INTERNATIONAL LABOUR ORGANIZATION

Building a social protection floor with the Global Jobs Pact

Second African Decent Work Symposium
Yaoundé, Cameroon, 6–8 October 2010

INTERNATIONAL LABOUR OFFICE GENEVA

ISBN: 978-92-2-123933-8 (print)
ISBN: 978-92-2-123934-5 (Web pdf)

First edition 2010

Building a social protection floor with the Global Jobs Pact: Second African Decent Work Symposium Yaoundé, October 2010 / International Labour Office, Social Security Department – Geneva, ILO, 2010
xxix, 142 p.

International Labour Office and Social Security Dept; African Decent Work Symposium Yaoundé 2nd, 2010, Yaoundé, Cameroon

conference report / social protection / social security policy / health insurance / guaranteed income / Africa

02.03.1

ILO Cataloguing in Publication Data

Printed by the International Labour Office, Geneva, Switzerland

Foreword

The following report was prepared with a view to assist the debate on the future of social protection in Africa at the Second African Decent Work Symposium focused on: "Building a social protection floor with the Global Jobs Pact" This Symposium will discuss and assess the achievements in the region, analyse the challenges and the obstacles along the path to build the decent social protection systems as requested by the Global Jobs Pact.

The report presents progress African countries are making in reinforcing their social protection policies and programmes aiming eventually at providing to all their citizens and their residents adequate social security.

This Yaoundé meeting follows the First African Decent Work Symposium, held in Ouagadougou, Burkina Faso, 1–2 December 2009, which has adopted the road map for the implementation in Africa of the Global Jobs Pact, which calls for adoption in each member country of a strategy for the effective extension of social security, including establishing a social protection floor of basic services and benefits, as recommended also by the Chief Executives Board (CEB) of the United Nations (UN) system.

This Symposium follows up also the 11th African Regional Meeting held in April 2007, which adopted the Decent Work Agenda in Africa 2007–15 and recommended that all African countries adopt coherent national social security strategies, notably for the creation or extension of a social security system. The continent has already defined a "Social Protection Framework for Africa" adopted at a ministerial meeting organized in Windhoek, Namibia, in October 2008.

During a Tripartite Meeting of Experts on Strategies for the Extension of Social Security Coverage organized by the ILO in Geneva from 2 to 4 September 2009, the experts endorsed strongly a two-dimensional strategy for social security extension. The first, "horizontal", dimension aims at extending social security coverage to all those in need through securing access – as a priority – to at least basic package of benefits. The second, "vertical" dimension of a strategy aims at reaching – as the country develops – higher levels of protection to reach at least those defined by the up to date ILO Conventions and Recommendations in the area of social security .

Both dimensions of this strategy – horizontal and vertical coverage extension – can be pursued in parallel and synergy. Many countries in Africa and other parts of the world have shown that coverage extension and strengthening of social insurance schemes can occur in parallel with the implementation of new programmes establishing the floor of social protection in the form of basic benefits and services accessible to the poorest and most vulnerable.

Our hope is that the Symposium reaches the objective to promote social security in the political agendas of African countries, as a means to reduce poverty and as a response to the economic financial and social crisis affecting the countries of the region, and in particular, the establishment of a social protection floor. The results of this Symposium will also be the important contribution of the African continent to the debate on the role of the ILO in the social security extension, the debate which will continue in 2011 at the 100th Session of the International Labour Conference.

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Acknowledgements

The factual parts of this report have been written on behalf of the International Labour Office (ILO) by Viviene Taylor, Head of Department of the School of Social Development at the University of Cape Town, and member of South Africa's National Planning Commission. Further inputs have been provided by officials of the ILO's Social Security Department and specialists based in the field in Africa: Michael Cichon, Krzysztof Hagemejer, John Woodall, Tharcisse Nkanagu, Xenia Scheil-Adlung, Ursula Kulke, Florence Bonnet, Christine Bockstal, Théopiste Butare, Luis Frota, Nuno Cunha de Mello.

The report draws on a number of recent publications and technical, policy and cooperation reports of the ILO, as well as reports for the International Labour Conference or the Governing Body. These include:

- *Social security: A new consensus* (Geneva, 2001).
- *Resolution and conclusions concerning social security* (Geneva, 2001).
- *Social protection as a productive factor*, Report to the Employment and Social Policy Committee of the Governing Body of the ILO, International Labour Conference, 89th Session (Geneva, 2005).
- *Conclusions on promoting rural employment for poverty reduction*, International Labour Conference, 97th Session, 2008 (Geneva, 2008).
- *Social health protection: An ILO strategy towards universal access to health care?*, Social Security Policy Briefings, Paper 1 (Geneva, 2008).
- *Setting social security standards in a global society: An analysis of present state and practice and of future options for global social security standard setting in the International Labour Organization*, Social Security Policy Briefings, Paper 2 (Geneva, 2008).
- *Can low income countries afford basic social security?*, Social Security Policy Briefings, Paper 3 (Geneva, 2008).
- *ILO Declaration on Social Justice for a Fair Globalization*. Adopted by the International Labour Conference at its 97th Session, Geneva, 10 June 2008.
- *Draft report on assessing health financing options in Sierra Leone* (Geneva, 2008).
- *Recovering from the crisis: A Global Jobs Pact*, resolution adopted by the International Labour Conference at its 98th Session, Geneva, June 2009.
- *Social security for all: Investing in social justice and economic development*, Social Security Policy Briefings, Paper 7 (Geneva, 2009).
- *Extending social security to all: A guide through challenges and options* (Geneva, 2010).
- *World Social Security Report 2010–11: Providing coverage in times of crisis and beyond* (Geneva, 2010).

– *Employment and social protection in the new demographic context*, Employment Policy Department and Social Security Department (Geneva, 2010).

In addition, the report draws on the following authored publications:

– Dixon-Fyle, K. and Mulanga, C. 2004. *Responding to HIV/AIDS in the world of work in Africa: The role of social protection*, ILO–AIDS Working Paper 5 (Geneva, ILO).

– Townsend, P. (ed.). 2009. *Building decent societies: Rethinking the role of social security in development* (Geneva, ILO; London, Palgrave Macmillan).

Executive summary

This regional African meeting completes a round of events organized at global and regional levels by the International Labour Office (ILO) within the broad scope of its Global Campaign on Social Security and Coverage for All.

The report is organized in six main chapters following a brief introduction. Chapter 1 sets out the context in which African countries seek to develop their social protection [1] policies, while Chapter 2 offers an overview of the prevailing situation of social security provision in Africa. Chapters 3 and 4 focus, respectively, on topical issues regarding social health protection and on schemes designed to provide income security for different groups of the population. These chapters each finish with a brief summary of conclusions specific to their topics. A broader synthesis of overall conclusions is presented in Chapters 5 and 6, with the objective of furthering the understanding of social security and its role in reducing poverty and mitigating the harsh impacts of recurring social and economic crises, as well as the impacts of the current global financial crisis on people in Africa. The appendices present a number of country case studies, together with a compilation of key statistics.

The policy context

In recent years there have been significant shifts in thinking within Africa and elsewhere in the world about how social security and social protection are understood, its links to sustainable economic development and its relevance as a comprehensive response to poverty and capability deprivations. That perspective is based on and reinforced by evidence gained from research in those African countries that have introduced social protection programmes; it contributes to demonstrating that government-led social protection programmes are not only necessary for sustained economic growth, but are generally affordable in low-income countries, certainly when considered as part of a package of measures, even if in some cases there is a short-term need for support by the international community by way of development assistance. A feature of policy-making in this environment has been the ability to progress beyond the question as to whether countries should have social protection programmes to ask, rather, how to promote successful implementation of social protection programmes in such a way as to ensure human development and inclusive economic growth.

Strategic and deliberate policy choices are now being considered by African governments as to what provisions should constitute a basic package of social protection, how to determine and benchmark the level at which provisions are made, what instruments would be required to monitor and evaluate programmes, and how to build capacity for implementation at national, local and subregional levels. Chapter 1 of the report describes the framework in which these trends are developing.

The policy impetus towards the expansion of social protection that has been evident in Africa in recent years reflects the efforts of both the ILO and the African Union (AU). The ILO has, over the years, adopted a number of Conventions and Recommendations on social security with a view to the ongoing promotion and application of those which have been assessed as being up to date. These instruments should be seen as more than simply *labour* standards; they apply to whole populations and thus are helping to realize social security as a universal human right.

[1] In this report the terms “social security” and social protection” are used in a manner which is largely interchangeable, unless the context specifically indicates otherwise.

Meanwhile, the Constitutive Act of the AU, adopted on 11 July 2000 in Lomé, Togo, set out and continues to reinforce the need to promote a common agenda to address issues affecting the people of the continent.

The need for a comprehensive approach to work and rights is clearly reflected in the Universal Declaration on Human Rights, and continues to be the subject of ongoing studies. [2] The promotion of "opportunities for women and men to obtain decent and productive work, in conditions of freedom, equity, security and human dignity" [3] becomes a critical building block of the approach to social protection by both the ILO and the AU. This goal must include "all workers" irrespective of their sectors, whether they are waged or unwaged, male or female, unregulated, self-regulated or homeworkers.

Social protection in the region is gaining momentum and efforts are being made to sustain and expand existing measures, with particular efforts to overcome the problems of exclusion.

Further important steps have been taken on a number of occasions, and meetings at Ouagadougou (2004), Livingstone (2006), Addis Ababa (2007) and Windhoek (2008) can be seen as milestones. At the Third Extraordinary Session of the Assembly of Heads of State and Government of the AU in September 2004 in Ouagadougou, Burkina Faso, poverty and unemployment were high on the agenda. This meeting resulted in the Ouagadougou Declaration and Plan of Action (PoA) whose declared aims are to empower people, open opportunities and create social protection and security for workers through building a people-oriented environment for development and national growth. The PoA envisages that resources would be mobilized for implementation of plans of action at each of the national, regional, and international levels. It recognizes the need to address social development, poverty alleviation and employment creation in a coherent and integrated manner.

Together, the Ouagadougou Declaration and PoA form the current blueprint for the AU strategy on social development. The linking of poverty reduction, productive employment and social protection in the Plan of Action correlate directly with the Decent Work Agenda of the ILO, and the Ouagadougou Declaration and Plan of Action together support the continuing efforts made to promote the Decent Work development agenda of the ILO, the objectives of which include the enhancement of the coverage and effectiveness of social protection for all sectors in society, particularly the poor and vulnerable.

The Livingstone Conference held in March 2006 represented yet another turning point in the commitment of African governments to promote social protection as an urgent response to the increasing vulnerabilities of people, in the face of both chronic deprivation and new crises in the region. The Livingstone Call for Action recognizes that a critical requirement for a comprehensive social development agenda is the promotion of an approach that links employment policies and poverty alleviation. The Call for Action adopts the guiding principle that social protection is embedded in both a human rights and an empowerment agenda.

[2] See for instance A. Sen: "Work and rights", in *International Labour Review* (Geneva, ILO, 2000), Vol. 139, No. 2, pp. 119–128; G. Standing: *Beyond the new paternalism: Basic security as equality* (London, Verso/ILO, 2002).

[3] ILO: *Decent work*. Report of the Director-General, International Labour Conference, 87th Session, Geneva, 1999, p. 3.

The ILO's 11th African Regional Meeting held in Addis Ababa in April 2007 agreed on the following target related to social security:

> All African countries adopt coherent national social security strategies, including for the introduction or extension of a basic social security package that includes essential health care, maternity protection, child support for school-age children, disability protection and a minimum pension. [4]

To achieve such an ambitious programme, Africa needs to campaign energetically so as to sensitize not only the populations at large but also policy-makers at the highest levels.

Most recently, the First AU Conference of Ministers in Charge of Social Development, held in Windhoek, Namibia from 27 to 31 October 2008, adopted the Social Policy Framework for Africa (SPF). This framework, noting that levels of investment in and access to social protection are still low in Africa, foresees the gradual building of social protection and social security "based on comprehensive longer term national social protection action plans. Measures will include: extending existing social insurance schemes (with subsidies for those unable to contribute); building up community based or occupation based insurance schemes on a voluntary basis, social welfare services, employment guarantee schemes and introducing and extending public-financed, non-contributory cash transfers." [5]

Under the Social Policy Framework, African countries are encouraged to choose the coverage extension strategy and combination of tools most appropriate to their circumstances. It notes, however, the emerging consensus "that a minimum package of essential social protection should cover: essential health care, and benefits for children, informal workers, the unemployed, older persons and persons with disabilities. This minimum package provides the platform for broadening and extending social protection as more fiscal space is created."

This document also indicates that such a "minimum package can have a significant impact on poverty alleviation, improvement of living standards, reduction of inequalities and promotion of economic growth and has been shown to be affordable, even in low-income countries, within existing resources, if properly managed".

Hence the approaches of both the ILO and the AU call for an extension of social protection schemes to all categories of workers and their families, through a mix of programmes that are responsive specifically to poverty and vulnerability. Such a mix of programmes is likely to include health, education and access to basic services such as water and sanitation – all designed to meet the needs of those most at risk, notably the working poor, the rural poor, women, children and the elderly living in poverty. The scope and the process of the implementation of social security programmes should naturally be responsive to the prevailing social and economic context in each country.

[4] ILO: *Conclusions of the 11th African Regional Meeting: The Decent Work Agenda in Africa 2007–15*, document AfRM/XI/D.3(Rev.), Geneva, p. 5, para. 17.

[5] AU: *Social Policy Framework for Africa*, First Session of the AU Conference of Ministers in Charge of Social Development, Windhoek, Namibia, 27–31 October 2008. Document CAMSD/EXP/4(1) (Addis Ababa). Available at: www.africa-union.org.

The social and economic context of Africa

The majority of African countries are poor, and in most a major proportion of the population lives below the poverty line. Poverty remains a difficult problem affecting millions of people, despite the progress made in some African countries through steady, albeit slow, rates of economic growth, reflecting stable macroeconomic policy environments. Chapter 2 of the report presents an overview of the relevant trends in the region, where not only the scale and depth of poverty but also the extent of unemployment result in devastating impacts on the most vulnerable and at-risk sectors of the population.

In the social and economic environment facing Africa, there is an urgent need to mobilize appropriate social protection strategies both to address poverty and at the same time to promote the Decent Work Agenda. This need must be placed in the demographic context, noting Africa's growing population, at well over 963 million in 2007, and its total fertility rate which, averaging around 5 for the period 2000–05, is estimated to be the highest of any region in the world. The population distribution according to age reflects a significant "youth bulge", with related problems of skills and jobs deficits emphasizing the need to integrate both active and passive labour market strategies with direct measures of social protection. Approximately 41 per cent of the total population are in the age range 0–14 years, highlighting the need for social protection measures to be sensitive to the developmental needs of children and to the vulnerabilities such a large part of the population faces. By comparison, the major economically active component of Africa's population, those falling in the age range 15–64 years, numbers a little over half of the total (56.4 per cent).

By any measure, poverty in Africa is a major factor and poverty-reducing strategies in the form of social protection are increasingly being seen by policy-makers as a key to making significant impacts on the extent and depth of poverty. Aspects of poverty which are perhaps less obvious but must nevertheless be taken into consideration are, first, its relative dimension, and, secondly, its dynamic rather than static character, which means that not only can people find themselves descending into deeper levels of poverty, but can also move, perhaps repeatedly, into and out of poverty.

The policy frameworks and social protection measures that aim to respond to the multiple deprivations of the poor must take into account not only "headline" poverty data but also the degree of "churn" or turnover within the poor population. High levels of poverty in all its forms nevertheless remain persistent. Recent studies have shown that the proportion of people living in *working poverty*, as assessed under the US$1 a day measure, has not improved, and that total poverty (according to this measure) has increased. However, it is necessary to answer many more questions than simply whether consumption has increased and incomes have risen, in order to assess the instrumental role of income and to determine how income is translated into capabilities and poverty reduction at individual and aggregate levels.

This chapter of the report goes on to consider more specifically the regional picture from the broader perspective of poverty viewed as deprivation of capabilities. It notes that the employment situation in the region has been aggravated even further than in the past by cutbacks in public-sector employment as a result of economic stabilization and longer term restructuring efforts. This leaves the vast majority of workers in the region to seek a living in the many different activities that make up the informal economy. Wage disparities, and more generally income disparities, already very large between the formal and informal sectors, have dramatically increased. Income inequalities also reflect inequalities in land ownership, assets and access to education and health care. In the context of growing informalization, casualization and feminization of labour markets, the emphasis is no longer on the promotion of full employment but rather on the need for decent work. The ILO places increasing emphasis on this need, conceptualizing decent work as "work that

not only provides a sufficient level of income but also ensures social security, good working conditions and a voice at work". [6]

In addition to chronic poverty, present circumstances provide a reminder that sudden economic downturns and financial shocks can also be features of the global economy. Lost wages and increased unemployment as a result of financial and economic crises impoverish families and communities and reduce people's ability to buy essential goods and services needed for survival. Global financial crises also result in squeezing government finances during times when protective policies are needed the most.

Establishing a *social protection floor* may seem particularly difficult in times of acute economic and social stress characterized by situations of chronic poverty, internal conflict and sudden economic downturns. However, there is ample evidence to show that even with relatively low income and limited resources, a government that guarantees a social minimum level of primary expenditures – including social services such as water sanitation, education and health care together with social transfers in cash or kind – can achieve remarkable results in terms of the expansion of human capabilities and development.

The social and economic context in Africa points to the urgent need for coherent and significant social protection interventions supported by continental and global actions. Based on societal consensus and the political will to extend social protection, policy options can be organized around three main clusters that are pivotal to the attainment of human well-being. These include: access to economic security through income support, through basic education and through primary health care. The degree and the nature of provision in each of these categories, however, can vary depending on the level of development and the resources available within a given society. Importantly, in Africa social protection strategies are not only poverty-reducing but also growth-enhancing.

Social health protection in Africa

Chapter 3 of the report presents an analysis of the situation of social health protection in Africa. Social health protection within the framework of social security is conceived as a series of public or publicly organized and mandated private measures against social distress and economic loss arising from ill health and the cost of required treatment. The objective of social health protection is therefore to ensure that the financial means to secure health care and access to quality health-care treatment is available.

Africa has the lowest level of social security expenditure on health of any region in the world and proportionately very high private expenditure. The lack of access to basic health-care services affects the lives of millions of the poorest people, especially children, women, the elderly and people living with disabilities, together with those living in post-conflict zones. Access to maternal health services, to pre- and post-natal health services and generally to primary health care in most African countries is very limited.

The global economic downturn has shaken Africa's economies severely and estimates of growth rates have been revised substantially, particularly for sub-Saharan countries. Reductions in growth are likely to be translated into increased unemployment, poverty, and shrinking funds available for health care.

[6] ILO: *World Employment Report 2004–05: Employment, productivity and poverty reduction* (Geneva, 2005), p. 24.

Against this background, it is essential to mitigate the impact of the crisis on health and poverty if further slowing of progress towards achieving the Millennium Development Goals (MDGs) is to be avoided. The consolidation of health status – which is vital for income generation, development, growth and wealth – will require an increasing commitment from African countries towards ensuring access to at least essential health services through improved social health protection schemes, seeking to cover more people with better services and provide financial protection against health-related poverty. In this context, the priority needs are to reach out to the poor, the most vulnerable, and those working in the informal economy.

The scale of need for social health protection coverage is overwhelming. The major gaps in coverage which exist at present impact severely on social and economic development. Within countries, inequities at regional and national levels result in significant geographical differences in health status. Between countries, the performance and extent of social health protection coverage – including access to health services and financial protection – varies significantly, often reflecting each country's degree of vulnerability in terms of poverty and the predominance of the informal economy.

Globally, countries with the highest vulnerability in these terms show the highest deficits in access to health services; variation between the regions can be measured by the ILO Access Deficit Indicator.[7] Within the African continent, very significant differences regarding the extent of the access deficit, and hence the level of challenge faced by the population when in need, can be observed, with the relative deficit ranging from a very high level to almost none.

A key issue regarding equitable access relates to out-of-pocket payments. Such payments are made directly by individuals to obtain health services or supplies, and fall outside any framework of risk- and burden-sharing, hence of fairness or equity. In Africa a major part of all health expenditure is spent on an out-of-pocket basis, and the result in terms of impaired access to health services and worsened poverty is very significant. The situation is often aggravated by gender inequities reflecting a variety of cultural and social factors.

A wide range of financial and physical barriers causes unequal access to health care at country level. The key factors include:

- high levels of out-of-pocket expenditure for medical care and drugs;
- widespread incidence of costs incurred as a result of unavoidable health events and interventions (for example, Caesarean sections), and which would be regarded as catastrophic if, as is not uncommon, such expenses exceed 40 per cent of households' net income;
- fragmentation of health systems leading to gaps in social health protection;
- restricted benefit packages that fail to address the actual needs;
- uneven urban and rural distribution of health-care facilities;

[7] This indicator is based on the density of health professionals. It uses Thailand as a benchmark, given that country's good health results with a ratio of one health professional for 313 population. See ILO: *Social health protection: An ILO strategy towards universal access to health care?*, Social Security Policy Briefings, Paper 1 (Geneva, 2008).

- gaps in the health workforce, often due to working conditions that fail the test of decency, and result in low-quality services;
- issues reflecting gender, cultural and ethnic factors impacting on access to health services; and
- the financial impact of the HIV/AIDS pandemic.

A set of indicators has been developed which distil many of these factors and, while describing and quantifying inequality in effective access to health services in Africa, may lend themselves to visual presentation. The following elements are reflected in the indicators:

- gaps in legal or formal coverage;
- deficits in financial resources;
- out-of-pocket payments which impoverish those suffering ill-health;
- health status outcomes related to maternal mortality;
- gaps in the professional and general staffing of health services.

In the light of the observed problems, the key question is how to improve the situation in terms of extending social health protection, with the ultimate aim of achieving universal coverage.

The mechanisms available by which financial resources for social heath protection systems may be generated fall into a rather small number of categories, namely:

- tax-funded national and public health services;
- subsidized national, social and community-based health insurances co-financed by contributions and premiums (typically paid by workers, employers or the insured); and
- other forms of private health insurance and cash benefits.

Allocations to the various contributory pools are provided from the general revenue as subsidies for the poor and vulnerable groups. Decisions on key aspects of social health protection should be based on the broadest possible processes of dialogue that include social partners and representatives of patients, health-care workers, health-care providers and the Government.

The policy framework and design of successful social health protection systems need to take into account concerns at three strategic levels:

- at the level of the individual, the varying needs and priorities regarding disease burden, poverty/vulnerability, age, gender, ethnic group, employment status and residence must be considered and adequately addressed;
- at the system or scheme level, the provision of benefits must be enabled and ensured by adequate, efficient and effective management and financing processes, together with resources such as medical equipment and staff;

- at the global level, social health protection systems should align with global public health priorities such as the MDGs and cross-border control of communicable diseases.

Progress remains limited, particularly in sub-Saharan Africa. In order to achieve universal social health protection coverage it is important to ensure effective access to an essential benefit package of adequate quality for all residents of a country. This must be planned in several important dimensions:

- legally mandated rights and entitlements to health care;
- physical availability of health-care infrastructure, equipment, drugs and qualified health-care workers;
- affordability of health-care and financial protection, i.e. the removal of financial barriers in access to health care without leading to impoverishment as a result of catastrophic health-care costs (those which, on a rather arbitrary definition, exceed 40 per cent of household net income), and the minimizing of out-of-pocket payments;
- fairness in setting contributions in insurance-based social health protection systems according to ability to pay;
- timely and correct information provided to beneficiaries regarding health-care rights and entitlements; and
- adequacy in the quality of care provided.

Effective policy-making will also require that health-financing mechanisms are embedded into a broader social protection floor (SPF-I) that addresses income and health-related poverty through social policies including in-kind and cash transfers for all in need – women and men, children, the elderly, the unemployed and people with disabilities – to address social determinants of ill health.[8] An essential benefit package should reflect the stipulations of the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), and the Medical Care and Sickness Benefits Convention, 1969 (No. 130), regarding the minimum medical care to be provided.

This chapter concludes that:

- Gaps in social health protection are jeopardizing economic and social security in many African countries. Shortfalls often reflect health system financial planning that is divorced from the objective of achieving universal coverage and so lacks both the effectiveness and efficiency needed to address key challenges.
- Equity in access is a critically important issue that needs to be addressed both at the regional and country levels. Significant levels of inequality are observed both between rural and urban areas, and the formal and informal economies, while the shortfall in access for women is of particular concern.
- Different funding mechanisms can be used, ranging from social security and social assistance to employers' liability, to maximize the affordability of social health protection at both the national and household levels.

[8] United Nations: Chief Executives Board for Coordination (CEB). *The global financial crisis and its impact on the work of the UN system*, CEB Issue Paper (New York, 2009), p. 20.

- The factors leading to success in the scaling up of efforts to extend social health protection are likely to include:
  - coherent legislation and institutional response;
  - shared international frameworks such as the MDGs and the social protection floor;
  - improving financing and funding through developing fiscal space;
  - including provisions for essential health benefit packages in social security schemes; and
  - enforcing legislation and monitoring progress.

Income security schemes

Chapter 4 of the report concerns schemes and systems designed to provide income security. In planning such schemes in Africa, even more than for other regions, a clear distinction should be made between the formal and informal components of the economy. On the formal side, contributory social insurance schemes provide benefits that are based on statutory (or legal) entitlements but are usually open only to those workers who are in full-time paid employment. In general, **governments** tend only to contribute to contributory social security schemes **as an employer** of public servants. For the informal economy, apart a few limited, uncoordinated and under-funded programmes of social assistance, there has historically been hardly any provision of income security or income support programmes on a scale large enough to reach the majority of those in need. However, everywhere in Africa there is now an ongoing debate on scaling up government-financed non-contributory programmes, and a range of new policies are being implemented or piloted.

There is wide variation within the **contributory social insurance schemes** in Africa. The contingencies most often covered are old age (pension benefits) and employment injury,[9] while many old-age pension schemes also provide benefits in case of disability and death of the breadwinner (survivors' pensions). On the other hand, the least often covered contingency is unemployment: schemes exist in only a few African countries. Family benefits are rarely provided. Sickness and maternity benefits are often not covered by social insurance schemes but are provided directly by employers on the basis of employers' liability, as required by provisions in the labour code or similar employment acts.

Coverage in the region generally for each of the contingencies specified in Convention No. 102 is extremely low, reflecting the low membership rates in the contributory systems. While coverage rates are higher than the continental average in the countries of North Africa generally as well as in South Africa, Mauritius and a few other countries, effective coverage rates of contributory schemes in most countries often fall well below 10 per cent, the scope of benefits is limited and benefit levels are unprotected against inflation, which is often persistently high.

[9] However, in many countries coverage for employment injury is much narrower than that required by ILO Convention No. 102, being limited only to lump-sum compensation in case of employment-related accidents. In addition, the percentage of actual accidents and incidence of employment-related diseases actually reported and compensated is also rather low.

Given the extent of poverty in the countries reviewed and that contributory social insurance schemes provide at best only a limited measure of social security to a minority, several major challenges and issues face the existing social insurance systems. Most importantly, such systems provide little or no coverage for those employed in agriculture and or for domestic workers, despite the fact that agricultural workers represent the majority of those employed in most countries of the region. As a result of this and a range of other factors, less than 10 per cent of the labour force in the region benefits from social security income protection in old age. An important consequence of this shortfall is seen in the phenomenon of *the working elderly*, with 80 per cent of older women and men who do not have regular income continuing to work, generally in the informal economy, until they are incapacitated. Many additional issues must be addressed, among them non-compliance, inappropriate statutory retirement ages, early withdrawal of funds, the situation of migrant workers, inadequate benefit levels, and discrimination against women.

For workers in the informal economy there is no comprehensive social security coverage, even if good progress is being made in the region in the provision of social transfers through either cash support or in-kind benefits such as food, schooling and health care. Non-contributory benefits may be provided to the indigent or those without any other means of survival, as well as to the most vulnerable such as orphans, women, children living in poverty, people with disabilities and the elderly. Such benefits are funded by the State, or in some cases through temporary donor support or the support of international non-governmental agencies. The trend of expert opinion suggests that cash transfers in Africa represent potentially the most efficient way of reaching the most vulnerable and the poorest, especially if such transfers are provided on a universal basis.

Consensus is strong in Africa on the urgent need to extend social protection measures to include all those who are most deprived, at risk and living in poverty. Despite this recognition of its important role, national budget allocations for social protection tend to fall far short of actual need. A review of aggregate social protection expenditure in sub-Saharan Africa shows that only 4–6 per cent of GDP (weighted for population) is spent on social security, and of this amount a larger proportion is spent on health care than on cash transfers. This level of allocation overall is the lowest amongst all regions of the world. If the analysis is broken down according to individual countries, however, there are great differences in national budgets and spending patterns on social security.

An issue of central importance in phasing in social protection reforms to respond to the identified gaps and priority areas is the need to implement plans within the financial and fiscal resources available to countries, in ways that are sustainable and at the same time ensure "vertical" equity (cross-subsidies from the rich to the poor through redistributive taxation) and "horizontal" equity (ensuring that all those who fall within a certain category of vulnerability or risk have access to fair treatment leading to similar outcomes).

The low coverage of the poorest and the rudimentary nature of social assistance programmes in Africa is largely due to inadequate budgetary support for social protection. As a result only a few of the intended beneficiaries are provided with support, and this is often only limited and short-term relief. Yet estimates by the ILO indicate that the provision of basic old-age and disability pensions, basic child benefits and social assistance to the working poor need absorb less than 4 per cent of GDP on average, showing that much more could be done in this area.

Emerging strategic options and challenges

Widespread consensus exists for the expansion of social security in Africa as a means to reduce poverty and as a form of investment in the future. By the end of October 2008

more than 38 African governments had indicated strong political commitment for the expansion of social protection in their countries. This is a significant step forward in promoting the expansion of social protection and moving progressively towards the implementation of the social protection floor.

Chapter 5 of the report presents an assessment of the implications. The policy commitment falters when it comes to matters of practical implementation and how to introduce the necessary changes within each country. The focus is uncertain, varying from mechanisms to identify and focus services on the most vulnerable groups (more specifically amongst children, people with disabilities and the elderly) to recommendations for approaches to longer term poverty reduction that can remove barriers to health, education and access to services while at the same time promoting decent work and social infrastructure development. The ILO promotes an approach which asserts that governments need not see social protection (at least in the medium to long term) as a trade-off between meeting social needs and minimizing of financial costs, so that the needs of those who are most vulnerable and at risk can be addressed together with the needs of those in chronic, structurally based poverty. A mix of policy and programme options is feasible and affordable for countries in Africa if these are based on the progressive and phased implementation of the social protection floor.

The key features which the ILO would seek to promote, and to assess, in the design and implementation of a national social security system may be summarized as follows:

- ***Universal coverage*** of income security and health systems: all (permanent and temporary) residents of a country should have gender-fair access to an adequate level of basic benefits that lead to income security and comprehensive medical care.

- ***Benefits and poverty protection as a right***: entitlements to benefits should be specified in a precise manner so as to represent predictable rights of residents and/or contributors; benefits should protect people effectively against poverty; if based on contributions or earmarked taxes, minimum benefit levels should be in line with the Social Security (Minimum Standards) Convention, 1952 (No. 102), or more recent Conventions providing for higher levels of protection, and the European Code of Social Security of the Council of Europe.

- ***Collective "actuarial equivalence"***[10] ***of contributions and benefit levels***: the benefits to be received by scheme members should represent both a minimum benefit replacement rate and a minimum rate of return in the case of savings schemes, which in turn must adequately reflect the overall level of the contributions paid; such minimum levels should be effectively guaranteed, preferably by the State.

- ***Sound financing***: schemes should be financed in such a manner as to ensure to the furthest extent possible their long-term financial viability and sustainability, having regard to the maintenance of adequate fiscal space for the national social security systems as a whole and individual schemes in particular.

[10] Expressions such as "actuarial equivalence" are not defined in a universally agreed way, indeed attracting some controversy, and should not, perhaps, be treated as having too precise a technical meaning. Nevertheless, while it is difficult to encapsulate in a pithy phrase, the idea represented here is important – broadly that on a basis which is collective and long-term the members of a social security scheme, specifically a pension scheme, should perceive that the basis on which benefits will be awarded reflects fairly their input by way of contributions.

- ***Responsibility for governance***: the State should remain the ultimate guarantor of social security rights, while the financiers/contributors and beneficiaries should participate in the governance of schemes and programmes.

In the light of the above principles as well as the factual analysis of the situation and performance of social security systems in Africa, a conceptual strategy for the Campaign to extend social security coverage can be seen to be two-dimensional in nature (and indeed reflects the two-dimensional perspective on equity described above). One dimension comprises the extension of some income security and access to health care, even if at a modest basic level, to the whole population. This dimension may be called *"horizontal"* extension. The second dimension would seek to provide higher levels of income security and access to higher quality health care at a level that protects the standard of living of people even when faced with fundamental life contingencies such as unemployment, ill health, invalidity, loss of breadwinner and old age. This dimension may be called the *"vertical"* aspect of extension. The metaphor that thus emerges for the extension of social security coverage is the image of a social security "staircase", in which the first level is composed of a social protection floor.

The assumption still persists that countries at lower levels of economic development must remain unable to afford to implement progressive measures of social security. Many development planners have simply assumed that there is insufficient fiscal space in such countries to finance social security benefits and, hence, that for them social security is not affordable. That this is an assumption, and a mistaken one, becomes clearer as evidence emerges that a minimum package of social security is affordable in even the poorest countries, as recent work by the ILO on the costs of a minimum package of social security in sub-Saharan Africa and Asia shows. Obviously, there are some cases where the fiscal space for social transfers cannot easily be extended in the very short run. Each case has to be assessed in detail. Emerging findings show, nevertheless, that "policy space" for financial manoeuvre may be wider than often assumed. The evidence shows that, almost everywhere, something can be done. The proportion of national income spent on social security does not, in fact, depend at all closely on how rich the country is. To a large extent, it depends on the prevailing political will that effectively defines the fiscal space available. To maximize fiscal space may, however unpopular, require substantial attention to the effectiveness of a country's tax and contribution collection mechanism. Without sound machinery for revenue collection no revenue can be redistributed. The challenge of increasing fiscal space has a different face for each country. A checklist of components for a national strategy may, however, include:

(1) tax reforms to increase fiscal resources including, in particular, enhancing the effectiveness and efficiency of tax collection;

(2) gradual increase in social spending as a proportion of GDP and as a proportion of total spending;

(3) redistribution between social policy areas to refocus expenditure on most urgent needs;

(4) refocus of spending within social sectors and policy areas to make certain spending more progressive and more effective in combating poverty and vulnerability.

Conclusions

Social security is first and foremost a human right and hence an obligation for all societies. It also acts as a social and economic facilitator of change and has the capacity to function as an effective financial stabilizer.

Chapter 6 considers the implications of the social protection floor and specifically the two-dimensional approach to the extension of social security described in Chapter 5, recommending a policy framework and implementation strategies.

The two-dimensional approach can be inferred from a wide range of instruments, documents and resolutions, notably the UN Declaration of Human Rights, the ILO Constitution together with the extended mandate defined in the Declaration of Philadelphia, the Conclusions of the International Labour Conference in 2001, the Conclusions of the ILO's 11th African Regional Meeting held in Addis Ababa in April 2007, the ILO Declaration on Social Justice for a Fair Globalization and the Global Jobs Pact, together with the up to date ILO Conventions and Recommendations, supplemented by emerging national experience and the experience gained to date through the ILO Global Campaign on Social Security and Coverage for All.

Countries can and should pursue both dimensions at the same time. General revenue financing should first focus on the *horizontal dimension*. However, solidarity-based financing should not stop at the basic level of protection. The *vertical dimension* should focus on the guaranteed access to a defined range of social security benefits and the safeguarding of adequate benefit levels as of right for all who contribute to the financing of social security systems through contributions or taxes. An important catalyst for this dimension would be provided by the promotion of a wider ratification of Convention No. 102 in Africa.

The social transfer component of the wider social protection floor (that also includes essential services that, as such, fall outside of the direct competence of the ILO), comprises a basic set of essential social guarantees realized through transfers in cash and in kind that could ensure that all residents have the necessary financial protection to afford, and have access to, a nationally defined set of essential health-care goods and services; that all children have minimum income security; that all those in active age groups who are unable to earn sufficient income on the labour markets enjoy a minimum income security through social assistance; and that all residents in old age and with disabilities [11] have guaranteed minimum income security through pensions for old age and disability.

There is no "one-size-fits-all" definition of the nature and level of the benefits. The term "guarantees" leaves open whether all or some of these transfers in cash or in kind are granted on a universal basis to all inhabitants of a country, whether they are granted based on contributory insurance schemes or whether they are granted only in case of need or may be tied to a number of behavioural conditions. The crucial point is that all people have access and a right to health services and means of securing a minimum level of income.

Fiscal space, institutional strength and levels of poverty and vulnerability should drive the decision-making process regarding, firstly, the means of constructing the social transfer component of the basic social protection floor, and secondly, the question of which benefits to introduce as a matter of priority within an overall implementation plan for the full set of basic guarantees. New cash transfer programmes, that have sprung up in about 30 developing countries around the world during the last one to two decades and are already providing elements of the social protection floor, have been successful in combating poverty, increasing school enrolment, boosting the social status of recipients, and improving their health and nutritional status. They demonstrate that the basic social security guarantees, or at least important elements of the package, can be afforded by developing countries. They are most successful where they form an integral part of an overall social security strategy.

[11] That is, a degree of disability that excludes them from labour market participation.

The core challenge for the financing of the basic social security guarantees remains the securing of the necessary fiscal space. The increase of fiscal space for social security thus requires political decisions with respect to the priorities of government spending and revenue generation, together in many cases with respect to investments in national tax reforms. The example of many African countries during the last decade shows that developing countries can increase their revenues relative to GDP.

The national experiences reviewed in the report show that successful national action to extend social security horizontally to all relies on the following crucial elements:

(i) compatibility and coherence of social security extension policies with a wider social and economic development strategy aiming at improving the standard of living through fair sharing of growth through a number of social, employment, educational, health and fiscal policy measures;

(ii) strong advocacy of poverty alleviation and the reduction of insecurity as a national policy priority through investments in social security by the social partners and other interested parties;

(iii) sound analytical work with respect to the identification of the main social security priorities and the lacunae in present protection systems;

(iv) sound quantitative analyses of the cost, benefits and long-term financial and fiscal sustainability of alternative benefit systems;

(v) the determination of protection priorities in a national consultation process, including tripartite social dialogue as a core element;

(vi) the determination of benefit entitlements and levels on a statutory basis;

(vii) guaranteed minimum benefit levels aimed at lifting beneficiaries above national poverty lines;

(viii) the creating of fiscal space through a combination of measures to:

- abolish inefficiencies in existing spending structures and behaviour;
- reallocate existing resources to those schemes of protection which are most effective in terms of poverty alleviation and the reduction of vulnerabilities and insecurity;
- widen the tax base and access new sources of public revenues;

(ix) strengthening the capacity to ensure effective and efficient programme management and supervision; and

(x) putting in place at an early stage effective monitoring and evaluation frameworks that ensure the targeting efficiency of social security and transfer benefits.

All mechanisms to extend social security coverage should be rooted in the context of an integrated national social security strategy. The ILO should support the conceptual development of a two-dimensional national social security extension and implementation strategy along the lines described above using the full range of means of action of the ILO; these consist of the generation, management and dissemination of knowledge, support for policy development, capacity building and technical advisory services. The technical advisory services to be provided by the ILO should be formulated on a dual focus basis,

around the concepts of the social protection floor and the promotion of the ratification of Convention No. 102.

Last, but not least, national social security plans should guide the ILO in the follow-up to the Declaration on Social Justice for Fair Globalization and to the Global Jobs Pact on a national level.

Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
AU	African Union
CSG	child support grant (South Africa)
DFID	Department for International Development (United Kingdom)
ECP	*Estratégia de Combate á Pobreza* (English: strategy to combat poverty), Angola
EDPRS	Economic Development and Poverty Reduction Strategy
EPRI	Economic Policy Research Institute (South Africa)
GDP	gross domestic product
GNI	gross national income
HDCs	human development countries
HDI	human development index
HIV	human immunodeficiency virus
HPI	Human Poverty Index
IFAD	International Fund for Agricultural Development
ILO	International Labour Organization
IMF	International Monetary Fund
ISSA	International Social Security Association
LHDCs	low human development countries
MDGs	Millennium Development Goals
NEPAD	New Partnership for Africa's Development
NGO	non-governmental organization
NSSF	National Social Security Fund
OECD	Organisation for Economic Co-operation and Development
OVC	orphans and vulnerable children
PEPs	public employment programmes
PFA	pension fund administrators

PSNP	Productive Safety Net Programme (Ethiopia)
PRGF	Poverty Reduction and Growth Facility
PRSP	Poverty Reduction Strategy Paper
PVA	poverty and vulnerability assessment
REC	regional economic community
SADC	Southern Africa Development Community
SASSA	South African Social Security Agency
SSSPs	social security service providers
SSW	social security worldwide
TASAF	Tanzania Social Action Fund
TB	tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
WHO	World Health Organization
WTO	World Trade Organization

Introduction

This Second African Decent Work Symposium follows the First African Decent Work Symposium held in Ouagadougou, Burkina Faso, 1–2 December 2009, which adopted the road map for the implementation in Africa of the Global Jobs Pact. The road map calls for the establishment in each International Labour Organization (ILO) member State of a strategy for the extension of social security, chiefly through the implementation of a social protection floor as recommended by the UN System Chief Executives Board for Coordination (CEB) in 2009.

The Summit also follows up on the ILO's 11th African Regional Meeting held in April 2007, which adopted the Decent Work Agenda in Africa 2007–15 and recommended that:

> All African countries adopt coherent national social security strategies, including for the introduction or extension of a basic social security package that includes essential health care, maternity protection, child support for school-age children, disability protection and a minimum pension. (ILO, 2007a, p. 5, para. 17.)

Already at its 89th Session in 2001, the International Labour Conference had adopted a resolution and conclusions concerning social security, giving priority to "policies and initiatives which can bring social security to those who are not covered by existing systems" (ILO, 2001a, Conclusions, para. 5). Subsequently, the Global Campaign on Social Security and Coverage for All was launched at the 91st Session of the Conference (2003) to promote the extension of coverage. At the First AU Conference of Ministers in Charge of Social Development, held in Windhoek, Namibia from 27 to 31 October 2008, a Social Policy Framework for Africa was adopted (AU, 2008a), in which social protection plays a central role. The pragmatic policy framework that is emerging from the campaign activities and policy development work envisages that countries which have not yet achieved universal or widespread coverage should first aim to put in place a basic and modest set of social security guarantees, in other words a social protection floor for all residents of a country.

There are many ways to achieve that set of basic social security guarantees as a first step in a national social security development strategy. Some countries will seek to extend social insurance and combine it with social assistance, others will subsidize social insurance coverage for the poor, while still others will seek to establish tax-financed universal schemes. Each such scheme has its limitations, but what is important is that people should have access to the basic guarantees.

This proposed policy approach has been discussed in a series of tripartite regional meetings on social security in Latin America, in the Arab States and in Asia held between 2007 and 2008, where it was adopted by ILO constituents. The main objective of the meetings was to share experiences among the participants on how to extend social security coverage, identify good practices and foster consensus on how to pursue further extension of social security coverage as a national policy priority. The discussions allowed a broad consensus to be reached on the priorities to be addressed in the coming years by ILO member States and the ILO itself in the context of not only the Global Campaign but also the Decent Work Country Programmes (DWCPs). This African Summit is the last one of that series of regional events.

The African Summit also seeks to promote the implementation of the Declaration on Social Justice for a Fair Globalization, adopted by the International Labour Conference at its 97th Session in June 2008. The Declaration "recognizes that the ILO has the solemn

obligation to further among the nations of the world programmes which will achieve the objectives of ... the extension of social security measures to provide a basic income to all in need, along with all the other objectives set out in the Declaration of Philadelphia". (ILO, 2008a, p. 6.)

Again, that mandate has been reaffirmed in the adoption by the ILO Conference at its 98th session in 2009 of the Global Jobs Pact, which endorses the social protection floor concept. The Global Jobs Pact requests countries that do not yet have extensive social security to build "adequate social protection for all, drawing on a basic social protection floor including: access to health care, income security for the elderly and persons with disabilities, child benefits and income security combined with public employment guarantee schemes for the unemployed and the working poor" (ILO, 2009b, p. 4, para 12(1)(ii)), and urges "the international community to provide development assistance, including budgetary support, to build up a basic social protection floor on a national basis". (ibid., p. 6, para. 22(9).)

The social protection floor is an element of the crisis response framework adopted by the Chief Executive Board of the UN System (CEB) in April 2009 as a coherent and unified United Nations (UN) response to the crisis. One of the nine joint initiatives for action at the global, regional and country levels refers to the establishment of a **social protection floor, consisting of a set of basic social transfers and entitlements that permit to access essential goods and services**. The ILO and WHO are jointly leading the initiative; a number of country activities are ongoing and a global coalition led by Ms Michelle Bachelet, former President of Chile, has been put in place to promote the concept of the social protection floor.

Following a request by the Governing Body the ILO organized in September 2009 a Tripartite Meeting of Experts on Strategies for the Extension of Social Security Coverage. The report on the Meeting concluded that the discussions amongst the delegates "reflected a large measure of agreement concerning the ongoing importance of social security and its role not only in individual welfare, but also with regard to broad economic growth and development. There was a consensus on the universal right to, and need for social security; and a reminder from all sides on the importance of social dialogue" (ILO, 2009c).

The summary of the Chairperson of the Meeting explicitly endorsed the two-dimensional strategy that the Office has pragmatically developed to extend the coverage of social security. One dimension comprises the extension of some income security and access to health care, even if at a modest basic level, to the whole population. This dimension is called the *"horizontal"* extension. The second dimension seeks to provide higher levels of income security and health protection to protect the standard of living of people even when faced with fundamental life contingencies such as unemployment, ill health, invalidity, loss of breadwinner and old age. This dimension is called the *"vertical"* aspect of extension. The horizontal dimension is conceptually identical with the idea of the social protection floor.

The Summit seeks to discuss and reach a consensus on implementation of the two-dimensional extension strategy for social security in Africa, where the coverage deficits are still one of the largest challenges of social and economic development policies.

This report provides an overview of the situation of social security [1] in Africa. It aims at furthering the understanding of social security and its role in reducing poverty, and

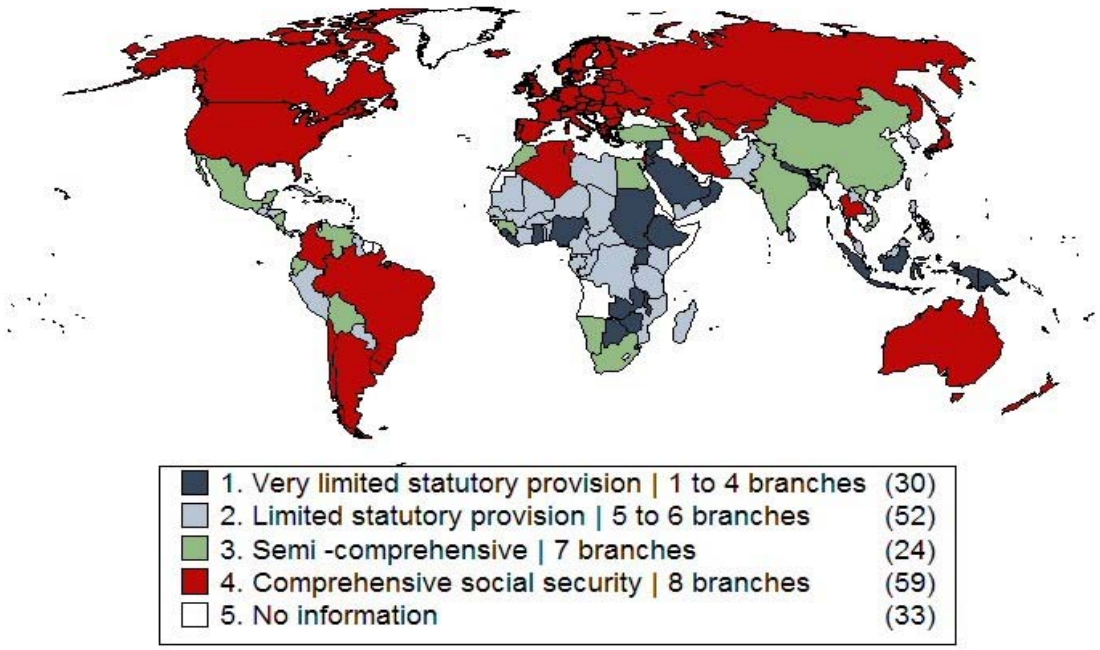
[1] In this report terms "social security" and "social protection" are used interchangeably.

mitigating the harsh impacts of recurring social and economic crises, as well as the impacts of the current global financial crisis on people in the region.

The concepts, definitions and approach to social security promoted by the ILO and the African Union (AU) as well as the broader UN system are clarified in Chapter 1. The historical background to the international social security and social protection agreements and covenants, as promoted by the ILO, demonstrates the level of global and Africa-wide consensus reached on the significant role of social security as a poverty-reducing strategy and as a contributor to economic growth and development. Some of the main social and economic features that characterize the region and contribute to wide-scale poverty and insecurity are analysed in Chapter 2 so as to situate social security provision within the realities facing the continent.

The map below shows the scope of legal coverage by social security schemes around the world, with the African continent as the region where the smallest portion of the population enjoys access to comprehensive social security systems.

Branches of social security: Number covered by a statutory social security programme, 2008–09



Sources: For identification of groups covered: SSA/ISSA, 2008 for Asia and Europe; 2009 for Africa and the Americas; quantification based on statistical databases: ILO, LABORSTA and KILM; and national statistical offices. Numbers in brackets give the number of countries included in each group.

Chapters 3 and 4 address the current situation of social security in Africa, focusing on its main components: affordable access to health care and guaranteeing income security. These chapters map social security systems, identifying some of the core dimensions of social security and providing an overview of the main challenges in 53 African countries. The status of social security systems as well as their scope and coverage and the types of benefits provided through health and income support programmes are discussed, including coverage in the formal, informal urban and informal rural economies. These chapters are based on the ILO Social Security Department's analysis of the state of social security in the world as presented in the *World Social Security Report 2010–11* (ILO, 2010a) and the separate study undertaken for the AU in 2008 (Taylor, 2008).

On the basis of this analysis and taking the policy environment into consideration, an emerging pattern of a benchmark extension strategy for Africa is discerned in Chapter 5. Policy conclusions are drawn in Chapter 6.

Selected case studies of national initiatives to extend social security programmes in Africa are described in Appendix I. They illustrate that social security is making a significant contribution to reducing poverty, building capabilities and promoting a virtuous circle of economic growth through human development. Lessons and best practices from the case studies provide pointers for policy and programme initiatives in other countries in Africa. Revealing the gaps in reaching the most vulnerable and poorest people through social protection, they highlight the challenges and priorities for future action in extending social protection to achieve a social floor below which no one should fall.

1. The policy context

1.1. General trends

There are significant shifts in thinking within Africa and elsewhere in the world about how social security and social protection are understood, its links to sustainable economic development and its relevance as a comprehensive response to poverty and capability deprivations. Such shifts are a move away from an incremental, piecemeal safety net or residual welfare approach to poverty, towards social protection as a comprehensive developmental policy that is seen as a necessary component of growth and human development.

Research-based evidence shows that countries with comprehensive social protection systems have, over time, been able to build inclusive social and economic processes with the participation of their poorest citizens. Today, many of these countries are leading industrial nations with highly developed economies and significantly higher human development indicators (Townsend, 2007, 2009).

Research on countries in Africa that have introduced social protection programmes reinforce such evidence and demonstrate that government-led social protection programmes are both necessary for sustained economic growth and are affordable in low-income countries when considered as part of a package of measures supported by the international community (DFID, 2006; Pal et al., 2005; ILO, 2008b). The lessons from these studies confirm that when social protection is located as a critical component of social policy and development, it has the potential to address multiple dimensions of poverty, to reduce inequities and inequalities and to play a role in the national economic growth agenda.

A key policy consideration related to such shifts in thinking is not whether countries should have social protection programmes but rather how to effectively achieve such social protection coverage as to generate human development and inclusive economic growth.

Strategic and deliberate policy choices are now being considered by African governments, specifically:

- What provisions should constitute the basic package of social protection?
- How should the level at which provisions are made be determined and benchmarked?
- What instruments would be required to monitor and evaluate programmes?
- How should capacity be built for implementation at national, local and subregional levels?

These and other questions are an important part of the strategic social protection agenda that is a focus of the AU and key development partners.

1.2. The policy impetus for extending social protection in Africa

Since its establishment in 1919 the ILO has adopted over the years a number of Conventions and Recommendations on social security. Significant turning points in social security policy development can be traced to the adoption of the Income Security

Recommendation, 1944 (No. 67), and the Medical Care Recommendation, 1944 (No. 69), which laid down a new doctrine of universality as the basis for the development of social security.

These two Recommendations reflected a fundamental change in approach to social security policies, as focus shifted from the social security protection of *workers* to the protection of the *whole population*. They laid the basis for the adoption of social security as a human right in the Universal Declaration of Human Rights in 1948 and, some years later, in the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1967. Over many decades the ILO has actively and consistently sought to translate what the right to social security means in changing and diverse social and economic contexts across the world. The ILO's Social Security (Minimum Standards) Convention, 1952 (No. 102), was a breakthrough in defining the nine branches of social security, in setting minimum standards for each and in setting standards or guidelines for the governance and sustainability of social security schemes (ILO, 2009c).

In Africa in recent years the policy impetus to promote and expand social protection has been driven by both the ILO and the AU. The Constitutive Act of the AU adopted by the 36th Ordinary Session of the Assembly of Heads of State and Government on 11 July 2000 in Lomé, Togo reinforced and continues to reinforce the need to promote a common agenda to address issues affecting the people of the continent. Articles 3 and 4 of the Constitutive Act emphasize the promotion and protection of human and people's rights in accordance with the African Charter on Human and People's Rights. Explicit mention is made of the intent to promote sustainable development at the economic, social and cultural levels as well as cooperation in all fields of human activity in order to raise the living standards of African peoples (AU, 2000). The Constitutive Act provides the overall framework within which subsequent discussions on poverty, unemployment and vulnerability are put on the agenda.

1.3. The Ouagadougou Declaration and Plan of Action

At its Third Extraordinary Session of the Assembly of Heads of State and Government of the AU in September 2004 in Ouagadougou, Burkina Faso, poverty and unemployment were high on the agenda. This meeting resulted in a Declaration on Employment and Poverty Alleviation in Africa, a Plan of Action, and a follow-up mechanism for implementation, monitoring and evaluation.

The declared aims of the Ouagadougou Declaration and Plan of Action (PoA) are to empower people, open opportunities and create social protection and security for workers through building a people-oriented environment for development and national growth. The PoA envisages that resources would be mobilized for implementation of plans of action at each of the national, regional, and international levels. It recognizes the need to address social development, poverty alleviation and employment creation in a coherent and integrated manner (AU, 2004).

Together, the Ouagadougou Declaration and PoA form the current blueprint for the AU strategy on social development. They place emphasis on the need for action at regional, national, and international levels. The Declaration also highlights the need to enhance the capacity of regional economic communities (RECs) to promote productive employment and social protection within the framework of regional and interregional cooperation in Africa. Member States of the AU and RECs are designated as the principal bodies responsible for the implementation of the Declaration and the Plan of Action, with the AU Labour and Social Affairs Commission as the coordinators of the implementing mechanism (AU, 2004). The linking of poverty reduction, productive employment and

social protection in the PoA relate directly to the Decent Work Agenda of the ILO (Taylor, 2008).

1.4. Promoting the Decent Work Agenda of the ILO

By including the enhancement of the coverage and effectiveness of social protection for all sectors in society, particularly the poor and vulnerable, the Ouagadougou Declaration and Plan of Action support the continuing efforts made to promote the Decent Work development agenda of the ILO. Referring to decent work as "work that not only provides a sufficient level of income but also ensures social security, good working conditions and a voice at work" the 2004–05 *World Employment Report* (ILO, 2005a, p. 23) highlights the extent to which millions of workers and their families, especially in Africa, are condemned to a life of poverty.

Empirically observable changes in global employment patterns reflect disturbing trends in relation to poverty and waged work. The *World Employment Report* (ibid., p. 24) estimates that 49.7 per cent of the world's workers are not earning enough to lift themselves and their families above the international US$2 a day poverty line and that 19.7 per cent of employed persons in the world are currently living on less than US$1 a day.

Not surprisingly the numbers of working poor increased in low-income countries, with sub-Saharan Africa having the largest share, estimated at 55.8 per cent in 2003. These trends also indicate that increasing numbers of people, besides working in hazardous conditions, are unable to provide adequately for themselves or their households. Alongside these trends, social security institutions are facing serious difficulties in fulfilling and keeping up with their mandates due to high levels of unemployment and fund management challenges. Furthermore, social security in the form of employment-related social insurance is increasingly being delinked from waged work as labour markets evolve and global markets extend (Taylor, 2007).

The social dimensions of current economic globalization processes are highlighting shifts in transnational production patterns that create new risks and vulnerabilities on top of existing structurally based poverty and unemployment in Africa. As more workers are being pushed into informal and casual labour, guarantees of long-term secure employment with health care, and pensions on retirement, are less available. In this context social protection must be considered an essential part of the Decent Work Agenda in Africa in order to ensure the human security of workers in both the formal and informal sectors of the economy. Because it is broader than employment-related social insurance measures, social protection can offer safeguards that protect all workers (both regulated and unregulated) within a comprehensive system of social provision.

The need for a comprehensive approach to work and rights is clearly reflected in the ILO standards and the Universal Declaration on Human Rights as well as in many recent studies (see Sen, 2000; Standing, 2002). The promotion of "opportunities for women and men to obtain decent and productive work, in conditions of freedom, equity, security and human dignity" (ILO, 1999, p. 3) becomes a critical building block of the approach to social protection by both the ILO and the AU. Sen (2000) asserts that this goal must include "all workers" irrespective of their sectors, whether they are waged or unwaged, male or female, unregulated, self-regulated and home workers. "There are different parts of the working population whose fortunes do not always move together, and in furthering the interests and demands of one group, it is easy to neglect the interests and demands of others' (ibid., p. 120).

This is an important reason why social protection in the region is gaining momentum and efforts are being made to sustain and expand existing measures, with particular efforts to overcome the problems of exclusion.

1.5. The Livingstone Call for Action and the Yaoundé Declaration

The Livingstone Conference held in March 2006 represented yet another turning point in the commitment of African governments to promote social protection as an urgent response to the increasing vulnerabilities of people, in the face of both chronic deprivation and new crises in the region. Significant consensus was reached on the need to implement, more widely throughout Africa, programmes such as social pensions and cash transfers to vulnerable groups including children, older people and people living with disabilities. An important meeting in Yaoundé also played a significant role in prioritizing action on social protection.

In line with the Ouagadougou Declaration and Plan of Action, the Livingstone Call for Action recognizes that a critical requirement of a comprehensive social development agenda is the promotion of an approach that links employment policies and poverty alleviation. The Call for Action adopts the guiding principle that social protection is embedded in both a human rights and an empowerment agenda.

Box 1
Agreement on social protection achieved in Livingstone, 2006

- Social protection programmes, including social transfers and cash transfers directly reduce poverty and inequality when combined with other social services.
- A sustainable basic package of social transfers is affordable within current resources of governments and with support from development partners.

Programme issues that were considered crucial to the implementation of this agenda included the affordability of social protection systems and their complementary role with other services. A significant outcome of Livingstone was achieving agreement that a sustainable basic package of social transfers is affordable within current resources of governments and with the support of international development partners.

1.6. The 11th ILO Regional African Meeting, 2007

The ILO's 11th African Regional Meeting held in Addis Ababa in April 2007 agreed on the following targets related to social security:

> All African countries adopt coherent national social security strategies, including for the introduction or extension of a basic social security package that includes essential health care, maternity protection, child support for school-age children, disability protection and a minimum pension. (ILO, 2007a, p. 5, para. 17.)

To achieve such an ambitious programme, Africa needs to campaign energetically so as to sensitize not only the populations at large but also policy-makers at the highest levels. Such a campaign can only take place within the context of the formulation and implementation of national DWCPs.

1.7. Coherence between social protection and Poverty Reduction Strategy Papers (PRSPs)

The last two decades have seen African governments exploring and implementing a range of initiatives including poverty reduction strategies and programmes to address poverty and social inequalities. Attempts to address the Millennium Development Goals (MDGs) by 2015, especially MDG 1 on income poverty and hunger, are falling short of expectations within sub-Saharan Africa. Recent emphases on the need to advance a social protection agenda has led a number of countries to introduce a national strategy of social protection within the framework of their poverty reduction strategy. Senegal did this in 2006 with the cooperation of the World Bank. Mozambique has recently developed a basic social security strategy (non-contributory) which organizes social protection in four components with relevance to the concept of a social protection floor. Zambia and the United Republic of Tanzania have incorporated social protection targets into their national development plans focused on poverty reduction. In this way countries are linking social protection and economic development policies and strategies.

Despite these attempts, the outcomes will still fall short of achieving the MDGs by 2015 at current rates of implementation. In many countries social protection and poverty reduction initiatives are still spread across different sectors in government, making it programmatically difficult to monitor their inputs and social and economic outcomes. Promoting policy coherence and integrating the multiple programmes that are under way across Africa will be necessary to ensure effective use of resources in order to meet the needs of the poorest and those most at risk.

Bilateral and multilateral arrangements with financial institutions and international development partners can influence the potential for policy and programme coherence on social protection in Africa. Efforts to achieve the MDGs can also be combined within a comprehensive social protection agenda. These goals are an important element of the development agenda and need to be included in the benchmarks against which the implementation of a comprehensive basic package of social protection measures is monitored. All the second generation of countries' PRSPs should include both MDG targets as well as the priorities that have come out of AU consultative processes on social protection. A sustainable social protection agenda in Africa requires the predictability of aid as well as increased aid flows in support of national social protection institutional capacity and budgets.

1.8. The immediate objectives and relevance of social protection in Africa

Social security programmes in Africa must address the needs of populations in which a large proportion, often the majority, lives below the poverty line.

The ILO (2009d) defines social security as the set of institutions, measures, rights and obligations whose primary goal is to provide – or aim to provide – according to specified rules, income security and medical care to individual members of society. This formulation may be interpreted in relation to societies – nations – as a whole, to social groups and to both formal and informal economies. On an operational level, social protection or social security systems may therefore be understood as incorporating:

- those cash transfers in a society that seek to provide income security and, by extension, to prevent or alleviate poverty;
- those measures which guarantee access to medical care, health and social services; and

- other measures of a similar nature designed to protect the income, health and well-being of workers and their families.

The principles embedded in this definition and understanding are that social security is redistributive in poverty reduction and alleviation, prevents social exclusion and promotes social inclusion.

The ILO specifically indicates that such an understanding of social security requires the establishment of non-contributory (for example, tax-financed) schemes, or other social assistance measures to provide support to those individuals and groups who are unable to make sufficient contributions for their own protection and are therefore excluded from more formal social security schemes – mainly those workers (and their families) in the informal economy. Governments, as the main driver of social protection measures, should adopt reforms that progressively include those currently without social protection (ibid., pp. 9–12).

Most recently, the First AU Conference of Ministers in Charge of Social Development, held in Windhoek, Namibia from 27 to 31 October 2008, adopted the Social Policy Framework for Africa (SPF). This framework, noting that levels of investment in and access to social protection are still low in Africa, foresees the gradual building of social protection and social security "based on comprehensive longer term national social protection action plans. Measures will include: extending existing social insurance schemes (with subsidies for those unable to contribute); building up community based or occupation based insurance schemes on a voluntary basis, social welfare services, employment guarantee schemes and introducing and extending public-financed, non-contributory cash transfers." (AU, 2008.)

Under the SPF, African countries are encouraged to choose the coverage extension strategy and combination of tools most appropriate to their circumstances. It notes, however, the emerging consensus "that a minimum package of essential social protection should cover: essential health care, and benefits for children, informal workers, the unemployed, older persons and persons with disabilities. This minimum package provides the platform for broadening and extending social protection as more fiscal space is created."

This document also indicates that such a "minimum package can have a significant impact on poverty alleviation, improvement of living standards, reduction of inequalities and promotion of economic growth and has been shown to be affordable, even in low-income countries, within existing resources, if properly managed".

Box 2
Africa adopts a definition of social protection

The AU understands social protection as a "package" of policies and programmes with the aim of reducing poverty and vulnerability of large segments of the population. This it does through a "mix" of policies/programmes that promote efficient labour markets, reduce people's exposure to risks, and contribute to enhancing their capacity to protect and cover themselves against lack of or loss of adequate income, and basic social services (AU, 2008).

Hence the approaches of both the ILO and the AU call for an extension of social protection schemes to all categories of workers and their families, through a mix of programmes that are responsive specifically to poverty and vulnerability. Such a mix of programmes is likely to include health, education and access to basic services such as water and sanitation – all designed to meet the needs of those most at risk, notably the working poor, the rural poor, women, children and the elderly living in poverty. The scope and the process of the implementation of social security programmes should naturally be responsive to the prevailing social and economic context in each country.

In the next chapter an analysis is provided of the social and economic context in Africa. This context highlights the importance of progressively expanding social protection to provide a minimum social floor below which no one should fall.

2. The social and economic context of Africa

The main aim of this chapter is to provide both quantitative and qualitative analysis of social and economic conditions in Africa. It is this context that determines the significance of social security and its impacts on the lives of those most vulnerable and at risk: the working poor and those who eke out a living in the informal economy. A sharp focus on Africa's social and economic conditions is also necessary in the wake of the recent global financial crisis that shook the world's largest economies in 2008, to discern the likely impacts of the crisis.

Poverty remains a difficult problem to resolve affecting millions of people, despite the progress made in some African countries through steady, albeit slow, rates of economic growth, reflecting stable macroeconomic policy environments. An overview of relevant trends in the region indicates both the scale and depth of poverty and the extent of unemployment, resulting in devastating impacts on the most vulnerable and at-risk sectors of the population. In this social and economic environment there is an urgent need to mobilize social protection strategies both to address poverty and at the same time promote a Decent Work Agenda.

2.1. Methodology

A desk review of research studies, literature, official policy and documentation has been the main method used to survey the current status of and trends in social security in Africa. Unemployment, poverty, and demographic features related to health and education are combined with an analysis of datasets drawn from various sources. Among the difficulties in undertaking such a review is that available information and data – both quantitative and qualitative – are fragmented and dispersed. Data on existing social security measures on the informal sector were hard to obtain, making it difficult to identify and cover critical issues related to the adequacy of coverage and gaps in social security.

Key demographic data for each country, human development and poverty indicators and employment and unemployment trends in Africa were obtained from databases of the ILO, the United Nations Development Programme–Human Development Report (UNDP–HDR) and the World Population Bureau (WPB). Information on current social protection programmes, legislative frameworks, and beneficiaries and services provided was obtained from databases of the International Social Security Association (ISSA), the ILO and the World Bank.

Data on social security for salaried workers were obtained through the ISSA "social security worldwide" web site and from the ILO's NATLEX web site. The report also draws on AU Commission/Division of Social Affairs statistical documents such as *The State of the African Population Report, 2008*, UNICEF reports on social protection and DFID-sponsored research on social protection in the region.

2.2. Africa's population structure

Africa's growing population, at well over 963 million in 2007 and with a total fertility rate averaging around 5 for the period 2000–05, is estimated to be the highest of any region in the world (see table SA1(b) in the statistical appendices). The population distribution according to age reflects a significant "youth bulge", with related problems of skills and jobs deficits emphasizing the need to integrate both active and passive labour market strategies with direct measures of social protection. Approximately 41 per cent of the total population are in the age range 0–14 years, highlighting the need for social protection

measures to be sensitive to the developmental needs of children and to the vulnerabilities such a large part of the population faces.

In comparison, the major economically active component of Africa's population, those falling in the age range 15–64 years, numbers a little over half of the total (56.4 per cent). Yet when one looks at this proportion of the population and existing employment opportunities in the region, one can only assume that large numbers of people in this category eke out an existence in the rural and informal economy. The category 65 years of age and over (3.4 per cent) reflects high mortality rates as well as low life expectancy because of poverty-related illnesses. A high proportion of people in this category are especially vulnerable owing to a number of factors, including disabilities, increasingly taking on the burden of care for orphans and children, reduced or no earning capacity and health-care risks. Social protection measures to reduce poverty and mitigate risks of those who are most vulnerable would have to be responsive to these age-related issues, and also to sex-related issues since a majority of those in the over-65 category are likely to be women.

The region's urban population constitutes 39.8 per cent of the total, with some countries reflecting a high degree of urbanization: Algeria (61 per cent), Gabon (92 per cent), Libyan Arab Jamahiriya (86 per cent), Mauritania (69 per cent), Morocco (62 per cent), Nigeria (41 per cent), Senegal (51 per cent), South Africa (57 per cent) and Tunisia (65 per cent). Still, in most countries in the region large proportions of their population live in the rural areas, where access to services such as water, infrastructure in the form of schools, clinics and transport are unavailable. Besides inequities in the spatial distribution of services, work opportunities in rural areas tend to be dominated by agriculture or subsistence farming with many economically active people being employed as casual or seasonal workers on an informal basis at wage levels lower than the national poverty lines.

A large part of Africa's population is exposed to risks and vulnerabilities compounded by age, gender, spatial and environmental factors. This is why social protection strategies need to prioritize children, women, the elderly and people in rural areas.

2.3. Poverty: A defining feature of Africa's social and economic context

By any measure, poverty in Africa is a major factor and poverty-reducing strategies in the form of social protection are increasingly being seen by policy-makers as a way of making significant impacts on the extent and depth of poverty. The country case studies presented in Appendix I demonstrate that it is possible to reduce poverty, inequality and promote development using social transfers and social services.

To be able to prioritize different types of social protection policy interventions, however, it is necessary to understand what poverty means and what its impacts are on various aspects of people's lives. Our understanding of poverty, both as a concept and as a social condition experienced by millions of people, has changed over time. From seeing it simply as a lack of access to income, or defining the poor as all those who fall below a defined income level, policy thinking on poverty has grown to reflect the multiple deprivations and vulnerabilities that affect the well-being of people living in poverty. There are many dimensions of well-being, and it is these working together that give people the building blocks that enable them to get out of poverty and to utilize economic and social opportunities to promote individual and collective development.

A multidimensional approach to poverty fits well with a freedom centred approach to development as articulated by Sen (1999). These dimensions include aspects of living

standards, such as decent waged work, literacy (schooling) and health (life expectancy, infant and maternal mortality). Other dimensions included in definitions of poverty today include conditions that increase vulnerability and promote social and political exclusion. Among the many different categories of people living in poverty, it is women, children, the elderly, people subsisting in the informal sector and in rural and peri-urban informal settlements who experience chronic poverty and are vulnerable to a wide range of risks. Age, gender, spatial, income- and work-related vulnerabilities combine with other conditions to leave households and communities in Africa in acute social and economic distress.

Another factor that must be taken into consideration is that poverty has a relative dimension. It has a dynamic, not static, character, which means that not only can people find themselves descending into deeper levels of poverty, but can also move, perhaps repeatedly, into and out of poverty. People's circumstances change; they can experience different types and levels of poverty throughout their lifecycle. Chronic poverty is experienced when people's income levels are extremely low and when they have either been born into poverty or have been in poverty over an extended period of time. Chronic poverty is intergenerational (transmitted from one generation to the next – for instance, mother to child) and results from structural conditions. Transient poverty is characterized by people falling in and out of poverty owing to various reasons such as unavailability of work, poor harvests, natural disasters, illness, macroeconomic shocks or financial downturns.

The policy frameworks and social protection measures that aim to respond to the multiple deprivations of the poor must take into account not only "headline" poverty data but also the degree of "churn" or turnover within the poor population. In a region such as Africa, where chronic and transient poverty combine with a number of different vulnerabilities, policy-makers also need to take note of the effects of policy on those located just above a given poverty line and what this means in relation to their vulnerability to external shocks. Financial, environmental and epidemiological crises tend to impose a disproportionate burden on those living in income-poor households. Social protection policies, to be effective, must be responsive to the needs of those who live in conditions of chronic poverty as well as those who are most vulnerable and at risk of falling into poverty.

2.4. Income poverty: Instrumental in multiple deprivations

Although income poverty is only one dimension of multiple deprivations, it is still a significant measure because income is instrumental in accessing a range of services including health, education, water, transport and social and economic opportunities. A quick look at where Africa is situated when it comes to headcount poverty using the international poverty lines of US$1.00 and US$1.25 a day from 1981 to 2005 (see table 2.1) highlights that despite slow and steady economic growth in many countries at an aggregate level the region has the highest percentage of people living below these poverty lines. Africa's demographic and socio-economic context is best understood when viewed against the poverty gap: sub-Saharan Africa's poverty gap index shows almost no change in the period 1981–2005 with a distance below the poverty line of 36.6 in 1981 and 36.4 in 2005.

In comparing these figures with those for regions starting from similar levels, such as South Asia and East Asia where considerable improvements can be noted in lifting people out of income poverty, several questions arise, for example: To what extent did social protection measures related to health care, education and access to social infrastructure

drive the growth paths of these regions? How did countries in these regions deal with macro-level risks and vulnerabilities?

Table 2.1. Headcount index for international poverty lines of US$1.00 and US$1.25 per day, and poverty gap, by region, 1981–2005 (percentages)

(a) Percentage living below US$1.00 a day

Region	1981	1984	1987	1990	1993	1996	1999	2002	2005
East Asia and Pacific	68.7	51.9	39.4	40.6	36.1	24.7	23.7	19.7	9.5
of which China	73.5	52.9	38.0	44.0	37.7	23.7	24.1	19.1	8.1
Eastern Europe and Central Asia	0.7	0.5	0.4	0.8	2.1	2.5	3.4	3.7	3.4
Latin America and Caribbean	7.4	9.1	8.4	7.1	7.3	7.9	7.9	6.6	5.0
Middle East and North Africa	3.6	2.7	2.9	2.3	2.2	2.3	2.6	2.0	2.0
South Asia	41.9	38.0	36.6	33.6	28.6	28.9	26.9	26.5	23.7
of which India	42.1	37.6	35.7	33.3	31.1	28.6	27.0	26.3	24.3
Sub-Saharan Africa	39.5	43.6	42.8	45.9	44.3	47.1	45.6	41.6	39.2
Total	41.7	35.0	29.9	29.8	27.0	23.6	22.8	20.7	16.1

(b) Percentage living below US$1.25 a day

Region	1981	1984	1987	1990	1993	1996	1999	2002	2005
East Asia and Pacific	78.8	67.0	54.4	56.0	51.2	37.1	35.5	29.6	17.9
of which China	84.0	69.4	54.0	60.2	53.7	36.4	35.6	28.4	15.9
Eastern Europe and Central Asia	1.6	1.2	1.0	1.5	3.8	4.5	5.4	5.6	5.0
Latin America and Caribbean	12.3	13.9	12.4	10.7	10.8	11.5	11.6	10.1	8.2
Middle East and North Africa	8.6	6.8	6.9	5.4	5.2	5.3	5.8	4.7	4.6
South Asia	59.4	55.6	54.1	51.1	46.1	46.9	44.1	43.8	40.3
of which India	59.8	55.5	53.6	51.3	49.4	46.6	44.8	43.9	41.6
Sub-Saharan Africa	50.8	54.7	53.4	54.9	54.8	57.5	56.4	52.7	50.4
Total	52.0	47.1	41.8	41.6	38.9	34.8	33.7	31.0	25.7

(c) Poverty Gap Index

Region	1981	1984	1987	1990	1993	1996	1999	2002	2005
East Asia and Pacific	55.8	45.9	38.2	38.1	35.0	26.6	25.5	21.3	13.6
of which China	59.3	47.3	38.2	40.9	36.6	26.3	25.6	20.6	12.2
Eastern Europe and Central Asia	1.9	1.4	1.2	1.7	3.4	3.9	4.6	4.5	4.0
Latin America and Caribbean	9.5	10.6	9.5	8.3	8.4	8.9	8.0	7.9	6.6
Middle East and North Africa	8.0	6.7	6.8	5.7	5.6	5.6	6.2	4.9	4.8
South Asia	41.2	38.4	37.2	35.5	32.2	32.6	31.0	30.8	28.7
of which India	40.8	38.2	36.7	35.3	34.1	32.4	31.3	30.9	29.5
Sub-Saharan Africa	36.6	39.6	38.7	39.9	39.7	41.9	41.0	38.7	36.4
Total	36.9	32.8	29.5	29.1	27.4	24.9	24.2	22.4	18.9

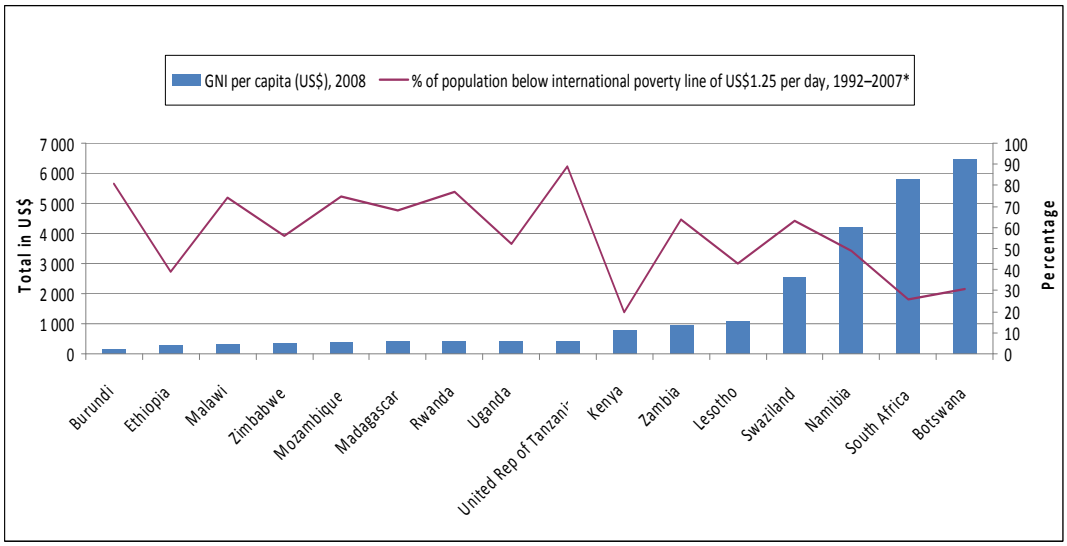
Source: Chen and Ravallion, 2008, pp. 32–33.

The significance of translating even limited economic growth into poverty-reducing economic growth strategies cannot be over emphasized. Figure 2.1 illustrates that there is no automatic relationship between overall economic activity measured by gross national

income (GNI) and reductions in income poverty measured by those living under a dollar a day. Using cross-country household survey data from its report *The State of the World's Children 2006,* UNICEF (2008) found that countries in Eastern and Southern Africa (ESA) are amongst the poorest, with an average poverty rate of 42 per cent and mean GNI per capita of US$980. In low-income countries in ESA mean GNI per capita is US$328, just over US$1,900 in lower middle-income countries (Angola, Lesotho, Namibia and Swaziland) and around US$3,900 in upper middle-income countries (Botswana and South Africa).

Turning even slight aggregate economic growth into changes in the lives of the poorest and most vulnerable peoples in the region requires both a better understanding of the multidimensional characteristics of poverty and a linking of macro social and economic policy objectives at national and regional levels.

Figure 2.1. Poverty and GNI per capita, Eastern and Southern Africa (ESA) (latest available year)



Source: UNICEF, 2010.

Taking account of the instrumental role of income and determining how income is translated into capabilities and poverty reduction at individual and aggregate levels requires being able to answer many more questions than simply whether consumption has increased and incomes have risen. For example: Is income growth concentrated in those just below the poverty line? Are more girls attending school? Are fewer mothers dying in childbirth? The regional picture from the broader perspective of poverty viewed as deprivation of capabilities is considered in the following sections.

2.5. Poverty and deprivation in health and education

Consensus is strong that access to health care and basic education, together with income from decent employment supplemented when necessary with social protection cash transfers, form key components of the social protection floor. Providing health care and education as well as an enabling environment for decent work and access to social protection transfers is today recognized as the responsibility of national governments within an international policy regime that protects and promotes the human rights of all and especially those who are poorest and most vulnerable.

Unnecessary human suffering and premature loss of life violate basic human rights, retard human development, and thus waste human potentiality. Disease and injury are causes as well as consequences of poverty and economic insecurity. The fear of

catastrophic illness is often cited as the single greatest insecurity reported by the poor (Narayan, 2000); not only are wages lost but the crippling costs of emergency health care can destroy a family's livelihood. The devastating impacts of global pandemics of old and new infectious diseases such as tuberculosis (TB), malaria and AIDS hit those who are poorest and most vulnerable.

The following sections provide an analysis of the extent and depth of deprivations in health and education using select indicators.

2.5.1. High fertility, maternal and child mortality rates

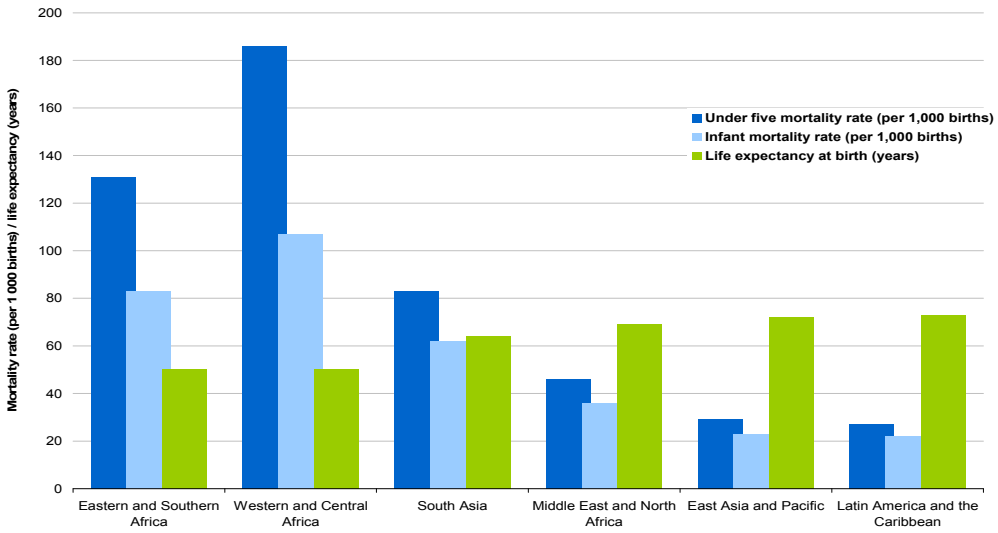
Africa's high fertility rate and high maternal and child mortality rates are an indication of the extent of deprivations in health care for the poorest. As shown in figure 2.2, infant and under-5 mortality rates are high. Links with indicators of low birth weight, stunting and malnutrition are shown in figure 2.3. The poorest countries have higher than average fertility rates (Burkina Faso 6.4, Chad 6.5, Mali 6.7, Niger 7.5 and Sierra Leone 6.5). Alongside such high fertility rates the region has very high child mortality and maternal mortality rates, large rural populations, high incidences of illiteracy, lagging women's rights and very low agricultural productivity resulting in low market values of women's time (Sachs, 2008; see also table SA1(b)).

Under-5 mortality rates of the poorest one fifth of the population in Benin, Burkina Faso, Cameroon, Guinea, Malawi, Mali, Mozambique, Niger, Rwanda, Uganda and Zambia are exceptionally high. Such trends have a direct bearing on the ability of these countries to lift themselves out of chronic and intergenerational cycles of poverty.

2.5.2. Low life expectancy

Life expectancy at birth for both sexes in the African region is estimated at 55 years. Life expectancy at birth is an important indicator of human development as well as a country's ability to sustain economic growth (see figure 2.2 and table SA1(b)).

Figure 2.2. Life expectancy at birth and infant mortality, by region, 2006



Source: UNICEF, 2008.

Botswana, Lesotho, Malawi, Swaziland, Zambia and Zimbabwe all have alarmingly low indicators of life expectancy, ranging between 33 to 40 years. Other countries in the African region also have disturbingly low life expectancy. The impact of HIV and AIDS

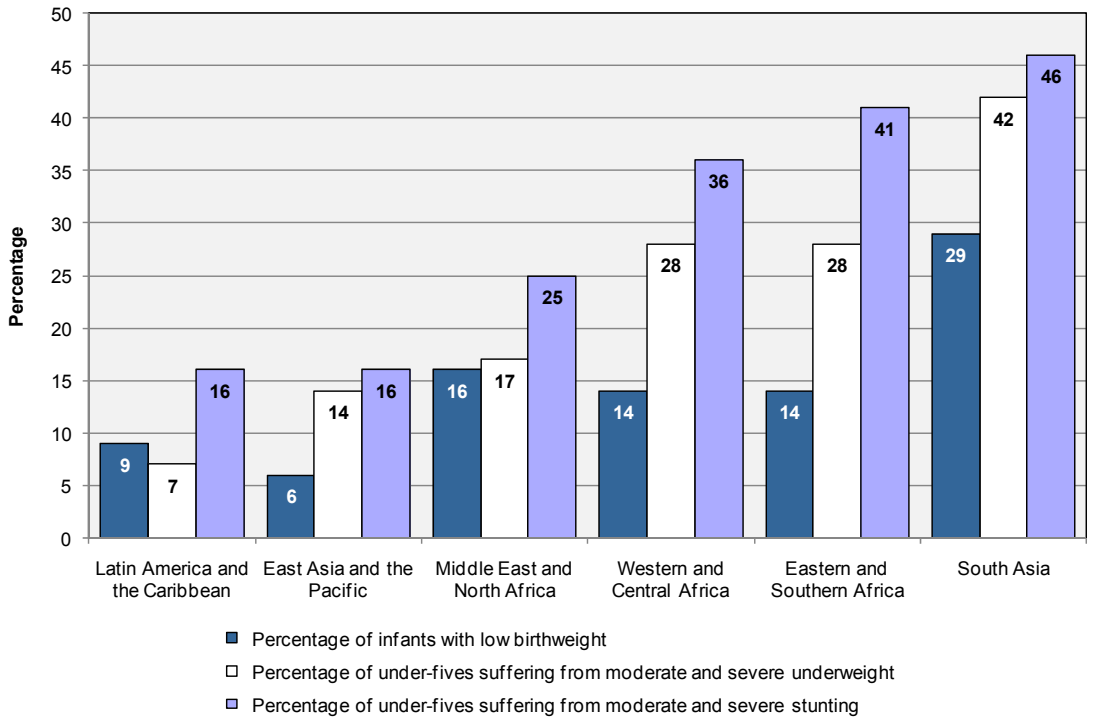
and other preventable infectious diseases account for such low life expectancy in these countries.

Life expectancy at birth in countries such as Algeria, Cape Verde, Egypt, Libyan Arab Jamahiriya, Mauritius, Morocco, Reunion, the Seychelles and Tunisia is relatively high, ranging from 70 to 76 years. These countries have also introduced significant measures to address vulnerability through a range of social protection programmes (in Algeria, for example, a cash transfer reaches over 7.4 million low-income people).

2.5.3. Malnutrition and deprivation in childhood

Approximately 24 per cent of children in Africa below 5 years of age were estimated to be underweight, while 26 per cent of the population were categorized as undernourished in the period 2000–04 (see table SA2). Selected indicators from African countries also reveal the significant extent of under-5 malnutrition and mortality rates.

Figure 2.3. Nutritional status and birth weight per region, 2000–06*



Note: * Data refer to the most recent year available during the period specified in the column heading.
Source: UNICEF, 2008.

2.5.4. The impact of HIV/AIDS on family and social structure

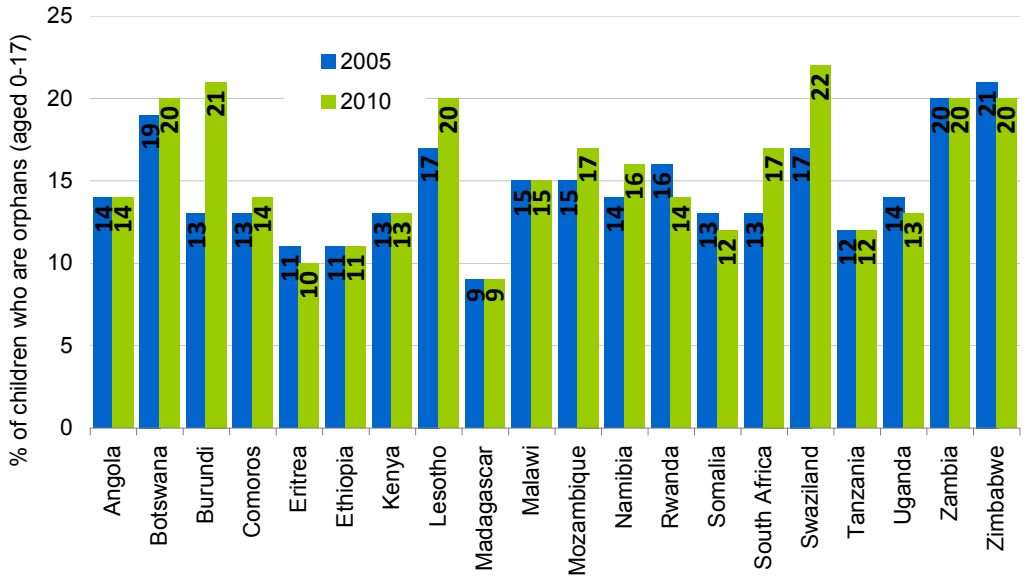
Among the adult population in Africa aged 15–49 years it is estimated that approximately 4 per cent were infected with HIV/AIDS by 2007–08 (see table SA2). The devastating impact of HIV/AIDS and other infectious diseases continues to erode the coping mechanisms of people in Africa. Even more significant is the silent revolution that is taking place in changes to African family structures and broader social structures. Normal family structures with parents, children and grandparents are changing in large parts of Africa.

In some of the worst affected areas hit by poverty and HIV/AIDS there are "skip generation" households (children and grandparents with parents missing), child-headed households (without either parents or grandparents) and orphans who have no extended

family support systems. The scope of the problem is evident when viewed against the numbers of orphans as a result of AIDS in figures 2.4 and 2.5.

Among the significant social implications is role displacement, where the burden of care falls onto children who have no access to health care, emotional or physical support, education or other essential resources to cope. Approximately 11 million children are estimated to have become AIDS orphans in the region (UNICEF, 2008). Such estimates are sure to influence the social development of households, communities and the region as a whole.

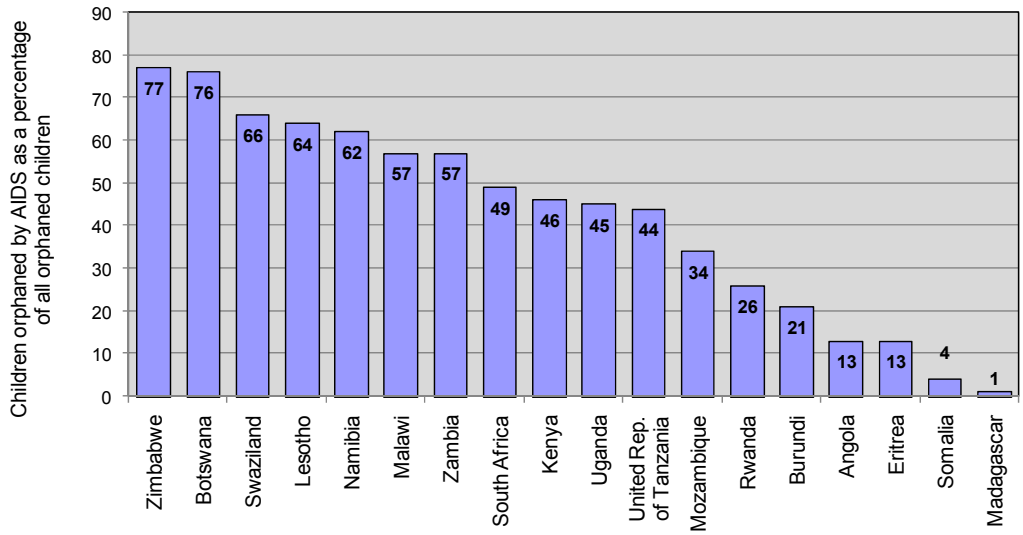
Figure 2.4. Percentage of children who are orphans, 2005, and projections for 2010



Source: UNICEF, 2006.

Urgent action is necessary to ensure the protection of children left destitute because of AIDS-related issues. A range of options is possible through "child sensitive" social protection measures that would reduce the negative impacts of the AIDS pandemic and in the short to medium term improve the life chances and opportunities available to children affected and infected by HIV/AIDS.

Figure 2.5. Children orphaned by AIDS as a percentage of all orphaned children, 2005



Source: UNICEF, 2006.

2.5.5. The impact of childhood malnutrition and deprivation

With 26 per cent of the population in Africa estimated to be undernourished (table SA2), malnutrition is bound to have multiple impacts. Inadequate early childhood nutrition contributes to long-term health and education problems, leading in turn to lower productivity through poorer health and higher absenteeism in the workplace (UNICEF, 2008; FAO, 2003). Conditions resulting from childhood deprivation also lead to long-term strains on a nation's health and education systems, draining resources that could efficiently target other social priorities.

Making the case for economic security achieved through both private and public (government) transfers, international studies demonstrate that more than half of additional income such as remittances, public transfers and pensions is allocated by poor families to increased food consumption (Pinstrup-Andersen and Padya-Lorch, 2001). The resulting improvements in health and nutrition directly improve not only the well-being but also the productivity of the very poor. Indeed, increased household expenditure on food increases local economic growth.

2.5.6. Poverty and deprivation in education

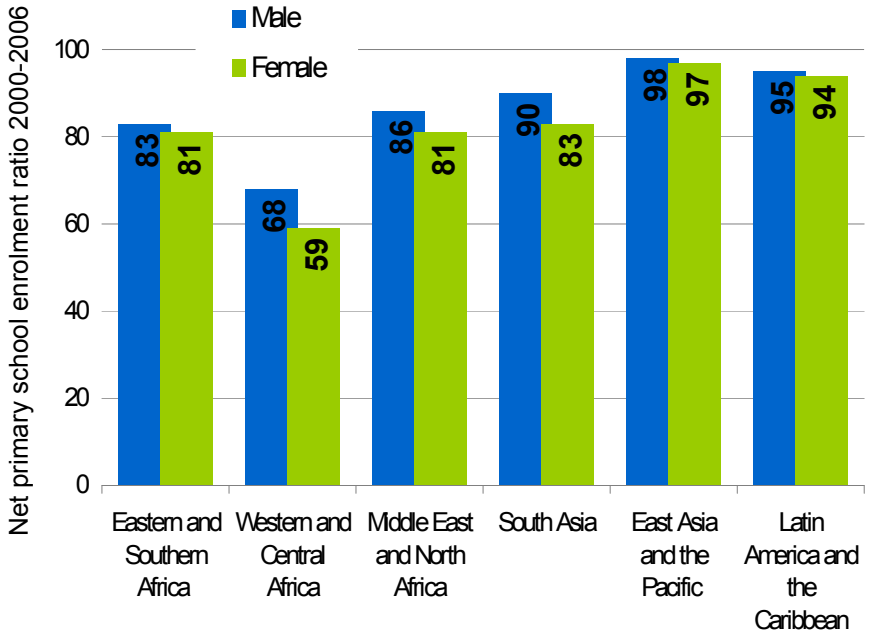
Alongside health deprivations, lack of access to basic education and literacy is also linked to human development. Education and incomes have always been related, but changes in production patterns and the global division of labour have increased the value and the role of education at an individual and societal level. Life choices and opportunities are conditioned by human capabilities (Sen, 1999). Individual, familial, and societal resilience to political instability and economic volatility is an outcome of basic education and well-being.

In times of crisis, such resilience depends upon a family's or a nation's asset base – human and social capital as well as material assets. Education is a fundamental individual and social asset that can cushion individuals against the negative consequences of rapid changes and crises.

The Asian financial crisis of 1997–98 hit those without education or skills hardest, because they lost their jobs and had few human or social assets to gain new employment. The lesson learned is that basic literacy and numeracy are essential today for effective functioning in the competitive labour markets that have resulted from globalization. At another level, female education is one of the strongest correlates of family health, and child health is a prerequisite for successful learning. Gender equity reinforces the positive gains of both health and education, and gender disparities affect both negatively.

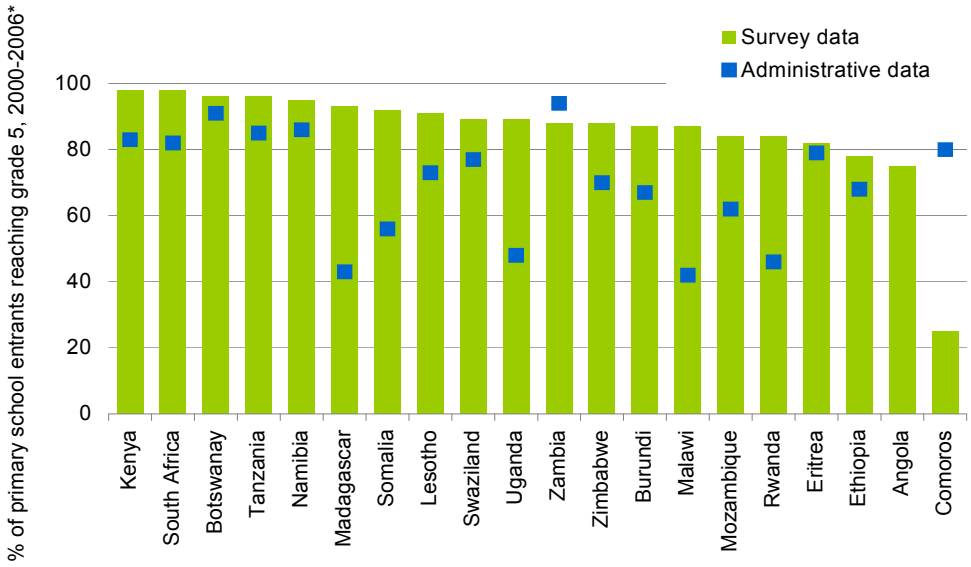
The literacy rate for females in Africa between 15 and 24 years was estimated at 69 per cent (calculated for the period 2000–04); for males of the same age group it was estimated at 81 per cent, highlighting the gender disparities between boys and girls in access to education (see table SA2). As can be seen figure 2.6, countries in Africa lag behind other regions when it comes to primary school enrolment. Of even greater concern is that despite the emphasis on the girl child and gender equity, school enrolment among girls continues to lag behind in all regions in Africa. As UNICEF (2008) points, grade 5 completion rates remain low (figure 2.7): despite increasing numbers school enrolments, a significant proportion of children enter late, repeat grades or leave without completing the five years of primary school generally accepted as a minimum for sustained literacy and other competencies.

Figure 2.6. Primary school enrolment ratio (net ratio) by sex and region, 2000–06*



Note: * Data refer to the most recent year available during the period specified in the column heading.
Source: UNICEF, 2008.

Figure 2.7. Percentage of primary school entrants reaching grade 5 by source of data, 2000–06*



Note: * Data refer to the most recent year available during the period specified in the column heading.
Source: UNICEF, 2008.

2.5.7. The social and economic impacts of low female enrolment in school

Girls' enrolment and attendance at school are low when compared to that of boys (figure 2.6). Little or no access to formal public health systems, reproductive health and social protection measures make the challenges more complex (Sachs, 2008, pp.191–2). Access to primary and secondary schooling, as well as to skills and vocational training,

continues to be a barrier to the development of children, especially that of girls – and thus a continuing barrier to the reduction of poverty among girls and women.

The World Bank estimates that for each additional year of schooling, a woman's income increases by 10–20 per cent, agricultural productivity increases by 10 per cent, infant mortality drops by 10 per cent, and the return on investment in deferred healthcare expenses is 25 per cent (Summers, 1994). Promoting access to schooling and keeping children in school, especially girls, is good for human development, economic growth and labour productivity. Making it possible for girls to attend school is also vital to their social empowerment and contributes to reductions in gender imbalances.

2.6. Access to services

Data are available only for service provision related to access to potable water and sanitation. For other services such as access to social infrastructure – schools, clinics and social welfare services for special categories of people including children, people with disabilities and youth – data are not readily available.

On average, 62 per cent of Africa's population has access to water. This aggregate however masks huge differences among countries as well as within countries (see table SA3). In Algeria, a water-scarce country, total water supply coverage is 85 per cent with urban access at 88 per cent and rural access at 80 per cent. In contrast, the Democratic Republic of the Congo has a total of only 22 per cent water supply coverage with 37 per cent urban and 12 per cent rural coverage; Madagascar and Somalia fare not much better. Sanitation coverage in the region is very uneven, with some countries, such as Rwanda, with a total coverage as low as 8 per cent and others, such as Libyan Arab Jamahiriya, as high as 97 per cent.

Lack of access to water and sanitation across the continent correlates with high prevalence rates of major diseases in affected countries. The situation is particularly acute in rural areas, so that the provision of water, sanitation, schools and clinics in rural areas and peri-urban informal settlements must be a priority for poverty-reducing strategies and in addressing vulnerabilities.

2.7. Labour market issues: Employment, unemployment and the informal sector

Although statistically labour force participation rates in Africa are high (see tables SA4(a) and (b)), in many African countries a large proportion of those economically active (particularly women) are either in unpaid employment as contributing family workers or are own-account workers in subsistence traditional agriculture (see table SA4(c)). The proportion of the labour force in full-time wage or salary employment, which is usually highly correlated with the proportion of those covered by employment-related contributory social security schemes, is thus in fact low (see table 2.2). This is one of the reasons why income poverty affects more than 40 per cent of the population in Africa. In the Latin American and Caribbean region, for example, the total figure for those in wage or salary employment among all employed is 62.7 per cent; the comparable figure for sub-Saharan Africa is only 22.9 per cent, well below the global average of 46.9 per cent. Statistical unemployment rates in many African countries, and in particular in rural areas, are low because in order to survive people engage in any form of economic activity, even in unpaid or most precarious types of employment, that may bring them at least some quantity of food or other staple goods.

Table 2.2. Employees (wage and salary workers) in the labour market worldwide, 2008 (percentages)

	Total		Men		Women	
	Employed = 100	Total working-age population = 100	Employed = 100	Total working-age population = 100	Employed = 100	Total working-age population = 100
South Asia	20.8	9.7	23.4	15.6	14.6	3.5
Sub-Saharan Africa	22.9	13.8	29.2	20.5	14.4	7.4
South-East Asia and the Pacific	38.8	21.9	41.5	28.6	35.0	15.1
East Asia	42.6	23.3	46.0	28.9	38.3	17.6
North Africa	58.3	24.4	58.8	38.5	56.7	10.5
Middle East	61.5	29.0	64.4	41.6	53.5	15.0
Latin America and the Caribbean	62.7	38.6	60.6	46.1	65.8	31.8
Central and South-Eastern Europe (non-EU) and CIS	76.6	41.5	75.4	48.0	78.0	35.7
Developed economies	84.3	46.6	81.7	51.8	87.5	41.6
World	46.9	26.5	47.4	33.0	46.0	20.1

Note: Labour force surveys distinguish between those who are employees (employed in wage or salary employment) and those who are not and thus are either self-employed (employers and own-account workers) or unpaid helping family workers. The table shows percentages of those who are employees among (1) all employed; (2) all population of working age, i.e. between 15 and 64.

Source: ILO calculations, based on ILO 2008c: *Key Indicators of the Labour Market* (KILM), fifth edition, www.ilo.org/public/english/employment/strat/kilm/ (using 2006 estimates for indicator 3: status of employment and indicator 2: employment to population ratio). Country classification also from KILM.

The high labour participation rates and low unemployment rates shown in statistical tables indicate that many economically active workers are either in survival agriculture or are self-employed in other types of the survivalist economy. It is these workers and their families who are without any social security and who form the majority of the income-poor.

Gender disparities continue to contribute significantly to the poverty experienced by women. Africa's economically active female population over the age of 15 years was estimated at 53 per cent between the period 1995 to 2002, while the economically active male population over the age of 15 years was set at 80 per cent during the same period. In sub-Saharan Africa where poverty in rural areas is high, 31 per cent of rural households are headed by women, reinforcing both the gender and spatial dimensions of poverty.

The ILO *World Employment Report 2004–05* notes that those regions that have managed to increase productivity levels in the longer run *and* to create employment opportunities for their growing labour forces are better able to reduce working poverty and overall poverty. They are more likely to reach the target of the first MDG: halving the proportion of people living on less than US$1 by 2015.

Worker remittances contribute significantly to Africa's economies (see table SA4(d)). In 2005, the total income from remittances was estimated at close to US$22 billion. The current global financial crisis is likely to have an impact on remittances: it will affect workers through unemployment and retrenchments and therefore looks set to deepen already high levels of income poverty. Without any predictable sources of income to cushion the effects of the crisis, poverty, malnutrition and deprivation are likely to leave millions of people in the region destitute.

Open unemployment in most countries is viewed typically as an urban phenomenon concentrated in population categories such as school-leavers. At the very time when large numbers of young people are entering the labour market, economies are growing only slowly or even contracting. Where jobs are being created, these require a set of skills and experience not readily available in the labour market in the African region (Taylor, 2008).

The employment situation in the region is further aggravated by cutbacks in public-sector employment as a result of economic stabilization and long-term restructuring efforts (referred to as economic structural adjustment programmes). This leaves the vast majority of workers in the region to seek a living in the many different activities that make up the informal economy. Wage disparities and more generally income disparities, already very large between the formal and informal sectors, have dramatically increased. Income inequalities also reflect inequalities in land ownership, assets and access to education and health care (Taylor, 2008).

Those subregions of Africa where only small percentages of the elderly population have access to any kind of pension are characterized by labour force participation rates of that population, compared to the rates for the younger population, much higher than elsewhere in the world (see table 2.3). It should be noted that although not many people in Africa survive to older ages, and that therefore the elderly constitute only a small portion of the population in many African countries, the average life expectancy of those who reach the age of 65 is only a few years shorter in other parts of the world: those who reach 65 will live another 11–14 years. These people need a pension as a source of income no less than people in more advanced economies – and maybe even more. Many of them will be unable to access and/or perform any decent employment during this period, yet increasing numbers of this age group can no longer rely on support from the extended family, particularly in those countries affected by HIV/AIDS. There is a strong need for public pension transfers for this population group, even if at first glance pensions may not seem to be a priority, given Africa's demographic structure.

Table 2.3. Participation in the labour market of elderly (65+), and life expectancy at age 65, 1980 and 2005

Regions	Labour force participation of those aged 65+, percentage of labour force participation of those aged 15+				Life expectancy at age 65	
	Men		Women		2000–05	
	1980	2005	1980	2005	Men	Women
Middle Africa	84.4	85.0	55.1	56.5	10.96	12.38
Western Africa	81.4	82.3	58.7	56.3	11.36	12.50
Eastern Africa	82.7	81.5	62.5	59.1	11.31	13.00
Northern Africa	59.9	42.9	61.5	22.3	12.81	14.58
Less developed regions	54.2	48.5	24.9	27.8	13.80	15.64
World	40.6	38.2	18.4	21.5	14.39	16.95

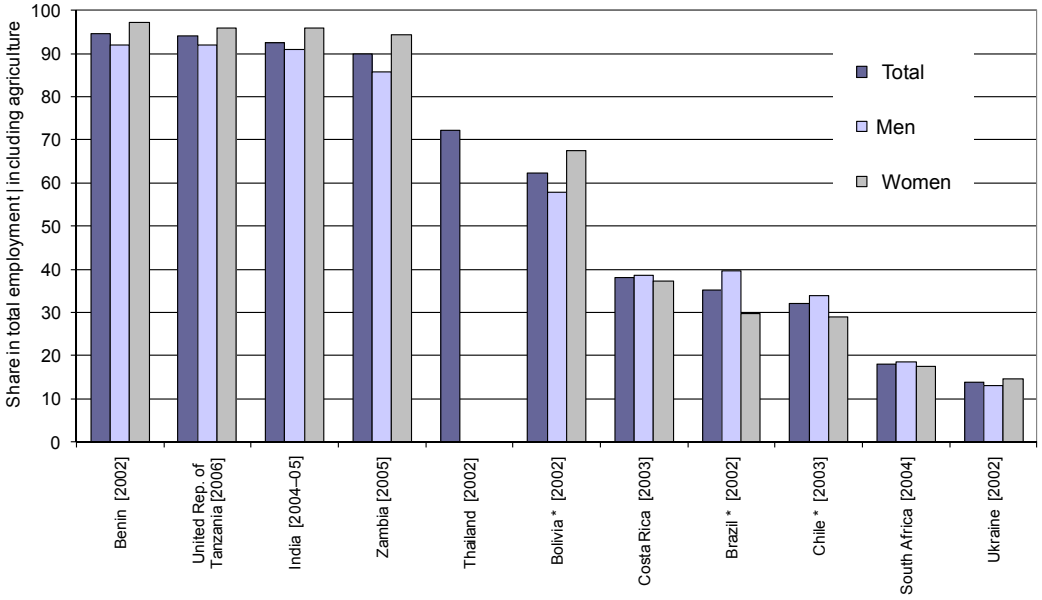
Sources: (1) Labour force participation: ILO calculations based on the ILO database *Economically Active Population Estimates and Projections*, version 5: 1980–2020 (ILO, 2009e), available at: http://laborsta.ilo.org/; (2) Life expectancy: UN, 2007. Country groupings according to UN World Population Prospects (see http://esa.un.org/unpp/index.asp?panel=5).

2.7.1. The informal economy

The proportion of those working in the informal economy in some African countries (for example, Benin, United Republic of Tanzania and Zambia) is close to 90 per cent of total employment (figure 2.8). The figure also shows that in these countries the female

share of employment in the informal economy is higher than the male share. Workers in the informal economy generally have no access to employment-related social security and are particularly vulnerable in times of crisis.

Figure 2.8. Employment in the informal economy as a percentage of total employment (including agriculture), various years



* Urban areas only.

Sources: ILO Bureau of Statistics database: Employment in the informal sector; figures for India from Kannan, 2006; for United Republic of Tanzania and for Zambia from ILO, 2008e, 2008f.

Workers, families and communities are increasingly at risk as labour markets evolve and global markets extend. No longer is it sufficient to be a reliable and industrious worker; a shudder in the national or regional economy has terrible effects across entire societies because of financial and economic globalization. In the context of growing informalization, casualization and feminization of labour markets, the emphasis is no longer on the promotion of full employment but rather on the need for decent work. Not only the ILO but others too place increasing emphasis on this need. Referring to decent work as "work that not only provides a sufficient level of income but also ensures social security, good working conditions and a voice at work", The ILO's *World Employment Report 2004–05* (p. 24) highlighted the extent to which millions of workers are unable to lift themselves and their families out of poverty.

Recent trends reflect empirically observable changes in global employment patterns in relation to poverty and waged work. The *World Employment Report 2004–05* estimated that 49.7 per cent of the world's workers were not earning enough to lift themselves and their families above the crude US$2 a day poverty line and that 19.7 per cent of employed persons in the world were living on less than US$1 a day. Unsurprisingly, the numbers of working poor have increased in low-income countries, with the largest share in sub-Saharan Africa, estimated at 55.8 per cent, followed by South Asia at 38.1 per cent in 2003.

The ILO report *Global Employment Trends for Women* (ILO, 2008d, p. 1) shows that while there are 18.4 per cent more women workers than a decade ago the numbers of women in unemployment also grew at 6.4 per cent compared to the male rate of unemployment of 5.7 per cent. The deficit in decent jobs pushes the poor into vulnerable and high-risk work. Indications are that at least five out of every ten people are in vulnerable employment. This is employment without any protection such as social security

and other basic rights such as representation and voice. The effects of economic insecurity are multiple and often result in feelings of oppression, anomie, demotivation, ill health, loss of dignity, breakdown of social solidarity at the household, community and other levels, and powerlessness.

2.7.2. Rural poverty

At least 75 per cent of the world's poor are said to live in rural areas, with the agricultural sector employing 40 per cent of the workforce in developing countries. In sub-Saharan Africa economic activity is mainly in agriculture. Rural poverty in eastern and southern Africa alone accounts for as much as 90 per cent of total poverty in these subregions. Overall trends indicate that approximately 80 per cent of poor people still depend on agriculture for their livelihoods (FAO/IFAD, 2008). In countries such as China and India rural poverty was reduced by rising agricultural output and investing in agricultural industries. Land tenure and land reform policies, alongside the promotion of household farming for subsistence, is said to have resulted in an overall fall in poverty of 10 per cent between 1958 and 1992 in some states in India. Investments in basic infrastructure such as transport and roads, water, electricity, health, education and social infrastructure also contribute to reducing rural poverty.

Given the extent and depth of poverty, the low levels of economic growth, the reliance on agriculture with limited alternatives for employment, the lack of basic infrastructure and lack of access to education, the importance of social protection programmes [1] is gaining ground. The AU is actively promoting the Ouagadougou and Livingstone Declarations, which aim to promote basic social protection measures in African states.

2.7.3. Famine, hunger and recurring food crises

Alongside economic insecurity as a result of structural crises, the region is facing the most severe food crisis yet. Some countries have reversed from being exporters of agricultural commodities to becoming importers, contributing to the unavailability of food. According to the Food and Agriculture Organization (FAO) some 16.7 million people were in need of emergency food assistance in the early years of the twenty-first century: in 2002, for example, Lesotho, Malawi, Zambia and Zimbabwe declared national disasters because of the extent of famine in their countries. The Darfur region, Mozambique and Swaziland, and many other countries in East and West Africa also face a precarious situation (FAO, 2002).

The food crisis in the region is not a recent phenomenon. Contributing factors include environmental ones such as natural disasters and poor land use, bad public policies at both national and international levels affecting agricultural production, and lack of income to buy seeds or to grow and purchase food (Taylor, 2004). These trends can be reversed through appropriate social protection measures. For instance increases in food availability accounted for a 26 per cent reduction in child malnutrition in developing countries between

[1] Social protection is here taken to include direct transfers to the poor, whether in cash or in kind (e.g. food and fertilizer), with or without a work requirement. Such transfers are only one aspect; others include public works programmes, discount vouchers for food distribution and feeding programmes and – less often in very poor countries – strictly social protection measures such as pensions and other cash entitlements. To some extent credit schemes and income-generating programmes, seen as part of broader development programmes, may also have some social protection functions.

1970 and 1995 (Smith and Haddad, 2000a). Increased food availability and female education together accounted for almost a 70 per cent reduction in child malnutrition (Smith and Haddad, 2000b).

2.8. Social impacts of recent global financial and economic crises

In addition to chronic poverty, present circumstances provide a reminder that sudden economic downturns and financial shocks can also be features of the global economy. Lost wages and increased unemployment as a result of financial and economic crises impoverish families and communities and reduce people's ability to buy essential goods and services needed for survival. Global financial crises also result in squeezing government finances during times when protective policies are needed the most.

The current global financial crisis triggered by the collapse of the housing credit market in the United States has multiple and far reaching impacts on Africa. Initial speculations that Africa would not be significantly affected by the financial crisis because of its peripheral links with global economic markets are being disproved.

Compared to the 1997–98 East Asian crisis, when countries that had "done everything right" saw their economic security suddenly evaporate, the current crisis is different. In today's interconnected global system economic and financial crises appear to have a faster onset, to be less predictable and more severe. International financial volatility has devastating impacts: financial and economic crises lead to social crises.

People's lives are systematically threatened by macroeconomic conditions – whether these are due to crises or adjustment policies or slow-downs. For example, in periods of high inflation or hyperinflation, or during financial or economic crises, persons from all layers of society may have their livelihoods threatened without notice. Many who previously had secure jobs and livelihoods suddenly lose them. Even those in professions such as teaching or nursing, as well as artisans, may suddenly lose their jobs and homes and fall into poverty.

While macroeconomic shocks are not a new phenomenon, their ability to immediately rock an economy to its core is a product of the era of globalization. The effects of these shocks are particularly harsh, as witnesses in the 1990s in Latin America and South-East Asia, and now in the United States and Europe. Within the countries affected by the crisis, it is the poor who bear the brunt of quick and severe economic downturns.[2] Others may face a future without their life savings. Those who were previously well-situated may tumble into poverty – and remain impoverished for years to come. Economic crises may also result in increased political instability, leading to social unrest and violence, and worsening other problems. New forms of social exclusion create new types of poverty. Food prices, already high for poor people, increase, as do transport and health-care costs, while the prospects of getting waged work vanish. Many who were adversely incorporated into society as casual or informal labour under exploitative conditions experience new forms of social exclusion.

[2] Ravaillon and Jalan (1997) found that in rural China for the poorest 10 per cent of the population, 40 per cent of a macroeconomic shock is transmitted to current consumption. For the richest third of the population, current consumption only falls by 10 per cent. Considering the respective reference points for the rich and the poor, it is clear that the poor feel the brunt of the crisis much more acutely than the rich.

In the absence of adequate decent work and poverty reduction strategies, different production systems coexist and create new vulnerabilities and risks on top of existing patterns. Trade in children and women, illegal trade in cultural resources, hazardous employment in informal markets and other illegal activities compromise the well-being of people and shut out certain categories of people from accepted forms of social participation. Work-based exclusion and exploitative relations intersect with and are mediated through other systems of inequality and domination such as gender, race and global capitalism.

Alongside growing unemployment and lack of waged income, rapid increases in food prices are drastically reducing the purchasing power of poor households, with many negative impacts on health and well-being. The International Fund for Agricultural Development (IFAD) and the Food and Agricultural Organization (FAO) estimate that approximately 105 million people in low income countries have fallen into poverty. The multiple impacts of the financial crisis look set to compound the food crisis for the poor. In a region with approximately 500 million people living on less than a dollar a day, food price increases and the resulting malnutrition and starvation are reversing progress in poverty reduction.

All the evidence suggests that the effects of the crisis on trade, investment, credit, growth and development are indeed also being experienced in Africa. Economic growth in the region is projected to fall by 2–4 per cent, with many negative effects as described in the following short sections.

2.8.1. Fluctuations in pension and retirement funds

Among the financial impacts is increased stock market volatility, resulting in losses on African stock markets with pension and retirement fund industries being negatively affected. Workers in the formal economy are likely to suffer setbacks in the short to medium term. Contributory-based unemployment insurance funds, provident funds and funds covering contingencies such as sickness and disability compensation are likely to be hardest hit. Low-waged workers and those in working poverty are likely to end up destitute if retrenched, because they will have minimal (if any) contributory benefits – joint employer–employee-based payments – to cushion their loss of wages.

2.8.2. Reductions in remittances

Increases in retrenchments and unemployment of African workers based in the United States and Europe as well as in other parts of the world are already leading to decreases in remittances. This has led to extreme social hardship for the workers concerned as well as for those households dependent on such remittances. In addition to reduced flows in remittances, losses in employment and wages in Africa will cause people to fall into even deeper poverty. The numbers of people living in poverty are therefore estimated to increase by 46 million in 2009.

2.8.3. Gender impacts

While the impacts of a financial crisis are experienced most severely among those who are poor, women and children are among the majority of the poor and as a result many of the effects are gendered. Women and men experience the effects of financial crisis differently. Women bear a disproportionately high burden of social care so that in times of financial crisis (as well as of climate change, disasters and conflict) they are hit hardest and often have no resources or livelihood alternatives to mitigate the harsh impacts.

2.8.4. Effects of crisis on government budgets and development aid

Some countries are already seeing a decline in government revenue, which may lead to a contraction of social expenditure. Government-funded health services, education, social assistance, infrastructure and basic services are all likely to be affected. Reductions in overseas development aid (both multilateral and bilateral) are also likely to have a severe impact on aid-dependent economies in Africa. As the Organisation for Economic Co-operation and Development (OECD) countries continue to suffer the effects of the crisis it may become difficult to predict amounts of aid.

2.8.5. The role of social security in times of crisis: Lessons learned

Lessons from the South-East Asian financial crisis highlight that it is precisely at these times that countries with sound social security systems are able to cushion the worst effects on people. Further, in countries where social security provision was strengthened and extended during the crisis, economic recovery occurred in a smoother and more sustained manner. The ILO finds (2010a) that in times of national and global economic crises, social security systems act as combined social and economic stabilizers. Social protection benefits paid to unemployed workers and other vulnerable recipients can prevent individuals and their families from falling into deeper poverty. They also reduce the fall in aggregate demand, so limiting the potential depth of recession and opening the way to recovery.

Establishing the social protection floor may seem particularly difficult in times of acute economic and social stress characterized by situations of chronic poverty, internal conflict and sudden economic downturns. However, there is ample evidence to show that even with relatively low income and limited resources, a Government that guarantees a social minimum level of primary expenditure – including social services such as water sanitation, education and health care together with social transfers in cash or kind – can achieve remarkable results in terms of the expansion of human capabilities and development (Sen, 1999).

2.9. Some conclusions

The social and economic context in Africa points to the urgent need for coherent and significant social protection interventions supported by continental and global actions. Based on societal consensus and the political will to extend social protection, policy options can be organized around three main clusters that are pivotal to the attainment of human well-being. These include: access to economic security through income support, through basic education and through primary health care. The degree and the nature of provision in each of these categories, however, can vary depending on the level of development and the resources available within a given society.

Importantly, in Africa social protection strategies are not only poverty-reducing but also growth-enhancing. The key issue in extending social protection is an understanding of how economic security contributes to protecting and promoting people's rights. Economic security leaves its footprint on people's lives in a number of ways. Through decent waged work or livelihoods people gain the means of improving their lives materially; this contributes to human dignity, independence, psychosocial and physical well-being, of both individuals and the collective. An adequate, stable income and essential assets are a necessary means for households to enjoy social capabilities such as basic health, nutrition, and education. Where public services are weak or non-existent people will need to pay for

these basic essentials; if they cannot pay they will go without. Investments in these social capabilities in turn contribute to further economic and livelihood security, creating a virtuous spiral.

3. Social health protection in Africa

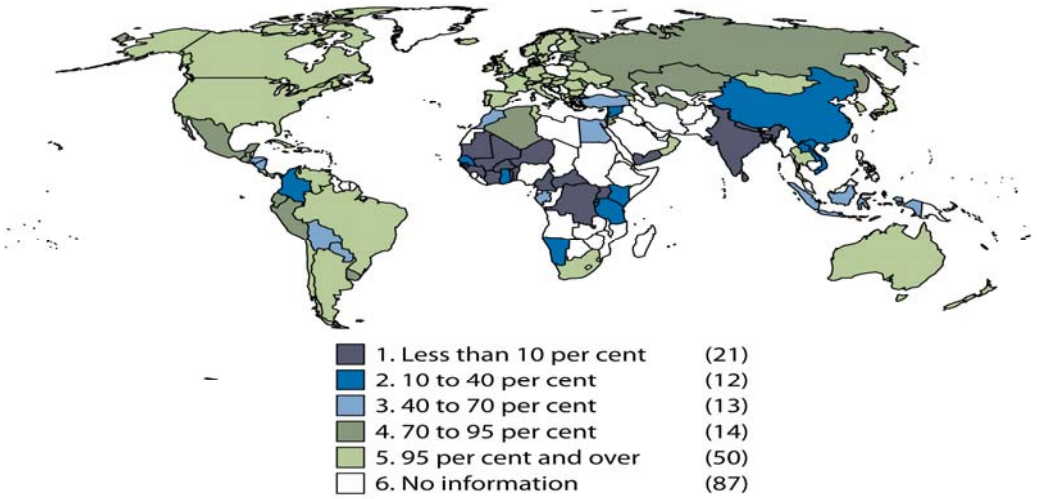
Social health protection within the framework of social security is conceived as a series of public or publicly organized and mandated private measures against social distress and economic loss arising from ill health and the cost of the required treatment. The objective of social health protection is therefore to ensure that the financial means to secure health care and access to quality health-care treatment is available.

Social health protection in Africa is basic. Access to affordable and quality health care is not available for the majority of poor people on the continent (figure 3.1). The ILO (2010a) estimates that total formal health-care coverage by contributory schemes in Africa remains below 1 per cent of the total population. While this is not surprising given the social and economic conditions, it does mean that in a region that is hardest hit by HIV/AIDS and other infectious diseases the very survival of those experiencing multiple deprivations is at stake. People living in rural areas and in informal settlements are especially vulnerable and experience the most difficulties in accessing health care.

Africa has the lowest level of social security expenditure on health of any region in the world and proportionately very high private expenditure (see figure 3.2). The lack of access to basic health-care services affects the lives of millions of the poorest people, especially children, women, the elderly and people living with disabilities, together with those living in post-conflict zones. Access to maternal health services, to pre- and post-natal health services and to primary health care generally is very limited in most African countries. High maternal mortality rates, infant mortality rates and malnutrition and other health deprivations point to a critical problem in health protection. In 1997, UNDP estimated the distribution of health-care services to poor people in developing countries and found that 27 per cent that did not have access to health care live in sub-Saharan Africa (see ILO, 2008g, p. 77). At the time this was the second lowest estimate after South Asia and correlates with the high levels of income poverty and deprivations in education in both these regions. The situation in Africa has worsened due to recurrence of old diseases (such as malaria and TB) and the HIV/AIDS pandemic.

Workers in the informal economy, on small farms and those in rural areas without formal health insurance are finding ways to address health-care needs through mutual support and microinsurance arrangements. Such community-based arrangements, which act as informal microfinance institutions, provide a lifeline to poor people. Mutual or community health organizations provide community-based or profession-based risk pooling to avert the consequences of catastrophic health costs. However, participation in these schemes is usually not affordable for the poorest.

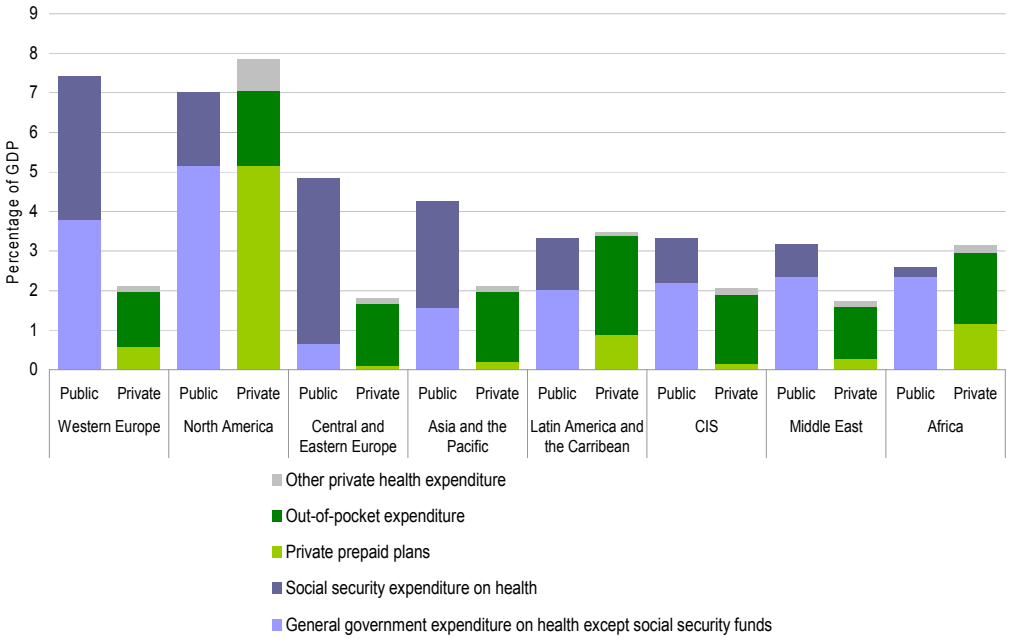
Figure 3.1. Health protection: Proportion of the population covered by law, latest available year (percentages)



Link: www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15109.

Source: National legislation, various dates. See ILO, GESS (ILO, 2009f).

Figure 3.2. Health-care financing levels and sources of funds, 2006 (percentage of GDP)



Link: www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15210.

Source: ILO calculations based on WHOSIS (WHO, 2009), 2006 data. See also ILO, GESS (ILO, 2009d).

3.1. Background

The global economic downturn has shaken Africa's economies severely and estimations of growth rates have been revised substantially, particularly for sub-Saharan countries. Reductions in growth are likely to be translated into increased unemployment, poverty, and shrinking funds available for health care. As a result it is – based on

experiences with past economic crises – expected that the health status of the population in countries most concerned will decrease and that maternal and infant mortality in particular will increase; the latter by up to 400,000 deaths (UNESCO, 2009) globally. Africa will be among the regions that are severely hit (ILO, 2009g).

Against this background, it is essential to mitigate the impact of the crisis on health and poverty if further slowing of progress towards achieving the MDGs is to be avoided. The consolidation of health status – which is vital for income generation, development, growth and wealth – will require an increasing commitment from African countries towards ensuring access to at least essential health services through improved social health protection schemes, seeking to cover more people with better services and provide financial protection against health-related poverty. In this context, the priority needs are to reach out to the most vulnerable, the poor and those working in the informal economy.

3.2. Equity in access to health care and financial protection in Africa: A key issue

The scale of need for social health protection coverage on the African continent is overwhelming. Severe gaps in coverage lead to large-scale inequities at both regional and national levels, resulting in significant differences in health status with related impacts on social and economic development.

3.2.1. Regional inequalities in social health protection coverage

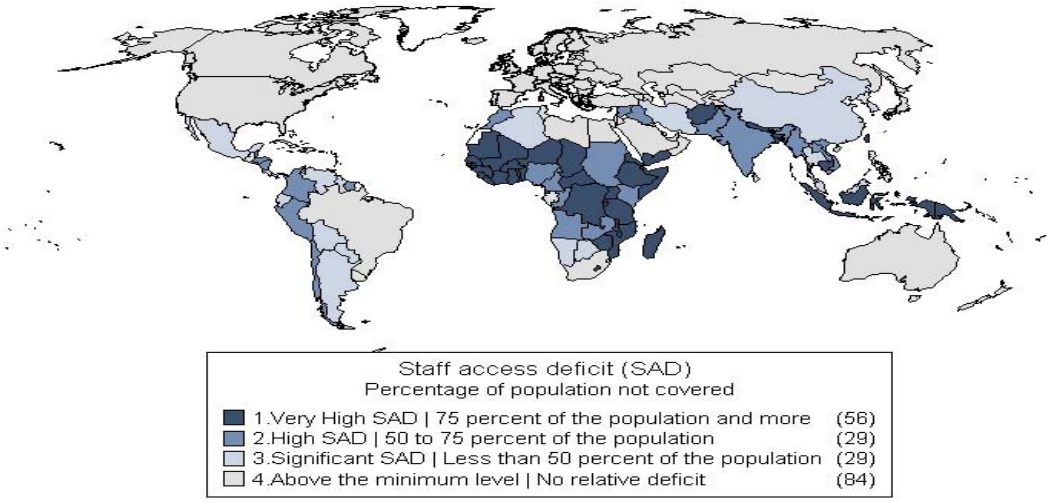
The performance and extent of social health protection coverage, including access to health services and financial protection, varies significantly according to the degree of vulnerability in terms of poverty and the extent of the informal economy. Figure 3.3 shows that:

– globally, Africa is among those regions with both the **highest vulnerability in terms of poverty and informal economy** and the **highest deficits in access to health services**, as measured by the ILO Access Deficit Indicator; [1]

– within the African continent significant differences are observed regarding the extent of the access deficit and hence the level of challenge faced by the population when in need, with the relative deficit ranging from a very high level to almost none.

[1] This indicator is based on the density of health professionals. It uses Thailand as a benchmark, given that country's good health results with a ratio of one health professional for 313 population (ILO, 2008g).

Figure 3.3. Global results of the ILO Access Deficit Indicator, 2008

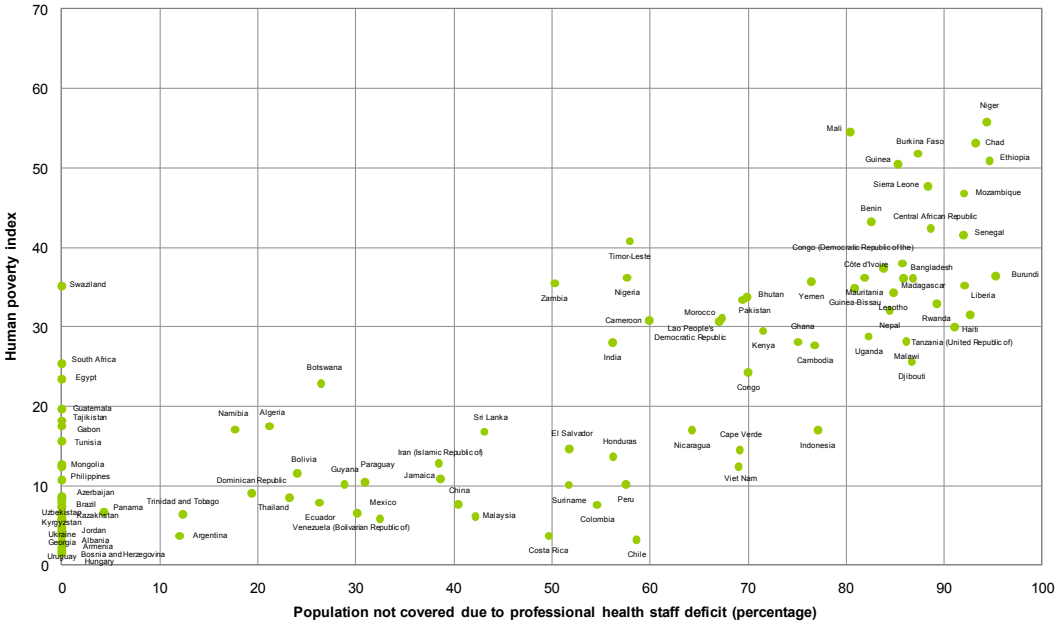


Source: ILO, 2008g.

Only a few countries in North and South Africa provide – from a national viewpoint – more than a minimum level access to health, while in the majority of African countries over 75 per cent of the population have no access to health services when in need, if gaps in the health workforce are considered. It is interesting to note that the countries most in need of social health protection provide least coverage, both globally and on the African continent. These are countries with the highest poverty levels and high levels of informal economy.

The strong correlation of the access deficit with poverty levels of countries can be observed in figure 3.4, which shows the global regression between access deficits to health services and the human poverty index (HPI). Most African countries are to be found on the upper right-hand side of the figure, indicating highest levels of both poverty and access deficits to health services.

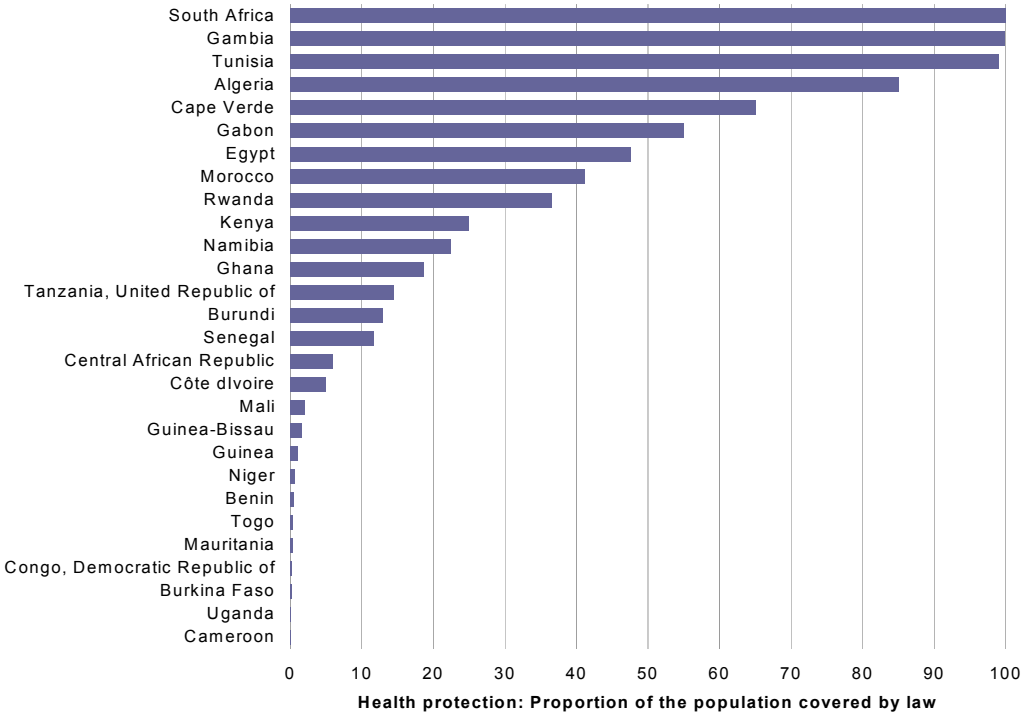
Figure 3.4. The human poverty index and staff-related access deficits, 2008



Source: ILO, 2008g.

Also, when focusing on legal coverage on the continent significant differences become obvious. While in North African countries such as Tunisia and Algeria 80 to 90 per cent of the population are covered, this is not the case in other parts of Africa. As shown in figure 3.5, in Kenya about 25 per cent of the population are covered, in the United Republic of Tanzania 14.5 per cent and in Burundi 13 per cent, while Togo and Burkina Faso provide coverage for only 0.4 and 0.2 per cent, respectively.

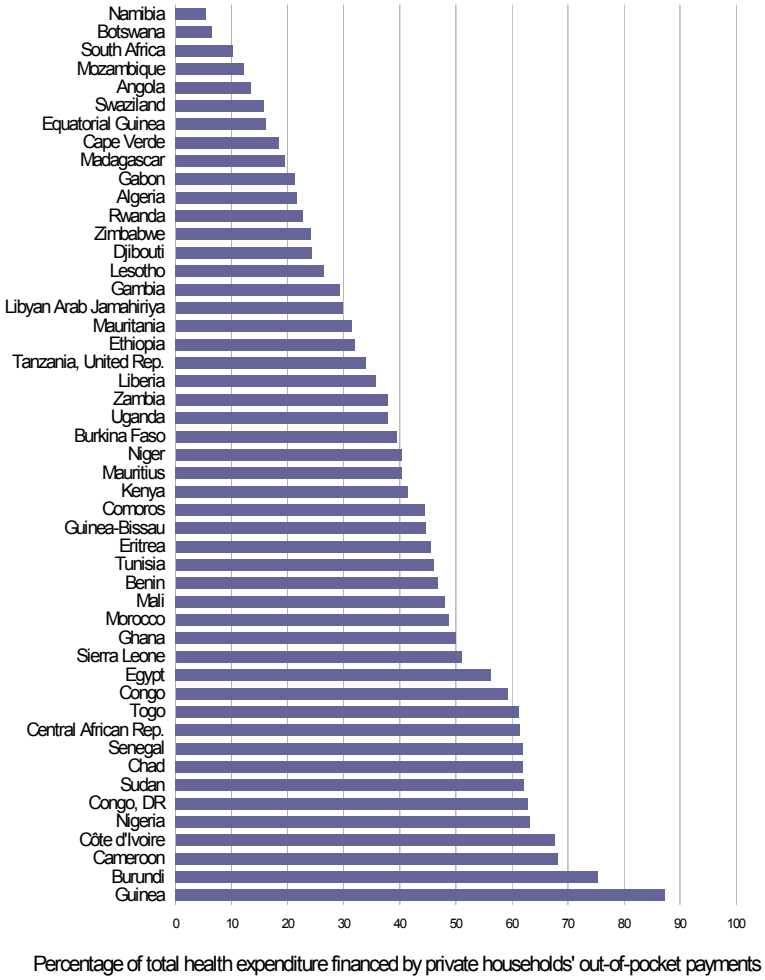
Figure 3.5. Social health protection coverage, selected African countries, 2008



Source: ILO, 2008g.

A key issue regarding equitable access relates to out-of-pocket payments (OOP). Such payments are made directly by individuals to obtain health services or supplies, and fall outside any framework of risk- and burden-sharing, hence of fairness or equity. In Africa a major part of all health expenditure is spent on an out-of-pocket basis, and the result in terms of impaired access to health services and worsened poverty is very significant. Figure 3.6 shows the extent of and differences in OOP among African countries.

Figure 3.6. Health expenditure financed by private households' out-of-pocket payments, 2008 (percentages)



Source: ILO, 2008g.

Payments for necessary medical care through OOP are regressive. Further, the poor are generally more prone to illnesses and need to access health services more frequently than wealthier groups of the population. In African countries, the negative impact of OOP on poverty and access to health services can be mitigated by social health protection, particularly if community-based schemes exist (table 3.1).

Table 3.1. Household financial mechanisms to cope with health-care expenses, South Africa, Kenya and Senegal, 2005 (percentage)

	South Africa		Kenya		Senegal	
	Uninsured	Insured	Uninsured	Insured	Uninsured	Insured
Sales of assets	5.9	10.6	1.0	0.2	15.4	4.4
Borrowing from friends or family	10.5	7.0	4.1	4.3	27.9	12.3
Borrowing from outside	11.5	3.0	–	–	3.2	6.1

Source: Scheil-Adlung et al.; 2006.

In Senegal, for example, about 15 per cent of the uninsured had to sell assets to pay for health care, while nearly 30 per cent had to borrow money from friends. Among those

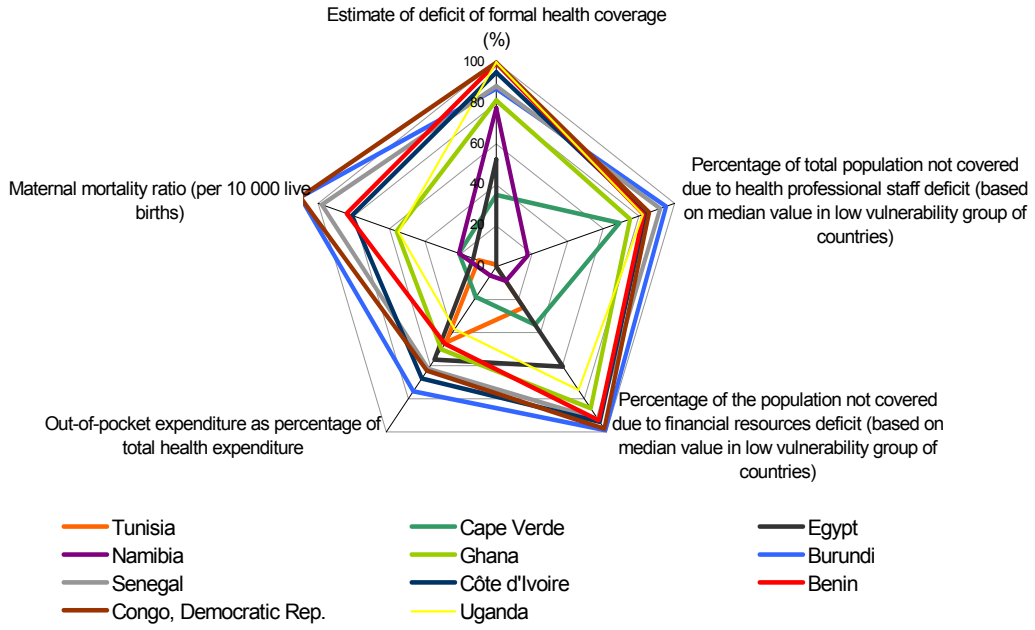
covered by social health insurance the rates were about 4 and 12 per cent, respectively – significantly lower.

Inequality in effective access to health services in Africa can be more easily visualized when comparing a set of indicators that consists of:

- gaps in legal or formal coverage;
- gaps in the professional and general staffing of health services;
- deficits in financial resources;
- out-of-pocket payments which impoverish those suffering ill-health;
- health status outcomes related to maternal mortality;

Figure 3.7 gives an overview of the situation in Benin, Burundi, Cape Verde, Côte d'Ivoire, Democratic Republic of the Congo, Egypt, Ghana, Namibia, Senegal, Tunisia and Uganda. These countries are representative of countries in Africa with comparable vulnerability in terms of poverty levels and the size of the informal economy.

Figure 3.7. Overview of social health protection performance, selected African countries, 2009



Source: ILO calculations, 2009: data from ILO, 2008g and WHO, 2009.

The graph reveals that health financing, health status and poverty are closely interlinked. In the African region, this cycle of impoverishment is characterized by vast deficits in all key indicators of effective access to health services:

- Countries such as Burundi show extreme maternal mortality ratios combined with a vast gap of more than 80 per cent in per capita health financing and the health workforce, resulting in more than 80 per cent OOP financing. Globally, Africa has the highest number of countries that use direct OOP as the main health financing mechanism (ILO, 2008g).

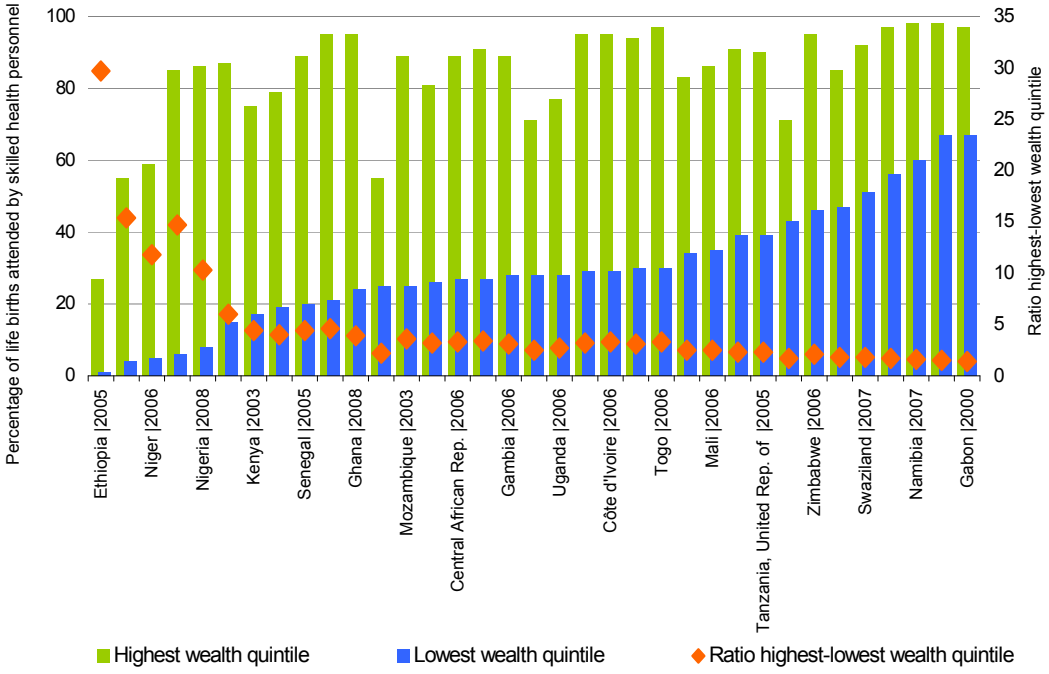
- Legal coverage of social health protection – that is, not indicating effective access to health care – varies significantly, between less than 1 and 25 per cent.

3.2.2. Inequalities in social health protection coverage within African countries

Within African countries there is significant inequality between various population groups in coverage and access to health services. This inequality is strongly gender-related: existing social health protection coverage often favours male employees in the formal sector or civil service who live in urban areas where health facilities are more frequent and better equipped than in rural areas (UN–DESA, 2009).

Systems – even if designed for the informal economy – hardly cover the catastrophic health expenditures that can appear frequently, for instance when complications in giving birth occur. Figure 3.8 reveals that within African countries the percentage of births attended by skilled health personnel is highly related to the wealth quintile e.g. in Senegal it is 20 per cent for the lowest quintile and 90 percent for the highest; in Chad it is 5 per cent for the lowest quintile and 55 per cent for the highest. In sub-Saharan Africa women in the wealthiest fifth of the population are six times more likely to deliver with health professionals than those in the poorest fifth (UN–DESA, 2006).

Figure 3.8. Births attended by skilled health personnel, various years between 2000 and 2008 (percentages, by wealth quintile)



Source: WHO Global Health Observatory, in WHO, 2009.

The impacts on girls' and women's health are reflected in maternal mortality rates, particularly for women living in rural areas characterized by high informality of the labour market. In sub-Saharan Africa, urban women are three times more likely to deliver with professional health staff than women in rural areas (ibid.).

Besides the health risks associated with pregnancy and childbirth, women also face increased health burdens owing to the impacts of globalization on working conditions, migration and climate change, which force many of the poorest to work in conditions of

increased insecurity, often abroad. Female workers are often laid off first, because many are unskilled and performing relatively simple tasks that can easily be automated.

Furthermore, in some specific cultural, social and political environments women are not given the voice to express grievances about lay-offs or economic conditions. In addition, women's relative lack of access to health care and subsequent low health status perpetuates the barriers to work and income generation.

The situation is aggravated by gender inequalities based on norms and policies that perpetuate discrimination against women and girls and often result in sexual and gender-based violence, low age of marriage and differential access to health-related resources. Gender-specific poverty reduction measures, improving female literacy and strengthening the rights of women in the economic sector are therefore among the key challenges to be addressed when striving to improve women's health.

The African region is globally the worst affected by the HIV/AIDS pandemic; according to the World Health Organization (WHO), about 80 per cent of those living with HIV/AIDS and TB are in sub-Saharan Africa. [2] The majority of children living with HIV/AIDS – most of whom were infected by their mothers during pregnancy, childbirth or breast feeding – also reside in the African continent. This situation has led to reductions in productivity, with consequent economic losses to families and communities due to decreased wages and earning capacity, as well as decreased hours of work due to time spent caring for a sick family member and time spent travelling to seek health care. The high cost of antiretroviral drugs further complicates the matter.

A wide range of financial and physical barriers causes unequal access to health care at the country level. Key reasons include:

- high levels of OOP expenditure for medical care and drugs;
- widespread incidence of costs incurred as a result of unavoidable health events and interventions (for example, Caesarean sections), and which would be regarded as catastrophic if, as is not uncommon, such expenses exceed 40 per cent of net household income;
- fragmentation of health systems leading to gaps in social health protection;
- restricted benefit packages that fail to address the actual needs;
- uneven urban and rural distribution of health-care facilities;
- gaps in the health workforce, often due to working conditions that fail the test of decency and result in low-quality services;
- issues reflecting gender, cultural and ethnic factors affecting access to health services; and
- the financial impact of the HIV/AIDS pandemic.

[2] www.who.int/features/factfiles/hiv/facts/en/index8.html.

3.3. How can social health protection in African countries be extended to achieve universal coverage?

3.3.1. Developing sustainable health financing mechanisms

The financing of social health protection has significant impact on the quality, cost, and availability of health services. The amounts of funding needed and the effective allocation of funds depend on the design of health protection schemes and systems.

It is characteristic of social health protection finance on the African continent that multiple financing methods exist. The dominant health protection schemes also appear to have regional patterns:

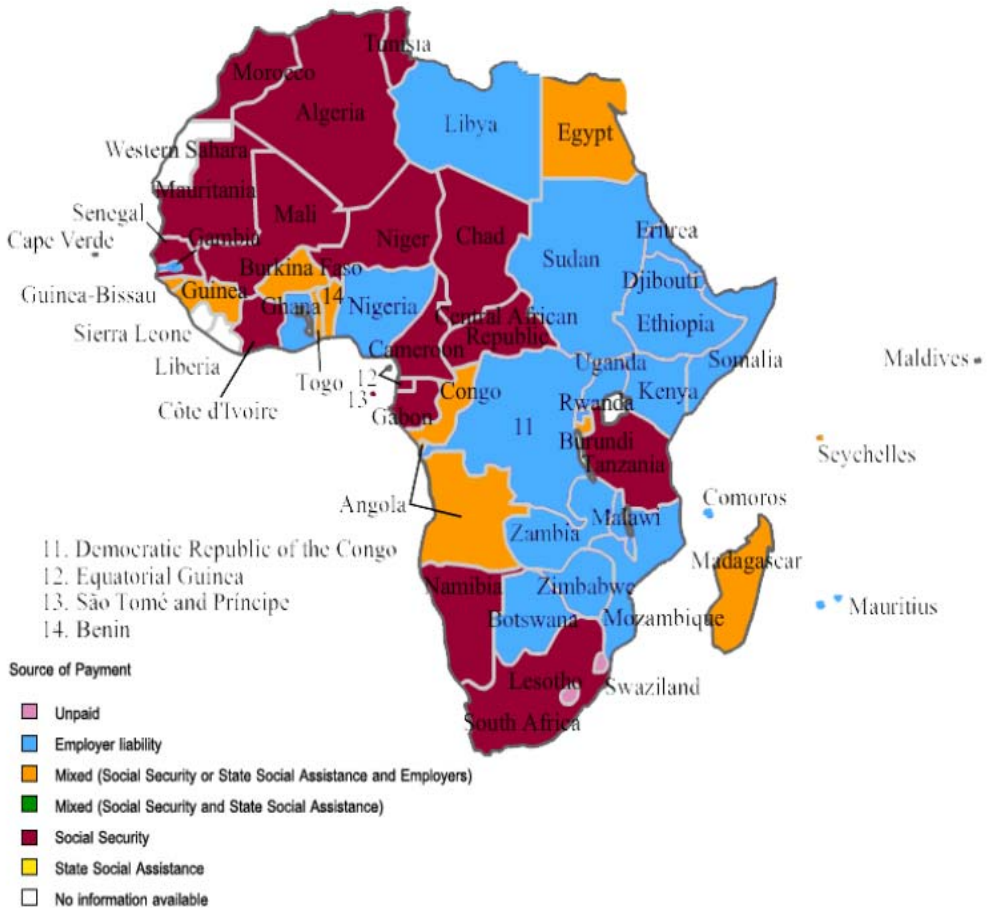
- North African countries such as Algeria, Egypt, Morocco and Tunisia predominantly finance social health protection through taxes, although they have a long history of social health insurance.

- In sub-Saharan Africa the systems were until recently mainly tax funded, but some years ago Burkina Faso, Ghana and Nigeria established social health insurance schemes while Sierra Leone and Uganda are at advanced stages of planning for similar social health insurance schemes in addition to funding from general government revenue.

- Mutual health organizations play a role in providing social health protection in Benin, Burkina Faso, Ghana and Senegal. Community-based health insurance (for example in Ghana and Senegal) and employment-based health schemes (for example in Nigeria) also play important roles in protecting the health of a large proportion of the population in many African countries.

The pluralistic approach to financing is also reflected in the use of sources for maternity cash benefits in Africa; these vary from employer liabilities, social security schemes or social assistance schemes to mixed systems (figure 3.9).

Figure 3.9. Sources of funding for maternity cash benefits in 50 African countries, 2008



Source: ILO, 2008h.

The mechanisms available by which financial resources for social health protection systems may be generated fall into a rather small number of categories, namely:

- tax-funded national and public health services;
- subsidized national, social and community-based health insurances co-financed by contributions and premiums (typically paid by workers, employers or the insured); and
- other forms of private health insurance and cash benefits.

Allocations to the various contributory pools are provided from the general revenue as subsidies for poor and vulnerable groups.

Considering the diverse health-care needs among the different population groups (such as the elderly, women, rural or urban residents, ethnic minorities) and the often significant challenges in reaching these groups, a pluralistic set of closely linked health protection schemes constitutes a pragmatic, efficient and effective approach. It requires, however, an integrated, coherent framework and the coordination of schemes with a view to achieving universal access to health services.

Decisions on key aspects of social health protection should be based on the broadest possible processes of dialogue that include social partners and representatives of patients, health-care workers, health-care providers and the Government.

The policy framework and design of successful social health protection systems need to take into account concerns at three strategic levels:

- At the level of the individual, the varying needs and priorities regarding disease burden, poverty/vulnerability, age, gender, ethnic group, employment status and residence must be considered and adequately addressed.

- At the system or scheme level, the provision of benefits must be enabled and ensured by adequate, efficient and effective management and financing processes, together with resources such as medical equipment and staff.

- At the global level, social health protection systems should align with global public health priorities such as the MDGs and cross-border control of communicable diseases.

3.3.2. Achieving universal coverage and effective access

Despite drawbacks due to the global food and financial crises, progress has been achieved in Africa over the last years:

- Levels of maternal and child mortality, measured in 2009 as progress towards achieving the MDGs, had decreased as compared to 1990.

- Reforms and related plans to extend social health protection have been undertaken or are currently being discussed in numerous countries including Egypt, Rwanda, Sierra Leone, South Africa and Uganda.

- Stimulus packages have cushioned the most severe health impacts of the crises. In South Africa, for example, such packages have focused on the fight against HIV/AIDS. A further R932 million will be set aside to fight HIV/AIDS and increase the number of people on antiretroviral treatment from 630,000 to 1.4 million by 2012. Further, welfare grants will increase by about 5 per cent and the cut-off age for the R240 child support grant (CSG) will increase to 15, affecting approximately 500,000 children. Additional important measures include a focus on school feeding programmes, additional taxes on cigarettes and alcohol, and public works to stimulate employment (Khatiwada, 2009).

But progress remains limited, particularly in sub-Saharan Africa. In order to achieve universal social health protection coverage it is important to ensure effective access to an essential benefit package of adequate quality for all residents of a country. This must be planned in several important dimensions:

- legally mandated rights and entitlements to health care;

- physical availability of health-care infrastructure, equipment, drugs and qualified health-care workers;

- affordability of health care and financial protection, i.e. the removal of financial barriers to access for health care without leading to impoverishment as a result of catastrophic health-care costs (those which, in a rather arbitrary definition, exceed 40 per cent of household income), and the minimizing of out-of-pocket payments;

- fairness in setting contributions in insurance-based social health protection systems according to ability to pay;

- timely and correct information provided to beneficiaries about health-care rights and entitlements; and

- adequacy in the quality of care provided.

In view of African experiences and ILO observations, it is vital to develop national coverage strategies that encompass not just one but *all existing financing mechanisms in a country* – including compulsory and voluntary schemes, for-profit and not-for-profit schemes, and public and private schemes that contribute, in the given national context, towards progress in achieving universal coverage and equal access to at least essential services.

However, it is important that the coverage plan or reform be based on the *rational* use of all financing mechanisms in order to avoid fragmentation and allow for solidarity in financing and burden sharing. This requires coordination of financing mechanisms and improvements of schemes with a view to efficient and effective filling of gaps and access deficits. Rationalization and coordination of health financing mechanisms within countries particularly implies:

- the optimizing of existing schemes as regards their efficiency and effectiveness in achieving universal access to at least essential health care and financial protection in case of sickness; and

- the creation of linkages between schemes to achieve synergies and increase the volume of resources and the size of the risk pool available for universal health care with a view to burden sharing and solidarity in financing.

Effective policy-making will also require that health-financing mechanisms are embedded into the broader social protection floor (SPF-I) that addresses income and health-related poverty through social policies including in-kind and in-cash transfers all in need – women and men, children, the elderly, the unemployed and people with disabilities, to address social determinants of ill health (UN CEB, 2009, p. 20).

An essential benefit package should reflect the stipulations of the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), and the Medical Care and Sickness Benefits Convention, 1969 (No. 130), regarding the minimum medical care to be provided. It should consist of a range of health services and financial protection measures that are made available to the population. The range of services provided should be defined with a view to maintaining, restoring or improving health, guaranteeing the ability to work and meeting personal health-care needs.

The benefit package needs to be defined at country level with a view to ensuring equitable, affordable and timely access to quality health services based on the specific health-care needs and disease burden of the covered population. It should be conducive to achieving overall development and poverty reduction, as spelt out in the MDGs and the human right to health and social security.

3.4. Challenges to implementing social health protection in Africa

A number of obstacles and challenges have been observed or envisaged in the establishment of social health protection schemes in Africa. These include efficiency and effectiveness, administrative challenges, inadequate capacity, lack of institutions, and lack of data.

The necessary administrative infrastructure for the implementation of social health protection schemes is lacking in most countries in Africa. Most important among these are human resources with the requisite skills. The available workforce lacks the skill and experience necessary for the efficient administration of cash transfers and to effectively manage the social health protection system. Further, the widening rural–urban differences negatively impact the establishment of the social health protection schemes in African countries, and key tools such as accurate census and population data are lacking.

The absence of data makes the development of policy strategies on extending coverage and access to social health protection difficult. National statistics, when compiled, tend to be partial and specific and do not allow comparative assessments of effective coverage and access.

It has been widely observed that social health protection schemes in Africa often unevenly favour the formal sector. Most government offices and large private firms and enterprises are located in urban centres where there are more and better equipped health facilities which make accessing health services easier for this group of people.

The problem that arises from this is the fact that the size of the formal sector is significantly smaller than that of the informal sector, which includes the urban self-employed, the urban unemployed, the elderly and the rural dwellers. Thus, there is a geographical and financial barrier to access to health services for a relatively larger proportion of the population.

Health protection for the poorest among and within African countries needs therefore to be prioritized. Loss of employment and income, and declining public budgets for health and social health protection, can lead to lower accessibility to health care for many people. Against this background, and considering other social protection challenges associated with the financial and economic crisis, the UN has established the social protection floor initiative (SPF-I), which aims at providing essential services and transfers to all those in need of social protection in order to not remain in or fall into poverty (UN CEB, 2009, p. 20). The ILO and WHO are the lead organizations for this initiative. Achieving universal access to health care through social health protection is a key element of the social protection floor; it is the focus of the ILO's longstanding cooperation with WHO on social health protection, which includes the foundation of the joint ILO–WHO–GTZ Consortium on Social Health Protection and its successor institution, the Providing for Health Initiative.

The design and implementation of social health protection policies which take the issues described above into account would improve health outcomes on the African continent and would also lead to reduced poverty, improved labour productivity and economic gains for Africa.

3.5. Conclusions

While further data are urgently required, it can be concluded that:

- Gaps in social health protection are jeopardizing economic and social security in many African countries. Shortfalls often reflect health system financial planning that is divorced from the objective of achieving universal coverage and so lacks both the effectiveness and the efficiency needed to address key challenges.

- Equity in access is a critically important issue that needs to be addressed both at the regional and country level. Significant levels of inequality are observed both between

rural and urban areas, and the formal and informal economies, while the shortfall in access for women is of particular concern.

- Different funding mechanisms can be used, ranging from social security and social assistance to employers' liability, to maximize the affordability of social health protection at both at the national and household levels.

- The factors leading to success in the scaling up of efforts to extend social health protection are likely to include:

  – coherent legislation and institutional response;

  – shared international frameworks such as the MDGs and the social protection floor;

  – improving financing and funding through developing fiscal space;

  – including provisions for essential health benefit packages in social security schemes; and

  – enforcing legislation and monitoring progress.

As a critical element of the social protection floor, universal publicly provided primary and essential health-care services should be the responsibility of Government. In this role as the primary provider of health services, governments should focus on prevention and health promotion (WHO, 1978).

4. Income security schemes

This chapter considers the issues relevant to the provision of income benefits – those designed to address the contingencies of old age, death of a family breadwinner, disability, employment injury, unemployment, maternity and sickness. Any of these contingencies can lead to loss of capacity to work and thus receive a wage or salary, jeopardizing individuals' and families' ability to sustain themselves. In planning income security schemes in Africa, even more than for other regions, a clear distinction should be made between the formal and informal components of the economy.

4.1. Income security in Africa: An overview

Historically, the needs of individuals or families suffering the contingencies listed above would be met as far as possible by families and kinship networks. Such informal social protection measures take various forms and are still common today in villages and rural areas in Africa, highlighting the essential underlying need for a certain degree of solidarity and mutual help. In West and Central Africa, in particular, such informal systems play a significant role in strengthening the capacity of households. Household and expenditure surveys conducted in countries such as Mali, for example, demonstrate the importance for survival of private transfers between households (*Ministère du Développement Social*–UNICEF, 2008).

Nevertheless, the demands of modern conditions, particularly the trend of movement from rural towards urban areas, and the weakening of capacity for family support of the traditional kind, means that more formal systems of social protection have become increasingly important. Everywhere in Africa there is now an ongoing debate on scaling up government-financed non-contributory programmes, and a range of new policies are being implemented or piloted. A natural approach is to seek to extend the coverage of existing schemes, which, however, provide mainly for workers in the formal economy. It is important, therefore, to find complementary approaches which address more effectively the needs of the vastly greater number of workers in the informal economy.

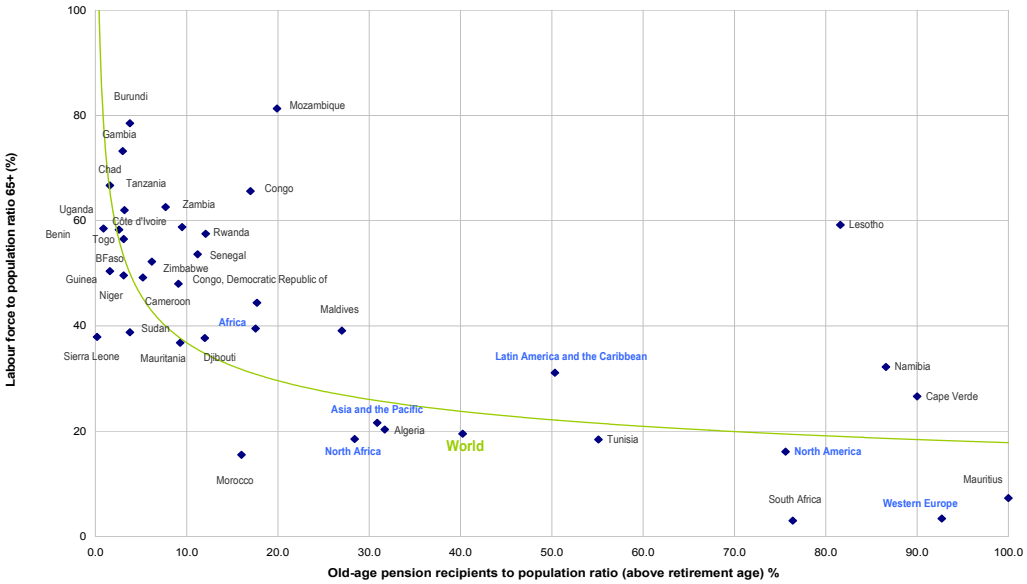
4.1.1. Deficiencies in coverage

The sectors in which contributory schemes contribute to effective provision vary from country to country. However, it is very rare that coverage extends to those working in agriculture, despite the fact that they constitute the majority of those employed in many African countries. Other vulnerable categories of workers for whom coverage is very patchy include, for instance, domestic workers (if salaried, this group may benefit from coverage in South Africa and Guinea), tenant farmers and sharecroppers (who have scheme access in Cape Verde), and convicts (who are employed, and thus covered, in prison workshops in Côte d'Ivoire and Madagascar). Self-employed workers are generally excluded in most countries in Africa. Where they are included, their participation is usually voluntary and conditional on making contributions at relatively high rates.

4.1.2. Old age and retirement

The generally poor level of coverage under social security schemes for income protection is vividly reflected in the phenomenon of the working elderly in Africa, with 80 per cent of older women and men who do not have regular income continuing to work, usually in the informal economy, until they become incapacitated (HelpAge International, 2008). There is a strong correlation between coverage by old-age pensions and the labour market participation rate of the elderly: in countries where pension coverage is limited to a minority the elderly have to work for survival (see figure 4.1).

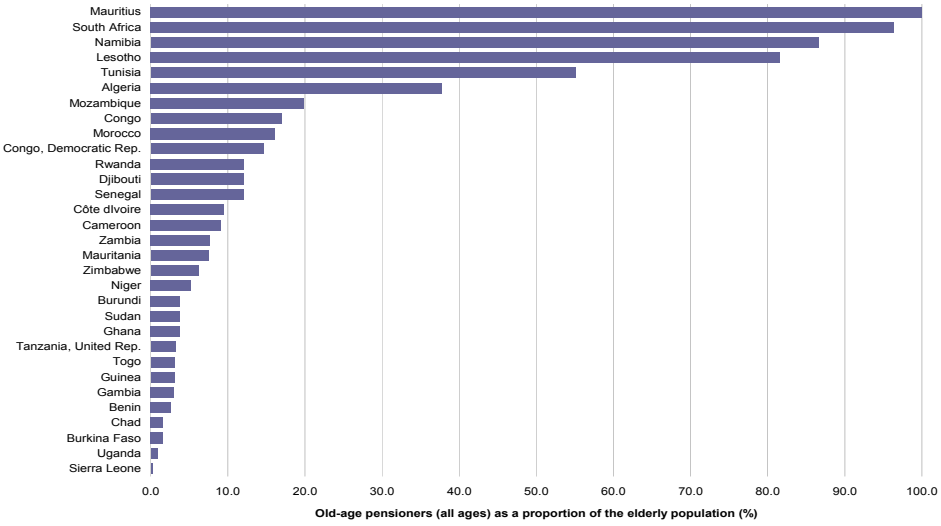
Figure 4.1. Persons above retirement age receiving pensions, and labour force participation of the population aged 65 and over, latest available year (percentages)



Sources: ILO Social Security Department, compilation of national available data collected in national pension social security schemes; ILO, LABORSTA (ILO, 2009h) for economically active population aged 65 and over.

Elderly women (60 years and older), despite their vulnerability due to age and poverty, are often the primary carers of children in families affected by HIV/AIDS. They carry the burden of childcare when working-age adult members of their families migrate in search of employment. Not only do these elderly people lack regular income, they are also likely to lack access to social services for themselves or those they care for (Wiman, Voipio and Ylonen, 2006). Poverty and vulnerability of people in old age can, however, be addressed through non-contributory government-funded income support measures. In countries such as Lesotho, Mauritius, Namibia and South Africa, where universal pensions have been introduced as part of government tax-funded social assistance schemes a greater percentage of the elderly population are covered. The variation amongst countries is illustrated in figure 4.2.

Figure 4.2. Old-age pensioners (all ages) as a proportion of the elderly population, 2008 (percentages)



Note: Population aged 60 and over, in some cases 65 and over, depending on the national legal retirement age.

Sources: ILO Social Security Department, compilation of national available data collected in national pension social security schemes; UN, 2009, medium variant. See also ILO, GESS (ILO, 2009f).

The average low life expectancy in Africa affects perceptions of fairness in specifying statutory retirement ages for old-age benefits, particularly in formal schemes of the social insurance type. At the age of 20, when many people would start contributing to the pension scheme, average life expectancy in Africa is 45 years, ranging from 53 years in North Africa to 37 years in Southern Africa and particularly low in countries affected by HIV/AIDS. When a statutory retirement age is set at age 55 or 60, as is typically the case in sub-Saharan Africa (see table SA6(b)), contributors tend to perceive this as unfair, since they may not survive to receive benefits for any substantial period of time. This is particularly noticeable in respect of males, who generally have lower life expectancies than females. Although the statistics cannot be properly interpreted on such a simplistic basis, and from a technical perspective such retirement ages are usually fully justified and may indeed need to be further raised if funding is to be sustained, entitlements to disability and survivors' pensions need to be strengthened for the sake of acceptability to members, while those branches of social security systems which will meet the more urgent needs of the younger population and their children, perhaps including family benefits which support families in child education, need to be developed.

4.1.3. Migrant workers

As noted in Chapter 2, families in Africa rely heavily on remittances from members living and working abroad – close to US$22 billion in 2005. Inter-household and private transfers of income through remittances represent an important means by which members of families provide a network of informal support. In West and Central Africa remittances were estimated in 2006 at US$10.4 billion and US$2.7 billion respectively; in Mali, for example, 18 per cent of the revenue of poor households comes from private inter-household transfers (*Ministère du Développement Social*–UNICEF, 2008). Notwithstanding their importance in the overall economic and social environment, however, little attention has been paid until very recently to the need to integrate social protection measures between countries for the increasingly high numbers of workers migrating across borders in the region. Many countries fail completely to address the right of foreign or migrant workers to take up membership of contributory social insurance schemes.

A small number of countries make provision for the future payment of pension benefits to their own insured nationals residing in other countries. One example is the subregional grouping of countries that includes Botswana, Namibia and South Africa, within which migration of workers has always been at relatively high levels. Migrant workers in this group of countries can participate in social insurance schemes in the host country; however, this right is subject to limitations. For example, in South Africa non-citizens are expected to return to their countries of origin at the end of their contracts, and they are not allowed to become members of unemployment insurance schemes (Van Kerken and Olivier, 2003). A further restriction is imposed by the principle of territoriality which requires that benefits be paid in the host country (Vonk, 2002). The present lack of "portability" of benefits is a major obstacle to the maintenance of social security rights.

4.1.4. Unemployment

Provision of unemployment benefit for former salaried workers is almost entirely lacking on the African continent, with the very limited exception of some forms of severance payments mandated under the employment acts of some countries, and is a severe deficiency affecting both migrant and non-migrant workers. While Côte d'Ivoire was reported in 2003 to have initiated a programme providing benefits to workers who lost their employment for economic reasons only (D'Haeseleer and Berghman, 2003), it has not been possible to confirm its continued existence.

4.2. The formal economy

4.2.1. Overview

Contributory social insurance schemes provide benefits that are based on statutory (or legal) entitlements, but are usually open only to those workers who are in full-time paid employment. In general, governments tend to contribute, if at all, to contributory schemes only as an employer of public servants. In some countries they may also contribute to funding for the provision of family allowances or for sickness and maternity benefits. One such example is observed in Chad, although it is unclear whether this subsidy is available only to salaried workers and their dependants or to the wider population.

Many social security arrangements which operate on a contributory basis for workers in the formal economy are organized as risk-pooling *social insurance* schemes. Sometimes, however, the financial mechanism used is that of *employers' liability*; this is the case for sickness and maternity benefits in many countries, and in some cases for leaving-service *severance payments*, although in other cases severance payments are better seen as simply representing deferred wages or salaries (see table SA7).

The design of contributory social insurance schemes varies widely from country to country. Variations in the parameters include the rates of contribution which may be paid by employers and workers to finance the different schemes; the duration of benefit payments in maternity and sickness benefit schemes; pensionable ages, which may not be equal for males and females within each country; and the definition of conditions under which survivors' benefits may be paid.

Table SA4(c) shows the proportion of those in waged employment in sub-Saharan Africa and in North Africa. The ILO estimates that approximately 20 per cent of all those employed are in waged or salaried employment in sub-Saharan Africa and about 60 per cent in North Africa (ILO, 2010a, section 2.1). Formal-sector waged workers in most African countries, whether in government service or employed by private-sector business, are able to contribute to social insurance, but they constitute the minority of the economically active population in the region. The data available indicate that, for instance, in Côte d'Ivoire in 1989 the coverage rate was less than 9 per cent (D'Haeseleer and Berghman, 2003), in Guinea in 2002 it was 2 per cent, while in Mozambique in 2009 only the 6 per cent of workers employed in the formal economy were likely to be covered. In the United Republic of Tanzania and in Zambia, effective coverage by contributory schemes is also less than 10 per cent (ILO, 2008e, 2008f). Far from improving, these figures are likely to have worsened with the onset of the global financial crisis. An analysis of the most recent available data indicates that overall percentages of Africa's working age population covered by contributory pension schemes are very low, ranging from 5 per cent in sub-Saharan Africa to 20 per cent in North Africa.

4.2.2. Contingencies

There is wide variation within the contributory social insurance schemes in Africa with respect to the scope of contingencies covered. The ILO Social Security (Minimum Standards) Convention, 1952 (No. 102), lists nine contingencies which together define the scope of a comprehensive national system of social security coverage.

The first contingency listed in Convention No. 102 is the need for medical care, which has been discussed in Chapter 2. The remainder concern benefits provided by way of *income protection*. These may be grouped in various ways; the following reflects the functional or departmental approach of social security administrations in many countries:

I. Old age, disability and survivors' benefits: old-age pensions and/or allowances, disability pensions and survivors' pensions – so-called *long-term benefits*.

II. Sickness and maternity benefits, the latter comprising cash benefits together with the relevant aspects of medical care benefits – so-called *short-term benefits*.

III. Work injury benefits: medical and cash benefits for temporary disability; permanent disability pensions for insured persons; pensions on the death of an insured worker for his or her survivors, including widows, widowers, and possibly orphans, parents and grandparents. In many countries this category of benefits is provided on a statutory basis through employer's liability and is therefore administered separately.

IV. Family benefits.

V. Unemployment benefits.

The contingencies most often covered in Africa are old age (pension benefits) and employment injury, [1] while many old-age pension schemes also provide pensions in case of disability and death of the breadwinner (survivors' pensions). On the other hand, the least often covered contingency is unemployment, schemes exist in only a few African countries (see table SA7). Family benefits are rarely provided. Sickness and maternity benefits are often not covered by social insurance schemes but are provided directly by employers on the basis of employers' liability, as required by provisions in the labour code or similar employment acts.

Coverage in the region generally for each of the contingencies specified in Convention No. 102 is extremely low, reflecting the low membership rates in the contributory systems. Table SA7 shows that theoretical statutory coverage (i.e. assuming full compliance with existing laws) for contributory old-age pensions amounts to less than 35 per cent of the working-age population in North Africa and 14 per cent in sub-Saharan Africa. Coverage rates for employment injury reach only 26 per cent for the working-age population in North Africa and 17 per cent in sub-Saharan Africa. In the case of unemployment benefit, the working population statutory coverage rate under contributory schemes is assessed to fall below 10 per cent for North Africa and may be as low as 1 per cent for sub-Saharan Africa. Effective – actual – coverage rates of contributory schemes are significantly lower than the statutory ones, often falling to well below 10 per cent overall.

4.2.3. Compliance with contribution obligations

Poor compliance by employers with their legal obligations to enrol employees in social security schemes and to pay the relevant contributions contributes to the low effective rates of coverage by contributory schemes. This is the case even in countries where workers' organizations and trade union representation are relatively strong. In South Africa, for example, many workers need to seek the assistance of advice offices and lawyers to ensure compliance. As a researcher at one of the Black Sash Advice Offices in South Africa states: "The lack of compliance by the private sector in honouring social insurance commitments remains a major challenge. This is a huge constraint – evidence for this is that 48 per cent of all the queries in our Pietermaritzburg regional office and 38 per

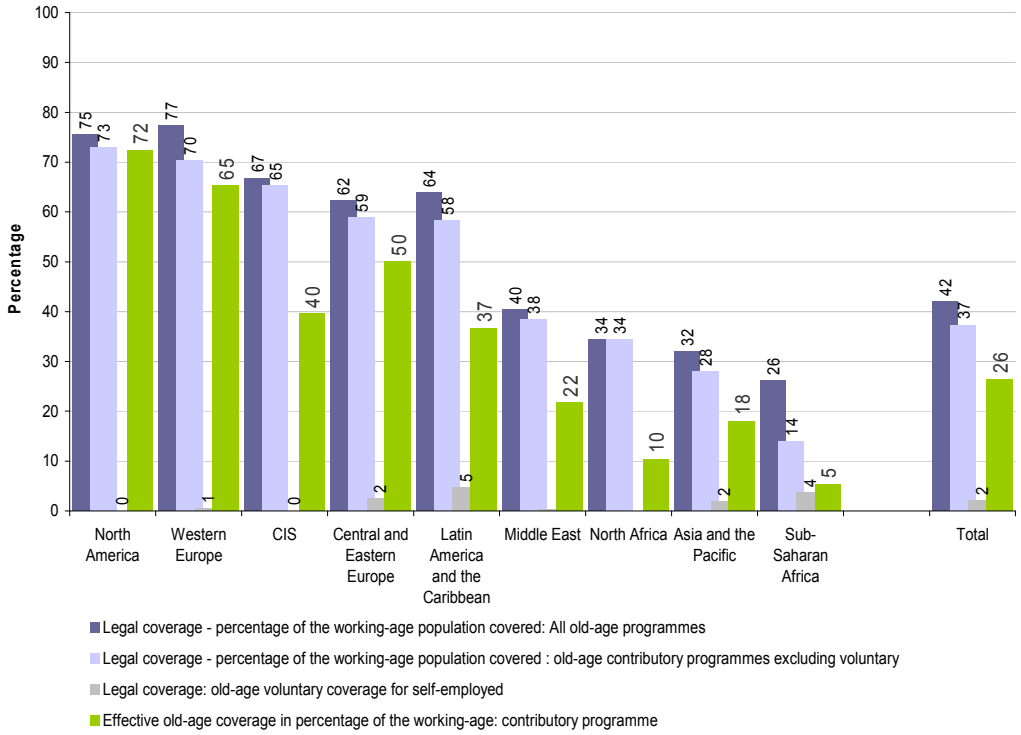
[1] However, in many countries coverage for employment injury is much narrower than that required by ILO Convention No. 102, being limited only to lump-sum compensation in case of employment-related accidents. In addition, the percentage of actual accidents and incidence of employment related diseases actually reported and compensated is also rather low.

cent of all queries in Grahamstown regional office are private pension fund queries and death benefit queries [to] beneficiaries or their dependants" (Taylor, 2008, pp. 60–61).

In many countries concerns arise even over government compliance with their obligations regarding employer contributions to social insurance funds, given that governments are often the major employers. In both the public and private sectors of the formal economy, non-compliance with employers' liability, arbitrary withdrawal of funds and changes to financing arrangements create economic insecurity for the workers concerned. In sectors such as agriculture, mining and hospitality or domestic work where workers lack effective representation, it is extremely difficult to monitor compliance even when the basic conditions of work supposedly include some form of employer/employee-based contribution. This situation reinforces the need for the social protection floor to provide minimum income guarantees, possibly in addition to other social transfers.

The difference between statutory (legal) coverage and effective coverage for old-age benefits in the different regions of the world is illustrated in figure 4.3.

Figure 4.3. Old-age pensions: Legal coverage and effective active contributors in the working-age population by region, 2008–09 (percentages)



Link: www.socialsecurityextension.org/gimi/gess/RessFileDownload.do?ressourceId=15143

Sources: ILO Social Security Department based on SSA/ISSA, 2008, 2009; ILO, LABORSTA (ILO, 2009h); national legislative texts; national statistical data for estimates of legal coverage; and compilation of national social security schemes data for effective coverage. See also ILO, GESS (ILO, 2009f).

4.2.4. Challenges in social insurance

Given the extent of poverty in the countries reviewed and that contributory social insurance schemes provide at best only a limited measure of social security to a minority, several major challenges and issues face the existing social insurance systems. These include the limited or complete lack of coverage for those employed in agriculture or in domestic work; the situation of the working elderly; non-compliance; inappropriate

statutory retirement ages; early withdrawal of funds; the situation of migrant workers; inadequate benefit levels, and discrimination against women.

The latter is of particular importance. With very few exceptions, women's labour in the home – caring for children, the elderly, or people with disabilities – is not recognized as "labour" by employment-related social insurance or assistance programmes; it is also likely to be the case that dependants are not covered. Where women are active in the labour market, wage rates and earnings are typically lower than for men, conditions of employment more precarious, and occupational choices more limited. This leads to discrimination against women through lack of access to pensions and other employment-related entitlements. Moreover, in the event of a family break-up or the death of a husband, the woman affected is denied entitlement to present or future unemployment or pension benefits.

4.3. The informal economy

4.3.1. Overview

For workers in the informal economy in Africa there is no comprehensive social security coverage. Reliable unemployment rates and informal employment figures are unavailable for most countries; even when these are available there is no indication of the definition of employment, unemployment, self-employment and informal employment. This presents a problem in the interpretation of data, as official definitions often mask the extent of unemployment. Capturing any data at all in the informal economy is difficult: although published statistics show, for example, an unemployment rate of 8.8 per cent in Mali and 4.5 per cent in Madagascar, or the percentage of non-agricultural employment in the informal sector lying in the range 71–74 per cent in Chad, Guinea, Mali and Mozambique, these figures give little real insight into earnings and the capacity to contribute to either formal social insurance or informal social security schemes.

Good progress is nevertheless being made in the region in the provision of social transfers, through either cash support or in-kind benefits such as food, schooling and health care. Non-contributory benefits may be provided to the indigent or those without any other means of survival, as well as to the most vulnerable such as orphans, women, children living in poverty, people with disabilities and the elderly. Such benefits are funded by the State, or in some cases through temporary donor support or the support of international non-governmental agencies. The trend of expert opinion suggests that cash transfers in Africa represent potentially the most efficient way of reaching the most vulnerable and the poorest, especially if such transfers are provided on a universal, systematic and regular basis. Although information on transfers is uneven, the available evidence supports this view that the poverty-reducing impacts of cash transfers for both individuals and in many cases entire households are significant.

4.3.2. Social transfers: The African experience

A brief survey of experiences across Africa is presented here; more detailed country case studies can be found in Appendix I.

In *South Africa* total coverage has increased through a number of social transfers and now reaches approximately 13 million individuals (or about 25 per cent of the population). The *Namibian* Government has increased its coverage and through nine cash transfer programmes now reaches a range of specific categories of people identified as vulnerable. *Botswana* introduced a social pension in 1997 for the elderly, and *Lesotho* also introduced a universal social pension for the elderly in 2004.

Eritrea began its cash transfer programme for former soldiers and widows in 1993. *Rwanda* provides a small cash transfer programme for demobilized soldiers, implemented by Government and financed jointly by Government and donors through a UNDP-administered fund. The Governments of *Mozambique, Swaziland, Zambia* and *Zimbabwe* have implemented national social assistance programmes targeted to the indigent and/or elderly.

Botswana, Ethiopia, Lesotho, Malawi, Namibia, South Africa, the United Republic of Tanzania and a number of other countries have implemented (or at least piloted) cash transfers for the most vulnerable, notably in the form of child and fostering grants targeted to orphans and other vulnerable children. Some of these transfers include in-kind assistance such as clothing and school supplies. *Botswana, Lesotho, Namibia* and *South Africa* provide disability grants. Some countries in Africa have worked with international agencies to address the social impact of disasters. UNICEF supported *Ethiopia* with cash transfers during the 1983–85 famines and delivered cash transfers to almost 95,000 people in 18,900 households. Recently, UNICEF has provided financial and technical assistance for pilot cash transfer programmes in *Kenya, Malawi* and *Zambia*.

Government social transfers in the form of social old-age pensions introduced, for example, in countries such as *South Africa* have increased the income of the poorest 5 per cent of the population by 50 per cent. Together with other cash transfers to special categories, the overall impact on poverty of the South African social security system has been to reduce the "destitution gap" by 47 per cent. The positive impact of cash transfers implemented as pilot projects and supported by donors in countries such as *Namibia* and *Zambia* reinforces the assessment of the effectiveness and efficiency of such interventions.

In *Lesotho*, findings show that 18 per cent of social pension recipients use their pension to create cash jobs for others. In the *United Republic of Tanzania* the ILO estimates that a non-contributory cash transfer in the form of a social pension would reduce poverty by 40 per cent (Gassmann and Behrendt, 2006).

On the other hand, while progress has been made in *Mozambique* its extent seems to have been rather limited to date: a number of cash transfer programmes – including the Food Subsidy Programme which, in practical terms, is provided in the form of a cash transfer structured as a social pension, a programme for people with HIV/AIDS, and a programme designed to promote school attendance – still reach only about 1 per cent of the population, or about 200,000 families. [2]

In *Angola* there are a number of government programmes focusing on children, war veterans and the disabled within the context of the government's strategy to combat poverty (ECP), which in turn is part of a medium and long-term development strategy.

[2] The programme in Mozambique nevertheless presents a number of innovative features. One aspect of the approach under the Food Subsidy Programme introduced in recent years is that the benefit is calculated according to the number of the dependants living with the direct beneficiary. This measure was taken in order to take account of the growing number of children living with elderly relatives due to the impact of HIV/AIDS. The Ministry of Women and Social Affairs (MMAS) has recently defined a National Basic Social Security Strategy, in which a Regulation for the Basic Social Security (RBSS) has been approved that closely reflects the four basic-package social transfer components of the social protection floor. One of its components is *Social Direct Action*, comprising social transfers to address the needs of the most vulnerable (older people, people with disabilities, those who are chronically ill, and households with orphans and vulnerable children (OVC)) and to answer to situations of transitory vulnerability. The other components are *Health Social Action, Education Social Action* and *Productive Social Action*, which including programmes of *Social Inclusion through Work*.

Some of these are being undertaken in partnership with UN agencies or financing from the World Bank (for example, programmes on HIV/AIDS, malaria and TB), although published information has not been found to show to what extent these programmes are reaching those in most in need.

In West and Central Africa, government-funded social transfer schemes are in their infancy and relatively few details are readily available. *Ghana's* Livelihood Empowerment against Poverty (LEAP) Programme was established in March 2008 in response to the food price crisis. It aimed to reach 53,000 households by the end of 2008 (Ghana, 2008). Even at its planned enrolment target of 164,000 within five years, LEAP will still only reach one fifth of those below the extreme (food) poverty line (Sultan and Schrofer, 2008). *Sierra Leone* introduced a Social Safety Net Programme in 2007 with the aim of reaching 16,000 extremely vulnerable households (Scott, 2008).

Burkina Faso adopted a Plan National d'Action Sociale (PNAS) in April 2007 and is now drafting a three-year implementation plan. *Cape Verde* adopted a National Social Protection Strategy in 2006 and has instituted a social pension scheme. By 2007, *Ghana* was in the process of adopting a national social protection strategy and has also launched a national health insurance system. *Mali* frames social protection as part of a broader social development policy, linked with a strong focus on extending health insurance coverage to the poor through the new *Assurance Maladie Obligatoire* (AMO) and the *Fonds d'Assistance Médicale*.

The Government of *Senegal* has a National Social Protection Strategy that, in association with the aim to extend health insurance to 50 per cent of the population by 2015, includes measures to insure rural populations against the risks of natural disasters.

The case studies in Appendix I illustrate the value of some income-protection measures, which together with social health protection effectively comprise elements of the social protection floor.

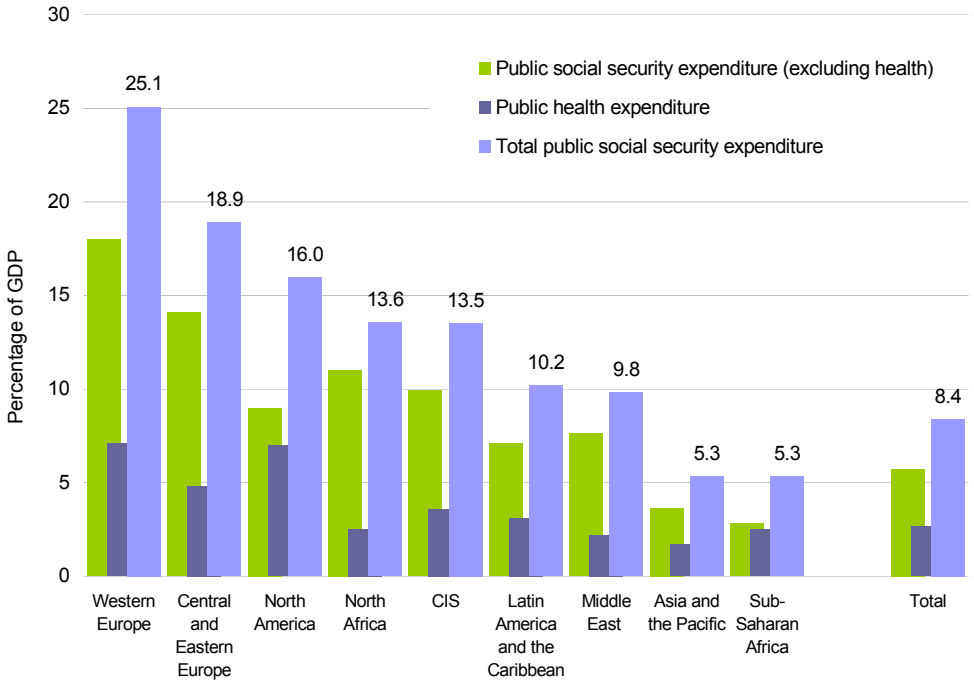
4.4. Financing

4.4.1. Budgetary issues

The affordability and financing of social security and social protection schemes is a particularly difficult question at a time of global economic downturn. The analysis set out below highlights these issues in relation, particularly, to the approaches described above towards strengthening protection for those working in the informal economy, but nevertheless includes issues which are equally relevant to the approaches appropriate to the formal economy.

Consensus is strong in Africa on the urgent need to extend social protection measures to include all those who are most deprived, at risk and living in poverty. Despite this recognition of its important role, national budget allocations for social protection tend to fall far short of actual need. A review of aggregate social protection expenditure in sub-Saharan Africa (ILO, 2010a) shows that only 4–6 per cent of GDP (weighted for population) is spent on social security, and of this amount a larger proportion is spent on health care than on cash transfers (see figure 4.4). This is the lowest allocation amongst all regions globally. The disaggregated data show, however, that there are great differences in national budgets and spending patterns on social security across countries.

Figure 4.4. Total public social security expenditure by region, weighted by population, latest available year (percentage of GDP)



Sources: ILO Social Security database; ILO, 2009f, 2010a.

An issue of central importance in phasing in social protection reforms to respond to the identified gaps and priority areas is the need to implement plans within the financial and fiscal resources available to countries, in ways that are sustainable and at the same time ensure "vertical" equity (fairness achieved through cross-subsidies from the rich to the poor through redistributive taxation) and "horizontal" equity (ensuring that all those who fall within a certain category of vulnerability or risk have access to fair treatment leading to similar outcomes).

The detailed country case studies in Appendix I of this report highlight the significance of strong political will in achieving successful social protection reforms and expansion, together with the importance of allocating adequate financial resources through the national budget to social security. Failure to match political commitment to adequate budget allocations will lead to low levels of coverage, continuing poverty and social and economic exclusion. Empirical evidence shows that those countries that have used the twin strategy of investing in social protection measures together with incentives to promote economic growth have been the most successful in achieving the desired outcomes in terms of human development and sustained economic growth. In Africa, *Botswana* and *Mauritius* are examples. Trade and industry goals and budget allocations must be integrated into policies on health, education and income transfers. Studies undertaken by the ILO (2008b) on the costs of a basic social protection package in Africa in low-income countries found that a basic package consisting of essential health care, universal pension, child benefit and targeted social assistance should be affordable and sustainable, possibly with support at the outset from international partners. Table 4.1 shows indicative cost estimates for one of the components of such a package, namely a cash transfer targeted to the poorest 10 per cent of the population.

Table 4.1. Cost of providing a social transfer equivalent to US$0.50 per day (PPP) to the poorest 10 per cent of households in Africa

Country	Cost of benefit (US$ millions)	As percentage of GDP	As percentage of estimated government expenditure	As percentage of development assistance
Burkina Faso	13.4	0.3	1.8	3.0
Cameroon	27.8	0.2	1.2	3.1
Ethiopia	50.8	0.7	2.4	3.4
Guinea	6.3	0.2	0.7	2.7
Kenya	77.2	0.5	1.7	16.0
Senegal	10.4	0.1	0.6	2.3
Tanzania, United Rep. of	82.4	0.7	3.1	4.9

Source: Pal, 2005.

Costs were calculated for basic child benefits, universal access to essential health care, a social assistance/100-day employment scheme for the poor in the active working-age range, and a universal basic old-age and disability pension. ILO estimates indicate that the initial gross annual cost of the overall basic social protection package (excluding access to basic health care, which to some extent is already financed) would be in the range of 2.2 to 5.7 per cent of GDP in 2010 (ILO, 2010a).

Although the costing exercise clearly shows that the funding needed should be feasible even in a low-income country, even a cursory comparison with current levels of investment shows that there is a large gap to be bridged. Major efforts are needed, first to identify analytically the modalities through which this gap can be filled, and secondly to put the necessary measures in place. These solutions will vary between countries, reflecting not only the different structures of the national budgets and allocations, and the different use of external resources, but also the differences in government revenue bases and the rates of increase that are possible. While it is vital to make the best use of traditional sources of revenue, it is important also to search for new solutions within the continent's own fiscal and macroeconomic context; such innovative solutions may include for example earmarked taxes and taxation on the exploitation of mineral resources. Predictable development aid is also a key element in creating the fiscal space within which to finance the basic social protection package.

4.4.2. Benefit levels and adjustments

Relatively little attention has been paid across the region to the need for adjustments to pensions and other benefits to maintain their real value in the face of price inflation. In those countries which do make such adjustments, the mechanisms vary: in *Cape Verde*, for example, adjustment is carried out every 12 months, while this is done by ad hoc decree in *Chad*; in *Mali* the adjustment tracks increases in the minimum wage, while in *Côte d'Ivoire* any increase is dependent on the availability of resources. In some instances the most recent adjustments were made as far back as the 1990s. The right to access social protection, especially through contributory schemes, is seriously undermined when such schemes fail to dispense benefits adequate to provide an effective buffer against poverty and which enable beneficiaries to meet their basic needs without the risk of sliding into deeper poverty. In many schemes the majority of pensioners receive only a fixed minimum level of pension which is often far from sufficient to keep recipients above the poverty line.

A different aspect of the adequacy of protection may be seen in the variation between countries in the provision of maternity leave (and in a few cases, such as *Mali*, paternity leave). Some countries such as *Chad, Côte d'Ivoire, Madagascar* and *Mali* provide for a range of valuable benefits for salaried women (for example pre-natal, birth, child and/or maternity allowances) but on a conditional basis often relating to length of service and attendance for medical examination.

4.5. Conclusions

Despite significant advances in the adoption of social security as a poverty-reducing strategy, across the region large parts of the population remain without any form of assistance. Huge gaps in coverage for government-provided social assistance leave without support the most vulnerable and those at risk of falling into deep (or deeper) poverty; many are simply unable to meet their most basic survival needs. Only 1 million of the estimated 30 million orphans in sub-Saharan Africa, most orphaned as a result of HIV/AIDS, are receiving any form of assistance. Providing social grants to the elderly poor, to children living in poor households and to the disabled would result in social and economic developmental outcomes that would reduce poverty, empower people and promote sustained economic growth.

As Kaseke (2008) notes, the low coverage of the poorest and the rudimentary nature of social assistance programmes in Africa is largely due to inadequate budgetary support for social protection. As a result only a few of the intended beneficiaries are provided with support, and this is often only limited and short-term relief. Yet estimates by the ILO indicate that the provision of basic old-age and disability pensions, basic child benefits and social assistance to the working poor need absorb less than 4 per cent of GDP of average, showing that much more could be done in this area and reinforcing the imperative that governments in Africa adopt appropriate measures (Wiman, Voipio and Ylonen, 2007).

5. Emerging strategic options and challenges

5.1. Outcomes matter

Widespread consensus exists for the expansion of social security in Africa as a means to reduce poverty and as a form of investment in the future. By the end of October 2008 more than 38 African governments had indicated strong political commitment for the expansion of social protection in their countries (AU, 2008b; HelpAge, 2008). This is a significant step forward in promoting the expansion of social protection and moving progressively towards the implementation of the social protection floor.

However, this commitment falters when it comes to matters of practical implementation and how to introduce the necessary changes within each country. The focus is uncertain, varying from mechanisms to identify and focus services on the most vulnerable groups (more specifically amongst children, people with disabilities and the elderly) to recommendations for approaches to longer term poverty reduction that can remove barriers to health, education and access to service while at the same time promoting decent work and social infrastructure development. Yet both the ILO and the AU promote an approach which asserts that governments need not see their choices in social protection (at least in the medium to long term) as a trade-off between meeting social needs and minimizing financial costs. The needs of those who are most vulnerable and at risk can be addressed together with the needs of those in chronic, structurally based poverty. A mix of policy and programme options is feasible and affordable for countries in Africa if these are based on the progressive and phased implementation of the social protection floor.

It is the outcomes of national social security strategies that matter, not the ways and means through which countries set out to achieve those outcomes. These can and should be as diverse as the circumstances of countries themselves. In carrying out technical advisory and capacity-building services in relation to social security, the approach followed – naturally within the mandate of the ILO as laid down in the Constitution and reflected in the Conventions and Recommendations – is intended, thus, to be essentially pragmatic, focusing on the quest for optimal social outcomes rather than engaging too deeply in futile academic debates as to the processes and methods for achieving them.

In line with this outcome focus, the key features which the ILO would seek to promote, and to assess, in the design and implementation of a national social security system may be summarized as follows:

- ***Universal coverage*** of income security and health systems: all (permanent and temporary) residents of a country should have gender-fair access to an adequate level of basic benefits that lead to income security and comprehensive medical care.

- ***Benefits and poverty protection as a right****:* entitlements to benefits should be specified in a precise manner so as to represent predictable rights of residents and/or contributors; benefits should protect people effectively against poverty; if based on contributions or earmarked taxes, minimum benefit levels should be in line with the Social Security (Minimum Standards) Convention, 1952 (No. 102), or more recent Conventions providing for higher levels of protection, and the European Code of Social Security of the Council of Europe.

- ***Collective "actuarial equivalence"*** [1] ***of contributions and benefit levels:*** the benefits to be received by scheme members should represent both a minimum benefit replacement rate and a minimum rate of return in the case of savings schemes, which in turn must adequately reflect the overall level of the contributions paid; such minimum levels should be effectively guaranteed, preferably by the State.

- ***Sound financing****:* schemes should be financed in such a manner as to ensure to the furthest extent possible their long-term financial viability and sustainability, having regard to the maintenance of adequate fiscal space for the national social security systems as a whole and individual schemes in particular.

- ***Responsibility for governance****:* the State should remain the ultimate guarantor of social security rights, while the financiers/contributors and beneficiaries should participate in the governance of schemes and programmes.

The following section seeks to delineate a generic benchmark strategy for developing appropriate, effective and efficient systems of social security in Africa as well as the ILO's Global Campaign on Social Security and Coverage for All.

5.2. An emerging benchmark strategy

In the light of the above principles as well as the factual analysis of the state and performance of social security in Africa, a conceptual strategy for the campaign to extend social security coverage can be seen to be two-dimensional in nature (and indeed reflects the two-dimensional perspective on equity described above). One dimension comprises the extension of some income security and access to health care, even if at a modest basic level, to the whole population. This dimension may be called *"horizontal"* extension. The second dimension would seek to provide higher levels of income security and access to higher quality health care at a level that protects the standard of living of people even when faced with fundamental life contingencies such as unemployment, ill health, invalidity, loss of breadwinner and old age. This dimension may be called the *"vertical"* aspect of extension.

5.2.1. The horizontal dimension

The Income Security Recommendation, 1944 (No. 67), provides a further description of the aim of income security schemes. For instance:

> income security schemes should relieve want and prevent destitution by restoring, up to a reasonable level, income which is lost by reason of inability to work (including old age) or to obtain remunerative work or by reason of the death of a male breadwinner (para. 1).

What constitutes a "reasonable level" is an open question. It applies equally to the definition of basic income security as well as to what constitutes essential health care. It relates to needs, for example, in relation to health services and also to political choices and discussions of affordability at the national level. Despite the patent need for income

[1] Expressions such as "actuarial equivalence" are not defined in a universally-agreed way, indeed attracting some controversy, and should not, perhaps, be treated as having too precise a technical meaning. Nevertheless, while it is difficult to encapsulate in a pithy phrase, the idea represented here is important – broadly that on a basis which is collective and long-term the members of a social security scheme, specifically a pension scheme, should perceive that the basis on which benefits will be awarded reflects fairly their input by way of contributions.

security and access to health care and the establishment of the universal right to social security, exclusion from coverage remains very high worldwide, notably in Africa, as discussed in detail elsewhere in this document.

Now, however, the UN Chief Executives Board for Coordination, reinforced by the ILO's Global Jobs Pact, have indicated a new strategic approach to the need for a horizontal extension through the promotion of a set of basic social security guarantees within the framework of a wider social protection floor. This concept, echoing the recommendations of the ILO Regional Conference for Africa in 2007, is the cornerstone of the policy framework that is developed further in the following section 5.3.

5.2.2. The vertical dimension

The social protection floor concept represents a crucial strategic approach to the issue of the "horizontal" extension of coverage amongst vulnerable and excluded populations, notably those working in the informal economy. Countries at lower levels of economic development cannot, in the short term, offer the integrated protection of social security at the benefit levels and range of contingencies that are defined in ILO social security standards.

As countries achieve higher levels of economic development – and gain fiscal room for manoeuvre – it is to be expected that steps will be taken, within the framework of the ILO Conventions [2] to put in place correspondingly higher levels of provision. The objective will be to build a level higher, and with wider perspectives, than simply the ground floor level.

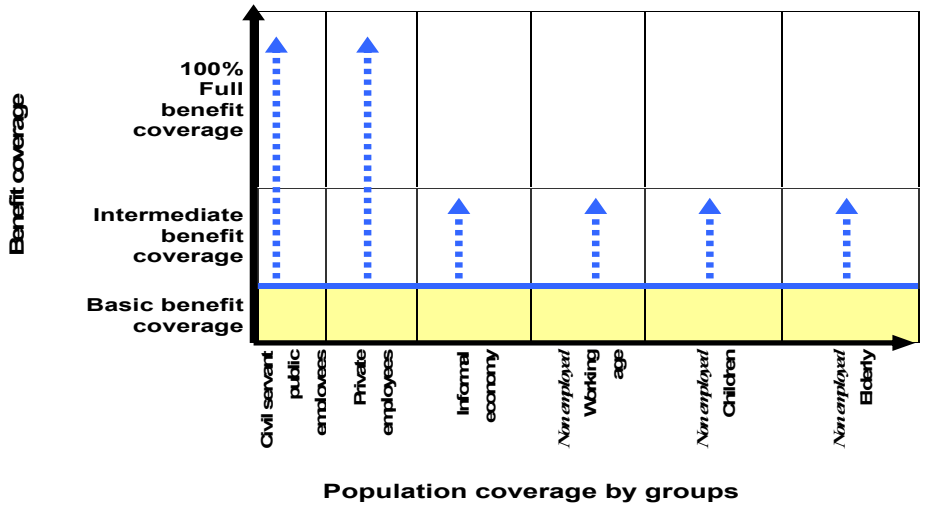
It is obvious that population groups with income levels higher than the poverty line will seek, and have a right, to create social security measures for themselves that provide significantly higher levels of income replacement in case of loss of income than those that may be deemed adequate as mere poverty protection. The mechanisms to achieve such levels of income replacement, or access to quality health care, are fairly well developed, ranging from social insurance – through community-based protection systems and tax-financed defined benefit schemes – to mandatory private insurance. ILO Conventions stipulate minimum benefit levels and thus help to promote effective income replacement in countries where they are ratified. In other countries they provide a unique set of internationally accepted minimum benchmarks for benefit levels against which to assess the design of national social security systems.

5.2.3. The social security staircase

The metaphor that thus emerges for the extension of social security coverage is the image of a social security "staircase". The floor level comprises a set of basic guarantees for all. For people with tax-paying or contributory capacity, a second level of benefits as a right (defined and protected regarding the minimum levels by law) can be introduced and, finally, for those with need or wish for high levels of protection, a "top floor" of voluntary private insurance arrangements can be organized (but should be subject to regulation and public supervision in the same way as all private insurance schemes). This metaphor is appropriate to countries at all stages of development, albeit that the number of people whose only protection consists of basic social guarantees is naturally larger in countries at lower levels of economic development.

[2] Convention No. 102 and the subsequent Conventions setting out stronger levels of protection in relation to the various contingencies.

Figure 5.1. The social security staircase



5.3. A minimum set of social security guarantees as part of the social protection floor

Noting the current high levels of exclusion the International Labour Conference, meeting in its 89th Session in 2001, stated in its conclusions concerning social security that: "Of highest priority are policies and initiatives which can bring social security to those who are not covered by existing systems." Accordingly, the Global Campaign on Social Security and Coverage for All was launched at the 91st Session of the ILC in 2003 with the aim of supporting this extension of coverage.

In order to translate into practice the aim of providing income security to all, including financial protection against catastrophic health expenditure together with access to health-care services, while recognizing that developing countries face strong financial constraints, the ILO recommends that they first aim to put in place a basic and modest set of social security guarantees.

With regard to income security, the suggested social security guarantees consist of providing income security to those who cannot or should not work: in particular protection to children (combined with other policies facilitating their access to health, nutrition and education), to pregnant women, to older people and to people with disabilities. At the same time, income support should be combined with employment guarantees and/or other labour market policies for those able and willing to work, but who are excluded from access to employment that would provide sufficient income.

Organizing income security guarantees for these particular population groups with specific needs goes far towards achieving the overall objective.[3] Providing specific child maintenance support to households is motivated by the need to secure the well-being of dependent children. Elderly and disabled people, who are generally unable to earn sufficient or any income by working, depend directly on income support for a dignified life and, for that reason, need specific attention. For the working-age population, income

[3] This would correspond with the International Labour Conference's 2001 statement that "all" should be covered.

security should prevent destitution stemming from insufficient income-earning opportunities or unemployment. It should go hand-in-hand with policies fostering access to remunerative employment and activities in the broader context of the Decent Work Agenda. [4] This segmentation, moreover, facilitates the possibility of sequential implementation of the basic set of guarantees according to the priorities and capacities of individual countries.

In relation to health care, while social security systems should provide financial protection against catastrophic health expenditure, attention should also be given to the specific needs of different population groups (children, women, the elderly, and so on) in defining an essential health-care benefits package at national level, the ultimate goal being the achievement of the requirements of ILO Conventions Nos 102 and 130.

In summary, the basic set of guarantees promoted by the ILO aim at a situation in which:

- all residents have the necessary financial protection to afford and have access to a nationally defined set of essential health-care services, in relation to which the State accepts the general responsibility for ensuring the adequacy of the (usually) pluralistic financing and delivery systems;

- all children have income security, at least at the level of the nationally defined poverty line, through family/child benefits aimed at facilitating access to nutrition, education and care;

- all those in active age groups who are unable to earn sufficient income in the labour market should enjoy a minimum income security through social assistance or social transfer schemes (such as income transfer schemes for women during the last weeks of pregnancy and the first weeks after delivery) or through employment guarantee schemes;

- all residents in old age and with disabilities [5] have income security at least at the level of the nationally defined poverty line through pensions for old age and disability.

The level of benefits and scope of population covered (for example, age eligibility for social pensions) for each guarantee should be defined having regard to national conditions (potential fiscal space, demographic structure and trends, income distribution, poverty spread and gap, and so on), political imperatives, the characteristics of groups to be covered and expected outcomes. In no circumstances, however, should the level of benefits fall below a minimum that ensures access to a basic basket of food and other essential goods and services. Modelling tools can help assess costs and budget implications of different scenarios of benefits. Decision making at the national level may benefit from evidence from other countries on the outcome of similar initiatives, together with micro-simulation techniques.

While the content of the health-care benefit packages has to be defined at the country level, it is important that certain minima are provided in order to achieve the overall objective of social health protection. Benefit packages need to be designed with a view not

[4] Thus, income security for this group is meant to have an enabling function, which opens up opportunities for developing forms of autonomy that bolster their capacity to face risks and address their needs.

[5] This means a degree of disability that excludes them from labour market participation.

only to generic priorities but also to equity and affordability, and paying regard to the needs, demands and perceptions of individuals. [6] While keeping the principle of universality in mind, this definition should focus, in an integrated way, on the most vulnerable; there may be a need for targeted interventions. In this context, a "one-size-fits-all" approach is likely to be insufficient and ineffective, and will not contribute to achieving the overall objectives of social health protection. [7] An integral part of benefit packages should consist of financial protection – in addition to effective access to health care – in order to shield the poor and avoid underutilization of health services. [8] The definitional questions of effective access to health care are discussed in Chapter 3.

To combat exclusion from social security requires that benefits are secured through an effective social guarantee. In many countries such a guarantee forms part of a social contract, which may be implicit or explicit (perhaps, as is often the case for health provision specifically, stated in the national Constitution) or take other legal forms. Despite the existence of such pledges, there can be a lack of an explicit guarantee and of effective mechanisms for people to realize their entitlements. Very often this leaves many members in society excluded from social security benefits. To avoid such problems, it is proposed that the set of benefits is guaranteed by the State and should be ensured for all potential beneficiaries (all members of society, in the case of health provision) through sustainable financing, adequate regulation and monitoring and the possibility of appeal when the guarantee is denied.

In summary, the rationale for introducing a basic set of social security guarantees is grounded in rights, but the level and scope of benefits in any given country will reflect the prevailing mix of needs and the capacity to finance the benefits. However, no discussion about guarantees can avoid the question of affordability. While it is important to recognize the political and normative nature of the notion of affordability, it is also necessary to recognize the very real and severe resource constraints faced by developing countries.

Part of the acknowledgement of fiscal reality involves defining an adequate level of benefits and prioritizing the way in which they are implemented. A national forward-looking social security strategy and diagnosis of priority needs can help to sequence the implementation of various social programmes and policy instruments, and this can be valuable when the full basic set of social security guarantees cannot be implemented at once, providing for immediate benefits in terms of poverty reduction, pro-poor growth and social development. Such an approach can ensure that the relevant social programmes and policy instruments are integrated into broader development frameworks. As countries achieve higher levels of economic development, their social security systems can also advance in parallel, extending the scope, level and quality of benefits and services provided.

[6] This involves: (a) covering health-care needs in terms of structure and volume of burden of disease; (b) responding to demands in terms of quality and expectations; (c) defining benefits in terms of primary, secondary (and tertiary if available) care and preventive care; (d) ensuring the legal right to health, sick leave and maternal leave.

[7] Attention should be given to addressing chronic diseases including long-term care as well as to reducing maternal, neo-natal and under-5 mortality. The latter is globally among the greatest challenges of social health protection. According to the *World Health Report 2005* (WHO, 2005), 11 million children under the age of 5 die each year. The same is true for some 500,000 mothers during maternity. It is also necessary to cover neglected diseases and the concerns of minorities.

[8] This requires reducing cost-sharing, out-of-pocket payments and other indirect costs such as transport costs and catastrophic health expenditures.

5.4. The affordability of social security in developing countries in Africa

The financial, fiscal and economic affordability and sustainability of social protection systems has become a major concern for countries at all stages of economic development. Hence a few observations are in order at this point to refute the notion that setting up redistributive social transfer systems may be unaffordable in developing countries. Evidence, from both financial studies and real national experience, shows that some level of social security can be afforded at early stages of national development.

Despite their potential positive effects on social and economic stabilization, investments in social security have not been seen to form a significant part of development strategies in low-income countries, even though many of these countries were experiencing a long-lasting social crisis before the onset of the present global economic downturn. It seems that most governments have simply assumed that social transfers are too big a burden on developing economies and would compromise growth. However, the economic arguments in favour of making resources available for investments in social security are overwhelming. It is noteworthy that the World Bank takes up the theme, in its *World Development Report 2005*, that poverty is a risk to security and lack of security is a hindrance to the investment climate. Beyond argument, productivity is a characteristic of people who enjoy a minimum level of material security and so can afford to take entrepreneurial risks, of those who are healthy and not hungry, and those with at least a reasonable level of schooling. Without basic social transfer schemes that foster health, adequate levels of nutrition and social stability, a country simply cannot unlock its full productive potential.

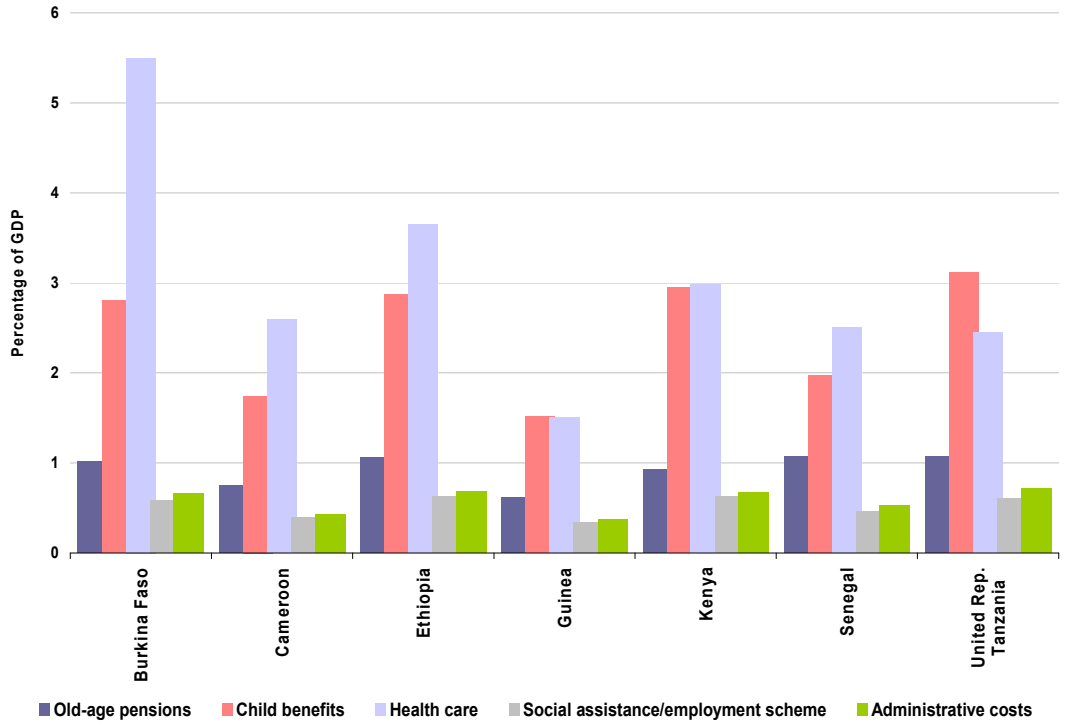
The amount of public resources allocated to social security does matter with respect to levels of actual coverage and social outcomes. One clear example comes from health care. It can be shown that, on the basis of statistics for mortality rates in different countries, there is a statistically significant correlation between the ratio borne by out-of-pocket payments to public health expenditure and various indicators of mortality (including adult mortality rates, child mortality rates and healthy life expectancy). If private out-of-pocket expenditure is not matched by even larger public health expenditure (i.e. expenditure from government budget(s) and social security schemes) higher mortality and reduced healthy life expectancy rates in the population can be expected. The same applies to investments in cash benefits providing income security in old age, disability, unemployment, and so on; there is a strong correlation between how much countries invest in social security benefits and poverty or other social indicators.

The assumption still persists that countries at lower levels of economic development must remain unable to afford to implement progressive measures of social security. Many development planners have simply assumed that there is insufficient fiscal space in such countries to finance social security benefits and, hence, that for them social security is not affordable. That this is an assumption, and a mistaken one, becomes clearer as evidence emerges that a minimum package of social security is affordable in even the poorest countries, as recent work by the ILO on the costs of a minimum package of social security in sub-Saharan Africa and Asia, shows.

The ILO has recently undertaken two costing studies (ILO, 2008b), one in Africa and the other in Asia, that provide a first estimate of the costs of a hypothetical basic social protection package in low-income countries now and over the coming decades. The indicative package included, along with basic child benefits; universal access to essential health care and a social assistance/100-day employment scheme for the poor in the active

working-age range, and also a universal basic old-age and disability pension.[9] The studies show that the initial gross annual cost of the overall basic social protection package (excluding access to basic health care that to some extent is financed already) is projected to be in the range of 2.2 to 5.7 per cent of GDP in 2010. Individual elements appear even more affordable (see figure 5.2).

Figure 5.2. Costs for components of a basic social protection package for selected countries in Africa, 2010 (percentage of GDP)

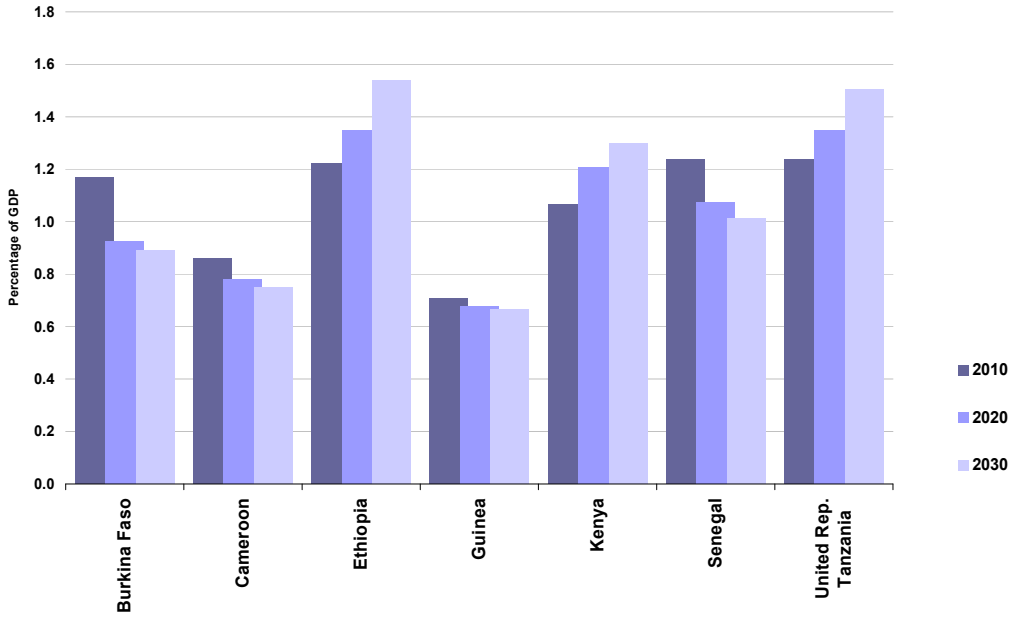


Source: ILO, 2008b.

The hypothetical annual cost of providing universal basic old-age and disability pension is estimated in 2010 at between 0.6 and 1.5 per cent of annual GDP in the countries considered. These costs for 2010 are estimated at, or below, 1.0 per cent of GDP in Cameroon and Guinea, while for Burkina Faso, Ethiopia, Kenya, Senegal and the United Republic of Tanzania the cost estimates fall between 1.1 and 1.5 per cent of GDP. As shown in figure 5.3 the cost of such pensions would increase only moderately by the year 2030 – despite the ageing process.

[9] It was assumed that the simulated universal old-age and disability pension would be set at 30 per cent of GDP per capita, with a maximum of one US dollar (PPP) per day (increased in line with inflation) and would be paid to all men and women aged 65 and older; and to persons with serious disabilities in working age (the eligibility ratio was assumed to be 1 per cent of the working-age population, which reflects a very conservative estimate of the rate of disability). The amount of child benefits was set at half the amount of pensions. The costs of universal access to essential health care were calculated on the basis of a health manpower ratio of 300 health professionals per 100,000 population.

Figure 5.3. Costs for basic universal old age and disability pensions for selected countries in Africa, 2010, 2020 and 2030 (percentage of GDP)

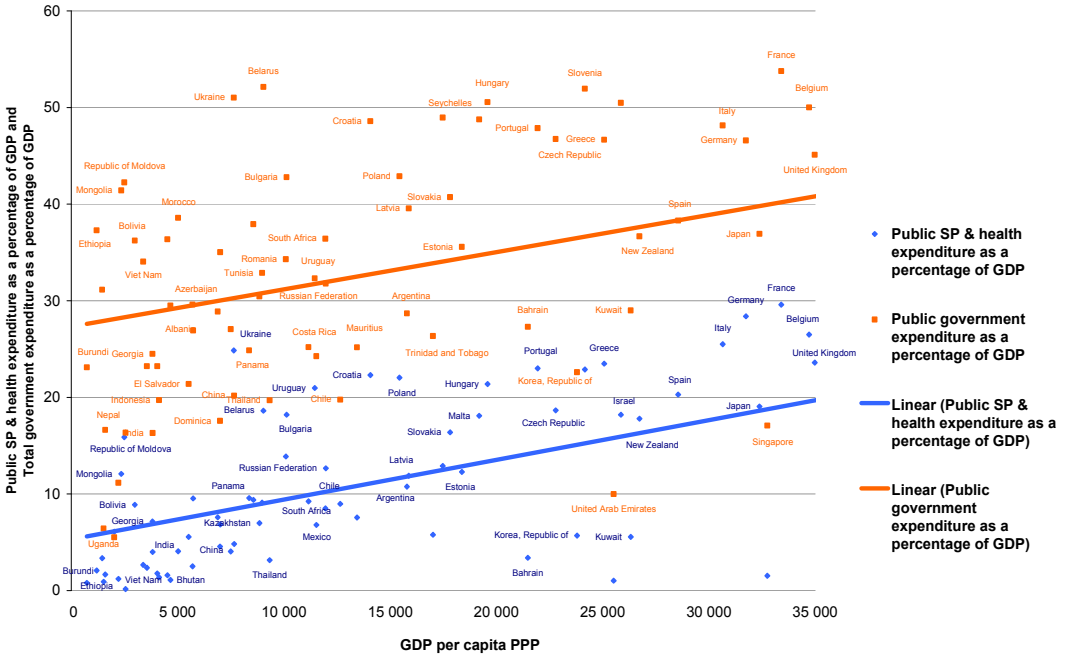


Source: ILO, 2008b, based on Pal et al., 2005, and updated calculations. These figures include assumed administration costs of 15 per cent of benefit expenditure.

A basic social protection package appears affordable, but in most cases on the condition that it is progressively implemented. In the case of some of these countries, this may require a joint effort with the international donor community for the duration of a suitable transition period. Low-income countries may, however, be able to reallocate their existing resources, for example, by progressively increasing social protection expenditure, towards an eventual target of 20 per cent of total government expenditure.

Obviously, there are some cases where the fiscal space for social transfers cannot easily be extended in the very short run. Each case has to be assessed in detail. However, figure 5.4 shows that "policy space" for financial manoeuvre may be wider than often assumed. The figure maps national public expenditure and public expenditure on social protection and health (according to the IMF definition) as percentage shares of GDP against the GDP per capita, resulting in two almost parallel regression lines. Clearly, in principle, both types of expenditure increase as GDP per capita increases. However, more interesting than the regression lines themselves is the surrounding cloud of expenditure levels. This indicates that, at similar levels of GDP per capita, countries are in a position to exercise a substantial degree of discretion regarding the level of overall public expenditure and, within that envelope, regarding the share of public resources allocated to social expenditure.

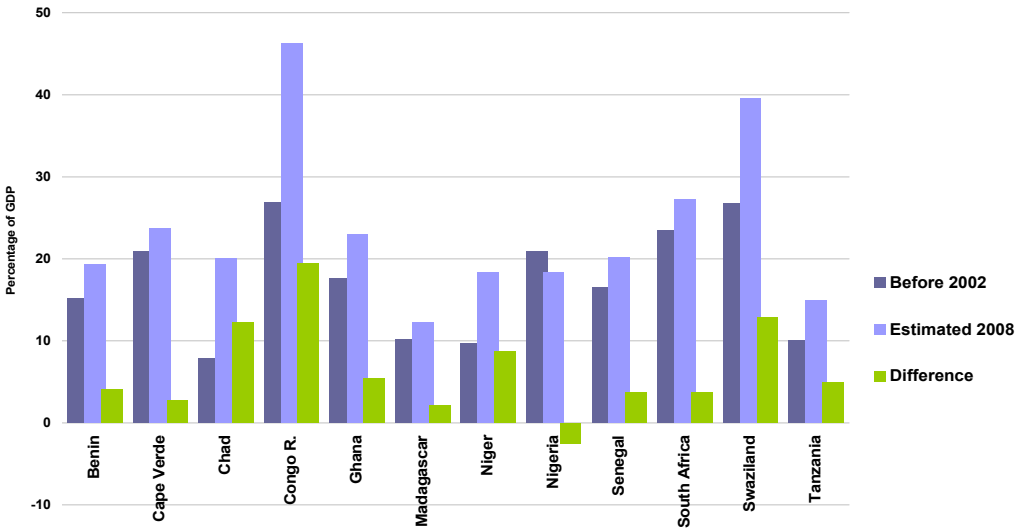
Figure 5.4. Total public expenditure and social expenditure at different levels of GDP per capita, latest available year



Source: IMF, 2009a (various years); UNDATA database (various years).

It is concluded that policy decisions regarding the financing of social security systems and negotiations seeking fiscal consensus between the different stakeholders of the public expenditure portfolio are made in a manner specific to each individual country. It should be noted in this context that domestic revenues in Africa alone increased from 2002 to 2007 (i.e. in the post-Monterrey period) by about US$230 billion. In sub-Saharan Africa alone, the share of domestic public revenues in GDP increased by 4 percentage points between 2002–07 (see figure 5.5). Given a sufficient level of policy priority, phasing in a package of modest social security benefits over, perhaps, a decade, with a net cost of around 4 per cent of GDP, does not seem to be unrealistic.

Figure 5.5. Increase of domestic public resources, selected African countries, 2002–07
(percentage of GDP)



Source: OECD, 2007.

ILO micro-simulation results for Senegal and the United Republic of Tanzania show that the introduction of basic old-age cash benefits can have a significant impact on poverty reduction. Gassman and Behrendt (2006) carried out simulations to estimate the cost of old-age and disability pension benefits at levels fixed at 70 per cent of the food poverty line per eligible individual. On that basis, they show that in the United Republic of Tanzania a universal old-age pension would cut poverty rates by 9 per cent, with a considerably stronger effect (36 per cent) for older men and women, and 24 per cent for individuals living in households with elderly family members. Likewise, for Senegal old-age and disability pensions are expected to have a more pronounced effect for older people, especially older women, and their family members.

Even more convincing than theoretical exercises is real-life experience. There is a growing body of evidence from the developing world that some components of basic social security packages now being implemented are proving affordable. There are many ways to achieve some affordable social security coverage in a developing country context as a first step to a national social security development strategy. While some countries seek to extend social insurance and combine it with social assistance, others subsidize social insurance coverage for the poor to enable them to enjoy participation in the general schemes, and still others seek to establish tax-financed universal or conditional schemes, also called social transfer schemes. Each approach has its advantages and its problems and each will be "path-dependent", in other words dependent on past developments and national values.

The most dramatic advance in social security coverage worldwide is presently being achieved by social transfer schemes. Some 30 countries (of which eight are in Africa) are already successfully putting in place elements of minimum social security packages through social transfer programmes. For example, in Brazil this is being done through the *Bolsa Família* programme; in Mexico it is being done through the *Oportunidades* programme; and in South Africa, Namibia and Nepal it is being achieved through tax-financed basic pension systems. The *Bolsa Família* programme is thought to be the largest social transfer scheme in the world, and presently covers some 46 million people at a cost of about 0.4 per cent of GDP. South Africa has also extended the coverage of its child grants system substantially, by more than 4 million beneficiaries over the last decade. In India the 100-day rural employment guarantee scheme (NREGS) has been rolled out nationwide, and a new act mandates the extension of basic social security coverage to about 300 million people hitherto not covered. But cash transfer (or universal benefit) schemes are being successfully implemented by still poorer countries. Nepal, for example, is currently extending the scope of its universal pension scheme, aiming to reduce the retirement age in due course from 75 to 65 years.

The evidence shows that, almost everywhere, something can be done.

5.5. Strategic challenges

Implementing the strategic concept of a social security staircase must address a number of pivotal challenges. Three of the most important are described in the following sections.

5.5.1. Combining effective protection with organizational flexibility

The concept of "social guarantees" creates organizational flexibility while protecting the bottom line of basic entitlements that everybody should enjoy, recognizing implicitly

that there is no "one-size-fits-all" approach to organizing either basic or higher level social security entitlements.

It has already been noted that there are many ways to achieve this set of basic social security guarantees as the first step of a national social security development strategy, whether through extending social insurance in combination with social assistance, through subsidized participation in social insurance coverage for the poor or through tax-financed universal schemes. Other countries will start with subsidized community-based schemes that seek to reach out to the informal sector. Each approach will have its advantages and its problems and many countries pursue mixed strategies, highlighting the country-specific and "path-dependent" character of development reflecting past experience and national values.

What matters in the end is that all people have access to a basic level of social security benefits, whether these are organized on the basis of social assistance, or are targeted conditionally, and whether organized as universal tax-financed benefits or as benefits of contractual rights based on contribution payments. The notion of a guarantee of access to social security benefits is thus an overarching concept that encompasses income transfers in cash and in kind that are paid based on social assistance or social security principles. In this framework, the myriad questions of a technical nature can be seen to represent a secondary level of consideration. It is the outcome of national social security strategies that matters primarily, rather than the ways and means countries choose to organize the outcomes. What will be common to all approaches is the central role of the State. All basic guarantees will require government financing or at least substantial co-financing. This is justified, since the protection of people against poverty is clearly an obligation of entire societies.

5.5.2. Achieving a coherent architecture of national social security systems

A further strategic challenge is to achieve a coherent interactive overall social security system comprising a number of levels, pillars and subsystems that achieve universal population coverage, reduce poverty and insecurity effectively and ensure efficiency through avoidance of overlapping multiple entitlements and adverse incentives that create over usage and excessive levels of dependency.

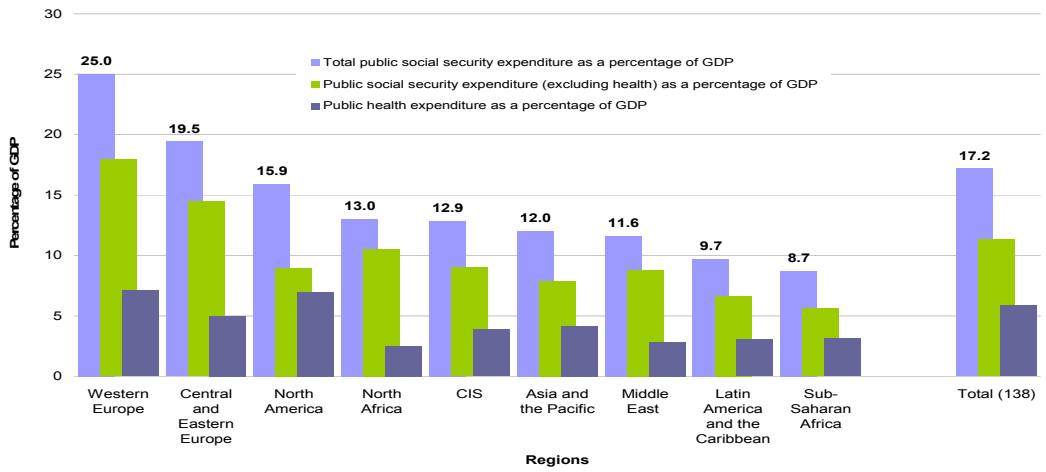
In the context of this strategic framework, the first question that has to be addressed is: are basic guarantee schemes compatible with higher level benefits systems such as social insurance schemes, and can these schemes be combined efficiently and effectively? In principle, the answer is "yes". There are decades of experience with the combination of social insurance schemes and social assistance schemes, or the combination of universal benefits schemes with higher level and insurance-based benefit systems. Examples can be found in many pension and health-care financing systems around the world.

However, ensuring efficiency and coherence is not necessarily easy. The design has, for example, to take into account that incentives created in one sub-system might lead to inefficiencies in another. The provision of a means- or income-tested social assistance pension, for example, can easily reduce incentives to contribute to a social insurance pension scheme for a large group of low-income workers. A universal flat rate pension catering for all would avoid such disincentives, as people would be allowed to accumulate benefits from two or more sources rather than having their social insurance pensions being deducted from their universal pension entitlements and vice versa.

5.5.3. Creating the necessary fiscal space

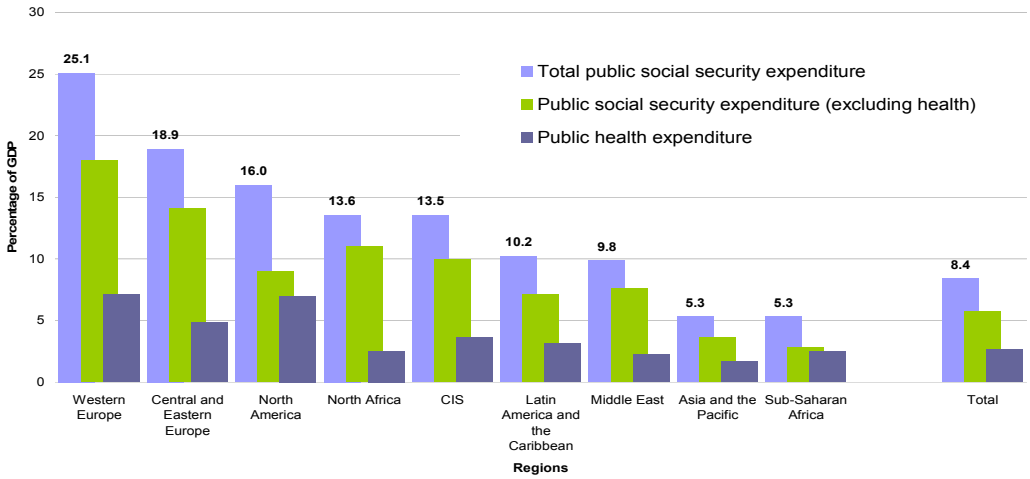
Amongst the countries of the world, 17.2 per cent of GDP on average is allocated to social security (see figure 5.6), if the country figures are weighted by national GDP. However, if the figures are weighted instead by population, the calculation shows that the "average" world resident finds that only 8.4 per cent of GDP is allocated as social security benefits in the form of cash and in-kind transfers (see figure 5.7). Country figures vary widely among the populations living in different regions, and among countries of different national income levels. While residents of Europe may see between 20 and 30 per cent of GDP invested in their social security, in Africa only 4–6 per cent of GDP is spent on social security benefits, and there more funds are spent on health care than on cash transfers aimed at providing income security.

Figure 5.6. Total public social expenditure, regional estimates weighted by GDP, latest available year between 2002 and 2007 (percentage of GDP)



Sources: ILO social security database, based on IMF, 2009a; OECD, SOCX (OECD, 2009); ILO social security inquiry (ILO, 2009i); ESSPROS (European Commission, 2009); WHOSIS (WHO, 2009). Country data are available in ILO, 2010a, statistical annex. See also ILO, GESS (ILO, 2009f).

Figure 5.7. Total public social expenditure, regional estimates weighted by population, latest available year between 2002 and 2007 (percentage of GDP)



Sources: ILO social security database, based on IMF, 2009a; OECD, SOCX (OECD, 2009); ILO social security inquiry (ILO, 2009i); ESSPROS (European Commission, 2009); WHOSIS (WHO, 2009). Country data are available in ILO, 2010a, statistical annex. See also ILO, GESS (ILO, 2009f).

Higher-income countries in general spend more, as a proportion of all available resources, than low-income countries. However, social security should not be seen as a luxury and can also be afforded by lower-income countries or countries with relatively "small" government in terms of available resources. Figure 5.9 shows clearly that, countries with the same level of government spending, measured as total expenditure in proportion to GDP, spend a widely different proportion of their available resources on social security. The proportion spent on social security does not, in fact, depend at all closely on how rich the country is; to a large extent it depends on the prevailing political will that effectively defines the fiscal space available. To maximize fiscal space may, however unpopular, require substantial attention to the effectiveness of a country's tax and contribution collection mechanism, for without sound machinery for revenue collection no revenue can be redistributed. The challenge of increasing fiscal space has a different face for each country. A checklist of components for a national strategy may, however, include:

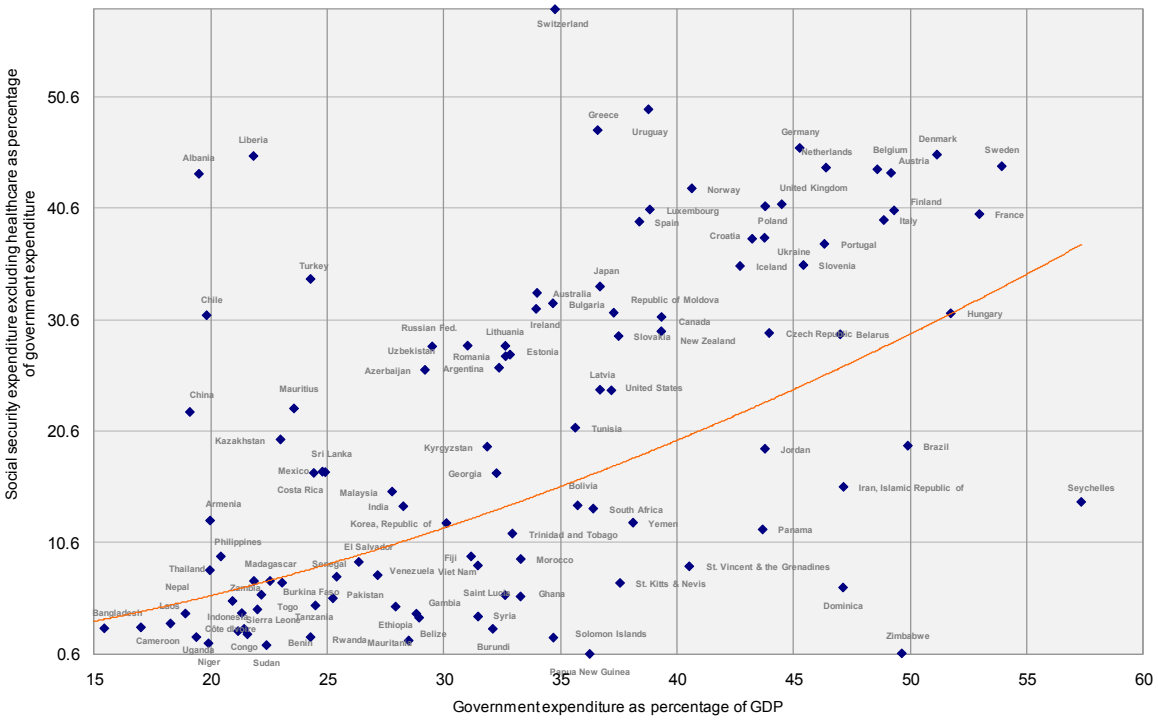
(1) tax reforms to increase fiscal resources including, in particular, enhancing the effectiveness and efficiency of tax collection;

(2) gradual increase in social spending as a proportion of GDP and as a proportion of total spending;

(3) redistribution between social policy areas to refocus expenditure on most urgent needs;

(4) refocusing spending within social sectors and policy areas to make certain spending more progressive and more effective in combating poverty and vulnerability.

Figure 5.8. Size of government and proportion of government expenditure allocated to social security, latest available year



Sources: IMF, 2009a (various years). See also ILO, GESS (ILO, 2009f).

6. Conclusions

Social security is first and foremost a human right and hence an obligation for all societies. It also acts as a social and economic facilitator of change and has the capacity to function as an effective financial stabilizer.

Social security systems not only prevent people from falling into poverty and reduce the likelihood of social unrest, but also embody an indispensable investment in people's productive capacity through enhanced access to better nutrition, health and education. They help to better manage risk and uncertainty and stabilize aggregate demand in times of economic crisis.

In order to achieve the MDGs aimed at bringing about greater social justice in Africa, as well as greater crisis resistance and preparedness, reliable social security systems need to be accessible to all. A basic package of social transfers and health services as part of the wider social protection floor is vital as a first building block in developing a national social security system. That floor is not the ultimate objective, but serves as a foundation for a further extension and improvement of social security o at a later stage of economic development.

6.1. A policy framework for the extension of national social security

The two-dimensional approach discussed in Chapter 5 (section 5.2) can be inferred from a wide range of instruments, documents and resolutions, notably the UN Declaration of Human Rights, the ILO Constitution together with the extended mandate defined in the Declaration of Philadelphia, the Conclusions of the International Labour Conference in 2001, the Conclusions of the ILO's 11th African Regional Meeting held in Addis Ababa in April 2007, the ILO Declaration on Social Justice for a Fair Globalization and the Global Jobs Pact, together with the up to date ILO Conventions and Recommendations, supplemented by emerging national experience and the experience gained to date through the ILO Global Campaign on Social Security and Coverage for All.

Countries can and should pursue both dimensions at the same time. General revenue financing should first focus on the *horizontal dimension*. However, solidarity-based financing should not stop at the basic level of protection. The *vertical dimension* should focus on the guaranteed access to a defined range of social security benefits and the safeguarding of adequate benefit levels as of right for all who contribute to the financing of social security systems through contributions or taxes. An important catalyst for this dimension would be provided by the promotion of a wider ratification of Convention No. 102 in Africa.

The social transfer component of the wider social protection floor (that also includes essential services that, as such, fall outside of the direct competence of the ILO), comprises a basic set of essential social guarantees realized through transfers in cash and in kind that could ensure that all residents have the necessary financial protection to afford, and have access to, a nationally defined set of essential health-care goods and services; that all children have minimum income security; that all those in active age groups who are unable to earn sufficient income on the labour markets enjoy a minimum income security through

social assistance; and that all residents in old age and with disabilities [1] have guaranteed minimum income security through pensions for old age and disability.

There is no "one-size-fits-all" definition of the nature and level of the benefits. The term "guarantees" leaves open whether all or some of these transfers in cash or in kind are granted on a universal basis to all inhabitants of a country, whether they are granted based on contributory insurance schemes or whether they are granted only in case of need or may be tied to a number of behavioural conditions. The crucial point is that all people have access and a right to health services and means of securing a minimum level of income.

Fiscal space, institutional strength and levels of poverty and vulnerability should drive the decision-making process regarding, firstly, the means of constructing the social transfer component of the basic social protection floor, and secondly, the question of which benefits to introduce as a matter of priority within an overall implementation plan for the full set of basic guarantees. New cash transfer programmes, that have sprung up in about 30 developing countries around the world during the last one to two decades and are already providing elements of the social protection floor, have been successful in combating poverty, increasing school enrolment, boosting the social status of recipients, and improving their health and nutritional status. They demonstrate that the basic social security guarantees, or at least important elements of the package, can be afforded by developing countries. They are most successful where they form an integral part of an overall social security strategy.

The core challenge for the financing of the basic social security guarantees remains the securing of the necessary fiscal space. The increase of fiscal space for social security thus requires political decisions with respect to the priorities of government spending and revenue generation, together in many cases with respect to investments in national tax reforms. The example of many African countries during the last decade shows that developing countries can increase their revenues relative to GDP.

6.2. Implementation strategies

The national experiences reviewed in the report show that successful national action to extend social security horizontally to all relies on the following crucial elements:

(i) compatibility and coherence of social security extension policies with a wider social and economic development strategy aiming at improving the standard of living through fair sharing of growth through a number of social, employment, educational, health and fiscal policy measures;

(ii) strong advocacy of poverty alleviation and the reduction of insecurity as a national policy priority through investments in social security by the social partners and other interested parties;

(iii) sound analytical work with respect to the identification of the main social security priorities and the lacunae in present protection systems;

(iv) sound quantitative analyses of the cost, benefits and long-term financial and fiscal sustainability of alternative benefit systems;

[1] That is, a degree of disability that excludes them from labour market participation.

(v) the determination of protection priorities in a national consultation process, including tripartite social dialogue as a core element;

(vi) the determination of benefit entitlements and levels on a statutory basis;

(vi) guaranteed minimum benefit levels aimed at lifting beneficiaries above national poverty lines;

(viii) the creating of fiscal space through a combination of measures to:

- abolish inefficiencies in existing spending structures and behaviour;
- reallocate existing resources to those schemes of protection which are most effective in terms of poverty alleviation and the reduction of vulnerabilities and insecurity;
- widen the tax base and access new sources of public revenues;

(ix) strengthening the capacity to ensure effective and efficient programme management and supervision; and

(x) putting in place at an early stage effective monitoring and evaluation frameworks that ensure the targeting efficiency of social security and transfer benefits.

All mechanisms to extend social security coverage should be rooted in the context of an integrated national social security strategy. The ILO should support the conceptual development of a two-dimensional national social security extension and implementation strategy along the lines described above using the full range of means of action of the ILO; these consist of the generation, management and dissemination of knowledge, support for policy development, capacity building and technical advisory services. The technical advisory services to be provided by the ILO should be formulated on a dual focus basis, around the concepts of the social protection floor and the promotion of the ratification of Convention No. 102.

Last, but not least, national social security plans should guide the ILO in the follow-up to the Declaration on Social Justice for Fair Globalization and to the Global Jobs Pact on a national level.

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Appendix I

Extending social protection programmes in Africa: Select case studies

African governments are in the process of crafting country-owned and led processes that are responsive to poverty, promote decent work and reduce vulnerability and social inequalities. While momentum for the expansion of social protection is building, the translation of political commitment and policy intentions into concrete programme deliverables remains a daunting task. Many governments in the region are taking initial steps in this direction. Other governments are already learning from their experiences of having introduced significant social protection reforms in recent years.

This appendix provides 11 country case studies where changes in income security (three countries) and changes in social health protection (eight countries) policies and programmes have taken place. They provide lessons from experience – both successes and common pitfalls – that can be used within Africa. The first part of each case study describes some of the main features of social protection in the country. This is followed by a discussion of the main lessons learned.

AI.1. Income security: Extending programmes

This section explores experiences from three countries in the region: Mauritius, Namibia and South Africa, providing key demographic and economic indicators for each. A short description of social protection programmes in the country, including expenditure, follows, together with a brief discussion of the impact of these programmes.

Mauritius

The history of social protection policy in Mauritius dates back to 1968, after independence. After benefiting from a boom in sugar exports and tourism, the country invested heavily in social services. This linking of economic and social goals continued even during the difficult period of economic structural adjustment between 1975 and 1986 when the Mauritian Government introduced free and universal social services. Maintaining these enabled Mauritius to cushion the negative social impacts of structural adjustment and also to achieve progressive improvements in health and education with a correspondingly high human development index (HDI) (see table A1). Life expectancy at birth and school enrolment is much higher than for other countries in the region, demonstrating the beneficial effects of an integrated approach to both social and economic development. By expanding its social investment even during economic structural adjustment Mauritius was later able to weather some of the contagion effects of the South-East Asian financial crisis.

Table A1. Mauritius: Key indicators

GDP (current US$) (billions)	2008	8.7
GNI per capita, Atlas method (current US$)	2008	6 400
External debt stocks (% of GNI)	2007	62.1
Life expectancy at birth, total (years)	2007	72
Population, total (millions)	2008	1.3
Population growth (annual %)	2008	0.6
School enrolment, primary (% net)	2007	95.4
Surface area (sq. km) (thousands)	2008	2.0
HDI ranking	2009	81

Sources: World Bank, 2009; UNDP, 2009.

Policy framework

In 1998 Mauritius went through a period of significant pension reform, with inputs made by an All Workers' Commission on Pension Rights. The process of consultation included the trade union movement and other civil society organizations. Comprehensive and coordinated legislation and policy related to social insurance and social assistance is in place. In this respect Mauritius appears to have a well-developed social security system.

Financing

Mauritius has an extensive social protection programme including non-contributory government assistance in the form of cash allowances to poor and vulnerable groups, and a system of contributory social insurance. The extent and scope of the social security system is reflected in table A2 on government expenditure and estimates for 2008/11. Social security spending between 2008 and 2009 was between 11.4 per cent and 12.1 per cent of total government expenditure. Significant funds are allocated for social protection in the budget, although what is included under this item is unclear.

Programmes

The basic old-age pension is universal and thus covers all Mauritian nationals from age 60 and above who have resided in Mauritius for at least 12 years after the age of 18 (although the residency requirement does not apply in respect of nationals aged 70 and older). The pension is non-contributory, with the total cost being borne by the State. Family allowances are also paid to needy families with three or more children, for children under 15 years old. There are a number of associated pensions and allowances including a widow's (survivor's) pension, orphan's pension and a guardian allowance.

Mauritius has a contributory earnings-related social insurance pension scheme that provides cover to employed persons, thus creating an integrated public/private benefit system linked to individuals' income. Employees are required to pay between 3 per cent and 5 per cent of earnings (depending on various employer and other agreements). Self-employed and non-employed persons can contribute voluntarily to the scheme. The bulk of the scheme is paid for through employer contributions and voluntary individual contributions, with the State making up any deficit that may arise. National pension legislation also makes provision for work-related coverage for injury, illness and disability, while unemployment legislation makes provision for unemployment insurance, the cost of which is covered by the State.

Administration

General administration of the programmes is carried out by the Ministry of Social Security (National Solidarity and Senior Citizens Welfare and Reform Institutions) while the Ministry of Labour (Industrial Relations and Employment) administers aspects of the unemployment benefits.

Table A2. Mauritius: Government social security expenditure and estimates, 2008–11

Programme	**2008–09 financial year**		**2010** (est.)	**2011** (est.)
	Revised estimates	**Approved estimates**		
	Rs millions	**Rs millions**	**Rs millions**	**Rs millions**
Policy and management for social affairs	49.1	41.2	53.2	56.4
Social protection	852.3	936.7	897.4	901.0
National pension management	7 717.1	7 809.5	8 126.5	8 180.3
Probation and social rehabilitation	52.4	44.8	64.8	66.5
Social welfare	211.1	187.8	173.1	135.8
Total for Ministry of Finance	8 882.0	9 020.0	9 315.0	9 340.0
Total government expenditure	78 175.0	74 800.0	80 566.0	84 784.0
Social security spending as % of total government expenditure	11.4	12.1	11.6	11.0

Source: Mauritius, Ministry of Finance, 2008.

Lessons from experience

Three lessons are noteworthy from this case study:

(1) Integrating social and economic growth objectives has ensured sustained and balanced development in Mauritius. An emphasis on free social services with access to education and health has resulted in a high human development ranking for the country according to the HDI (ranked 81 in 2009). Significant progress is being achieved with regard to the well-being of the population.

(2) Policy changes and programme reforms were informed by the participation at various stages of all stakeholders, including trade union and civil society organizations.

(3) The higher than average life expectancy (72 years) is a good indicator of the progress made, although as the population lives longer there will be greater demands made on the social security system to provide for pensions and other assistance. This has already been recognized by the gradual increase in retirement age from 60 to 65 over ten years commencing in 2008.

Despite these advances, the Government of Mauritius "recognizes that the social security system in place has been slow to adjust to the rapid evolution and modernization of the society" and that "the social assistance programmes need to be more effectively targeted and efforts made to improve and consolidate the outreach of ongoing delivery of services to the most vulnerable groups". There is also a need for an accessible central database that includes policy, regulations and the types of social protection measures available to citizens.

(Full details of Mauritian social protection measures can be found at: www.gov.mu/portal/goc/mof/files/20052006/social.pdf, and www.ssa.gov/policy/docs/progdesc/ssptw/2006-2007/africa/mauritius.pdf).

Namibia

Namibia's social security system has been undergoing various reforms since 1990 when the country became independent and legislation and regulations introduced had to ensure that there was no longer any discrimination on the basis of race. In 1994 and 1998 social security legislation was amended to ensure that employees received unemployment, sickness, maternity and other work-related benefits. Namibia has suffered multiple social crises: the country is experiencing high levels of unemployment and poverty, and a large youth population cannot be absorbed into the workforce because of a lack of job growth. Extreme poverty and inequality are particular features of rural and peri-urban areas. As table A3 shows, life expectancy at birth is low, at 53 years, indicating lack of access to affordable health care as well as the impacts of the HIV/AIDS pandemic.

Table A3. Namibia: Key indicators

GDP (current US$) (billions)	2008	8.6
GNI per capita, Atlas method (current US$)	2008	4 200
Life expectancy at birth, total (years)	2007	53
Population, total (millions)	2008	2.1
Population growth (annual %)	2008	1.6
School enrolment, primary (% net)	2007	86.5
Surface area (sq. km) (thousands)	2008	824.3
HDI ranking	2009	128

Sources: World Bank, 2009; UNDP, 2009.

Policy framework

There is strong political support for social protection in Namibia. Improvement in the lives of Namibians is emphasized in the ambitious Vision 2030 policy adopted in 2004, which is managed and monitored by the National Planning Commission and which would see Namibia develop into an industrialized and prosperous country by 2030. The country's social protection plan forms a component of Vision 2030. Various pieces of legislation are enacted to ensure social protection services are targeted to those in need. The main legislation is the Social Security Act.

Financing

In the 2008–09 government budget, social security and welfare services showed growth from 9.3 per cent in 2007–08 to 10.3 per cent of overall government expenditure. This budget item does not include health or education expenditure, which are reflected separately. An extensive social pension scheme for the elderly is government-financed, as are other family and child support programmes. A development fund exists for socio-economically disadvantaged persons, and students at institutions of higher learning.

Programmes

Namibia introduced a social pension in the 1970s and now implements nine cash transfer programmes. These transfers include a maintenance grant for children under the age of 18 whose parents earn below a certain income, and extensive social assistance to old-age pensioners, war veterans and disabled persons (including persons who have developed full-blown AIDS). The social old-age pension is universal and thus ensures that poverty and vulnerability in old age is reduced. However, there is no national insurance scheme in Namibia.

Administration

The Namibian Social Security Commission manages the Social Security Act which provides for benefits mainly related to employment such as maternity, death and sickness benefits as well as compensation for employment-related injuries and illnesses. Local institutional capacity needs to be developed to design, develop, implement, monitor and evaluate social protection programmes. In addition, the management of the various social protection mechanisms takes place in a number of different locations in government; this fragmentation does not lend itself to efficient coordination.

Non-governmental initiatives

In January 2008 in the Otjivero–Omitara area 100 kilometres east of Windhoek, the Namibian Basic Income Grant Coalition launched a project that provides a basic income grant (BIG) of N$100 to all residents below the age of 60, without no conditions attached. The grant is being given to every person registered as living in Otjivero–Omitara in July 2007, whatever their social and economic status. The project was designed and implemented by the BIG Coalition and is comprised of representatives from civil society organizations, trade unions and the Council of Churches.

Funds for the project were raised from civil society and donors. The pilot phase of the project ends in December 2009. Initial evaluations indicate significant improvements in the overall quality of life of the people, improvements in local economic development and increasing social participation and social cohesion.

Lessons from experience

(1) Although per capita GNI is high, the universal old-age and invalidity pensions have stimulated markets for locally produced goods and services. The old-age pension not only reduces destitution among recipients but is also responsible for supporting entire households.

(2) The social pension and other grants have demonstrated their capacity to act as economic and social stabilizers. There is evidence that the cash paid through the Namibian social pension is spent on supporting children to go to school despite the absence of adequate schooling. School enrolments in Namibia are steadily increasing (see table A3).

(3) The BIG pilot project is the first universal cash transfer of its kind in Africa. It is an innovative response from civil society that demonstrates the value of unconditional cash transfers in promoting human development, increasing local economic consumption and growth, reducing extreme levels of destitution and facilitating social inclusion.

(4) Initial assessments of the BIG pilot fit well with the impacts made by cash transfers in reducing poverty and promoting economic growth elsewhere in Namibia. The assessments indicate that at a local level there are significant positive social and economic impacts. These include increases in school attendance, decreases in school drop-out rates from 30–40 per cent to 5 per cent, falling crime rates by 20 per cent and a reduction in child malnutrition from 42 per cent to 17 per cent. Aggregate income growth in the community by more than the total amount of grants allocated indicates that the cash transfer plays a role in stimulating economic growth through consumption and is used to generate other economic activities.

South Africa

South Africa has a well-established non-contributory social security system that has been going through a period of extensive reforms since 1994. Among the tasks that faced the post-apartheid democratic State was the removal of race-based and spatial inequities in the social security system. Like Namibia, South Africa has a mid-level ranking in the medium human development category of the HDI, although the country aspires to reach the level of high human development.

Table A4. South Africa: Key indicators

GDP (current US$) (billions)	2008	276.8
GNI per capita, Atlas method (current US$)	2008	5 820
External debt stocks (% of GNI)	2007	15.8
Life expectancy at birth, total (years)	2007	50
Population, total (millions)	2008	48.7
Population growth (annual %)	2008	1.7
School enrolment, primary (% net)	2007	85.8
Surface area (sq. km) (thousands)	2008	1 219.1
HDI ranking	2009	129

Sources: World Bank, 2009; UNDP, 2009.

Policy framework

The Constitution of the Republic of South Africa of 1996, section 27(1)(c) entrenches social security as a right and mandates the State to take reasonable legislative and programme measures to progressively realize the right to social security. Major reforms to social security provision have been under way and have led to the establishment of new and amended pieces of legislation to regulate social assistance and social insurance including medical aid, unemployment insurance and pension fund arrangements. These include the Social Assistance Act of 2004 and the Unemployment Insurance Fund Act of 2001, among many others. The South African Government has adopted an approach that is consistent with comprehensive social protection and at a policy level sees health care, education, work-related benefits and social assistance in the form of cash grants and programmes to address poverty as part of its response.

Table A5. South Africa: Selected social indicators, 2004–08

	2004	**2006**	**2008**
Social grants beneficiary numbers (thousand)	9 407	11 983	13 386
Percentage of households			
In the bottom quintile receiving any grant income	40.2	69.4	75 (est.)
Reporting children often or always going hungry	5.2	2.4	2.0
Percentage of children aged 7–18 in school	94.3	94.1	94.7 (2007)
Public health professionals per 100,000 uninsured	20 (2003)	24	26
South Africans			
Infant mortality under age 1 per 100,000 births	48.8	46.5	45.2 (2007)

Source: South Africa, National Treasury, 2009.

Financing

Policy and legislative reforms of social security are matched by significant government budget allocations to extend social security in the form of social assistance (social grants) to those who qualify (refer to table on social grant expenditure) Since 1994, the Government has significantly expanded its expenditure on social grants.

Table A6. South Africa: Social grants expenditure, 2005–06 to 2011–12 (percentage of GDP)

	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12
				Preliminary outcome	Medium-term estimates		
R million							
Social grants transfers	50 708	57 032	62 467	71 161	80 380	88 126	95 237
SASSA administration	3 324	3 819	4 551	4 610	5 135	5 589	6 047
Total	54 032	60 851	67 018	75 771	85 515	93 715	101 284
Percentage of GDP	3.40	3.40	3.20	3.30	3.50	3.50	3.40

Source: South Africa, National Treasury, 2009.

Social grants are funded from general tax revenue. Slow but sustained economic growth over the past decade has seen government expenditure on social grants remain within 3.2–3.5 per cent of GDP.

Programmes

South Africa has non-contributory social assistance programmes in the form of cash transfers for the following categories:

- CSG. The grant aims at alleviating child poverty and is paid up to the age of 16 to the carer of the child living in income-poor households. The take-up of this grant has increased over the last four years and today (2010) reaches millions of children.
- Social old-age pension. The pension is provided to income-poor elderly females aged 60 and above, and males aged 63 years and above. The pension age for males is progressively being lowered to 60 years of age.
- Disability grant. The grant is paid to medically diagnosed income-poor people with disabilities between the ages of 18 and 60 if female, and 18 and 65 years if male. A grant for income-poor AIDS patients is also provided.
- A foster care grant is paid for the care of children who are placed by Court Order in foster care and who are between the ages of 0 and 18 years. Extension orders from a Court can ensure that the grant is paid until the age of 21 if the child is still in school.
- A care dependency grant is paid for the care of disabled children between the ages of 1 and 18 years.
- Pension for war veterans.
- Relief of social distress.

Although social grant beneficiaries are required to meet a means test, in effect the social old-age pension and the CSG are almost universal because of income poverty as a result of unemployment and lack of paid work.

Contributory social security

An Unemployment Insurance Fund (UIF) provides unemployment benefits for those in the employment sector, and also benefits for maternity leave and for those employees who become sick or disabled as a result of their employment. The Fund is built up by contributions from employees and employers, with the State contributing a further 25 per cent of the cost.

A Road Accident Fund funded through a dedicated fuel levy is used to provide relief to persons injured in car accidents.

South Africa has a well-established private sector contributory (employer–employee) benefit system for those in full-time permanent jobs. The State runs its own retirement scheme for state employees and there are a number of private retirement pensions for persons employed outside the state sector. Nevertheless, the pension system excludes 42 per cent of the formally employed whose earnings levels are too low to allow them to gain membership or whose conditions of work in certain sectors disallow them from participation. It is these people who reach retirement without savings and income security and who fall back on the state social pension.

Huge gaps also exist in the social protection of the unemployed, the jobless, and persons working in the informal sector and in the rural economy.

Administration

Non-contributory social protection measures are funded by the Government with oversight provided by the Department of Social Development and implementation by South African Social Security Agency (SASSA) – a government-funded agency.

Lessons from experience

(1) Since 1994, the State has moved swiftly to entrench social protection as a right and to give effect to this right through significant programme interventions.

(2) The reform process included a wide range of stakeholders representing workers, civil society organizations, government and the private sector.

(3) Active and organized civil society mobilization for effective poverty reduction through social grants reinforced the government move to expand social assistance.

(4) Various investigations into social security reform also included the costing of such reforms and the need for the removal of significant barriers to access on the basis of race, gender, age, disabilities, and other forms of exclusion.

(5) Government-funded social assistance programmes in the form of cash transfers are the most efficient and extensive anti-poverty strategies. Cash transfers today reach over 13 million people (see table A5).

(6) Despite the extensive cash transfer programmes, large numbers of untrained people remain jobless and live in extreme poverty owing to South Africa's history of apartheid and social exclusion. It is estimated that close to 30 per cent of working-age adults are in chronic poverty because of structural unemployment.

(7) In the absence of cash transfers in the form of social and other grants, over 50 per cent of households would fall below a minimum subsistence level. By 2002, existing social assistance programmes had reduced the poverty gap by 23 per cent.

(8) Cash transfers combined with access to primary health care, primary education and free basic services such as water, sanitation and housing have reduced inequality.

AI.2. Extending social health protection

Given the epidemiological crisis in the region, extending and reforming social health protection in Africa is not an option; it is an imperative. All indicators (see Chapter 2) point to high mortality rates, low life expectancy at birth, widening malnutrition and the increasing spread of infectious diseases. The effects on individuals and their families, on communities and on entire economies are catastrophic. While governments in the region are working to address the need for reform and expansion of health, the global environment supports the urgent need for health reform and access to quality affordable health-care services.

Since the Bamako Initiative (1987), there have been some advances in health-care reform in certain countries in the region. The Bamako Initiative placed emphasis on increasing access to primary health care by raising the effectiveness, efficiency, financial viability and equity of health services. The aim was to promote an integrated minimum health-care package in order to meet basic community health needs, focus on access to medicaments and enable regular contact between health-care providers and communities. Many countries in Africa adopted the Bamako Initiative and sought to scale up health services. Other global campaigns led by the WHO and the ILO also provided the impetus for health reforms.

In this section eight country case studies are presented to illustrate how the core challenges in extending social health protection are being addressed. It is important to reiterate here that the experience provided by these studies demonstrates that even under very complex conditions it is possible to bring together multiple partners to agree on the direction of health reforms.

Burkina Faso

Burkino Faso is a medium-sized landlocked country covering 274,000 square kilometres, with a population of 15.2 million in 2008 and population growth of 2.8 per cent per annum. There is low life expectancy at birth, of 52 years, while GDP for 2008 was US$7.9 billion.

Burkina Faso ranks as one of the lowest in terms of the HDI at position 177 out of 182, and the country has historically been poorly served by inadequate social protection mechanisms. Health-care coverage was extremely limited with total formal coverage estimated at 0.2 per cent and out-of-pocket expenditure at 52.2 per cent of total health expenditure. A number of factors related to poverty, mortality rates and low human development drove the need for health-care reform.

Policy reforms

Over the last 20 years new initiatives have been put in place to provide social security, particularly in the health sector. Significant policy shifts and organizational reforms have taken place over the last decade. New organizations to support health care, to promote microinsurance (mainly for the agricultural sector) and to secure basic human needs have been formed. This has largely been the result of increased activity by the Directorate for Mutual Benefit Associations within the Ministry of Employment, Labour and Social Security.

Table A7. Burkina Faso: Key indicators

GDP (current US$) (billions)	2008	7.9
GNI per capita, Atlas method (current US$)	2008	480
External debt stocks (% of GNI)	2007	21.7
Life expectancy at birth, total (years)	2007	52
Population, total (millions)	2008	15.2
Population growth (annual %)	2008	2.9
School enrolment, primary (% net)	2008	58.1
Surface area (sq. km) (thousands)	2008	274.0
HDI ranking	2009	177

Sources: World Bank, 2009; UNDP, 2009.

Financing

Health-care spending in Burkina Faso increased from F7.7 billion in 1990 to F33 billion in 2000. The spending focused on decentralized health care, including increased attendance at public primary health-care facilities (of which many more were provided), the provision of essential drugs and drug regimes, and the general liberalization of health-care provision in both the public and private sectors. Over the reform period there was a perceptible shift in health expenditure allocation with proportionately more funds being spent on investment in the system (mainly infrastructure) compared to expenditure on staffing costs.

Essential to the programme was the implementation of cost-recovery mechanisms to partly cover the cost of improved health care. General government expenditure on health as a percentage of total expenditure on health increased notably, from 39.6 per cent in 2000 to 56.9 per cent in 2006 (table A8). At the same time out-of-pocket expenditure dropped from 94.4 per cent to 91.5 per cent, indicating some improvement in access to health care.

External resources for health have increased, so that total social security expenditure on health as a proportion of general government expenditure has decreased from 0.8 per cent in 2000 to 0.2 per cent in 2006. This could be because of the mixed financing arrangements that are now in place in Burkina Faso, as can be seen from table A8. Significant community-based microinsurance schemes, external resources and increases in private expenditure are widening access to health care.

Table A8. Burkina Faso: Health expenditure, 2000 and 2006

	2000	2006
Total expenditure on health as % of gross domestic product	5.1	6.3
General government expenditure on health as % of total expenditure on health	39.6	56.9
Private expenditure on health as % of total expenditure on health	60.4	43.1
General government expenditure on health as % of total government expenditure	8.9	15.8
External resources for health as % of total expenditure on health	13.9	32.9
Social security expenditure on health as % of general government expenditure on health	0.8	0.2
Out-of-pocket expenditure as % of private expenditure on health	94.4	91.5
Private prepaid plans as % of private expenditure on health	1.0	2.1
Per capita total expenditure on health at average exchange rate (US$)	11	27
Per capita total expenditure on health (PPP int. $)	41	73
Per capita government expenditure on health at average exchange rate (US$)	4	15
Per capita government expenditure on health (PPP int. $)	16	41
Total formal coverage as % of population (state, social, private and mutual health insurance schemes)	0.2	–

Sources: WHO, 2009; ILO, 2008g.

Improvements in health-care delivery

There was greater public oversight over regional district health facilities and the supply of drugs was rationalized. Legislation was introduced to promote development of the private health-care sector. Hospital governance was targeted with a view to improving the operation of the hospitals.

Lessons from experience

(1) There was strong political and policy support for health-care reform with both national and international partners' involvement in the process.

(2) A mixed financing approach was introduced, with contributions from government, community-level microinsurance schemes, the private sector and external resources. This meant that increases in government expenditure on health could be phased in gradually.

(3) Within the health sector staffing requirements were neglected; this had an impact on the quality of and access to primary health care.

(4) Despite these significant reforms and increases in resources the results hoped for were not achieved: there was no significant increase in the use of primary care services. This is because the improved access to primary health facilities and the improved availability of drugs was hindered by the increase in costs to patients. As the country introduced partial cost recovery charges for health care there was a decrease in the use of public health facilities (Haddad et al, 2006).

Egypt

Although Egypt is a low-income country with a slow moving economy and low growth, and also with high levels of unemployment and poverty, it has a wide network of health-care facilities and options available to its citizens. Egypt has a small but well established health insurance system operated by the Health Insurance Organization (HIO) which covers approximately 50 per cent of the population. In-patient care is mainly provided in hospitals that are run and owned by the HIO. Nearly a third of health expenditure is spent on pharmaceuticals of one sort or another. However, there are too many uncoordinated role-players in the provision of health services and too little quality assurance. In addition the private sector appears to be somewhat under-regulated.

Table A9. Egypt: Key indicators

GDP (current US$) (billions)	2008	162.8
GNI per capita, Atlas method (current US$)	2008	1 800
External debt stocks (% of GNI)	2007	23.2
Life expectancy at birth, total (years)	2008	70
Population, total (millions)	2008	81.5
Population growth (annual %)	2008	1.8
School enrolment, primary (% net)	2007	95.7
Surface area (sq. km) (thousands)	2008	1 001.5
HDI ranking	2009	123

Sources: World Bank, 2009; UNDP, 2009.

Policy reforms

In 1997 the Government started a process of health-care reform, designed to run until 2018, to improve the provision, quality and efficiency of the health-care system. A key aspect of the reform is a family health model that focuses on developing and improving district health-care services through a more decentralized approach. The main constraint is the lack of administrative and management capacity to develop the scheme in the more difficult areas of the country.

Financing

The social health insurance system is funded by contributions of up to 4 per cent of an individual's salary, of which the employee pays 25 per cent and the employer the balance. There are lower rates for pensioners and widows and a subsidized rate for state employees. Benefits under the social insurance system are considerably higher than those offered by the public health system. There is also a plan in place to improve the coverage of the scheme, particularly for employed persons.

Table A10. Egypt: Health expenditure, 2000 and 2006

	2000	**2006**
Total expenditure on health as % of gross domestic product	5.6	6.3
General government expenditure on health as % of total expenditure on health	40.1	41.4
Private expenditure on health as % of total expenditure on health	59.9	58.6
General government expenditure on health as % of total government expenditure	7.5	7.3
External resources for health as % of total expenditure on health	1.0	0.8
Social security expenditure on health as % of general government expenditure on health	23.8	26.4
Out-of-pocket expenditure as % of private expenditure on health	94.1	94.9
Private prepaid plans as % of private expenditure on health	0.4	0.2
Per capita total expenditure on health at average exchange rate (US$)	82	92
Per capita total expenditure on health (PPP int. $)	208	320
Per capita government expenditure on health at average exchange rate (US$)	33	38
Per capita government expenditure on health (PPP int. $)	84	132
Total formal coverage as % of population (state, social, private and mutual health insurance schemes)	47.6	–

Sources: WHO, 2009; ILO, 2008g.

Lessons from experience

(1) Expansion of health-care coverage is an ongoing process; improved and expanded coverage is not yet evident.

(2) Increases in government health-care expenditure were phased in and priority was given to decentralizing health-care services to widen the reach of such services.

(3) In the reform process emphasis was given to making family health care affordable and accessible.

(4) Pharmaceutical companies need to be included in health-care reform initiatives so that they can also commit to reducing the high costs of drugs and related medical supplies.

Kenya

Kenya has achieved impressive economic growth in recent years, leading to a fall in poverty by 10 per cent to 46 per cent of the population since 2000. Nevertheless, deep social, ethnic and regional inequalities remain. While Kenya is on track for full or partial achievement of some MDGs, the goals on child mortality and maternal health will probably not be achieved, according to current projections. A significant constraint for accessing good quality health care, besides a lack of funds by households, is the shortage of qualified health-care personnel, especially in rural areas.

Just over half of total health expenditure is out-of-pocket, while 16 per cent is raised through the statutory National Hospital Insurance Fund (NHIF). The NHIF was established in 1966, making Kenya the first country in Africa to introduce compulsory health insurance. The NHIF covers workers in the formal sector and the self-employed; a recent extension is that pensioners and "organized groups" can enrol voluntarily. In total, the scheme has 1.5 million members constituting together with their dependants 25 per cent of the population (2007). The scheme covers in-patient medical needs and most admissions for a fixed number of days.

Table A11. Kenya: Key indicators

Population, total (millions)	2008	39.8
GDP per capita (PPP int. $)	2008	1 711
Life expectancy at birth, total (years)	2007	53
Infant mortality rate per 1,000 live births	2007	80
Under-5 mortality per 1,000 live births	2007	121
Maternal mortality per 100,000	2007	410
Health expenditure per capita (US$)	2006	105
Staff-related access deficit (%)	2008	60
Skilled birth attendance access deficit (%)	2008	58

Sources: ILO, 2008g; UNICEF, 2009; IMF, 2009b; WHO, 2009.

A draft bill for a national social health insurance fund (NSHIF) was submitted to Parliament in 2004 has not yet been passed because of budgetary concerns on the part of the Government. The NSHIF was planned as a compulsory insurance scheme with solidarity-based and income-rated contributions. Coverage was to extend to the entire population, thus achieving access to affordable health care for all. Furthermore, the establishment of a strong Fund for health services was expected to lead to significant cost savings and efficiency gains.

The ILO estimates that 60 per cent of the population have no effective access to health services when needed.

Rwanda

With the highest population density in Africa (approximately 300 people per square kilometre), Rwanda has had to make extraordinary efforts to rebuild its health-care structure and infrastructure following the devastating genocide of the mid-1990s when over a million people died and many more fled the country. The genocide left the country with a significant shortage of health-

care professionals, while the physical and social infrastructure and the economy were virtually destroyed.

Table A12. Rwanda: Key indicators

GDP (current US$) (billions)	2008	4.5
GNI per capita, Atlas method (current US$)	2008	410
External debt stocks (% of GNI)	2007	14.9
Life expectancy at birth, total (years)	2008	50
Population, total (millions)	2008	9.7
Population growth (annual %)	2008	2.8
School enrolment, primary (% net)	2007	93.6
Surface area (sq. km) (thousands)	2008	26.3
HDI ranking	2009	167

Sources: World Bank, 2009; UNDP, 2009.

Policy reforms

Following 1996 a new health-care plan was introduced in a document called Vision 2020 which, in the spirit of the Bamako Initiative, focused on:

- primary health care;
- decentralization;
- community participation in health;
- development of human resources;
- strengthening of the health information system; and
- an inter-sectoral approach to health.

A social insurance scheme has also been implemented, designed to provide mainly poor communities with health- and related services. A medical insurance regime for public servants was established in 2001. For salaried employees in the private sector, medical care is ensured by their respective employers. Employers may choose either to be affiliated with the scheme for public servants or to contract with private insurance companies. The general population, including those in rural areas and working in the informal sector, obtains medical care through mutual associations, which have developed at a rapid rate since 2001. A large majority (85 per cent) of the Rwandan population is now covered by these insurance programmes, according to figures (2008) from the Ministry of Finance and Economic Planning. Members have access to all services and medicines offered at health centres and hospitals. Coverage excludes prostheses and cosmetic surgery.

Institutional capacity

Implementing the policy direction requires both institutional capacity as well as finances. The Rwandan Government is steadily working towards achieving this goal. The country established the Kigali Health Institute primarily to train health-care professionals for the country (mainly technicians and nursing staff).

Table A13. Rwanda: Health expenditure, 2000 and 2006

	2000	**2006**
Total expenditure on health as % of gross domestic product	4.2	10.9
General government expenditure on health as % of total expenditure on health	39.2	42.5
Private expenditure on health as % of total expenditure on health	60.8	57.5
General government expenditure on health as % of total government expenditure	8.2	18.8
External resources for health as % of total expenditure on health	52.0	52.4

	2000	2006
Social security expenditure on health as % of general government expenditure on health	6.4	4.1
Out-of-pocket expenditure as % of private expenditure on health	40.7	38.6
Private prepaid plans as % of private expenditure on health	0.9	9.2
Per capita total expenditure on health at average exchange rate (US$)	9	33
Per capita total expenditure on health (PPP int. $)	24	89
Per capita government expenditure on health at average exchange rate (US$)	4	14
Per capita government expenditure on health (PPP int. $)	9	38
Total formal coverage as % of population (state, social, private and mutual health insurance schemes)	36.6	–

Sources: WHO, 2009; ILO, 2008g.

Financing

Rebuilding and expanding access to primary health care has required a substantial increase in health funding backed by solid political stability and support. That such support has been forthcoming is clear from health expenditure increases in 2008 to 12 per cent of the national budget, up from 4.25 per cent in 1996. Of this, 60 per cent has been decentralized in the form of resources to the various health districts.

Funding for the newly introduced social insurance scheme and strategy comes mainly from donor sources and requires more long-term and sustainable forms of funding than are presently available.

For public servants the contribution rate is 15 per cent of basic salary, of which 7.5 per cent is paid by the employer and 7.5 per cent by the employee. For military personnel the contribution rate is 22.5 per cent of gross salary, of which 17.5 per cent is paid by the Government and 5 per cent by military staff member. Mutual health-care insurance programmes are supported by household-based contributions. The head of household usually pays a collective contribution for all dependants equal to RwF1,000 per household member per year. The amount paid by an insured individual is fixed at 10 per cent of the total cost of health treatment provided. The extremely poor are exempted from paying these fees and are given free access to the facility.

Lessons from experience

(1) The WHO reports that there have been some significant improvements in health care, particularly in the battle against HIV and AIDS which is showing a downward trend in the prevalence of the disease. Rwanda has developed some of the highest health-care coverage in the developing world, with all workers in the formal sector covered through either public or private schemes, and the rest of the population covered by the community-based health mutual insurances. Rwanda's health mutuals are said to be a success story in Africa, playing an especially significant role in eradicating malaria (Logie et al., 2008).

(2) Like many African countries, Rwanda does not have sufficient trained health staff. Most districts in the country have only two doctors per 100,000 population, which is well below the minimum suggested by WHO of ten doctors per 100,000 (ibid.).

(3) The Government has a number of challenges to deal with, particularly a high population growth rate of 2.8 per cent per annum. As this is likely to place a great deal of pressure on government resources, reproductive health, women's health and education will probably be the major focus to ensure effective family health and population development.

(4) A further challenge comes from the high number of orphans in the country who have to be cared for both financially and from a health-care perspective.

Senegal

Over the last 30 years the Government of Senegal has prioritized health-care provision; as a result the health budget tripled between 1980 and 2000. Health indicators show an improvement and life expectancy (at birth) has increased significantly as compared to many African countries. The country also has a relatively low HIV and AIDS prevalence rate. Nevertheless, there are still large

disparities in Senegal's health system and coverage. The bulk of high-level health-care professionals (including doctors, dentists and pharmacists) live in the capital, Dakar. The distribution of health-care services is therefore problematic; for many Senegalese, securing good basic health care can be costly and time consuming

Table A14. Senegal: Key indicators

GDP (current US$) (billions)	2008	13.2
GNI per capita, Atlas method (current US$)	2008	970
External debt stocks (% of GNI)	2007	23.4
Life expectancy at birth, total (years)	2008	56
Population, total (millions)	2008	12.2
Population growth (annual %)	2008	2.6
School enrolment, primary (% net)	2007	71.9
Surface area (sq. km) (thousands)	2008	196.7
HDI ranking	2009	166

Sources: World Bank, 2009; UNDP, 2009.

Policy reforms

The Ministry of Health and Prevention has made good progress in achieving the health-related MDGs over the past decade. In recent years the Ministry of Health has launched a 10-year National Health Development Plan that seeks to provide better coordination of health-care provision across the country and improved usage and efficiency of donor assistance.

As part of its poverty prevention strategies Senegal is hoping to improve the social protection system to provide insurance cover for up to half the population by 2015. This improvement in social security will contribute considerably to the ongoing efforts to improve the quality of health care.

Table A15. Senegal: Health expenditure, 2000 and 2006

	2000	**2006**
Total expenditure on health as % of gross domestic product	4.3	5.8
General government expenditure on health as % of total expenditure on health	36.9	56.9
Private expenditure on health as % of total expenditure on health	63.1	43.1
General government expenditure on health as % of total government expenditure	8.5	12.0
External resources for health as % of total expenditure on health	17.4	12.3
Social security expenditure on health as % of general government expenditure on health	17.9	4.0
Out-of-pocket expenditure as % of private expenditure on health	91.7	77.0
Private prepaid plans as % of private expenditure on health	7.1	19.5
Per capita total expenditure on health at average exchange rate (US$)	20	44
Per capita total expenditure on health (PPP int. $)	54	92
Per capita government expenditure on health at average exchange rate (US$)	7	25
Per capita government expenditure on health (PPP int. $)	20	52
Total formal coverage as % of population (state, social, private and mutual health insurance schemes)	11.7	–

Sources: WHO, 2009; ILO, 2008g.

Financing

General government expenditure on health care has increased (table A15) with the total formal coverage of the population at 11.7 per cent. Out-of-pocket expenditure has dropped significantly

from a high of 91.7 per cent in 2000 to 77 per cent in 2006, which would indicate that health care is becoming more affordable.

A United States (USAID) funded project has been working with 149 local governments in 22 health districts and has benefited more than a third of the Senegalese population. Part of the programme includes providing matching funding to provide resources for local health needs and to improve the training of local health-care workers (USAID, 2009).

Lessons from experience

(1) Working in partnership with international development assistance, the Government has been able to implement a number of reforms and to fund the provision of district-level health-care services.

(2) Senegal has adopted a twin strategy of building on and improving a district health-care system as well as improving the network and quality of state hospitals. There has been no trade-off between improvements in the quality of care within hospitals and the extension and expansion of health-care services at district levels.

Sierra Leone

The social health protection scheme in Sierra Leone is currently based on tax-funded services that are hardly affordable, often unavailable and of poor quality. Financial protection for user fees and out-of-pocket payments is absent.

As a result, Sierra Leone's health indicators are among the worst in the world. The low life expectancy and the high infant and maternal mortality rates are indicative of the severe problems in access to adequate and timely health care. The access deficit indicators show that the large majority of the population does not have access to adequate health care as a result of insufficient availability and/or training of health-care personnel, and that the majority of pregnancies and deliveries occur without adequate maternal care.

Table A16. Sierra Leone: Key indicators

Population, total (millions)	2008	5.1
GDP per capita (PPP int. $)	2004	310
Life expectancy at birth, total (years)	2004	37–40
Infant mortality rate per 1,000 live births	2004	165
Under-5 mortality per 1,000 live births	2004	286
Maternal mortality per 100,000	2004	1 300–2 000
Health expenditure per capita (US$)	2007	7.5
Staff-related access deficit (%)	2007	88
Skilled birth attendance access deficit (%)	2007	58

Sources: ILO, 2008g; UNICEF, 2009; IMF, 2009b; WHO, 2009.

Against this background, the Government of Sierra Leone together with the workers' and employers' representatives have committed themselves to progress by introducing the Sierra Leone Social Health Insurance scheme (SLESHI). SLESHI is designed as a universal, unitary national scheme that covers the entire population, including the vulnerable and poor. Related reform discussions are currently under way.

It is suggested that the benefits of the scheme include primary health-care services and limited secondary care at district-level hospitals. It is also envisioned that the SLESHI benefits will complement existing donor programmes, for example those on maternal protection, and that the benefit package will include coverage of catastrophic health-care expenditure. The establishment of SLESHI should be accompanied by strong efforts to upgrade health-care facilities and improve the quality of care at all levels.

Financing might be based on funds from various sources, such as taxes and contributions, thus ensuring that sufficient funds are generated and financial sustainability achieved. It is proposed that

contributions for the most vulnerable and poor be waived and covered by taxes, while economically active workers earning income should contribute according to their capacity to pay. Other sources of funding include the introduction of an employers' contribution and it is suggested to redirect a proportion (2–3 per cent) of both the general goods and service tax as well as VAT revenue towards the scheme.

The ILO is strongly supporting the development of SLESHI and the related preparatory work.

Tunisia

Tunisia, ranked as a medium HDI country, has an efficient and effective health-care system dominated by the public sector, but with a growing private sector in recent years. The country has a strong integrated approach to health-care provision through creating linkages with national economic development plans. There is a network of basic health-care centres across the country so that primary health care is readily accessible. Most Tunisians live in close proximity (within 5 kilometres) of such a facility.

Table A17. Tunisia: Key indicators

GDP (current US$) (billions)	2008	40.2
GNI per capita, Atlas method (current US$)	2008	3 290
External debt stocks (% of GNI)	2007	60.8
Life expectancy at birth, total (years)	2007	74
Population, total (millions)	2008	10.3
Population growth (annual %)	2008	1.0
School enrolment, primary (% net)	2007	95.0
Surface area (sq. km) (thousands)	2008	163.6
HDI ranking	2009	98

Sources: World Bank, 2009; UNDP, 2009.

Table A18. Tunisia: Health expenditure, 2000 and 2006

	2000	**2006**
Total expenditure on health as % of gross domestic product	5.6	5.1
General government expenditure on health as % of total expenditure on health	48.5	44.2
Private expenditure on health as % of total expenditure on health	51.5	55.8
General government expenditure on health as % of total government expenditure	6.8	6.7
External resources for health as % of total expenditure on health	0.9	0.9
Social security expenditure on health as % of general government expenditure on health	26.7	25.2
Out-of-pocket expenditure as % of private expenditure on health	81.7	81.7
Private prepaid plans as % of private expenditure on health	16.6	16.6
Per capita total expenditure on health at average exchange rate (US$)	114	156
Per capita total expenditure on health (PPP int. $)	271	355
Per capita government expenditure on health at average exchange rate (US$)	55	69
Per capita government expenditure on health (PPP int. $)	131	157
Total formal coverage as % of population (state, social, private and mutual health insurance schemes)	99	–

Sources: WHO, 2009a; ILO, 2008g.

Policy approach

The country's social health protection system is highly ranked and has led to a life expectancy of 74 being attained. It is one of the few countries in Africa to achieve almost universal coverage through insurance provided by either public or private schemes. Public insurance is provided through the National Pension and Social Provision Fund. In addition, poor and low-income individuals are provided with free health care. The health insurance system nevertheless faced a series of problems during the 1990s: these included difficulties regarding efficiency, quality, equity, and satisfaction of stakeholders and users.

Financing

Government expenditure on health as a percentage of total health expenditure shows declines from 48.5 per cent in 2000 to 44.2 per cent in 2006 (table A18). While expenditure patterns show a slight decrease, total health-care coverage remains stable at 99 per cent.

Lessons from experience

(1) Tunisia has achieved excellent health-care coverage through strong government-led reform initiatives. Current reform efforts are aimed at maintaining the effectiveness and efficiencies achieved, improving the financing of health care and developing an appropriate mix between the growing private sector and the public sector.

(2) There are also increased efforts to overcome the disparities that exist between the well-resourced coastal areas and the more rural inland areas. This reform is taking place in the context of diminishing donor assistance, since the country's key social indicators are showing improvement.

(3) The cost and responsibility for payment contributions of both employers and employees is unequally distributed, and out-of-pocket expenses remain relatively high.

Uganda

Uganda has made progress in reducing poverty in recent years but still faces severe problems in health-care coverage and health status. Its mortality rates for mothers, infants and children are among the highest in the world, but life expectancy has increased and the ratio of the poor decreased since the beginning of the decade. Its skilled birth attendance access deficit is higher than that of countries with much lower health expenditure per capita (for example, Sierra Leone). Because of insufficient staffing levels at health-care facilities, over three-quarters of the population have no access to health care.

Table A19. Uganda: Key indicators

Population, total (millions)	2008	32.7
GDP per capita GDP (PPP int. $)	2007	320
Life expectancy at birth, total (years)	2008	52
Infant mortality rate per 1,000 live births	2008	75
Under-5 mortality per 1,000 live births	2008	137
Maternal mortality per 100,000	2008	435
Health expenditure per capita (US$)	2007	27
Staff-related access deficit (%)	2008	78
Skilled birth attendance access deficit (%)	2008	61

Sources: ILO, 2008g; UNICEF, 2009; IMF, 2009b; WHO, 2009.

The draft of the National Health Sector Policy 2010–20 explores the concepts of universal coverage and social health protection (specifically risk-pooling and prepayment). This is in accordance with government aims to achieve access for all to a minimum package of services, to ensure equitable distribution of services and to make more effective and efficient use of health resources.

Against this background, the Government has recently launched an initiative to reform social health protection in the country with a view to achieving universal coverage. The reform will build on experience with social health insurance. The possible roles of the existing social security institution (the National Social Security Fund – NSSF) and a new national health insurance scheme are currently being evaluated with a view to covering different groups of the population as well as sharing administrative functions.

A national health insurance is proposed, which would ultimately become a mandatory scheme for all residents of Uganda, financed by contributions, offering a minimum health services package and managed by an independent government agency.

The issues currently being debated refer to the appropriate strategy for achieving universal coverage for all citizens and residents. The current plan foresees a timeframe of 15 years to reach universal coverage, rolling out coverage in the initial stages to civil servants only. In later stages the formal sector would be covered and universal coverage, including for informal economy workers and their families, would be achieved. Furthermore, the NSSF is planning to broaden its range of benefits for its members from the formal sector to health-care services.

Uganda is an example of a pluralistic and gradual approach to extending social health protection coverage. The need for coordination within the existing and proposed structures of social health protection is evident, and the potential benefits of managing the various approaches with a view to universality and equitable access are clear: coverage could be extended through using the most efficient mix of existing and new structures, for example, covering the existing NSSF membership through an extension of NSSF benefits and also ensuring that from the beginning the reform benefits broad population groups, including the poor and informal workers.

AI.3. Some conclusions and lessons from case studies

Individual country experience is rich in detail on how to navigate and introduce reforms to extend social protection. The case studies show that it is possible for low- and medium-income countries to achieve improvements in health and income poverty through systematic actions led by governments. In countries that have taken an integrated approach to both economic and social goals, human development and economic growth have both achieved success. In this concluding section some of the main features of these experiences are highlighted.

(1) In all 11 country case studies policy reform action was country-led and focused.

(2) Goals, policies and action plans related to income security and social health protection were produced and negotiated within the countries and were supported by national and international partners.

(3) In countries such as Burkina Faso, Mauritius, Namibia, Senegal and South Africa a wide range of non-governmental groups and organizations were involved in the reform process. Although the processes were in most cases government-initiated and led there was an understanding that addressing income and health security requires collective action.

(4) Policy reforms must be matched by effective budget allocations and organizational system reforms.

(5) The international community, including donors, have played an important role in supporting the reform processes.

(6) Measures to ensure access to health care of the poorest can be hindered by the introduction of user fees for cost recovery purposes. Price acts as a barrier to income-poor households.

(7) Social protection systems require extensive monitoring and maintenance.

This review of country cases has shown that despite budget and revenue constraints countries are able to introduce measures to expand both income and health security so that these measures reach the poorest. Where programmes are universal or close to universal rather than means-tested countries have been able to achieve significant success. In Mauritius there was clear evidence that access to education enhanced developments in health and income. Accelerated and focused programme action to extend social protection requires investments in basic health care, education and income transfers, because together these measures provide the vital core for human survival and economic growth.

Appendix II

Statistical appendix

Table SA1. Selected demographic indicators – (a) Overview, various years 2000–10

	Total population (thousands)	**Urban population** (% of total)	**Sex ratio** (males per 100 females)	**Population growth rate** (%)		**Infant mortality rate** (per 1,000)	**Total fertility rate**	**Mortality under age 5** (per 1,000)	**Distribution by age** (%)		
									0–14	**15–64**	**65+**
	2007	**2007**	**2007**	**2000–05**	**2005–10**	**2005–10**	**2005–10**	**2005–10**			**2007**
Algeria	33 858	61.1	101.9	1.5	1.5	31.1	2.4	33	28.3	67.1	4.6
Angola	17 024	38.4	97.3	2.8	2.8	131.9	6.4	231	46.1	51.5	2.4
Benin	9 033	47.3	101.7	3.2	3.1	98.0	5.4	146	43.7	53.6	2.7
Botswana	1 882	49.8	98.9	1.3	1.2	46.5	2.9	68	34.6	61.9	3.5
Burkina Faso	14 784	18.4	100.2	3.2	2.9	104.4	6.0	181	45.8	51.1	3.0
Burundi	8 508	10.8	95.9	2.9	3.9	99.4	6.8	169	44.4	53.0	2.5
Cameroon	18 549	49.5	99.9	2.3	2.1	87.5	4.3	144	41.1	55.3	3.5
Cape Verde	530	59.2	92.7	2.4	2.3	24.6	3.4	29	38.5	57.4	4.1
Central African Republic	4 343	42.9	95.3	1.7	1.8	96.8	4.6	163	42.3	53.9	3.8
Chad	10 781	25.5	98.8	3.7	3.0	119.2	6.2	189	46.2	50.9	2.9
Comoros	839	37.6	100.7	2.7	2.5	48.4	4.3	63	41.5	55.7	2.7
Congo	3 768	62.2	98.4	2.5	2.1	70.3	4.5	102	41.8	55.0	3.2
Congo, Dem. Rep. of the	62 636	33.2	98.1	2.8	3.2	113.5	6.7	196	47.3	50.1	2.6
Côte d'Ivoire	19 262	45.5	103.0	1.8	1.8	116.9	4.5	183	41.0	55.7	3.2
Djibouti	833	84.0	99.9	2.2	1.7	85.3	3.9	126	37.3	59.6	3.1
Egypt	75 498	43.3	100.2	1.8	1.8	29.3	2.9	34	32.7	62.4	4.9
Equatorial Guinea	507	53.7	98.0	2.3	2.4	92.3	5.4	155	42.2	53.7	4.1
Eritrea	4 851	21.1	96.4	4.1	3.4	55.3	5.0	77	42.9	54.7	2.4

	Total population (thousands)	**Urban population** (% of total)	**Sex ratio** (males per 100 females)	**Population growth rate** (%)		**Infant mortality rate** (per 1,000)	**Total fertility rate**	**Mortality under age 5** (per 1,000)	**Distribution by age** (%)		
									0–14	**15–64**	**65+**
	2007	**2007**	**2007**	**2000–05**	**2005–10**	**2005–10**	**2005–10**	**2005–10**			**2007**
Ethiopia	83 099	16.4	99.0	2.6	2.5	86.9	5.3	145	43.8	53.2	2.9
Gabon	1 331	92.6	100.1	1.8	1.5	53.8	3.1	86	34.9	60.5	4.6
Gambia	1 709	24.5	100.3	3.2	2.7	74.2	4.7	128	40.8	55.3	3.9
Ghana	23 478	46.3	102.8	2.3	2.0	56.6	3.8	90	38.2	58.1	3.7
Guinea	9 370	39.8	101.9	1.9	2.1	102.5	5.4	156	43.1	53.7	3.1
Guinea-Bissau	1 695	36.9	97.7	3.0	3.0	112.7	7.1	195	47.7	49.3	3.0
Kenya	37 538	42.1	99.4	2.6	2.6	64.4	5.0	104	42.7	54.7	2.6
Lesotho	2 008	16.6	89.1	1.1	0.7	64.6	3.4	98	39.9	55.4	4.7
Liberia	3 750	45.2	100.0	2.8	4.2	132.5	6.8	205	47.2	50.7	2.2
Libyan Arab Jamahiriya	6 160	86.4	107.4	2.0	2.0	18.0	2.7	20	30.2	65.8	4.0
Madagascar	19 683	27.5	98.9	2.9	2.7	65.5	4.8	106	43.3	53.5	3.2
Malawi	13 925	17.4	98.9	2.7	2.6	89.4	5.6	132	46.9	50.1	3.0
Mali	12 337	40.7	94.9	2.9	3.0	128.5	6.5	200	47.6	48.9	3.5
Mauritania	3 124	69.2	102.5	2.9	2.6	63.0	4.4	92	39.8	56.6	3.6
Mauritius *	1 262	44.5	98.4	0.9	0.8	14.0	1.9	17	23.6	69.7	6.8
Morocco	31 224	62.3	96.7	1.1	1.2	30.6	2.4	36	29.2	65.5	5.3
Mozambique	21 397	38.6	94.3	2.5	2.0	95.9	5.1	164	44.4	52.4	3.2
Namibia	2 074	34.6	97.4	1.6	1.3	42.3	3.2	66	37.5	59.0	3.5
Niger	14 226	25.6	102.9	3.5	3.5	110.8	7.2	188	48.0	48.8	3.2
Nigeria	148 093	46.1	99.9	2.5	2.3	109.5	5.3	187	43.8	53.2	2.9
Rwanda	9 725	24.7	93.2	3.3	2.6	112.4	5.9	188	42.9	54.7	2.4
Sao Tome and Principe	158	39.7	98.2	1.7	1.6	72.3	3.9	95	41.2	54.6	4.2
Senegal	12 379	51.8	99.1	2.6	2.5	65.7	4.7	115	41.6	54.1	4.3
Seychelles	87	–	–	1.2	0.6	–	–	–	–	–	–

	Total population (thousands)	**Urban population** (% of total)	**Sex ratio** (males per 100 females)	**Population growth rate** (%)		**Infant mortality rate** (per 1,000)	**Total fertility rate**	**Mortality under age 5** (per 1,000)	**Distribution by age** (%)		
									0–14	**15–64**	**65+**
	2007	**2007**	**2007**	**2000–05**	**2005–10**	**2005–10**	**2005–10**	**2005–10**			**2007**
Sierra Leone	5 866	41.2	97.0	4.1	2.4	160.3	6.5	278	42.9	53.8	3.3
Somalia	8 699	37.4	98.5	3.0	3.0	116.3	6.0	193	44.3	53.1	2.6
South Africa	48 577	57.8	96.7	1.2	0.6	44.8	2.6	66	31.8	63.7	4.5
Sudan	38 560	41.7	101.4	2.1	2.2	64.9	4.2	105	40.0	56.4	3.6
Swaziland	1 141	21.8	93.6	1.4	0.7	71.0	3.4	114	38.7	58.0	3.3
Tanzania, United Rep. of	40 454	38.8	99.0	2.5	2.5	72.6	5.2	118	44.3	52.7	3.0
Togo	6 585	37.0	97.9	3.0	2.7	88.6	4.8	126	42.8	54.1	3.1
Tunisia	10 327	65.0	101.4	1.1	1.1	19.8	1.9	22	24.7	68.9	6.3
Uganda	30 884	12.7	100.1	3.1	3.2	76.9	6.5	127	49.1	48.4	2.4
Zambia	11 922	37.7	99.3	1.9	1.9	92.7	5.2	157	45.5	51.5	2.9
Zimbabwe	13 349	36.3	98.9	0.8	0.9	58.0	3.2	94	38.5	58.0	3.6
Africa	963 680	39.8	99.3	2.3	2.3	85.3	4.7	140	41.0	56.4	3.4

Note: * Including Agalega, Rodrigues and Saint Brandon.

Source: UN, Department of Economic and Social Affairs, Population Division, *World Population Prospects*, *The 2006 Revision.*

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Table SA1. (b) Fertility, child and maternal mortality and life expectancy at birth, by region, 2000, 2005 and 2009

Major area, region or country	Total fertility rate (per woman)		Infant mortality rate (per 1,000 births)		Mortality under age 5 (per 1,000 births)		Life expectancy at birth						Maternal mortality ratio (per 100,000 live births)	Lifetime risk of maternal death (1 in n)
							Both sexes combined (in years)		Male (in years)		Female (in years)			
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2005	2005
World	2.7	2.5	54	46	81	69	65.8	68.0	63.6	65.8	68.0	70.2	400 [4]	92 [4]
More developed regions [a]	1.6	1.6	8	6	10	8	75.4	77.4	71.7	73.9	79.0	80.8	11 [4]	5 900 [4]
Less developed regions [b]	3.0	2.7	59	50	89	76	63.7	66.0	62.1	64.3	65.5	67.8	450 [4]	76 [4]
Least developed countries [c]	5.0	4.3	95	80	154	128	53.0	56.5	51.8	55.2	54.3	57.8	870 [4]	24 [4]
Less developed regions, excluding least developed countries [d]	2.7	2.4	50	41	71	60	66.0	68.1	64.3	66.3	67.8	70.0	–	–
Less developed regions, excluding China	3.4	3.0	66	55	99	84	61.7	64.1	60.0	62.3	63.4	66.0	–	–
Sub-Saharan Africa [e]	5.6	5.0	100	86	169	143	49.6	52.0	48.2	51.0	51.0	53.1	900 [4]	22 [4]
Africa	***5.1***	***4.5***	***93***	***80***	***156***	***132***	***52.3***	***54.6***	***50.9***	***53.5***	***53.7***	***55.8***	***820*** [4]	***26*** [4]
Eastern Africa [1]	*5.8*	*5.2*	*90*	*73*	*150*	*119*	*49.8*	*54.0*	*48.4*	*53.0*	*51.3*	*54.9*	–	–
Burundi	5.8	4.5	109	96	190	162	46.9	50.9	45.6	49.4	48.1	52.4	1 100	16 [4]
Comoros	4.3	3.9	63	46	85	59	61.8	65.8	59.8	63.6	63.9	68.1	400	52 [4]
Djibouti	4.8	3.8	98	82	146	121	53.6	55.8	52.0	54.4	55.1	57.2	650	35 [4]
Eritrea	5.4	4.5	66	52	96	72	55.9	60.0	53.5	57.6	58.3	62.2	450	44 [4]
Ethiopia	6.2	5.2	94	76	160	126	51.4	55.7	49.9	54.3	53.0	57.1	720	27 [4]
Kenya	5.0	4.9	71	62	114	100	52.8	54.9	51.7	54.5	53.9	55.3	560	39 [4]
Madagascar	5.6	4.6	79	63	125	96	56.5	60.8	55.0	59.2	58.0	62.5	510	38 [4]
Malawi	6.2	5.5	104	80	160	115	51.0	53.9	49.3	52.9	52.8	54.7	1 100	18 [4]
Mauritius [2]	2.0	1.8	16	14	20	17	71.3	72.1	67.6	68.5	75.1	75.8	15	3 300 [4]
Mayotte	4.5	3.0	8	7	10	9	74.7	76.0	71.0	72.3	79.3	80.3	–	–

Major area, region or country	Total fertility rate (per woman)		Infant mortality rate (per 1,000 births)		Mortality under age 5 (per 1,000 births)		Life expectancy at birth						Maternal mortality ratio (per 100,000 live births)	Lifetime risk of maternal death (1 in n)
							Both sexes combined (in years)		Male (in years)		Female (in years)			
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2005	2005
Mozambique	5.7	5.0	108	86	188	145	47.6	48.1	46.0	47.4	49.3	48.8	520	45 [4]
Réunion	2.4	2.4	7	7	10	9	75.3	76.6	71.1	72.5	79.5	80.7	–	–
Rwanda	5.9	5.3	113	97	181	151	43.1	50.7	41.2	48.8	44.9	52.5	1 300	16 [4]
Somalia	6.5	6.4	115	107	191	176	48.4	50.1	46.8	48.7	50.0	51.5	1 400	12 [4]
Uganda	6.8	6.3	87	72	145	118	46.3	53.5	45.6	52.8	46.9	54.1	550	25 [4]
Tanzania, United Republic of	5.7	5.5	82	62	138	100	50.7	56.3	49.6	55.5	51.9	57.1	950	24 [4]
Zambia	6.2	5.7	107	90	182	152	42.0	46.4	40.9	45.8	43.2	46.9	830	27 [4]
Zimbabwe	3.9	3.4	68	54	110	88	43.3	45.7	40.6	45.3	46.2	45.6	880	43 [4]
Middle Africa	*6.4*	*5.5*	*118*	*110*	*201*	*186*	*47.2*	*48.6*	*45.6*	*47.2*	*48.8*	*50.1*	–	–
Angola	6.8	5.6	138	113	240	198	43.6	47.6	41.7	45.6	45.4	49.6	1 400	12 [4]
Cameroon	5.0	4.5	90	85	150	141	51.5	51.4	50.5	50.8	52.5	51.9	1 000	24 [4]
Central African Republic	5.4	4.7	113	103	193	175	46.4	47.4	44.3	45.9	48.6	48.8	980	25 [4]
Chad	6.6	6.1	131	128	213	208	49.3	49.0	47.8	47.7	50.9	50.2	1 500	11 [4]
Congo	4.8	4.3	75	79	120	129	53.6	53.7	52.2	52.8	55.0	54.7	740	22 [4]
Congo, Democratic Republic of	6.9	5.9	121	115	207	195	46.3	47.8	44.7	46.2	48.0	49.4	1 100	13 [4]
Equatorial Guinea	5.8	5.3	108	97	185	164	48.7	50.6	47.3	49.5	50.2	51.8	680	28 [4]
Gabon	4.1	3.2	58	49	90	76	59.9	60.9	57.9	59.6	62.0	62.1	520	53 [4]
Sao Tome and Principe	4.6	3.7	79	71	106	93	63.8	65.9	62.1	63.9	65.5	67.7	–	–
Northern Africa	*3.3*	*2.8*	*51*	*40*	*70*	*54*	*66.0*	*68.4*	*64.3*	*66.6*	*67.7*	*70.2*	*160* [4]	*210* [4]
Algeria	2.6	2.3	42	29	46	31	70.1	72.7	68.8	71.2	71.3	74.1	180	220 [4]
Egypt	3.3	2.8	43	33	51	39	68.2	70.3	66.6	68.6	69.9	72.2	130	230 [4]
Libyan Arab Jamahiriya	3.2	2.6	22	17	24	19	72.3	74.3	70.0	72.0	75.2	77.2	97	350 [4]

Major area, region or country	Total fertility rate (per woman)		Infant mortality rate (per 1,000 births)		Mortality under age 5 (per 1,000 births)		Life expectancy at birth						Maternal mortality ratio (per 100,000 live births)	Lifetime risk of maternal death (1 in n)
							Both sexes combined (in years)		Male (in years)		Female (in years)			
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2005	2005
Morocco	2.7	2.3	42	29	52	34	68.7	71.6	66.6	69.4	70.9	73.9	240	150 [4]
Sudan	5.1	4.1	77	67	127	107	56.1	58.5	54.5	57.0	57.7	60.1	450	53 [4]
Tunisia	2.1	1.8	24	19	27	21	72.6	74.2	70.6	72.1	74.7	76.3	100	500 [4]
Western Sahara	3.2	2.6	59	42	79	52	62.6	66.5	61.0	64.8	64.4	68.7	–	–
Southern Africa	*3.0*	*2.6*	*60*	*46*	*86*	*66*	*55.4*	*51.8*	*52.7*	*50.4*	*58.2*	*53.0*	–	–
Botswana	3.4	2.8	64	34	96	48	50.6	55.1	49.3	55.1	51.9	54.8	380	130 [4]
Lesotho	4.1	3.3	78	67	113	99	50.5	45.6	48.1	45.0	52.3	45.7	960	45 [4]
Namibia	4.0	3.3	52	32	76	46	58.8	61.7	57.1	60.8	60.3	62.4	210	170 [4]
South Africa	2.9	2.5	59	45	84	65	55.8	51.7	52.9	50.3	58.8	53.1	400	110 [4]
Swaziland	4.2	3.5	82	62	122	94	50.8	46.4	49.2	47.1	52.2	45.5	390	120 [4]
Western Africa[3]	*5.8*	*5.1*	*109*	*96*	*190*	*162*	*48.9*	*51.5*	*48.0*	*50.7*	*49.8*	*52.3*	–	–
Benin	6.0	5.4	97	82	144	116	58.3	61.9	57.1	60.7	59.4	63.0	840	20 [4]
Burkina Faso	6.3	5.8	90	79	180	153	50.4	53.4	49.3	52.0	51.4	54.7	700	22 [4]
Cape Verde	3.7	2.7	34	24	42	29	69.0	71.7	66.1	68.7	71.4	74.1	210	120 [4]
Côte d'Ivoire	5.2	4.5	94	85	137	119	55.4	57.9	53.9	56.7	57.5	59.3	810	27 [4]
Gambia	5.6	5.0	90	75	136	113	53.9	56.3	52.4	54.6	55.5	58.0	690	32 [4]
Ghana	4.7	4.2	69	72	111	115	57.9	56.8	57.0	55.9	58.8	57.7	560	45 [4]
Guinea	6.0	5.3	117	95	186	141	53.3	58.4	51.5	56.4	55.1	60.4	910	19 [4]
Guinea-Bissau	5.9	5.7	125	111	218	191	45.8	48.2	44.3	46.7	47.4	49.8	1 100	13 [4]
Liberia	5.9	5.0	110	93	174	135	54.4	58.7	52.9	57.3	56.0	60.1	1 200	12 [4]
Mali	5.8	5.4	117	104	219	185	45.6	48.8	45.1	48.1	46.2	49.5	970	15 [4]
Mauritania	5.1	4.4	73	72	121	118	56.5	57.0	54.6	55.0	58.4	59.0	820	22 [4]

Major area, region or country	Total fertility rate (per woman)		Infant mortality rate (per 1,000 births)		Mortality under age 5 (per 1,000 births)		Life expectancy at birth						Maternal mortality ratio (per 100,000 live births)	Lifetime risk of maternal death (1 in n)
							Both sexes combined (in years)		Male (in years)		Female (in years)			
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2005	2005
Niger	7.5	7.1	119	85	232	165	46.4	51.9	45.8	51.1	47.0	52.9	1 800	7 [4]
Nigeria	5.9	5.2	121	108	210	184	45.9	48.2	45.2	47.6	46.5	48.7	1 100	18 [4]
Senegal	5.6	4.9	64	58	134	117	54.1	55.9	52.7	54.4	55.5	57.5	980	21 [4]
Sierra Leone	5.4	5.2	130	102	213	144	41.9	47.9	40.4	46.7	43.4	49.2	2 100	8 [4]
Togo	5.1	4.2	86	69	122	94	59.8	62.9	57.6	61.2	61.9	64.6	510	38 [4]

Definitions: *Total fertility rate (per woman):* The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality. It is expressed as children per woman. (Source: UN, 2009, glossary: http://esa.un.org/UNPP/index.asp?panel=7). *Infant mortality rate (per 1,000 births):* Probability of dying between birth and exact age 1. It is expressed as deaths per 1,000 births. (Source: UN, 2009, glossary: http://esa.un.org/UNPP/index.asp?panel=7). *Mortality under age 5 (per 1,000 births):* Probability of dying between birth and exact age 5. It is expressed as deaths per 1,000 births. (Source: UN, 2009, glossary: http://esa.un.org/UNPP/index.asp?panel=7). *Life expectancy at birth:* The average number of years of life expected by a hypothetical cohort of individuals who would be subject during all their lives to the mortality rates of a given period. It is expressed as years. (Source: UN, 2009a, Glossary: http://esa.un.org/UNPP/index.asp?panel=7). *Maternal mortality ratio (per 100,000 live births):* Number of maternal deaths per 100,000 live births during a specified time period, usually one year. (Source: WHO indicator definitions and metadata, 2008 (WHO, 2009a) (www.who.int/whosis/indicators/compendium/2008/en/)). *Lifetime risk of maternal death (1 in n):* Detailed information from WHO in J. Willmoth: "The lifetime risk of maternal mortality: Concept and measurement", in *Bulletin of the World Health Organization* (Geneva), Vol. 87, No. 4 (April 2009), pp. 245–324 (www.who.int/bulletin/volumes/87/4/07-048280/en/index.html).

Notes: – Not available. * Only countries or areas with 100,000 inhabitants or more in 2009 are listed individually; the rest are included in the regional groups but are not listed separately. [a] More developed regions comprise Europe, Northern America, Australia–New Zealand and Japan. [b] Less developed regions comprise all regions of Africa, Asia (excluding Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia. [c] Least developed countries: 49 countries, of which 33 in Africa, ten in Asia, five in Oceania plus one in Latin America and the Caribbean. [d] Other less developed countries comprise the less developed regions excluding the least developed countries. [e] Sub-Saharan Africa refers to all of Africa except Northern Africa, with the Sudan included in sub-Saharan Africa. [1] Including Seychelles. [2] Including Agalega, Rodrigues and Saint Brandon. [3] Including Saint Helena, Ascension and Tristan da Cunha. [4] Maternal mortality in 2005 and lifetime risk of maternal death (1 in n): Regional estimates developed by WHO, UNICEF, UNFPA and The World Bank (http://whqlibdoc.who.int/publications/2007/9789241596213_eng.pdf).

Sources: Total fertility rate (per woman); infant mortality rate (per 1,000 births); mortality under age 5 (per 1,000 births) and life expectancy at birth: based on UN Population Division. 2009. *World Population Prospects: The 2008 Revision* (New York). Medium variant of the population projections. Maternal mortality ratio (per 100,000 live births): WHO Statistical Information System (WHOSIS) (WHO, 2009) – www.who.int/whosis/indicators/compendium/2008/3mrf. Lifetime risk of maternal death (1 in n): United Nations Children's Fund (UNICEF) as presented in UNDATA: http://data.un.org/ [Last update: 11 February 2009].

Table SA2. Selected social indicators, by region, various years

Indicator	Region						
	Africa	Sub-Saharan Africa	Northern Africa	Western Africa	Eastern Africa	Middle Africa	Southern Africa
Underweight children age <5 (%)	24	26	15	27	25	29	11
Literacy rate, ages 15–24, 2000–04, female (%)	69	69	72	66	67	64	94
Literacy rate, ages 15–24, 2000–04, male (%)	81	80	84	77	81	79	93
Economically active, female, ages 15+, 1995–2002 (%)	53	62	21	56	76	62	48
Economically active, male, ages 15+, 1995–2002 (%)	80	84	68	86	88	86	62
Population living in urban areas of 750,000+, 2005 (%)	14	13	19	15	6	18	28
Undernourished population, 2002–04 (%)	26	31	8	15	40	55	4
Population with access to improved water sources, 2006 (%)	64	58	87	58	54	52	92
Population mid-2009 ('000)	998 705	835 988	204 989	296 726	313 351	125 483	58 156
Birth rate (annual number of births per 1,000 total population)	36	39	25	40	40	42	24
Rate of natural increase (birth rate minus death rate, expressed as a %)	2	3	2	3	3	3	1
Infant mortality rate (infant deaths per 1,000 live births)	74	80	38	80	76	95	48
Life expectancy at birth, both sexes (years)	55	51	69	51	51	51	52
Urban population (%)	38	35	50	42	22	41	56
HIV/AIDS among adult population, ages 15–49, 2007–08 (%)	4	5	0	3	6	3	19
GNI PPP per capita, 2008 (US$)	2 660	1 950	5 370	1 600	1 030	1 650	9 380
Density (population/sq. km)	33	34	24	48	49	19	22
Population living below US$2 per day (%)	65	74	18	76	78	74	45

Source: Population Reference Bureau, 2009.

Table SA3. Access to services, 2000–06

	Telecommunications				Access to electricity				Water supply coverage (%)			Sanitation coverage (%)		
	Main telephone line (per 100 inhabitants)		Mobile lines (per 100 inhabitants)		Final consumption (GWh)		Distribution losses		Total	Urban	Rural	Total	Urban	Rural
	2000	2006	2000	2006	2000	2005	2000	2005	2004			2004		
Algeria	5.79	8.52	0.28	62.95	18 592	26 656	4 105	4 475	85	88	80	92	99	82
Angola	0.49	0.62	0.2	14.33	1 157	2 128	211	384	53	75	40	31	56	16
Benin	0.81	0.89	0.87	12.13	399	589	59	113	48	57	41	40	64	19
Botswana	8.27	7.78	12.17	46.78	1 959	2 494	164	144	95	100	90	42	57	25
Burkina Faso	0.47	0.7	0.22	7.46	–	–	–	–	63	70	60	11	14	10
Burundi	0.3	0.41	0.24	2.03	–	–	–	–	79	92	77	36	47	35
Cameroun	0.63	0.79	0.68	18.89	2 719	3 490	761	655	66	86	44	51	58	43
Cape Verde	12.57	13.8	4.54	20.99	–	–	–	–	80	86	73	43	61	19
Central African Republic	0.26	0.29	0.14	2.48	–	–	–	–	75	93	61	27	47	12
Chad	0.14	0.13	0.07	4.65	–	–	–	–	42	41	43	9	24	4
Comoros	0.98	2.33	–	4.50	–	–	–	–	86	92	82	33	41	29
Congo	0.75	0.4	2.38	12.25	260	445	180	198	58	84	27	27	28	25
Congo, Dem. Rep. of the	–	0.02	–	7.44	2 442	2 851	228	275	22	37	12	9	8	10
Côte d'Ivoire	1.78	1.41	3.2	22.03	2 757	3 046	699	1 008	84	97	74	37	46	29
Djibouti	1.54	1.56	–	6.37	–	–	–	–	73	76	59	82	88	50
Egypt	8.64	14.33	2.14	23.86	64 330	87 505	10 750	17 184	98	99	97	70	86	58
Equatorial Guinea	1.35	1.99	1.1	19.26	–	–	–	–	43	45	42	53	60	46
Eritrea	0.84	0.82	–	1.36	173	232	38	46	60	74	57	9	32	3
Ethiopia	0.37	0.91	–	1.09	1 419	2 334	167	287	39	83	31	12	50	4
Gabon	3.18	2.59	9.79	54.39	989	1 177	234	279	88	95	47	36	37	30
Gambia	2.65	2.98	0.45	25.99	–	–	–	–	82	95	77	53	72	46

	Telecommunications				Access to electricity				Water supply coverage (%)			Sanitation coverage (%)		
	Main telephone line (per 100 inhabitants)		Mobile lines (per 100 inhabitants)		Final consumption (GWh)		Distribution losses		Total	Urban	Rural	Total	Urban	Rural
	2000	2006	2000	2006	2000	2005	2000	2005	2004			2004		
Ghana	1.08	1.58	0.66	23.09	6 055	5 955	1 616	975	56	61	52	35	40	31
Guinea	0.32	0.33	0.56	2.36	–	–	–	–	50	78	35	18	31	11
Guinea-Bissau	0.93	0.42	–	9.22	–	–	–	–	59	79	49	35	57	23
Kenya	0.95	0.84	0.42	20.91	3 408	4 912	867	1 066	62	89	46	48	56	43
Lesotho	1.24	2.97	1.21	19.99	–	–	–	–	79	92	76	37	61	32
Liberia	0.21	0.21	0.05	4.87	–	–	–	–	61	72	52	27	49	7
Libyan Arab Jamahiriya	10.79	8.09	0.71	65.81	10 132	16 865	3 592	2 973	–	–	–	97	97	96
Madagascar	0.34	0.68	0.39	5.47	–	–	–	–	31	67	16	56	75	49
Malawi	0.45	0.8	0.47	3.33	–	–	–	–	67	96	62	46	66	42
Mali	0.38	0.59	0.1	10.87	–	–	–	–	50	78	36	46	59	39
Mauritania	0.74	1.1	0.6	33.57	–	–	–	–	40	30	49	36	55	20
Mauritius	23.53	28.45	15.08	61.50	–	–	–	–	100	100	100	94	95	94
Morocco	4.96	4.12	8.16	52.07	12 838	17 629	2 122	4 048	81	99	56	73	88	52
Mozambique	0.5	0.33	0.3	11.60	1 013	9 143	243	1 629	40	37	41	36	38	35
Namibia	6.19	6.84	4.61	24.37	2 386	2 884	260	314	87	98	81	25	50	13
Niger	0.19	0.17	–	3.35	–	–	–	–	59	64	57	18	79	5
Nigeria	0.49	1.26	–	24.05	8 688	17 286	5 618	5 644	48	67	31	44	53	36
Rwanda	0.23	0.18	0.5	3.40	–	–	–	–	46	66	44	8	8	8
Sao Tome and Principe	3.3	4.74	–	11.51	–	–	–	–	79	89	73	25	32	20
Senegal	2.16	2.37	2.63	24.99	1 337	1 699	236	767	75	90	64	33	57	17
Seychelles	26.72	25.44	33.63	86.52	–	–	–	–	88	100	75	–	–	100
Sierra Leone	0.42	0.49	0.26	2.21	–	–	–	–	57	75	46	39	53	30
Somalia	0.36	1.22	1.14	6.08	–	–	–	–	29	32	27	26	48	14

	Telecommunications				Access to electricity				Water supply coverage (%)			Sanitation coverage (%)		
	Main telephone line (per 100 inhabitants)		Mobile lines (per 100 inhabitants)		Final consumption (GWh)		Distribution losses		Total	Urban	Rural	Total	Urban	Rural
	2000	2006	2000	2006	2000	2005	2000	2005	2004			2004		
South Africa	10.88	9.97	18.28	83.33	162 516	198 306	17 053	15 281	88	99	73	65	79	46
Sudan	1.24	1.72	0.07	12.66	2 058	3 461	376	646	70	78	64	34	50	24
Swaziland	3.16	4.27	3.27	24.29	–	–	–	–	62	87	54	48	59	44
Tanzania, United Rep. of	0.5	0.4	0.32	14.78	1 913	2 256	555	817	52	85	42	90	90	90
Togo	0.92	1.3	1.08	11.23	521	585	36	86	52	80	36	35	71	15
Tunisia	9.99	12.42	1.25	71.88	8 979	11 228	1 117	1 681	93	99	82	85	96	65
Uganda	0.25	0.36	0.52	6.73	–	–	–	–	66	67	61	60	71	58
Zambia	0.78	0.79	0.92	14.02	6 039	8 012	249	417	62	86	37	27	41	13
Zimbabwe	2.19	2.56	2.34	6.49	10 494	12 143	1 422	742	81	98	72	53	63	47
Africa	2.52	3.11	2	21.77	345 789	457 346	53 377	62 643	62	83	50	44	58	34

Note: Electricity: International Energy Agency – Online database, 2007.

Source: Telecommunications: International Telecommunication Union – Online database, 2007. Water supply coverage and sanitation coverage: WHO and UNICEF, 2006, Joint Reporting Form and WHO regional offices reports; October 2006. Data for Benin, Burkina Faso, Democratic Republic of the Congo, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mauritania, Mozambique, Niger, Rwanda, Senegal, United Republic of Tanzania, Uganda and Zambia are from Getting Africa on track to meet the MDGs on water and sanitation, A status review of sixteen African countries, 2006, report on a regional initiative by AMCOW, AfDB, EUWI, WSP and UNDP.

Table SA4. Labour force and employment indicators – (a) Labour force to population ratios at ages 15–64

Major area, region or country	Labour force participation rates of population at ages 15–64 (percentages)											
	Total				Male				Female			
	2000	2005	2010	2020	2000	2005	2010	2020	2000	2005	2010	2020
World (total)	70.3	69.9	69.9	69.8	83.6	82.9	82.6	82.7	56.7	56.6	56.8	56.6
More developed regions [a]	71.3	71.7	72.3	73.1	79.1	78.6	78.7	78.8	63.7	64.8	65.9	67.5
Less developed regions [b]	70.1	69.5	69.3	69.2	84.8	83.9	83.4	83.4	54.8	54.6	54.7	54.4
Least developed countries [c]	74.8	75.0	75.1	75.7	86.5	85.8	85	84.6	63.3	64.4	65.4	66.9
Less developed regions, excluding least developed countries [d]	69.4	68.7	68.4	68	84.6	83.7	83.2	83.2	53.6	53.1	53.1	52.2
Less developed regions, excluding China	64.9	65.2	65.6	66.1	83.4	83.2	82.9	82.9	46.1	46.9	47.9	48.9
Sub-Saharan Africa [e]	71.1	71.6	72.1	73.2	82	81.8	81.7	82	60.5	61.6	62.7	64.5
Africa	***67.7***	***68.1***	***68.8***	***70.0***	***81.5***	***81.3***	***81.6***	***81.8***	***54.1***	***55.1***	***56.2***	***58.2***
Eastern Africa [1]	*83.3*	*83.8*	*84.1*	*84.5*	*88.6*	*88.3*	*87.9*	*88.0*	*78.1*	*79.5*	*80.3*	*81.1*
Burundi	91.0	90.0	90.0	91.3	90.5	88.6	88.2	89.5	91.4	91.3	91.7	93.0
Comoros	77.9	79.4	80.8	81.7	84.1	85.1	86.0	85.7	71.6	73.7	75.6	77.6
Djibouti	70.3	71.2	72.0	74.1	82.3	81.0	79.8	79.9	58.4	61.4	64.1	68.3
Eritrea	69.7	71.8	74.4	75.5	83.6	83.9	84.6	83.9	56.6	60.5	64.6	67.2
Ethiopia	83.7	86.3	87.1	87.5	92.1	91.9	90.7	90.4	75.5	80.8	83.5	84.7
Kenya	82.9	83.0	83.6	84.2	89.0	88.6	88.8	88.5	77.0	77.5	78.4	80.0
Madagascar	88.1	88.0	87.7	88.2	90.4	90.0	89.3	89.5	85.9	86.0	86.0	87.0
Malawi	76.8	76.9	76.0	76.1	78.2	78.7	77.7	78.1	75.4	75.1	74.3	74.0
Mauritius [2]	64.5	63.6	62.4	61.9	84.7	81.8	79.3	77.2	44.2	45.3	45.5	46.7
Mozambique	86.8	86.4	86.0	85.3	87.2	86.9	86.5	85.7	86.5	86.0	85.5	84.8
Réunion	64.2	64.8	65.0	64.4	71.5	71.3	70.7	68.7	57.1	58.5	59.5	60.2
Rwanda	87.4	86.4	87.4	87.7	87.3	85.4	86.1	86.3	87.5	87.3	88.6	89.1
Somalia	72.8	72.1	71.8	71.5	86.1	86.1	86.1	85.9	59.8	58.6	57.9	57.5
Uganda	86.4	86.1	85.8	85.9	91.8	91.5	91.1	90.9	81.1	80.7	80.4	80.7
Tanzania, United Republic of	90.3	90.0	90.0	90.0	91.5	91.2	91.2	91.2	89.1	88.9	88.8	88.8
Zambia	70.5	69.8	69.7	70.7	78.7	78.7	79.6	81.2	62.5	61.0	59.9	60.0
Zimbabwe	71.6	69.6	67.9	70.9	79.0	77.0	75.5	79.6	64.7	62.9	61.0	62.4
Middle Africa	*73.2*	*73.1*	*73.3*	*74.2*	*86.4*	*85.9*	*85.4*	*85.2*	*60.3*	*60.6*	*61.4*	*63.3*
Angola	83.9	83.3	82.6	82.3	91.1	90.3	88.8	87.4	76.9	76.7	76.5	77.3
Cameroon	67.3	67.8	68.4	69.8	82.7	82.3	82.0	81.5	52.2	53.3	54.8	57.9
Central African Republic	78.7	79.0	79.4	80.8	87.1	87.1	87.1	87.5	70.6	71.2	71.9	74.2
Chad	72.5	70.7	70.5	70.3	79.9	78.1	77.7	77.4	65.2	63.4	63.4	63.3
Congo	72.3	72.7	73.3	75.4	84.0	83.7	83.5	83.6	60.9	61.8	63.2	67.2
Congo, Dem. Rep. of the	71.9	71.8	72.2	73.3	87.6	87.2	86.9	86.9	56.7	56.9	57.9	59.9
Equatorial Guinea	64.5	65.8	67.2	67.6	95.2	94.3	93.7	93.1	34.8	38.1	41.2	42.6
Gabon	75.9	76.7	77.7	79.8	84.9	83.9	82.7	83.9	67.2	69.6	72.6	75.7

Major area, region or country	Labour force participation rates of population at ages 15–64 (percentages)											
	Total				Male				Female			
	2000	2005	2010	2020	2000	2005	2010	2020	2000	2005	2010	2020
Sao Tome and Principe	60.0	61.8	62.6	63.6	76.6	78.4	78.4	78.9	44.0	45.8	47.3	48.6
Northern Africa	*53.6*	*53.6*	*54.4*	*54.7*	*78.8*	*78.4*	*79.5*	*79.6*	*28.2*	*28.6*	*29.3*	*29.8*
Algeria	57.7	59.7	61.3	61.5	82.2	82.6	82.8	80.9	32.7	36.2	39.3	41.7
Egypt	51.3	50.6	51.7	51.9	77.1	76.7	79.5	80.8	25.2	24.3	23.8	23.0
Libyan Arab Jamahiriya	52.1	54.2	55.1	53.5	77.6	80.2	81.8	80.0	23.7	25.6	26.2	25.4
Morocco	56.3	55.3	55.3	55.7	84.3	83.6	83.7	84.7	29.5	28.4	28.3	28.4
Sudan	52.7	53.1	53.3	54.3	75.3	74.7	73.9	73.9	30.0	31.4	32.5	34.4
Tunisia	51.0	50.6	51.0	51.6	76.0	74.0	73.7	73.9	25.8	27.0	28.0	29.0
Western Sahara	74.6	76.6	78.4	80.4	82.2	81.9	82.2	82.9	65.8	70.3	74.1	77.5
Southern Africa	*56.4*	*58.0*	*60.2*	*62.1*	*64.5*	*65.4*	*67.9*	*70.1*	*48.6*	*50.8*	*52.7*	*54.0*
Botswana	76.7	77.8	79.1	81.1	81.7	81.7	82.2	83.5	71.8	73.8	75.9	78.5
Lesotho	75.1	75.1	75.3	76.5	81.0	79.6	78.4	78.5	70.4	71.5	72.7	74.8
Namibia	57.2	57.8	58.9	62.2	65.0	64.1	64.0	66.7	49.9	51.8	53.9	57.8
South Africa	54.8	56.5	58.9	60.6	63.1	64.2	67.0	69.2	46.9	49.1	50.9	51.9
Swaziland	63.8	64.5	65.6	69.3	79.0	76.9	75.7	78.3	50.4	53.1	56.1	60.3
Western Africa [3]	*64.1*	*64.3*	*64.7*	*65.5*	*78.8*	*78.4*	*78.1*	*77.5*	*49.6*	*50.3*	*51.3*	*53.4*
Benin	73.4	73.4	73.6	74.1	81.6	79.2	78.0	77.1	65.2	67.6	69.1	70.9
Burkina Faso	85.3	85.6	85.7	86.0	91.5	91.3	91.3	90.9	79.5	80.0	80.3	81.0
Cape Verde	65.5	67.6	69.6	72.1	85.1	83.4	82.8	83.6	48.7	53.7	57.7	61.3
Côte d'Ivoire	67.0	67.1	67.5	68.8	82.4	82.6	82.6	83.2	49.9	50.6	51.7	54.1
Gambia	78.5	78.3	77.9	77.5	85.9	85.7	84.9	83.8	71.2	71.2	71.1	71.3
Ghana	75.5	75.5	75.6	76.9	77.1	76.2	75.9	76.9	73.9	74.7	75.4	76.9
Guinea	86.3	86.2	86.3	86.9	90.5	90.2	89.9	89.5	82.1	82.2	82.7	84.2
Guinea-Bissau	73.2	73.2	73.3	73.3	85.1	85.5	85.5	85.5	61.7	61.3	61.3	61.3
Liberia	73.1	72.9	72.9	73.4	77.9	77.3	76.7	76.3	68.4	68.7	69.2	70.4
Mali	52.9	52.9	53.2	53.3	69.9	69.0	68.0	65.5	37.0	37.8	39.1	41.5
Mauritania	70.0	71.0	71.7	72.2	82.5	82.3	81.9	80.6	57.4	59.5	61.2	63.7
Niger	63.0	63.3	63.3	63.2	88.6	88.1	87.9	87.3	38.6	39.4	39.4	39.8
Nigeria	56.9	57.0	57.3	58.0	75.4	74.9	74.6	73.4	38.7	39.2	40.1	42.5
Senegal	76.8	77.1	77.6	78.6	90.4	90.1	89.6	88.8	63.6	64.6	66.0	68.9
Sierra Leone	68.9	67.7	67.3	66.5	68.5	67.8	68.0	67.4	69.2	67.6	66.7	65.6
Togo	73.9	74.8	75.8	77.1	86.9	86.6	86.3	86.0	61.3	63.3	65.4	68.3

Definitions: See table SA4(b).

Notes: See table SA4(b).

Source: ILO, 2009e: *Economically active population estimates and projections 1980–2020* (EAPEP), table E5, (http://laborsta.ilo.org/applv8/data/EAPEP/eapep_E.html).

Table SA4. (b) Labour force to population ratio at age 65 and over

Major area, region or country	Labour force participation rates of population at age 65+ (percentages)											
	Total				Male				Female			
	2000	2005	2010	2020	2000	2005	2010	2020	2000	2005	2010	2020
World	19.8	20.3	20.5	21.0	29.9	29.0	27.7	25.9	12.0	13.5	14.8	17.1
More developed regions [a]	9.7	10.3	10.2	10.4	14.2	14.5	13.6	13.0	6.7	7.5	7.8	8.5
Less developed regions [b]	26.8	26.7	26.6	26.3	39.0	37.1	35.0	31.7	16.1	17.7	19.4	21.6
Least developed countries [c]	48.1	48.1	45.6	44.6	65.1	64.5	59.0	55.6	34.0	34.5	34.7	35.6
Less developed regions, excluding least developed countries [d]	24.8	24.7	24.8	24.6	36.6	34.6	32.8	29.6	14.4	16.1	17.9	20.3
Less developed regions, excluding China	30.6	30.2	29.9	29.5	45.1	43.1	40.9	37.3	18.2	19.4	20.8	23.0
Sub-Saharan Africa [e]	48.6	48.6	48.1	48.1	62.5	62.9	62.0	60.8	37.5	37.3	37.4	38.3
Africa	***40.9***	***40.0***	***40.1***	***39.5***	***55.3***	***54.1***	***53.9***	***52.1***	***29.1***	***28.8***	***29.1***	***29.5***
Eastern Africa	*59.9*	*60.1*	*58.9*	*58.9*	*74.2*	*74.4*	*72.1*	*70.4*	*48.3*	*48.7*	*48.6*	*50.1*
Burundi	78.4	77.3	77.1	77.1	81.0	77.4	76.8	76.8	76.9	77.2	77.2	77.3
Comoros	55.0	54.6	53.6	51.8	75.8	74.5	72.1	67.2	38.8	38.9	39.1	39.4
Djibouti	10.4	9.3	8.0	6.5	19.6	16.9	13.8	9.6	3.1	3.2	3.4	4.0
Eritrea	43.4	42.2	41.0	42.8	62.8	59.2	48.1	43.3	31.2	31.5	36.8	42.5
Ethiopia	46.8	56.5	57.7	61.2	67.6	76.3	76.3	76.4	29.4	39.9	42.2	48.7
Kenya	56.1	54.9	53.2	49.6	72.7	71.0	68.1	60.7	41.4	41.4	41.1	41.0
Madagascar	71.4	63.4	60.0	59.8	81.3	75.7	72.0	71.3	63.0	53.1	50.0	50.0
Malawi	88.7	88.7	89.0	88.9	94.2	94.8	95.1	95.3	84.0	83.8	84.2	84.4
Mauritius	10.2	8.0	5.0	3.6	18.2	13.4	6.8	3.6	4.4	4.1	3.7	3.6
Mayotte	–	–	–	–	–	–	–	–	–	–	–	–
Mozambique	79.3	78.2	77.7	77.4	83.8	84.6	84.8	84.9	75.9	73.5	72.7	72.4
Réunion	2.2	2.1	2.2	2.2	3.4	3.2	3.0	2.7	1.4	1.4	1.6	1.9
Rwanda	56.3	53.2	51.4	50.7	60.2	53.9	49.4	48.0	53.5	52.8	52.7	52.6
Somalia	46.3	45.9	45.8	45.8	59.2	59.7	60.0	60.0	35.5	34.3	34.1	34.0
Uganda	61.1	60.5	60.2	59.9	79.1	79.1	79.3	79.3	46.6	45.8	45.4	45.1
Tanzania, United Republic of	67.6	62.6	58.0	56.5	84.3	78.5	68.6	65.3	54.3	50.3	49.9	49.9
Zambia	63.5	62.6	62.2	61.8	75.1	75.9	76.1	76.1	54.5	52.8	52.4	52.3
Zimbabwe	61.6	50.5	44.4	43.2	70.3	59.7	54.7	53.3	54.6	43.7	37.2	36.8
Middle Africa	*54.1*	*53.9*	*52.3*	*52.8*	*68.9*	*69.1*	*67.3*	*66.9*	*42.8*	*42.4*	*40.9*	*42.0*
Angola	54.7	53.6	52.7	52.4	71.2	71.2	71.1	71.0	41.6	40.0	38.5	38.2
Cameroon	60.2	61.4	51.8	51.8	69.3	69.4	61.8	61.8	52.6	54.8	43.6	43.6
Central African Republic	72.6	72.9	72.9	73.1	82.0	81.6	81.5	80.9	65.8	66.8	67.1	68.1

Major area, region or country	Labour force participation rates of population at age 65+ (percentages)											
	Total				Male				Female			
	2000	2005	2010	2020	2000	2005	2010	2020	2000	2005	2010	2020
Chad	68.9	66.1	66.0	65.7	85.8	86.9	87.0	87.0	55.8	49.6	49.3	49.1
Congo	62.3	62.4	62.9	63.1	66.1	65.8	64.9	63.9	59.5	59.8	61.5	62.6
Congo, Democratic Republic of the	46.5	46.6	47.5	48.7	64.4	64.7	64.2	63.7	33.6	33.4	35.1	37.3
Equatorial Guinea	38.3	38.4	38.4	38.5	57.3	57.3	57.4	57.5	23.0	23.1	23.1	23.2
Gabon	45.9	44.2	46.7	47.8	57.5	52.7	55.0	55.0	36.6	37.4	39.7	41.4
Sao Tome and Principe	21.2	20.6	19.3	17.8	34.9	34.5	33.2	31.1	9.2	8.8	8.6	8.6
Northern Africa	*20.7*	*18.1*	*19.1*	*18.9*	*37.1*	*32.2*	*33.5*	*32.3*	*6.7*	*6.3*	*7.2*	*7.8*
Algeria	22.6	22.1	22.8	23.3	27.4	25.9	25.3	25.0	18.7	18.9	20.7	21.9
Egypt	13.0	7.9	10.6	11.1	26.1	16.0	20.0	20.0	2.3	1.3	3.0	4.0
Libyan Arab Jamahiriya	20.3	19.4	18.4	16.1	36.7	35.3	33.1	27.8	3.7	3.7	3.8	4.2
Morocco	22.2	20.9	19.9	18.8	42.6	41.4	39.9	36.7	3.5	3.5	3.5	3.5
Sudan	39.0	38.1	37.8	37.7	72.5	70.9	70.5	70.1	10.7	10.4	10.1	10.0
Tunisia	17.7	16.4	15.6	15.4	32.8	31.0	30.1	30.0	3.4	3.5	3.6	3.7
Western Sahara	40.6	37.7	35.5	34.5	44.7	39.2	35.6	34.3	36.7	36.0	35.4	34.7
Southern Africa	*14.1*	*18.2*	*25.2*	*25.7*	*20.3*	*28.5*	*36.1*	*36.1*	*9.9*	*11.7*	*18.7*	*20.0*
Botswana	35.4	22.3	24.6	26.3	52.8	36.8	40.1	40.9	24.9	13.5	15.0	17.0
Lesotho	59.5	57.9	55.1	51.5	69.1	67.3	61.8	53.3	52.5	51.3	50.8	50.6
Namibia	32.8	30.3	29.6	28.6	39.5	34.7	33.3	31.1	27.8	27.1	27.0	27.0
South Africa	9.9	15.5	23.8	24.8	15.0	25.4	34.7	35.6	6.5	9.3	17.3	18.9
Swaziland	39.0	37.2	33.1	25.0	64.4	59.5	51.0	33.6	20.2	20.3	20.2	20.1
Western Africa	*44.3*	*43.4*	*42.3*	*41.6*	*58.3*	*57.4*	*56.4*	*54.9*	*32.2*	*31.4*	*30.3*	*30.4*
Benin	57.5	56.9	55.7	50.7	82.4	81.1	78.2	65.3	39.8	39.6	39.4	39.4
Burkina Faso	52.9	51.2	50.1	47.7	72.4	71.3	70.0	64.7	37.5	36.8	36.6	36.5
Cape Verde	26.5	23.4	22.0	21.3	51.8	47.0	45.3	45.0	11.1	10.6	10.5	10.4
Côte d'Ivoire	48.1	47.2	46.7	47.2	69.9	67.5	65.9	65.1	25.3	26.3	27.4	30.4
Gambia	73.7	73.3	72.7	72.5	87.2	86.7	86.4	86.1	61.5	61.3	60.7	60.6
Ghana	59.0	57.6	49.9	49.1	66.7	64.4	60.0	59.4	52.2	51.5	40.7	39.9
Guinea	50.7	50.0	49.1	42.9	75.0	74.4	72.3	57.7	31.5	31.3	31.2	31.2
Guinea-Bissau	46.6	47.7	50.1	51.1	64.4	65.0	65.2	65.3	32.3	33.7	37.9	39.9
Liberia	49.9	49.6	49.5	49.4	77.3	77.7	77.9	78.0	28.2	27.5	27.3	27.2
Mali	23.8	22.8	22.1	21.2	36.0	35.5	35.8	35.7	13.7	13.0	12.5	12.3
Mauritania	41.3	39.9	37.9	34.2	59.4	57.6	54.3	46.0	26.7	25.8	25.4	25.1
Niger	54.6	54.2	53.8	54.3	75.3	75.7	75.7	75.8	28.6	28.4	28.4	28.5
Nigeria	38.6	37.5	37.0	36.6	49.9	49.1	48.7	48.2	29.3	27.9	27.3	27.0
Senegal	53.3	51.8	50.2	46.9	61.2	59.5	56.5	50.0	45.2	44.3	44.2	44.2

Major area, region or country	Labour force participation rates of population at age 65+ (percentages)											
	Total				Male				Female			
	2000	2005	2010	2020	2000	2005	2010	2020	2000	2005	2010	2020
Sierra Leone	37.8	36.8	36.7	36.6	51.0	52.8	53.1	53.2	27.5	24.3	24.0	23.9
Togo	53.3	52.8	52.1	50.3	74.2	72.7	70.1	63.7	37.0	37.4	38.3	40.1

Definitions: *The economically active population* comprises all persons of either sex who furnish the supply of labour for the production of goods and services during a specified time reference period. According to the 1993 version of the System of National Accounts, production includes all individual or collective goods or services that are supplied to units other than their producers, or intended to be so supplied, including the production of goods or services used up in the process of producing such goods or services; the production of all goods that are retained by their producers for their own final use; the production of housing services by owner–occupiers and of domestic and personal services produced by employing paid domestic staff. *Economically active population for specific age range* = Employed + unemployed in the same age range. *Labour force participation rates of population at age 15–64 (percentage)* = Economically active population aged **15–64** / Population aged **15–64**. *Labour force participation rates of population at age 65 and over (percentage)* = Economically active population aged **65 and over** / Population aged **65 and over**.

Methodology: See ILO, 2009e. *Economically active population estimates and projections: 1980–2020* (fifth edition), methodological description (http://laborsta.ilo.org/applv8/data/EAPEP/EAPEP_methodology.pdf).

Notes: These estimates and projections are for international comparisons and are neither superior nor necessarily inferior to national estimates and projections, which are produced using country-specific additional information. This additional information is: (a) not necessarily available to us for all countries; and/or (b) different between countries and so would make international comparability difficult. [a] More developed regions comprise Europe, Northern America, Australia–New Zealand and Japan. [b] Less developed regions comprise all regions of Africa, Asia (excluding Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia. [c] The least developed countries are 49 countries, 33 in Africa, ten in Asia, five in Oceania plus one in Latin America and the Caribbean. [d] Other less developed countries comprise the less developed regions excluding the least developed countries. [e] Sub-Saharan Africa refers to all of Africa except northern Africa, with the Sudan included in sub-Saharan Africa.

Source: ILO, 2009e: *Economically active population estimates and projections 1980–2020* (EAPEP), table E5, (http://laborsta.ilo.org/applv8/data/EAPEP/eapep_E.html).

Table SA4. (c) Status in employment, latest available year

Country	Year	Status in employment																		
		Total							Male							Female						
		Wage and salaried workers	Total self-employed workers (a + b + c)	Employers (a)	Own-account workers (b)	Members of producer's cooperatives (c)	Contributing family workers	Not classified	Wage and salaried workers	Total self-employed workers (a + b + c)	Employers (a)	Own-account workers (b)	Members of producer's cooperatives (c)	Contributing family workers	Not classified	Wage and salaried workers	Total self-employed workers (a + b + c)	Employers (a)	Own-account workers (b)	Members of producer's cooperatives (c)	Contributing family workers	Not classified
Algeria	2004	59.8	31.7	5.0	26.7	–	8.2	0.3	61.9	30.7	5.8	24.9	–	7.1	0.4	49.8	36.6	1.3	35.3	–	13.6	0.3
Botswana	2006	62.2	9.6	4.8	4.8	–	2.1	26.1	60.5	12.3	3.7	8.6	–	3.2	24.0	58.6	15.3	2.5	12.8	–	4.3	21.8
Burkina Faso	1994	3.6	26.3	0.3	26.0	–	69.2	0.8	5.8	40.7	0.5	40.2	–	52.2	1.4	1.4	11.0	0.0	11.0	–	87.3	0.3
Cameroon	2001	19.2	59.3	1.6	57.7	–	18.2	3.3	29.3	57.0	2.1	54.9	–	9.5	4.2	8.7	61.7	1.1	60.6	–	27.2	2.5
Cape Verde	2000	38.9	31.8	2.5	29.3	–	10.3	19.0	43.8	32.6	3.3	29.4	–	6.5	17.1	33.0	30.9	1.6	29.2	–	14.8	21.3
Chad	1993	4.9	65.6	0.2	65.4	–	28.3	1.2	8.8	76.7	0.3	76.4	–	13.2	1.3	0.8	53.7	0.1	53.6	–	44.4	1.1
Egypt	2007	61.4	29.9	17.0	12.9	–	8.7	–	58.5	27.4	14.1	13.3	–	14.1	–	47.9	18.2	3.4	14.8	–	33.9	–
Equatorial Guinea	1983	21.1	38.3	–	–	–	39.5	1.2	30.7	51.8	–	–	–	16.5	1.3	6.0	16.8	–	–	–	76.5	0.0
Ethiopia	2006	46.3	42.8	0.7	41.8	0.3	10.0	0.4	49.3	41.8	1.0	40.5	0.4	7.8	0.5	42.7	44.0	0.4	43.4	0.2	12.7	0.3
Gabon	1993	45.2	45.4	0.6	44.8	–	3.5	5.8	58.6	35.4	0.9	34.5	–	2.0	4.0	29.2	57.5	0.2	57.3	–	5.3	7.9
Lesotho	1999	25.7	5.5	0.8	4.8	–	–	68.8	22.5	4.6	0.7	3.8	–	–	73.0	29.9	6.8	0.8	6.0	–	–	63.4

Country	Year	Status in employment																			
		Total							Male							Female					
		Wage and salaried workers	Total self-employed workers (a + b + c)	Employers (a)	Own-account workers (b)	Members of producer's cooperatives (c)	Contributing family workers	Not classified	Wage and salaried workers	Total self-employed workers (a + b + c)	Employers (a)	Own-account workers (b)	Members of producer's cooperatives (c)	Contributing family workers	Not classified	Wage and salaried workers	Total self-employed workers (a + b + c)	Employers (a)	Own-account workers (b)	Members of producer's cooperatives (c)	Contributing family workers	Not classified
Madagascar	2005	13.4	–	–	34.1	–	52.3	0.1	16.0	–	–	51.8	–	32.1	0.1	10.8	–	–	16.1	–	73.0	0.1
Malawi	1987	16.1	83.9	0.2	83.5	0.3	–	–	29.0	71.0	0.1	70.7	0.3	–	–	3.9	96.1	0.0	95.7	0.4	–	–
Mali	2004	13.6	71.4	–	–	–	15.0	–	15.2	66.4	–	–	–	18.4	–	11.4	78.4	–	–	–	10.2	–
Mauritius	2008	78.0	20.7	4.4	16.2	0.1	0.9	0.4	80.0	17.6	3.3	14.2	0.1	2.1	0.4	83.8	11.5	1.1	10.4	–	4.4	0.3
Morocco	2008	47.5	37.4	3.2	32.2	2.0	15.0	0.1	43.8	32.0	2.5	27.9	1.6	24.0	0.1	34.0	17.3	0.8	16.0	0.5	48.6	0.1
Namibia	2004	72.8	22.3	5.6	16.7	–	4.4	0.4	76.0	20.4	6.6	13.7	–	3.2	0.4	68.8	26.6	4.3	22.3	–	5.8	0.4
Rwanda	1996	6.0	61.4	0.1	61.3	–	31.2	1.4	9.4	56.2	0.1	56.2	–	32.7	1.6	3.3	65.5	0.0	65.5	–	30.0	1.2
Sao Tome and Principe	1991	71.2	26.8	0.4	26.4	–	0.8	1.3	72.3	25.5	0.5	25.1	–	0.8	1.3	68.9	29.2	0.1	29.1	–	0.7	1.2
Senegal	1991	11.3	55.4	0.6	54.8	–	28.5	4.8	14.4	52.7	1.0	51.7	–	25.3	7.6	7.5	58.7	0.1	58.6	–	32.4	1.4
Sierra Leone	2004	7.6	–	74.3	–	–	18.1	–	11.3	–	73.9	–	–	14.8	–	3.7	–	74.7	–	–	21.6	–
South Africa	2008	84.5	15.0	7.5	7.5	–	0.4	–	84.4	14.7	5.5	9.2	–	0.9	–	84.2	14.4	3.0	11.4	–	1.4	–
Swaziland	1997	76.4	21.1	1.5	19.6	–	1.1	1.4	82.7	15.3	1.6	13.7	–	0.8	1.2	67.4	29.4	1.3	28.1	–	1.5	1.7
Tanzania, United Republic of	2006	10.5	78.1	1.8	76.3	–	11.4	–	15.3	75.0	2.6	72.4	–	9.7	–	6.1	80.9	1.0	79.9	–	13.0	–

Country	Year	Status in employment																						
		Total							Male								Female							
		Wage and salaried workers	Total self-employed workers (a + b + c)	Employers (a)	Own-account workers (b)	Members of producer's cooperatives (c)	Contributing family workers	Not classified	Wage and salaried workers	Total self-employed workers (a + b + c)	Employers (a)	Own-account workers (b)	Members of producer's cooperatives (c)	Contributing family workers	Not classified	Wage and salaried workers	Total self-employed workers (a + b + c)	Employers (a)	Own-account workers (b)	Members of producer's cooperatives (c)	Contributing family workers	Not classified
Tunisia	2003	64.3	26.8	–	–	–	8.7	0.2	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Uganda	2003	14.5	59.4	0.3	59.1	–	26.1	–	22.2	67.5	0.4	67.1	–	10.3	–	7.5	52.1	0.2	51.9	–	40.5	–		
Zambia	2003	18.7	59.7	0.0	59.7	–	19.6	1.9	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Zimbabwe	2002	37.7	50.4	0.5	49.9	–	11.9	–	51.0	38.6	0.6	38.0	–	10.4	–	23.1	63.2	0.3	62.9	–	13.6	–		

Definitions: *Wage and salaried workers* are all those workers who hold the type of job defined as "paid employment jobs". Employees with stable contracts are those "employees" who have had, and continue to have, an explicit (written or oral) or implicit contract of employment, or a succession of such contracts, with the same employer on a continuous basis. "On a continuous basis" implies a period of employment which is longer than a specified minimum determined according to national circumstances. (If interruptions are allowed in this minimum period, their maximum duration should also be determined according to national circumstances.) Regular employees are those "employees with stable contracts" for whom the employing organization is responsible for payment of relevant taxes and social security contributions and/or where the contractual relationship is subject to national labour legislation. *Self-employed workers* are those where the remuneration is directly dependent upon the profits (or the potential for profits) derived from the goods and services produced (where own consumption is considered to be part of profits). The incumbents make the operational decisions affecting the enterprise, or delegate such decisions while retaining responsibility for the welfare of the enterprise. (In this context "enterprise" includes one-person operations.) *Employers* are those workers who, working on their own account or with one or a few partners, hold the type of job defined as a "self-employment job" and, in this capacity, on a continuous basis (including the reference period) have engaged one or more persons to work for them in their business as "employee(s)". The meaning of "engage on a continuous basis" is to be determined by national circumstances, in a way which is consistent with the definition of "employees with stable contracts". (The partners may or may not be members of the same family or household.) *Own-account workers* are those who, working on their own account or with one or more partners, hold the type of job defined as "a self-employment job" and have not engaged on a continuous basis any "employees" to work for them during the reference period. It should be noted that during the reference period the members of this group may have engaged "employees", provided that this is on a non-continuous basis. (The partners may or may not be members of the same family or household.) *Members of producers' cooperatives* are workers who hold a "self-employment" job in a cooperative producing goods and services, in which each member takes part on an equal footing with other members in determining the organization of production, sales and/or other work of the establishment, the investments and the distribution of the proceeds of the establishment amongst their members. (It should be noted that "employees" of producers' cooperatives are not to be classified in this group.) *Contributing family workers* are those who hold a "self-employment" job in a market-oriented establishment operated by a related person living in the same household, who cannot be regarded as a partner, because their degree of commitment to the operation of the establishment, in terms of working time or other factors to be determined by national circumstances, is not at a level comparable to that of the head of the establishment. (Where it is customary for young persons, in particular, to work without pay in an economic enterprise operated by a related person who does not live in the same household, the requirement of "living in the same household" may be eliminated.) Workers *not classifiable by status* include those for whom insufficient relevant information is available, and/or who cannot be included in any of the preceding categories. For further information see ILO, *International classification by status in employment (ICSE)* available at: http://laborsta.ilo.org/applv8/data/icsee.html.

Sources: ILO, 2008c: *Key Indicators of the Labour Market* (KILM), and KILMnet September 2009, table 3: Status in employment (by sex); ILO, 2009h: LABORSTA, table 2D: Total employment, by status in employment (thousands).

Table SA4. (d) Unemployment as a percentage of the labour force, various years

Country	Unemployment as a percentage of the labour force											
	Total				Male				Female			
	1995	2000	2005	2008	1995	2000	2005	2008	1995	2000	2005	2008
Algeria [1, 10]	–	27.3	15.3	13.8	–	26.6	12.9	12.9	–	31.4	17.5	18.4
Botswana [2, 3]	21.5	15.8	17.6	–	19.4	14.7	15.3	–	23.9	17.2	19.9	–
Burkina Faso [9]		2.4	–	–	–	2.3	–	–	–	2.6	–	–
Burundi [4]	–	14.0	–	–	–	15.0	–	–	–	13.2	–	–
Cameroon [1, 2]	8.1	7.5	–	–	9.5	8.2	–	–	6.5	6.7	–	–
Côte d'Ivoire [9]		4.1	–	–	–	–	–	–	–	–	–	–
Egypt	11.3	9.0	11.2	–	7.6	5.1	7.1	–	24.1	22.7	24.3	–
Ethiopia [3]	–	–	5.0	–	–	–	2.5	–	–	–	7.8	–
Lesotho [4, 5]	39.3	27.3	–	–	30.7	20.8	–	–	47.1	34.2	–	–
Liberia [10]	–	–	–	5.6	–	–	–	6.8	–	–	–	4.2
Madagascar	–	5.8	–	–	–	6.0	–	–	–	5.7	–	–
Mali [5, 6]	3.3	–	8.8	–	3.3	–	7.2	–	3.3	–	10.9	–
Mauritius	9.8	–	9.6	7.2	7.8	–	5.8	4.1	13.9	–	16.5	12.7
Morocco	–	13.6	11.0	9.4	–	13.8	10.8	9.4	–	13.0	11.5	9.5
Namibia [6]	–	–	21.9	–	–	–	19.4	–	–	–	25.0	–
Niger	5.1	–	–	–	3.6	–	–	–	8.1	–	–	–
Réunion [2]	37.1	36.5	29.5	24.5	33.7	34.4	26.6	22.8	41.7	39.1	33.3	26.5
Rwanda [2]	0.6	–	–	–	0.8	–	–	–	0.3	–	–	–
Senegal [3]	–	–	11.1	–	–	–	7.9	–	–	–	13.6	–
Sierra Leone [6]	–	–	2.8	–	–	–	3.1	–	–	–	2.5	–
South Africa	–	25.4	26.7	22.9	–	22.2	22.6	20.0	–	29.2	31.7	26.3
Tanzania, United Rep. of [3]	–	–	4.3	–	–	–	2.8	–	–	–	5.8	–
Tunisia [5]	15.9	15.7	14.2	–	15.5	15.3	13.1	–	17.4	16.9	17.3	–
Uganda [7]	–	–	3.2	–	–	–	2.5	–	–	–	3.9	–
Zambia	–	12.9	–	–	–	14.1	–	–	–	11.3	–	–
Zimbabwe [4, 5]	6.9	6.0	–	–	8.7	7.3	–	–	5.1	4.6	–	–

For further information see:
– the definition of unemployment in the ILO STATISTICS web site, available at http://laborsta.ilo.org/applv8/data/c3e.html; and
– Resolution concerning statistics of the economically active population, employment, unemployment and underemployment, adopted by the 13th International Conference of Labour Statisticians (Geneva, 1982), available at: www.ilo.org/wcmsp5/groups/public/---dgreports/---integration/---stat/documents/normativeinstrument/wcms_087481.pdf.

Notes: [1] For 2000, data 2001. [2] For 1995, data 1996. [3] For 2005, data 2006. [4] For 2000, data 1999. [5] For 1995, data 1997. [6] For 2005, data 2004. [7] For 2005, data 2003. [8] For 2008, data 2006. [9] For 2000, data 1998. [10] For 2008, data 2007.

Source: ILO, 2009h: LABORSTA, table 3A: Unemployment, general level (thousands).

Table SA4. (e) Employment and remittances, various years

	Year	Unemployment rate			Participation rate (>15) 2006	Inactivity rate (>15) 2006			Worker remittances (US$ million)				
		Total	Men	Women		Total	Men	Women	2001	2002	2003	2004	2005
Algeria	2007	13.8	11.8	14.4	58.6	41.4	19.6	63.4	670	1 070	1 750	2 460	1 950
Angola	2006	25.2	–	–	82.4	17.6	8.5	26.3	–	–	–	–	–
Benin	–	–	–	–	69.9	30.1	13.9	46.4	84	76.2	55.4	63	63
Botswana	2003	23.8	21.4	26.3	57.6	42.4	30.4	54.1	26	27	39	93	125
Burkina Faso	1998	2.4	2.3	2.6	83.4	16.6	10.6	22.4	50	50	50	50	50
Burundi	1990				92.7	7.3	6.7	8.0	–	–	–	–	–
Cameroon	2001	7.5	8.2	6.7	65.7	34.3	20.1	48.2	11	11	11	11	11
Cape Verde	–	–	–	–	53.5	46.5	24.1	66.0	81	85	92	113	137
Central African Republic	–	–	–	–	79.6	20.4	10.6	29.5	–	–	–	–	–
Chad	1993	0.69	1.1	0.3	71.6	28.4	22.5	34.1	–	–	–	–	–
Comoros	–	–	–	–	72.4	27.6	12.7	42.2	12	12	12	12	12
Congo	–	–	–	–	72.0	28.0	12.3	43.2	12	10	13	15	11
Congo, Dem. Rep. of the	2007	8.9	–	–	75.7	24.3	9.4	38.6	–	–	–	–	–
Côte d'Ivoire	1998	4.1	–	–	64.4	35.6	11.3	61.2	116	120	142	159	160
Djibouti	1991	43.5	41.9	46.7	67.9	32.1	17.0	47.0	–	–	–	–	–
Egypt	2006–07	9.1	6.8	24.0	46.5	53.5	26.8	79.9	2 911	2 893	2 961	3 341	5 017
Equatorial Guinea	–	–	–	–	70.6	29.4	9.0	48.9	–	–	–	–	–
Eritrea	1984				73.6	26.4	9.7	41.8	–	–	–	–	–
Ethiopia	2005	5.4	2.7	8.2	79.9	20.1	10.8	29.1	18	33	46	134	174

	Year	Unemployment rate			Participation rate (>15) 2006	Inactivity rate (>15) 2006			Worker remittances (US$ million)				
		Total	Men	Women		Total	Men	Women	2001	2002	2003	2004	2005
Gabon	1993	18.0	19.3	16.4	72.5	27.5	16.7	38.2	5	3	6	6	6
Gambia	–	–	–	–	72.5	27.5	13.9	41.0	7	7	6.5	6.2	5.8
Ghana	1999	10.1	9.4	10.1	72.8	27.2	24.7	29.7	46	44	65	82	99
Guinea	1994	3.09	4.6	1.7	83.6	16.4	12.6	20.3	9	15	111	42	42
Guinea-Bissau	–	–	–	–	76.5	23.5	7.4	38.9	10	18	23	28	28
Kenya	1999	9.8			79.4	20.6	10.5	30.4	516.78	395.34	494.34	371	524
Lesotho	1997	39.29	30.7	47.1	58.4	41.6	26.5	53.9	209	194	287	355	327
Liberia	–	–	–	–	68.9	31.1	16.6	45.5	–	–	–	–	–
Libyan Arab Jamahiriya	2006	14.8	–	–	59.3	40.7	18.0	65.5	10	7	8	10	15
Madagascar	2003	5.0	3.8	6.2	82.5	17.5	13.8	21.1	11	17	16	11	11
Malawi	1998	0.89	1.2	0.6	87.5	12.5	10.5	14.4	1	1	1	1	1
Mali	2004	8.8	7.2	10.9	76.9	23.1	17.7	28.0	88	137	154	155	177
Mauritania	–	–	–	–	69.3	30.7	15.8	45.6	2	2	2	2	2
Mauritius	2007	8.8	5.6	15.6	60.6	39.4	21.2	57.2	215	215	215	215	215
Morocco	2005	11.0	10.8	11.5	52.8	47.2	19.7	73.2	3 261	2 877	3 614	4 220.8	4 589
Mozambique	–	–	–	–	83.8	16.2	17.0	15.4	42	53	70	58	57
Namibia	2001	31.1	26.8	35.9	54.4	45.6	37.2	53.5	9	7	12	16	16
Niger	2005	16.0	12.0	25	83.0	17.0	4.9	29.1	22	19	25.5	60	60
Nigeria	–	–	–	–	65.1	34.9	14.8	54.5	1 166.6	1 208.9	1 062.8	2 272.7	3 329
Rwanda	1996	0.6	0.9	0.4	81.4	18.6	16.4	20.5	8	7	9	10	21
Sao Tome and Principe	2000	14.39	12.5	17.8	51.5	48.5	25.3	70.7	1	1	1	1	1

	Year	Unemployment rate			Participation rate (>15) 2006	Inactivity rate (>15) 2006			Worker remittances (US$ million)				
		Total	Men	Women		Total	Men	Women	2001	2002	2003	2004	2005
Senegal	–	–	–	–	68.1	31.9	19.0	44.4	305	344	511	633	633
Seychelles	1992	34.59	27.7	41.1	–				2	2	5	7	11
Sierra Leone	–	–	–	–	74.7	25.3	5.8	43.9	7	22	26	24.7	2
Somalia	–	–	–	–	76.6	23.4	5.2	40.9	–	–	–	–	–
South Africa	2005	26.7	26.8	26.6	62.0	38.0	20.8	54.2	297	288	435	523	658
Sudan	–	–			47.4	52.6	28.8	76.4	740	978	1 224	1 403	1 016
Swaziland	1997	25.2	20.0	26.0	52.1	47.9	25.2	68.1	74	62	88	89	81
Tanzania, United Rep. of	2001	5.09	4.4	5.8	88.0	12.0	9.9	13.9	15	12	9.1	10.9	16
Togo	–	–	–	–	69.8	30.2	10.1	49.7	69	104	148	179	179
Tunisia	2005	14.2	13.1	17.3	52.1	47.9	25.1	70.8	927	1 071	1 250	1 432	1 393
Uganda	2003	3.2	2.5	3.9	78.4	16.9	13.7	20.0	342	421	306	368	450
Zambia	1998	12.0	13.0	12.0	74.3	21.6	9.0	34.0	–	–	–	–	–
Zimbabwe	2002	8.19	10.4	6.1	73.8	25.7	15.3	35.9	–	–	–	–	–
Africa									12 408	12 910	15 415	19 099	21 727

Source: Employment: ILO, KILM database, March 2007, various domestic authorities. Workers remittances: World Bank. Global Development Finance 2007.
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Table SA5. Demographic trends in Africa, 2000–50 – (a) Dependency ratio

Major area, region or country	Total dependency ratio (%)					Old-age dependency ratio (%)					Youth dependency ratio (%)				
	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050
World	59.1	55.3	52.7	52.3	56.0	10.9	11.3	11.6	17.8	25.3	48.3	44.1	41.2	34.5	30.6
More developed regions [a]	48.5	47.8	48.1	61.1	71.3	21.3	22.6	23.6	36.2	44.9	27.2	25.2	24.4	24.8	26.4
Less developed regions [b]	61.9	57.2	53.8	50.8	53.8	8.1	8.5	8.8	14.6	22.5	53.8	48.7	44.9	36.2	31.3
Least developed countries [c]	84.0	80.0	76.0	61.8	52.5	5.8	5.8	5.8	7.3	11.3	78.2	74.2	70.2	54.5	41.2
Less developed regions, excluding least developed countries [d]	58.9	53.9	50.4	48.6	54.1	8.4	8.9	9.3	16.1	25.6	50.5	45.0	41.1	32.5	28.5
Less developed regions, excluding China	67.4	63.0	59.1	51.4	51.9	7.3	7.6	7.9	12.2	19.3	60.1	55.4	51.2	39.2	32.6
Sub-Saharan Africa [e]	88.5	86.0	83.5	65.4	52.4	5.7	5.7	5.8	6.4	9.1	82.9	80.3	77.7	58.9	43.3
Africa	***83.9***	***80.2***	***77.6***	***62.6***	***52.5***	***6.0***	***6.0***	***6.1***	***7.4***	***10.8***	***78.0***	***74.2***	***71.5***	***55.2***	***41.7***
Eastern Africa [1]	*92.9*	*90.4*	*87.9*	*67.9*	*52.9*	*5.7*	*5.7*	*5.7*	*6.1*	*8.6*	*87.2*	*84.7*	*82.2*	*61.8*	*44.3*
Burundi	96.6	79.4	68.7	56.4	49.5	5.7	5.1	4.7	6.7	11.5	90.9	74.3	63.9	49.7	38.0
Comoros	74.8	70.8	69.9	53.4	51.6	5.3	5.2	5.2	7.6	14.5	69.5	65.6	64.7	45.8	37.1
Djibouti	78.2	70.7	63.6	51.6	46.7	4.8	5.1	5.4	7.7	12.4	73.4	65.6	58.2	43.9	34.3
Eritrea	89.1	79.3	78.6	54.6	50.8	4.6	4.2	4.5	4.4	10.8	84.6	75.1	74.1	50.2	40.0
Ethiopia	95.3	91.9	86.5	64.1	48.2	5.7	5.9	6.0	6.6	9.2	89.5	86.0	80.5	57.6	39.0
Kenya	88.5	83.5	83.3	64.3	53.4	5.2	5.0	4.8	6.0	9.3	83.3	78.5	78.5	58.3	44.1
Malawi	95.8	99.3	96.2	73.5	54.3	5.9	6.1	6.1	6.2	7.4	89.9	93.2	90.1	67.3	46.9
Mauritius [2]	46.7	45.4	42.2	49.8	60.0	8.5	9.4	10.7	21.3	32.7	38.2	35.9	31.5	28.4	27.3
Mayotte	91.0	81.9	69.9	49.1	46.4	5.3	5.4	5.6	8.5	16.7	85.6	76.5	64.3	40.6	29.6
Mozambique	88.0	89.6	89.3	68.0	52.9	5.9	6.1	6.2	6.8	7.8	82.1	83.6	83.0	61.2	45.1

Major area, region or country	Total dependency ratio (%)					Old-age dependency ratio (%)					Youth dependency ratio (%)				
	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050
Réunion	52.9	51.9	50.8	55.0	57.5	9.8	10.8	11.7	21.9	28.7	43.1	41.1	39.1	33.1	28.9
Rwanda	94.0	82.3	81.2	65.6	54.4	5.2	4.8	4.5	5.8	9.1	88.8	77.5	76.8	59.8	45.3
Somalia	88.4	90.1	90.8	78.8	60.5	5.2	5.3	5.2	6.0	7.5	83.2	84.9	85.7	72.8	53.1
Uganda	109.4	108.1	105.1	79.4	56.3	5.9	5.4	5.2	4.1	6.4	103.5	102.7	99.9	75.3	49.9
Tanzania, United Republic of	90.9	90.8	91.8	74.5	57.4	5.5	5.8	6.0	6.1	8.0	85.4	85.1	85.8	68.4	49.4
Zambia	92.7	96.1	97.0	73.0	54.5	5.5	5.8	6.0	5.2	6.2	87.1	90.3	91.0	67.8	48.3
Zimbabwe	84.0	81.1	77.3	55.0	46.2	6.3	6.8	7.3	5.7	10.5	77.7	74.2	70.0	49.2	35.8
Middle Africa	*97.4*	*94.9*	*90.5*	*68.9*	*51.8*	*5.8*	*5.6*	*5.5*	*5.6*	*7.8*	*91.6*	*89.3*	*85.0*	*63.4*	*44.0*
Angola	98.2	94.9	89.2	71.3	54.6	4.9	4.8	4.7	5.5	7.7	93.2	90.1	84.5	65.8	47.0
Cameroon	86.8	82.6	79.6	60.3	50.6	6.6	6.5	6.4	6.7	10.0	80.2	76.1	73.2	53.6	40.6
Central African Republic	84.6	83.2	79.3	60.5	49.9	7.2	7.1	6.9	7.1	9.7	77.4	76.1	72.3	53.4	40.2
Chad	96.6	95.8	93.9	76.3	56.4	6.1	5.7	5.5	5.4	6.9	90.5	90.1	88.4	70.8	49.4
Congo	86.4	82.0	78.6	56.6	49.1	7.2	7.0	6.8	6.6	11.2	79.1	75.0	71.8	50.0	37.8
Congo, Democratic Republic of the	103.0	101.3	96.2	70.9	50.8	5.4	5.3	5.2	5.0	7.1	97.6	95.9	91.0	65.9	43.7
Equatorial Guinea	91.1	83.3	77.3	72.7	54.1	6.8	5.8	5.1	9.1	8.1	84.3	77.4	72.2	63.6	46.0
Gabon	84.2	75.6	66.4	53.6	48.0	8.8	7.8	7.2	9.7	14.2	75.4	67.8	59.2	43.9	33.8
Sao Tome and Principe	87.2	85.0	79.2	54.1	48.5	8.2	8.1	6.9	7.0	13.6	79.0	76.9	72.2	47.2	34.9
Northern Africa	*68.4*	*60.5*	*56.5*	*49.5*	*52.1*	*7.1*	*7.2*	*7.3*	*11.7*	*20.8*	*61.3*	*53.3*	*49.2*	*37.8*	*31.4*
Algeria	62.0	52.0	46.3	44.9	55.8	6.8	6.9	6.8	12.6	27.5	55.2	45.1	39.5	32.3	28.3
Egypt	70.0	60.8	58.1	49.7	50.8	7.3	7.2	7.3	11.5	19.8	62.7	53.6	50.8	38.2	31.1
Libyan Arab Jamahiriya	55.1	51.8	52.5	42.3	57.5	5.2	5.8	6.6	11.6	27.7	49.9	46.0	45.9	30.7	29.8
Morocco	62.2	55.1	50.2	48.3	54.3	7.6	8.1	8.1	14.6	25.5	54.6	47.0	42.1	33.7	28.7
Sudan	83.3	79.0	73.4	55.4	48.9	6.0	6.2	6.4	8.1	12.8	77.3	72.9	67.0	47.3	36.2

Major area, region or country	Total dependency ratio (%)					Old-age dependency ratio (%)					Youth dependency ratio (%)				
	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050
Tunisia	57.1	47.8	42.0	45.8	59.7	9.9	9.9	9.6	17.1	33.2	47.2	37.9	32.4	28.7	26.5
Western Sahara	60.5	51.0	44.7	43.9	52.6	4.0	3.5	3.4	9.9	23.7	56.5	47.5	41.3	34.0	28.9
Southern Africa	*61.8*	*57.7*	*55.3*	*52.3*	*47.9*	*5.9*	*6.3*	*7.0*	*11.4*	*13.9*	*55.9*	*51.4*	*48.3*	*40.9*	*34.0*
Botswana	69.8	63.0	58.2	51.4	45.9	5.1	5.7	6.1	8.7	11.5	64.7	57.3	52.1	42.7	34.4
Lesotho	87.6	81.5	76.2	61.9	51.2	8.8	8.7	8.4	8.5	9.1	78.7	72.9	67.9	53.4	42.1
Namibia	79.8	73.8	66.8	54.9	47.7	6.2	6.1	6.1	8.5	11.8	73.7	67.7	60.7	46.4	35.9
South Africa	59.4	55.6	53.6	51.6	47.9	5.8	6.3	7.1	11.9	14.5	53.6	49.3	46.6	39.7	33.3
Swaziland	90.3	82.1	73.0	59.9	47.3	5.6	5.8	5.9	6.9	6.6	84.7	76.3	67.1	53.0	40.8
Western Africa [3]	*88.1*	*85.6*	*83.8*	*64.4*	*53.0*	*5.5*	*5.5*	*5.6*	*6.2*	*9.1*	*82.6*	*80.1*	*78.2*	*58.3*	*43.9*
Benin	91.8	88.2	85.8	67.8	53.6	6.1	5.9	6.1	6.9	9.9	85.8	82.3	79.7	60.9	43.7
Burkina Faso	96.1	91.9	93.9	72.1	54.6	4.3	4.0	3.9	4.3	6.9	91.8	87.9	90.0	67.8	47.7
Cape Verde	91.0	78.2	65.5	50.5	50.8	8.4	8.1	6.8	10.5	21.1	82.6	70.1	58.7	40.0	29.8
Côte d'Ivoire	80.8	81.5	79.6	60.8	50.1	5.8	6.5	7.0	7.7	11.0	75.0	75.0	72.6	53.1	39.1
Gambia	84.1	83.9	81.6	63.0	50.3	5.0	5.1	5.2	5.8	8.6	79.1	78.8	76.4	57.1	41.7
Ghana	80.5	75.9	71.8	58.9	53.3	6.0	6.1	6.3	7.9	12.2	74.5	69.8	65.5	51.1	41.1
Guinea	89.4	86.8	84.9	67.6	53.0	5.8	5.8	6.1	7.1	9.9	83.5	81.1	78.8	60.5	43.2
Guinea-Bissau	82.8	84.9	85.4	72.8	58.2	6.4	6.3	6.4	6.8	8.3	76.5	78.6	79.0	66.0	49.9
Liberia	89.3	87.0	83.9	65.1	51.7	5.6	5.6	5.7	7.2	10.0	83.7	81.4	78.2	57.9	41.8
Mali	92.7	88.5	86.5	68.3	54.3	5.0	4.5	4.3	4.3	6.9	87.7	84.0	82.2	64.0	47.4
Mauritania	81.5	76.3	72.1	54.6	48.5	4.9	4.7	4.6	6.2	11.3	76.6	71.6	67.5	48.4	37.2
Niger	102.4	103.8	108.8	97.1	71.2	4.1	4.1	4.1	4.6	5.1	98.3	99.8	104.7	92.5	66.1
Nigeria	88.1	85.7	83.5	61.2	50.4	5.6	5.7	5.8	6.3	9.4	82.5	80.0	77.7	55.0	41.0
Senegal	92.3	88.2	84.2	58.9	49.0	4.7	4.6	4.4	4.4	8.7	87.5	83.6	79.8	54.5	40.4

Major area, region or country	Total dependency ratio (%)					Old-age dependency ratio (%)					Youth dependency ratio (%)				
	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050
Sierra Leone	79.1	80.7	82.9	66.2	53.5	4.0	3.5	3.4	3.6	6.2	75.2	77.2	79.5	62.6	47.3
Togo	85.7	80.7	75.8	57.8	50.5	6.0	6.1	6.3	7.8	12.8	79.7	74.6	69.5	50.0	37.7

Definitions: *Total dependency ratio:* A measure showing the number of dependants (aged 0–14 and over the age of 65) to the total population (aged 15–64). This indicator gives insight into the number of people of non-working age compared to the number of those of working age. A high ratio means that those of working age – and the overall economy – face a greater burden in supporting the ageing population. The total dependency ratio is the sum of youth and old-age dependency ratio. *Old-age dependency ratio:* Population aged 65 years or over to the population aged 15–64. *Youth dependency ratio:* A measure showing the number of youth dependants (aged 0–14) to the total population (aged 15–64). The youth dependency ratio includes only under-15s. For example, if in a population of 1,000 there are 250 people under the age of 15 and 500 people between the ages of 15–64, the youth dependency ratio would be 50 per cent (250/500).

Notes: Countries or areas listed individually are only those with 100,000 inhabitants or more in 2009; the rest are included in the regional groups but are not listed separately. [a] More developed regions comprise Europe, North America, Australia–New Zealand and Japan. [b] Less developed regions comprise all regions of Africa, Asia (excluding Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia. [c] The least developed countries comprise 49 countries: 33 in Africa, ten in Asia, five in Oceania and one in Latin America and the Caribbean. [d] Other less developed countries comprise the less developed regions excluding the least developed countries. [e] Sub-Saharan Africa refers to all of Africa except northern Africa, with the Sudan included in sub-Saharan Africa. [1] Including Seychelles. [2] Including Agalega, Rodrigues and Saint Brandon. [3] Including Saint Helena, Ascension and Tristan da Cunha.

Source: Based on UN, 2009: *World Population Prospects: The 2008 Revision*. Projections based on medium variant of the population projections.

Table SA5. (b) Ageing

Major area, region or country	Population under 15 (% of total population)					Population over 60 (% of total population)					Population over 80 (% of total population)				
	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050
World	30.3	28.4	26.9	22.7	19.6	9.9	10.2	11.0	16.5	21.9	1.1	1.3	1.5	2.3	4.3
More developed regions [a]	18.3	17.0	16.5	15.4	15.4	19.5	20.1	21.8	28.8	32.6	3.1	3.7	4.3	6.4	9.5
Less developed regions [b]	33.2	31.0	29.2	24.0	20.3	7.5	8.0	8.6	14.2	20.2	0.7	0.8	0.9	1.6	3.5
Least developed countries [c]	42.5	41.2	39.9	33.7	27.0	4.9	5.0	5.2	7.0	11.1	0.3	0.4	0.4	0.6	1.1
Less developed regions, excluding least developed countries [d]	31.8	29.3	27.3	21.9	18.5	7.9	8.5	9.3	15.8	22.7	0.7	0.9	1.0	1.8	4.1
Less developed regions, excluding China	35.9	34.0	32.2	25.9	21.5	6.7	7.0	7.5	11.8	17.8	0.6	0.7	0.8	1.3	2.7
Sub-Saharan Africa [e]	44.0	43.2	42.3	35.6	28.4	4.8	4.8	4.9	5.9	9.1	0.3	0.3	0.4	0.5	0.8
Africa	***42.4***	***41.2***	***40.3***	***34.0***	***27.3***	***5.1***	***5.2***	***5.4***	***6.9***	***10.6***	***0.4***	***0.4***	***0.4***	***0.6***	***1.1***
Eastern Africa [1]	*45.2*	*44.5*	*43.7*	*36.8*	*29.0*	*4.6*	*4.6*	*4.7*	*5.5*	*8.7*	*0.3*	*0.4*	*0.4*	*0.5*	*0.8*
Burundi	46.2	41.4	37.9	31.8	25.4	4.4	4.4	4.4	6.5	12.3	0.4	0.4	0.4	0.5	0.9
Comoros	39.8	38.4	38.1	29.9	24.4	4.7	4.7	4.7	7.7	13.7	0.4	0.4	0.4	0.5	1.3
Djibouti	41.2	38.4	35.6	29.0	23.4	4.5	4.9	5.4	8.0	13.1	0.2	0.3	0.3	0.6	1.1
Eritrea	44.7	41.9	41.5	32.5	26.5	4.0	4.0	4.1	4.6	10.8	0.3	0.3	0.3	0.4	0.7
Ethiopia	45.8	44.8	43.2	35.1	26.3	4.7	4.9	5.1	6.1	9.6	0.3	0.3	0.4	0.6	0.9
Kenya	44.2	42.8	42.8	35.5	28.8	4.1	4.0	4.1	5.5	9.3	0.4	0.4	0.4	0.5	0.8
Madagascar	45.1	44.3	42.5	34.1	26.9	4.8	4.6	4.6	6.7	10.3	0.3	0.4	0.4	0.5	1.1
Malawi	45.9	46.8	45.9	38.8	30.4	4.7	4.7	4.9	5.2	7.2	0.3	0.3	0.4	0.5	0.7
Mauritius [2]	26.0	24.7	22.2	19.0	17.1	8.7	9.9	11.6	20.6	26.1	0.9	1.1	1.3	2.7	5.9
Mayotte	44.9	42.1	37.9	27.2	20.3	4.2	4.5	5.0	8.6	16.4	0.5	0.5	0.5	1.0	2.2
Mozambique	43.7	44.1	43.9	36.4	29.5	5.0	5.0	5.1	6.0	7.7	0.3	0.4	0.4	0.6	0.8
Réunion	28.2	27.1	26.0	21.4	18.3	9.4	10.1	11.1	19.9	23.8	1.1	1.3	1.5	2.5	5.8
Rwanda	45.8	42.5	42.4	36.1	29.3	4.1	3.9	3.8	5.3	9.6	0.2	0.3	0.3	0.4	0.7

Major area, region or country	Population under 15 (% of total population)					Population over 60 (% of total population)					Population over 80 (% of total population)				
	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050
Somalia	44.2	44.6	44.9	40.7	33.1	4.4	4.3	4.3	5.3	7.1	0.3	0.3	0.3	0.4	0.6
Uganda	49.4	49.3	48.7	42.0	31.9	4.1	4.0	3.8	3.6	6.5	0.3	0.3	0.3	0.4	0.5
Tanzania, United Republic of	44.7	44.6	44.7	39.2	31.4	4.6	4.7	4.9	5.3	7.7	0.3	0.3	0.4	0.5	0.7
Zambia	45.2	46.0	46.2	39.2	31.3	4.6	4.7	4.8	4.4	6.3	0.3	0.3	0.4	0.5	0.5
Zimbabwe	42.2	41.0	39.5	31.8	24.5	5.1	5.6	5.8	4.9	12.0	0.5	0.6	0.6	0.8	0.7
Middle Africa	*46.4*	*45.8*	*44.6*	*37.5*	*29.0*	*4.6*	*4.6*	*4.5*	*5.2*	*8.1*	*0.3*	*0.3*	*0.3*	*0.4*	*0.6*
Angola	47.1	46.2	44.7	38.4	30.4	4.0	3.9	3.9	5.1	7.8	0.2	0.2	0.3	0.3	0.6
Cameroon	42.9	41.7	40.8	33.4	27.0	5.4	5.4	5.4	6.3	10.2	0.4	0.5	0.5	0.6	0.9
Central African Republic	41.9	41.5	40.3	33.3	26.8	6.0	5.9	5.8	6.7	10.0	0.4	0.5	0.5	0.6	0.9
Chad	46.0	46.0	45.6	40.2	31.6	4.8	4.6	4.4	4.8	7.0	0.3	0.3	0.3	0.3	0.5
Congo	42.5	41.2	40.2	31.9	25.4	5.8	5.7	5.7	6.5	11.5	0.5	0.5	0.5	0.6	0.9
Congo, Democratic Republic of the	48.1	47.7	46.4	38.6	29.0	4.3	4.2	4.2	4.7	7.5	0.3	0.3	0.3	0.3	0.6
Equatorial Guinea	44.1	42.2	40.7	36.8	29.9	5.1	4.6	4.3	8.1	8.4	0.5	0.5	0.4	0.4	1.1
Gabon	40.9	38.6	35.6	28.6	22.8	6.6	6.3	6.4	9.3	14.1	0.8	0.8	0.8	0.9	1.7
Sao Tome and Principe	42.2	41.6	40.3	30.6	23.5	6.5	5.8	5.3	6.7	13.3	0.5	0.6	0.6	0.5	1.1
Northern Africa	*36.4*	*33.2*	*31.5*	*25.3*	*20.6*	*6.4*	*6.6*	*7.2*	*11.6*	*19.4*	*0.5*	*0.5*	*0.6*	*1.1*	*2.5*
Algeria	34.1	29.6	27.0	22.3	18.2	6.3	6.5	6.9	13.3	24.3	0.6	0.6	0.7	1.1	3.4
Egypt	36.9	33.3	32.1	25.5	20.6	6.5	6.7	7.5	11.4	19.2	0.5	0.5	0.6	1.1	2.3
Libyan Arab Jamahiriya	32.2	30.3	30.1	21.6	18.9	5.3	6.0	6.6	12.4	23.1	0.4	0.5	0.6	1.4	3.4
Morocco	33.6	30.3	28.0	22.7	18.6	7.2	7.5	8.1	14.3	22.9	0.6	0.6	0.8	1.3	3.3
Sudan	42.2	40.7	38.7	30.5	24.3	5.1	5.4	5.7	7.9	12.7	0.4	0.4	0.4	0.7	1.3
Tunisia	30.1	25.7	22.8	19.7	16.6	9.1	9.2	9.7	16.9	28.2	0.8	0.9	1.1	1.8	4.6
Western Sahara	35.2	31.4	28.5	23.7	18.9	3.8	3.6	4.0	11.4	21.8	0.3	0.3	0.3	0.5	2.4
Southern Africa	*34.6*	*32.6*	*31.1*	*26.9*	*23.0*	*5.9*	*6.4*	*7.2*	*10.5*	*13.7*	*0.4*	*0.5*	*0.6*	*1.2*	*2.0*
Botswana	38.1	35.2	32.9	28.2	23.6	4.8	5.4	5.9	8.0	12.4	0.3	0.4	0.5	0.8	1.2

Major area, region or country	Population under 15 (% of total population)					Population over 60 (% of total population)					Population over 80 (% of total population)				
	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050	2000	2005	2010	2030	2050
Lesotho	42.0	40.1	38.5	33.0	27.9	6.9	6.8	7.0	6.8	9.4	0.6	0.6	0.7	0.9	0.8
Namibia	41.0	39.0	36.4	29.9	24.3	5.1	5.3	5.6	8.0	12.1	0.4	0.5	0.5	0.8	1.4
South Africa	33.6	31.7	30.3	26.2	22.5	5.9	6.5	7.3	11.1	14.2	0.4	0.5	0.6	1.3	2.2
Swaziland	44.5	41.9	38.8	33.1	27.7	4.7	4.9	5.3	5.9	7.8	0.3	0.4	0.4	0.6	0.7
Western Africa [3]	*43.9*	*43.2*	*42.6*	*35.4*	*28.7*	*4.7*	*4.8*	*4.8*	*5.8*	*9.2*	*0.3*	*0.3*	*0.3*	*0.4*	*0.7*
Benin	44.7	43.7	42.9	36.3	28.5	4.9	5.0	5.0	6.4	9.6	0.4	0.4	0.4	0.5	0.9
Burkina Faso	46.8	45.8	46.4	39.4	30.9	3.6	3.5	3.3	4.3	7.1	0.2	0.2	0.1	0.2	0.4
Cape Verde	43.2	39.3	35.5	26.6	19.7	6.5	5.9	5.4	10.8	20.3	0.7	0.5	0.7	0.7	2.8
Côte d'Ivoire	41.5	41.3	40.4	33.0	26.0	5.3	5.7	6.1	7.1	11.0	0.3	0.3	0.4	0.7	1.0
Gambia	43.0	42.8	42.1	35.1	27.7	4.8	4.8	4.9	6.0	8.9	0.2	0.1	0.1	0.3	0.6
Ghana	41.3	39.7	38.1	32.1	26.8	5.2	5.4	5.8	7.7	11.8	0.4	0.4	0.5	0.7	1.2
Guinea	44.1	43.4	42.6	36.1	28.2	4.9	5.1	5.2	6.4	9.7	0.3	0.3	0.3	0.5	0.9
Guinea-Bissau	41.8	42.5	42.6	38.2	31.6	5.4	5.5	5.5	5.6	7.9	0.4	0.4	0.4	0.5	0.6
Liberia	44.2	43.5	42.5	35.1	27.5	4.7	4.8	4.9	6.7	9.9	0.3	0.3	0.3	0.5	0.9
Mali	45.5	44.5	44.1	38.0	30.7	4.3	4.0	3.8	4.4	7.3	0.2	0.2	0.1	0.2	0.4
Mauritania	42.2	40.6	39.2	31.3	25.1	4.4	4.4	4.4	6.7	11.6	0.2	0.2	0.2	0.3	0.8
Niger	48.6	48.9	50.1	46.9	38.6	3.5	3.5	3.5	3.8	4.8	0.1	0.1	0.1	0.2	0.3
Nigeria	43.9	43.1	42.4	34.1	27.3	4.8	4.9	4.9	6.0	9.6	0.3	0.3	0.3	0.5	0.8
Senegal	45.5	44.4	43.3	34.3	27.1	4.2	4.1	3.9	4.8	9.3	0.1	0.1	0.1	0.2	0.5
Sierra Leone	42.0	42.7	43.5	37.7	30.8	4.0	3.6	3.5	4.0	6.7	0.1	0.1	0.1	0.1	0.3
Togo	42.9	41.3	39.5	31.7	25.0	5.0	5.2	5.5	7.5	12.5	0.3	0.4	0.4	0.7	1.2

Notes: Countries or areas listed individually are only those with 100,000 inhabitants or more in 2009; the rest are included in the regional groups but are not listed separately. [a] More developed regions comprise Europe, North America, Australia–New Zealand and Japan. [b] Less developed regions comprise all regions of Africa, Asia (excluding Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia. [c] The least developed countries comprise 49 countries: 33 in Africa, ten in Asia, five in Oceania and one in Latin America and the Caribbean. [d] Other less developed countries comprise the less developed regions excluding the least developed countries. [e] Sub-Saharan Africa refers to all of Africa except northern Africa, with the Sudan included in sub-Saharan Africa. [1] Including Seychelles. [2] Including Agalega, Rodrigues and Saint Brandon. [3] Including Saint Helena, Ascension and Tristan da Cunha.

Source: Based on UN, 2009: *World Population Prospects: The 2008 Revision*. Projections based on medium variant of the population projections.

Table SA6. Social security statutory provision by branch – (a) Overview

Country	Number of branches covered by one programme at least		Existence of a statutory programme							
	Number of branches covered by one programme at least	Number of social security branches covered by a statutory programme | Strict definition[2]	Sickness	Maternity	Old age	Invalidity	Survivors	Family allowances	Employment injury	Unemployment
Algeria	8	Comprehensive social security | 8 branches	X	X	X	X	X	X	X	X
Angola	–	–	–	–	–	–	–	–	–	None
Benin	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Botswana	4	Very limited statutory provision | 1–4 branches	▲	▲	X	None	X	X	X	▲
Burkina Faso	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Burundi	6	Limited statutory provision | 5–6 branches	X	▲	X	X	X	X	X	None
Cameroon	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Cape Verde	7	Semi-comprehensive | 7 branches covered	X	X	X	X	X	X	X	None
Central African Republic	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Chad	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Congo	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Congo, Democratic Republic of the	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Côte d'Ivoire	6	Limited statutory provision | 5–6 branches	Δ	X	X	X	X	X	X	None

Country	Number of branches covered by one programme at least		Existence of a statutory programme							
	Number of branches covered by one programme at least	Number of social security branches covered by a statutory programme | Strict definition[2]	Sickness	Maternity	Old age	Invalidity	Survivors	Family allowances	Employment injury	Unemployment
Djibouti	–	–	–	–	–	–	–	–	–	None
Egypt	7	Semi-comprehensive | 7 branches covered	X	X	X	X	X	None	X	X
Eritrea	–	–	–	–	–	–	–	–	–	None
Ethiopia	4	Very limited statutory provision | 1–4 branches	▲	▲	X	X	X	None	X	None
Gabon	5	Limited statutory provision | 5–6 branches	Δ	▲	X	X	X	X	X	None
Gambia	4	Very limited statutory provision | 1–4 branches	None	–	X	X	X	None	X	None
Ghana	4	Very limited statutory provision | 1–4 branches	Δ	None	X	X	X	None	X	None
Equatorial Guinea	7	Semi-comprehensive | 7 branches covered	X	X	X	X	X	X	X	None
Guinea	7	Semi-comprehensive | 7 branches covered	X	X	X	X	X	X	X	None
Guinea-Bissau	–	–	–	–	–	–	–	–	–	None
Kenya	5	Limited statutory provision | 5–6 branches	Δ	X	X	X	X	None	X	None
Lesotho	–	–	–	–	–	–	–	–	–	None
Liberia	4	Very limited statutory provision | 1–4 branches	None	None	X	X	X	None	X	None
Libyan Arab Jamahiriya	6	Limited statutory provision | 5–6 branches	X	X	X	X	X	None	X	▲
Madagascar	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Malawi	1	Very limited statutory provision | 1–4 branches	None	None	None	None	None	None	X	None
Mali	6	Limited statutory provision | 5–6 branches	Δ	X	X	X	X	X	X	None

Country	Number of branches covered by one programme at least		Existence of a statutory programme							
	Number of branches covered by one programme at least	Number of social security branches covered by a statutory programme | Strict definition[2]	Sickness	Maternity	Old age	Invalidity	Survivors	Family allowances	Employment injury	Unemployment
Morocco	7	Semi-comprehensive | 7 branches covered	X	X	X	X	X	X	X	None
Mauritania	6	Limited statutory provision | 5–6 branches	Δ	X	X	X	X	X	X	None
Mauritius	6	Limited statutory provision | 5–6 branches	▲	▲	X	X	X	X	X	X
Mozambique	5	Limited statutory provision | 5–6 branches	X	X	X	X	X	None	None	None
Namibia	7	Semi-comprehensive | 7 branches covered	X	X	X	X	X	X	X	None
Niger	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Nigeria	4	Very limited statutory provision | 1–4 branches	Δ	▲	X	X	X	None	X	▲
Réunion	–	–	–	–	–	–	–	–	–	–
Rwanda	4	Very limited statutory provision | 1–4 branches	▲	▲	X	X	X	None	X	None
Sao Tome and Principe	6	Limited statutory provision | 5–6 branches	X	X	X	X	X	None	X	None
Senegal	5	Limited statutory provision | 5–6 branches	Δ	X	X	None	X	X	X	None
Seychelles	7	Semi-comprehensive | 7 branches covered	X	X	X	X	X	None	X	X
Sierra Leone	4	Very limited statutory provision | 1–4 branches	None	None	X	X	X	None	X	None
Somalia	–	–	–	–	–	–	–	–	–	–
South Africa	7	Semi-comprehensive | 7 branches covered	X	X	X	X	None	X	X	X
Sudan	4	Very limited statutory provision | 1–4 branches	None	None	X	X	X	None	X	None
Swaziland	4	Very limited statutory provision | 1–4 branches	None	None	X	X	X	None	X	None
Tanzania, United Republic of	5	Limited statutory provision | 5–6 branches	Δ	X	X	X	X	None	X	▲

Country	Number of branches covered by one programme at least		Existence of a statutory programme							
	Number of branches covered by one programme at least	Number of social security branches covered by a statutory programme | Strict definition[2]	Sickness	Maternity	Old age	Invalidity	Survivors	Family allowances	Employment injury	Unemployment
Togo	6	Limited statutory provision | 5–6 branches	▲	X	X	X	X	X	X	None
Tunisia	8	Comprehensive social security | 8 branches	X	X	X	X	X	X	X	X
Uganda	4	Very limited statutory provision | 1–4 branches	None	None	X	X	X	None	X	None
Zambia	4	Very limited statutory provision | 1–4 branches	Δ	None	X	X	X	None	X	None
Zimbabwe	4	Very limited statutory provision | 1–4 branches	None	▲	X	X	X	None	X	None

Notes: X = One statutory programme at least. ▲ = Limited provision (e.g. labour code only). Δ = Only benefit in kind (e.g. medical benefit). n.a. = Not applicable. – = Not available.

Additional information: The number of branches covered by one programme at least is the sum for a given country of the social security branches for which a programme exists through national legislation. This indicator can take the value 0 to 8 according to the total number of branches covered by one or several statutory provisions. The eight following branches are taken into consideration: sickness, maternity, old age, survivors, invalidity, family allowances, employment injury and unemployment. A programme or a scheme can be of several types: social insurance, social assistance, universal, employer liability (under the responsibility of the employer as mentioned in the legislation or the labour code) or mandatory private. The number of branches covered by one programme at least provides an overview of the scope of legal social security provision.

Sources: SSA/ISSA, 2009: *Social security programs throughout the world: Africa* (Geneva, ISSA); national legislation.

Table SA6. (b) Old age

Major area, region or country	Type of programme	Statutory pensionable age		Contribution rates			Estimate of legal coverage for old age as a percentage of the working-age population
		Men	Women	Employee	Employer	Financing from government	All programmes: contributory and non-contributory
Algeria	Social insurance	60	55	7	10	No contribution	25–50 per cent
Benin	Social insurance	60	60	3.6	6.4	No contribution	Less than 25 per cent
Botswana	Universal	65	65	No contribution	No contribution	Whole cost	Over 75 per cent
Burkina Faso	Social insurance	56	56	5.5	5.5	No contribution	Less than 25 per cent
Burundi	Social insurance	60	60	2.6	3.9	No contribution	Less than 25 per cent
Cameroon	Social insurance	60	60	2.8	4.2	No contribution	Less than 25 per cent
Cape Verde	Social insurance	65	60	3	7	No contribution	25–50 per cent
Central African Republic	Social insurance	60	60	4	3	No contribution	Over 75 per cent
Chad	Social insurance	55	55	2	4	No contribution	Less than 25 per cent
Congo	Social insurance	60	60	4	8	No contribution	Less than 25 per cent
Congo, Democratic Republic of the	Social insurance	65	60	3.5	3.5	Discretionary | Irregular contribution	Less than 25 per cent
Côte d'Ivoire	Social insurance	55	55	3.2	4.8	No contribution	Less than 25 per cent
Egypt	Social insurance	60	60	10	15	Discretionary | Irregular contribution	25–50 per cent
Equatorial Guinea	Social insurance	60	60	4.5	21.5	Discretionary | Irregular contribution	Less than 25 per cent
Ethiopia	Social insurance	60	60	4	6	No contribution	Less than 25 per cent
Gabon	Social insurance	55	55	2.5	5	No contribution	Less than 25 per cent
Gambia	Social insurance; provident funds	60	60	No contribution	15	No contribution	Less than 25 per cent
Ghana	Social insurance	60	60	5	12.5	No contribution	50–75 per cent
Guinea	Social insurance	55	55	2.5	4	No contribution	Less than 25 per cent

Major area, region or country	Type of programme	Statutory pensionable age		Contribution rates			Estimate of legal coverage for old age as a percentage of the working-age population
		Men	Women	Employee	Employer	Financing from government	All programmes: contributory and non-contributory
Kenya	Provident funds	60	60	5	5	No contribution	Less than 25 per cent
Liberia	Social insurance; social assistance	60	60	3	3	No contribution	50–75 per cent
Libyan Arab Jamahiriya	Social insurance	65	60	3.75	10.5	Discretionary | Irregular contribution	Less than 25 per cent
Madagascar	Social insurance	60	55	1	9.5	No contribution	Less than 25 per cent
Malawi	No statutory provision	n.a.	n.a.	n.a.	n.a.	n.a.	None | Limited provision
Mali	Social insurance	58	58	3.6	5.4	No contribution	25–50 per cent
Mauritania	Social insurance	60	55	1	2	No contribution	Less than 25 per cent
Mauritius	Universal; social insurance	60	60	3	6	Discretionary | Irregular contribution	Over 75 per cent
Morocco	Social insurance	60	60	3.96	7.93	No contribution	Less than 25 per cent
Mozambique	Social insurance; social assistance	65	65	–	–	–	–
Namibia	Universal; social insurance	60	55	–	–	–	Over 75 per cent
Niger	Social insurance	60	60	1.6	2.4	No contribution	Less than 25 per cent
Nigeria	Mandatory private insurance; social insurance	50	50	7.5	7.5	No contribution	Less than 25 per cent
Rwanda	Social insurance	55	55	3	3	No contribution	50–75 per cent
Sao Tome and Principe	Social insurance	62	57	4	6	No contribution	25–50 per cent
Senegal	Social insurance	55	55	5.6	8.4	No contribution	Less than 25 per cent
Seychelles	Universal; social insurance	63	63	2.5 + a flat rate amount	20 + a flat rate amount	Discretionary | Irregular contribution	Over 75 per cent
Sierra Leone	Social insurance	60	60	5	10	2.5	50–75 per cent
South Africa	Social assistance; universal	61	60	No contribution	No contribution	Whole cost	Over 75 per cent
Sudan	Social insurance	60	60	8	17	No contribution	25–50 per cent
Swaziland	Provident funds; social assistance	50	50	5	5	No contribution	25–50 per cent

Major area, region or country	Type of programme	Statutory pensionable age		Contribution rates			Estimate of legal coverage for old age as a percentage of the working-age population
		Men	Women	Employee	Employer	Financing from government	All programmes: contributory and non-contributory
Tanzania, United Republic of	Social insurance; provident funds	60	60	10	10	No contribution	50–75 per cent
Togo	Social insurance	60	60	4	8	No contribution	–
Tunisia	Social insurance	60	60	4.74	7.76	No contribution	25–50 per cent
Uganda	Provident funds	55	55	5	10	No contribution	Less than 25 per cent
Zambia	Social insurance	55	55	5	5	No contribution	25–50 per cent
Zimbabwe	Social insurance	60	60	4	4	No contribution	Less than 25 per cent

Definitions: *Statutory pensionable age*: Refers to statutory retirement age according to the legislation. If several statutory retirement ages exist (e.g. depending on sector of activity), the selected age should be the most representative one in terms of persons covered. *Contribution rates:* Where there are several contribution rates, the average or most common rate is indicated or a reference to a specific note. *Legal coverage:* Legal coverage is distinct from effective coverage. A population group can be identified as legally covered if there are existing legal provisions that such a group should be covered by social insurance for a given branch of social security, or will be entitled to specified benefits under certain circumstances – for instance, to an old-age state pension on reaching the age of 65, or to income support (including old-age social pension) if income falls below a specified threshold. *Estimate of legal coverage*: Estimates of the extent of legal coverage use both(i) information on the groups covered by statutory schemes for a given branch in national legislation (e.g. wage workers; all employed; employees in the public sector), and (ii) available statistical information quantifying the number of persons concerned at the national level. The identification of the groups covered is based on the information compiled in *Social Security Programmes Throughout the World* (SSA/ISSA, 2008, 2009). Their quantification uses mostly ILO LABORSTA completed when necessary with national data (mostly from household surveys or establishment surveys). The legal extent of coverage rate for a given branch of social security is the ratio between the estimated number of people legally covered and – as appropriate – the working age population, the economically active population; the number of employees (that is wage and salary workers), the total number of employed persons (including employees, self-employed etc.), or the total population (especially in the case of health protection).

Notes: n.a. Not applicable. – Not available.

Sources: SSA/ISSA, 2008, 2009: *Social Security Programs Throughout the World* (Washington, DC and Geneva): The Americas, 2009; Europe, 2008; Asia and the Pacific, 2009; Africa, 2009. For estimates of legal coverage: ILO, 2009h: LABORSTA (http://laborsta.ilo.org/): Total and economically active population; employment (total, by status, public sector employment). National statistical offices: datasets and reports from national labour force surveys or other household or establishment surveys (link to national statistical offices web sites: http://laborsta.ilo.org/links_content_E.html#m2).

Table SA7. Regional estimates of legal coverage for old age, employment injury and unemployment, 2008–09

Old age

Region	Old age legal coverage as a percentage of the working-age population			
	All old-age social security programmes	Old-age contributory programmes excluding voluntary	Old-age contributory voluntary coverage for self-employed	Old age non-contributory programmes
North America	75.4	73.0	0.0	2.5
Western Europe	77.4	70.4	0.5	6.5
CIS	66.8	65.3	0.0	1.5
Central and Eastern Europe	62.3	58.9	2.4	0.9
Latin America and the Caribbean	63.8	58.4	4.7	0.8
Middle East	40.3	38.5	0.3	1.6
North Africa	34.4	34.4	0.0	0.0
Asia and the Pacific	31.9	27.9	1.9	2.1
Sub-Saharan Africa	26.1	14.0	3.7	8.5
Total	42.0	37.3	2.0	2.7

Employment injury

	Legal employment injury coverage as a percentage of:			
	Working-age population		Economically active population	
	Mandatory	Voluntary	Mandatory	Voluntary
Africa	19.0	1.6	26.3	2.2
Sub-Saharan Africa	17.1	1.8	22.2	2.4
North Africa	26.3	0.8	46.2	1.4
Asia and the Pacific	20.8	0.2	25.9	0.3
Middle East	36.0	0.0	61.6	0.0
Latin America and the Caribbean	41.5	2.6	55.2	3.5
Central and Eastern Europe	54.5	2.8	82.4	4.3
CIS	55.8	0.2	75.8	0.3
North America	67.1	0.0	84.5	0.0
Western Europe	61.8	3.3	84.2	4.5
Total	30.3	0.8	39.3	1.1

Unemployment

1. As a percentage of the working-age population

	Legal unemployment coverage as a percentage of the working-age population			
	Mandatory contributory coverage	Non-contributory coverage	Voluntary contributory coverage	Contributory and non-contributory coverage
North America	65.7	0.0	0.0	65.7
Western Europe	60.3	2.9	0.8	64.5
CIS	49.0	0.5	1.1	56.2
Central and Eastern Europe	50.5	0.7	2.8	54.0
North Africa	9.9	4.1	0.0	14.0
Asia and the Pacific	6.3	6.8	0.5	12.9
Middle East	11.5	0.0	0.0	11.5
Latin America and the Caribbean	7.2	3.0	1.0	10.2
Sub-Saharan Africa	1.1	2.7	0.0	3.8
Total	18.4	3.1	0.6	22.3

2. As a percentage of economically active population

	Legal unemployment coverage as a percentage of economically active population			
	Mandatory contributory coverage	Non-contributory coverage	Voluntary contributory coverage	Contributory and non-contributory coverage
Western Europe	79.4	3.9	1.0	85.0
North America	81.4	0.0	0.0	81.4
Central and Eastern Europe	75.5	1.0	4.6	81.0
CIS	68.3	0.6	1.6	77.8
North Africa	17.2	7.4	0.0	24.7
Asia and the Pacific	8.8	9.0	0.8	17.5
Middle East	17.3	0.0	0.0	17.3
Latin America and the Caribbean	10.0	4.0	1.3	14.0
Sub-Saharan Africa	1.9	2.2	0.0	4.1
Total	25.7	3.8	0.9	30.6

Notes: Regional estimates weighted by the working-age population (old age) or the economically active population (employment injury and unemployment).

Sources: ILO Social Security Department based on SSA/ISSA, 2008, 2009; ILO, 2009h: LABORSTA; national legislative texts; national statistical data for estimates of legal coverage.

Table SA8. Public social security expenditure (total and without health expenditure) as a percentage of GDP, 2000 and latest available year

Major area, region or country	Public social security expenditure excluding health care as a percentage of GDP				Health			Total	
	2000	Latest year available [a]	Year	Source	2000	Latest year available [a]	Source	2000	Latest year available [2]
Regional average (weighted by population)									
Western Europe		17.98				7.10			25.08
Central and Eastern Europe		14.08				4.82			18.91
North America		8.98				6.98			15.96
North Africa		11.02				2.53			13.56
CIS		9.93				3.59			13.52
Middle East		7.09				3.11			10.20
Latin America and the Caribbean		7.63				2.20			9.83
Asia and the Pacific		3.65				1.68			5.32
Sub-Saharan Africa		2.81				2.51			5.32
World		5.72				2.67			8.39
Africa									
Benin	0.70	1.00	2005	SSI	2.19	3.00	WHO	2.89	4.00
Burkina Faso	1.80	1.60	2004	SSI	2.06	3.30	WHO	3.86	4.90
Burundi	0.90	1.10	2006	SSI	0.55	0.74	WHO	1.45	1.84
Cameroon	0.40	0.50	2006	SSI	1.33	1.46	WHO	1.73	1.96
Chad	0.40	0.10	2005	SSI				0.40	0.10
Congo	1.10	0.90	2005	SSI	1.21	0.89	WHO	2.31	1.79
Côte d'Ivoire	0.40	0.90	2004	SSI	1.31	0.87	WHO	1.71	1.77
Egypt [1, 5, 6]	6.72	11.51	2007	IMF	2.24	2.56	WHO	8.96	14.07
Ethiopia [2, 6]	–	6.46	2002	IMF	–	3.12	WHO	–	9.58
Gambia	1.30	1.20	2003	SSI	1.96	2.94	WHO	3.26	4.14
Ghana	0.80	1.90	2004	SSI	3.03	2.32	WHO	3.83	4.22
Guinea	0.20	0.10	2005	SSI	0.66	0.67	WHO	0.86	0.77
Liberia	11.33	9.87	2005	IMF	1.17	4.36	WHO	12.50	14.23
Madagascar [2, 5, 6]	0.33	0.27	2007	IMF	1.37	2.01	WHO	1.70	2.28
Mauritania	0.30	0.80	2004	SSI	1.99	1.53	WHO	2.29	2.33
Mauritius	5.14	5.91	2007	IMF	1.99	2.08	IMF	7.13	7.99
Morocco [3, 6]	3.02	–	n.a.	IMF	1.41	–	WHO	4.43	–
Mozambique	0.20	0.70	2006	SSI	3.79	3.26	WHO	3.99	3.96
Namibia	–	1.80	2004	SSI	4.82	4.98	WHO	–	6.78
Niger	0.30	0.50	2005	SSI	1.87	1.92	WHO	2.17	2.42
Rwanda	0.50	0.80	2005	SSI	1.57	4.10	WHO	2.07	4.90
Senegal [1]	1.80	1.90	2006	SSI	1.95	1.70	WHO	3.75	3.60
Seychelles	7.71	12.61	2007	IMF	3.78	4.10	IMF	11.49	16.71
Sierra Leone [1]	0.30	1.00	2006	SSI	2.25	1.72	WHO	2.55	2.72

Major area, region or country	Public social security expenditure excluding health care as a percentage of GDP				Health			Total	
	2000	Latest year available [a]	Year	Source	2000	Latest year available [a]	Source	2000	Latest year available [2]
South Africa	3.65	8.43	2005	IMF	3.23	3.92	IMF	6.88	12.35
Sudan	0.50	0.30	2003	SSI	0.79	1.26	WHO	1.29	1.56
Tanzania, United Rep. of [4, 5]	0.40	1.20	2007	SSI	2.03	3.26	WHO	2.43	4.46
Togo	1.20	1.30	2003	SSI	1.24	1.05	WHO	2.44	2.35
Tunisia [5, 6]	6.01	7.50	2007	IMF	2.72	2.32	WHO	8.73	9.82
Uganda	0.10	0.40	2006	SSI	1.77	1.94	AHO	1.87	2.34
Zambia	1.60	1.60	2006	SSI	2.92	2.43	WHO	4.52	4.03
Zimbabwe	0.30	0.30	2005	SSI	3.58	3.63	WHO	3.88	3.93

Definitions: Public social security expenditure (total and without health expenditure) in percentage of GDP. *Numerator:* Total annual public social security expenditure is the sum of expenditure (including benefit expenditure and administration costs) of all existing public social security/social protection schemes or programmes in the country. The scope of the indicators corresponds to the scope of the Social Security (Minimum Standards) Convention, 1952 (No. 102), which established nine classes of benefits: medical care, sickness benefit, unemployment benefit, old-age benefit, employment injury benefit, family benefit, maternity benefit, invalidity benefit and survivors' benefit, plus other income support and assistance programmes, including conditional cash transfers, available to the poor and not included under the above classes. *Denominator*: Gross domestic product. Numerators and denominators should be expressed in national currency units, current prices. For analytical purposes this indicator is disaggregated into health and non-health public social security expenditure. And, when possible and depending on data availability, disaggregate the non-health social security expenditure into old-age benefit expenditure and other non-health social security expenditure.

Interpretation:

- Total public social security expenditure synthesizes the overall public redistributive effort and is closely correlated with overall coverage. It is a useful indicator for comparative purposes at the national and scheme levels but its interpretation presents inherent difficulties (whether in global level, composition or changes over time) in relation to further contextual information (legal framework, economic and social context):
  - (i) While social protection expenditure is – in the longer run – positively correlated with overall coverage (its scope, extent and level), it may also change due to factors other than coverage changes.
  - (ii) Changes in social security expenditure are often countercyclical – a fall in total public social security expenditure in percentage of GDP could result from higher employment rates (declining unemployment) or from a reduction in occupational injuries which could point towards progress.
  - (iii) In specific branches (e.g. employment injury insurance) increase or decrease in expenditure may be a result of changes in the need or utilization of those benefited (more or fewer accidents at work) and not changes in coverage.
  - (iv) Aggregate expenditure can be distributed in various ways among lower and higher income population: expenditure may be high (or increase) as a result of the expansion of a specific generous programme for relatively narrow, better-off groups of the population (such as civil servants or military personnel).
  - (v) This indicator should be analysed in relation to the different branches covered at the statutory level and their respective share (health, old age, unemployment). Many developing countries do not have, at a statutory level, a comprehensive social system covering the nine branches as mentioned above. One common situation is a system covering long-term benefits (old age, survivors and invalidity) and work injury benefit.
  - (vi) Comparison across countries is difficult as countries differ with respect to the level of taxes imposed on social benefits directly and indirectly. When such taxation rules change over time within the country, the interpretation of changes in social protection expenditure should also be affected.
  - (vii) Demographic structure, and in particular share of older persons, is another factor that can have a direct impact on old-age and health expenditure and accordingly on the global public expenditure indicator.
  - (viii) The size of the formal and informal economy has direct implications for the coverage of social insurance and other contributory schemes.
- Social security systems around the world relate to various institutional structures, including public, private and mixed; compulsory and voluntary; universal and targeted programmes. This indicator relates to public expenditure and has to be considered in relation to the national context and the possible development of private social security schemes. In many countries private (mandatory or voluntary) expenditure substitutes for expenditure on public programmes. In some countries with large private mandatory funded schemes, focusing only on public expenditure will not provide an accurate picture of social protection expenditure. This is an example of countries where this indicator should be analysed in combination with private expenditures (making the distinction between mandatory and voluntary expenditures).
- Many but not all of these arrangements are employment-based. Covered population groups can go beyond workers, as the common goal of social security is to provide basic protection against the financial consequences of basic life contingencies for workers and their families.

Notes: [a] Latest year available: Same year for the three indicators. [1] For 2000, data 2002. [2] For 2000, data 2001. [3] For 2000, data 1999. [4] For 2000, data 2003. [5] WHO data, 2006 instead of 2007. [6] Health public expenditure from WHO for 2000, as the comprehensive general government data are not available in IMF for this year. 2007 data from IMF (general government-level data).

Sources: IMF, 2009a: *Government Finance Statistics*, Public social protection (excluding health) expenditure in percentage of GDP; ILO, 2009i: *Social Security Inquiry* (SSI), table E-1f: Public social protection expenditure excluding health benefit in kind as a percentage of GDP; WHO, 2009: WHOSIS: Public health expenditure in percentage of GDP (combination of existing indicators).

Table SA9. Public social security expenditure by branch as a percentage of GDP, latest available year

Major area, region or country	Percentage of GDP													
	Total				Old age	Health		Unemployment		Active labour market	Survivors	Family allowances	Disability	Employment injury	Other [3]
	Total public	Total public without health	Year	Source			Source		Source						
Africa															
Benin	4.0	1.0	2005	SSI	0.5	3.0	WHO	0.00			0.01	–	<0.1	<0.1	0.5
Burkina Faso	4.9	1.6	2004	SSI	0.6	3.3	WHO	0.00			0.10	0.3	0.0	0.0	0.5
Burundi	1.8	1.1	2006	SSI	0.6	0.7	WHO	0.00			0.10	–	0.0	0.2	0.2
Cameroon	2.0	0.5	2005	SSI	0.3	1.5	WHO	0.00			0.10	–	0.0	0.0	0.1
Congo	1.4	0.5	2005	SSI	0.3	0.9	WHO	0.00			0.10	–	0.0	–	0.1
Côte d'Ivoire	1.8	0.9	2006	SSI	0.5	0.9	WHO	0.00			0.10	–	0.1	0.0	0.1
Gambia	4.1	1.2	2003	SSI	0.1	2.9	WHO	0.00			–	0.0	–	–	1.1
Mauritania	2.8	0.8	2003	SSI	0.5	2.0	WHO	0.00			0.03	–	0.0	0.1	0.1
Mauritius	8.1	5.9	2007	IMF	2.0	2.2	WHO	0.00	SSI		0.40	–	0.5	0.0	3.0
Mozambique	4.0	0.7	2006	SSI	0.2	3.3	WHO	0.00			0.10	–	0.0	–	0.4
Namibia	6.8	1.8	2004	SSI	1.1	5.0	WHO	0.00			0.10	0.3	0.1	–	0.2
Niger	2.7	0.5	2004	SSI	0.2	2.2	WHO	0.00			0.04	–	0.0	0.0	0.2
Rwanda	4.9	0.8	2005	SSI	0.5	4.1	WHO	0.00			0.10	0.0	0.1	–	0.1
Senegal	3.6	1.9	2006	SSI	1.1	1.7	WHO	0.00			0.30	0.1	0.0	–	0.3
South Africa	12.0	8.4	2005	IMF	1.2	3.6	WHO	0.10	SSI		0.01	1.3	0.8	–	5.1
Tanzania, United Republic of	4.5	1.2	2007	SSI	0.4	3.3	WHO	0.00			0.20	0.0	0.0	0.0	0.5
Togo	2.4	1.3	2003	SSI	0.7	1.1	WHO	0.00			0.10	0.0	0.0	0.0	0.4

Major area, region or country	Percentage of GDP												
	Total				Old age	Health		Unemployment	Active labour market	Survivors	Family allowances	Disability	Employment injury	Other [3]
	Total public	Total public without health	Year	Source			Source	Source						
Tunisia	9.6	7.1	2004	IMF	3.3	2.4	WHO	0.01		0.90	0.1	0.3	0.2	2.3
Uganda	2.4	0.4	2005	SSI	0.1	2.0	WHO	0.00		0.01	0.0	0.0	–	0.2
Zambia	4.0	1.6	2006	SSI	0.9	2.4	WHO	0.00		0.20	0.0	0.3	0.0	0.2

Notes: – Not available. * Not counted elsewhere.

Sources: IMF, 2009a: *Government Finance Statistics*, Public social protection (excluding health) expenditure in percentage of GDP; ILO, 2009i: *Social Security Inquiry* (SSI), table E-1f: Public social protection expenditure excluding health benefit in kind as a percentage of GDP; WHO, 2009: WHOSIS: Public health expenditure in percentage of GDP (combination of existing indicators).