Good Practices in Anti-Poverty Family-Focused Policies and Programmes in Africa: Examples and Lessons Learnt

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Paper prepared for the United Nations Expert Group Meeting on "Good Practices in Family Policy Making: Family Policy Development, Monitoring and Implementation: Lessons Learnt", New York, 15-17 May 2012

1.0 Introduction

For many African societies the family has, for generations, being the basis for the sustenance of society, offering material, social, emotional and caregiving support for its members in times and need and crisis such as unemployment, illness, bereavement, or old age (African Union, 2004). Despite prevailing socio-economic and demographic transformations that have stretched and in some cases exhausted, the support mechanisms that were traditionally offered by the family in Africa (Mokomane, forthcoming), the family still plays a crucial role in Africa's development as government in the continent continue to recognise that development efforts that are family-focused are key to sustainable socio-economic development. At the **regional level** this recognition is highlighted in various documents such as the *Dakar/Ngor Declaration on Population, Family and Sustainable Development* (1992), which among other things called on governments to give due consideration to the rights and responsibilities of all family members, to ensure that measures are put in place to protect the family from socio-economic distress and disintegration, and to integrate family concerns into all development plans. Another example of early commitment to improve the welfare of African families is Resolution CM/Res 1466 (LVIII) of the former Organization of African Unity; this resolution urged Member States to lend priority to the observance of the International Year of the Family (1994) as proclaimed by the United Nations.

Post-1994, key regional blueprints that indirectly affect the African family, in that they advocate for the promotion of social protection and social security measures for family members, include: *the Ouagadougou Declaration and Plan of Action* (2004) which aimed at empowering people, opening up employment opportunities, enhancing social protection and security through decent work and a people-oriented environment for development and national growth (Taylor, 2008); the *Livingstone Call for Action on Social Protection* (2006) which called on African governments to strengthen social protection and social transfer interventions; develop costed plans for social protection; engage in capacity building and experience sharing on social protection; adopt comprehensive social protection schemes for older people; and introduce universal social pensions; the *Yaoundé Call for Action* (2006) which advocated comprehensive social protection, focusing on a universal pension especially for the older people (European Communities, 2010); the *Social Policy Framework for Africa (*2008*)* which proposed a minimum package of essential social protection for families, targeting healthcare as well as benefits for children, informal workers, the unemployed, old people, and persons with disabilities; and the *Khartoum Declaration on Social Policy Action towards Social Inclusion* (2010) which sets out a comprehensive approach to social protection in Africa.

However a post-1994 landmark in the continent's efforts to address family concerns was the development and adoption of the African Union *Plan of Action on the Family in Africa* in 2004. With a focus on nine priority areas, the Plan of Action on the Family is meant to serve as an advocacy instrument for strengthening family units, addressing their needs, improving their general welfare, and enhancing the life chances of family members. With regard to poverty alleviation the Plan of Action calls on Member States to "develop national capacities to reduce poverty at the family level and to increase the income per capita and GDP" (p.10). It also aims at guiding African Union Member States in designing, implementing, monitoring and evaluating appropriate national policies and programmes for the family on the basis of their specific requirements and needs.

The recent mid-term review of the Plan of Action (African Union, 2010) found, among other things that:

- Only ten of the 25 AU member states which participated in the review have purposely adjusted their respective programmes and policies in accordance with the PoA requirements.
- Only two of the countries have created government ministries or departments responsible for the family (Ministry of Women's Promotion and Family, Cameroon; and department responsible for Culture and Family Affairs, Uganda).

- Only one country, Senegal developed a Road Map on Family Policy which identifies priority areas such as economic promotion, health and education for the development of the family. (Evidence from elsewhere, however, indicates that South Africa is currently developing a White Paper on Family policy)

Based on the responses received, it was also noted that over time some countries recorded a decrease in their budget allocation to family related sectors. Madagascar, for example, allocated 17.6% of its budget to education in 2007, a decrease from 22% in 2005. Similarly, Benin followed suit by allocating 23.8% to education in 2006 and 22.8% in 2007.

At the **sub-regional level**, the Southern African Development Community (SADC), through its 2003 *Charter of Fundamental Social Rights* mandated Member States to ensure that workers be given adequate social protection; this was extended to social services and development social welfare in the 2007 *SADC Code on Social Securit*y. The East African Community, on the other hand, is committed to improving social protection for persons with a disability, while the region's Inter-Governmental Authority on Development emphasizes the link between social protection and food security. Harmonization of labour laws and child protection constitute the focal areas of the Economic Community of West Africa or ECOWAS (Economic Commission for Africa, 2011).

Despite the apparent sub-regional commitment to the improvement of family welfare, anti-poverty family-focused policies and programmes in the form of social protection, tend to be more prevalent in in East and Southern Africa where they are largely aimed at mitigating the effects of HIV and AIDS (Adato & Bassett, 2009). As a recent scoping study (Devereux & Cipryk, 2009) found, 'the social protection debate has been slower to start in West Africa than elsewhere, and there appears to be little political will to engage seriously with social protection in the region …' (p. 24); and similarly that 'there is little discussion of social protection in the East Africa region, either among the public or in the media, and little political appetite for serious engagement with social protection, beyond an on-going preoccupation with national and household food security' (p. 25).

Largely as a result of the foregoing regional and sub-regional commitments, and the accumulating evidence of the effectiveness of social protection in low-income countries throughout the world, at the **national level,** a growing number of African governments are designing and developing national social protection strategies, often in the context of more comprehensive versions of poverty reduction strategy papers (PRSPs) aimed at achieving economic growth, poverty reduction and sustainable development (Adato and Hoddinott, 2008; Niño-Zarazúa et al., 2010). The mid-term review of the Plan of Action on the Family noted that in terms of family welfare, most PRSPs address issues related to gender, child rights, marriage laws, employment creation, and reproductive health. The review further noted that:

> Most member states have developed and implemented programs to enhance the capacity of the families and support them with income generating activities and micro credit schemes, with a view to ensuring self-reliance and independence. Such programmes include training for unemployed (Mauritius), a sensitive taxation system for vulnerable families (Zimbabwe), national micro credit programmes (Lesotho), loans without interest (Algeria) as well as donations in kind through solidarity actions (e.g. cattle, food items- Burundi). In Liberia, through the Central Bank, the Government has adopted a financial policy entitled "The Liberian Strategy for Financial Inclusion. The objective of this national strategy for inclusive finance in the next five years is to create viable microfinance providers that facilitate sustained financial access to Liberians who have no access to the formal sectors (both un-served and underserved – in rural, semi-urban and urban areas) through the delivery of a diverse range of financial services (loans, saving, remittances, micro-insurance, etc) that are client responsive and cost effective. Furthermore, Liberia has community based Susu and Credit Clubs that most family members seek assistance from (P.9).

Therefore while most African government lament a lack of resources to meet the demand for service and social assistance, there are also cases of successful programmes and measures that can be cited as good practices of anti-poverty family-focused policies and programmes. For the purpose of this paper, these policies and programmes can be categorised into two: (1) contributory social protection instruments in which individuals pool their resources to manage shocks to their livelihoods, and (2) non-contributory social protection instruments which entail the provision of non-contributory benefits by public and private agents (Nwuke et al, 2009). Both contributory and non-contributory social protection instruments can reduce family poverty in the short term by raising family consumption, and breaking the intergenerational transmission of poverty by putting family members in a better socio-economic position (Arriagada, 2011).

2.0 Examples of good practices in anti-poverty family-focused policies and programmes

This section gives examples of good practise of both contributory and non-contributory social protection instruments in Africa. Particular focus is placed on sub-Saharan Africa, the sub-region most affected by poverty (United Nations, 2010). For the purpose of this paper, a good practice is a policy or programme have had reported positive impacts and/or evaluation results, and that can be used as a benchmark.

2.1 Contributory social protection instruments

Nwuke et al (2009) categorised contributory social protection instruments in sub-Saharan Africa into five: contributory pension schemes; national health insurance schemes; private health insurance schemes; community-based insurance schemes; and weather or crop insurances. According to Nwuke and colleagues, these schemes have direct and indirect effects on poverty, labour supply, health and education, and can contribute to the development of domestic financial markets, thus promoting saving and investment.

2.1.1 Contributory Pension Schemes

Available evidence (see, for example, International Social Security Agency Association, 2008) shows that as with all contributory social protection instruments, pensions schemes in many African countries are available only to formal sector waged workers, in either the public or private sectors, who are able to contribute to social insurance; informal sector workers, some 72% of all non-agricultural workers in the region (Heyzer, 2006), do not have access to these benefits. Thus these pension schemes are only available to the minority of the economically active population in the region. Against this background, the **Unemployment Insurance Fund (UIF**) in South Africa can be hailed as a good example of a contributory pension scheme that includes domestic and informal sector workers, albeit on a small scale.

Through the Fund, employers deduct, each month, 1% of workers' pay as their contribution prescribed by law. The deductions can then be paid out in the form of five types of benefits:

i. *Unemployment benefits***.** If an employee loses their job, due to dismissal, contract termination by their employer or the employer's insolvency and the employee has not found another within 14 days, they can apply for the unemployment benefit within six months of becoming unemployed, and can claim benefits for up to 34 weeks (238 days).
ii. *Illness benefit* is payable if an employee is ill and is unable to work for more than 14 days and not receiving a salary or receiving only a part of your salary from their employer. The employee must be willing to undergo medical treatment.
iii. *Maternity benefit.* When a female employee is due to have a baby they are entitled to 17 weeks (121 days) maternity benefits. In the case of a miscarriage the employee can claim for six weeks (42 days).
iv. *Adoption benefits* can be applied for when an employee adopts a child under the age of two years and take unpaid leave or are receiving only a portion of your salary while you are at home caring for the child. Only one parent may claim the benefit.

v. *Dependent's benefits c*an be applied for if the person who has been financially supporting the household dies. The spouse of the deceased can claim the benefit even if he or she is in employment. The application must be made within six months of the date of the death of the deceased contributor.

Overall, the Unemployment Insurance Fund assists not only those who lose their jobs, but also those who stop receiving a salary for a period of time as a result of pregnancy, illness or taking care of an adopted child under the age of 2. Also family members left behind upon the death of the breadwinner in the family are assisted by the Fund. The Fund thus contributes to the alleviation of family poverty by providing short-term unemployment insurance to all workers who qualify for unemployment-related benefits. The Fund's limitations, other hand, include evasion and non-compliance especially among small business owners and domestic workers' employers, and limited capacity typo manage the schemes on a national scale.

2.1.2 National Health Insurance Schemes

Healthcare is among the key basic services that are essential in any fight against poverty (Castro-Leal, 2000). It is for this reason that user fees for healthcare in developing countries have drawn criticism for the inequitable barrier they create for the poor. Social health protection—where individuals are guaranteed access to an adequate package of healthcare based on needs rather than on the ability to pay--is thus a critical component of social protection (Jones and Holmes, 2010). This can be achieved through health insurance schemes, whether national or community-based. The government-led programme in Ghana is frequently cited as good practices of the former.

National Health Insurance Fund of Ghana

In order to abolish out-of-pocket user fees for health services, in 2003 the Ghanaian Parliament passed the National Health Insurance Act, which introduced a compulsory health insurance scheme that covers all person resident in Ghana, It is "an act to secure the provision of basic health care services ... through mutual and private health insurance schemes, to put in place a body to register, license, and regulate health insurance schemes, and to accredit and monitor health care providers operating under health care schemes; to impose a health insurance levy and to establish a National Health Insurance Fund that will provide subsidy to licensed district mutual health insurance schemes". The Ghanaian Fund offers affordable medical coverage to informal-sector workers and their families for an annual premium equivalent to US$18.00

Source: International Social Security Association (2008). *Dynamic social security for Africa: An agenda for development.* Geneva: International Social Security Association

2.1.3 Community-based insurance Schemes

Community-based health insurance refers to voluntary private non-profit insurance schemes formed on the basis of mutual aid, solidarity and the collective pooling of risks. They are highly participatory with members, many of whom are informal sector workers, actively participating in the management of the scheme. Rwanda's *mutuelles de santé* is a good example of such a scheme. Introduced against the background of low use of curative health services, especially among the rural poor, and lack of affordable health insurance options for the rural poor the scheme was aimed at increasing the use of curative health services, especially among the uninsured rural poor. Mutuelles are funds pooled by community members to cover a package of basic health services provided at the health centre level. The results and lessons learnt can be summarised as follows (UNDP, undated)

Results:

- Enrollment in the community health insurance scheme grew from 7% in 2003 to 27% in 2004, to 41% in 2005, and to 74% in 2007.
- Although many of the improvements in Rwanda's health system cannot be attributed directly to *mutuelles de santé*, there is evidence that the scheme has increasingly eased access to health services.
- Some key health indicators in Rwanda have improved over the last 5 years:

- The use of curative services grew from 33.4 percent in 2002 to 44 percent in 2006.
- Infant mortality fell from 107/1000 in 2000 to 86/1000 in 2005.
- Under-five mortality fell from 196/1000 in 2000 to 152/1000 in 2005.
- Maternal mortality decreased from 1071/100000 in 2000 to 750/100000 in 2005.
- Assisted deliveries increased from 34.2 percent in 2003 to 42 percent in 2006

Lessons Learned:

- Although the government subsidizes contributions to the *mutuelle* fund for the poorest portion of the population, the co-pay could still hinder access to services for the poor.
- Because of their high vulnerability, particularly to climatic shocks that affect agricultural productivity, the rural poor sometimes lose income and cannot make contributions to the *mutuelle* fund for their families. This affects enrollment for the poor.
- Decentralization and strong local governments provide an enabling environment for community insurance schemes to work. This is because they require strong community mobilization and institutional support. Fiscal decentralization and the decentralization of service delivery in the health sector have helped to strengthen and roll out the *mutuelle* insurance scheme in Rwanda and have efficiently targeted the poor.
- The creation of strong partnership between central government, local government, civil society, faith-based organizations, donors and the private sector has been critical for the introduction and strengthening of the health insurance scheme. This collaboration has ensured coordinated service delivery and a learning process in building the *mutuelle* system. Donors and civil society have helped to finance the scheme and to overcome the gap in capacity.
- Subsidizing the poor enables equitable access to services. The *mutuelle* subsides for the indigent (extremely poor) have ensured that the poor are brought into the mainstream of service delivery.
- A bottom-up and incremental approach to the insurance scheme has ensured progressive introduction and strengthening of the institutional and legal framework, broad

2.2 Non-contributory social protection instruments

Barrientos et al (2010:7) categorises non-contributory social protection instruments in developing counties into three: (1) pure income transfers; these include social assistance (transfers to poor households, child and family allowances and social pensions; (2) programmes that provide transfers plus interventions aimed at human, financial or physical asset accumulation; and (3) integrated poverty reduction programmes. Using this typology, the following are some of the good practices of social assistance in Africa.

2.2.1 Pure income transfers

Social assistance

Basic Income Grant Pilot Project (BIG), Namibia, 2007-2009.

This pilot project was the first universal cash transfer pilot project in the world. It provided all Namibia citizens aged under the age of 60 years living in Otjivero-Omitara, a rural area 100km from the capital Windhoek with N$ 100 (±US$ 13) each month from January 2008 until December. Selection of beneficiaries was therefore universal

Monitoring and evaluation

- Baseline survey of the settlement area: in November 2007 (2 months before the first pay-out) collected data on the socio-economic situation of the residents,
- Panel surveys: July and November 2008, covering the same households and individuals as in the baseline survey.
- Information gathering from key informants and set of case studies of particular individuals.

Evaluation results

- Household poverty dropped significantly: residents below the food poverty line fell from 76% to 37% within one year.
- People engaged in income-generating activities rose from 44 to 55%, and productive incomes increased by 14%. A local market was created as a result of increased buying power.
- Child malnutrition reduced significantly: the number of underweight children fell from 42% to 10%.
- Pre the BIG, almost half of school-going children did not attend school regularly. Pass rates stood at 40% and drop-out rates were high. Many parents were unable to pay school fees. After the introduction of the BIG, nearly 90 % of the parents could pay fees, nonattendance due to financial reasons dropped by 42%, and drop-out rates fell from 40% to almost zero.
- Average household debt fell from N$1,215 to 772 (US$164 to 104 approximately), and savings increased, as reflected in increasing ownership of large and small livestock, and poultry

Pilot cash transfer schemes, Zambia.
The pilot schemes began in 2004 in Kalomo, 2005 in Kazungula, 2006 in Chipata and 2007 in Monze and Katete The schemes provide cash transfers to households in extreme poverty, or to categorical groups with the overall objective of reducing extreme poverty. In Katete beneficiaries are individuals over the age of 60 years old. In Kalomo, Kuazungula and Chipata the target is the 10% poorest households. In Monze the target are children suffering from malnutrition. In the Kalomo, Kazungula and Monze District, each approved household receives about US$ 10.00 per month in cash, those with children (any number) get a bonus of approximately US$ 2.50. Higher transfers, with bonuses for children enrolled in primary and secondary school, were also tested in one pilot district. In Katete, pensioners receive US$ 15 per month; the cash is transferred bimonthly. Beneficiaries are selected through community identification using a set of household level criteria including the presence of older people, disabled or children

Monitoring and evaluation
- Internal monitoring and evaluation by the Ministry responsible.
- External evaluation coordinated by a Technical Working Group, focused on the feasibility, cost-effectiveness, and replicability of the pilot programmes

Evaluation results
- Asset ownership among beneficiaries went up despite the amounts being very small.
- While not much change could be detected for big livestock, ownership of goats increased from 8.5 % at baseline to 41.7% at evaluation. Chicken ownership increased from 42.4% to 57.6%.
- The number of beneficiary households making investments quadrupled from roughly 14% to 50% and the average amount invested doubled.
- 71% of all households mentioned that they had invested part of the social cash and 52% of them started to have generated some extra income.

2.2.2 Child and family allowances
South Africa and Mauritius are the only African countries that have cash transfers that are specifically child-focused, although they are received by parents or caregivers, majority of who are women. To the extent that child benefits can impact the health and development outcomes of children as well as overall family wellbeing-, South Africa's main child programmes, the Foster Care Grant, the Child Support Grant, and the Care Dependency Grant are good practices of child and family allowances.

Foster child grant *is p*aid to a foster parent who is a citizen, permanent resident, or refugee of South Africa at the time of the application. There must be a court order indicating the foster

care status of the child. The child must be aged 18 or younger (age 21 if a student) and remain in the care of the foster parent. Beneficiaries may only receive one benefit at a time

Child support grant is a means-tested income transfer (R240/month; pprox US$21 as at April 2009) **aimed at** reducing poverty and vulnerability among children. It is paid to the primary caregiver of a child or children aged 17 or younger. The primary caregiver must be aged 16 or older and a citizen or permanent resident of South Africa at the time of the application. The grant is paid for up to six children if they are not biologically related; otherwise, there is no limit. Means test: Annual income must be less than 30,000 rand for a single person; 60,000 rand for a couple.

Care dependency grant (means-tested): Paid to a parent, foster parent, or primary caregiver of of children (aged 1-17) with severe disabilities who require permanent care and have been medically certified to be care-dependent. The grant is equal in value to the Disability Grant, and is converted to a Disability Grant when the recipient turns 18. The objective of teyh grant is to support households with children with special needs and to replace lost earnings of the caregiver looking after the child. It thus excludes those children who are cared for in state institutions and infants under one year because young babies have full-time care needs, whether or not they have disabilities. Receipt of the grant is subject to a means test consisting of both an asset and income threshold. The parent/caregiver must pass an income or means test. Beneficiaries may only receive one benefit at a time; a foster parent may receive more than one benefit at a time.

2.2.3 Social pensions

The earliest unconditional cash programmes in sub-Saharan Africa were old age pensions established in South Africa (1928), Namibia (1949), and Mauritius (1958). These programmes, according to Niño-Zarazúa et al (2010), have their roots in the South African social pension scheme introduced in the 1920s to protect the minority white population against poverty in old age. Unconditional cash transfers however became more widespread from the mid-1990s in response to the impact of HIV and AIDS on families. Given that the epidemic affected Southern Africa the most, where it left many households without members of working age and shifted the burden of care to older people, the pattern of current unconditional cash transfers in sub-Saharan Africa is that they exist mostly in Southern Africa (albeit increasingly in East Africa) and are in the form of categorical old age pensions.

One of the widely cited- good practice is the **Lesotho Old Age Pension**, which was started by Kingdom's the Government in 2004. It is a universal pension scheme for all citizens of Lesotho older than 65 years. As at 2007, the monthly amount of the pension was about US$29. The pension's evaluation results showed that:

- About 90% of the sampled respondents' households were living below the poverty line compared to about 70% after the inception of the programme.
- The average poverty gap has also decreased from M135 to M90 per month per household. However, the impact has been eroded by the presence of other dependents such as HIV/AIDS orphans within the elderly pensioners' households who need to be taken care of by other safety nets

Another example of a social pension good practice is the **Disability grant, South Africa**. This consists of two types of grants: permanent or temporary disability grants. The latter are valid for up to twelve months, where after they fall away and for the former recipients are obliged to reapply and submit a new medical assessment and report This income and asset-tested grant is payable to adults unable to work due of a mental or physical disability and are in need of financial support. As of April 2009, the Disability grant was R1,010 / month (US$132)

2.3 Income transfers

2.3.1 Public works

Expanded Public Works Programme (EPWP), *South Africa* started in 2004. This is a nationwide programme covering all aspects of government and state-owned enterprises that aims to draw significant numbers of unemployed into productive work, accompanied by training, so that they increase their capacity to earn an income. The key objectives of the EPWP Phase 1 (2004/5-2008/9) were to: draw significant numbers of the unemployed into productive work (in the infrastructure, environmental, social and economic sectors) to enable them to earn an income; provide unemployed people with education and skills; ensure that beneficiaries of the EPWP were either enabled to set up their own business/ service or become employed once they exit the programme; and utilize public sector budgets to reduce and alleviate unemployment. All of these were to be achieved through the creation of social and economic infrastructure and provision of social services as a means of meeting basic needs (Altman, 2012).

At the end of the first phase EPWP had achieved its goals in that it had creating at least one million temporary work opportunities, of which at least 40% of beneficiaries will be women, 30% youth and 2% people with disabilities. The EPWP Phase 2 was launched in April 2009 and aims at the creation of 2 million full time equivalent (FTE) jobs for poor and unemployed people so as to contribute to halving unemployment by 2014, through the delivery of public and community services.

Although EPWP the achieved its initial target, some important constraints on its capacity for expansion were identified. For example, in order to halve unemployment, available projections suggest that EPWP might need to create 600,000 to 2.8 m opportunities per year by 2014. Thus, if meant to be a fall back option, it is noteworthy that it only reached about 4% of the unemployed. Other limitations were that: the EPWP had too many objectives loaded onto it; government has not been effective at intensifying labour use in its infrastructure procurement; wages earned and jobs created as proportion of expenditure fell; and like most public works programmes in sub-Saharan Africa (Altman, 2012) opportunities were very short and pay was below market wages (McCord & Slater, 2009)

2.3.2 Asset protection and accumulation

Productive Safety Net Program, Ethiopia, 2005. The first component is a labour intensive public works scheme employing chronically food insecure on rural infrastructures projects such as road construction and maintenance, irrigation, reforestation. The second component is Direct Support, an unconditional transfer of cash or food to vulnerable households with no able-bodied members.

The objective is to provide transfers to the food insecure population in a way that prevents asset depletion at the household level and creates community assets. The PSPN provides cash or food aid to vulnerable households in exchange for public work or direct support to people unable to do public work. The aim is to improve conditions in the community and enlarge the capacity of the individual as a sustainable measure to prevent food insecurity in the household. The value of the cash transfer amounts to about 30 Birr (±US$2) per person per month. An impact evaluation of the programme found:

- Improved the quantity and quality of food for the beneficiaries.
- 75% of the beneficiaries reported eating more and better and 25% reported building up some assets (Devereux et al. 2006:36).
- PSNP is unable to provide food security if food prices increase dramatically or food availability in the market decreases significantly. PSNP still needed time to mature and to overcome its structural weaknesses, although the economic, social and political context in Ethiopia markedly limits its impact. In spite of all these constraints, PSNP has achieved limited positive results which demonstrate the potential of this program

2.3.2 Other in-kind transfers

*Cash & Food Transfers Pilot Project (CFTPP), Lesotho 2007-2008; World Vison***.**
World Vision designed a pilot cash transfer programme that was implemented alongside other in-kind food aid programming. In order to compare the advantages of different transfers and because both options were deemed appropriate, some households in the pilot received only cash transfers, while others received a mixture of food and cash

The project was evaluated through a community Household Surveillance System carried out twice a year to investigate household demographics, migration, income and production, borrowing, agricultural production, access to food aid, household food stocks and sources, food consumption, coping strategies, assets and livestock ownership. The evaluation found that:

- 12% of the aid recipients would have preferred only food rations for future assistance, while the rest preferred cash or a combination of food and cash (Devereux and Mhlanga, 2008).
- The food and cash transfers constrained and reduced hunger in target households.
- Food was shared with other households more than cash transfers, but food brought with cash transfers was a source of sharing.
- Because of ruptures in the WFP pipeline, beneficiaries receiving cash transfers had more predictable assistance than those receiving a combination of food and cash.
- The project monitoring and evaluation made a strong contribution to the project organisation and service delivery.

Food and Cash Transfer project (FACT project), Malawi, 2005-2006.
Concern Worldwide distribute food and cash to poor households with the aim to: provide nutritional support to households overlooked by the government's emergency response; provide a temporary safety net to minimize the need for destructive coping strategies; and explore the effectiveness of cash transfers in addressing food insecurity in humanitarian emergencies.

FACT delivered a package of food (20kg maize, 4kg beans, 1 litre cooking oil) plus cash (equivalent to the cost of buying the same package of food at current local prices) each month. Together, this was to cover half of households' food needs. Cash transfer varied from 350 MK/month (about US$10) for small households to 2,450MK/month for large households and were adjusted each month to allow for food price variation.

Beneficiaries were identified using 'community triangulation' method whereby consensus helped determine who should be included or excluded

To evaluate the project Concern implemented a comprehensive monitoring system, designed to: measure the extent to which the project stabilized household food supply and prevented asset sales; assess the accuracy of targeting; and assess the appropriateness of cash as a means of tackling food insecurity and the impact cash transfers had on household and community dynamics and local markets. Evaluation results were as follws:

- About 60% of cash received was spent on food and about 84% of beneficiaries stated that food was their biggest expenditure.
- Consumption was higher and diets were more diverse in beneficiary households compared to non-beneficiaries.
- Beneficiaries were less likely to adopt damaging coping strategies that could undermine their future livelihood viability, such as selling their productive assets and borrowing at high interest rates to buy food.

- Cash transfers were used for a wide variety of purposes –basic needs (staple food, relish, groceries, health), investment (farming, business, education, assets), other needs (repaying debts, social obligations), and wasteful consumption (alcohol, womanizing).

2.4 Summary and recommendations

The aim of this paper was to highlight good practices in anti-poverty family-focused policies and programmes in Africa. A key finding was that while the continent has been innovative in having a Plan of Action on the Family, six years after its adoption by the African Union, many countries still lag behind and fail to implement its key tenets, including those aimed at reducing poverty and social excision. Rather many African countries address family poverty and social exclusion within the frameworks of poverty reduction strategy papers (PRSPs) aimed at achieving overall national economic growth, poverty reduction and sustainable development. However given the documented centrality and indispensability of the family in Africa's sustainable development and poverty reduction efforts, it is imperative for countries in the region to encourage and support the effective multi-sectoral implementation of the key recommendations of the *Plan of Action on the Family in Africa as well as to* develop and integrate policies and strategies to address families in vulnerable and crisis situations. Based on the review of the good practices, the following recommendations are also noteworthy (see also Mokomane, 2011) by all African family wellbeing and poverty reduction stakeholders:

There is need to:

- Promote regional networks for research and information exchange on policy and programme options, experiences and good practices to assist in developing national contextualized family policies aimed at addressing family wellbeing in general, and family poverty and social exclusion in particular.
- Develop appropriate indicators and practical methodologies for assessing the direct and indirect effects of anti-poverty family-focused policies and programmes on overall family well-being;
- *Draw on good practices from other parts of the world to* create guidelines for effective extension and delivery of anti-poverty family-focused programmes and services.
- *Strengthen the monitoring and evaluation of all* anti-poverty family-focused policies and programmes that are being implemented in the continent. The results of these evaluations should be widely disseminated for possible replication where appropriate.
- *Aim at achieving wider coverage* through a diagnosis of unfulfilled needs and ways to meet them; strengthening institutions and social dialogue; and formulating action plans that can be monitoring and evaluated.

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