300 000 in 2006, while the number of care dependency grants paid per month increased from 3815 in 1997 to 88 679 in February 2006 (Pauw & Mncube 2007: 16).

Research has indicated that South Africa's social assistance programme is helping to reduce poverty, contributing to social cohesion, and having a positive impact on the economic opportunities of households (Masango 2004). The Inter-Regional Inequality Facility (IRIF) has argued that social grants are the most pro-poor item of government expenditure (IRIF 2006). In addition, social grants provide households with income and support second-order effects that further reduce poverty. In particular, households that receive social grants are more likely to send young children to school, provide better nutrition for children and have members looking for work more intensively, extensively and successfully than do workers in comparable households without social grants (IRIF 2006). Studies elsewhere have shown that conditional cash transfers (CCTs) reduce poverty, improve education and health outcomes, and alleviate various other sufferings of the poor, such as child labour and child mortality (FV Soares 2007; S Soares 2007). A paper that examined the impact of CCT programmes on reducing inequality in Brazil, Chile and Mexico, demonstrated a reduction in inequality (S Soares et al. 2007). Woolard has estimated that the impact on child poverty in South Africa is significant, with the percentage of children in poverty falling from 42.7 per cent to 34.3 per cent and those children in ultra-poverty from 13.1 per cent to 4.2 per cent (Woolard 2003: 9).

The provision of grants also contributes to an increase in the number of children enrolling in schools. Living in a household that receives grants is correlated with a higher success rate in finding employment. At the macro-economic level, the social-grants programme tends to increase domestic employment while promoting a more equal distribution of wealth (Masango 2004).

Challenges and constraints

- The implementation and administration of social grants was initially devolved to the provinces. A government review identified a number of problems, including fraudulent grants, delays in approving and paying grant applications, and difficulties in accessing payment, with great inequity across provinces. Consequently, in 2004, the South African Social Security Agency (SASSA) was established to implement and administer social grants.
- There have also been allegations that the CSG has perverse incentives, one of which is to encourage women and especially teenagers to have more children (Makiwane & Udjo 2007). The findings on this matter are still inconclusive and a formal study has been commissioned by the Department of Social Development (DSD) to investigate the relationship between the CSG and teenage pregnancy.

Conclusion

Studies have demonstrated the effectiveness of the various types of child support grants in addressing the needs of vulnerable children and reducing poverty. However, relatively little is known about the link between government social grants and the private social safety net or about the differential impacts of social grants, by gender and by geographical areas, or their effects on health or labour migration (IRIF 2006). The use of a means test and different policy interpretations may act as a significant barrier to a greater take-up of social grants among poor households. This is particularly so in the poorest rural areas, where the poor have the least access to the official identification documents necessary to access social grants (IRIF 2006).

Bana Pele: children first

Gauteng province, with almost 20 per cent of the South African population, is highly urbanised and is the industrial heartland of South Africa. The 2001 Census found that the Gauteng population was 8.8 million, which represented an increase of over 1.5 million over a five-year period (StatsSA 2005). There are more men than women in Gauteng, particularly in the 20 to 44-year age group. Of all the country's provinces, Gauteng is the highest net recipient of migrants.

With the third term of government in 2004, the provincial government outlined its five-year strategic priorities. These were to:

- Enable faster economic growth and job creation.
- Fight poverty and build safe, secure and sustainable communities.
- Foster healthy, skilled and productive people.
- Deepen democracy and nation building and realise the constitutional rights of people.
- Build an effective and caring government. (GPG 2004)

Due to poor employment levels, the benefits of economic growth in Gauteng have not yet translated into broad-based income redistribution and poverty alleviation (GPG 2004). Levels of inequality, as measured by the Gini Coefficient, increased by three per cent between 1995 and 2000 to 0.61. Growing inequality has been most pronounced within the black African population (GPG 2004).

The number of households with monthly incomes below R1 200 grew by eight per cent between 1999 and 2000. However, the inclusion of the social wage component (in free basic services, healthcare and education) into the calculation of the Gini Coefficient would probably result in an improvement in these figures. While job creation programmes have made progress in providing short-term employment, these are not large-scale enough to make a significant impact on unemployment. About 48 per cent of children live in poor households, with 51 per cent of under-five's living below the poverty line (GPG 2004). Between 1995 and 1999 the poverty rates among children increased from 24.2 per cent to 37.8 per cent. According to the 1999 National Food Consumption Survey, approximately 40 per cent of Gauteng's children aged between one and nine experienced hunger. The most significant contribution towards helping the most vulnerable has been the social grant system, which is regarded as targeting the poorest sections of the population. Nationally, the poorest 20 per cent of households receive the largest amounts in grants. The percentage change in social grants between 1999 and 2002 in Gauteng was 294 per cent (GPG 2004).

In response to these socio-economic challenges, and as part of its vision for 2014, the Gauteng provincial government developed an integrated poverty alleviation programme aimed specifically at providing relief and creating security networks for the most impoverished and vulnerable children in the province. The Bana Pele ('children first') programme is steered by the Gauteng DSD and was launched in 2005. Through this initiative, the provincial government intends to give practical effect to the principles of Batho Pele ('people first') in public service delivery and to further the constitutional rights of children to education, recreational facilities, adequate nutrition, proper shelter, peace, good health and the right to protection from poverty and disease. The programme was also designed to lay a sound foundation for future performance and the advancement of children, and to provide an opportunity to break the cycle of poverty (GPG 2004).

Table 3.7: Bana Pele principles

Principle	Description
Put children first	The best interest of the child shall be the primary consideration
Consultation	Children should be consulted about the Bana Pele programme
Services standards	Children should be told what level and quality of services they will receive
Access	All children should have equal access to services to which they are entitled
Courtesy	Children should be treated with courtesy, consideration and respect
Information	Children should be given full, accurate information about the services they are entitled to receive
Redress	If the promised standard of service is not delivered, children should be offered an apology, a full explanation and a speedy and effective remedy. When complaints are made, children should receive a sympathetic, positive response
Participation	All children have a right to be heard and to participate in the affairs that affect their well-being

Source: www.banapele.gpg.gov.za

Structure and components

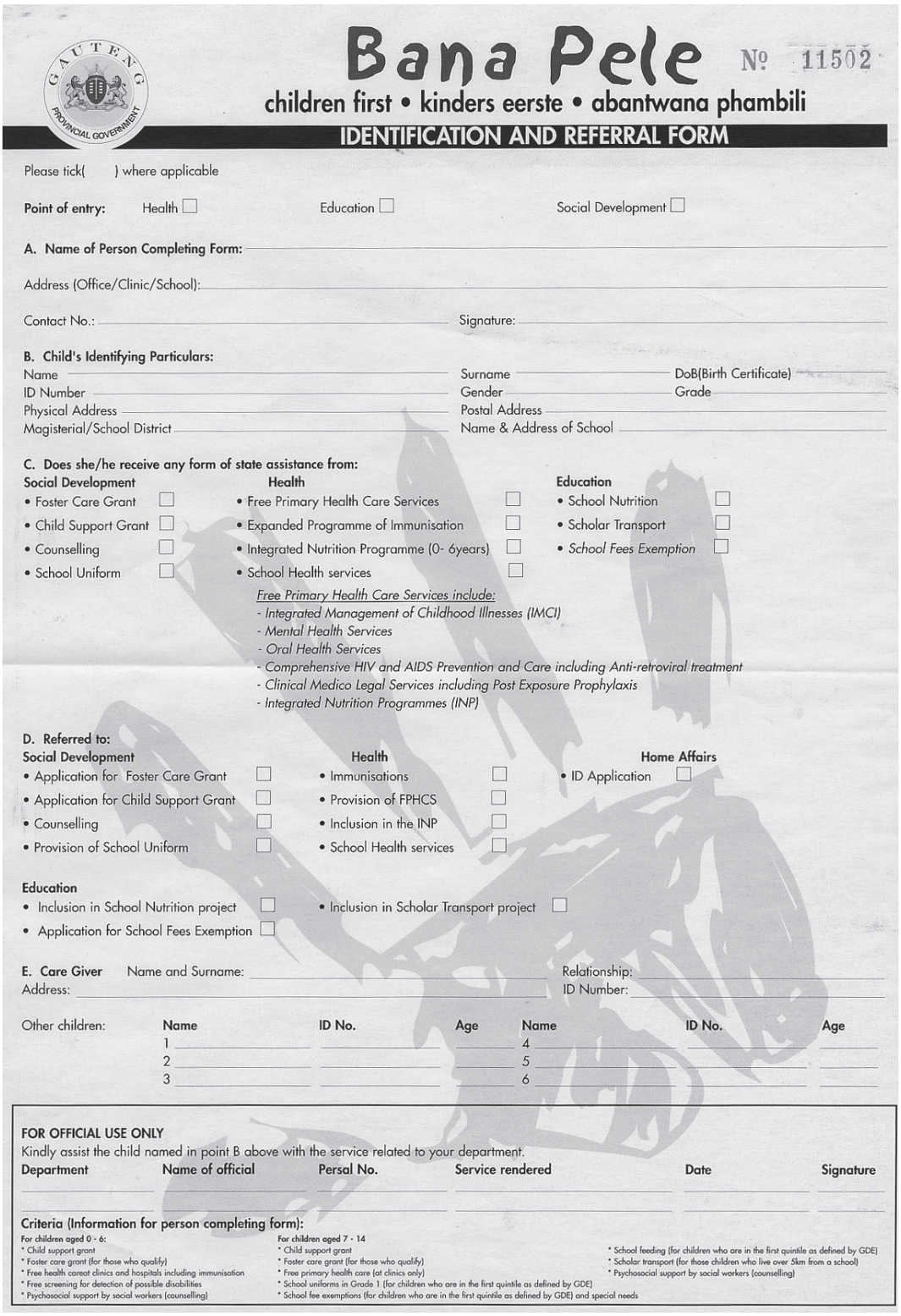
Bana Pele is conceptualised as a pro-poor, comprehensive and integrated package of free services aimed at vulnerable a children, and includes child support grant and foster care grant for those children who are under the care of foster parents. In addition, those children eligible for the child support grant (children between birth and the age of 14 years) are also entitled to:

- Free PHC services at clinics and hospitals.
- Free screening for the early detection of disabilities and special needs as well as psychosocial support by social workers for school-going children, between the ages of seven and 14 years.
- Free school uniforms for learners in the first grade (this applies to children who are in the first quintile as defined by the Department of Education).
- School-fee exemptions (awarded specifically to children in the poorest communities within the province).
- A school feeding scheme and scholar transport for children living over five km away from the nearest school. (GPG 2007)

Moreover, the programme is designed to access services from various entry points such as clinics, hospitals, schools, and social welfare and development service points. One referral form has been designed for use in social development (welfare), clinics and schools. A primary-care nurse who attends to a vulnerable child, for example, will complete the Bana Pele form and refer the child to the nearest social assistance point.

The Bana Pele programme also strives to invest in local initiative as one of its key objectives and this is achieved essentially through the use of local entrepreneurs as the major suppliers of school uniforms and feeding. To broaden the scope of the programme, the GPG has also committed itself to addressing other social problems affecting children, such as the child abuse, exploitation, neglect and violence that are inarguably detrimental to their well-being and development. This is meant to be achieved through the collective efforts of all key role-players – community-based organisations (CBOs), local communities, health workers and teachers – who are also essential members of the Bana Pele network.

Figure 3.1: Bana Pele identification and referral form



Bana Pele

№ 11502

children first • kinders eerste • abantwana phambili

IDENTIFICATION AND REFERRAL FORM

Please tick( ) where applicable

Point of entry: Health ☐ Education ☐ Social Development ☐

A. Name of Person Completing Form: _____

Address (Office/Clinic/School): _____

Contact No.: _____ Signature: _____

B. Child's Identifying Particulars:

Name _____ Surname _____ DoB(Birth Certificate) _____

ID Number _____ Gender _____ Grade _____

Physical Address _____ Postal Address _____

Magisterial/School District _____ Name & Address of School _____

C. Does she/he receive any form of state assistance from:

Social Development		Health		Education	
• Foster Care Grant	☐	• Free Primary Health Care Services	☐	• School Nutrition	☐
• Child Support Grant	☐	• Expanded Programme of Immunisation	☐	• Scholar Transport	☐
• Counselling	☐	• Integrated Nutrition Programme (0- 6years)	☐	• *School Fees Exemption*	☐
• School Uniform	☐	• School Health services	☐		

Free Primary Health Care Services include:
- *Integrated Management of Childhood Illnesses (IMCI)*
- *Mental Health Services*
- *Oral Health Services*
- *Comprehensive HIV and AIDS Prevention and Care including Anti-retroviral treatment*
- *Clinical Medico Legal Services including Post Exposure Prophylaxis*
- *Integrated Nutrition Programmes (INP)*

D. Referred to:

Social Development		Health		Home Affairs	
• Application for Foster Care Grant	☐	• Immunisations	☐	• ID Application	☐
• Application for Child Support Grant	☐	• Provision of FPHCS	☐		
• Counselling	☐	• Inclusion in the INP	☐		
• Provision of School Uniform	☐	• School Health services	☐		

Education

- Inclusion in School Nutrition project ☐
- Inclusion in Scholar Transport project ☐
- Application for School Fees Exemption ☐

E. Care Giver Name and Surname: _____ Relationship: _____

Address: _____ ID Number: _____

Other children:	Name	ID No.	Age	Name	ID No.	Age
	1			4		
	2			5		
	3			6		

FOR OFFICIAL USE ONLY

Kindly assist the child named in point B above with the service related to your department.

Department	Name of official	Persal No.	Service rendered	Date	Signature

Criteria (Information for person completing form):

For children aged 0 - 6:
* Child support grant
* Foster care grant (for those who qualify)
* Free health careat clinics and hospitals including immunisation
* Free screening for detection of possible disabilities
* Psychosocial support by social workers (counselling)

For children aged 7 - 14
* Child support grant
* Foster care grant (for those who qualify)
* Free primary health care (at clinics only)
* School uniforms in Grade 1 (for children who are in the first quintile as defined by GDE)
* School fee exemptions (for children who are in the first quintile as defined by GDE) and special needs
* School feeding (for children who are in the first quintile as defined by GDE)
* Scholar transport (for those children who live over 5km from a school)
* Psychosocial support by social workers (counselling)

Source: www.banapele.gpg.gov.za

The Bana Pele programme operates within a framework that adheres to the principles set out in Table 3.7. Figure 3.2 illustrates the *Bana Pele* identification and referral form.

Achievements and impact

- According to the Gauteng DSD, 487 545 children under the age of six were benefiting from the Bana Pele programme in 2007.
- Around 1.1 million children between the ages of seven and 14 years have been aided, and more than 1.6 million parents currently draw benefits from the programme.
- Furthermore, about 39 000 children in the province are receiving foster care grants and more than 25 000 foster parents are receiving government assistance.
- More than 310 000 primary school children are exempted from paying school fees in Gauteng and 378 298 learners are on the school nutrition programme; the provincial government's target was to reach 400 900 children for 2007.
- Forty thousand learners have received free new school uniforms and more than 66 000 learners are transported to school by bus every day.
- In terms of job creation, about 25 women's groups across Gauteng have been involved in the manufacturing of the school uniforms, and many other women have secured employment as feeding-scheme service providers.

Critique, challenges and constraints

Implementation is the major challenge, and relates to a lack of capacity, insufficient resources and the duplication of efforts. The intention of the programme was to develop a uniform electronic information system that would enable seamless referral across social-sector departments (social assistance, education and health). To a large extent, implementation has been paper-based and the health sector will consider the installation of computers only in the 2007/2008 financial year. The hospitals have also not been well integrated into the referral system, creating many missed opportunities for referrals and for ensuring a safety net for children.

Conclusion

While many of the services contained in the Bana Pele programme are not entirely new in the current social assistance system, more children are likely to benefit from the extension of the services provided through the programme, The mechanism is potentially effective through the integrated approach followed in terms of identifying, referring and tracking beneficiaries, and establishing a common database of children who are in need within the province. This information will be made available to municipalities who will, in turn, incorporate it in their indigent policies. While Bana Pele shows promise and appears to be a worthwhile endeavour, at the time of the appraisal a formal impact assessment of the programme had not been done. Many of the indicators are output-based (number of beneficiaries), rather than impact-based (reduction in vulnerability).

Zimbabwe

Zimbabwe is classified as a low-income country in southern Africa, with a per capita income of US$363 (UNDP 2006b). The country has an estimated population of 12.9 million, with 35.4 per cent in urban areas, and the majority living in rural areas (ibid.).

Basic Education Assistance Module (BEAM)

BEAM was launched in January 2001 as one component of the Enhanced Social Protection Project (ESPP). This collection of programmes formed a core part of the government's wider social protection strategy at the beginning of the millennium (RHVP 2007). The other components of ESPP are public works (PW), children in especially difficult circumstances (CEDC), essential drugs and medical supplies (EDMS), and the development of a longer-term social protection strategy (SPS).

Structure and components

BEAM's main development objective is to prevent irreversible welfare losses for poor households who resort to extreme coping mechanisms, like withdrawing children from school in response to increasing poverty. It is a national school-fee assistance programme targeting vulnerable children of school-going age (six to 19 years), implemented by the Ministry of Public Service, Labour and Social Welfare in conjunction with the MoE for sport and culture (Mararike 2006).

The high levels of poverty, brought about largely by the worsening macro-economic situation in the country, and its effects on national net enrolment rates at both primary and secondary levels provided BEAM's rationale. Since 2001 the macro-economic situation has worsened considerably, further increasing the demand for BEAM. The programme provides tuition, levy and examination-fees assistance, targeting children who have never been to school or who have dropped out of school, or are likely to do so, due to a lack of funds.

The BEAM model is based on community participation in beneficiary selection through school selection communities. A BEAM community selection committee, consisting of three members of the school development committee (one of whom is the school principal) and at least six elected community representatives, selects eligible children. A new selection committee is elected each year. Councillors and traditional leaders are not eligible for election to the committee, with their role being limited to mediation in the event of disputes.

At the start of each school year, the selection committee is advised of budget allocations for primary, secondary and district recipients for special education to assist vulnerable groups. The budget allocations determine the total number of children to be assisted each year. The fee structure of the schools in which the children will be enrolled also determines the number of students to be assisted through BEAM. The selection committee convenes a meeting annually to select potential beneficiaries based on predetermined criteria such as whether the beneficiary is an orphan, has never been to or has dropped out of school due to economic hardships, or is living on the street. The committee also receives nominations for beneficiaries from community members. The committee determines the final list for consideration based on the fee structure and the budget allocation for each category (primary, secondary and special schools). The list of selected students is published to enhance transparency and accountability.

Achievements and impact

In 2005 the BEAM budget was Z$195 billion and assisted 969 962 pupils, representing 27 per cent of enrolment. BEAM is a robust mechanism with the potential to have a positive, far-reaching impact on the poorest children, providing an example of how governments can work closely with communities to develop sustainable structures which can appropriately target and assist vulnerable children.

The broader impact on health status is not known, but there is generally an inverse relationship between the level of education and the disease burden for most infectious diseases (Vandemoortele & Delamonica 2000; Kelly 2006). Education levels are strongly predictive of better knowledge, safer behaviour and reduced HIV infection rates (UNAIDS 2002; World Bank 2002).

Programme weaknesses

The Regional Hunger and Vulnerability Programme has noted the following weaknesses:

- Children cannot be sponsored or supported at mid-year.
- School fees increase drastically in the middle of the year.
- The targeting and selection of children is problematic. (RHVP 2007)

CHAPTER 4

Policy appraisals: East and West Africa

Ethiopia

Ethiopia in East Africa had an estimated population of 75.6 million people in 2004, the vast majority of whom were living in rural areas (UNDP 2006b). It is classified as a low-income country. Almost 45 per cent of the population is under the age of 15, life expectancy at birth is 47.7 years, and the IMR is 110 per 1000 live births (ibid.). Roughly 50 per cent of the population is poor, with an estimated per capita income of US$100 (World Bank 2004). Many more people are vulnerable due to the cumulative effects of repeated droughts, deforestation, soil erosion and degradation (World Bank 2004).

Food insecurity is one of the defining features of rural poverty in Ethiopia (FewsNet 2005). As a result, Ethiopia appeals for emergency food aid every year to meet the consumption needs of at least five million people who are chronically short of food (World Bank 2004; FewsNet 2005).

Productive Safety Net Programme (PSNP)

Structure and components
The development objective of the PSNP is to move from a relief-oriented to a development-oriented safety net by:

- Providing predictable, multi-annual resources.
- Replacing food with cash (in cash transfers) as the primary medium of the grant.
- Making resources available for critical capital, technical assistance and administrative costs.

The PSNP consists of *labour-intensive public works*, in the form of grants to households whose adults participate in public works sub-projects; and *direct support* – grants to households who are labour-poor and cannot undertake public works (MoARD 2004; World Bank 2004). Beneficiaries include (but are not limited to) orphans, pregnant and lactating mothers, elderly households, and other labour-poor, high-risk households with sick individuals (such as people living with HIV and AIDS), and the majority of female-headed households with young children (MoARD 2004; World Bank 2004).

The PSNP is one of the government's flagship reform programmes and is envisaged as a major instrument for achieving the government's stated goal of reducing vulnerability and attaining food security for between five and six million chronically food-insecure people by 2009 (World Bank 2004). The rationale is to shift from emergency humanitarian aid to a productive safety-net system financed through multi-year, predictable resources. It is being implemented with the support of the World Bank at an estimated cost of US$170 million in the first year to cover approximately five million chronically food-insecure people.

The objectives of the programme are to:

- Reduce the number of Ethiopians suffering from extreme hunger, malnutrition and poverty (MDG 1).
- Restore and rehabilitate the environment through soil and water conservation activities (MDG 7).

- Build and maintain public infrastructure (such as rural roads).
- Enable smallholder farmers to take on economic activities with higher risk but higher return (like adopting higher-yielding seeds requiring costly input). (World Bank 2004)

The PSNP aims to strengthen community involvement through supporting community targeting and local-level participatory planning. In addition, public works activities are emphasised to address some of the underlying causes of food insecurity, especially with respect to soil and water conservation. The proposed measures are expected to lead to significant improvements in the productivity of the safety net over the current humanitarian system (MoARD 2004; World Bank 2004).

PSNP key result indicators

- At least 95 per cent of eligible beneficiaries are confirmed as chronically food insecure.
- At least 50 per cent of eligible beneficiaries participating in public works or in direct support have received grants rather than food.
- At least 95 per cent of disbursements to eligible beneficiaries for public works sub-projects have been made according to identified needs.
- At least 95 per cent of disbursements to eligible beneficiaries for direct support have been made according to identified needs.
- At least 75 per cent of capital and administrative budget is used by woredas (districts).
- At least 75 per cent of *kebeles* (wards) have developed and approved safety-net plans, taking into account community preferences.
- At least 60 per cent of public works sub-projects are assessed as technically sound.
- At least 50 per cent of *woredas* are presenting accurate and complete financial reports.
- At least 60 per cent of all participating *woredas* are reporting fully on physical progress.
- A management information system that provides sufficient and timely information for use by management has been established and is operational.

Achievements and impact

The PSNP is a component of the larger Food Security Programme (FSP) administered by the Ministry of Agriculture and Rural Development (World Bank 2004). Although the PSNP was officially launched on 22 February 2005, beneficiaries in many areas only received cash or food distributions in April/May 2005. FewsNet (2005) raised concerns that the delayed implementation might exert more pressure on the emergency resources in some areas, exacerbating the food crisis.

Slater et al. (2006), in a review of the PSNP policy, programme and institutional linkages, have concluded that the PSNP is already having a significant impact. There is evidence that several important changes have taken place in study areas in terms of nutrition, attitudes, and risk-taking behaviours. The main changes are as follows.

- In terms of food consumption, beneficiaries are commonly eating more food, of different types, of better quality, more often.
- In terms of asset protection, significant numbers of beneficiaries are able to avoid selling food to pay for short-term household needs such as medicine or school fees, and have been able to avoid selling productive assets like livestock and land. They have been able to avoid loans for food; avoid migrating, thereby allowing more investment in their own household livelihood activities; avoid low-paid and insecure casual labour; and avoid harvesting their crops prematurely to meet immediate food shortages.

- In terms of asset building, PSNP is also being used for a range of productive investments; for example in education, livestock and savings schemes.
- PSNP is also playing a key role in allowing people to feel secure enough in their income to take productive loans, which they previously found too risky. This indirectly enhances the asset-building role of the PSNP. (Slater et al. 2006)

The authors concluded that the benefits of public goods produced through public works have already led to tangible benefits, and they have the potential to do more, especially those related to roads to bring markets closer, activities to enhance soil potential and water management, and clinics and schools where these have been lacking.

Sharp et al. reviewed the targeting design, implementation and outcomes of the PSNP in its first year to 18 months of operation (Sharp et al. 2006). The study found that the PSNP is reaching the poor (Sharp et al. 2006). The institutional structures for combined administrative and community targeting are in place in most areas (though not all), and were functioning with varying degrees of success. No systematic corruption or large-scale abuse of the targeting system was found.

Constraints and challenges

Sharp et al. identified nine areas for improvement, summarised in Table 4.1.

Table 4.1: Key recommendations 12–18 months post-PSNP implementation, Ethiopia

Recommendation	Brief description
Public works (PW) and direct support (DS) targeting	• Drop pre-set quotas for direct support and set a ceiling of days per month rather than days per week • Labour-poor households eligible for the PW should receive transfers for the full family, even if they cannot cover the full work allocation • Community task forces should have authority to grant temporary maternity and sick leave for PW beneficiaries
Temporal targeting of public works and payments	• Plan PSNP works to minimise disruption to other activities conducive to the self-sufficiency and welfare of beneficiaries
Child labour and schooling	• Monitoring and supervision are needed to ensure that children are not employed on the PW
Re-targeting and registration	• Drop the requirement to re-target every six months
Appeals and grievance processes	• Ensure that community targeting processes are transparent, participatory and well managed
Monitoring	• Improve monitoring and strengthen the rapid response mechanism
Geographical targeting	• Develop guidelines
Gender	• Improve gender aspects of programme, including women's participation • Enable women to combine participation in the programme with their domestic and other work, without incurring an excessive workload damaging to their health and to the welfare of children
National and regional targeting guidelines	• Revise the guidelines

Sources: Sharp et al. 2006; Slater et al. 2006

Nigeria

Nigeria is a West African country, with an estimated population of 128.7 million people in 2004, with about 47.3 per cent of the population in urban areas (UNDP 2006b). In 2006 almost 45 per cent of the population was under the age of 15, life expectancy at birth was 43.3 years, and the IMR was 101 per 1 000 live births (ibid.).

The 1998 UNDP Human Development Report (HDR) for Nigeria described the country as 'a rich country with a poor population and the poorest and most deprived OPEC country' (UNDP 1998). Between 1980 and 1992, the average poverty incidence in Nigeria increased from 0.28 to 0.43 (www.napeponline.com). By 1999, the HDI was only 0.416 and about 70 per cent of the population was below the breadline (PCU n.d.).

The key problems identified were:
- Poor coordination of activities and the absence of continuous policy formulation.
- Lack of sustainability of programme and projects.
- The absence of achievable target setting.
- The absence of monitoring and evaluation.
- The duplication of functions and activities.

This crisis led to the birth of the National Poverty Eradication Programme (NAPEP).

The National Poverty Eradication Programme (NAPEP)

Structure and components
NAPEP is not a sector project implementation agency, but a coordination facility that ensures that the core poverty eradication ministries are effective (www.atikuabubakar.net). It commenced in 2002. NAPEP's overall aim was to spearhead the government's ambitious programme of eradicating absolute poverty amongst Nigerians (www.atikuabubakar.net). Absolute poverty was defined as the condition where a person or group of persons are unable to satisfy their most basic requirements for survival in terms of food, clothing, shelter, health, transport, education and recreation.

NAPEP was structured to integrate four sectoral schemes:
- A youth empowerment scheme (YES) provides unemployed youth with opportunities for skills acquisition, employment and wealth generation.
- A rural infrastructure development scheme (RIDS) has the objective to ensure the provision and development of infrastructure needs in the areas of transport, energy, water and communication, especially in rural areas.
- The social welfare services scheme (SOWESS) aims to provide basic social services including quality primary and special education, strengthening the economic power of farmers, providing PHC, etc.
- The natural resources development and conservation scheme (NRDCS) aims to bring about a participatory and sustainable development of agricultural, mineral and other resources.

NAPEP's target is to wipe out poverty in Nigeria by the year 2010. There are three stages to the attainment of this ambitious target:
- The restoration of hope for poor people in Nigeria. This involves providing basic necessities to hitherto neglected people, particularly in the rural areas.
- The restoration of economic independence and confidence.
- Wealth creation.

The National Poverty Eradication Council (NAPEC), chaired by the president, is the apex organ for policy formulation, coordination, monitoring and review of all poverty eradication activities in the country.

Achievements and impact

NAPEP has established structures at all levels nationwide. Under its Capacity Acquisition Programme (CAP), it has trained 140 000 unemployed youths, and 5 000 others who had received training as tailors and fashion designers were resettled (PCU 2006). A total of 50 000 unemployed graduates have also benefited from NAPEP's Mandatory Attachment Programme.

NAPEP has also established a database of all unemployed youths in all 36 states of the federation and the Federal Capital Territory (FCT). About 1.1 million youths have so far been registered. Such data could be used to target groups in any future poverty alleviation effort (PCU 2006).

Installation of equipment as part of the Rural Telephone Project is in progress. NAPEP has also set the stage for the Poverty Reduction Strategy Process (PRSP), which has been cautiously welcomed (Elumilade et al. 2006; Garuba n.d.).

Challenges and weaknesses

Garuba has noted that the Nigerian government appears to have shown some commitment to the implementation of this programme, but that the programme still suffers from most of the ills of the past (Garuba n.d.).

Elumilade et al. have argued that, while NAPEP is a good initiative, poverty appears to have worsened in Nigeria because of poor management of human and natural resources, bad government, corruption over many years and a huge external debt of 32 billion dollars (Elumilade et al. 2006). Similarly, Oyesanmi et al. note that the impact of various programmes has not contributed significantly to the well-being of the poor, that community participation has been inadequate and that the awareness of the programme is much higher among the educated elite than among illiterate people (Oyesanmi et al. n.d.).

CHAPTER 5

Policy summaries and recommendations

Review of policies appraised

We have reviewed policies, implemented in southern, East and West Africa, designed to provide free services (three policies), cash transfers (two policies), two policies focused on integrating and coordinating government activities for maximum impact and one policy aimed at reducing social exclusion of pregnant teenagers. Table 5.1 presents an overview.

We have pointed out in earlier chapters that the dominant discourse has been around poverty. It has been argued that poverty policy in southern Africa should be seen against the backdrop of colonialism, occupation, civil wars and apartheid, acute inequalities and high HIV prevalence (South African Institute of International Affairs 2001).

An evaluation of the free social service policies has shown an increase in the utilisation of these services (health and education). Oxfam has argued that in low-income countries, the most pro-poor health systems are those providing universal services that are free or almost free (Emmett et al. 2006). It appears that these policies are progressive, and benefit the poor. However, the success of policy implementation depends critically on the involvement of those civil servants who have to implement the policies to ensure that poor people are not further disadvantaged by the system (in South Africa and Mozambique).

The evaluation of the policies on cash transfers (in South Africa, Mozambique and Ethiopia) has shown that cash-transfer programmes as a form of social assistance are not new in SSA. In Mozambique, various studies have demonstrated the effectiveness of the cash transfer programme in addressing the needs of poor urban people, and in reaching the majority of those targeted by the programme (Rogers 1994; Schubert 1995; Datt et al. 1997; Low et al. 1998). However, rural coverage and the impact of cash programmes on rural poor people remain critical outstanding questions. The South African child support programme is well established and studies have demonstrated the effectiveness of the various types of child support grants in addressing the needs of vulnerable children and reducing poverty. In Ethiopia, analyses after 18 months of programme implementation have shown that several important changes have taken place in study areas in terms of nutrition, attitudes and risk-taking behaviour.

However, the extent to which these cash transfer programmes impact on health and well-being has been inferred and not measured directly. It appears that the critical factors determining the success of cash transfer programmes include appropriate design, strong multi-sectoral political support and adequate administrative capacity (Low et al. 1998).

Factors enabling or constraining policy implementation include international, national and local actions. Among these factors are research evidence, political and economic support, community/civil society support, advocacy and lobbying, public consultation and debate about policy and programmes, law enforcement, and a functioning accountability system.

Table 5.1: Summary of policies appraised

Botswana: Diphalana pilot programme to retain pregnant teenagers at schools	
Policy intention/objectives	• Provide uninterrupted basic education for targeted girls by helping to reduce first and repeated pregnancies • Ensure that students who do become pregnant complete school • Improve the scholastic performance of teenage mothers
Target population	Pregnant teenage girls and fathers-to-be
Year of commencement	1996
Health inequality/ vulnerability addressed	Inequality of economic opportunity
Formal monitoring and evaluation	Partial
Mozambique: Urban cash transfer programme (GAPVU/INAS)	
Policy intention/objectives	Social assistance safety net aimed at reduction of absolute poverty
Target population	Vulnerable women and children, elderly and disabled people, socially excluded persons
Year of commencement	1990
Health inequality/ vulnerability addressed	Poverty and social exclusion
Formal monitoring and evaluation	Yes
Mozambique: Free education policy	
Policy intention/objectives	Improve school enrolments and pupil retention rates
Target population	Children in primary school
Year of commencement	2005
Health inequality/ vulnerability addressed	Retention
Formal monitoring and evaluation	No
South Africa: Free healthcare	
Policy intention/objectives	Increase access to care for pregnant women, children, elderly and disabled
Target population	Vulnerable groups, e.g. women, children, users of public health services, the elderly and the disabled
Year of commencement	1994/1995
Health inequality/ vulnerability addressed	Not explicit, except to remove barriers of access to healthcare
Formal monitoring and evaluation	Yes
South Africa: Social transfers — child support grants	
Policy intention/objectives	Poverty relief for vulnerable (poor, fostered, disabled) children
Target population	Children up to 14 (CSG) and up to 18 for foster care and dependency care
Year of commencement	1994/1995

Health inequality/ vulnerability addressed	Poverty and marginalisation
Formal monitoring and evaluation	Yes
South Africa: Bana Pele	
Policy intention/objectives	Integrated and comprehensive pro-poor social services to children
Target population	Children up to 14
Year of commencement	2005
Health inequality/ vulnerability addressed	Poverty and marginalisation and vulnerability
Formal monitoring and evaluation	No
Zimbabwe: Basic education assistance module (BEAM)	
Policy intention/objectives	Reducing the number of children dropping out of, or not attending school, because of economic hardship
Target population	School children in both urban and rural areas who are unable to attend school because of economic hardships
Year of commencement	2001
Health inequality/ vulnerability addressed	Economic hardship/poverty
Formal monitoring and evaluation	Not clear
Ethiopia: Productive Safety Network Programme (PSNP)	
Policy intention/objectives	Reduce vulnerability and attain food security for five to six million chronically food-insecure people by 2009
Target population	Vulnerable women and children, elderly households, other labour-poor, high-risk households with sick individuals
Year of commencement	2005
Health inequality/ vulnerability addressed	Food insecurity, chronic poverty
Formal monitoring and evaluation	Yes
Nigeria: National Poverty Eradication Programme (NAPEP)	
Policy intention/objectives	A coordination facility that aims to spearhead the government's ambitious programme of eradicating absolute poverty by 2010
Target population	All poor people
Year of commencement	2004
Health inequality/ vulnerability addressed	Poverty
Formal monitoring and evaluation	Partial

The main barriers identified to policy implementation were wide-ranging, and included political and fiscal constraints, a lack of skills and human resources, the attitudes of public servants, vested interests, alleged abuse by consumers and an inadequate policy communication strategy. The *lack of political support* was listed as the strongest barrier to passing legislation or implementing certain policies.

In general, there is inadequate monitoring of policy implementation, either because of a lack of baseline data or because of problems with indicators and the measurement of input, process, output and impact. However, there has been increasing emphasis on improving monitoring and evaluation capacity and defining indicators upfront (as in the case of the Ethiopian programme). Initiatives have included the establishment of dedicated units, recruitment and capacity building.

Recommendations

The main recommendations emanating from the policy appraisal are as follows:

- Initiate a process to measure health inequalities and advocate the revival of a strong global movement to address health inequalities, with a focus on poor and vulnerable people.
- Build strong public-service systems that guarantee universal access to social services (e.g. healthcare and education). Such public services must support and empower women and girls and build an ethos where staff are involved and encouraged to take pride in their contribution.
- Facilitate the participation of civil society in local and national planning, budget and implementation processes, and ensure that they have oversight of service delivery.
- Strengthen monitoring and evaluation of programmes and services, identify outcome indicators and ensure that baseline indicators are measured.

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