SOCIAL PROTECTION AND CHILDREN:
OPPORTUNITIES AND CHALLENGES IN GHANA

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LIST OF ACRONYMS

ADF	African Development Fund
AfDB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
AU	African Union
BECE	Basic Education Certificate Examination
CBA	Centre for Budget Advocacy (ISODEC)
CBHI	Community-based Health Insurance
CEPS	Customs, Excise and Preventive Service
CHPS	Community-based Health Planning and Services
CHRAJ	Commission on Human Rights and Administrative Justice
CWIQ	Core Welfare Indicators Questionnaire
CLIC	Community LEAP Implementation Committee
CLS	Child Labour Survey
CPI	Consumer Price Index
CPRC	Chronic Poverty Research Centre
CRS	Catholic Relief Services
CSEC	Children in Commercial Sexual Exploitation
CSO	Civil Society Organisation
DACF	District Assembly Common Fund
Danida	Danish International Development Agency
DFID	UK Department of International Department
DHS	Demographic and Health Survey
DOVVSU	Domestic Violence and Victim Support Unit
DSW	Department of Social Welfare (MESW)
ECD	Early Childhood Care and Development
ECG	Education Capitation Grant
ECG	Electricity Company of Ghana
ECOWAS	Economic Community of West African States
EPI	Expanded Programme on Immunisation
FDI	Foreign Direct Investment
FGM	Female Genital Mutilation
GAC	Ghana AIDS Commission
GAVI	Global Alliance for Vaccines and Immunisations
GDI	Gender-related Development Index
GDP	Gross Domestic Product
GES	Ghana Education Service
GET	Ghana Education Trust Fund
GHS	Ghana New Cedi
GHS	Ghana Health Service
GJAS	Ghana Joint Assistance Strategy
GLSS	Ghana Living Standards Survey
GoG	Government of Ghana
GPRSI	Ghana Poverty Reduction Strategy
GPRSII	Growth and Poverty Reduction Strategy
G-RAP	Ghana Research and Advocacy Programme
GSS	Ghana Statistical Service
HDI	Human Development Index
HDR	Human Development Report
HIPC	Heavily Indebted Poor Countries Initiative
HIRD	High Impact Rapid Delivery
HIV	Human Immunodeficiency Virus
IBP	International Budget Project
IDA	International Development Association
IFAD	International Fund for Agricultural Development
ILO	International Labour Organization
IMF	International Monetary Fund
IPC	International Poverty Centre
IPEC	International Programme on the Elimination of Child Labour (ILO)
ISODEC	Integrated Social Development Centre
KfW	German Development Bank
LEAP	Livelihood Empowerment Against Poverty

M&E	Monitoring and Evaluation
MASLOC	Microfinance and Small Loans Centre
MDA	Ministries, Departments and Agencies
MDBS	Multi-donor Budget Support
MDG	Millennium Development Goal
MDRI	Multilateral Debt Relief Initiative
MESW	Ministry of Employment and Social Welfare
MHO	Mutual Health Organisation
MICS	Multiple Indicator Cluster Survey
MLGRDE	Ministry of Local Government, Rural Development and Environment
MMR	Maternal Mortality Ratio
MMYE	Ministry of Manpower, Youth and Employment
MOFA	Ministry of Food and Agriculture
MOFEP	Ministry of Finance and Economic Planning
MOWAC	Ministry of Women and Children's Affairs
MTCT	Mother-to-child transmission
MTEF	Medium-term Expenditure Framework
NCCE	National Commission on Civic Education
NDPC	National Development Planning Commission
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental Organisation
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NSPS	National Social Protection Strategy
NYES	National Youth Employment Scheme
ODI	Overseas Development Institute
OOP	Out-of-pocket Payment
OVC	Orphans and Vulnerable Children
PAMSCAD	Programme of Action to Mitigate the Social Costs of Adjustment
PFM	Public Financial Management
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-child Transmission
PNDC	Provincial National Defence Council
PRA	Participatory Rural Appraisal
PRSP	Poverty Reduction Strategy Paper
PSIA	Poverty and Social Impact Assessment
RHP	Reproductive Health Programme
SCREAM	Supporting Children's Rights through Education, the Arts and the Media (ILO)
SHI	Social Health Insurance
SIF	Social Investment Fund
SPLIT	Social Protection and Livelihood Team
SSNIT	Social Security and National Insurance Trust
STI	Sexually Transmitted Infection
SWAp	Sector-wide Approach
U5MR	Under-five Mortality Rate
UK	United Kingdom
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Program
UNECA	United Nations Economic Commission for Africa
UNESCO	UN Education, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
US	United States
USAID	US Agency for International Development
VAT	Value-added Tax
VIP	Village Infrastructure Programme
WACAP	West African Cocoa/Agricultural Project (ILO)
WFP	World Food Programme
WISE	Women's Initiative for Self-employment
WHO	World Health Organization

PREFACE AND ACKNOWLEDGEMENTS

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

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

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

Specifically, the study was intended to provide:

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

The study combined a broad desk review of available literature, official documents and data covering the region as a whole on five key dimensions of social protection systems, with in-depth case studies in five countries, resulting in 10 reports produced overall. These are as follows[1]:

Five regional thematic reports:

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

[1] Full titles are listed in the references.

- R. Holmes and A. Barrientos (2009) 'Child Poverty: A Role for Cash Transfers? West and Central Africa';
- C. Walsh, with N. Jones (2009) 'Maternal and Child Health: The Social Protection Dividend, West and Central Africa'; and
- N. Jones (2009) 'Promoting Synergies between Child Protection and Social Protection, West and Central Africa'.

Five country case study reports:

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

For this report on social protection and children in Ghana, we would like to extend our deep appreciation for the support we received from the Hon. Frema Osei-Opare, who was Deputy Minister of Manpower, Youth and Employment at the time of the research. We are grateful for the help she provided in mobilising the full support of the ministry to ensure the success of this study. We would also like to acknowledge the assistance provided by other key staff of the ministry, including Angela Asante-Asare, National Coordinator of Social Protection at the time of the research, and Mrs Margaret Kutsoati, then Director of the Department of Social Welfare (DSW). Several other staff of DSW generously gave up time to assist the research through interviews and the provision of documents and data. We would also like to thank John Debrak Acquah, District Director DSW in Yilo Krobo, for receiving us and arranging our valuable meetings with local community members and DSW staff in the district.

Many other experts and officials assisted us, and a full list is provided in Annex 1. However, we would like to thank in particular the UNICEF Representative in Ghana, Yasmin Haque and UNICEF staff who directly facilitated and encouraged the work of the research team: Tamar Schrofer, Julianna Lindsey and Charles Dzradosi. Finally, we would like to thank Anthony Hodges, Chief of Social Policy from the UNICEF West and Central Africa Regional Office, for his extensive comments.

While we have done our best to reflect the valuable insights and suggestions they provided, we alone are responsible for the final text, which does not necessarily reflect the official views of the Ministry of Employment and Social Welfare, UNICEF or ODI.

EXECUTIVE SUMMARY

Since the early 1990s, Ghana has made impressive strides in terms of economic growth, poverty reduction and democratic governance. Nevertheless, substantial swathes of the population still live in poverty and are vulnerable to a range of economic, social, lifecycle and environmental shocks and risks.

Children are especially vulnerable, owing to their immaturity and dependence on adults. Indeed, severe shocks and deprivations can be life threatening for very young children. More generally, the abuses and deprivations during childhood can have lifelong consequences. By the same token, child-sensitive social protection programmes not only provide short-term protection but also, by contributing to investments in children (improved nutrition, health care and education), help to break the cycle of poverty and contribute to broader growth and development.

STUDY OVERVIEW

This report is one of several produced as part of a regional study on social protection and children in West and Central Africa, which included in-depth case studies in Ghana and four other countries (Congo, Equatorial Guinea, Mali and Senegal). The Ghana report reviews the existing social protection programmes in the country, analysing the extent to which they are contributing to the reduction of poverty and vulnerability among children and their caregivers. It also analyses underlying capacity constraints and financing issues, and makes a series of policy recommendations to strengthen social protection and ensure that programmes benefit the poorest children and their families.

SOCIAL PROTECTION PROGRAMMES IN GHANA

Traditional concepts of social protection, based on the notion of mutual support, are still strongly rooted in Ghanaian culture, but are eroding under the influence of modernisation. More modern forms of social protection began after World War II with the introduction of pensions for formal sector workers and their families. However, these formal social security provisions cover only a small part of the population (less than 10%), leaving unprotected the vast majority of the poor, who rely on subsistence agriculture and the informal sector. It has only been in the past few years that attention has been given to the challenge of developing a broader, more comprehensive social protection system that would address the vulnerabilities and risks facing the mass of the population, and help to promote poverty reduction and human development.

The country's poverty reduction strategies have put a strong emphasis on vulnerability reduction, and in 2007 a draft National Social Protection Strategy (NSPS) was completed. Meanwhile, a range of social protection programmes have been rolled out, many with a specific focus on children. These include:

- *Social assistance* programmes, notably the School Feeding Programme, the education capitation grant (ECG) and the Livelihood Empowerment Against Poverty (LEAP) cash transfer programme, launched in March 2008;
- *Social insurance* schemes, in particular the National Health Insurance Scheme (NHIS), which is heavily state subsidised, has enrolled 45% of the population since its establishment by Act of Parliament in 2003 and has been accompanied by a series of payment exemptions for vulnerable groups, including pregnant and postpartum women (with a further exemption promised in 2008 for children under 18);
- *Social welfare services*, including programmes to prevent and respond to child protection problems such as child labour, trafficking and sexual exploitation;

- *Social equity measures*, including a series of new laws to tackle issues of discrimination and violence (relating to disability, human trafficking, domestic violence, etc).

Compared with most countries in the region, Ghana has clearly made impressive progress in developing a comprehensive social protection policy framework and in implementing operational programmes, some of which have been taken to significant scale.

CHALLENGES

However, a number of challenges remain. The NSPS remains to be adopted formally by the Cabinet. The country faces difficult macroeconomic and fiscal challenges, which are being exacerbated by the global economic crisis. Nonetheless, the government has safeguarded social protection spending and, in the 2009 budget, increased expenditure on LEAP, expanded the School Feeding Programme and increased the funding for the ECG by 50%, while also introducing a new programme to provide free exercise books and school uniforms to 1.6 million poor children.

Institutional and organisational constraints are holding back the expansion of some programmes, and weak interagency coordination is making it difficult to ensure the effective complementarity of programmes.

Above all, there are still major barriers to extending social protection coverage to many of the poorest and most vulnerable Ghanaians who need social protection programmes the most. Despite a range of exemptions, the NHIS still reaches only about half the total population, and membership is lowest among the poorer quintiles, owing to the cost of registration and annual premiums. LEAP is still a relatively small pilot programme and, even after its initial five-year implementation period, will reach only about one-sixth of the extreme poor. Substantial additional funds would be required to take LEAP to scale, reach those still unable to afford health insurance and implement the announced NHIS fee exemptions for children. Meanwhile, social welfare services are small, fragmented and under-funded, depending precariously on donor resources in most cases.

POLICY RECOMMENDATIONS

The report concludes with a series of recommendations, aimed at further strengthening the social protection system and in particular ensuring that social protection benefits the poorest children and their families.

1. **Formally adopt the NSPS**. To provide a coherent overall framework for the country's expanding portfolio of social protection programmes, and ensure the necessary coordination and financing, it is important for the draft NSPS to be adopted formally by the Cabinet. The government should also consider backing the strategy with legislation, in order to establish clear legal entitlements and ensure the long-term commitment of resources.

2. **Strengthen the pro-poor character of the NHIS**. A key next step is to implement the exemption of children from NHIS premium payments, which was announced in May 2008 but has not yet been put into effect. Other key reforms are the planned free enrolment of LEAP beneficiaries in the NHIS and the abolition of registration fees for children. Together, the implementation of these measures would help to accelerate progress towards the achievement of Millennium Development Goals (MDGs) 4 and 5 on child and maternal mortality.

3. **Plan for the long-term scale-up of LEAP**. A number of challenges need to be addressed to ensure that the LEAP programme has maximum impact on reducing childhood poverty and vulnerability. At present, the proposed coverage of the programme and its budget requirements for the next five years are rather modest – covering just 3% of the total population and less than 0.1% of gross domestic product (GDP) by the end of the initial five-year phase of programme implementation. Scale-up beyond this, to reach all extremely poor households and their children, will require changes to the narrow categorical approach used for targeting, as well as the organisational strengthening of the Department of Social Welfare (DSW) and the mobilisation of additional funds. However, at about 1% of GDP, the cost of providing transfers for all extremely poor households would be fiscally affordable.

4. **Strengthen social welfare services for children and promote synergies with other dimensions of social protection**. In order to address the wide range of socio-cultural, gendered and economic risks to which children are vulnerable, it is important to continue to strengthen the social welfare programmes that provide preventative and responsive child protection services. The risks faced by children cannot be addressed solely by cash transfers and social insurance, but require specialised services. If violence, exploitation, abuse and neglect of children are to be addressed effectively, the current fragmented small child protection programmes will need to be scaled up and corresponding budget increases secured. The Ministry of Employment and Social Welfare's (MESW) dual role as the ministry responsible for both LEAP and many of these services provides an opportunity to develop strong synergies between these complementary programmes, including mechanisms for referral and integrated case management.

5. **'Ring-fence' and expand social protection provision in response to the shocks from the global crisis**. The adverse impacts of the global economic crisis on poor households justify 'ring-fencing' social protection provision, despite the current macroeconomic and fiscal constraints, and indeed justify expanding programmes to protect populations to the greatest degree possible.

6. **Continue to promote public expenditure reforms in order to maximise fiscal space opportunities**. Maximising fiscal space opportunities necessitates not only advocating for increased budget allocations, but also addressing expenditure allocation and usage inefficiencies. Civil service reform, especially in the education and health sectors (owing to the high wage bill), has been identified as a major priority. Any effort to advocate for greater investment in child-sensitive social protection should therefore be framed in accordance with these broader fiscal debates. It is also critical that capacity-strengthening support is provided to social sector ministries, including MESW and the Ministry for Women and Children's Affairs (MOWAC), in order to enhance programme and budget planning and execution. In the medium to long term, a significant boost to public finances may come from the expected revenue from oil, which could substantially increase the resources available for social protection, assuming oil revenues are well managed. A strong focus on social protection would help to contribute to redistribution and inclusive growth, as well as poverty reduction and human development, thereby avoiding the social problems that have plagued many oil producers in Africa. This will require medium- to long-term planning for the financing of the scale-up of social protection programmes, including LEAP, in order to ensure long-term sustainability.

7. **Improve programme design and monitoring and evaluation (M&E)**. As experience is gained and programmes are scaled up, it will be essential to ensure maximum efficiency and equity, so that scarce resources are used as best as possible and benefit those who are most in need. As noted

above, this will require further equity measures to ensure NHIS coverage of the poorest, including through the implementation of the promised exemptions for children. In the case of LEAP, particular attention needs to be given to ensuring the rigour of the targeting methodology. The development of a robust impact evaluation framework for LEAP is also crucial, including the development of a baseline, so that the lessons of the pilot phase are learned, adjustments in programme design can be made and evidence of impacts can be used to garner broader political support and secure the increases in budgetary allocations that will be needed for scale-up.

8. **Strengthen capacity for social protection design and delivery**. The agenda set out above will require substantial investments to strengthen the capacity of the government agencies responsible for social protection programmes. Particular attention needs to be given to strengthening the capacity of MESW as the ministry responsible for the overall social protection strategy, as well as both LEAP and a wide range of social welfare services.

9. **Strengthen interagency coordination**. Cross-agency coordination is vital in order to ensure complementarity of services, effective linkages between national and sub-national programme staff and also quality oversight of social protection services by the legislature. Weaknesses in this respect have so far made it difficult, for example, to link up LEAP beneficiaries to the additional services promised in the original programme design. A first step towards improved coordination has been the establishment of the Social Protection and Livelihood Team (SPLIT), headed by MESW, which brings together many of the key government actors. This is complemented by the role of the joint donor–government social protection and vulnerability group. The single register established by the LEAP programme provides an excellent basis for developing a centralised information management system that can cover all major social protection programmes and beneficiaries, but will need to be complemented by other knowledge management mechanisms.

10. **Support capacity-strengthening initiatives for non-governmental actors and the media with regard to social protection**. In order to promote greater accountability and transparency regarding the use of resources to tackle poverty and vulnerability it will be critical to support children's rights and gender equality advocates' engagement in social protection policy dialogue processes. This will not only contribute to strengthening child and gender-sensitive programme design, implementation and evaluations, but also promote synergies with non-governmental initiatives in programme districts. Capacity building for the media will similarly help to raise the quality of public debate on these issues.

1. CONCEPTUALISING CHILD-SENSITIVE SOCIAL PROTECTION

Over the past decade, Ghana has made impressive inroads in terms of reducing poverty and achieving macroeconomic stability and political liberalisation. Indeed, international assessments of the country frequently herald it as a 'shining example' of development, not only in the region of West Africa but also on the African continent more broadly (e.g. GJAS Partners, 2007; World Bank, 2008). However, others caution that macroeconomic fundamentals have been prioritised at the expense of social service provision and quality and tackling social exclusion. Geographical disparities, unequal gender relations and voicelessness among the poor all remain particular problems (NDPC, 2004).

In recent years, Ghana has seen the introduction of a substantial number of legislative reforms and policies aiming to address various dimensions of poverty and social exclusion. There has been increasing policy and public attention to social protection instruments, including those that specifically identify and target childhood poverty and vulnerability (GoG, 2005a; MMYE, 2007c). The inclusion of Ghana as a case study in the United Nations Children's Fund's (UNICEF) West and Central Africa review of social protection for children and their caregivers constitutes an important opportunity to assess the strengths and weaknesses of these social policy developments to date.

Figure 1: Location of Ghana in West Africa

The objective of this study is to provide an in-depth understanding of the actual and potential role of social protection systems in reducing poverty, vulnerability and risk among children in Ghana. Increasingly, social protection is conceptualised as a set of public actions (potentially in tandem with private initiatives – either formal private sector or informal individual or community initiatives) which address poverty, vulnerability and risk *throughout the lifecycle*. Just as there is already a recognition that we need to take into account both the monetary and the non-monetary dimensions of poverty, it is now also widely understood that vulnerability and risk are multidimensional, with natural and environmental, economic, health and social axes. Furthermore, the distribution and intensity of these risks and vulnerabilities often vary during the lifecourse (infant, child, youth, adult, aged) and according to social group positioning (gender, ethnicity, class, etc).

In the case of infants and children, the experience of risk, vulnerability and deprivation is shaped by four broad characteristics:

- The multidimensionality of children's rights to survival, development, protection and participation;
- Changes over the course of childhood in terms of vulnerabilities and coping capacities (e.g. young infants have much lower capacities than teenagers to cope with shocks without adult care and support);
- The relational nature of children to adults – given the dependence of children on the care, support and protection of adults, especially in the earlier parts of childhood, the individual vulnerabilities of children are often compounded by the vulnerabilities and risks experienced by their caregivers;
- Voicelessness – although marginalised groups often lack voice and opportunities for participation in society, voicelessness in childhood has a particular quality, owing to legal and cultural systems that reinforce their marginalisation (Jones and Sumner, 2008).

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

Table 1: Risks and vulnerabilities – Lifecycle and childhood manifestations

Type of risk	Lifecycle manifestation	Child-specific manifestation
Natural (natural disasters) and environmental (human-generated environmental degradation, e.g. climate change, pollution, deforestation)	General (loss of household assets, lower productivity, etc)	Children more vulnerable owing to physical and psychological immaturity
Economic (macroeconomic shocks, inflation, unemployment, etc)	General (household poverty)	As above, with specific impacts on child nutrition, school attendance and dropout, access to health services, child labour, child trafficking and child sexual exploitation
Lifecycle	Age-dependent	Physical and psychological vulnerabilities compounded by political voicelessness
Social (violence within families, communities and wider societies, social exclusion and discrimination)	Lack of security, family breakdown, increased poverty, lost opportunities	Physical and psychological trauma in family, school or community settings, inadequate adult care, lost opportunities for healthy growth and development
Health (diseases, malnutrition, unsafe water, lack of sanitation)	Age-dependent	Children under five years especially vulnerable (malnutrition, vaccine preventable diseases, malaria, pneumonia, diarrhoeal diseases); very young children and adolescents at higher risk of contracting HIV

A notable exception is HIV/AIDS, to which adolescents are particularly exposed, along with very young children (owing to the risks of mother-to-child transmission – MTCT).

In view of the particularly severe, multiple and intersecting deprivations, vulnerabilities and risks faced by children and their caregivers in West and Central Africa, we have adapted Devereux and Sabates-Wheeler's (2004) transformative social protection framework for this study. This interprets social protection as encompassing protective, preventative, promotive and transformative dimensions. In essence, this means that social protection measures may play one or more of the following roles: i) provide protection from adversity (e.g. through 'safety nets'); ii) prevent harmful coping responses, such as the sale of assets or resort to child labour; iii) help promote ways out of poverty and vulnerability, notably by promoting investments in human capital development (especially during childhood); and iv) transform social relations by empowering the oppressed and discriminated. Arguably, social protection also contributes to the reduction of social inequality and exclusion and, in fragile developing countries, to social stability and conflict prevention.

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

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

These instruments are used to address the vulnerabilities of the population in general, but can also be adapted to address the specific risks faced by children, as mapped out in Table 2.

Given the close actual and potential linkages between women's empowerment and child wellbeing (what was dubbed the 'double dividend' in UNICEF's 2007 State of the World's Children Report), each of the general categories of social protection could be assessed also through a gender-sensitive lens. Namely, to what extent is each type of social protection addressing gender-specific risks and vulnerabilities, overcoming gender barriers to services, supporting women's care responsibilities and ensuring the inclusion of women in programme design and evaluation?

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

Type of social protection	General household-level measures	Specific measures for children
Social assistance	Conditional and unconditional cash transfers, food aid	Scholarships, school feeding, cash transfers with child-related conditionalities, fee waivers for education, childcare and use of child health services
Social insurance	Heath insurance and other risk-pooling mechanisms such as disaster insurance and unemployment insurance	Subsidies for health insurance for children (e.g. waivers on premiums and co-payments)
Social welfare services	Preventative and responsive social welfare services focused on those needing protection from violence and neglect – e.g. shelters for women, rehabilitation services, etc	Child foster systems, preventative and responsive services to address child-focused domestic and community violence, child trafficking and child labour
Social equity measures	Anti-discrimination legislation, affirmative action policies, asset protection	Adoption and implementation of legislation to promote child rights and address rights deprivations (e.g. violence, trafficking, early child marriage, etc), including as perpetrators (special treatment and rehabilitation services for young offenders); efforts to promote children's voice and agency
Complementary measures		
Complementary basic services	Health, education, economic/financial, agricultural extension	Child-focused health care services, pre, primary and secondary school, childcare services
Complementary pro-poor or growth with equity macroeconomic policy frameworks	Policies that support growth + distribution	Policies that support progressive realisation of children's rights in line with macroeconomic growth indicators

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

Such an analysis aims to identify appropriate policy entry points for strengthening social protection and to identify the processes and opportunities in which social protection can be politically sustainable.

2. SCOPE OF THE STUDY

The scope of this study includes:

- A situation analysis of: i) the existing poverty situation and types of vulnerability and risk affecting children in Ghana; ii) current social protection systems and programmes in the country and their impact on children and their caregivers;

- An informed assessment of the potential role of social protection in reducing poverty and vulnerability among children in Ghana, focusing particularly on: i) cash transfers; ii) health insurance; and iii) mechanisms to strengthen child protection services;

- An assessment of the priority needs for strengthening social protection systems in the country, through: i) an analysis of the political context, key institutional, policy and civil society actors as well as ways in which social protection debates could be effectively framed; and ii) a child-sensitive budget analysis to identify financing arrangements for strengthened social protection;

- Programming and policy recommendations to inform the development of a strategy to promote social protection systems that benefit children by UNICEF in Ghana.

These four components are informed by both a multidisciplinary perspective, drawing on quantitative, qualitative and participatory data to draw attention to the complex interplay of macro-, meso- and micro-level factors that underpin social protection systems.

The research team held interviews in Accra with more than 40 key informants from the Ministries of Manpower, Youth and Employment (MMYE); Health; Education; Local Government, Rural Development and Environment (MLGRDE); Women and Children's Affairs (MOWAC); and Finance and Economic Planning (MOFEP), and from non-governmental organisations (NGOs), academia, UN agencies and other multilateral and bilateral development partners.

These were complemented by a fieldwork trip to Yilo Krobo district in the Eastern Region, where focus group discussions in three communities were undertaken with traditional leaders, beneficiaries of the Livelihood Empowerment Against Poverty (LEAP) cash transfer programme and LEAP community leader monitoring committees. Key informant interviews were also held with district-level authorities, service providers and NGOs (see Annex 1). Review and analysis of key documents, legislation and programme evaluations were also carried out.

The rest of the report is structured as follows. Sections 3 and 4 set the general country context within which social protection challenges and responses can be understood. Following a general overview of the political, social and economic context in Section 3, there is a more specific and detailed analysis of poverty and vulnerability, with particular reference to children, in Section 4.

Section 5 then provides a broad assessment of Ghana's existing social protection system, covering the policy framework and the main social protection programmes of importance for children. Section 6 examines the financing of social protection, situating this within a broader assessment of Ghana's public finances and 'fiscal space'.

Sections 7-9 focus on three specific aspects of social protection in Ghana: first, the actual and potential role of cash transfers to households as a mechanism for tackling child poverty and vulnerability (Section 7); second, an analysis of the role of Ghana's National Health Insurance Scheme (NHIS) and related issues concerning barriers of access to health services by the poor (Section 8); and third, the potential for synergy between child-focused social welfare services and the broader social protection system (Section 9).

Section 10 concludes with observations about the challenges of policy engagement to strengthen the social protection system, and a set of specific policy recommendations arising from the analysis in the previous chapters.

3. POLITICAL AND SOCIOECONOMIC DEVELOPMENT CONTEXT

Ghana is commonly heralded as the 'shining star' of Africa. Although the post-independence period of 1965-1983 was characterised by macroeconomic instability and uneven and volatile growth, the government launched a broad economic restructuring programme in the early 1980s which has contributed to renewed growth and a significant decline in poverty (World Bank, 2008). Although almost half the population still lives on $1 per day or less, aggregate poverty rates declined from 52% in 1992 to 28.5% in 2005/06, in terms of the nationally defined poverty line. Over this same period, extreme poverty, defined in terms of basic nutritional requirements, declined from 37% to 18.2%.

The national poverty lines used as of 2005/06 were as follows:

- A lower poverty line of 2,884,700 old cedis (equivalent to GHS 288.47) per adult per year[2]. This focuses on what is needed to meet the nutritional requirements of household members. Individuals whose total expenditure falls below this line are considered to be in extreme poverty: even if they allocated their entire budgets to food, they would not be able to meet their minimum nutrition requirements (if they consume the average consumption basket). This poverty line was equivalent to the 700,000 old cedis line used in the previous Poverty Profile (GSS, 2000), before being inflated with the 1999 to 2006 Consumer Price Index (CPI). This line was 37.8% of mean consumption levels in 2005/06.

- An upper poverty line of 3,708,900 old cedis (GHS 370.89) per adult per year: This incorporates both essential food and non-food consumption. Individuals consuming at levels above this can be considered able to purchase enough food to meet their nutritional requirements, and to be able to meet their basic non-food needs. This poverty line is equivalent to the 900,000 old cedis used in the previous Poverty Profile (GSS, 2000), before being inflated with the 1999 to 2006 CPI. This line was 48.6% of mean consumption levels in 2005/06 (GSS, 2007).

Poverty does, however, remain more concentrated in rural Ghana (64% of the population) and especially in the three northern regions. Furthermore, the country's Human Development Index (HDI) ranking still lags behind its gross domestic product (GDP) per capita ranking (138 compared with 122). As such, the key challenge facing the country is to harness economic growth in order to address social exclusion, particularly that stemming from spatial poverty, gender inequalities, age, disability and income status (UNDP, 2007).

The country's economic improvements have been accompanied by growing political liberalisation since the 1990s, with comparatively positive indicators in terms of political rights, civil liberties and freedom of the press (Booth et al., 2005). This is reflected in the government's active participation in the African Peer Review Mechanism, an African Union (AU) governance initiative (interview, 2008). However, democratic deficits, especially the weak accountability of the executive and patronage politics, persist. This is reflected in Ghana's rank of 70th out of 169 countries in the Transparency International Corruption Perceptions Index (World Bank, 2008).

[2] As part of ongoing economic reforms, Ghana introduced a new currency, the new Ghana cedi (GHS), in 2007, at a rate of one new Ghana cedi to 10,000 old cedis. Throughout this report, the new Ghana cedi is used, with old cedi values for periods prior to 2007 converted into their new cedi equivalent. To facilitate international comparison, US dollar values are also sometimes provided, using the average exchange rate for the period in question.

Table 3: Key country statistics

Population (total)	23.5 million (2007)
Urban	36%
Rural	64%
Poverty rate	28.5% (2005)
Extreme poverty rate	18.2% (2005)
GDP per capita	$2700 purchasing power parity
HDI	0.553 (135th) (2007)
GDP per capita rank minus HDI rank	-8 (2007)
HDI to Gender-related Development Index (GDI) ratio	99.3% (65th) (2007)

Sources: UNDP (2007); GSS (2007).

3.1 POLITICAL CONTEXT: BACKGROUND AND POLICY PRIORITIES

Ghana was, in 1957, the first sub-Saharan African nation to achieve independence. The nation was led by the charismatic leader Kwame Nkrumah, who was elected President of the republic in 1960 and who remained in power until ousted in a military coup in 1966. Subsequently, military rule was punctuated only by a brief democratic interlude, from 1969-1972. It continued under the populist leadership of Jerry Rawlings from 1979 until 1992, at which time Rawlings formed the National Commission for Democracy and oversaw the passage of a new democratic Constitution. Rawlings went on to win 60% of the vote in multiparty presidential elections in November of the same year. The 1990s witnessed a gradual improvement in the political climate between the government and opposition forces, which culminated in the consolidation of democratic rule, with a peaceful transfer of power to the opposition New Patriotic Party, led by John Kufuor, in 2000. There was another peaceful transfer of power from government to opposition in the December 2008 general elections, won by the National Democratic Congress, led by John Evans Attah Mills, who became President.

Overall, contemporary Ghana has reasonable governance indicators relative to other low-income country peers. For example, its ranking in the World Press Freedom Index continues to improve, to 29th internationally in 2007 (World Bank, 2008)[3]. Ghana has also largely escaped the civil strife that has plagued some of its West African neighbours. However, in 1994-1995, land disputes in the north of the country gave rise to ethnic-based violence, with more than 1000 deaths and the displacement of 150,000 people.

The country enjoys a relatively vibrant civil society (comprised of trade unions, professional associations, women's rights groups, home-town associations and faith-based groups), and an increasingly active diaspora, both of which have been significant drivers of governance reforms (Crook, 2005a; 2005b). Nevertheless, there is still considerable scope to increase opportunities for participatory decision-making processes. This is particularly evident in the fact that progress towards fiscal decentralisation has been patchy at best. Central government appears to be reluctant to delegate major fiscal authority to local government tiers owing to concerns about local capacity[4], as well as a potential loss of resources and influence (GJAS Partners, 2007). This is reflected in the fact that one-third of the membership of Ghana's 170 district assemblies and all the district chief executives are appointed by the President rather than elected. This process of devolution has

[3] The government has also received improving scores in the World Bank's Governance and Corruption indicator tables.

[4] Key capacity constraints identified by a 2005 Capacity Enhancement Needs Assessment included: i) poor communication of policy changes to the populace; ii) weak regulatory frameworks; and iii) insufficient channels for public consultation in policy decision-making processes.

been further complicated by the existence of a dual system of power and authority, whereby elected secular authorities coexist with traditional chiefs. The latter 'remain a very significant element in society which cannot be ignored' (Crook, 2005b), especially with regard to land administration practices.

At the regional level, Ghana has emerged as a strong supporter of both regional integration and the conflict prevention initiatives of the Economic Community of West African States (ECOWAS). It is also an active participant in UN peacekeeping activities, including the Kofi Annan International Peace Keeping Training Centre (World Bank, 2008). In 2007, President Kufuor served as the Chair of the AU, but in terms of models Ghana's sights tend to be set on middle-income countries in Latin America, such as Brazil and Mexico (interview, 2008).

In terms of policy priorities, the government of Ghana is seeking to capitalise on hard-won gains in terms of relative political stability and improving economic indicators; it hopes to attain middle-income status by 2015. This is reflected in the strong focus on economic growth, private sector competitiveness and macroeconomic stability in the second generation poverty reduction strategy paper (PRSP), the Growth and Poverty Reduction Strategy (GPRSII). It can also be seen in the government's attention to tackling social sector challenges, as evidenced by the wide-ranging legal and policy changes made in the past few years. Indeed, there is an encouraging statement in the GPRSII, one which indicates more than simply discursive commitment, rather a more considered social protection agenda, informed by an understanding of the multidimensionality of poverty across both the lifecourse and generations. Furthermore, there is evidence of an understanding of the need to address both social and economic risks (GoG, 2005a):

> Consistent with the Gender and Children's Policy, the Draft National Youth Policy, the Draft National Disability Policy, and Draft National Ageing Policy, a comprehensive Social Protection Framework will cover the vulnerable and excluded in society. It will promote conditional and unconditional cash transfer systems and other support to displaced workers, while they seek employment, pregnant and lactating women, and provide target subsidies to the elderly, pensioners, smallholder farmers and people with disabilities. The Social Protection Strategy will also expand the coverage of the School Feeding Programme, and facilitate access to micro-credit for small scale informal operators.

Government expenditure on social development as a percentage of total expenditure still remains relatively low, as indicated by Table 4 below and as discussed in detail in Section 6. However, because of the country's demonstrable progress in terms of political and economic stability, donor support through a range of different modalities, including sector-wide approaches (SWAps), general budget support, public-private partnerships and HIPC (Heavily Indebted Poor Countries Initiative) funding, has made a substantial contribution to funding available in the social sectors.

Table 4: Priorities in public spending

Public expenditure on health (% of GDP), 1991	1.2
Public expenditure on health (% of GDP), 2004	2.8
Public expenditure on education (% of GDP), 1991	3.2
Public expenditure on education (% of GDP), 2002-2005	5.4
Military expenditure (% of GDP), 1990	0.4
Military expenditure (% of GDP), 2005	0.7
Debt service, total (% of GDP), 1990	6.2
Debt service, total (% of GDP), 2005	2.7

Sources: Foster and Zormelo (2002); UNDP (2007).

3.2 KEY ECONOMIC FACTORS: DRIVERS OF THE ECONOMY

The Ghanaian economy has grown consistently since the turn of the millennium, with GDP growth increasing from 3.7% to 6.4% between 2000 and 2007 (World Bank, 2008). Growth has been driven by cocoa and gold, as well as an increasingly diverse array of other export commodities, including fish and marine products, timber, mining (aluminium, diamonds) and pineapples. Ghana enjoys an open trade regime, with exports to Europe and the US accounting for 53% and 7%, respectively, of total Ghanaian exports. On the other hand, African markets account for just 11%. Nevertheless, as elaborated in more detail in Section 6, a number of key challenges need to be tackled. These include vulnerability to both fluctuating commodity prices and natural disasters, especially in the north of the country (as highlighted by major floods and drought in 2007) and the still high proportion of subsistence agriculture. Challenges further include the need to address energy infrastructure problems and the development of more extensive transport and communication infrastructure.

With the discovery of major offshore reserves in 2007, there is considerable optimism about a major economic boost in the near future (IMF, 2009b). Ghana is wisely using the years before this oil comes on-stream to create a sound management mechanism, so as to avoid the 'resource curse' suffered by some other oil-producing countries (interview, 2008; Oxfam America and ISODEC, 2009).

Remittances and tourism are also increasingly important sources of foreign exchange. Private transfers netted approximately $1.5 billion in 2005, with increases likely in the future as a result of Ghana's high levels of skilled emigration, especially to the US, Canada and the UK (Adams et al., 2008). Tourism revenues have also grown steadily, reaching $1 billion in 2005 (World Bank, 2008).

These positive developments have been put at risk, however, by the succession of global economic shocks since 2008: the food and fuel price crisis, which had only partially abated as of mid-2009, and the global financial/economic crisis, which risks reducing Ghana's commodity export earnings, tourism receipts, remittances, access to foreign capital and aid flows. The country's capacity to cope with these shocks has been undermined by a weakening of macroeconomic discipline since 2006, which left the country with one of the region's largest overall fiscal deficits (estimated at 13.5% of GDP), a widening current account deficit (18.2% of GDP) and high inflation (16.5%) in 2008 (IMF, 2009a).

3.3 SUMMARY OF KEY POINTS

- On account of a stabilising economy from the mid-1990s and consistent growth since 2000, Ghana appears to be well on track in terms of reaching the Millennium Development Goal (MDG) on halving poverty by 2015, although this progress could be undermined by the global economic crisis.
- Key economic drivers include mineral wealth, agricultural and forestry exports (especially cocoa), remittances and tourism. Although considerable efforts at economic diversification have been made, the country is still vulnerable to fluctuating international commodity prices and to the constraints of underdeveloped energy, transport and communication infrastructure. Additional challenges are discussed in more depth in Section 6 on fiscal space.
- Economic advances have been matched by political liberalisation, at least at the national level. However, social sector policy priorities will also need to be backed up by both greater public expenditure resource allocation and more substantial decentralisation, particularly in light of the regional disparities highlighted in Section 4.

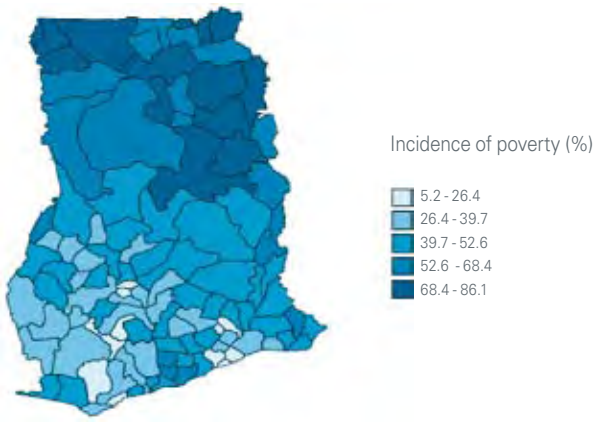
4. ANALYSIS OF POVERTY AND VULNERABILITY

Although Ghana has made important strides in reducing aggregate poverty levels, the most recent Ghana Living Standards Survey (GLSS) data indicate that 28.5% of the population lives below the national poverty line and that approximately 18% of Ghanaian citizens can be categorised as extremely poor (GSS, 2006). The household vulnerability headcount is estimated to be even higher, with a vulnerability to poverty ratio of 1.25 (Appiah-Kubi et al., 2008). In contrast with many of its West African peers, Ghana has a growing body of data and analysis on poverty and vulnerability trends, which this section summarises, highlighting in particular the geographical and gender- and age-specific manifestations of poverty and vulnerability.

4.1 KEY DATA ON POVERTY AND VULNERABILITY AT THE HOUSEHOLD LEVEL

As is starkly illustrated by the poverty map below, poverty levels are significantly higher in the Savannah regions of the country, in particular in the three northern regions.

Figure 2: Poverty in Ghana, by district



Source: GSS (2000; 2001).

Urban/rural and regional inequalities are further highlighted in Table 5. Inequality has been increasing at both a national aggregate level and regionally; urban and rural Savannah areas have been the most negatively affected. In urban areas, vulnerability is exacerbated by housing insecurity, with over 40% of urban survey respondents saying that eviction is 'likely or very likely', compared with 16% of rural households (GSS et al., 2004).

Consumption-based poverty has been declining over time, but is still significant, and demonstrates important regional and economic sector disparities (see Table 6). The Ghana Statistical Service (GSS) 2003 Core Welfare Indicators Questionnaire (CWIQ) asked households whether or how often they 'had difficulty satisfying food

needs'. Nationally, only 13% fell into the categories of 'often' or 'always' having difficulty satisfying their food needs, but in the Upper East region the figure was 40.4% (GSS, 2006). A study for the Chronic Poverty Research Centre (CPRC) noted that: 'Vulnerability to poverty in the northern communities is predicated upon food security. This part of the country tends to have a single rainy season. The dual rainy season in the south of the country reduces somewhat the food security constraint' (Oduro and Aryee, 2003).

Table 5: Gini index of consumption inequality, by locality and urban/rural areas, 1991-2006

	1991/92	1998/99	2005/06
Urban/rural			
Urban	0.321	0.340	0.355
Rural	0.329	0.358	0.361
Locality			
Accra	0.324	0.283	0.368
Urban Coastal	0.296	0.336	0.362
Urban Forest	0.318	0.342	0.317
Urban Savannah	0.338	0.298	0.379
Rural Coastal	0.316	0.344	0.320
Rural Forest	0.325	0.327	0.327
Rural Savannah	0.326	0.373	0.384
National	0.353	0.378	0.394

Source: Coulombe and Wodon (2007). See also GSS (2007).

This 2003 participatory poverty assessment revealed varying types of poverty (Oduro and Aryee, 2003). Communities reported that the chronically hungry, also described as the extreme poor or 'God's poor', were impoverished as a result of a combination of unfavourable circumstances. This group was comprised of the aged, disabled, widows and children. Another chronically poor group identified in the participatory assessments consisted of those without physical or social assets. A third category was described as the 'deprived but hardworking' or 'hand-to-mouth' group. This category comprised the majority in the communities surveyed. In poor rural communities, especially in the north, they may be particularly vulnerable to seasonal fluctuations and their living conditions can be almost as difficult as those of the perennially poor (ibid).

Table 6: Consumption-based share of population in poverty, 1991-2005 (%)

	2005/2006			1998/99			1991/992		
	Total	Urban	Rural	Total	U rban	Rural	Total	Urban	Rural
Sex of household head									
Female	19.2	10.5	26.8	35.4	19.8	45.7	43.1	24.5	56.2
Male	31.4	10.9	42.4	41.0	19.2	50.7	54.9	29.4	65.9
Age of household head									
Less then 30	16.6	6.4	23.2	19.8	7.9	26.5	31.4	12.0	40.4
30 to 39	25.4	7.9	36.0	35.7	13.2	45.9	47.7	19.9	62.2
40 to 49	30.3	12.5	42.5	43.1	22.6	54.6	57.9	32.9	72.8
50 to 59	32.6	13.4	43.9	43.4	21.9	54.0	53.6	32.0	66.3
60 and over	31.9	11.3	41.5	44.8	26.4	53.1	58.5	37.3	64.9
1 individual	3.6	3.0	4.3	5.6	4.3	6.8	9.4	3.2	13.7

Table 6 *(cont.)*

	2005/2006			1998/99			1991/992		
	Total	Urban	Rural	Total	U rban	Rural	Total	Urban	Rural
2 to 3 individuals	10.2	5.5	14.0	18.1	9.0	23.8	25.7	8.2	35.6
4 to 5 individuals	22.4	9.1	31.5	34.3	14.1	45.0	46.5	22.7	58.0
6 to 7 individuals	30.4	9.4	42.3	47.9	24.7	58.9	57.8	30.5	72.0
8 individuals or more	53.5	27.1	62.5	55.9	35.4	63.3	69.3	45.9	79.5
Education level of head									
No education	43.8	22.6	49.7	54.3	33.2	60.8	61.4	40.2	68.0
Primary	25.2	11.4	32.0	38.4	22.7	44.8	55.2	30.1	65.1
Secondary 1	17.2	7.8	25.2	29.4	14.2	38.5	41.3	21.0	56.5
Secondary 2	8.5	4.8	18.3	15.1	5.5	31.0	20.4	11.5	43.9
Higher	4.2	2.6	9.0	16.3	9.4	25.1	24.4	14.0	36.9
Marital status of head									
Never married	11.0	6.6	18.7	15.5	6.1	25.2	23.0	5.4	36.5
Married	30.9	10.9	41.5	40.5	20.1	50.1	53.9	29.3	65.6
Divorced/widowed	21.1	11.8	28.6	38.5	19.2	49.0	44.1	24.4	55.7
Industry of head									
Agriculture	39.3	22.1	41.9	51.7	40.4	53.4	64.9	43.4	68.0
Mining/quarrying	5.2	0.0	9.1	6.9	0.0	11.8	28.4	21.4	34.6
Manufacturing	16.8	8.6	29.9	30.4	17.1	42.7	39.3	23.1	58.2
Utilities	0.0	0.0	0.0	18.1	5.0	56.0	22.0	28.2	0.0
Construction	13.0	7.1	25.1	26.3	16.5	36.1	42.0	42.9	41.0
Trading	11.7	7.6	20.3	25.3	13.0	38.6	32.8	24.2	45.8
Transport/communication	13.8	9.3	25.6	9.1	6.9	15.3	24.9	22.7	35.1
Financial services	8.2	6.1	22.4	13.1	0.0	48.1	8.5	7.1	13.3
Community and other services	10.7	5.8	22.0	24.5	18.8	31.0	36.4	22.9	55.4
Employment status of head									
Public sector	8.3	5.3	16.0	21.4	12.9	31.5	35.0	22.3	51.6
Private formal sector	10.6	5.8	20.8	13.5	10.2	18.9	30.2	26.4	38.6
Private informal sector	15.8	14.0	18.5	23.8	14.7	29.9	35.7	33.1	39.7
Self-employed (agriculture)	40.3	23.5	42.7	52.4	43.0	53.7	66.1	48.1	68.5
Self-employed (other)	14.2	7.1	26.4	27.7	15.6	40.7	35.6	22.1	53.9
Not working	32.5	13.6	52.5	42.5	16.8	61.2	41.7	22.8	58.5
Migration									
Yes	28.0	10.6	39.5	37.2	17.5	49.1	54.3	30.2	66.7
No	30.5	11.8	38.1	44.1	25.4	50.0	47.1	22.9	58.2
Land ownership									
Yes	21.6	9.9	35.1	37.2	16.4	51.7	-	-	-
No	36.0	13.2	41.8	44.8	37.5	46.2	-	-	-
Total	28.5	10.8	39.2	39.5	19.4	49.5	51.7	27.7	63.6

Source: Coulombe and Wodon (2007).

In addition to regional variation, poverty and vulnerability disparities are reflected in terms of occupation. The great majority of people in Ghana are employed in the informal sector. Within this, agriculture and sales/retail are the principal occupational areas for women, with agriculture being more important in rural areas and sales/retail dominating in urban areas. Skilled manual work is also significant, and a minority of women hold managerial or professional posts. While agriculture still dominates male economic activity in rural areas (75% of men), in urban areas men have more diverse occupations, with more men in skilled manual occupations and managerial jobs.

Overall, however, agriculture is a key livelihood source, especially for the poor. As the first GPRS notes (GoG, 2002):

> Poverty is by far highest among food crop farmers. Their poverty remains nearly 19% above the national average of 40% in 1998/99 and they, together with those in non-farm self-employment, experienced the least reduction (9%) in poverty. This is of concern for three reasons: (1) the contribution of food crop farmers to the national incidence of poverty is much in excess of their population share, (2) poverty among food crop farmers is also much more pronounced based on the measure of extreme poverty, and (3) women are more predominant in both the food crop and non-farm self-employment sectors. Although the incidence of poverty among export farmers remains relatively high (39%), they experienced the largest reduction in poverty (25%). The strength of their poverty reduction reflects a number of factors including the conscious policy effort to promote the growth of non-traditional exports in the 1990s, their relatively easier access to financing, and their increasing access to markets.

An obvious risk associated with agriculture is variable rainfall (compounded by the lack of irrigation and rainwater storage systems), as highlighted by the 2007 floods in the northern region of Ghana. There are, of course, other risks too. As GPRSII notes (GoG, 2005a), agriculture is plagued by:

> … bushfires, post harvest losses and uncertainties, storage, transportation and marketing problems. An equally important constraint is the dearth of affordable credit in agriculture. Even in the flagship of the cocoa sector, the only credit that was ever available from the organised bank in the system was via the short-term seasonal credit of the foreign buying companies... this makes crop farming a high-risk enterprise.

The problems associated with poor access to credit were also reflected in responses to the Ghana CWIQ, where 56% of households gave family and relatives as their 'source of financial assistance in times of great difficulty' (GSS, 2003). Just 12.5% mentioned any sort of organised credit institution (whether public, private or informal moneylender) and a full one in four respondents said they would have 'no-one' to turn to. A majority of people in rural areas said they felt 'insecure' (54%), with perceptions slightly more positive in urban areas (42%) (GSS, 2006).

4.2 GENDER- AND AGE-SPECIFIC MANIFESTATIONS OF POVERTY AND VULNERABILITY

Childhood poverty and vulnerability are linked to household-level poverty and vulnerability but also have a number of important distinctive features. These include the following: i) childhood is a dynamic life stage in which children's capacities are evolving; ii) children require more care and protection than adults as they are not only undergoing complex biological, neurological, social and moral development, but are also more vulnerable to disease, abuse and exploitation; iii) children are often voiceless, with little opportunity to participate in decisions about their life; and iv) because of higher levels of vulnerability and reliance on adults, childhood poverty has a strong relational

nature, meaning that intra-household dynamics and distribution of power and resources may have a profound effect on their experience of poverty (Jones and Sumner, 2007). For children, windows of opportunity thus tend to be more finite: those that are missed may have lifelong and irreversible effects (Harper et al., 2003).

In terms of childhood monetary poverty, existing data suggest that, as is the case in other sub-Saharan African countries, the child poverty headcount is significantly higher than that of adults[5]. This can be seen in Table 7, based on data from the 1998/99 GLSS 4 (GSS, 2000). This analysis is corroborated by Deaton and Paxon (1997), who found that in Ghana 'adults are 10 percent better off than the elderly, and 20 percent better off than children'. It also triangulates with Adjasi and Osei's finding (2007) that poverty increases with household size. Perhaps not surprisingly, there are also differences in the child poverty headcount over the course of childhood: the poverty headcount diminishes with age, perhaps reflecting the generally higher poverty rate among households with young children. Among school-age children, the poverty headcount for children who are not in school is particularly acute.

Table 7: Household poverty headcount in Ghana, 1998/99

Aggregate poverty measures	Headcount ratio	Poverty gap ratio	Severity of poverty	Expenditure shortfall to raise households above poverty line
	43.57	15.66	7.67	35.95

Table 7b: Child poverty headcount in Ghana, 1989/99

Children by age category	5-10	11-13	14-16	Total 5-16
Children in total population (%)	19.0	8.7	7.3	35.0
Poverty headcount among children (%)	48.1	45.9	44.1	43.6
Poverty headcount among children not attending school (%)*	17.6	11.8	21.5	
Poverty among children not attending school as ratio of national poverty	144.0	175.3	194.9	

Note: * This figure is very high compared with the other 18 African countries in the study.

Source: Based on Kakawani et al. (2005), drawing on 1998/99 GLSS 4 data (GSS, 2000).

4.2.1 HEALTH AND LIFECYCLE VULNERABILITIES: CHILD SURVIVAL AND DEVELOPMENT

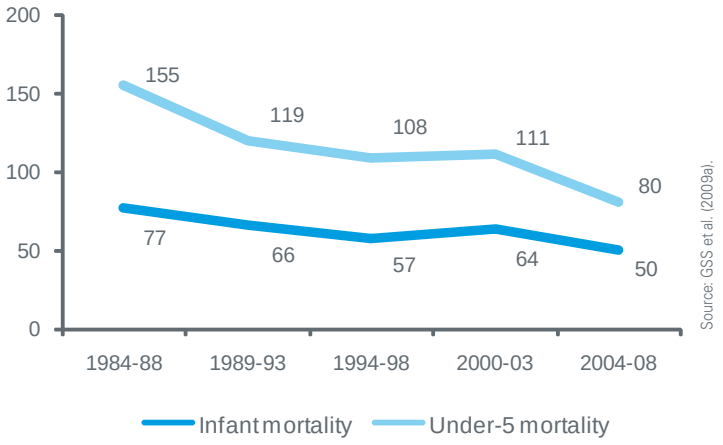
Health and lifecycle vulnerabilities are particularly significant for infants and young children. As highlighted in the discussion below, the children at greatest risk are those in rural areas, those in low wealth quintile households and those with mothers with low education levels. These vulnerabilities can be further compounded by location in disadvantaged regions, where service coverage is more restricted and of lower quality. Although Ghana's indicators are better than in many other countries in West and Central Africa, there are still substantial gaps to be addressed.

[5] Note that more recent data are not available. Barrientos and De Jong's 2004 analysis of children and cash transfers is similarly based on 1998 data. Here, the headcount was 68% and the adult-to-child poverty ratio 1.08.

Child health and child mortality

After making little progress in reducing its high under-five mortality rate (U5MR) during the 1990s and the early part of the current decade, there are signs of a significant improvement in the past few years, possibly reflecting the major policy initiatives taken in recent years, such as the High Impact Rapid Delivery (HIRD) programme and the establishment of the NHIS. The previous slow pace of progress (a reduction in the U5MR from 119 per 1000 live births in 1989-1993 to 111 in 2000-2003) contrasted sharply with the country's progress in almost halving monetary poverty. However, preliminary results from the most recent demographic and health survey (DHS), conducted in 2008, indicate a reduction in U5MR to 80 per 1000 live births in 2004-2008 (see Figure 3). There was also an improvement in infant mortality, to 50 per 1000 live births in 2004-2008, although this has been slower than for under-five mortality (GSS et al., 2009a). In short, mortality has become increasingly concentrated in the first year of life, including in particular the neonatal period (first month of life).

Figure 3: Under five and infant mortality rates, 1988-2008 (deaths per 1000 live births)



It is still too early to tell whether this renewed progress will be sufficient to ensure Ghana's achievement of MDG 4 – a two-thirds reduction in under-five mortality by 2015. However, the reduction in mortality has been accompanied by a number of encouraging improvements in underlying child health indicators. For example, the proportion of children aged 12-23 months who had received all immunisations on the EPI (Expanded Programme on Immunisation) rose from 47% in 1988 to 69% in 2003 and 79% in 2008, according to DHS data, although there are still important regional and rural/urban disparities (with a rate of only 58.5% in Northern Region in 2008). There has been a large increase in the use of mosquito nets, with the proportion of children under five sleeping under a net rising to 41% by 2008. But there has been less progress with respect to curative care of children. According to the 2008 DHS, only half (51%) of children with symptoms of acute respiratory infections (ARI) or fever are taken for treatment to a health facility or provider, and this proportion falls to 41% for children with diarrhoea (GSS et al., 2009a).

There are large disparities in under-five mortality, associated particularly with geographical location and the economic status of households (see Table 8). Full data are not yet available from the 2008 DHS, but the previous DHS survey in 2003 shows that U5MR was by far the highest in the three northern regions, with a rate in Northern Region (154 per 1000 live births) about two times higher than that in Greater Accra (75 per 1000 live births) (GSS et al., 2004).

The 2003 DHS also shows that the mortality rate declines with increasing household wealth (from 128 per 1000 live births in the bottom wealth quintile to 88/1000 in the top quintile) and mother's level of education (from 125/1000 among children of mothers with no education to 92/1000 for those with at least junior secondary school). Children of very young mothers (aged under 20) also appear to suffer a higher than average rate of mortality (U5MR of 131/1000) (GSS et al., 2004).

Table 8: Under-five mortality by background characteristics (deaths per 1000 live births)

	1993	1998	2003
Residence			
Urban	89.9	76.8	93.0
Rural	149.2	122.0	118.0
Region			
Western	131.8	109.7	109.0
Central	128.0	142.1	90.0
Greater Accra	100.2	62.0	75.0
Volta	116.4	98.0	113.0
Eastern	93.2	89.1	95.0
Ashanti	97.6	78.2	116.0
Brong-Ahafo	94.6	128.7	91.0
Northern	237.0	171.3	154.0
Upper West	187.7	155.6	79.0
Upper East	180.1	155.3	208.0
Mother's education			
No education	165.7	130.8	125.0
Primary	141.2	112.5	120.0
Middle/junior secondary school	89.0	91.3	92.0
Secondary/higher	40.7	59.8	34.0

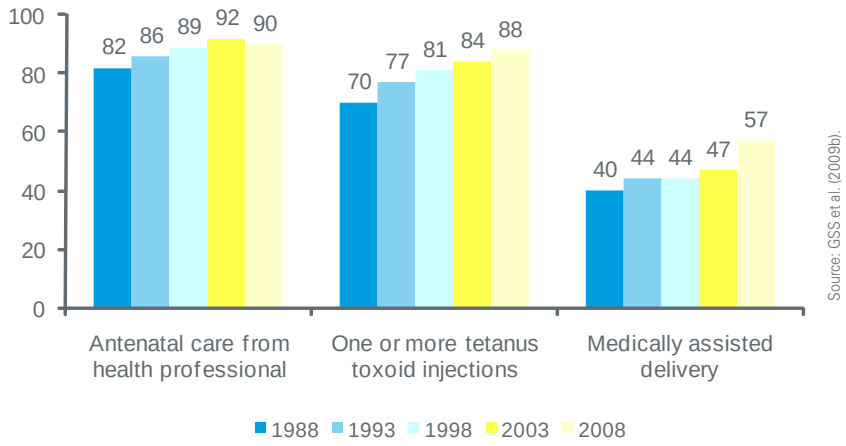
Source: GSS et al. (2004).

Maternal health and mortality

Slow progress in reducing Ghana's maternal mortality ratio (MMR) is also a major concern. There are no consistent historical data, which makes it difficult to draw clear conclusions about trends, but there is a general recognition that it has proven difficult to reduce MMR. According to World Health Organization (WHO) estimates, MMR was reduced by only one-quarter between 1990 and 2000, from 740 to 540 deaths per 100,000 live births (WHO, 2006) – a rate of reduction much too low to achieve MDG 5. A maternal health survey, conducted in 2007, has produced the most recent estimate, of 451 per 100,000 live births for the period 2000-2007, calculated from sibling data history (the sisterhood method) (GSS et al., 2009b).

As can be seen in Figure 4, although almost all mothers in Ghana receive some antenatal medical care (90% in 2008, rising to 95% if deliveries assisted by community health workers are included), and the majority have four or more checkups, the level of births assisted by skilled personnel still remains low, particularly in rural areas. Nonetheless, the proportion of deliveries assisted by health professionals rose from 47% in 2003 to 59% in 2008 (GSS et al., 2009b). Maternal malnutrition also remains an important concern and is often exacerbated by traditional nutritional taboos during pregnancy (especially with regard to protein intake).

Figure 4: Trends in maternity care (% of births)



DHS surveys have identified obstacles to women's access to health care as a major contributing factor to maternal mortality. According to the 2003 DHS (GSS et al., 2004), the groups most likely to report major difficulties in accessing health care were rural women (80%), women without education (83%) and women in the bottom wealth quintile (88%). Ease of access to health care seems to improve steadily with education and greater wealth, although one in two women with a secondary education reported access issues. Cost was the most frequently cited obstacle to accessing health care (54%), followed by needing transport (33%), distance (32%) and not wanting to go alone (20%). Cost, distance and transport were much more frequently a problem for poorer women. Women in the bottom wealth quintile report more obstacles of all sorts, including knowing where to go or concern that there may not be a female health care provider. The majority of households in rural Ghana are over 30 minutes from a health clinic or hospital; one in four households is more than one hour away. This contrasts with just 20% of households more than 30 minutes from these health facilities in urban areas (GSS et al., 2004).

HIV/AIDS

The risk of MTCT of HIV is an important concern in Ghana, as reflected in the Ghana HIV/AIDS strategic framework. MTCT is estimated to account for about 15% of all HIV transmissions in Ghana. Data from the 2003 DHS (GSS et al., 2004) suggest that general knowledge about HIV transmission during pregnancy, delivery and breastfeeding is relatively high (ranging between 69% and 75% among women and 74% and 82% among men). However, there is very low awareness (16%) that the risk of MTCT can be reduced if a mother takes special drugs during pregnancy. As in other areas, urbanisation, education and wealth have a positive impact on knowledge of MTCT, whereas disadvantaged regions (especially Upper West and Northern) are associated with low levels of awareness (ibid).

Malnutrition

Malnutrition is another significant risk during early childhood in particular, and contributes to child mortality. Estimates of the incidence of stunting among children under five in Ghana range from around 30-32% in 2003, with 10-12% severely stunted, to 28% stunted in 2008, with 9.8% severely stunted (GSS et al., 2009a). These figures suggest that, despite the progress in reducing monetary poverty, chronic malnutrition remains a serious problem among children in Ghana.

Children with low birth weight are more likely to be stunted than average (40% incidence of stunting according to the 2003 DHS (GSS et al., 2004)), suggesting chronic malnutrition affected the mother during pregnancy as well as after birth. Children whose mothers are uneducated, who live in households in the lowest wealth quintile or who live in rural areas are more likely to be underweight than average. Preliminary data from the 2008 DHS (GSS et al., 2009a) show that children in rural areas are one and a half times more likely to be stunted than children in urban areas (32.3% compared with 21.1%). The highest rates of stunting are in Eastern and Upper East Regions (37.9% and 36.0%). Data by quintiles are not yet available from the 2008 DHS, but the 2003 DHS found a strong correlation between stunting and poverty: 42% of children from the lowest wealth quintile were stunted, compared with 13% of children in the top quintile. There are similar geographic and economic disparities with respect to maternal nutrition. In addition, the 2003 DHS indicated that the risk of stunting is higher for children whose mothers are absent or who have decreased spacing between births.

Limited access to water and sanitation

Access to safe drinking water and sanitation is another important factor affecting child nutrition and health. As can be seen from Tables 9 and 10, although there has been steady progress over time in terms of increasing access to water, children in rural and low wealth quintiles remain significantly more vulnerable to unsafe water sources. These risks are, in turn, compounded by distance to water sources, where rural families have further to travel. As water carrying is often done by children, especially girls, this is another important indicator of child vulnerability.

Table 9: Access to potable water, by locality and standard of living quintile (% of households)

		1991/92	1998/99	2005/06
Urban	Lowest	55	55	76
	Second	68	69	86
	Third	77	77	84
	Fourth	79	84	86
	Highest	84	94	91
Rural	Lowest	32	45	64
	Second	32	46	60
	Th ird	35	50	61
	Fourth	34	52	66
	Highest	41	58	67

Source: GSS (2007).

Table 10: Time to water source

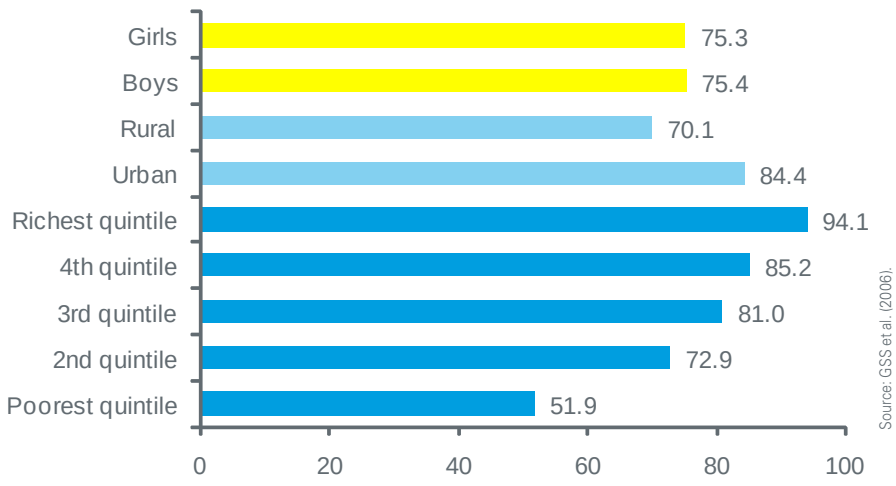
	Urban		Rural		Total	
	1998	2003	1998	2003	1998	2003
<15 minutes (%)	79.7	79.8	44.0	46.5	56.6	61.8
Households within 15 min of safe water supply (%)					49.0	67.2
Median time to source (minutes)		4.3		14.3		9.4

Source: GSS et al. (2004).

4.2.2 EDUCATION

Another significant risk facing children is lack of access to education, which may translate into disadvantage both over the lifecourse and (because of the impact of mothers' education on children) through generations. The latest available data suggest that approximately three-quarters of Ghanaian primary age children attend school at the correct age. The primary school net attendance ratio was 75.3% in 2006, according to the 2006 Multiple Indicator Cluster Survey (MICS) (GSS et al., 2006). There is almost no difference between boys' and girls' primary school enrolment rates, with the largest variation between different wealth quintiles (51.9% attendance among bottom quintile children, rising steadily to 94.1% among the top quintile), age (48.3% of six year olds as against 87.6% of 11 year olds) and rural/urban residence (70.1% of rural primary age children were in school compared with 84.4% of urban children). The regions with the lowest rates of primary school attendance were Northern (54.6%) and Upper West (60.4%); attendance was the highest in the capital (86.8%).

Figure 5: Net school attendance rates by gender, urban/rural area and wealth quintiles, 2006



A similar pattern, with improving but overall lower levels of attendance, is repeated for secondary school. Wealth appears to be the most significant determinant, with net attendance rates rising from 16.9% in the bottom wealth quintile to 71.5% in the top quintile. The urban/rural divide widens slightly from primary level also, with 57.4% of urban secondary age children in school as opposed to 35.7% in rural areas. There is only a very slight increase in the gender divide compared with primary level, with male and female net attendance rates at 45.2% and 44.9%, respectively. The regions with the lowest secondary school attendance rates are again in the Savannah areas, with rates less than 30% in the three northern regions, according to the 2006 MICS.

4.2.3 EXPLOITATION, VIOLENCE AND ABUSE

The extent to which children suffer exploitation, violence or abuse is another key dimension of children's vulnerability. Poverty is one of the main determining factors for many child protection problems, such as child labour, trafficking and sexual exploitation. However, there are also social and cultural risk factors, making child vulnerability a complex, multidimensional phenomenon.

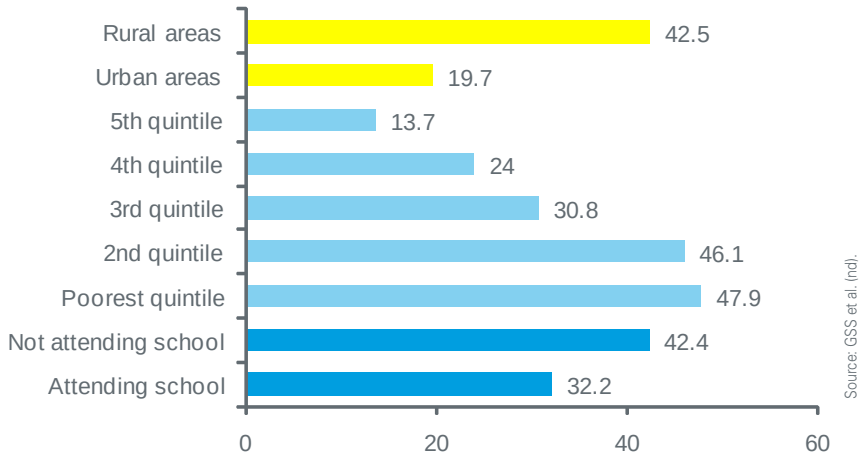
In the case of child labour, any analysis of the underlying determinants is hampered by data constraints. Data on child labour in Ghana are relatively limited and no trend data are available. This is in part because only recently has child labour been recognised as a significant concern, worthy of policy attention. There are also important cultural dimensions, with work seen as an important mechanism for imparting life skills among the younger generation (interview, 2008). Aside from small-scale qualitative surveys, the main sources of data are the 2001 Ghana Child Labour Survey (CLS) and the 2006 MICS (GSS, 2003; GSS et al., 2006). Besides the most harmful forms of child labour, it is important to understand the time constraints that children face, including time spent on household chores or farming, that may prevent them from having adequate time for school, homework and leisure activities.

According to the MICS data, 33.9% of children aged 5-14 years old are engaged in child labour[6]. While relatively few children are engaged in work outside the household (3% and 6% in paid and unpaid work, respectively), over a quarter of children are working within the household. There are large differences across quintiles, with 47.9% of children in the lowest quintile working and 13.7% in the highest quintile, as shown in Figure 6. Child labour is far more widespread in rural areas (42.5%) than in urban areas (19.7%), and is particularly prevalent in the three northern regions (53.5% in Upper East, 50.1% in Upper West and 43.6% in Northern).

Given the time trade-offs between working and attending school, it is not surprising that child labour is more prevalent among children not attending school (42.4%) than among those who do go to school (32.2%).

[6] The MICS defines child labour on the following basis: for ages 5-11, engagement in at least one hour of economic work or 28 hours of domestic work; for ages 12-14, engagement in at least 14 hours of economic work or 28 hours of domestic work.

Figure 6: Children aged 5-14 involved in child labour, 2006 (%)



The CLS found that 27% of children were engaged in child labour, according to International Labour Organization (ILO) Convention 138. This defines as unacceptable children under the age of 12 working or children between the ages of 12 and 14 engaged in heavy labour. Some 10.9% of children were engaged only in economic activity; a further 16% combined it with schooling. Rates were similar for girls and boys: there exists only a slight tendency for boys to have higher rates of involvement in labour activities. However, rural children were more than three times more likely to be working than urban children, and were also significantly more likely to be out of school, working or otherwise.

Table 11: Distribution of working children aged 5-14 (%)

	Services	Industry	Agriculture
Age group			
5-9	18.3	5.4	76.3
10-14	24.6	6.8	6.4
5-14	22.6	6.4	71
Gender			
Male	13.6	4.9	81.5
Female	32.5	8	59.5
Male and female	22.6	6.4	71

Source: GSS (2003).

Again according to the CLS, almost all children performed some household chores (88%); girls and rural children were slightly more likely to do so than boys or urban children, with rural girls having the highest rate (93%).

Not surprisingly, the education level of the head of the household strongly affects child labour and schooling, with the children of more educated household heads much less likely to be working or combining work and school. Interestingly, children in female-headed households are less likely to be working and more likely to be in school than those in male-headed households. This is true for all levels of parental education. Children in rural households headed by uneducated men are most likely to be working and not in school (23%).

Table 12: Children aged 5-14, by gender, type of activity and residence (%)

Gender	Type of activity	Urban	Rural	Total
Male	Work only[a]	1.8	16	11.2
	Study only[b]	87.4	53.2	64.9
	Work and study[c]	6.8	21.5	16.4
	Total work*	8.6	37.5	27.6
	Total study**	94.2	74.7	81.4
	Neither	4	9.3	7.5
Female	Work only[a]	4	14.6	10.5
	Study only[b]	81.4	53.9	64.4
	Work and study[c]	9.5	19.6	15.8
	Total work*	13.6	34.2	26.3
	Total study**	90.9	73.5	80.2
	Neither	5.1	11.9	9.3
Total	Work only[a]	2.9	15.4	10.9
	Study only[b]	84.3	53.5	64.7
	Work and study[c]	8.2	20.6	16.1
	Total work*	11.1	36	27
	Total study**	92.5	74.1	80.8
	Neither	4.5	10.5	8.3

Notes: * 'Total work' refers to children who work only and children who work and study (a+c).
** 'Total study' refers to children who study only and children who work and study (b+c).

Source: GSS (2003).

Table 13: Children aged 5-14, by per capita income quintile, gender and activity (%)

	Q1	Q2	Q3	Q4	Q5	All
Male						
Work only	20.3	15	9.3	7.9	2.2	11.3
Study only	55.2	60.6	65	68	82	65.7
Work and study	17.5	17.1	19	18	12	16.6
Neither	11.5	7.5	7.6	6.5	3.7	7.6
Female						
Work only	17.8	14.1	9	8	4.3	10.6
Study only	54.5	59.5	64	68	77	64.9
Work and study	16.5	13.9	19	17	13	15.9
Neither	14.9	12.5	7.7	6.5	5.5	9.3
Total						
Work only	19.2	14.6	9.2	8	3.3	11
Study only	54.9	60.1	64	68	80	65.3
Work and study	17	15.6	19	17	12	16.3
Neither	13.1	9.8	7.6	6.5	4.6	8.4

Note: Totals may not add up to 100 owing to rounding. Household expenditure is used as a proxy for income. Quintile 1 represents lowest expenditure category and Quintile 5 highest.

Source: GSS (2003).

Another important underlying problem is the fact that many children appear to be receiving inadequate nurture and care within the home. This appears to have social, cultural and economic dimensions. The 2006 MICS found that only 59.8% of children live with both their parents and that 14.3% of children do not live with either of their parents. 7.7% of children are orphans of one or both parents. But orphan-hood is not the main reason why many children do not live with their parents: 11.2% of children have both their parents alive but do not live with them. This shows the high prevalence of informal fostering in Ghanaian society. To some extent, this reflects the resilience of traditional extended family relationships and obligations. However, some children appear to end up in households where they are poorly treated and subject to exploitation. Other problems include family breakdown and domestic violence, the widespread phenomenon of fathers' absenteeism and neglect of children and the consequences of children's separation from parents owing to migration.

In addition, culturally rooted attitudes and practices, including gender biases, put children's wellbeing at risk. These include the widespread acceptance of physical punishment as an appropriate means of disciplining children. According to the 2006 MICS, 42.5% of mothers and caretakers believe that children need to be physically punished. Female genital mutilation (FGM) is a limited phenomenon in most of Ghana (with a national prevalence rate of 3.8% nationally in women aged 15-49, falling to only 1.4% in the 15-19 age group), but is very high in Upper West Region (56.1%).

By contrast, child marriage, which overwhelmingly affects girls, is a widespread problem, one which violates children's rights and compromises the development of girls. It frequently results in early pregnancy and/or social isolation and exclusion, high fertility, maternal mortality and domestic violence. According to the 2006 MICS, 4.4% of women aged 15-49 were married before the age of 15, although this is clearly becoming less common, as the percentage falls to 2.1% for women aged 15-19 (see Table 14). About a quarter (25.9%) of women aged 15-49 were married before the age of 18, a figure that seems to be declining more slowly, as 22.0% of women aged 20-24 had been married before the age of 18. Of women aged 15-19, 8.1% are either married or in union. As would be expected, there are significantly higher rates in rural than urban areas. Vulnerability to child marriage arrangements is further exacerbated by poverty, with significantly higher prevalence among the three lowest wealth quintiles.

Table 14: Early marriage by location and wealth quintile (%)

	% of girls married before 15	% of girls married before 18
Residence		
Urban	3.3	20.5
Rural	5.3	30.6
Wealth quintile		
Lowest	5.6	32.5
Second	7.0	34.5
Third	5.2	29.0
Fourth	2.8	23.8
Highest	2.4	14.6
Total	4.4	25.9

Source: GSS et al. (2006).

The lack of birth registration is an additional risk factor for many children. The UN Convention on the Rights of the Child (UNCRC) affirms that every child has the right to a name, a nationality and protection from being deprived of his or her identity. Birth registration is a fundamental means of securing these rights. According to the 2006 MICS, approximately half (51.4%) of Ghanaian children are registered. Mother's education and urban residence appear to be the most significant factors increasing the likelihood that a child's birth will be registered. Cost, distance and lack of knowledge of the procedures involved are the most significant obstacles reported by those whose children are not registered. There are also some significant regional disparities, with particularly low registration in the Eastern, Volta and Northern regions (see Table 15).

Table 15: Birth registration by region, 2006 (%)

Total	**51.4**	Volta	46.5
Male	55.2	Eastern	38.3
Female	50.7	Ashanti	56.2
Urban	68.5	Brong-Ahafo	49.4
Rural	42.0	Northern	46.6
Western	48.3	Upper East	53.2
Central	52.3	Upper West	50.1
Greater Accra	71.8		

Source: GSS et al. (2006).

4.2.4 GENDER INEQUALITY

In order to understand child wellbeing, it is critical to explore intra-household dynamics and care arrangements. As White (2002) argues, '"child-centred" development practice must not be "child-only": social and economic justice for poor children must be tackled in the context of their families and communities'. In most societies, women shoulder a disproportionate share of this care burden (see Kabeer, 2003).

Table 16: Adult and youth literacy by gender and location (%)

	1997	2003	Margin of error	Rural	Rural poor	Urban	Urban poor
Adult literacy	**48.5**	**53.4**	**1.1**	**39.8**	**22.3**	**69.6**	**54**
Male	62.4	65.8	1.1	52.6	31.1	81.9	68.3
Female	37.2	42.3	1.2	28.2	13.7	58.9	41.2
Youth literacy	**64.1**	**68.7**	**1.1**	**56.4**	**39.7**	**81.7**	**73.1**
Male	71.8	74.5	1.2	63.1	44.1	87.5	79.3
Female	57	62.9	1.3	49.3	33.2	76.4	65.9

Source: GSS (2003).

In line with evidence from other countries, Ghanaian women's education has an influential effect on child welfare. The relationship between the two variables themselves is revealed by DHS data, which show that the majority of women in the bottom wealth quintile have no education (63%). From the middle wealth quintile upwards, however, most women have at least some secondary education. Ghana's north/south divide surfaces here too. According to the 2003 DHS (GSS et al., 2004), women in the northern districts are,

on average, the least educated, with 79% of women in Northern Region without education (Upper East 72%; Upper West 63%). Although there have been slighter faster improvements in female literacy rates over the past decade, male literacy rates remain higher among adults overall as well as among youth (see Table 16).

In Ghana, female-headed households, which represent 30% of total households, have significantly lower average levels of poverty than male-headed households (19.2% versus 31.4%) This may partially explain why child wellbeing is in some respects better in female-headed households. Specifically, as seen above, children in those households are more likely to be in school and less likely to be engaged in child labour than others (GSS et al., 2004).

The Poverty and Social Impact Assessment (PSIA) (NDPC, 2004) and the Human Development Report (HDR) (UNDP, 2007), however, do highlight gender as a key determinant of poverty and vulnerability, especially given women's concentration in food crop farming. A more detailed assessment is difficult, given data constraints. While women's pay levels and inheritance rights are crucial areas of gender relations, the household surveys conducted in Ghana unfortunately have little to say on these issues. However, the 2003 DHS did collect data on the form of women's remuneration and women's control over their earnings. Some 86% of economically active women reported earning cash, either alone (61%) or in combination with in-kind payment. Even 80% of women working in agriculture reported that cash was part of their payment for work. Responses about household decision making and control of women's earnings also paint a relatively optimistic picture for women: 80-90% of women of all areas and social groups report that they alone, or jointly with another household member, decide how their earnings are spent. Very few women have no say – the highest figure is 18% in Upper West Region. Autonomy rises with age, getting married and having children – and is only weakly enhanced by education and greater wealth (GSS et al., 2004).

These findings are broadly in keeping with Ghana's ranking according to the international Gender Equity Index, which measures gender differences in education, empowerment and economic activity. Ghana fares relatively well in terms of education and economic activity rates, but its score is very low in terms of empowerment as measured by the percentage of women in decision-making positions[7]. As we discuss in more detail later in the report, this limited voice and agency may be reflected in the limited attention paid to the gender dynamics of poverty and vulnerability in the design of social policy and social protection programmes.

Table 17: Gender Equity Index scores, 2008

Education	Economic activity	Empowerment	Total score
79.7	82.5	12.8	58

Source: www.socialwatch.org/en/avancesyRetrocesos/IEG_2008/tablas/valoresdelIEG2008.htm.

Violence against women remains a major concern in Ghana, with very high levels of domestic violence (Ark Foundation, 2007). The 2003 DHS found, for example, that 49% of women felt that a man was sometimes justified in beating his wife. While this figure is much smaller than that of Mali (89%), it is still a high figure. When one excludes the Northern and Upper districts, where over 76% of women accept wife beating in some circumstances, the figure drops to 42%. Men – at least in their responses to surveys – appear less tolerant of wife beating than women, with only 32% of men saying it is sometimes justified. In the north of the country, however, a clear majority of men accept wife beating.

[7] This includes the percentage of women in technical positions, in management and government positions, in Parliament and in ministerial posts. Ghana's position has fallen by 7% between 2004 and 2008, and at 58 is in the top third of the African region but still below the world average score of 61.1.

4.2.5 COPING STRATEGIES

If we define vulnerability as the state of being in which people are not able to cope with threats to their wellbeing or access resources without incurring a damaging loss (Dercon, 2005), it is important to consider how children and their caregivers will be involved in and impacted by household and community-level risk reduction, mitigation and coping strategies. In terms of *risk reduction strategies*, in many communities, especially in the north of the country, out-migration has been a strategy to reduce the risk of unemployment (Appiah-Kubi et al., 2008). While remittances derived from migration may result in improved household resources and room for child-related expenditures, the effects on children can also be potentially negative. Those effects can include disrupted schooling if they accompany parents to new destinations and, if they are left behind, more pressures to be involved in work activities, especially household chores, owing to there being fewer remaining adults to take care of household management and caring responsibilities. Hashim (2005) also finds that children migrating independently from the north to the south of Ghana in order to take advantage of educational or training opportunities, or to earn an independent income, face a number of risks. These include not receiving adequate care in foster households or the need to invest significant time in household labour in exchange for board and lodging, receiving inadequate training in apprenticeship arrangements and working long hours for little or no pay.

Risk mitigation strategies can include livelihood diversification, including increased involvement in economic activities by women and children, migration and encouraging early marriage (Appiah-Kubi et al., 2008). In the case of women's increased involvement in income generation activities, this may exacerbate women's time stress and reduce time spent supervising children. A growing body of evidence suggests that women are likely to continue to bear household management and care-giving responsibilities, but that more work is shouldered by older siblings, especially girls, unless accessible and affordable community childcare is provided (Woldehanna et al., 2008). Additional effects could include reduced time spent breastfeeding and/or reduced time spent on cultivating food crops, both of which are detrimental to children's nutrition and development. For children, greater involvement in work activities risks their not having enough time to study and attend school regularly. In severe cases, labour participation may result in school dropout. All of these risks may reduce income earning potential in the future (ibid).

Risk coping refers to actions taken to reduce the impact of a risk event once it has occurred. Research in Kumasi, Ghana, suggested that in many cases the poor have few options. Participatory rural appraisal (PRA) responses from rural communities included praying to God, borrowing or seeking assistance from relatives and friends, stealing or fraud and relying on boyfriends in the case of urban women (Ashong and Smith, 2001). Other options that households identified included rationing food (less nutritious foods and fewer meals, putting children at greater risk of malnutrition), withdrawing children from school temporarily, sending children out to work, securing loans at high interest rates and selling produce at low rates (Appiah-Kubi et al., 2008).

4.3 SUMMARY OF KEY POINTS

The main areas of poverty and vulnerability for children that a child-sensitive social protection system should take into consideration include the following:

- *Health and lifecycle vulnerabilities* affecting children and mothers are particularly problematic in the Ghanaian context of significant progress in reducing broader monetary poverty. These include the heightened risks of child mortality among children in rural and low wealth quintile households, as well as

those with low maternal education rates; MTCT of HIV; stunted child development owing to malnutrition, especially in the food-insecure regions in the north of the country; and high maternal mortality, especially as a result of the distance to and cost of health care services, including at the time of delivery. Children living in communities with limited access to water and sanitation services are also at greater risk.

- *Vulnerability to educational deprivations:* Ghana is making good progress in terms of the educational targets of MDGs 2 and 3, but location and poverty still constitute important barriers to school attendance, particularly at secondary level. Children in Northern and Upper West Regions are especially vulnerable to poor human capital development.

- *Vulnerability to exploitation, violence, abuse and neglect:* The dearth of trend data makes it difficult to assess progress over time on problems such as child labour, child marriage and lack of birth registration. Existing data suggest that vulnerability here is closely associated with rural and low wealth households, as well as disadvantaged geographic regions.

- *Gender-related vulnerabilities:* Because of the relational nature of childhood poverty and the asymmetrical responsibilities for care-giving work assigned to women, understanding the pattern of gender relations is important for the design of child-sensitive social protection policies and programmes. Survey data suggest that Ghanaian women fare relatively well in terms of economic participation, poverty headcount and household decision making, but female food crop farmers remain one of the most impoverished groups. Female literacy rates are still significantly below those of men and domestic violence is a serious concern.

- *Coping strategies and their child-specific effects:* In the absence of a broader social safety net, existing evidence suggests that Ghanaian families adopt a number of strategies to manage risk and cope with household shocks, and that some of these have potentially adverse effects on children. These include out-migration of children (with or without parents), withdrawal from school, increased child labour and a reduction in the quality and quantity of food consumption.

The extent to which these issues are addressed in Ghana's current social protection framework is analysed in subsequent sections.

5. NATIONAL SOCIAL PROTECTION POLICY AND PROGRAMMES

The conceptualisation of social protection underpinning this report emphasises the importance of policies and programmes that address both economic and social risks and vulnerability. This section provides an overview of existing social protection programmes in Ghana that fall into the following categories identified in Devereux and Sabates-Wheeler's 2004 transformative social protection framework: **social assistance** to extremely poor individuals and households; **social welfare services** to those who need special care and support; and **social insurance** to protect people against the risks and consequences of livelihood, lifecycle and other shocks. We also provide a brief summary of existing social equity measures that protect children and their caregivers against social risks such as discrimination. The analysis pays attention to both formal and informal initiatives, as well as the socio-political and institutional context in which these policy frameworks and programmes are operating.

Concepts of social solidarity, based on the notion of kin-based mutual support, were solidly anchored in traditional Ghanaian culture, and to some degree these informal mechanisms still exist today, although they appear to be eroding under the influence of modernisation. More modern forms of social protection began after World War II with the introduction of pensions for retired public employees and were later extended to the formal private sector workforce. However, these social security provisions covered only a small part of the population (less than 10%), leaving unprotected the vast majority of the poor, who rely on subsistence agriculture and the informal sector. During the structural adjustment period of the 1980s, limited social safety nets were introduced through the Programme of Action to Mitigate the Social Costs of Adjustment (PAMSCAD) programme, essentially for public sector workers made redundant by the harsh reforms introduced at the time. In 1984, milestone legislation was introduced to protect the inheritance rights of widows and their children. It has only been in the past few years that attention has been given to the challenge of developing a broader, more comprehensive social protection system that would address the vulnerabilities and risks facing the mass of the population, and help to promote poverty reduction and human development.

5.1 MAPPING EXISTING SOCIAL PROTECTION PROGRAMMES[8]

Addressing social exclusion and vulnerability was one of five core pillars of GPRSI, and remains an important component (although less prominent) in GPRSII. Moreover, although MMYE's draft National Social Protection Strategy (NSPS) of March 2007 is yet to be approved by Cabinet[9], it does provide a comprehensive framework within which to assess existing social protection initiatives and it has spurred new initiatives, especially the LEAP cash transfer programme, discussed in Section 7. The NSPS defines social protection as efforts that 'go beyond income support and include the strengthening of social cohesion, human development, livelihoods and protection of rights and entitlements' (MMYE, 2007a). Ghana's PSIA in 2004 (NDPC, 2004) identified the following segments of the population as being particularly vulnerable: those suffering severe

[8] Note that NGO social protection programmes are not included in this mapping, as this was beyond the scope of the current study. However, such a mapping would be of value, given the fragmented knowledge base on such initiatives at a national level.

[9] Unexplained delays occurred throughout 2007, and in May 2008 the sector working group on vulnerability and social exclusion agreed to withdraw the NSPS so as to revise the analysis based on the recently available GLSS5 data.

livelihood insecurity (particularly rural farmers) and those with a lack of access to services, resources and rights as well as an inability to demand accountability, especially women. Importantly, it also includes explicit attention to social protection programmes that address children's rights to protection, survival and development. In short, at the level of policy intention, there is now both a far-ranging understanding of the rationale for social protection and a clearly articulated vision as to how this could be effectively tackled.

Our mapping of social protection programmes in Ghana (see Annex 2 and below) shows that there is a broad range of programmes focusing on increasing children's access to school, addressing youth underemployment and unemployment, providing affordable health insurance, supporting rural farmers' livelihoods and addressing the care needs of orphans and vulnerable children (OVC) and people with disabilities. Of note, however, is the limited number of programmes specifically targeted at: i) the livelihood needs of non-youth adults; and ii) empowering women and addressing gender inequalities (notwithstanding the identification of gender as a key axis of disadvantage in both the 2004 PSIA and the 2007 Ghana HDR). To date, while these programmes have been implemented by multiple government agencies (Ministry of Food and Agriculture (MOFA), Ministry of Health, Ministry of Education, MLGRDE, MMYE, the Department for Social Welfare (DSW) and the National Health Insurance Authority (NHIA), there has been little, if any, coordination across sectors.

In terms of formal **social assistance**, the Ghanaian government already implements the following[10]:

- *Education Capitation Grant:* Introduced in September 2005, this aims at improving school enrolment and retention in line with the MDGs by providing public schools with grants to cover tuition and other school levies previously paid by households. This programme is a type of fee waiver, aimed at reducing household expenditure and thereby promoting demand for education. Initially, the ECG was piloted in 40 of the country's most deprived districts and set at a rate of $2.70 for boys and $3.80 for girls. However, over time this gender-sensitive policy was changed to a gender-neutral one, where by the government paid the same fee for all children. Overall, the ECG has been evaluated as a major success. The significant growth in school enrolment rates since 2005 has been attributed to the programme. In the first year alone, primary net enrolment rates increased from 59% to 69% in the areas under coverage, with a higher increase for girls. The capitation grant was extended to all public schools throughout the country in September 2006, and its value was increased by 50% in the 2009 budget. In 2009, the government also announced a new scheme to provide free textbooks and school uniforms to 1.6 million children in deprived districts.

- *School feeding:* A School Feeding Programme was introduced in 2004, assisted by the New Partnership for Africa's Development (NEPAD). The primary goal of the programme is to increase school enrolment and retention by providing at least one daily meal to children in deprived districts. Over 590,000 children in deprived schools and communities benefited in 2008 (MOFEP, 2008). However, as will be discussed in greater detail below, the design, targeting and implementation of the programme have suffered from significant weaknesses, as revealed in a high profile evaluation report and media exposé in early 2008. The sustainability of the programme is currently in question as a result (interview, 2008). However, the government announced a further expansion of the programme to cover more districts in 2009.

[10] This section draws on our social protection matrix in Annex 2 as well as the useful summary in the NSPS (NDPC, 2007).

- *Public works programmes:* A number of community-based programmes provide employment for unemployed and underemployed youth. These include the National Youth Employment Scheme (NYES) (which aims to create 500,000 jobs between 2006 and 2009)[11], the National Forest Plantation Programme (32,000 fulltime jobs created as of 2004) and the Mass Cocoa Spraying Programme (60,000 jobs created as of 2004).

- *Integrated agriculture input support:* This programme was established by MOFA in response to the 2004 PSIA and provides loans and agricultural inputs to smallholder farmers.

- *Microfinance programmes:* There is a general consensus that access to credit for the extreme poor remains a major challenge in the country. A number of microfinance programmes involving loans to the informal sector for productive activities have been implemented, especially for women. Earlier programmes suffered from poor targeting methods and low loan recovery rates, but the Social Investment Fund (SIF), described below, has addressed this to some extent. Other microfinance programmes include the Women Development Fund and the MASLOC (Microfinance and Small Loans Centre) scheme.

- *LEAP cash transfer programme:* Initiated in March 2008, this programme is designed to provide cash transfers to extremely vulnerable households. LEAP built on the experience of a UNICEF-supported programme of DSW, which covered the health insurance costs of OVC in districts with high HIV/AIDS prevalence rates. In its initial phase, LEAP is continuing to target caregivers of OVC, but has added destitute elderly and persons with severe disabilities. In response to the food crisis in 2008, as well as the floods in northern Ghana in the same year, the World Bank supported a temporary expansion of the programme in the food-insecure northern regions of the country, known as 'Emergency LEAP'. More details are provided in Section 7.

In the case of **social insurance**, the following schemes are in place:

- *Contributory pension schemes:* The Social Security and National Insurance Trust (SSNIT) offers long-term protection to contributors through an elderly persons' pension, disability benefits and death/survivors benefits, under the 1991 Social Security Law (PNDC[12] Law 247). These benefits cover only three of the nine types of benefits included in the minimum standards of social protection established by ILO Convention 102. Employees and employers contribute respectively 5% and 12.5%, respectively. As of 2001, there were slightly fewer than 800,000 SSNIT contributors, constituting about 9.3% of the economically active population (Kumado and Gockel, 2003). These are overwhelmingly workers in the formal sector, with only a very small percentage (2%) in the informal sector. The scheme has been criticised for low coverage rates, low benefit levels and non-payment into the scheme on the part of some employers despite deducting the amounts from workers' wages. SSNIT also runs programmes for student loans and for housing mortgages, essentially for formal sector employees. There is also a parallel pension scheme for public sector employees enrolled before 1972, set up under the Pension Ordinance of 1946 and known as Cap 30. The fundamental weakness of these schemes is that they

[11] Our interviews suggested, however, that there had been significant problems with payment of these youth to date (2008).

[12] The Provincial National Defence Council was in government after the People's National Party's elected government was overthrown by Jerry Rawlings on 31 December 1981, remaining in power until 7 January 1993.

reach only a very small proportion of the population, leaving uninsured the majority of Ghanaians, including the vast majority of the poor, who depend for their livelihood on the informal sector.

- *National Health Insurance Scheme:* The NHIS was established by the National Health Insurance Act in 2003 and is aimed at providing sustainable and equitable health insurance for all. It is funded from a combination of sources: the National Health Insurance Levy, which consists of a 2.5% addition to value-added tax (VAT) and import duties; the pass-through of contributions from employees enrolled in the SSNIT; resources provided by the Ministry of Health and donors; and the premiums paid by non-subsidised 'mutual health' members. The coverage rate as of the end of 2008 was approximately 54% of the population. As will be discussed in Section 8, although the NHIS is not explicitly pro-poor, the proportion of marginalised groups covered by exemptions is increasing.

- *Health insurance for OVC:* This UNICEF-supported DSW pilot project covered the NHIS premium costs for OVC in 20 districts with high HIV/AIDS prevalence rates. It provided the seeds for the LEAP cash transfer programme discussed in Section 7.

The government of Ghana is also implementing, with varying success, a number of **social welfare service programmes** for various deprived groups:

- *Supplementary feeding* is designed to provide supplementary energy and nutrients for pregnant and postpartum women, infants and children, including those who are in need of rehabilitation for severe malnourishment[13].

- *Community-based Rehabilitation Programme:* This programme aims to ensure that people with disabilities can receive integrated family and community support, especially through the implementation of disability-friendly services at the community level.

- *DSW services:* The Maintenance and Custody, Child Subsistence Grant, Alternative Care and Child Rights Protection programmes are all designed to protect the overall welfare of the child through a range of custody, maintenance and care arrangements. Coverage is nationwide and approximately 3000 cases are handled by DSW annually.

- *ILO/IPEC (International Programme on the Elimination of Child Labour) Time-bound Child Labour Programme:* This aims to eliminate the worst forms of child labour in the country through capacity building and awareness raising of employers, inspectors and parents; poverty reduction programmes for parents; and rehabilitation and reintegration support for children withdrawn from child labour. The programme is focused on the areas of the country in which child labour is endemic, including cocoa plantations, quarries and mines.

- *Services to tackle child sexual violence and exploitation:* These services include awareness creation, withdrawal from exploitative contexts and rehabilitation, psycho-social counselling, rescue and integration, education and health services. Tourist sites, particularly in Accra, have been a focus of intervention, with 271 children rescued to date.

[13] Targeted school and supplementary feeding programmes are also implemented by the World Food Programme (WFP) in the food-insecure northern regions of Ghana (interview, 2008).

The social protection programmes described above are all modern, formal mechanisms, established by the state, but many Ghanaians participate in and benefit from **informal social protection mechanisms**. Bortei-Doku Aryeetey and Doh (2007) identify five main sources of informal social protection, which are all based on traditional principles of reciprocity and mutual exchange:

- *Kin-based support systems:* In times of need, such as hunger, disease and old age, individuals have traditionally depended on family or clan members for assistance in the form of either cash or in-kind benefits (Nukunya, 1998 quoted in ibid). Such groups are not necessarily location based, as they have formed so-called hometown-based groups in urban areas and also in the Ghanaian diaspora.

- *Remittances:* The proliferation of money transfer institutions in Ghana attests to the rapid growth in the volume of migrant remittances (an estimated $1.5 billion in 2005 (GJAS Partners, 2007)), which are largely used to cover 'family maintenance' costs such as school fees, social activities (especially funeral costs) and living expenses (Quartey, 2005 quoted in ibid).

- *Trades associations:* These are non-kin based groups, formed around a common professional identity, which provide important support functions. They are estimated to involve about 9% of the population (SSNIT, nd, quoted in ibid).

- *Faith-based support networks:* These are one of the fastest social security systems in Ghana among both Christian and Muslim populations, with an estimated 51% of the population holding membership in a religious organisation. Faith-based groups provide support during key lifecycle events (birth, marriage, death) and in some groups payment levels are formalised.

- *Credit societies:* Termed 'susu', these groups serve to mobilise mutual funds in the informal sector, and are estimated to involve about one-third of the population. Similar credit unions are also found in a number of workplaces, churches and schools.

The main distinction that Bortei-Doku Aryeetey and Doh (2007) note between formal and informal systems is that the latter are not time bound, i.e. they do not distinguish between present and future risk management and are therefore very flexible. However, over time, owing to both growing urbanisation and modernisation and the declining importance of the extended family, many of these forms have gradually been eroding, prompting the need for greater attention to formal social protection mechanisms.

In terms of **complementary activities**, the GPRSII's focus on human development has seen the implementation of a number of social sector reforms aimed at attracting and retaining better qualified personnel (especially in rural areas and in the health sector) and improving service quality (Education Reform Policy, Health Reform Policy). Multiple new national policies addressing the specific needs of particular social groups have also been developed, including the Draft National Disability Policy, National Population Policy, Draft Youth Policy and Draft National Ageing Policy.

Of particular relevance to our focus on children is the new Integrated Child Development Policy. This includes the Early Childhood Care and Development (ECD) Policy which aims to 'ensure that Ghanaian children receive the best possible care and start in life to guarantee their survival in a knowledge-based world' (GoG, 2005a). It strives simultaneously to reduce the care burden of women and girls, as well as to bring attention to child protection issues (especially juvenile justice, harmful forms of child labour,

trafficking and sexual exploitation, streetism and OVC)[14]. It also includes a recent policy to integrate kindergarten (four to six years old) into the primary school system.

In the case of promoting gender equality, there is a general recognition that priority needs to be given to tackling the implementation challenges involved in turning existing legal frameworks into living, meaningful documents (GoG, 2005a). However, broader social and income generation support services are largely lacking, or are implemented on a small scale only.

Two development funds are also worthy of mention. First, SIF was established by the government, the African Development Fund (ADF) and the UN Development Program (UNDP) as a mechanism to channel resources to the poor under the GPRS. SIF places particular emphasis on facilitating access to basic social services and microfinance schemes. Second, the District Assembly Common Fund (DACF) has earmarked expenditures for a number of specified social policy initiatives, including services for the disabled, people living with HIV/AIDS (PWLHA), self-help projects and capacity-strengthening programmes.

5.2 IMPACT OF EXISTING SOCIAL PROTECTION SCHEMES

Overall, it would appear that, while a number of important vulnerabilities have been identified and programmes developed to address them, formal social protection suffers from poor targeting and relatively low coverage (with the important exceptions of the ECG and increasingly the NHIS). In justifying the need for a national social protection framework and a cash transfer programme, the NSPS argues that, while extant social assistance programmes 'have made considerable efforts to reduce poverty and improve the livelihoods of Ghanaians, experience indicates that sustainable mechanisms to empower those facing extreme poverty were insufficient' (MMYE, 2007a). As a result, the extremely poor lack not only access to basic social infrastructure, goods and services, but also the means to exit the poverty trap into which they have fallen, despite broader national-level growth. Moreover, the document adds that interventions to date have focused on assistance, rather than prevention of livelihood decline, and furthermore have achieved only limited coverage and impact owing to uncoordinated programme delivery and poor targeting. These shortcomings are echoed in the 2004 PSIA and the 2007 Ghana HDR. The latter pays particular attention to the weak culture of 'monitoring of implementation' (UNDP, 2007), a theme also highlighted by a number of key informants, who pointed out that there had been little investment in rigorous impact assessments of social programmes (interviews, 2008).

While, as will be discussed in some depth in Section 7, there are important technical capacity constraints with regard to pro-poor targeting, political factors appear to be just as important in shaping coverage outcomes. In the case of the School Feeding Programme, for instance, although the initial design was to create an incentive for poor families to invest in their children's schooling, in practice the programme has been implemented in non-poor districts in addition to those that are poor. Furthermore, at least in some instances, this was motivated by reasons of political expediency (interview, 2008). A similar scenario has presented itself in the case of the rollout of the LEAP cash transfer programme, where decisions are being informed more by consideration of geographical spread than by explicitly targeting areas of extreme poverty (interviews, 2008). Nationwide coverage is not a concern per se, but emerges as more problematic given the resource constraints discussed in Section 6.

[14] See Section 9 for further discussion.

5.3 POLITICAL AND INSTITUTIONAL CONSTRAINTS

Hickey (2007) argues that any effort to understand the extent to which the poorest benefit from social protection needs to consider the interrelationships between social protection and politics. These are manifested at three levels: systemic (e.g. political institutions), societal (e.g. public attitudes) and institutional (e.g. historically embedded 'rules of the game'). Hickey also suggests that there is a global politics to social protection that cuts across these interrelated dimensions, within which donors and related international policy discourses are particularly relevant.

5.3.1 SYSTEMIC CONSTRAINTS

An important constraint facing the introduction of policies and programmes in low-income countries is concern about affordability, especially given multiple competing development priorities. Ghana's GPRSII is strongly focused on growth and harnessing human resources in order to meet the country's goal of reaching middle-income status by 2015. As such, the NSPS has had to be framed in language that recognises these development priorities, as the following statement illustrates (MMYE, 2007a):

> The Strategy is founded on the philosophy that all Ghanaians if afforded the opportunity, can contribute towards the process of transforming Ghana into a middle income country by the year 2015. Vulnerable and excluded segments of the population potentially reverse the gains of overall developmental efforts because of their tendency to take away rather than contribute to national economic activity. Furthermore, the youth (aged between 15-35 years) who are the most vibrant sector of the society and constitute an estimated 26% of the total population require critical attention. Their situation is characterized by among others unemployment with its attendant problems of social vices, disillusionment and poverty [but they are] … full of potentials which if properly harnessed could be channelled towards effective human resource development and also for socio-economic advancement.

In this regard, advocates for social protection within the government have made good use of a growing body of evidence that links social protection to human capital development and higher economic growth (ibid):

> The misconception that Social Protection represents wasteful handouts to undeserving poor people has been overtaken by recent research and thinking, which indicates that it contributes to development and growth in several ways. It facilitates investment in human and physical assets thereby reducing the risk of future poverty. It enhances risk-taking livelihood strategies. It provides safety nets and facilitates social and economic cohesion, reducing the likelihood of conflict. Finally, it helps correct market failures such as imperfect credit and insurance markets. It is therefore an indispensable element of economic growth and ultimately, an effective development strategy.

This instrumentalist approach may have implications for programme design and implementation, as we will discuss in Section 7, but could be complementary to a more rights-based approach, depending on the advocacy and sensitisation work carried out to support this new policy area.

Another important factor in the Ghanaian context is the limited coordination among government ministries, departments and agencies (MDAs). This is likely to be one of the most pressing challenges to be tackled as the LEAP programme is scaled up and the NSPS is implemented. Slater and Tsoka (2007) emphasise that forging linkages with more powerful and resource-rich ministries is of critical importance in cases where the implementing agency is weak and capacity constrained, as is the case with DSW, which is responsible for LEAP and the NSPS more generally. This weakness has been officially recognised in recent capacity assessments (Yuster, 2007; 2008; DSW, 2008), and a Social Protection and Livelihood Team (SPLIT) has been set up as a coordinating body, involving different ministries and agencies. The NSPS assigns the overall coordinating role for social protection to the MMYE (renamed the Ministry of Employment and Social Welfare following the 2008 elections). However, given the current relatively weak status of MESW, effective change will require sustained expert support and mentoring, as well as a strong degree of buy-in from other ministries as to the value of a social protection agenda (interview, 2008).

While it is clear that MESW and, within it, DSW in particular are genuinely committed to the social protection agenda, the level of political support on the part of more powerful ministries is less clear. Part of this ambivalence appears to owe to insufficient information both across and within MDAs. However, it seems also to stem from the fact that these ministries are facing significant challenges of their own in terms of improving service accessibility and quality (interviews, 2008).

Fortunately, there are some encouraging signs. For example, the Ministry of Health is interested in learning from MMYE's pro-poor targeting experiences and in linking up LEAP beneficiaries to the NHIS (interview, 2008). Support from MOFEP appears to be mixed. On the one hand, there are concerns, not because of opposition to the content per se, but because of the public finance implications. These concerns are related to the wage bill in the social sectors, the sustainability of funding a social grant programme such as LEAP and the rapid scale-up of the programme without sufficient baseline information and assessments from a pilot (interviews, 2008). On the other hand, MOFEP is supporting the process and allocated GHS 2 million ($1.7 million) in the 2007 and 2008 budgets, and increased this to GHS 7.5 million in the 2009 budget. Given that this type of social protection is a relatively new area and that more advocacy and sensitisation are required with line ministries and MOFEP to achieve buy-in and ownership, this initial support is a promising first step.

Weak interagency linkages are exacerbated by poor knowledge management systems and a weak evidence-informed policymaking culture. No database currently exists, but MESW plans to establish a centralised database on social protection programmes in order to monitor implementation, while also facilitating the referral of beneficiaries between programmes and case management across different agencies. As will be discussed in Section 7, the single register established as a database on LEAP beneficiaries is seen as the starting point for building such a system, but to date this also remains unelaborated. In addition, given a very small potential pool of social protection expertise and an environment in which the same select researchers carry out analyses for multiple stakeholders, the scope for rigorous debate and new ideas, as well as the opportunity for challenging existing paradigms, remains somewhat limited.

An additional constraint is the relative weakness of the legislative branch, which acts only to a limited extent as an effective check and balance on the power of the executive. The Ghanaian Parliament is hampered by its limited role in the 1992 Constitution, its low levels of resources and expertise and the low levels of engagement and support it receives from development partners (World Bank, 2003).

5.3.2 SOCIETAL CONSTRAINTS

An analysis of both recent press clippings on the launch of the LEAP programme (see Section 7) and our key informant interviews suggests that there is only mixed public support for social protection initiatives (interviews, 2008). There appears to be a public ethos that the poor need to pull themselves out of poverty through work. It requires some effort to convince the public of even the necessity of providing support to those without productive work capacities, such as caregivers of OVC, the elderly and the disabled. This belief has regional dimensions: while there is strong evidence that poverty and vulnerability are significantly higher and more concentrated in the north of the country, support to target public expenditure allocations disproportionately in the north in order to tackle such economic and social disadvantage is relatively weak. As the 2007 Ghana HDR notes (UNDP, 2007):

> Bringing the northern regions to par with the South requires intensive social and financial investment beyond the current levels. Strong political and socio-cultural will as well as sheltered funding arrangements are required … [in order to] enhance capabilities in human development and restore the dignity and progress of the excluded in these areas.

Given their involvement in projects aimed at tackling poverty and exclusion, Ghana's vibrant civil society organisations (CSOs) could play an important role in raising public awareness about social protection as a means to promote social inclusion. However, to date, their role in policy advocacy has been relatively limited, owing to a dearth of financial and human resources, as well as a deficit of quality data with which to effectively challenge and engage the government (ibid)[15].

5.3.3 INSTITUTIONAL CONSTRAINTS

In comparison with many of its neighbours, Ghana's good governance record is making further progress, as evidenced by its improving scores in the World Bank's Governance and Corruption indicator tables (World Bank, 2008). Multiparty democracy appears to have been consolidated with peaceful transfers of power to the opposition party in 2000 and 2008. Nevertheless, Booth et al. (2005) argue that Ghana is still best characterised as a neo-patrimonial state, wherein patronage politics, rather than explicit development objectives and legal rules, dominate the decision-making process. This is reinforced by a political culture of weak evidence-informed decision making, information sharing and knowledge management (interview, 2008). Limited attention has been paid so far to the establishment of a either a rigorous baseline or a monitoring and evaluation (M&E) system, both of which are critical for assessing programme effectiveness and impacts. If not corrected, the lack of hard evidence on the impacts and cost effectiveness of LEAP could

[15] The launch of the Ghana Research and Advocacy Programme (G-RAP) donor funding window for CSOs to engage in policy advocacy activities may start to address this deficit. See Section 10 for further discussion.

affect the future scale-up of budgetary allocations for its planned expansion. A good sign is that, despite capacity constraints, DSW is moving ahead to establish a baseline and an impact evaluation framework. More specifically, the planned collaboration with the Yale/Isser Panel Survey is a promising method of undertaking an impact evaluation.

5.3.4 GLOBAL POLITICS

Ghana's efforts to introduce a social protection framework are clearly shaped by a broader global debate on the role of social assistance in addressing poverty and vulnerability. This is evidenced by the frequent references throughout Ghanaian social protection design documents to best practices from other regions and by officials' participation in study tours and South–South learning exchanges (especially with Brazil), supported by the donor–government sector working group on vulnerability and social exclusion. Currently, the donor community (especially the UK Department for International Development (DFID), UNICEF and more recently the World Bank[16]) is highly supportive of social protection efforts (GJAS Partners, 2007), as evidenced by the levels of funding and technical support (e.g. for developing targeting tools). Some local analysts, however, argue that donors emerged late on the scene to support the development of social protection thinking and programmes. Some fear that current programmes such as LEAP may end up being the casualty of donor faddism and question the sustainability of current funding support (interviews, 2008)[17].

5.4 CONCLUDING REMARKS

Ghana has already embarked on the design of a national social protection framework, which identifies children as a key vulnerable group. It has also initiated a range of important social protection programmes, including the NHIS, the ECG, the School Feeding Programme and the LEAP cash transfer programme – all of which have a strong focus on children. Some of these programmes, in particular NHIS and LEAP, are pioneering initiatives for the West and Central African region and deserve to be followed with interest in the coming years.

There are, however, a number of important challenges in realising the potential of these initiatives so that they have a significant impact in tackling childhood poverty and vulnerability. These include establishing stronger awareness and ownership of social protection among ministries other than MESW (including inclusion in annual programme plans and budget allocations), supporting capacity strengthening within MESW (and DSW in particular) so that they can effectively take on a new policy coordination role and strengthening coordination mechanisms across MDAs to maximise cross-sectoral synergies. In addition, learning from these programmes and strengthening their effectiveness could be significantly enhanced if appropriate investments are made in both quality data collection and robust M&E systems, which should include both quantitative measures as well as opportunities for programme participant feedback.

[16] In 2008, the World Bank provided additional resources to support the scaling up of the LEAP programme to assist poor households in the food-insecure regions of the north.
[17] See further discussion in Section 7.

6. FISCAL SPACE FOR SOCIAL PROTECTION PROGRAMMES

Social protection systems have been historically weak and under-resourced in most of sub-Saharan Africa. Total spending has been around 0.1% of GDP, which is significantly below expenditure on social protection in other parts of the world, including the Middle East and North Africa, where the average is approximately 5.7% of GDP (Coudouel et al., 2002). This chapter examines the current situation in Ghana with regard to what Heller calls 'fiscal space', namely the 'room in a government's budget that allows it to provide resources for a desired purpose without jeopardising the sustainability of its financial position or the stability of the economy' (Heller, 2005).

We wish to identify the scope for the additional financing of social protection systems and individual programmes in a sustainable manner, given the overall fiscal situation in Ghana. We provide a general overview of the country's macroeconomic and fiscal position, as well as the progress made in the management of public resources, before focusing more specifically on the fiscal challenges related to investments in social services and the potential fiscal space for social protection. An important theme underlying this section is that resourcing for social protection is shaped by both fiscal constraints and the politics of the budget process.

6.1 OVERVIEW OF THE MACROECONOMIC AND FISCAL SITUATION

Over the past five years, Ghana's economic performance has been quite strong, although the widening of the fiscal deficit and rising inflation have become a serious concern and the country is facing new risks from the global food, fuel and financial crises. Real GDP growth has been impressive, reaching an estimated 7.2% in 2008 (IMF, 2009a), but is projected to decelerate in 2009 (see Table 18).

This growth has been relatively broad based, covering various export commodities (cocoa, gold, other mining, timber, fish and marine products and fruit) as well as food crop production, with the exception of the northern regions, where floods have resulted in localised food shortages and sharp price increases. Robust growth is also accredited to the stimulus provided by higher public sector expenditure and strong public and private sector investments, including new power generation and other infrastructure investments (World Bank, 2008). There are, however, a number of possible risks to growth. First, rising inflation has become a growing concern. Consumer prices have risen sharply (16.5% in 2008), driven by domestic demand pressures and rising world oil and food prices.

Second, Ghana has a persistent current account deficit, which has been widening in recent years, reflecting both a very large trade deficit and a relatively constant level of donor support as a share of GDP. Third, the country's fiscal position has deteriorated significantly, with an overall fiscal deficit (including grants) that has widened from 3.7% of GDP in 2005 to 13.5% of GDP in 2008 (IMF, 2009a). The main driver of government spending has been the wage bill, accounting for just under half of overall tax revenues and reaching almost 10% of GDP as a result of a series of pay awards (see discussion below). In addition, since 2007 higher spending has also resulted from emergency energy sector-related expenditures (IMF, 2008). Overall, however, capital spending to improve infrastructure and accelerate growth has not been as high as intended (World Bank, 2008).

Table 18: Selected economic and financial indicators, 2005-2009 (% of GDP unless otherwise indicated)

	2005	2006	2007	2008 est.	2009 proj.
National accounts and prices					
Real GDP growth (%)	5.9	6.4	6.1	7.2	4.5
Real growth in GDP per capita (%)	3.2	3.8	3.5	4.5	1.9
Consumer price inflation (%)	15.1	10.2	10.7	16.5	14.6
Government operations					
Total revenue	21.8	21.9	22.7	22.8	22.4
Grants	5.2	5.5	6.0	4.6	5.4
Total expenditure	30.7	34.4	37.2	40.9	34.6
Overall balance (including grants)	-3.7	-7.0	-8.5	-13.5	-6.8
Total government debt	77.1	41.9	49.8	51.4	56.3
Domestic debt	17.9	24.8	26.1	26.6	29.6
External debt	59.2	17.1	23.7	24.8	26.7
External sector					
Current account balance (including official transfers)	-8.1	-9.7	-11.7	-18.2	-10.9
Current account balance (excluding official transfers)	-12.4	-12.8	-15.5	-22.1	-15.2

Source: IMF (2008; 2009a).

The fiscal deficit has been financed by both domestic and external borrowing. Although total government debt declined significantly, from 77.1% in 2005 to 41% in 2006, following Ghana's achievement of HIPC completion point status, debt has been steadily increasing again in the past two years and is projected to be as high as 56.3% of GDP by 2009 (IMF, 2008). If this trend continues, there are fears that the debt burden may once again become unsustainable.

In terms of Ghana's macroeconomic outlook, growth is likely to decline sharply in 2009-2010, owing to the adverse impact of the global economic crisis and the new government's need to reduce the fiscal and balance of payments deficits and curb inflation. However, in the longer run, Ghana stands to benefit from the start of oil production, provided that these resources are used efficiently. Prospects look positive in this regard, given the initiation of a broad-based national consultation process by the government on how best to manage Ghana's oil resources (IMF, 2008).

Several cautionary notes should be sounded, however. In order to contain the wage bill, civil service reforms appear pressing, as is elaborated further below. Promoting a more skilled labour force is also an urgent priority. Low-productivity agriculture continues to provide 50% of employment (GJAS Partners, 2007), while human and social development has not kept pace with the country's increasing GDP per capita rank, as Section 3 discussed.

6.2 PROGRESS IN MANAGEMENT OF PUBLIC RESOURCES

The budgetary system is still widely perceived as suffering from important weaknesses and inefficiencies, including susceptibility to leakages and corruption (Killick, 2005). This is manifested in the fragmentation of information sources on the budget across sectors and government levels as well as in the imbalance of power and resources between the National Development Planning Commission (NDPC), which is responsible for policy planning, and the much more powerful MOFEP (interviews, 2008).

Some efforts are being made to address these shortcomings. First, three laws that jointly constitute a public financial management (PFM) and accountability framework (financial administration, procurement and internal audit laws) were passed in 2003. Furthermore, MOFEP has developed a strategic plan to address the disjuncture between budgets, policy formulation and programme expenditures in 2006 (GJAS Partners, 2007). This included developing a medium-term expenditure framework (MTEF) and providing support to MDAs and sub-national governments to strengthen the credibility of their budgets (interview, 2008). Public expenditure tracking surveys have been introduced to learn more about spending within the sectors and identify inefficiencies: the two surveys covering the health and education sectors were conducted in 2008.

There have also been important advances in addressing the Paris Declaration principles on aid effectiveness, as evidenced by the introduction of multi-donor budget support (MDBS), which now accounts for approximately 35% of all donor funding. A recent evaluation suggests that, overall, the augmentation of budget resources through MDBS has 'helped the government to apply funds in response to needs, which earmarked resources could not have done' (ODI, 2007; Lawson et al., 2007).

However, multiple and intersecting constraints persist. First, the budget process remains relatively closed, with limited transparency, as highlighted by the 2007 Budget Transparency Report by the International Budget Project (IBP) in Washington, DC and the Centre for Budget Advocacy (CBA) at the Integrated Social Development Centre (ISODEC) in Accra. Ghana scored 0% on four out of six indicators on the Open Budget Index for past budgets up until 2005[18]. Moreover, although Parliament has to approve the budget and has recently constituted a Finance Select Committee, owing to problems of timetabling, resource and capacity constraints it has 'been unable to provide effective scrutiny and control … Parliamentary scrutiny tends to be hurried, superficial and partisan' (Killick, 2005). Further complicating advances in transparency and accountability is the incomplete process of decentralisation and the related difficulties in improving coordination and planning across different levels of government (Darlan and Anani, 2007). The qualitative research findings of CBA revealed that, although the government invites budget inputs publicly and publishes highlights of the budget in the press, communities and local authorities were largely uninformed about resource allocations for specific projects and were neither consulted nor involved in M&E processes: 'Similarly, communities had no idea about the type of materials required for the execution of projects. In some cases, contractors were not introduced to communities and so they had no means of monitoring projects awarded on contract by District Assemblies' (IBP and CBA, 2007).

This may also be related to a lack of budget literacy among citizens, which authorities may need to address if they want to attract meaningful public participation. Without this, current programming approaches struggle to harness a community sense of ownership and willingness to participate and contribute to new programmes and projects.

[18] In order to gauge a government's commitment to budget transparency and accountability, the Open Budget Index assesses: i) the availability of key budget documents; ii) the quantity of information they provide; and iii) the timeliness of their dissemination to citizens. Ghana scored 0% for providing no information at all through pre-budget statements, in-year reports on execution, end-of-year reviews and the Auditor General's reports. However, the country scored 64% for providing 'significant information' on the budget proposal (IBP and CBA, 2007).

6.3 FISCAL CHALLENGES TO INVESTMENT IN SOCIAL SERVICES

Although GPRSII saw a shift in emphasis away from social development towards economic growth, poverty-related expenditures have increased steadily during the same period. Ghana's pro-poor expenditure rose from 4.8% of GDP in 2002 to 10.4% in 2007 (see Table 19). As a result, the country is now broadly in line with average pro-poor spending[19] of post-HIPC decision point countries. Most of the spending is on basic education, health and rural electrification, which together account for more than 60% of domestically financed poverty reduction spending (World Bank, 2008).

Importantly, poverty-related expenditure is continuing to increase, from 26.3% of total expenditure in 2007 to 30.8% in 2008. Moreover, according to estimates prepared for the June 2007 Consultative Group meeting held in Accra, external assistance during 2006 totalled almost $1.2 billion, of which budget support represented close to 30%. The remainder was provided in the form of project support for sectors, with an emphasis on areas that reduce poverty or support GPRS priorities.

Table 19: Poverty-related expenditure by area (% of GDP)

	2003	2004	2005	2006	2007 proj.
Basic education	3.6	3.7	3.8	4.0	4.3
Primary health care	1.0	1.4	1.7	1.7	2.0
Agriculture	0.2	0.2	0.2	0.4	0.4
Rural water	0.1	0.1	0.2	0.2	0.1
Feeder roads	0.5	0.4	0.4	0.6	0.4
Rural electricity	0.1	0.2	0.4	0.9	1.6
Other	1.1	1.6	1.7	2.7	1.6
Total	6.5	7.7	8.5	10.5	10.4

Source: World Bank (2007).

Interestingly, the Budget Law does not assume that all social sector spending is pro-poor and instead accounts separately for pro-poor expenditure, showing this figure as a share of total expenditure per sector. So, for instance, the government spends approximately 20% of its budget on education, and approximately 60% of that can then be considered pro-poor according to government standards (see Table 20).

Sector composition is not further disaggregated. The Budget Law in Ghana does not provide a detailed breakdown of social sector spending, itemising the resources going to different programmes. This makes it difficult to know, for example, how much the government is spending on particular social protection

[19] Poverty-related expenditures include the following domestically financed expenditures from the Appropriation Act: i) education sector – non-formal education, pre-school, basic education, technical and vocational education, teacher training and education management and supervision, plus a fraction of the expenditures on special education (50%) and general administration (50%); ii) health sector – district health services, regional public health expenditures, oncology expenditures, funding for the International Red Cross and health learning materials, plus a fraction of the expenditures on regional health support services (50%), psychiatric hospitals (50%), regional clinical care (50%), health training institutions (70%) and institutional care (60%); iii) agriculture sector – crop services provided through the regional agriculture development units and projects funded by the International Development Association (IDA); iv) works and housing sector – community water and sanitation, rural housing and rural hydrological drainage; v) roads and transport sector – feeder roads and road safety; vi) energy sector –rural electrification programmes; and vii) other sectors – national vocational training, social welfare programmes and others.

programmes, such as cash transfers, or on particular vulnerable groups, such as children[20]. Moreover, there is limited understanding about either funding gaps faced by regions with a higher poverty incidence (especially in the north) or the extent to which public spending is aligned with the government's broader policy goals.

Another important limitation is the mounting size of the wage bill, especially in the health and education sectors. The wage bill has been identified as a major concern for sustainable growth in the country, as it currently represents just under half of overall tax revenues. Pay anomalies between services are generating pressures for further increases[21]. As such, the international financial institutions have argued that payroll expenditures are crowding out expenditures in other areas, not only in the short term but also because of permanent obligations on public resources.

Table 20: Poverty reduction expenditure by sub-sectors

	2007 revised planned	2008 planned
Total poverty reduction expenditure as % of total government expenditure	26.3	30.8
Basic education expenditure as % of total education expenditure	60.0	63.5
Primary health care expenditure as % of total health sector expenditure	54.7	51.9
Poverty agriculture expenditure as % of total agriculture sector expenditure	90.5	68.4
Feeder roads expenditure as % of total roads and transport expenditure	24.6	22.1
Other poverty expenditure as % of total government expenditure	4.6	5.2

Source: MOFEP (2008).

On the one hand, this situation is arguably reducing the available fiscal space for other poverty reduction initiatives, including social protection. While the increased wage bill reflects, in part, a correction to historically low levels of pay and an effort to stem a substantial brain drain of qualified personnel to both the private sector and overseas, wage increases need to be undertaken within the context of civil service reform to increase efficiency and attract highly skilled workers (World Bank, 2008).

On the other hand, one of the constraints facing the delivery of basic services, especially in rural areas, is the shortage of personnel. For instance, in the case of DSW, which is responsible for implementing the LEAP cash transfer programme at community level, the very limited number of district-level staff is having to be complemented by volunteer youth enrolled in the NYES (interview, 2008). This suggests that viewing the wage bill as a non-productive recurrent cost instead of as an essential part of investing in human capital development may be creating a false dichotomy. There seems to be a general consensus that reforms could bring about greater staff productivity, but at the same time, although better off than some of its West African neighbours, Ghana is understaffed in the health sector, even by African regional standards (see Table 21 below). Moreover, the three most deprived regions – Northern, Upper West and Upper East – have the worst doctor/population ratio. There are also considerable regional disparities in terms of the nurse/population ratio (NDPC, 2007).

[20] Given that the budget line 'other poverty expenditure' includes social welfare, HIV/AIDS and women and children's affairs, it is likely that social protection spending comes under this line item.

[21] Also, higher spending on wages and salaries has meant that ministries with large payrolls (e.g. Education and Health, which together account for over two-thirds of payroll expenditures) have experienced the largest increase in expenditures. Thus, by mid-2007 the government had responded to the need for fiscal space for energy-related and payroll expenditures with an across-the-board 30% reduction in the budget ceilings for services and non energy-related capital expenditures (World Bank, 2008).

Table 21: Density of health workforce in Africa per 1000 population, 2002

	Africa region	Ghana	Senegal
Physicians	0.217	0.15	0.06
Nurses and midwives	1.172	0.92	0.32
Environmental and public health workers	0.049	--	0.07
Community health workers	0.449	--	--
Health management and support	0.411	0.90	0.05

Source: WHO (2006).

6.4 FISCAL SPACE FOR SOCIAL PROTECTION

One of the key axes of debate around the introduction of social protection programmes is financial viability, and it is of particular concern in low-income countries (Harvey and Holmes, 2006). As Ghana begins to embark on the rollout of the NSPS, and especially a cash transfer programme for the extremely poor, an important question therefore concerns the fiscal scope for expansion from pilot projects to larger swathes of the population.

International figures suggest that the implementation of a basic social protection package is likely to cost between 6% and 8% of GDP in low-income countries (Pal et al., 2005). This would include funding for both social assistance (social pensions and a child school-related transfer), which is estimated to amount to 2-3% of GDP, as well as slightly more expensive social insurance (basic health coverage), which would amount to 3-4% (Barrientos, personal correspondence, 2008).

In Ghana, a target of 24.4% for social protection expenditure as a percentage of GDP was included in the 2006 Annual Progress Report for GPRSII (GoG, 2007b, extracted from a 2006 MMYE table). However, no information is available on either how this indicator is defined (except that it appears to include employment generation) or how the target was set. Similarly, no information is provided on progress towards the target. Given that pro-poor expenditure for the same time period was only 26% in total (see above), this appears to be an error and to suggest that greater thought is required as to how to develop an appropriate indicator for progress on social protection expenditure. In this regard, it is important to bear in mind the particular challenges involved in identifying public expenditure on social protection. Social protection programmes cut across multiple sectors. In the case of Ghana, this includes MESW, MOWAC, MLGRDE, the Ministry of Education and the Ministry of Health, as discussed in Section 3. As such, the 2006 Annual Progress Report on the Implementation of the GPRSII candidly noted: 'Issues of vulnerability and exclusion are not adequately addressed, particularly in the area of data availability and disaggregation. For instance data on social protection expenditures is currently not available to determine the adequacy or otherwise of resources going to activities for the vulnerable and excluded' (NDPC, 2007).

These data limitations notwithstanding, we are able to draw some conclusions about the financial sustainability of current programming based on an analysis of the financing of individual social protection programmes. As Table 22 below suggests, financing for current social protection programmes appears to be manageable. It is of use to note, however, that the faster than envisaged expansion of the LEAP programme in 2008 (in response to the food price crisis) was supported by donor funding, which raised some concerns about sustainability among MOFEP staff given that social protection requires a long-term fiscal commitment (interview, 2008).

Table 22: Select social protection programmes and financing mechanisms

Programme	Financing details
NHIS	Typically, social insurance relies on mixed financing from contributions and government subsidies. However, the NHIS is largely financed through a 2.5% earmarked addition to VAT and import duties, plus the pass-through by SSNIT of 2.5% of contributors' income. There is modest additional revenue from member contributions through the mutual health component of NHIS, as well as some resources from the Ministry of Health and donors. These financing mechanisms have ensured the generation of the substantial resources required to sustain the provision of a large proportion of subsidies (interview, 2008). Overall, the NHIS accounts for 29% of health sector spending (Adanu et al., 2008).
NYES	In line with the tax-financed nature of social assistance, the NYES is funded from a number of public funds[22]. Since 2007, a mobile phone 'communications tax' has been introduced to further support the NYES, although it is unclear how substantial this revenue is likely to be.
LEAP cash transfer programme	Funding for the initial rollout of LEAP in 2008 was based on a combination of DSW budget resources plus donor support from both World Bank funding for northern food-insecure districts and HIPC funds. At the current transfer amount of GHS 8-15 per household, the estimated cost to reach the target of 165,000 extremely poor households by Year 5 of the programme would amount to the equivalent of 0.09% of GDP, or approximately 0.38% of total tax revenue (MMYE, 2007b)[23]. It should be noted that this target number of households covers only 18% of the country's extreme poor.
School Feeding Programme	In the case of the School Feeding Programme, the costs have been shared between MLGRDE and donors (especially the Netherlands). Sustainable funding is currently uncertain, owing to mismanagement and corruption allegations rather than unmanageable costs per se.
ECG	The ECG has been funded by the Ministry of Education, with GHS 129.5 million ($111.8 million) allocated in 2006 (NDPC, 2007).

There are, according to Handley (2009), only two genuinely sustainable means of creating additional fiscal space for further programming at a government's disposal: revenue mobilisation and reallocation. Aid is relevant, but basing social protection funding on aid flows is unlikely to be sustainable owing to the long-term obligations arising from social protection programmes.

In terms of increasing revenue, there are two principal channels: increased economic activity (real GDP growth) and increased tax revenue as a proportion of GDP. Current growth rates put Ghana on track not only for meeting the MDG on halving poverty levels by 2015 but also for achieving middle-income status in the same timeframe. This is attributed to an increasingly open trade regime, increasing foreign direct investment (FDI) and also, as long as the government learns from the 'resource curse' phenomenon, the prospect of oil revenues (IMF, 2008). However, the extent to which growth can be maintained and harnessed for poverty reduction activities depends on both the severity of the impacts of the global economic crisis and the government's ability to correct the serious macroeconomic imbalances that emerged in 2006-2008, including the large fiscal deficit. In terms of tax revenue, innovative tax initiatives have proven to date to be a successful route for social protection financing, as discussed in Table 22. It is possible, for example, that either the percentage from VAT revenue could be increased or that other potential revenue sources, such as the National Lottery or SIF, could be tapped.
Reallocating expenditure in line with national development strategy priorities and to achieve greater

[22] The DACF, Ghana Education Trust Fund (GET Fund), NHIS, Road Fund, HIPC Fund and Investment Fund.

[23] This would represent more than 73% of the 2007 MMYE budget and would entail significant public financial management capacity strengthening for the ministry as the coordinating agency for national social protection. The DSW's capacity to generate internal revenue is very limited – its main source of income is NGO registration fees, which it is currently planning to double in order to increase revenue. Options for increasing the availability of funds to DSW coordinated social protection programmes include the DACF, which has some funding earmarked for HIV/AIDS (1%) and disability services (5%).

operational efficiency is the sustainable second option for creating additional fiscal space. As discussed, achieving a better balance between salaries and non-salary recurrent expenditure is a priority for expenditure reallocation, as is greater attention to regions with high levels of deprivation. Expenditure tracking surveys are likely to help further in identifying areas for potential reallocation. Overall, although PRSPs are not necessarily a good indication of the drivers of policy (Booth et al., 2008), given both the relatively high and increasing level of pro-poor spending and the explicit endorsement of a social protection system in GPRSII there may be room for optimism that social protection will be accorded some degree of priority in budget allocation decisions. In the short term, overall fiscal constraints are tight and the NSPS is yet to be approved, so line ministries may have less traction on which to base potential lobbying efforts (interview, 2008).

The scope to expand social protection expenditure is also shaped significantly by political factors. As Handley (2009) argues, even in a case where fiscal space for additional expenditures either already exists or might feasibly be created, there is no certainty that all, or even some, of that space will be spent on social protection: allocation of fiscal space depends on national political priorities. As discussed in Section 3, the political environment in Ghana is oriented strongly towards growth. Investment in human capital development is framed as expedient for national economic development, but social protection for the poor and vulnerable is less politically palatable. Indeed, in a recent capacity assessment, DSW was seen as having struggled to convince government counterparts of the value of investing in equitable human development (MMYE, 2008a):

> Mobilising financial resources for social welfare services is beset with a myriad of challenges resultant chiefly from widespread perceptions that vulnerable and marginalised people cannot be supported with adequate state interventions to improve on their economic situations. Sceptical perceptions of [the] inability of persons experiencing impoverishment and vulnerability [to] rise out of helplessness have been reinforced over time by [the] inability of DSW to demonstrate impact and influence national social policies that reflect in budgetary allocations for social services.

Increased aid in the form of grants and concessional loans is a third, and less sustainable, channel through which to generate fiscal space, as the likely level, duration and predictability of donor spending must be taken into consideration. Where aid is non-earmarked, as in the case of budget support and debt relief, government priorities again come into play. Significantly, a substantial proportion of the (20-year) HIPC funds is being used to cover social protection-type programmes: 3.6% for a MOWAC microcredit programme, 3.6% on LEAP, 20% for education and 31% on school feeding. The stability of such funding choices is uncertain, as illustrated by the government's use so far of Multilateral Debt Relief Initiative (MDRI) funds: in 2006 they were allocated to growth promotion and housing; in 2007 they were deployed to address the energy crisis (interview, 2008).

Overall, donors do appear to be committed (although by some accounts only relatively recently) to a social protection agenda (especially as a means to address extreme poverty and the spatial poverty of the north). This is clearly reflected in the Ghana Joint Assistance Strategy (GJAS), the inclusion of the development of a national social protection strategy as an MDBS framework target and the existence of an active sector working group on social protection, involving both the government and development partners. As the agenda of public-private health partnerships, like the Global Fund and the Global Alliance for Vaccines and Immunisations (GAVI), shifts increasingly towards both reaching the most marginal or 'hardest to reach' populations and health systems-strengthening initiatives, there is also potential for such funding to be used to help finance health-related social protection programmes.
There could, however, be a potential contradiction between, on the one hand, the concern with reining in

the wage bill and the fiscal deficit as part of sound PFM and, on the other, the need to ensure adequate human resourcing in the social sectors (MESW, Health, Education) in order to meet demand for services with quality provision. There could also be difficult trade-offs between social protection programmes and the need to improve delivery of education and health services. Bussolo and Medvedev (2007) show that, to reach the education and health-related MDGs, Ghana will need to increase investment in these sectors by 3% and 19% per annum, respectively.

6.5 SUMMARY OF KEY POINTS

The government faces acute fiscal pressures in the short term, owing to the need to correct the serious macroeconomic imbalances that emerged in 2006-2008 and the adverse shocks emanating from the global economic crisis. The extent to which social protection financing can expand in the medium term will depend in part on the success of the government's efforts to restore macroeconomic and fiscal stability, as well as on its continuing efforts to strengthen the country's PFM system and improve the efficiency of expenditure.

Current social protection expenditure is reaching only a small proportion of the poor and vulnerable. Expanding fiscal space for social protection will depend to a large extent on political decisions as well as on the macroeconomic and fiscal factors outlined above. Internationally, governments have been responding to the crisis not only by 'ring-fencing' their social protection provision but also by developing stronger social safety nets (and increasing spending on them) in order to protect their populations from the adverse social consequences of the economic shocks.

A favourable factor in Ghana is the increasing priority being given to pro-poor public expenditure, although within this there are also difficult trade-offs with competing priorities for the expansion and improvement of education and health services. Both the commitment in GPRSII to social protection and the draft NSPS indicate significant government endorsement of social protection as a mechanism to promote growth and development, as well as to provide a safety net. The government has in fact devoted substantial resources already for social protection, notably for the financing of the NHIS, and stepped up its expenditure commitments in the 2009 budget despite the difficult fiscal environment. This has included a 50% increase in funding for the ECG, extension of school feeding to additional deprived districts, a scheme to provide free exercise books and school uniforms to 1.6 million children and a substantial increase in the budget allocation for LEAP, from GHS 2.2 million in 2008 to GHS 7.5 million in 2009.

In the medium to long term, a significant boost to public finances will come from the expected revenue from oil, which could substantially increase the resources available for both basic social services and social protection, as long as the government manages these resources well and remains firmly committed to pro-poor strategies for growth and development. This will require medium- to long-term planning for the financing of the scale-up of social protection programmes, including LEAP, in order to ensure long-term sustainability. The ideal framework for this would be the MTEFs at sectoral (MESW) and macro levels.

7. CASH TRANSFERS AS A MECHANISM TO TACKLE CHILDHOOD POVERTY

A growing body of evidence indicates that cash transfers can have positive impacts on reducing childhood poverty. Devereux et al. (2005) reviewed a number of cash transfer programmes in Southern Africa (cash-for-work, direct cash transfers and pension schemes) and found that vulnerable children are able to benefit from cash transfers even if they are not the direct targets. Cash transfers to households were found to be spent mostly on food, clothes, seeds and meeting the costs of services like education and health. Furthermore, evaluations of the Child Grant Programme in South Africa and targeted conditional cash transfers in Latin America show that cash transfers, combined with additional investments in basic service provision, are an effective tool in reducing child poverty. They improve child nutrition, raise birth registration and school enrolment rates and increase overall survival rates (Barrientos and de Jong, 2004; Jones et al., 2008).

In early 2008. Ghana launched a pilot cash transfer programme, called Livelihood Empowerment Against Poverty (LEAP), which aims to supplement the incomes of 'dangerously poor households' through time-bound cash transfers and to link them up with complementary services so that they can, over time, 'leap out of poverty'.

This section discusses the programme design and initial implementation strengths and weaknesses of LEAP, with a view to informing discussions about the planned scale-up of the programme. The analysis begins by presenting the findings of a simulation exercise, which assesses the potential benefits of different types of transfers and their respective cost implications. The discussion then turns to questions of targeting, demand-side approaches to social protection and issues of administrative capacity.

7.1 THE LEAP CASH TRANSFER PROGRAMME

The LEAP programme has a complex, multi-layered targeting design involving indicators for district and community poverty, as well as human capital and service availability. There are five categories of beneficiaries, who are identified as being among the most vulnerable in society: i) caregivers of OVC; ii) pregnant and lactating women; iii) impoverished elderly; iv) severely disabled; and v) fisher folk and subsistence food crop farmers. OVC were initially defined as children who were infected or affected by HIV/AIDS, but this concept has been broadened to include other categories of extremely vulnerable children. As of May 2009, LEAP had benefited approximately 26,200 households, with 131,000 individual beneficiaries, in 74 districts (out of 178 districts nationally). DSW in MESW, which manages the programmes, aims to scale up gradually to reach 165,000 households within five years.

To reach the targeted groups, LEAP uses a mix of targeting methods, including proxy means testing and community-based selection. Districts are selected based on four criteria: poverty incidence; HIV/AIDS prevalence; rates of child labour; and access to social services (DSW, 2008), although the relative weights accorded to each of these criteria remain unclear. Within a district, community LEAP implementation committees (CLICs), consisting of traditional leaders, district assembly members, representatives of teachers and nurses, religious leaders and other community leaders, do an initial identification of the most vulnerable households in their communities. Local social welfare officers of the DSW then administer a means-testing questionnaire to the identified households. Data are fed into a computerised information management system, known as the 'single register', and analysed based on weights accorded to the proxy variables that make up the eligibility formula. A list of proposed beneficiaries is then generated, within a resource limit previously set for each community. This list is

sent back to the relevant CLIC for verification and approval. The DSW then provides the approved beneficiaries with the necessary documentation and incorporates them into the 'payment album', which is managed by Ghana Post, the agency used for the delivery of the transfers (UNICEF Ghana Country Office, correspondence).

The value of transfers depends on the number of eligible dependents in the household, based on a sliding scale up to a maximum of four dependents. The transfer ranges from GHS 8 ($6.90) per month for one dependent to a maximum of GHS 15 ($12.90) for four dependents (DSW, 2008). The programme is also meant to be 'time bound' in the sense that beneficiaries are expected to 'graduate' from the programme within three years.

The OVC component of LEAP is intended to be a conditional cash transfer programme, whereas the transfers to the elderly and persons with severe disabilities are unconditional. Officially, the transfers for OVC include the following conditions:

- Enrolment and retention of school-age children in school;
- Birth registration of newborn babies and their attendance at postnatal clinics;
- Full (EPI) vaccination of children up to the age of five;
- Non-trafficking of children and their non-involvement in the 'worst forms of child labour' (i.e. labour detrimental to the safety, health and development of children, including their attendance at school).

The original design included an additional condition for registration of beneficiaries in the NHIS, but this was discontinued as NHIS registration and premiums were too costly for the ultra-poor households benefiting from LEAP. Instead, MESW has been negotiating with the Ministry of Health for free enrolment of LEAP beneficiaries in the NHIS.

The initial pilot phase of the programme, which was launched in March 2008, is significantly less complex in design for both logistical and political reasons (see discussion below). The transfer currently provides GHS 16-30 every two months to caregivers of OVC, impoverished elderly and persons with severe disabilities (DSW, 2008). Details of programme graduation have not yet been worked out. In addition, only limited progress has been made to date in implementing the LEAP programme's declared intention of linking beneficiaries to other complementary services[24]. Furthermore, LEAP conditions have not been enforced in practice, although beneficiaries are made aware of them, and so they could be considered as 'soft conditionalities'. In addition, beneficiary forums are held on payment days as a way of sharing information and raising awareness of beneficiaries' duties and responsibilities.

7.2 CASH TRANSFER OPTIONS, THEIR POVERTY REDUCTION EFFECTS AND COST IMPLICATIONS

In order to better assess proposals for the extension of social protection in Ghana, we undertook a simulation exercise to assess different cash transfer options, their likely impact on childhood poverty and their required budgetary allocations. Given some basic parameters for the scope and design of social transfer programmes, as well as the availability of relevant data, it is possible to calculate the magnitude of resources required for these options and to assess their affordability.

[24] This has included linkages through for instance the ECG, EPI and agricultural extension services (DSW, 2009)

7.2.1 UNIVERSAL (CATEGORICAL) APPROACHES.

We began by simulating the costs of two types of universal (or categorical) cash transfer programmes – child benefits and social pensions – before moving on to consider alternative targeted programmes. The parameters for the scope and design of universal programmes were:

- A universal child transfer equivalent to 30% of the extreme (food) poverty line, provided monthly for each child aged 0-14;
- A universal social pension transfer equivalent to 70% of the extreme (food) poverty line, payable monthly to each person over the age of 65;
- Administration and delivery costs assumed to be 10% of transfer expenditure.

Note that the transfer amount for child benefits is equivalent to GHS 7.20, which is close to the actual value of the LEAP transfer for the first dependent (GHS 8). However, unlike LEAP, the transfers are not capped at four dependents per households and are not subject to a sliding scale.

The simulations for Ghana relied on demographic information projected from the 2000 Census (see Table 23). The extreme poverty line, set by the government at GHS 288 ($249) per adult, was used as the threshold for calculating the benefit levels (30% per child and 70% per elderly person). Market exchange rates were used for conversion to US dollars.

Table 23: Demographic and economic indicators used for simulations

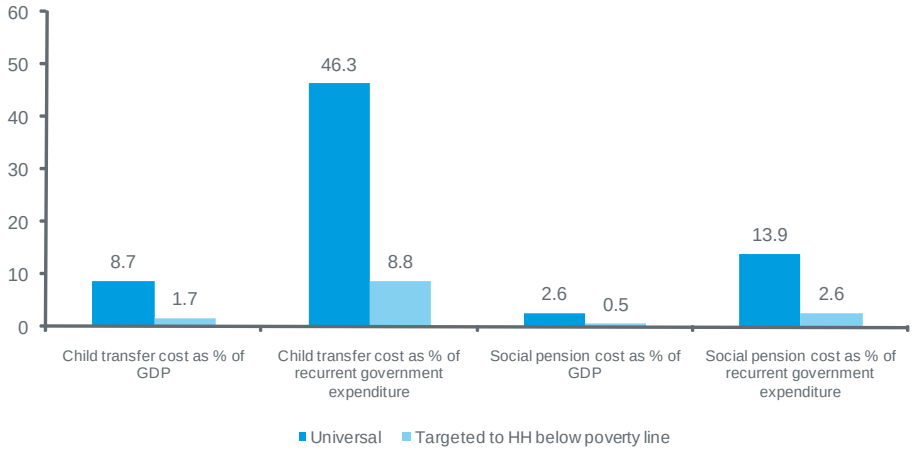
Population	21,434,200
% children (aged 0-14)	41
% older persons (65+)	5
GDP (US$ million, purchasing power parity) 2005	21.4
Recurrent government expenditure (% GDP) 2005	18.2
Extreme poverty line (US$) 2005/06	64.6
Poverty headcount rate, 2005	28.5

Sources: Economic indicators and total population from Wold Bank Global Purchasing Power Indicators database; poverty data from GoG (2007b); GSS (2007).

The results from the simulations are presented in Figure 7[25]. The simulations estimate that a universal child transfer, based on the assumptions set out above, would require 8.7% of GDP and 46.3% of government recurrent expenditure. A universal social pension scheme would require 2.6% of GDP, or 13.9% of recurrent government expenditure. Clearly, neither a universal child benefit nor a universal social pension would be affordable in Ghana unless the assumptions were radically changed – for example, by narrowing the age range eligible for transfers and/or by drastically cutting the benefit level. Another alternative would be to target only those households in extreme poverty. These selective options are considered in the next section.

[25] Owing to data limitations, the estimates come from basic linear simulations from aggregate country data. Further work is needed to generate more accurate estimates and sensitivity analysis to assess their reliability. This would include the use of household survey data to estimate more accurately poverty incidence among different groups under study and their consumption shortfall. Similarly, modelling the impact of the programmes under study would provide evidence on the benefit side. Modelling second order effects from social transfer programmes could provide information on the longer-term effects of the programmes, for example the impact of improved child nutrition on life prospects and productivity.

Figure 7: Simulated cost of universal and targeted child benefits and social pensions



7.2.2 TARGETED APPROACHES

In addition to the universal schemes, Figure 7 shows the costs of providing child benefits and social pensions (based on the same age and benefit assumptions) to children in households below the national poverty line. We had to make the assumption that the poverty headcount rates among children and older people were the same as the rates for the total population. In the case of older persons, and in countries where older people live in extended households and old age income support programmes are largely absent, this can be a reasonable assumption to make. In the case of children the situation is different, as the norm is for children to have a higher poverty rate than the total population. This implies that the figures below are an underestimate of the likely costs of a child transfer scheme. We have also made the assumption that selection can be done perfectly, at an additional cost of 5% of transfer expenditure (on top of the 10% administration and delivery costs we had assumed in earlier simulations).

As Figure 7 shows, given both Ghana's relatively limited fiscal space and its relatively low incidence of poverty, the budgetary advantages of selection are likely to be significant. Assuming (with the provisos noted above) that children show the same poverty incidence as a member of the population taken at random, a child transfer to all children would reach, roughly, four children in non-poor households for every one child in a poor household. The budgetary advantages of selection are therefore likely to be significant. Even assuming slightly higher management costs (an additional 5% of transfer expenditure), the cost of the scheme if limited to poor households is roughly one-fifth of that without selection. The estimated cost of a child transfer scheme providing 30% of the poverty line to children in poverty would absorb 1.7% of GDP or 8.8% of recurrent government expenditure. A social pension transferring 70% of the poverty line to each person aged 65 and older would require 0.5% of GDP or 2.6% of recurrent government expenditure. These options are clearly more affordable than the universal schemes presented earlier, but are still somewhat costly in the context of the country's current macroeconomic and fiscal difficulties – although potentially more affordable once oil revenues come on stream.

We did not run additional simulations for variants of these options. However, the results above suggest that a cash transfer programme for all children in households below the extreme poverty line would cost no more than about 1% of GDP, which is affordable.

How do these scenarios compare with the assumptions and expected costs of the LEAP programme? First, the targeted beneficiaries in the LEAP programme are both broader and narrower. They are broader in the sense that people with disabilities, pregnant women, the elderly and certain occupational categories are also proposed. They are, however, narrower in the sense that only OVC rather than all children living in poverty or extreme poverty are targeted. In addition, as noted above, since June 2008, the number of eligible LEAP beneficiaries has been capped at four per household, and the size of the transfer declines with each additional beneficiary (DSW, 2008). LEAP proposes to reach only one-sixth of extreme poor households in its first five years (165,000 households). As such, the proposed budget outlays are significantly more modest; as can be seen in Table 24, they represent just 0.09% of GDP and 0.23% of total government expenditure by Year 5. In other words, the government's fiscal commitment to the LEAP cash transfer programme is at present very cautious and limited.

Table 24: LEAP sustainability indicators as calculated in 2007 programme design

	Year 1	Year 2	Year 3	Year 4	Year 5
% shares of LEAP to					
Total government expenditure (%)	0.13	0.10	0.14	0.19	0.23
Total MMYE allocation (%)	25.99	20.25	32.76	53.17	73.09
Total poverty reduction expenditure (%)	0.60	0.47	0.66	0.94	1.12
Total GPRS allocation to human resource development (%)	0.28	0.21	0.29	0.42	0.50
Total NHI levy (%)	3.69	2.89	4.07	5.75	6.88
Total tax revenue (%)	0.21	0.16	0.23	0.32	0.38
Total direct taxes (%)	0.76	0.59	0.84	1.18	1.41
HIPC assistance grants (%)	4.93	3.86	5.44	7.69	9.20
MDRI grants (%)	14.02	11.91	17.93	27.06	34.61
Total nominal GDP (%)	0.05	0.04	0.05	0.08	0.09
Efficiency indicators					
Administrative (GHS)	6,164,787	2,938,524	3,752,038	4,951,315	6,097,707
Cost transfer ratio	3.4	0.7	0.5	0.4	0.3
Cash transfer (3% of transfer) (GHS)	53,885	125,733	233,503	413,122	589,148
M&E (15% of administrative costs) (GHS)	797,074	366,886	458,939	591,938	718,508

Note: Current exchange rate used was GHS 1 to US$0.86.
Source: MMYE (2007b).

7.3 DOES TARGETING MAKE SENSE IN GHANA?

Whether or not to target social protection programmes has become an important issue for debate among analysts and practitioners interested in social protection. There is a particularly pressing concern in low-income countries in sub-Saharan Africa, where poverty rates are typically very high but fiscal space is limited. Critics argue that poverty targeting requires information to identify poor households that may be difficult and expensive to collect, as well as administrative capacity to manage a targeted system that low-income countries may lack. Targeting may also induce social costs such as stigmatisation, reinforced exclusion of

beneficiaries or social tensions among recipients and non-recipients (e.g. Paugam, 1991, in Dain (nd)[26]; Jones et al., 2008). However, Adato and Hoddinott (2007) argue that 'targeting social protection programmes is a means to an end, where the end is ensuring that poor households are the ones who benefit from social protection programmes' and that, on balance, existing targeted programmes in the developing world deliver a greater share of programme benefits to poor households. This argument is further nuanced by Farrington et al. (2007), who emphasise that implementation methods and practice strongly influence outcomes.

7.3.1 POLITICS OF TARGETING

In unpacking the pros and cons of targeting, a first important question concerns politics. Given very high levels of poverty, what are the political implications of targeting specific groups of people? In Ghana, with 28.5% of the population below the official poverty line and 18% below the extreme poverty line, rates are high but still relatively lower than those in many of the country's neighbours. Nevertheless, Ghana's focus on the contribution of all citizens to national economic development and its goal of achieving middle-income status have made targeting the 'deserving poor' a prominent theme in the debate around social protection. In the LEAP design document (MMYE, 2007b), a number of vulnerable target groups were identified, as detailed above. However, the recognition that such groups should be supported so as to mitigate economic and social risk is explicitly time bound in the document. According to LEAP discourse, as a result of the programme's cash transfer and complementary services, all beneficiaries should be aiming to graduate and 'leap out of poverty'[27] within three years of programme enrolment. While this may be theoretically possible in the case of two of the five categories (pregnant and lactating women and fishermen and subsistence farmers), it appears both unrealistic and potentially unethical in the other cases (caretakers of OVC, impoverished elderly and severely disabled). This goal highlights the fact that the programme's overarching objective is framed as increasing the number of productive citizens rather than as reducing the poverty gap and social vulnerabilities. Moreover, our key informant interviews suggested that the two categories above will no longer be included in rollout owing to fears of 'encouraging' large families in the case of pregnant women and because of large numbers in the case of fisher folk and subsistence farmers (interview, 2008).

Equally importantly, although spatial poverty targeting (using poverty maps) is explicitly mentioned as the basis for regional, district and community selection (see Table 25), LEAP design involves a large number of criteria without any clear weights, which hinders transparency and makes the selection process overly complex. Moreover, while poverty and food insecurity[28] rates are much higher in the three northern regions of Ghana than elsewhere, a political decision has been made to expand the pilot programme from an initial 21 districts, which overlap with a UNICEF-supported OVC programme (which involved payments to cover NHIS premiums) in HIV/AIDS-prevalent districts, into districts in all regions of the country (interviews, 2008). In other words, the evidence regarding both the loose correlation between HIV/AIDS prevalence and poverty rates and the significant variation in poverty rates across regions is not being used to inform decision making. Targeting so far would appear to be based on practical considerations (already established linkages with districts) in the first case and more political calculations in the second, although DSW officials have mentioned additional pragmatic criteria, such as the high prevalence of child

[26] Paugam argues that 'the process of identification, eligibility and qualification that substantiate and legitimate the right to assistance are designated as part of the ritual of degradation of the needy population's social status. To be assisted is to be stigmatized, thus excluded' (as paraphrased by Dain, nd).

[27] Indicators for 'graduation' are relatively vague: 'Beneficiaries whose capacities have improved and can meet their basic needs will be assisted to graduate from LEAP to engage in self-sustaining livelihood activities'.

[28] The WFP and World Bank are in the process of refining a map of food-insecure communities (in response to the floods of 2007).

labour or trafficking in certain newly added districts[29]. Moreover, there are concerns that additional budget resources are being allocated to increase the scale rather than the quality of the programme (interview, 2008). This is in turn prompting concerns about sustainability – in terms of both institutional capacities and longer-term financial resources (interview, 2008).

Concerns about poor regional targeting were temporarily mitigated to some extent by World Bank funding. The Bank provided funding for six months to expand the programme in northern regions to alleviate the livelihood and food insecurity crisis caused both by flooding and the global food price crisis in 2008.

Table 25: LEAP multi-level targeting design

Regional	Community	Household
Average rainfall	Level of income security based on livelihood types/cycles	Adverse health conditions
Road density	Road density	Level of NHIS registration
Under-five mortality	Under-five mortality	Availability of/access to quality basic social services
School attendance	Level of NHIS registration	
Basic Education Certificate Examination (BECE) results	School attendance	
	BECE results	
	High incidence of worst forms of child labour	
	High prevalence of HIV/AIDS	
	Serious impact of disasters	

Source: MMYE (2007b).

Another concern in terms of targeting childhood poverty is the fact that LEAP is using a categorical approach, which excludes the vast majority of children. As discussed in Section 4, approximately 16% of all children are officially categorised as living in especially difficult circumstances. The general vulnerability headcount, by comparison, is 49% and the child vulnerability headcount is very likely to exceed half of the child population. This indicates that the lack of effective poverty and vulnerability targeting is likely to exclude a significant number of vulnerable children from LEAP programme coverage.

7.3.2 ADMINISTRATIVE CAPACITY

A second set of considerations involves the administrative capacity required to carry out effective targeting. There are a number of possible targeting methods, as presented in Box 1.

In the Ghanaian case, a mix of household assessment and categorical targeting is being used. As Section 7.1 outlined, households are assessed to determine poverty levels but coverage is also currently dependent on the presence of OVC, elderly persons and people with disabilities.

[29] The political dimensions of the targeting debate were evident in the widely differing explanations of the targeting process provided by DSW staff and document authors.

Box 1: Targeting methods

Targeting is characterised by four stages:

1. A set of policy decisions about who is to be supported through transfer programmes;
2. The design and implementation of mechanisms to ensure that support is provided to those intended, with minimal errors of inclusion (i.e. leakage and exclusion);
3. The process of identifying those who are eligible, and of keeping beneficiary lists up-to-date; and
4. Information and communication mechanisms to ensure that intended beneficiaries understand their entitlements.

In practice, a number of targeting methods are usually combined. Common targeting methods include:

Individual/household assessment, which involves direct assessment, household by household or individual by individual, as to whether the applicant is eligible for the programme – this is usually done by a means test or poverty indicator instruments. This method is the most technical and labour-intensive and therefore requires a great deal of institutional capacity. Other, simpler individual assessment mechanisms include proxy means tests, with no independent verification of income, which may be made on the basis of a household visit by a programme social worker using simple proxy indicators such as housing quality and food stocks, and community based-targeting, which uses a group of community members or a community leader to decide who in the community should benefit. Proxy means tests are, however, prone to large exclusion and inclusion errors, owing to the difficulty of using simple poverty proxies to identify exactly the intended beneficiaries, as well as the risk of manipulation of the eligibility criteria. Community-based targeting can be distorted by patronage, communal bias or 'elite capture', particularly in communities that are highly stratified and/or socially divided.

Categorical targeting involves the definition of categories, all members of which are eligible to receive benefits. It involves defining eligibility in terms of individual or household characteristics that are fairly easy to observe, hard to falsify and correlated with poverty. Categories commonly used include age, geography, gender, disability, ethnicity and OVC.

Self-targeting may appear to give unrestricted access to benefits but the design makes the programme attractive only to the poorest. This can be done by using low wages on public works schemes, putting restrictions on the timing of transfers so that there is a requirement to queue, providing in-kind transfer benefits that are of lower quality or have inferior characteristics or using locations where the poor are highly concentrated so that the non-poor have higher costs of travel.

Source: Based on Farrington et al. (2007).

While MESW and the government–donor sector working group on social protection and vulnerability have made laudable efforts to learn from the experiences of implementing cash transfer programmes in Latin America and East and Southern Africa, it is also the case that social protection in general, and targeting in particular, are a new area for MESW and DSW. In the past, they have focused largely on the rights of excluded or vulnerable individuals (children whose fathers do not pay maintenance, juvenile justice cases, adoption cases, etc) rather than addressing the social and economic needs or rights of the vulnerable and excluded as a group (interview, 2008). Accordingly, coordinating a cash transfer programme to target the vulnerable and extremely poor involves a conceptual reorientation that is not necessarily in keeping with existing staff strengths. Furthermore, there has not yet been an investment in the intensive type of training or re-skilling required (interview, 2008). This is reflected, for example, in some of the design flaws of the household questionnaire for the 'single register' system, a centralised database on all recipients. These include an excessive number of questions on housing quality; lack of specificity regarding the type of support households receive; a question on income that solicits only information

about the dominant income earner, rather than tapping the relative contributions of all adults and children; and inattention to household power dynamics by asking household heads, rather than caregivers, to fill out the questionnaire.

In addition, while external expertise (with support from donors, especially DFID and UNICEF) was solicited to design the LEAP document, very limited follow-up support has been provided. DSW career staff have therefore had little access to requisite guidance and expert inputs as they embark on implementing the design document[30]. This dearth is particularly evident in the case of developing M&E systems. While a baseline has proven critically important in Latin American countries, especially Mexico, and in Zambia in demonstrating the impact of cash transfer programmes, in order to counter political opposition (Nigenda and Gonzalez-Robledo, 2005), and while a baseline was written into the LEAP pilot design, it has yet to be initiated, owing to capacity constraints. As of May 2009, specific steps were being taken to establish a baseline and to design an impact evaluation system.

7.3.3 SOCIAL IMPLICATIONS OF TARGETING

A final set of considerations around targeting relate to the social implications of targeted programmes. What are the implications of different forms of targeting on community and intra-household relations? Even if a decision is made to use poverty maps as way to identify the extreme poor, these are available only down to the district level (Coloumbe, 2005). A process is still needed to identify the poorest communities and households. One option is community-based targeting, where respected community members are responsible for identifying the poorest. Indeed, this approach has already been adopted by LEAP in the form of the CLICs, along with a form of proxy means testing.

While it is clearly too early to assess the effectiveness of such committees, our observations during field work in Yilo Krobo district suggested that, unless explicit attention is paid to committee composition by DSW, these committees are likely to be heavily male dominated, given the pervasive gender inequalities discussed in Section 4. They are also constituted by members of the local elite. This could lead to certain risks, including local clientelism and selection biases. Committee members also complained that their role was only voluntary, suggesting that the sustainability of the CLICs as targeting and monitoring mechanisms may need to be reconsidered.

In terms of household dynamics, the transfer is currently given directly to the person identified as the primary caregiver in the household. Given that in this current pilot stage many of the recipients are likely to be in single-parent households on account of their status as carers of OVC in HIV/AIDS high prevalence districts, the effects on intra-household relations are as of yet less than clear. Moreover, although caregivers in the Ghanaian context are typically thought of as female, 10-15% of current beneficiaries are male. Focus group discussion participants in two or more adult households did suggest, however, that the caregiver had been able to determine the way the money was spent, either individually or in consultation with a partner. The most frequent answers regarding how the first LEAP transfer had been spent included payment of NHIS

[30] This weakness has been recognised in capacity assessment reports by Yuster (2007) and a capacity-strengthening programme has been prepared and costed. This programme is yet to be implemented.

Box 2: Community participation in LEAP

Cash transfer programmes also call for profound changes in the understanding and practice of citizenship and participation. One author (Piron, 2004) has commented that 'the realisation of human rights, including the design of, and access to, appropriate social protection schemes, requires developing the capacities of rights-holders to know and claim their rights. Various empowerment strategies are required to achieve this, including those that permit "active, free and meaningful participation" in decision-making processes.'

Because of Ghana's recent democratic history and stalled decentralisation process, notions of citizenship and rights are not well embedded within Ghanaian political culture. Indeed, in part because of the overlay of traditional chieftaincies characterised by patronage-based politics on modern party politics, the exercise of political power remains highly clientelistic (Crook, 2005a). Some CSOs, such as ISODEC, the Centre for Democratic Development, and Participatory Development Alternatives, are starting to address these democratic deficits (Booth et al., 2005).

Notwithstanding concerns about potential clientelism discussed above, the design of the LEAP programme, with its strong focus on CLICs and the involvement of community leaders in implementation and monitoring activities, provides a window of opportunity for community participation in the implementation and management of the programme, as well as creating feedback loops between beneficiaries and DSW. The beneficiary forums held on paydays by DSW also provide a valuable opportunity for direct discussion between social welfare officers and beneficiaries on entitlements, procedures, complementary services and the observance of LEAP conditions.

Although not yet emphasised by DSW, the two-monthly visits by district programme coordinators to beneficiary communities could be utilised to improve access to information on complementary services. Furthermore, they provide an opportunity to discuss ways in which the physical accessibility, cultural appropriateness and social inclusiveness of services could be addressed. In addition, public consultations of this nature would also provide a possible space for discussing the best ways to harness potential synergies between existing informal traditional social protection mechanisms discussed in Section 4 and formal social assistance programmes such as cash transfers. Lastly, the training sessions offered to district coordinators by DSW could also usefully incorporate a module on how programme implementation could simultaneously foster an understanding of citizenship rights and responsibilities.

premiums; purchase of school supplies, including uniforms, shoes or bags; and acquisition of essential food items. District-level government staff also emphasised that they were of the view that targeting women caregivers would be the most effective, owing to the high rates of alcohol consumption among local men (interview, 2008).

7.4 ARE DEMAND-SIDE APPROACHES APPROPRIATE?

Ensuring that citizens have equitable access to quality basic services is an underlying principle of social protection and requires attention to both demand- and supply-side issues. Cash transfers increase demand by the poor and vulnerable for services by augmenting the household income base and, in the case of conditional transfers, through mandated service utilisation.

The corollary of demand-side approaches is therefore to ensure that demand is met by corresponding improvements in the quantity and quality of public services. A recent World Bank capacity assessment of service delivery in Ghana, by Darlan and Anani (2007), argues that delivering services to the poor suffers from a number of important institutional constraints: weak decentralisation, especially in terms of fiscal

decentralisation; a weak regulatory framework; confusion about roles between key actors (especially between traditional chiefs and local elected authorities); and a dearth of community involvement in decision making and management arrangements. While reform initiatives have been introduced as mentioned above, the 2006 Annual Progress Report on the Human Development Resource Pillar of GPRSII (NDPC, 2007) indicates that there has been only slow progress and/or that an assessment could not be made owing to inadequate data.

On the positive side, the LEAP programme has been conceptualised as a cross-sectoral initiative, coordinated by DSW but involving a decision-making committee with representation from the Ministry of Health, MOFA, MLGRDE, Ministry of Education, MOWAC and the MESW Department of Labour. According to the LEAP design document, as soon as participants qualify for cash transfers and are registered in the single register system, they are also linked to complementary services designed to address other aspects of deprivation. Implementation to date, however, suggests that much more attention is required to put into effect these important linkages. Currently, in the case of OVC, they are assisted to obtain birth registration[31]. Looking forward to future programme expansion, the document includes a list of additional services, grouped according to livelihood creation/provision, livelihood protection, promotion and social empowerment, which would ideally be offered to the five targeted vulnerable groups (see Table 26).

More recently, a mapping has been initiated as to the availability of these additional services at the district and community levels, including initiatives related to livelihood/income-generating activities, health, child labour, educational skills and emergency and crisis (DSW, 2009). But costings will have to be undertaken for the provision of these services in beneficiary communities (interviews, 2008; MMYE, 2007b). Part of the problem appears to be limited practical coordination efforts to date. While meetings have been held involving multiple MDAs, intra- and interagency information sharing has been weak as few of the key informants we interviewed were well informed about LEAP implementation plans, although more recent evidence suggests that efforts are being made to overcome this (DSW, 2009). Moreover, while the NSPS and the LEAP document contain clear resource estimates, they pertain only to the LEAP transfers rather than the broader package of complementary services that LEAP purports to offer beneficiaries. This constitutes an important lacuna, as it indicates that other ministries with social protection-related functions and responsibilities besides MMYE have not considered the financial implications of a demand-side social protection programme. This is a particularly important issue to address if discussions about the scale-up of the LEAP programme are to be adequately informed by considerations of fiscal space and economies of scale. District assemblies effectively lobbied to support the provision of such services.

In addition to service availability, issues of service quality need to be addressed. As discussed in Sections 6 and 8, citizen social accountability exercises have highlighted poor people's dissatisfaction with existing services. They have drawn particular attention to issues of direct and indirect costs and the insensitive attitudes of service providers. Other indicators of service dissatisfaction can be seen in the much higher reliance on pharmacists, rather than medical personnel, in the case of illness (see Section 8) and in the growing trend of households in the higher wealth quintiles to use private education and health services (Coulombe and Wodon, 2007).

[31] Although the official DSW discourse and media version is that participants are automatically registered for the NHIS, our fieldwork interviews suggested that it would be more accurate to say that participants are 'encouraged' to use their cash payments to register their families. But even this is difficult in the case of families with multiple children. A number of women we spoke with emphasised that they would rather wait until they could afford to register all children rather than make decisions about supporting particular children.

Table 26: Complementary services matrix

Target group	Livelihood needs	Complementary services
1. Subsistence farmers and fishermen	Shelter, food, clothing, soap, water, medical support	• NHIS Indigent Card • Agricultural input support • Microfinance and income-generating activity support • MOFA skills training • MOFA extension services • Ministry of Fisheries Alternative Livelihoods Project • Women's Development Fund (MOWAC)
2. Extremely poor aged 65+	Shelter, food, clothing, soap, water, medical support	• NHIS Indigent Card • Free bus ride • Micronutrients • Food supplements/supplementary feeding
3. Persons with disabilities without productive capacity	Shelter, food, clothing, soap, water, medical support	• NHIS Indigent Card **Caregivers** • NHIS Indigent Card • Agricultural input support • Microfinance and income-generating activity support • Skills training for caregivers
4. Caregivers of OVC (able to work)	Shelter, food, clothing, soap, water, medical support	**Caregivers** • NHIS Indigent Card • Agricultural input support • Microfinance and income-generating activity support • Skills training for caregivers • Women's Development Fund (MOWAC) **OVC** • ECG • School Feeding Programme • Free bus ride • Micronutrients • Food supplements/supplementary feeding • Post-basic (15+) skills training/apprenticeship
5. Caregivers of PLWHA (able to work)	Shelter, food, clothing, soap, water, medical support	• Agricultural input support • Microfinance and income-generating activity support • Skills training for alternative income-generating activities • Women's Development Fund (MOWAC) **PLWHA** • Subsidised fees for antiretroviral therapy (ART) • Ghana AIDS Commission (GAC) support to PLWHA associations • Food supplements • Supplementary feeding
6. Lactating mothers with HIV/AIDS (able to work)	Shelter, food, clothing, soap, water, medical support	• Subsidised fees for prevention of MTCT (PMTCT)/ART • GAC support to PLWHA associations. • Food supplements/supplementary feeding • Agricultural input support • Women's Development Fund (MOWAC) • Skills training

Source: MMYE (2007b).

7.5 ARE THE ADMINISTRATIVE/GOVERNANCE CONDITIONS FOR THE EFFECTIVE DELIVERY OF CASH TRANSFERS IN PLACE?

Different types of cash transfers require varying levels of administrative capacity. Simple targeting mechanisms and unconditional cash transfers require the least administrative capacity. More technically complex forms of targeting, such as proxy means testing, and the application of conditions for transfers, require considerably more administrative capacity and monitoring (Farrington et al., 2007). The Ghana LEAP programme is targeted, although currently focused on categorical targeting rather than means testing and, as discussed above, DSW, as the LEAP coordinating body, faces substantial constraints in undertaking targeting which urgently need to be addressed. Through the Vulnerability and Social Protection Sector Working Group, development partners are currently providing support to GSS to develop targeting tools; this might, in turn, prove valuable for the future rollout of LEAP (interview, 2008).

In terms of conditionality, LEAP is probably best described as quasi-conditional. While programme participants are supported to carry out birth registration for their children when they first enrol, the other 'conditions' appear to be interpreted more as a useful public education mechanism than as requirements to be strictly enforced. Non-compliance does not result in disqualification from the programme. That is, although communication efforts around the programme have alerted the population to the importance of recipients sending their children to school, attending postnatal clinics and not involving their children in child labour and trafficking, in practice there appear to be no clear mechanisms in place to monitor compliance or apply sanctions to those who do not abide by the conditions. The CLICs rely on voluntary labour and, because members live in the communities and interact daily with many of the beneficiaries, it is unlikely that they would want to set themselves up as 'policing' fellow community members (interviews, 2008). Given the low level of human and financial resources available to the district DSWs, combined with poor transport links to reach remote communities, this approach is probably realistic.

Ensuring cross-MDA coordination in terms of programme implementation and resource allocation is a critical feature of the LEAP design. However, given the relative institutional weakness and limited convening power of MESW, a top priority is to ensure that the NSPS is finally approved by the Cabinet and a coordinating unit established. A five-year capacity-strengthening plan supported by DFID is a promising step in this regard. In addition, greater information sharing and knowledge management efforts could also facilitate understanding and buy-in from other ministries, as discussed in Section 6.

The availability of financial or banking services for the poor is another key consideration (Devereux and Sabates-Wheeler, 2004). As there are only limited rural banks and microcredit schemes in rural Ghana, LEAP has decided to make use of the Ghana Post as the mechanism for channelling money to programme beneficiaries, because of the greater penetration of post offices across the country.

Finally, good governance is as much about civil society holding national and sub-national authorities accountable as it is about government reforms. The child rights-focused NGOs in Ghana, including the Ghana National Coalition on the Rights of the Child, have only recently begun to engage in social protection policy debates. A substantial number of NGOs are involved in the provision of small-scale social assistance projects, and therefore potentially have rich lessons to share.

7.6 CONCLUDING REMARKS

Ghana is one of the first countries in West Africa to have introduced a cash transfer programme. This is all the more noteworthy given that the government's primary focus is on economic growth rather than poverty reduction and social inclusion as such. MESW, supported by donors, has made laudable efforts to learn from the experiences of other low- and middle-income countries during the programme design phase. Very preliminary evidence suggests that beneficiary families highly value the LEAP transfers and are investing at least some of the money in covering school-related expenses for their children, paying for health costs and financing essential food items.

A number of challenges will need to be addressed, however, to ensure that the programme has maximum impact on reducing childhood poverty and vulnerability. First, both the proposed coverage of the LEAP programme and its budget allocation for the next five years are rather modest – covering just 3% of the total population and less than one-tenth of 1% of GDP by the end of the initial five-year phase of the programme.

Second, although children may benefit from increased general family resources derived from cash transfers, in terms of direct targeting of children only OVC are included. This is despite the fact that the extreme poverty headcount for children is significantly higher than the percentage of OVC in the child population, with the general poverty headcount higher still. Scale-up beyond this, to reach all children in extremely poor households, will require changes to the narrow categorical approach used for targeting, as well as the organisational strengthening of DSW and the mobilisation of substantial additional funds.

Third, in view of our fiscal space analysis in Section 6 and the cost simulations in this section, as well as organisational and staff constraints in DSW, there are clear constraints on how ambitious a scale-up would be possible in the short to medium term. However, precisely because of the shocks emanating from the global crisis and their adverse impact on many poor households, there is a strong argument not only to protect LEAP expenditure but also to increase spending to ensure the implementation of the programme's existing rollout plan. So far, the signs are promising, as the government increased its funding for LEAP in the 2009 budget. In the longer term, the government could make the scale-up of LEAP a major funding priority as oil revenues expand fiscal space, with a view to surpassing the current five-year target of 165,000 households, and expand the programme to all households below the extreme poverty line, at a cost of only about 1% of current GDP.

Fourth, addressing the institutional capacity constraints, particularly those of DSW, to promote effective implementation is also a pressing priority. This should include the improvement of targeting mechanisms, as well as the development of a robust impact evaluation framework, so that lessons of the pilot phase of LEAP are learned, adjustments in programme design can be made and evidence of impacts is used to garner broader political support and the increases in budgetary allocations that will be needed for scale-up.

Finally, cross-agency coordination will also be vital given that the programme's success in tackling the poverty and vulnerability of children and their caregivers will lie in the successful delivery of a complementary package of services, involving several sectors.

8. SOCIAL HEALTH INSURANCE: NHIS AND HEALTH EQUITY

This section provides an overview of current health programming and its financing, with special reference to issues concerning equity of access by children and women to essential child and maternal health services. It focuses in particular on the role of the NHIS as a mechanism for health equity and as a means to ensure better health care provision for impoverished children and their carers.

GPRSII has three broad health policy objectives: improving access to health care through national health insurance; bridging the equity gap in access to quality health and nutrition services; and enhancing service delivery efficiency. Although in the preface to GPRSII health receives less attention than education in terms of its contribution to national growth, health care reform has been an important part of government policy in recent years. This is exemplified by an emphasis on 'creating wealth through health', including the introduction of the NHIS in 2004 and the Community-based Health Planning and Services (CHPS) programme.

The government is attempting to meet the target set in the Abuja Declaration (2001) and the Maputo Declaration (2003) for governments to allocate 15% of their budgets to health, although it is difficult to know whether this target has been achieved as there are no comprehensive data on actual health expenditure. From 2006 to 2009, the budgeted health sector share of total government expenditure, as presented in the MTEF, has been between 14.6% and 16.2%, although it has dropped slightly to 14.3% in 2009. This includes the statutory allocation to the National Health Insurance Fund.

8.1 MATERNAL AND CHILD HEALTH SERVICES

As discussed in Section 4, the key challenge facing Ghana in terms of child and maternal health is how to accelerate progress in reducing mortality rates. Until recently, infant and under-five mortality rates had been declining very slowly, contrasting with the rapid progress in reducing monetary poverty and improvements on other human development indicators. Preliminary data from the most recent DHS, conducted in 2008, indicate a recent acceleration of the reduction in infant and under-five mortality, to 50 and 80 per thousand live births respectively in 2004-2008, possibly reflecting the important policy initiatives taken to promote child health and access to health services more generally. Although data limitations make trend analysis almost impossible, maternal mortality rates remain very high. At the Health Care Summit held in May 2008, frontline service providers, CSOs and some donors dubbed the country's high maternal mortality a 'national emergency'.

Child and maternal mortality rates are especially high in rural areas, in the northern regions, among the lower wealth quintiles and in households with low maternal education levels. Maternal and child malnutrition are major contributors, as is the increasing 'feminisation' of HIV/AIDS infections in the country[32] and the correspondingly increasing MTCT rates[33].

[32] The UN Economic Commission for Africa (UNECA, 2004) argues that gender inequality has fuelled the feminisation of HIV/AIDS; currently, 58% of those living with HIV/AIDS in sub-Saharan Africa are women. Gender inequalities, especially the challenges women face in terms of negotiating safe sex, both within the world of work as well as within the household, increase women's rate of infection.

[33] High HIV/AIDS rates are geographically clustered and do not correlate with poverty. For example, while the northern regions are the most impoverished, they have the lowest HIV/AIDS infection rates.

In general, more progress has been made in expanding coverage of preventative health programmes, such as immunisation, Vitamin A supplementation and distribution of anti-malarial bed nets, compared with curative care of childhood illnesses. However, as Section 4 showed, only about half of children are taken to a health facility or health provider in the event of symptoms of ARI, fever or diarrhoea. Furthermore, while immunisation rates are improving steadily, children from rural, impoverished households, especially girls, are still more likely to lack coverage (UNICEF, 2006).

A number of programmes exist to tackle these problems[34] but, as we argue below, available evidence suggests that they are inadequate in terms of scale, targeting and resources. To address child malnutrition, the Ghana Free of Malnutrition programme promotes improved feeding practices, including breastfeeding and complementary feeding for infants. It targets behaviour change, community-based growth promotion and micronutrient supplementation programmes[35]. More recently, the HIRD programme, which is based on the Integrated Management of Childhood Diseases approach, has been introduced in Ghana. This approach emphasises immunisation, use of insecticide treated bed nets and anti-malarial drugs[36], maternal health care (in both the pre and postpartum periods) and nutrition.

To address maternal mortality, efforts have been made to increase women's utilisation of health services and improve maternal health. These efforts include the 2004 policy of exempting payment for maternal deliveries in all district health facilities. This exemption has had a modest positive effect on the rate of supervised deliveries[37] and the provision of four antenatal health and nutrition checkups to pregnant women. It has also increased the rate of provision of bed nets for pregnant women through the Malaria Control Programme. Mortality reduction efforts also include the Reproductive Health Programme (RHP), which provides safe motherhood services: family planning, prevention and management of unsafe abortions and prevention and management of reproductive tract infections. As of 2005, RHP was present in 92% of all communities although, as discussed below, distance still remains a concern for many rural women (UNICEF, 2007b). However, despite these existing programmes, there has been a dearth of efforts to address socio-cultural attitudes such as nutritional taboos during pregnancy and lactation. Furthermore, there remain gender barriers to both health service utilisation and quality of care. These barriers include women's lower levels of economic empowerment and less power over decisions such as family size and resource allocations for health (Agyare-Kwabi, 2006).

In the case of HIV/AIDS, the GAC has overseen the implementation of the National HIV/AIDS and Sexually Transmitted Infections (STIs) Policy. This policy includes community awareness raising and school education programmes, campaigns against stigmatisation, increased provision of adolescent-friendly treatment of STIs, ART, treatment for opportunistic infections, voluntary counselling and testing and home-based care

[34] In Ghana, private not-for-profit health care providers, largely church-based, account for over 30% of total national provision (interview, 2008). There are very few for-profit health care providers.

[35] This includes iodised salt, iron+folate and Vitamin A supplements. Children above five years are covered under the School Health and Adolescent Health programmes.

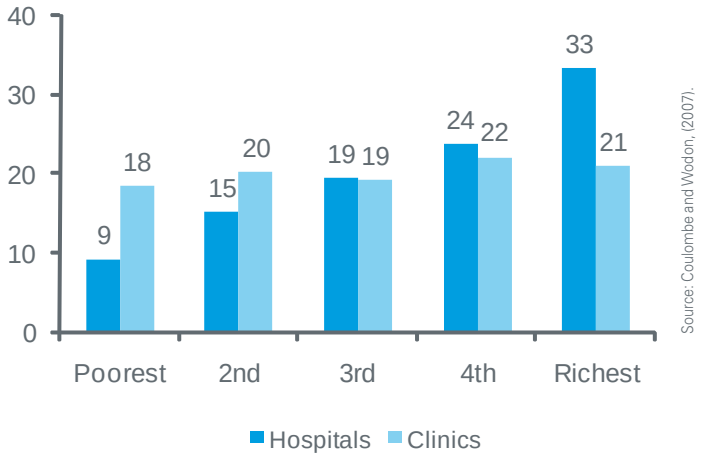
[36] The 2006 MICS study (GSS et al., 2006) also indicates that almost one-third of households have at least one mosquito net and about one-fifth have an insecticide treated net. An Integrated Child Health Campaign was carried out in November 2006, ensuring that more than 90% of children under two years old (about 1.8 million children) received a long-lasting insecticide treated bed net (UNICEF, 2007b).

[37] The rate of supervised deliveries increased from 37.8% in 2004 to 40.3% in 2005 and 44.5% in 2006. This increase could be attributed to the free delivery policy. However, regional disaggregated data showed mixed results. Unfortunately, there are some bottlenecks in the flow of funds for exemptions. The sector is gradually rolling out the exemptions through the NHIS.

at both the district and sub-district levels[38]. To prevent MTCT of HIV specifically, a programme involving improved delivery services and counselling on infant feeding is being implemented and gradually scaled up by the National AIDS Control Programme under the Ministry of Health[39]. Unfortunately, this programme does not appear to be informed by a gender perspective and as a result is failing to tackle the underlying gender power relations that lie at the heart of women's inability to protect themselves from transmission (interview, 2008).

While all of the above programmes provide targeted health services for women and children, important shortcomings persist. Distance to health services remains a major concern. According to 2005 government data, only 60% of all Ghanaians have access to a health facility that conforms to the WHO standard of being located fewer than 8km from home; this figure is significantly lower in the three northern regions (Agyare-Kwabi, 2006). As Figure 8 shows, use of clinics is fairly evenly spread across quintiles, although still lower in the poorest quintile (18% of visits) than in the other four quintiles, while use of hospitals is clearly inequitable, with almost four times as many visits in the wealthiest quintile as in the poorest (Coulombe and Wodon, 2007). Cost and limited knowledge of health care options among the extreme poor and the uneducated are other major obstacles for women. More levels of exclusion mean more challenges in ensuring access to care. It is therefore crucial that health care policies and programmes are informed by a clear analysis of the underlying social determinants of health-seeking behaviour (Sen and Ostlin, 2007).

Figure 8: Share of visits to public health facilities by quintile, 1991-2006 (%)



[38] In addition, as discussed in Section 7, the DSW supported by UNICEF implemented a pilot social transfer programme for HIV/AIDS orphans in 20 districts with high HIV/AIDS prevalence rates (up to 10%), involving direct payment of children's NHIS premiums.

[39] Among mothers tested for HIV/AIDS, 3.4% are HIV positive but this is thought to under-represent the number of total infections, as many mothers are not tested and thus remain unaware of their status (UNICEF, 2007b).

Some of these access issues are being addressed through the CHPS programme, which is a community-based health care delivery programme aimed at providing care that is proximate, basic, situated within cultural understandings of health and wellbeing and responsive to community needs, while engaging with and involving the community in planning[40]. The expansion of clinics across the country has had a moderate pro-poor effect. A recent evaluation suggested that, in communities with CHPS, children were both more likely to receive preventative care, as measured by vaccination, and more likely to see a medical professional in the event of illness[41].

However, a number of problems in terms of access and quality still remain. First, although CHPS coverage is as high as 60% in some districts, overall coverage remains relatively low[42]. Second, a number of the programme design characteristics fail to take into account the multidimensionality of poverty: i) the expense of the drugs prescribed still has to be borne by patients; ii) district health boards are responsible for providing human resources without additional funding sources; iii) the community is responsible for providing the clinic infrastructure, involving both time and material resources, which may be difficult for the extreme poor to provide; and iv) the programme relies on community management and administration, which not only do the poorest and most needy communities often lack but also fails to address the fact that socially excluded groups may still find it difficult to access care owing to existing community inequalities. Lastly, in order to address maternal health care deficiencies, well-equipped clinics and well-trained midwives are necessary, neither of which CHPS addresses (interview, 2008).

8.2 CURRENT HEALTH FINANCING

The 1990s saw a burgeoning of community-based health insurance (CBHI) schemes in Ghana, largely as a mechanism for avoiding the potentially catastrophic health care expenditures associated with the 'cash and carry' system of user fees at point of service. In response to this trend, and in an effort to provide more sustainable and equitable health insurance for all, the government passed National Health Insurance Act 650 in 2003. This introduced a hybrid social health insurance/mutual health organisation (MHO) system based on a district-wide insurance scheme. Whereas private insurance poses significant equity concerns in terms of affordability and feasibility in low-income countries, social health insurance (SHI) is compulsory insurance based on pooled contributions and covering a specified benefit package typically contracted from public and private providers. Historically, SHI covered workers in the formal sector and the MHO model focused on coverage for the informal sector, although today SHI is moving toward broader coverage (see Box 3).

[40] This programme is based on a successful pilot initiative called Navrongo Experiment (Kassena-Nankana district in northern Ghana). It is part of Ministry of Health guidelines for decentralising primary health care in order to improve access to services.

[41] Please note this is a national average and regional distribution was not specified.

[42] http://www.ghana-chps.org/to2.htm.

Box 3: Health insurance in low income countries - an emerging debate

The provision of social security coverage for medical care is a new policy area for most low-income countries, outside the small formal sector. Following independence in many sub-Saharan African countries, the limited resources available for health care were put into hospital and urban care facilities. With the introduction of Primary Health Care initiatives following the WHO Alma Ata Declaration of 1978, health sector improvement was undertaken in many African countries, often with donor assistance. A variety of coverage packages were introduced, covering basic health care and protection from major endemic diseases. Networks of rural health care centres were also constructed. However, these efforts coincided with the structural adjustment policies imposed in the 1980s and many African governments were forced to cut back their health sector budgets. Out of necessity for cost recovery, user fees were introduced in many African countries, with negative effects on service utilisation owing to out-of-pocket payments (OOPs) (especially in the case of emergency and long-term medical care), particularly among the poorest populations. With the more recent recognition of the weak state of many health sectors, a period of health sector reforms has been undertaken with the aim of improving sector performance, realising international development goals and fulfilling the right to health.

In order to expand health insurance coverage, local health insurance schemes, alternately titled CBHI schemes or MHOs, have been put forth as a complementary solution, given the difficulties of expanding SHI beyond the formal sector. As MHO/CBHI schemes are voluntary schemes in which contributions are not risk related, there is generally a high level of community involvement in their running. Structure takes on many forms, with the most important distinctions lying in the degree of community responsibility assumed. While MHO/CBHI offers a promising bottom-up strategy for insuring rural, agricultural and informal sector populations, the schemes face many difficulties. These include weak managerial capacity at the community level, weak demand-side interest in investing in insurance, low-quality health care services and often a still prohibitively high cost of premiums and co-payments for the poorest populations. Such obstacles may be feasible to address through appropriate sensitisation of communities to insurance concepts, adequate training and, most critically, external/government funding to subsidise contributions for the poorest. These solutions may make MHO/CBHI schemes a potential complementary solution to covering vulnerable populations through a national progression towards effective universal SHI or the taxed-based provision of free essential health services.

However, recent experience suggests that, while social protection is achieved for those covered by MHO/CBHI schemes, the poorest remain excluded to a large degree. By contrast, the complete removal of user fees for a basic package of services has seen dramatically greater increases in service utilisation, particularly for the lowest wealth quintiles of the population. As such, MHO/CBHI schemes may be a good complementary programme in a context of user fees. The level of investment required to develop well-managed MHO/CBHI schemes and to subsidise the contributions of the poorest might be more effectively channelled towards the removal of user fees for these vulnerable populations, resulting in a greater and more equitable investment return.

Sources: Carrin et al. (2005); Huber et al. (2003); James et al. (2006); Scheil-Adlung et al. (2006); Yates et al. (2006).

Since the creation of the NHIA in 2004, at least 145 district mutual health schemes have been established. In addition to members registered through these schemes, NHIS includes those contributing through SSNIT (essentially formal sector workers) as well as several categories of members who are enrolled free under different exemptions: i) children less than 18 years if both parents are card holders; ii) the aged above 70; iii) SSNIT pensioners; and iv) the indigent. The latter are defined as people who are unemployed, have no visible source of income or support and lack a fixed place of residence. In total, there were 12.5 million registered members (54% of the population) by the end of 2008. Of these, 10.4 million (or 45% of the population) were card-holding members, i.e. members who had completed their payments and received cards, thereby becoming eligible to access services under the NHIS.

The NHIS is funded by transfers from the SSNIT (a share of SSNIT members' contributions), the National Health Insurance Levy (a 2.5% addition to VAT and import duties), contributions from the Ministry of Health and development partners and the premiums paid by members of the mutual schemes. In 2008, provisional data indicate that total contributions to the National Health Insurance Fund, which excludes the revenue of the mutual schemes, was GHS 318 million. This is projected to increase to GHS 375 million in 2009 (see Table 27). Almost half comes from import duties (through the Customs, Excise and Preventive Service (CEPS)).

Table 27: Contributions to the National Health Insurance Fund

	2008 original budget	2008 provisional outturn	2009 budget estimates
SSNIT	35,424,000	104,419,539	117,377,746
VAT collection	74,405,513	72,029,861	98,831,416
CEPS collection	125,600,000	141,866,300	159,000,000
Total fund	**235,429,513**	**318,315,700**	**375,209,162**

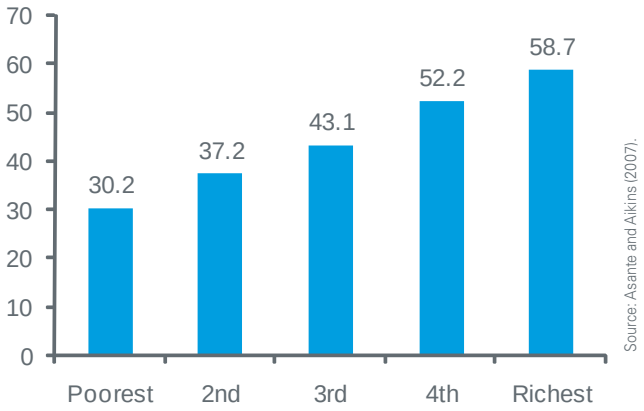
Source: 2009 Budget Statement, Appendix 3A MTEF 2007-2009 total receipts.

For SSNIT contributors, NHIS premiums are progressive, related to income. However, for the majority of NHIS members who depend on the informal sector, premiums are generally flat rate and therefore regressive. On paper there is a progressive scale of premiums from GHS 7.20 to GHS 48.00 a year, but in practice a flat rate has often been applied owing to difficulties experienced by the schemes in applying the means test. Urban schemes in 2008 were charging closer to GHS 15-20, including registration. Many other schemes are charging the lowest rate of GHS 7.20. The one-off registration costs themselves had risen to GHS 4.00 by the end of 2008. This represents a significant barrier to enrolment, especially for large families.

Subsidies are also provided by the National Health Insurance Fund, which is financed out of a 2.5% contribution of SSNIT for the following categories of people: i) formal sector workers who contribute to SSNIT; ii) children less than 18 years if both parents are card holders; iii) the aged above 70; iv) SSNIT pensioners; and v) the indigent. The latter are defined as people who are unemployed, have no visible source of income or support and lack a fixed place of residence. In just four years, by mid-2008, over 9 million people had been enrolled as NHIS members. This represents 45% of the total population, indicating a rapid rollout. Rates in some regions were even higher. In the Eastern Region, figures suggest that, with the introduction of subsidies under the NHIS, by 2005 the majority of those covered (62.5%) were from the above-mentioned exempted categories (Appiah-Denkyira and Preker, 2007)

The GPRSII has framed Ghana's rollout of the NHIS as an effort to 'protect all citizens against preventable and manageable diseases' and to address the 'cash and carry' financial barrier to health care access for the poor. But what have been the pro-poor effects of the NHIS? First, an analysis of coverage rates by wealth quintile demonstrates that the NHIS is not equitable. Data from a study in two districts found that far fewer people from lower wealth quintiles were enrolling owing to cost barriers (see Figure 9).

Figure 9: Percent of population holding NHIS card, by wealth quintiles



A participatory M&E report on the NHIS in 2008 confirmed that there are significant barriers to enrolment by the poor (NDPC, 2008). 77% of individuals who had not registered with the NHIS cited affordability as the main reason (85% in the case of rural respondents). The survey report also provides some evidence that renewal is not automatic: 5.2% of respondents did not renew in 2008, with the primary reason being cost (50.3% of respondents, ranging from 65.1% in the lowest socioeconomic group to 34.8% in the highest).

Despite this cost-based differential enrolment, however, the way in which the NHIS is implemented does appear to be going some way to address demand-side issues, according to a recent survey. Findings suggest that, regardless of quintile, people are aware of the scheme and do not perceive distance to constitute a major obstacle in terms of registration. Furthermore, there is satisfaction with the service; people are re-enrolling (Asante and Aikins, 2007). Other research (Appiah-Denkyira and Preker, 2007) has found that a high proportion of NHIS members are in the exempt categories: 62.5% in Eastern Region as early as 2005.

However, because of the stringent criteria used to assess indigents, only 2.3% of all members were classed as indigent. This figure is much lower than the GLSS5 estimate of either 28.5% living below the poverty line or the 18% living below the extreme poverty line. Additionally, although more than half of the subsidy-receiving NHIS members (64% of the total) were children under 18 years, there has been strong advocacy by child rights advocates, especially UNICEF, that children should be de-linked from their parents. This led to announcements in 2008 to extend fee exemptions to all children under 18 and for additional maternal health services (see discussion below).

8.3 OPTIONS FOR EXPANDING HEALTH SERVICE FINANCING

A major focus of the health sector reform agenda in the developing world centres around health financing, as discussed in Box 1. Ensuring greater equity in access to health services requires movement towards health financing mechanisms that separate payment from utilisation, ensuring access based on necessity of care rather than ability to pay (Bhatia and Mossialos, 2004). Insurance mechanisms serve to distribute the burden of financing among various partners rather than solely on the government. As can be seen from the analysis of Ghana's NHIS, SHI has already proven relatively effective in reaching a large segment of the Ghanaian population, albeit with a slight bias against the poor, despite a wide range of exemptions. The government and donors[43] are aware of this bias and are seeking to increase coverage for the poorest and most vulnerable in a number of ways. To ensure that the options selected are effective and sustainable, three broad issues need to be considered: political opportunities and constraints; institutional capacity; and demand-side factors. This section discusses each in turn.

8.3.1 POLITICAL OPPORTUNITIES AND CONSTRAINTS

In response to a growing concern to ensure that the poor, and especially mothers and children in light of Ghana's slow progress on MDGs 4 and 5, are able to benefit from NHIS provisions, the government announced the introduction of several important new exemption policies in 2008. The first builds on the prior exemption of all children from annual fees and registration costs and constitutes a de-linking of children from their parents' NHIS membership status. Although this option spurred debates about universalism versus targeting, the President in May 2008 issued a directive allowing all children to receive treatment irrespective of parents' enrolment in NHIS (interview, 2008). Although this reform was tabled, it was not enacted before Parliament rose in December before the elections. As of May 2009, the measure had still not been formally approved.

The second measure, which was implemented from July 2008, provided for the free NHIS enrolment of all pregnant women (with premiums and registration charges waived). This provided a card giving the full NHIS benefit package, i.e. not just maternity services, for the period of a year. Prenatal care had always been exempt from payment. The new measure also covered newborns up to three months, since women usually register in the second month of pregnancy at the earliest.

Significantly, this further expansion of NHIS coverage was funded fully from the government budget. This shows a continuing willingness to attempt to improve the equity of the scheme, relying heavily on tax-based financing and only to a limited extent on members' contributions. Another pending decision on exemptions concerns the proposed enrolment of the LEAP beneficiaries, which is still under negotiation between MESW and the Ministry of Health. In short, large government transfers to the National Health Insurance Fund have financed a growing range of exemptions, as well as subsidising the medical care received by contributors. Although exact data are not readily available, it appears that state funding accounts for about 90% of the overall resources of the NHIS, with contributors providing the balance of about 10%.

There is also some potential scope to secure funding for health insurance from donors, through both MDRI funds and the Global Fund. The latter, in 2008, introduced a new gender strategy framework with related

[43] The leading donors in the health sector in Ghana are the US Agency for International Development (USAID), the World Bank, DFID, the Netherlands and the Danish International Development Agency (Danida).

funding windows. This potential must nevertheless be contextualised within the broader debates around funding for the health sector, given concerns about the high and inefficient wage bill. If quasi ceilings are imposed on the wage bill, then meeting the new demand for health services generated by expanding NHIS subsidies may be compromised.

8.3.2 INSTITUTIONAL CAPACITY

Institutional capacity is another important variable to consider in any reflection on options to expand health financing in a pro-poor and sustainable way. Here the evidence is mixed. On the one hand, the NHIS has enjoyed unanticipated success as well as political support from the top leadership. Moreover, government–donor dialogue and cooperation in the health sector has been well organised over the past 10 years owing to a SWAp, biannual health summits and annual programmes of work (interview, 2008). On the other hand, many of the capacity and institutional constraints identified in Sections 5, 6 and 7 are also relevant here.

Weak PFM capacity
In the context of a broader move among the donor community towards budget support in Ghana, there is concern within the Ministry of Health, as well as among those who work with it, that health sector staff lack the technical and negotiation skills to defend their budget with MOFEP and may not get all the resources they require (interviews, 2008). These capacity constraints may also affect the effective implementation of the MTEF in the health sector.

Weak inter-sectoral coordination
Promoting linkages and synergies within and across MDAs remains a challenge (GJAS Partners, 2007). Inter-sectoral coordination is particularly important in the case of both effective nutrition service delivery and HIV/AIDS prevention and treatment. Agencies as diverse as the Ministry of Health, MOWAC, GAC, MOFA, MLGRDE, Ministry of Education and the district assemblies all have a role to play (Dalan and Anani, 2007).

8.3.3 ADDRESSING DEMAND-SIDE ISSUES

Low utilisation rates of health care services persist, especially in rural areas, where transport access remains limited and expensive. Utilisation rates are particularly low in cases demanding urgent or emergency medical attention, where the costs of already expensive health care are further compounded by access costs (interviews, 2008). As a result, there is a growing trend towards heavy reliance on pharmacists rather than clinics or hospitals in the case of illness. If demand for NHIS services is to be strengthened among the poor, for whom annual registration fees constitute a significant outlay, the perception of low quality service must be urgently addressed. The challenge remains to ensure that those living beneath the poverty line have access to affordable health care. The GHS 11 ($9.5) fee required to register for the NHIS amounts to 3.8% of annual consumption expenditure for a household living on the extreme poverty line, or more than 45% of one month's consumption expenditure[44].

The following testimonies from a social accountability citizen score card exercise in 2004 highlight concerns about quality (Institute of Policy Alternatives Ghana, 2006). They include poor staff attitudes and quality of

[44] Expenditure for health has been defined as catastrophic if it exceeds 40% of income after subsistence needs have been met (although some studies have used threshold values as low as 5-20% of household income) (Xu et al., 2003).

care, expensive or unavailable drugs, insensitive birth attendants and insufficient information about health care costs and exemptions.

- *They [medical staff] do not give the needed attention to patients – they sometimes completely refuse to attend to poor people who are sick people at times (particularly during the night and weekends), insult and shout at these patients.* Afram Plains district, Eastern Region.
- *Drug affordability and availability is bad; we buy the expensive drugs from the drug stores.* Danku, Wa district, Upper West Region.
- *Many mothers prefer to deliver at home or with traditional birth attendants owing to poor attitudes of nurses. This sometimes results in complications and death. The needed attention and care is also not given at clinics.* Afram Plains district, Eastern Region.
- *I paid for my wife who went to deliver, only to hear from someone that I was not supposed to pay but I could not go back for my money.* Boli, Wa district, Upper West Region.
- A chief in West Mamprusi argued that the poor state of health services has led him to believe that *'to die is honey and to live is salt'*.

Many of these concerns relate to the quality of training of medical personnel. As we discussed in Section 6, considerable investment has recently been made to attract and maintain higher quality health service personnel by increasing remuneration packets. As part of the government's efforts to stem the brain drain of qualified medical personnel, recent wage hikes have resulted in health professionals in Ghana now enjoying one of the highest remuneration levels in sub-Saharan Africa. The policy focus has now shifted to addressing public service provision inefficiencies (interviews, 2008). In this regard, the 2007 GJAS has emphasised the importance of results-based management and accountability systems. These include civil service training; reform of central management agencies; the overhaul of the public sector pay and pensions system; evidence-based planning and learning through the introduction of a Health Management Information System; support for policy-related research; and the development of a comprehensive human resources management strategy that would define clear career progressions and management functions within the civil service.

More also needs to be done to improve the sensitivity of health service professionals, especially those working in poor rural communities. Existing training programmes need to be reviewed and strengthened, and more regular capacity-building initiatives introduced to address public concerns about quality care. An additional policy option is to consider better integration of traditional health practitioners into the general health system. Both our own interviews and a World Bank Institute report argue that integration has thus far been incomplete (Dalan and Anani, 2007). While the NHIS is reluctant to include traditional health providers in its list of covered services, it is currently undertaking a review of traditional health products to see which (if any) should be included under covered drugs (interview, 2008). Although health experts we interviewed emphasised that there is limited evidence of effective synergies between traditional and modern health care systems, there is a growing body of evidence that suggests that training for routine modern medical interventions can be provided to traditional health providers. This would allow them to continue to play a role in health care provision while capitalising on their close community linkages.

8.4 CONCLUDING REMARKS

The NHIS has made important advances in providing a substantial segment of the population with affordable access to health services and protection against catastrophic health costs in a relatively short period of time. The 2008 announcements de-linking all children from their parents' NHIS registration status and providing pregnant and postpartum mothers with NHIS exemptions also represent major advances in reducing cost barriers to essential health care for vulnerable populations, although the exemption of children still has to be implemented.

These measures could reinforce the recent acceleration of progress towards achievement of MDG 4 (reducing under-five mortality rates by two-thirds) and MDG 5 (reducing maternal mortality by three-quarters). The NHIS participatory M&E report already points to some positive benefits, including a 70% delivery rate in health facilities and a narrowing of the differential between socioeconomic groups. However, the report still showed that only 42.2% of lowest quintile mothers delivered in a health facility, compared with 92-94% in the top two quintiles, underscoring the need for stronger equity measures (NDPC, 2008).

Indeed, options need to be explored in order to provide exemptions for adults living below the poverty line, especially given the importance of good adult health in facilitating the support and care of children. The LEAP cash transfer programme is one mechanism that will facilitate access for the extremely poor although, as discussed in Section 7, the current five-year rollout objective will reach only a fraction of extremely poor households. As has been noted above, MESW and the Ministry of Health have been negotiating to arrange for automatic free enrolment of LEAP beneficiaries under the NHIS 'indigent' category, which is exempted from premium payments. However, this has created some legal difficulties, which as of May 2009 had not been resolved. By definition a LEAP beneficiary lives in a household and is therefore not eligible for this status if the law is strictly applied. However, there is some leeway in implementation at the scheme/community level. This is one key issue that requires a policy decision in order to synchronise legislation and policy in the health and social welfare sectors.

Some other NHIS implementation problems affect access by children in poor households and need to be addressed. The NHIS participatory M&E report indicated that some NHIS mutual schemes register only three children per family, even if both parents (or a certified single parent) are members. This is not policy, but rather an implementation challenge, and is an area that needs close monitoring and correction. Again, the issue is M&E and greater awareness generally of rights (and responsibilities) under the NHIS.

The enrolment charge for children whose parents are already NHIS members has been a further barrier for large families, who are often among the poorest. It is understood that the proposed subsidy rate for exempt categories in 2009 will include the registration charge, subject to parliamentary approval, thereby removing this financial access barrier.

To finance these additional exemptions, the government may have to explore new resource mobilisation options, such as an increase in the National Health Insurance Levy or additional donor funding. In addition, institutional capacity constraints need to be addressed, both through technical support to health ministry personnel with regard to budget planning and MTEF preparation and implementation and via a commitment to improved inter-sectoral coordination. Finally, supply-side constraints need to be addressed by strengthening the quality of health personnel training and management, including responsiveness to health facility users and gender sensitivity.

9. STRENGTHENING CHILD PROTECTION SERVICES WITHIN BROADER SOCIAL PROTECTION SYSTEMS

Child-sensitive social protection services entail tackling both economic and social risks and vulnerabilities. As Section 4 discussed, while poverty is a key risk factor, especially for problems such as child labour, trafficking and sexual exploitation, social and cultural factors lie behind some forms of child abuse, such as child marriage, FGM, *trokosi*[45] and physical punishment of children in the home and schools. Child vulnerability is thus a complex, multidimensional phenomenon, associated with a range of risk factors. This section discusses the extent to which Ghana's broader social protection framework can serve to strengthen preventative and responsive services to protect children from violence, exploitation, abuse and neglect.

9.1 CHILD PROTECTION LEGISLATION AND PROGRAMMES

The government of Ghana has identified a number of key child protection priorities: commercial sexual exploitation of children; child trafficking; child labour; HIV/AIDS orphans; street children; child abuse; harmful socio-cultural practices; and children without birth registration (see Section 4). Efforts to develop an evidence base on these problems have been spurred largely by international agencies, including UNICEF (the MICS has sections on birth registration, child labour, domestic violence, child marriage and orphans), UNDP (the 2007 Ghana HDR includes sections on violence against children and harmful traditional practices) and the ILO. However, the government is also starting to take greater responsibility for monitoring and documenting these issues. This growing commitment is evidenced by the 2003 CLS; studies on child labour in the cocoa plantations overseen by MOWAC (2006; 2007); a decentralised database at the district level on children involved in the worst forms of child labour, coordinated by the Child Labour Unit in MMYE; a database on OVC and children in the juvenile justice system with which the DSW interacts; birth registration records overseen by MLGRDE; and a database on reported domestic violence cases coordinated by the Domestic Violence and Victim Support Unit (DOVVSU) of the Ghana Police Service. There is still, however, a dearth of reliable information on child trafficking and commercial sexual exploitation, prevalence of HIV/AIDS orphans and incidence of harmful socio-cultural practices[46].

Moreover, but perhaps not surprisingly, given the large number of agencies involved in aspects of child protection, a centralised information management system providing for comprehensive tracking of progress towards the fulfilment of children's rights to protection from violence, exploitation and abuse is lacking. While a single register is being established as part of the LEAP programme, given the targeting categories (only OVC, not other children), it is likely that many vulnerable children will be excluded. However, as evidence from the pilot emerges and the programme is rolled out, discussions concerning the utility of the single registry system could constitute a good entry point to develop a broader database on interventions to address child-specific vulnerabilities.

[45] Trokosi is a traditional practice among the Southern Ewes of Ghana. It is a form of ritual servitude where young girls serve as slaves, providing both physical and sexual labour to priests. Young girls (virgins) are usually offered to the traditional shrine to serve for the sins of the father or the family or as a ransom for the family.

[46] This would in theory be MOWAC's responsibility but none of its documentation suggests it has such a monitoring system in place. Such harmful practices include trokosi, FGM, early marriage and nutritional taboos.

Key informant interviews suggested that, partly in response to this growing knowledge base, though owing also to increasing media attention, there has recently been an erosion of the reluctance to recognise and publicly discuss these issues. Inaccurate reporting in the international press on the prevalence of child labour in Ghana reportedly engendered considerable government defensiveness. It has also, however, contributed to more concerted efforts to tackle the root causes of child labour and trafficking. This has included research efforts to understand the market dynamics supporting child labour in different sectors[47]; community sensitisation initiatives supported by the Child Labour Unit and ILO in 20 districts (interview, 2008); and education and awareness raising programmes in schools[48]. Nevertheless, there is still much work to be done in terms of public awareness raising, including the sensitisation of journalists to child rights concepts and issues and further training of officials to effectively respond to violations, especially at sub-national level. As discussed further below, both the current scale of pilot projects and the level of resourcing required to realise such goals are undoubtedly inadequate.

9.2 EXISTING CHILD PROTECTION SYSTEM

In terms of a comprehensive legal framework addressing child protection issues, Ghana scores relatively well. At the centre are the 1998 Children's Act and the complementary 2002 Child Rights Regulations, both of which build on the 1992 Ghanaian Constitution. More specific aspects of child protection are then tackled in the 2007 Domestic Violence Act, the 2005 Human Trafficking Act, the 2003 Juvenile Justice Act and the 1965 Registration of Birth and Deaths Act. The main concern is law enforcement, which is weak. For example, the trokosi system is prohibited by law, but police are reluctant to intervene owing to the weight of traditional cultural beliefs.

In addition, National Action Plans on OVC, on Human Trafficking and on Combating Harmful Forms of Child Labour have been or are being developed to provide a clear framework for the implementation of these laws. Children's panels, which bring together a range of experts and service providers on a regular basis, have been established in all 10 regions to serve as a forum to discuss child protection-related issues[49].

However, as mentioned above, the institutional infrastructure to coordinate and effectively implement the legislation suffers from a number of serious weaknesses. First, there is a lack of clarity in terms of mandates, roles and responsibilities between the child-related aspects of the work of DSW, which provides support for children in the juvenile justice system and applies a social work approach to the care and protection of vulnerable children, and the MOWAC Department of Children, which also has some child protection programmes. Responsibilities for programmes on child labour straddle MOWAC and the Child Labour Unit of MESW. This has led to weak coordination, duplication of efforts and well-recognised tensions and rivalries between the two agencies[50]. Despite this, however, discussions of reforms have engendered some level of resistance. This is in part because of the perverse institutional incentives created by the division of labour between MDAs, including the provision of material resources to implementing, but not policy formulation, agencies[51].

[47] For example, in the case of the cocoa sector, the high cost of adult labour coupled with an adult labour shortage owing to urban migration has contributed to a demand for child labour. Other contributing factors include high prices for cocoa exports on the international market and inadequate social responsibility mechanisms on the part of transnational chocolate manufacturers.

[48] The ILO is currently implementing a programme called SCREAM (Supporting Children's Rights through Education, the Arts and the Media) which uses art, media and education to raise children's awareness of child rights issues.

[49] However, district-level child panels have been established in less than 30% of the 138 districts to date.

[50] In the case of ECD, for example, DSW has responsibility for the custodian dimensions and MOWAC's responsibility lies with child development aspects.

[51] As an implementing agency, departments have access to new computer equipment and cross-country vehicles, as well as travel allowances. Policy formulation agencies, on the other hand, typically lack such material perks. In addition, although a recent capacity assessment of DSW recommended that the department focus more on developing regulatory frameworks and less on individual case work, this would entail a significant reorientation of staff job descriptions (engendering possible resistance) as well as a substantial investment in retraining.

Second, poor coordination also extends to work among other agencies responsible for child protection issues, including the Child Labour Unit in MMYE, the ILO Child Labour Project within the Department of Labour, GAC and DOVVSU.

Third, staff capacity to engage in policy analysis, data collection and analysis and M&E is very limited, owing in part to the time constraints of capable staff (Yuster, 2008; interview, 2008).

Fourth, MOWAC, and to a lesser degree DSW, are woefully under-funded. MOWAC, for example, receives around one-fifth of 1% of the annual government budget. The community monitoring and data collection initiatives of the Child Labour Unit in MESW, which are fully funded by the ILO, are rather unrealistically relying on voluntary labour. There are, as of yet, no government funds earmarked for use when the ILO withdraws in early 2009. Moreover, our interviews suggested that the unit was more optimistic about receiving external donor support than it was about lobbying for government resources.

Another important aspect of a child protection system to consider is the role of NGOs. Many NGOs and faith-based organisations are working to address child protection issues, and more than 150 NGOs have formed the Ghana Coalition on the Rights of the Child. However, most of these organisations suffer from major capacity weaknesses. The likelihood of significant advances being made in terms of capacity strengthening appears somewhat slim given that funding for NGOs is typically time bound and project based (interview, 2008).

Linkages between government agencies and NGOs in this area also remain infrequent and relatively weak. Our visit to Yilo Krobo district suggested that the capacity of government to monitor the activities of NGOs involved in child protection activities is likely to be inadequate. Such oversight is crucial, however, given the heavy reliance on NGOs as service providers.

9.3 PROMOTING SYNERGIES BETWEEN CHILD PROTECTION AND SOCIAL PROTECTION

A key challenge facing the development of child-sensitive social protection policies and programmes is how best to strengthen protection systems and related social services through integration within a broader package of social protection initiatives. In the Ghanaian case, the fact that DSW has been selected as the lead agency to coordinate the implementation of the new high profile LEAP cash transfer programme, as well as the broader NSPS, suggests that there are important opportunities for promoting synergies.

At a conceptual level, DSW is already both supportive and involved in child protection activities, especially those pertaining to child maintenance payments, juvenile justice and the care and protection of OVC. Moreover, several of the 'conditionalities' of the LEAP programme include child protection priorities, namely birth registration of children and preventing the involvement of children in excessive or harmful forms of child labour or trafficking. While the ability of DSW to monitor this effectively at community level is likely to be determined by the willingness of the CLICs to carry out their monitoring duties on a voluntary basis, a valuable community awareness-raising opportunity exists in the theoretical linkage between LEAP and children's protection. Community visits by DSW staff could be an opportunity to sensitise programme participants to children's rights and the need to develop community strategies to tackle violations of these rights. These may include harmful traditional practices such as child marriage, preadolescent initiation rituals and the trokosi

system. In other words, because of the light touch approach to conditionality and monitoring within the LEAP programme to date, there exists a unique opportunity to focus not on the promotion of punitive sanctions, but rather on public education efforts about children's right to protection from violence and neglect.

Currently, the target group for the LEAP programme is caregivers of orphans, many of whom may have been orphaned owing to HIV/AIDS given that the 20 districts where the programme is being rolled out were selected based on their high HIV/AIDS prevalence rates. Again, this provides an opportunity to reach vulnerable children and ensure that some of their immediate basic needs are covered through both the cash transfer as well as free health insurance registration. Through media and other communication efforts, it will also provide a useful forum to highlight the needs of OVC and the importance of investing in their wellbeing.

Another important potential entry point is the single registry system being developed by the LEAP coordination unit in DSW. This could contribute to addressing the lack of a centralised knowledge management system on children and children's rights in Ghana. However, as discussed in Section 7, not only are there concerns about the breadth and technical validity of the registry system, but also the involvement and coordination of other government agencies in the design and rollout of LEAP have been less than optimal. In the case of child protection issues, the relatively limited knowledge of the programme among MOWAC and CLU staff suggests that this coordination challenge will be particularly important to address if synergies are to be achieved.

Even after such a system is established, significant resource constraints will need to be addressed. Here, some important lessons could be learned from the holistic support (both financial and psychological) that the Ark Foundation, a women's NGO based in Accra, provides to women and children victims of domestic violence. These interventions entail long-term (often several years) support of individual cases, including provision of housing, clothes and food; protection from abusive partners, including relocation to avoid susceptibility to harm; and psycho-social counselling (Ark Foundation, 2007). The ongoing ILO Global Social Trust project, which is working with children – and their families – involved in the worst forms of child labour, is another example of good practice[52]. Working in 20 districts with just 3500 children, the project provides a package of support to families which includes coverage of basic health care (including maternal health) costs and school-related expenses (such as uniforms, learning materials, bags), as well as providing entrepreneurial training for the parents. It has also established a community monitoring committee and data collection system. In short, provision of a comprehensive package of services to address the multidimensional poverty and vulnerability that many women and children face is resource intensive in terms of both funding and staff time and should not be underestimated.

Maximising synergies with LEAP, which is likely to remain relatively small scale over the next five years, is not the only entry point for strengthening child protection and social protection programming linkages. The NHIS has much more extensive coverage, including free services for children under 18 years and for pregnant and lactating women. While this alone is insufficient to tackle other cost barriers (especially transport) and time poverty constraints that hinder health care seeking behaviour, as discussed in Section 8, health service usage has increased significantly. Even among the lower quintiles there has been more access to health care, and with the introduction of the 2008 exemptions this trend can be expected to continue. Integrating protection-

[52] Such sharing of experiences across agencies could be valuable, especially given that the evaluation of the HIV/AIDS OVC cash transfer programme supported by UNICEF has not been completed.

related services with primary health care clinics would thus be an important opportunity to strengthen child protection initiatives, both preventative and promotive, among poor communities. This would necessitate ensuring that there are adequate numbers of female service providers in rural districts as well as introducing training modules on how to address child protection issues in a culturally sensitive manner. Rather than addressing incidents of abuse directly, a referral system could be established to link victims to the local DSW or DOVVSU within the police system.

9.4 CONCLUDING REMARKS

In order to achieve the underlying objective of social protection systems to address not just economic, but also social vulnerability and risk, coordination between agencies responsible for the design and implementation of different social protection instruments is imperative. In this regard, it is fortuitous that the lead agency coordinating the NSPS and the LEAP programme has a history of concern for and experience of working with children and adults who require protection from neglect and abuse. This will facilitate the identification and realisation of possible complementarities between social transfer and child protection systems; it will also help reduce interagency coordination bottlenecks and institutional rivalries.

Promoting linkages between the NHIS and child protection services is another potential avenue through which to strengthen child protection and social protection synergies. With high coverage rates, which are consistently increasing owing to the maternal and child fee exemptions recently enacted, health clinics are likely to be one of the more frequent interfaces between at-risk children and the authorities.

The resource constraints facing child protection services cannot be underestimated, however. Current budget allocations to programmes addressing the protection of women and children are miniscule. However, if violence, exploitation, abuse and neglect of children are to be effectively addressed, current pilot initiatives will need to be scaled up and corresponding budget increases secured.

10. CONCLUSIONS AND POLICY RECOMMENDATIONS

Ghana has made important strides forward in developing a strategic framework for a comprehensive social protection system that includes a strong focus on addressing child poverty and protecting children as a specific category with accentuated vulnerabilities and multiple types of risks. The government has drafted the NSPS and initiated a range of important social protection programmes, including the NHIS, the ECG, the School Feeding Programme and the LEAP cash transfer programme – all of which have a strong focus on children. Some of these programmes, in particular the NHIS and LEAP, are pioneering initiatives, without parallel in most countries of the West and Central African region.

However, major challenges still remain. The NSPS remains to be adopted formally by the Cabinet. The country faces difficult macroeconomic and fiscal challenges, which are being exacerbated by the global economic crisis, as well as institutional and organisational constraints that are holding back the expansion of some programmes. Above all, there are still major barriers to reaching many of the poorest and most vulnerable Ghanaians, who need social protection programmes the most. Despite a range of exemptions, the NHIS still reaches only about half the total population, and membership is lowest among the poorer quintiles. LEAP is still a relatively small pilot programme and, even after its initial five-year implementation period, will reach only about one-sixth of the extreme poor.

Based on the analysis in the preceding chapters, this report concludes with a series of policy recommendations, which are intended to inform policy formulation as the government moves ahead with the further strengthening and consolidation of the social protection system. The recommendations are intended in particular to ensure that social protection reaches and benefits the poorest children and their families. More detail is provided in Annex 6, which presents a detailed policy matrix.

1. **Formally adopt the NSPS.** To provide a coherent overall framework for the country's expanding portfolio of social protection programmes, and ensure the necessary coordination and financing, it is important for the draft NSPS to be adopted formally by the Cabinet. The government should also consider the advisability of backing the strategy with legislation, in order to establish clear legal entitlements and thus ensure the long-term commitment of resources to social protection programmes.

2. **Strengthen the pro-poor character of the NHIS.** The NHIS has succeeded in providing a substantial segment of the population with affordable access to health services and protection against catastrophic health costs in a relatively short period of time. These achievements have been complemented by the 2008 announcements de-linking all children from their parents' NHIS registration status and providing pregnant and postpartum mothers with NHIS exemptions. A key next step is to implement the exemption of children from premium payments, which has unfortunately been delayed. Other key reforms are the planned free enrolment of LEAP beneficiaries in the NHIS and the abolition of registration fees for children. Together, the implementation of these measures could help to reinforce the recent acceleration of progress towards achievement of MDGs 4 and 5.

3. **Plan for the long-term scale-up of LEAP.** A number of challenges will need to be addressed to ensure that the LEAP programme has maximum impact on reducing childhood poverty and

vulnerability. At present, the proposed coverage of the programme and its budget requirements for the next five years are modest – covering around only 10% of the population living below the poverty line with an investment of less than 0.1% of GDP by the end of the initial five-year phase of programme implementation. Scale-up beyond this, to reach at least all extremely poor households and their children, will require changes to the narrow categorical approach used for targeting, as well as the organisational strengthening of DSW and the mobilisation of additional funds. However, at about 1% of GDP, the cost of providing transfers for all extremely poor households would be fiscally affordable. Any such plan should be informed by rigorous M&E processes (see below).

4. **Strengthen social welfare services for children and promote synergies with other dimensions of social protection.** In order to address the wide range of socio-cultural, gendered and economic risks to which children are vulnerable, it is important to continue to strengthen the social welfare programmes that provide preventative and responsive child protection services. The risks faced by children cannot be addressed solely by cash transfers and social insurance, but require specialised services. If violence, exploitation, abuse and neglect of children are to be effectively addressed, the current fragmented and small-scale child protection programmes will need to be scaled up and corresponding budget increases secured. MESW's dual role as the ministry responsible for both LEAP and many of these services provides an opportunity to develop strong synergies between these complementary programmes, including mechanisms for referral and integrated case management. In particular, the LEAP beneficiary forums provide a valuable opportunity to raise awareness about children's protection rights, and important gains could be made by strengthening awareness among frontline service providers not only in the DSW but also among local health and education providers which are in regular contact with children. Particular attention should also be paid to strengthening gender awareness and gender analysis capacities among staff both nationally and at the decentralised level in order to better tackle gender-specific risks and vulnerabilities.

5. **'Ring-fence' and expand social protection provision in response to the shocks from the global crisis.** The government faces acute fiscal pressures in the short term, owing to the need to correct the serious macroeconomic imbalances that emerged in 2006-2008 and the adverse shocks emanating from the global economic crisis. However, the adverse impacts of these shocks on poor households justify 'ring-fencing' social protection provision and indeed expanding programmes to protect vulnerable populations to the greatest degree possible. Laudably, this has been the approach taken by the government, which has stepped up its expenditure commitments in the 2009 budget. These include increasing funding for the ECG by 50%, introducing the provision of free textbooks and school uniforms to poor children, and expanding the School Feeding Programme and LEAP, despite the difficult fiscal environment.

6. **i) Continue to promote public expenditure reforms in order to maximise fiscal space opportunities for social protection.** Maximising fiscal space opportunities necessitates not only advocating for increased budget allocations but also addressing expenditure allocation and usage inefficiencies. Civil service reform, especially in the education and health sectors (owing to the high wage bill), has been identified as a major priority. Any effort to advocate for greater investment in child-sensitive social protection should therefore be framed in accordance with these broader fiscal debates. It is also critical that capacity-strengthening support is provided to social sector ministries, including MESW and MOWAC, in order to enhance programme and budget planning and execution.

ii) In the medium to long term, take advantage of oil revenues to build a stronger social protection system. In the medium to long term, a significant boost to public finances may come from expected revenue from oil, which could substantially increase the resources available for social protection, provided these resources are well managed. A strong focus on social protection would help to contribute to redistribution and inclusive growth, as well as poverty reduction and human development, thereby avoiding the social problems that have plagued many oil producers in Africa. This will require medium- to long-term planning for the financing of the scale-up of social protection programmes, including LEAP, in order to ensure long-term sustainability. The ideal framework for this would be the MTEFs at sectoral (MESW) and macro levels.

7. **Improve programme design and M&E.** As experience is gained and programmes are scaled up, it will be essential to ensure maximum efficiency and equity, so that scarce resources are used as best as possible and benefit children and their caregivers most in need. As noted above, this will require further equity measures to ensure NHIS coverage of the poorest, including through the implementation of the promised exemptions for children. In the case of LEAP, particular attention needs to be given to ensuring the rigour of the targeting methodology. The development of a robust impact evaluation framework for LEAP, including the development of a baseline, is also crucial, so that the lessons of the pilot phase are learned, adjustments in programme design can be made and evidence of impacts can be used to garner broader political support and secure the increases in budgetary allocations that will be needed for scale-up.

8. **Strengthen capacity for social protection design and delivery.** The agenda set out above will require substantial investments to strengthen the capacity of the government agencies responsible for the design, implementation and M&E of social protection programmes. Particular attention needs to be given to strengthening the capacity of MESW as the ministry responsible for the overall social protection strategy, as well as both LEAP and a wide range of social welfare services. Here the joint donor–government sector working group on social protection and vulnerability already plays a valuable role and could usefully continue to channel its energies in this direction.

9. **Strengthen interagency coordination.** Cross-agency coordination is vital in order to ensure the complementarity of services. Weaknesses in this respect have so far made it difficult, for example, to link up LEAP beneficiaries to the additional services promised in the original programme design. A first step towards improved coordination has been the establishment of the SPLIT, headed by MESW, which brings together many of the key government actors. This is complemented by the role of the joint donor–government social protection and vulnerability group. The success of this group will depend on high-level political will as MESW faces significant institutional and capacity challenges.

   Given the vital role that the legislature could play in overseeing government action with regard to social protection, it is also important that greater efforts are made to strengthen awareness among national assembly members, and especially the Committee on Social Affairs, about ongoing social protection initiatives.

   The single register established by the LEAP programme provides an excellent basis for developing a centralised information management system that can cover all major social protection programmes and beneficiaries. This should be complemented by additional knowledge management mechanisms

to ensure better documentation and sharing of information about social protection programmes and complementary services, especially from the national to the decentralised government level.

10. **Support capacity strengthening initiatives for non-governmental actors and the media with regard to social protection.** In order to promote greater accountability and transparency regarding the use of resources to tackle poverty and vulnerability it will be critical to support children's rights and gender equality advocates' engagement in social protection policy dialogue processes. This will not only contribute to strengthening child and gender-sensitive programme design, implementation and evaluations, but also promote synergies with non-governmental initiatives in programme districts. Capacity building for the media will similarly help to raise the quality of public debate on these issues.

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MMYE	Mr. Peter Ayayee	Programme Assistant.	24/04/08
MMYE	Miss Asabea Annor	Programme Assistant.	24/04/08
DSW	Mrs. Margaret Kutsuatsi	Director, DSW	24/04/08
DSW	Mr. William Youni	Research Officer	24/04/08
DSW	Mr. Nat Khing Tackie	Budget Officer	24/04/08
DSW	Mr. Lawrence Ofori Addo	LEAP Coordinator	
Ark Foundation	Angela Dwemena Aboagye	Executive Director	25/04/08
Ark Foundation	Naa Atwei Awotwi	Programme Officer	25/04/08
ISSER	Dr. Robert Osei	Consultant for LEAP finances	25/04/04
Ernst and Young	Mr. Djabanor Narh	Consultant for LEAP M&E	25/04/08
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MLGRDE	Mrs. Levina Owusu	Director, School Feeding Programme	25/04/04
CLU	Mrs. Stella Ofori	Senior Child Labour Officer	
CLU	Mrs. Elisabeth Akanbonbiri	Senior Labour Officer	
ILO	Mrs. Margaret Sackey	National Programme Manager	25/04/08
ILO	Mr. Patrick Nelson	Programme Officer	25/04/08
ILO	Mr. Emmanuel Kwame Mensah	Programme Officer	25/04/08
Netherlands Embassy	Dr. Marius de Jong	Health sector lead	28/04/08
MOESS	Mr. Daniel Zogblah-	PPME, Statistics	29/04/08
NDPC	Dr. K Appiah-Kubi	Director, Planning Coordination	29/04/08
NDPC	Mr. Jerry Odotei	Deputy Director, Policy	29/04/08

ANNEX 1. LIST OF KEY INFORMANTS *(cont.)*

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NDPC	Mrs. Alice Amekudzie	Programme Officer	29/04/08
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GSS	Mr. Charles Cartey	Assistant Statistician	30/04/08
MOESS	Mr. Charles Tsegah	Director, PBME	30/04/08
DFID	Dr. Sonya Sultan	Social Development Specialist	30/04/08
Department of Children (MOWAC)	Florence Annor	Research Officer	
Department of Children (MOWAC)	Ruth Addison	Senior Programme Officer	
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Institution	**Name**	**Position**	**Date**
Department of Children (MOWAC)	Samuel Acquah	Senior Accounts Officer	
Department of Children (MOWAC)	Israel Akrobotu	Research Officer	
NHIS	Mr. Francis Adjei	Deputy Director, Office of the Chief Executive	
Traditional Leader	Amina Agbleze – Plao Division	Queen Mother	01/05/08
Traditional Leader	Maku Tetteh- Bunase Division	Queen Mother	
Traditional Leader	Mami Yoo Banase – Okper Division	Queen Mother	01/05/08
Traditional Leader	Padeki Borti – Nyewer division	Queen Mother	01/05/08
Traditional Leader	Dede Mami Yoo – Nyewer division	Queen Mother	01/05/08
Traditional Leader	Amettor Dzasse – Neyewer division	Queen Mother	01/05/08
Traditional Leader	Afino Mamle – Bunase division	Queen Mother	01/05/08
Traditional Leader	Teiko Kwawusi – Ogome division	Queen Mother	01/05/08
Traditional Leader	Keni Teiko – Nyewer division	Queen Mother	01/05/08
Traditional Leader	Dede Laayoo Nyewer division	Queen Mother	01/05/08

ANNEX 1. LIST OF KEY INFORMANTS *(cont.)*

Traditional Leader	Kuku Appartey – Bornya division	Queen Mother	01/05/08
Traditional Leader	Adam kuor Okra – Okper division	Queen Mother	01/05/08
Traditional Leader	Dede Keni – Okper	Queen Mother	01/05/08
Traditional Leader	Nuertey Ologo Okper	Assistant. to Queen Mother	01/05/08
New Somanya Community	Mr. James Tei	CLIC Chairman (LEAP)	
CLIC Member (Ahinakwa)	Mr. John K. Awartey	CLIC Member Catechist	01/05/08
CLIC Member (Ahinakwa)	Mr. S.K Adamtey	Teacher	02/05/08
CLIC Member (Ahinakwa	Dade Mantse Tetteh-Dumor	Chief (Traditional Leader)	02/05/08
CLIC Member (Ahinakwa	Agnes Mantey	Community Health Nurse	02/05/08
CLIC Member (Ahinakwa	Victoria Tetteh	Hairdresser	02/05/08
UNFPA	Mr. Ian MacFarlane	Deputy Director	02/05/08
UNFPA	Mrs. Mercy Konadu	Programme Officer	02/05/08
Centre for Social Policy Std	Dr. Ellen Bortei Doku Aryeetey	Acting Head	
Chrismek Foundation	Mr. Chris Mensah	President	02/05/08
DHIS	Solomon Kwao	District Director, DHIS	02/05/08
District Assembly	Mr. John Kisseadu	M&E Focal Person on HIV/AIDS	02.05/08
DSW	Mr. John Debrah Acquah	District Director	02/05/08
Plan Ghana	Mr. Kofi Addae Debrah	Livelihood Advisor	05/05/08
Plan Ghana	Mr. Victor Antwi	Programme Support Manager	05/05/08
MOFEP	Mr. Tony Nyamiah	MTEF Programmer	05/05/08
MOFEP	Mrs. Angela Farhart	MDBS Unit	06/05//08
Ministry of Health	Dr. Frank Nyonator	Director, PPMED	06/05//08

ANNEX 2: CORE SOCIAL PROTECTION PROGRAMMES – SOCIAL ASSISTANCE, SOCIAL INSURANCE AND REGULATORY FRAMEWORKS

Type of social protection	Programme title	Timeframe	Administrative arrangements	Funders	Programme objectives	Amount/ type of transfer	Targeting/ eligibility	Coverage	Cost	Method of evaluation	Results/ outcomes
Social assistance											
In-kind											
Unconditional cash transfer	LEAP	5-year pilot from 2007	DSW	GoG, DFID	To provide social grants support to supplement subsistence needs of extremely poor. To link beneficiaries to complementary services that would enhance their wellbeing. To promote integrated social development through public–private partnerships.	A graduated type of transfer based on the number of qualified beneficiaries in a household. Amount ranges from GHS 8-15 for a maximum of 5 beneficiaries per household.	Extremely poor aged above 65 years. Severely disabled persons.	20% of the extremely poor in Ghana (18.2%).	c $26 million for the 5-year period.	Baseline survey. Programme activity. Processes and results monitoring. Beneficiary assessment.	Percentage of households that rose above the extreme poverty line with the LEAP cash transfer. General programme impact on health education and food security of beneficiaries.
Child grants	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Social pensions	SSNIT	Not limited	SSNIT	GoG, employers and workers	SSNIT seeks to income replacement to Ghanaian workers and their dependants in the event of old age, permanent disability or death.	5% contribution of worker's salary and 12.5 % contribution of employer.	All formal workers in Ghana and, in recent times, informal sector workers.	About 1 million contributors with 58,000 pensioners .	$79,870, 500 for year ending 31 Dec 2006 (SSNIT, 2006).	N/A	N/A

Type of social protection	Programme title	Timeframe	Administrative arrangements	Funders	Programme objectives	Amount/ type of transfer	Targeting/ eligibility	Coverage	Cost	Method of evaluation	Results/ outcomes
Conditional cash transfer for human development	LEAP	5-year pilot from 2007	DSW	GoG, DFID	To provide social grants support to supplement subsistence needs of extremely poor. To link beneficiaries to complementary services that would enhance their wellbeing. To promote integrated social development through public–private partnerships.	A graduated type of transfer based on the number of qualified beneficiaries in a household. Amount ranges from GHS 8-15 for a maximum of 5 beneficiaries per household.	OVC		c $26 million for 5-year period.	Baseline survey. Programme activity. Processes and results monitoring. Beneficiary assessment.	Percentage of households that rose above the extreme poverty line with the LEAP cash transfer. General programme impact on health education and food security of beneficiaries.
Fee waivers	Capitation Grant Scheme	Since 2005	Ghana Education Service (GES)	GoG	To provide access to basic education in all parts of the country.	GHS 3 per child per academic year.	All children of school-going age in Ghana who enrol in public schools.	All children in public basic schools since 2005.	GHS 14.24 million spent in 2007.	School data collection by Planning Budget Monitoring and Evaluation Division.	Increased enrolment at basic level. Primary gross enrolment ratio 2006 93.7%; 2007 96.4%.
Food transfers	Take Home Ration	Phasing out	GES, WFP	WFP, World bank	To reduce the level of malnutrition among school girls in the north.		42,000 girls in upper primary and junior secondary.	42,000 school girls mostly in the north.		Strategic report 2006.	Increased gender parity index in three northern regions.

Type of social protection	Programme title	Timeframe	Administrative arrangements	Funders	Programme objectives	Amount/ type of transfer	Targeting/ eligibility	Coverage	Cost	Method of evaluation	Results/ outcomes
School feeding	School Feeding Programme in the 3 Northern Regions of Ghana/ Take Home Ration	Phased out	GES, Catholic Relief Services (CRS)/ USAID	USAID, CRS	To provide one hot nutritional meal a day for school children and also take home ration for children scoring 85% attendance per month.	-	Primary school and pre-school children who make 85% attendance a month.	74,200 school children in 593 schools.		-	Raised enrolment and improved school attendance.
School feeding	School Feeding Programme	2005	School Feeding Secretariat under MLGRDE	GoG, Net. Embassy, NEPAD	To provide one hot meal a day for school children in primary school.	GHS 0.30 per day per child.	Selected schools in very deprived communities or districts.	1500 children in deprived schools and communities by 2010.	$328 million for 5-year period [53].	-	Increased enrolment.
Targeted nutrition	WFP Country Programme for Ghana	2006-2010	Ministry of Health	WFP	To reduce the level of malnutrition among pregnant and lactating women and children under 5 years old.	-	Pregnant women, lactating mothers, children under 5 who are at risk of malnutrition.	60,000 [54] pregnant women, lactating mothers, children under 5 who are at risk of malnutrition.	-		
Targeted nutrition	Health and Nutrition Programme for school children in selected communities in Northern Region.	Since 2000	Christian Children Fund Canada, beneficiary districts assemblies, GES	Christian Children Fund Canada	Education on proper nutrition for children, capacity building for parents, health nutrition assessment periodically.	School children from the poorest communities in the Northern Region.	8400 children, 520 mothers received training.	-			

[53] http://www.ghanaweb.com/GhanaHomePage/diaspora/photo.day.php?ID=104247. Accessed 28 June 2009.
[54] http://www.wfp.org/countries/ghana. Accessed 28 June 2009.

Type of social protection	Programme title	Timeframe	Administrative arrangements	Funders	Programme objectives	Amount/ type of transfer	Targeting/ eligibility	Coverage	Cost	Method of evaluation	Results/ outcomes
Public works	Village Infrastr. Programme (VIP)	1997-2002	MOFA, VIP Secretariat	IDA, Internat. Fund for Agric. Devt (IFAD), GoG, German Devt Bank (KfW)	Primary objective to improve quality of life of Ghana's rural poor by increasing transfer of technical and financial resources to improve basic village-level infrastructure.	-	Most deprived rural communities in Ghana		$70 million[55].	-	Labour-intensive construction projects provided incomes for poor rural households.
Microcredit	MASLOC (GoG, 2006)	-	MOWAC	GoG	To administer, coordinate and monitor microcredit and small loan schemes and promote decentralised microfinance system.	GHS 100-500 and above per beneficiary (women).	Poor men and women in Ghana.	10,000 beneficiaries in Greater Accra Region alone in 2007 [56].	GHS 46 million.		Disbursement began a little over 18 months ago.
	SIF	Started in 1998 to date	SIF Secretariat	UNDP, African Devt. Bank (AfDB), GoG	To provide direct targeted and sustainable assistance to Ghana's urban and rural impoverished communities. [57]				30,950 million. (SIF, 2006).		Increased income generation opportunities for beneficiaries.
Social insurance											
Health insurance	NHIS	2003	NHIS Secretariat	GoG, SSNIT contributor and beneficiary contribs	To enable residents in Ghana to obtain, at least basic health care services without paying money at the point of delivery of the service.	Annual Premium is GHS 90 + admin and registration costs of GHS 2.	All adults who pay stipulated premium and exempted groups such as SSNIT pensioners, children under 18, persons aged 70+ and indigents.	National coverage.	GoG released GHS 140.33 million towards NHIS in 2007.	Annual Progress Report of GPRS.	Registered as at end of 2007 is 9,733,000 (48% of total population (NDPC, 2008). Of this number only 42% have been issued with cards.

55 http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/1997. Accessed 28 June 2009.
56 http://www.ghanaweb.com/GhanaHomePage. Accessed 28 June 2009.
57 http://sifinghana.org. Accessed 28 June 2009.

Type of social protection	Programme title	Timeframe	Administrative arrangements	Funders	Programme objectives	Amount/ type of transfer	Targeting/ eligibility	Coverage	Cost	Method of evaluation	Results/ outcomes
Social equity (transformation)											
Regulatory frameworks to protect vulnerable groups	Persons with Disability Law (2006)	2006	MMYE		Law to secure rights of persons with disability, provide employment, education, transportation and health care services.	Act provides for incentives such as tools but no specific amounts.	All persons with disabilities.	National.		Law has just been passed.	
	1992 Constitution of Ghana	1992	Various sectors					National.			
Human Trafficking Act (2007)	2007	MOWAC, MMYE		The law aims at prohibiting the recruitment, transport and transfer of human beings particularly children for the purposes of exploitation.				National.			
	Care Reform Initiative (2006-2011)				Multi-sectoral 5-year initiative focuses on de-institutionalising and reintegrating OVC and provision of minimum standards by DSW to run an orphanage.						

Type of social protection	Programme title	Timeframe	Administrative arrangements	Funders	Programme objectives	Amount/ type of transfer	Targeting/ eligibility	Coverage	Cost	Method of evaluation	Results/ outcomes
	Domestic Violence Act (2007)	2007	Ghana Police through DOVVSU, DWS, Department of Women of MOWAC		Domestic Violence Act is intended to protect the rights of people who suffer domestic abuse or violence.			National.			
	Children's Act 1998 (Act 560)	1998	Multi-sectoral		Children's Act of 1998 is a reform seeking legislation that consolidates laws relating to children's rights provisions, maintenance and adoption. It also regulates child labour and apprenticeships.			National.			

ANNEX 3: GOVERNMENT CHILD PROTECTION SERVICES

Type of child protection service	Policy commitment	Programme title	Responsible government agency	Funders	Type of service/benefit	Objectives	Targeting	Coverage	Programme budget
Services to tackle harmful forms of child labour	Support for the implementation of Time-bound Programme for the Elimination of Worst Forms of Child Labour	ILO/IPEC Time-bound Programme	MMYE, MOWAC, NDPC, National Commission on Civic Education (NCCE), Commission on Human Rights and Administrative Justice (CHRAJ), Employers,	ILO, GoG, UNICEF, World Bank	Capacity building, withdrawal of children from child labour, sensitisation programmes, poverty reduction programmes for poor parents, rehabilitation and reintegration of children withdrawn from child labour.	Elimination of child labour in Ghana. Minimising and/or eliminating sexual exploitation of children.	Children in worst forms of child labour.	Child labour endemic areas in the country.	$4,750,000 external funding agency and $394,300 local contribution.
	DSW services	Maintenance and Custody Programme Child Subsistence Grant Programme Alternative Family Care Programme Child Rights Protection and Promotion Programme	DSW	GoG and varied donor agencies	Custody and maintenance, cash transfers, etc.	To protect the overall welfare of the child.	Universal to children in Ghana.	Country wide but usually over 3000 cases per year.	About GHS 130 million per year (DSW Budget Unit in Accra).
	Support for the implementation of West African Cocoa/Agricultural Project (WACAP) for the Prevention and Elimination of Hazardous Child Labour in Ghana	ILO/IPEC WACAP for the Prevention and Elimination of Hazardous Child Labour in Ghana	MMYE and Child Labour Unit, Ghana Employers Association, MOWAC	ILO/IPEC, Government of Ghana	Capacity building, withdrawal of children from child labour, sensitisation programmes, poverty reduction programmes for poor parents, rehabilitation and reintegration of children withdrawn from child labour.	Elimination of child labour in Ghana. Minimising and/or eliminating sexual exploitation of children.	Children in worst forms of child labour.	Cocoa-growing areas in the country and commercial agricultural centres.	Support for the implementation of WACAP for the Prevention and Elimination of Hazardous Child Labour in Ghana.

Type of child protection service	Policy commitment	Programme title	Responsible government agency	Funders	Type of service/benefit	Objectives	Targeting	Coverage	Programme budget
Services to tackle sexual violence against children	On the basis of the Children's Act 560 (1998) On the basis of the Domestic Violence Act (2007)	Prevention and Withdrawal of Children in Commercial Sexual Exploitation (CSEC) (ING, 2006a)	International Needs Ghana (ING)	ING and ILO/IPEC	Awareness creation, withdrawal and rehabilitation.	To deepen public awareness. To withdraw and rehabilitate children in CSEC.	Girls in CSEC.	Tourist sites in Ghana particularly Accra (271 rescued so far).	GHS 43,000.
	On the basis of the Children's Act 560 (1998) On the basis of the Domestic Violence Act (2007)	16-day action on violence against women and children by CSOs (annual programme of action)	DOVVSU, Ghana Judicial Service, ING, Ark Foundation, Women's Initiative for Self-employment (WISE)	Government of Ghana Ark Foundation ING	Psychosocial counselling, rescue and reintegration into normal social life. Education and other health services are provided.	Creating public awareness on the need to protect women and children against sexual violence. Strengthen enforcement of the child protection legislations.	Women and children who suffer from sexual violence or are vulnerable to sexual violence.		
Services to tackle violence against children including harmful traditional practices (ING, 2006b)	On the basis of the Children's Act 560 (1998) On the basis of the Domestic Violence Act (2007)	Rescue of Children in Trokosi. Residual Service by DOVVSU, DSW.	ING, DOVVSU, Ghana Judicial Service.	GoG, ING, other CSOs.	Health service, educational service, psychosocial counselling.	Protect children from harmful traditional practices. Rescue and rehabilitate children in trokosi.	Children victims of physical or psychological violence and girls in trokosi.	Country-wide but particularly Volta Region of Ghana for trokosi issues.	-

ANNEX 4: INFORMAL TRANSFERS IN GHANA[58]

Type of social protection	Objectives	Type of assistance	To whom and for whom	From whom	Coverage	Regularity	Relative importance	Impacts
Informal/ traditional social protection								
Family remittances	To provide some financial support to family members	Cash transfers	To family members or relatives	Ghanaians in the diaspora or internal migrants to urban areas	Countrywide	Throughout the year and usually through money transfer institutions like Western Union, Vigo, etc	Meeting household expenditure, provision of housing facilities, food and transport	Improved livelihood security
Church-based welfare systems	Provide support to church members in times of death, sickness of disability	In-kind and cash	Church members and non-members, orphanages, hospitals, etc	Church leadership	Countrywide	Throughout the year	Meet some subsistence needs of beneficiaries	Helps the poor and the needy to survive economic hardships
Ethnic-based association	Provide welfare support to members (funeral expenses, petty trading, outdooring, payment of health and educational fees	In-kind or cash	Members of ethnic associations in urban and rural communities	Ethnic-based associations	Countrywide	Support provided to needy members anytime they are needed	Infrastructural development of local communities	Have insulated members from harsh effects of crises
Corporate social responsibility	Community development	School building, hospital equipment, recreational facilities and educational scholarships	Rural communities and other communities where corporate institutions operate	Corporate institutions	Countrywide	Provided any time of the year	Commendable community development initiatives	
Traditional rulers initiatives		Educational scholarships	Educational fund administered by traditional councils or special committees	Resources are mobilised from c itizens, corporate bodies or rich and high-profile individuals	Needy but brilliant students		Access to higher education for the less privileged	

[58] See Bortei-Doku Aryeetey and Doh (2007).

ANNEX 5: SELECTED KEY BASIC SERVICE DELIVERY AND COMPLEMENTARY SOCIAL PROTECTION ACTIVITIES

Programme	Programme details and results (where available)	Institutional arrangement
Pre-school education	Ghana's policy on Early Childhood Care and Development (2004) takes into account new ECD approaches, primarily focusing on the protection of child's right to develop the full cognitive, emotional, social and physical potential. The policy seeks to develop policy guidelines and an institutional framework to guide stakeholders, to assign responsibilities and to put in place coordinating and monitoring mechanisms for promoting early childhood development in Ghana. As part of the education sector reform, Ghana in its 2005 Education Strategic Plan indicated that 70% of all primary schools will have kindergartens attached by 1015. it is also indicated that gross enrolment ratio at pre-school level is expected to hit 86%. In respect of the policy, guidelines were prepared for the establishment of kindergartens throughout the country.	MOWAC, MMYE
Birth registration (UNESCO, 2006)	An audio visual advert on birth registration has been developed. 1000 trained community health nurses from 10 regions trained in the registration of births. There has been an increase in birth registration coverage from 51% to 65%. Coverage was 43% as at September 2005. It was expected to reach 60% by the end of 2005, which is still below the target of 65%. Child Health Promotion Week in 2006 recorded a 20% increase over the previous year.	
Corporate social responsibility programmes	Most corporate institutions in Ghana practice corporate social responsibility. This usually takes the form of community development approach where institutions provide educational material including school building, health facilities, recreational facilities and, in certain cases, scholarship to students in selected communities.	Uncoordinated
Health Roadmap Policy	Ministry of Health has launched the health sector Programme of Work for the year 2008 on the theme of Creating Wealth through Health. The work plan is expected to provide a platform for quality health service delivery for the country, particularly in the area of the NHIS.	Ministry of Health, Ghana Health Service, NHIA
Economic strategy	GPRSI was developed and implemented. GPRSII 2006-2009 is also under implementation. Annual progress reports revealed growth in macroeconomic indicators.	NDPC, MOFEP and MDAs

ANNEX 6: POLICY RECOMMENDATIONS MATRIX

Policy implications	Knowledge base	Awareness	Policy framework	Implementation	Institutional responsibility and capacity	Opportunities for engagement and strategic partnerships
Mainstreaming children into national social protection systems	Ghana has a growing array of social protection initiatives, including social assistance, social insurance, social services and equity measures. It has a range of informal mechanisms as well as the new NSPS framework to guide coordination efforts. There is, however, a pressing need to both establish a central database on these mechanisms and to invest in rigorous and coordinated impact evaluations to assess efficacy of these programmes. Good practice examples from which Ghana can learn include the UN International Poverty Centre (IPC) in Brasilia and the Mexican government's investment in evaluation of social protection. To ensure that evaluations are child and gender sensitive, an advisory panel of relevant specialists should be established to assist with the development of evaluation terms of reference, selection of evaluation experts and peer review.	Awareness about the value of social protection initiatives in terms of addressing poverty and vulnerability and strengthening human capital is growing in Ghana. Knowledge exchange and South–South learning should be further encouraged to increase the awareness of officials at both national and sub-national levels. Understanding is vital in order for legislators and civil society actors to see the potential for, and good practice in, developing a national social protection system. Examining the evidence, both national and international, on the strengths and weaknesses of different social protection instruments (school feeding, cash transfers, girls' education stipends, etc) is a critical next step as Ghana moves to effectively mainstream children into the social protection system.	The NSPS, with its emphasis on human capital development, provides a strong foundation on which to build. However, it is important to ensure that adequate policy focus and resources are invested in social protection mechanisms that address not only human capital and lifecycle vulnerabilities, but also vulnerability to neglect and abuse. This will necessitate that the NSPS framework is complemented with a rights-based approach;. Child-friendly social services and the implementation of legislative frameworks that emphasise equity and non-discrimination need to be conceptualised and operationalised as an integral part of Ghana's social protection policy framework. As such, both the current revision of the draft NSPS document and the discussions about MMYE's new coordination role will provide important windows of opportunity to engage with these issues.	Thus far, Ghana's social protection mechanisms have been implemented with highly varied degrees of success. The ECG and the NHIS are two good examples of success. Common ingredients include promoting a demand-side approach to service use; a strong degree of high-level and cross-sectoral political buy-in; carefully phased rollout; and the use of a baseline and regular M&E. In the case of the NHIS, although a registration fee was never levied against children, they have subsequently been de-linked from their parents in recognition of the relational nature of children's poverty. The School Feeding Programme, on the other hand, has suffered from a number of weaknesses, the most important of which is the lack of rigorously implemented criteria for targeting the programme to the poorest. Between one-fifth and one-quarter of children live in extreme poverty; developing both the political will and the technical capacity to target these children first is a pressing challenge. Given resource and capacity constraints, a sequenced approach is both necessary and in line with the UNCRC's principle of progressive realisation. The long-term vision for child-sensitive social protection must of course include all vulnerable children. In the short to medium term, however, particular attention is needed to address those children in very difficult circumstances.	The identification of MMYE as a coordinator for Ghana's social protection system is an important first step. However, to achieve success MMYE will need to be supported by intensive capacity strengthening and re-skilling. Awareness raising in, and sensitisation of, other line ministries is also required in order in order to maximise synergies across sectors. In order to promote more effective coordination, efforts are also required to clarify the respective roles and responsibilities of MMYE, DSW and MOWAC in addressing child- and gender-specific experiences of poverty and vulnerability. Current tension regarding role overlap needs to be urgently addressed in order to maximise the use of scarce resources for children and women. The value of a robust M&E system on social protection cannot be overestimated. It is vital both in terms of lesson learning and for ensuring the political sustainability of social protection programmes which require long-term fiscal commitments. Existing capacity is lacking in MMYE – additional personnel (staff and/or consultants) with both evaluation expertise and an understanding of childhood poverty and gender analysis – are urgently required. Sufficient ring-fenced funding for quality M&E is also imperative.	**Line ministries:** MMYE needs to both prioritise sensitisation efforts with other line ministries and explore possible entry points for collaboration on social protection programmes. **Decentralised governments:** Awareness raising and sensitisation efforts by DSW for other government agencies is important to promote strong coordination at the district level. **Legislature:** Awareness raising and sensitisation efforts for the social affairs committee is also critical so that legislators can hold the government accountable for social protection outcomes. **Donors:** Should continue to build on current efforts to support coordinated knowledge management and M&E on social protection mechanisms and their impacts on different vulnerable groups, especially women and children. **NGOs:** In addition to increasing awareness of the new social protection policy frameworks, NGOs should seek to coordinate their social protection-related initiatives with government initiatives so as to promote synergies. This could include being part of the centralised database of complementary services to which LEAP programme participants could be connected. **Media:** Media capacity building about social protection would both ensure more accurate reporting and promote greater societal buy-in.

Policy implications	Knowledge base	Awareness	Policy framework	Implementation	Institutional responsibility and capacity	Opportunities for engagement and strategic partnerships
Developing and delivering child-sensitive cash transfer systems	Given that cash transfers are a very recent phenomenon in Ghana, evidence on the impacts of the current LEAP programme pilot is still minimal. Our field work, combined with anecdotal evidence (including that covered in the press), suggests that the scheme has been welcomed by programme beneficiaries and is providing some support to impoverished families who are caring for OVC. In order to understand impacts of the transfers over time, however, a more comprehensive baseline assessment will be required than that which has been carried out to date. This is especially important given that an evaluation of the UNICEF-supported transfer programme pilot for HIV/AIDS OVC, which informed the design of the LEAP, was not completed. To address this evidence gap, it will be important to commission a rigorous evaluation at the end of Year 1 of the programme (in March 2009) to assess its effects on child wellbeing in order to better shape the design of the rollout phase.	Awareness levels as to the benefits of cash transfers for alleviating childhood poverty and vulnerability are still relatively low in Ghana. An important constraint is the focus in current political culture on economic growth rather than poverty alleviation per se. Valuable sensitisation efforts have been undertaken in a number of communities to promote better awareness of the programme. The programme has also attracted considerable media coverage since its launch. It is critical, however, both that the sensitisation efforts are scaled up to communities across the country and that the information provided is in line with the realities of programme implementation. Sensitisation materials used to date reflect the original design documents, but there have been important changes, especially in targeting. These changes need to be accurately represented to ensure citizens are adequately informed and to secure their buy-in. Educating journalists on social protection and linkages to combating childhood poverty could support these community awareness-raising efforts.	The LEAP programme document provides a good framework for a social cash transfer and has been informed by international good practice as well as South–South learning. The attention to targeting is also welcome, as highlighted in our simulation exercise, on the grounds of poverty reduction potential and affordability. However, the LEAP document targeting design is currently too complex; the pilot is indicating that it is difficult to operationalise. Given LEAP's aim to reach the extreme poor, greater attention to existing poverty mapping is required. This is also critical in order to ensure that a greater number of poor and vulnerable children benefit from the programme, rather than the current more narrow focus on OVC. It is important to note that the current five year rollout plan is very modest in scale, with just one-sixth of the population living below the extreme poverty line currently targeted. This highlights that social cash transfers are still in a fledgling stage in Ghana and that a wider package of social protection instruments will be critical to address poverty and vulnerability more comprehensively.	While it is still early to assess the efficacy of the LEAP implementation process, initial indications suggest that the identification of beneficiary households has been carried out without the possible negative effects on community dynamics that cash transfers could engender. It is important that there is no evidence of either beneficiary stigmatisation or intensification of community tension. Programme participants' understanding of the rationale of the programme, however, appears to be mixed. There is some confusion about the conditional aspects (no child labour or trafficking and mandatory birth registration) and limited understanding that the cash is intended to offer households flexibility in addressing their basic needs. This could be improved by greater training of the DSW personnel charged with district-level programme implementation, as well as by more attention to sensitisation efforts for government officials, service providers and the public. Information needs to be informed by the real contours of the pilot, rather than the theoretical design document. Despite the fact that the LEAP document includes a full annex on M&E mechanisms, a robust baseline assessment has not yet been carried out or planned. This urgent priority, which needs to be informed by the perspectives of men, women and children, is crucial if effective learning from the project is to be achieved. It is also critical in order to ensure that the single registry system information is of maximum utility.	Given their history dealing with vulnerable populations, MMYE and DSW are particularly well placed to coordinate the LEAP programme. They are, however, one of the less powerful ministries in Ghana. They have limited convening power and face significant capacity and resource constraints. While an institutional capacity assessment has been conducted and support from DFID secured, implementation has been delayed. This is a pressing concern and will require substantial resources and technical support over the medium term, at both national and sub-national levels. International good practice suggests that cross-sectoral coordination and buy-in is critical to the success of cash transfers; this requires high-level political will. In this regard, it will be important to identify focal points in coordinating ministries to address both the supply side and information constraints that currently hinder the realisation of the complementary services component of the LEAP programme. Ostensibly, such focal points have been selected. However, our key informant interviews suggested that information is not being effectively disseminated to staff involved in implementation. MOWAC, the Ministry of Health, the Ministry of Education and MLGRDE, are among those impacted.	Top priorities for MMYE and DSW to address are the implementation of an institutional capacity-strengthening programme; careful planning and implementation of a baseline for M&E purposes; and ensuring regular and well-planned coordination meetings with other line ministries. The sector working group on social protection can also play an important role, through technical and financial inputs, in supporting the realisation of these priorities. Engaging with the detail of design and evaluation issues will be imperative given MMYE capacity deficits. Civil society groups appear not to have engaged significantly with the LEAP programme. However, to ensure that the programme is both child and gender sensitive in its design, implementation and impacts, it will be important for both gender equality and children's rights advocates to become better informed and more active. It is crucial to seek opportunities for synergies with non-governmental initiatives in programme districts.

Policy implications	Knowledge base	Awareness	Policy framework	Implementation	Institutional responsibility and capacity	Opportunities for engagement and strategic partnerships
Developing and delivering child-sensitive health financing mechanisms	There is a growing body of evidence on the NHIS social health insurance programme which suggests that significant progress has been made in terms of providing greater health care coverage; almost 50% now have social health insurance. It is clear, however, that the exemption policy for indigents is inadequate to provide access for those living below the extreme poverty line (approx 18%), let alone the poverty line (approx 30%). The recent decisions to de-link all children (under 18 years) from their parents, as well as to provide exemptions for pregnant and postpartum mothers, represent a very significant step towards ensuring that vulnerable groups are not excluded.	There appears to be widespread awareness about the NHIS. However, our fieldwork suggested that there was some level of uncertainty about exemptions for children. To maximise healthcare access it will be crucial that awareness campaigns are carried out to inform the population about the recent decisions to de-link all children from their parents' registration and to provide free maternal and postpartum care. Campaigns should involve not only the media, but also village and traditional authorities.	The NHIS policy framework is clear and has addressed issues of sustainability by ensuring that the contribution from the formal pension system, SSNIT, is enshrined in legislation. The framework does not, however, have a pro-poor approach. This is illustrated by both the very strict criteria that must be met to apply for 'indigent status' and the very small percentage of people who have met the criteria to date. In order to ensure broader pro-poor coverage, it will be important to promote creative synergies between the NHIS scheme and other social protection instruments, such as the LEAP cash transfer programme. Given the relational nature of childhood poverty, ensuring that caregivers and families have access to health insurance is critically important.	The implementation of the NHIS has been relatively effective, especially given its short history. This is due to high-level political commitment as well as attention to ongoing M&E. There are, however, major concerns about service quality and the impact that this has on demand for health insurance, especially among lower wealth quintile populations. There are fears that the health sector wage bill already risks becoming unsustainable; this is compounded by recent salary reforms. Focus needs to be on institutional and individual capacity strengthening to promote more efficient and responsive service delivery.	Ghana's rates of child and maternal mortality remain very high. It is clear that in addition to the new health insurance exemptions, concerted efforts are needed to address child and maternal health policy quality so that families will be motivated to make use of health services. Such reform efforts need to be led by Ministry of Health, in coordination with MMYE and MOWAC, and to focus on non-monetary barriers to health service usage. These reforms may include tackling distance and transport constraints to health facilities through greater support for community health clinics, mobile clinics or transport subsidies; awareness-raising efforts to address nutritional taboos during pregnancy; promoting deliveries supported by trained birth attendants; and increasing gender sensitivity among health service professionals in order to raise the quality of care and thus demand. In the case of child mortality, programmes to improve maternal nutrition and low birth weight issues need to be strengthened. Other measures include increasing the number of trained birth professionals in poor rural communities and ensuring access to safe water sources and sanitation. Women's time poverty, which often hinders breastfeeding, could be addressed through other social protection (e.g. cash or food transfers) means.	The successful rollout of the NHIS in a short period of time highlights that if political will exists then major change is feasible. The Ministry of Health needs to foster similarly high levels of commitment in order to ensure that the access that social insurance coverage affords is matched by efforts to tackle non-monetary barriers to healthcare access. In particular, there needs to be a commitment to strengthening the quality of interlinked child and maternal services. Through regular monitoring and policy advocacy, the sectoral working group on health and CSOs need to hold the government accountable to its commitments to MDGs 4 (reducing child mortality by two-thirds) and 5 (reducing maternal mortality by three-quarters).

Policy implications	Knowledge base	Awareness	Policy framework	Implementation	Institutional responsibility and capacity	Opportunities for engagement and strategic partnerships
Ensuring social protection systems are informed by an understanding of and respond to child-specific social risks	The knowledge base on children's risk and vulnerability to abuse, neglect and violence is still quite limited in Ghana. There has, for example, only been one general survey on child labour, though there has more recently been detailed analytical work on specific sectors. This makes it difficult to track and assess changes over time. Similarly, data on child marriage and birth registration is only cross-sectional at this stage; it was first collected in the 2006 MICS. Data on the prevalence of child neglect, violence and exploitation are also limited; they are largely to restricted case work data from the DSW and small-scale qualitative studies.	The extent to which child-specific social risks (an absence of protection from neglect and abuse) are conceptualised as part of a larger social protection system is limited, with the exception of some staff in DSW. In order to promote an understanding of child-sensitive social protection as a policy approach which aims to tackle social, lifecycle, and economic vulnerabilities, awareness raising and sensitisation efforts are essential. They should target the line ministries involved in the implementation of social protection programmes at both the national and sub-national levels. Capacity-building work with journalists could also usefully include this dimension.	Ghana has a strong body of legislation and policy frameworks addressing child protection issues. This provides an excellent foundation for promoting social protection as a policy approach which addresses children's social, lifecycle and economic vulnerabilities. Furthermore, the NSPS includes OVC as a target beneficiary group (especially children affected by HIV/AIDS and children with severe disabilities). However, while this strategy refers to creating linkages with broader child protection mechanisms, it provides very limited detail. Given that the NSPS is currently undergoing revisions in order to integrate GLSS5 data into the poverty and vulnerability projections, Ghana is provided with a good opportunity to both strengthen concrete linkages and raise awareness of child protection mechanisms. The LEAP cash transfer programme has as a condition the requirement that families not involve their children in labour or trafficking. However, as discussed above, this condition largely involves raising awareness rather than robust monitoring.	There have been a number of small-scale pilots which seek to link social protection instruments focused on economic risks with children's lifecycle and social risks. These include both the ILO-supported child labour prevention and rehabilitation pilot and the UNICEF-supported DSW transfer programme for OVC. Evaluation findings need to be widely shared in order to promote learning and to inform the design of the LEAP rollout.	Ensuring that social protection mechanisms deliver an integrated approach to addressing children's economic and social vulnerabilities is the responsibility of both the MMYE and MOWAC. Given the current lack of clarity about precise mandates, roles and responsibilities, it is important to use the window of opportunity around the revision and launch of the NSPS to address these issues. It will also be vital to ensure that the MOWAC Department of Children is included in capacity-building initiatives related to social protection.	UNICEF is currently engaged, from the international level to the regional level, in both research and policy advocacy related to child-sensitive social protection. It is therefore critical that UNICEF plays a role in promoting knowledge sharing and learning in Ghana. It is also important that line ministries with child-related responsibilities play an active role in the social protection sectoral working group. This will ensure that a child-sensitive perspective is integrated into all high-level social protection policy discussions. Hosting a national-level workshop to discuss experiences and good practices could promote important learning among civil society groups working on social or economic vulnerability issues. Such an event could also serve as a forum to discuss options for knowledge management and lesson sharing on a more regular basis (whether virtually or through face-to-face events).

Policy implications	Knowledge base	Awareness	Policy framework	Implementation	Institutional responsibility and capacity	Opportunities for engagement and strategic partnerships
Maximising existing fiscal space opportunities for child-sensitive social protection	Existing evidence suggests that the funding arrangements for current social protection programmes are sustainable (esp. the NHIS and LEAP at its currently proposed scale). Our simulation also suggested that, in light of both the country's relatively robust current fiscal situation and its future prospects, there would be scope to expand child-sensitive social protection to include a child grant for all children living beneath the poverty line (at 1.65% of GDP).	There appears to be limited awareness about the affordability of a child grant targeted at children in households below the poverty line (based on media coverage and key informant interviews related to the LEAP programme). Scaling up the sensitisation road show that was initiated in 2007 (to promote buy-in to LEAP as well as the broader NSPS) is therefore important.	The LEAP policy document provides a breakdown of costs for three scale-up options; and identifies scope within the existing budget to cover all these options. However, to date the government has opted for the least ambitious scale-out option, which covers only one-sixth of the extreme poor. This leaves many poor children without access to the programme. Our analysis of the simulated costs of a targeted child grant covering all children in households living below the poverty line, however, suggests that such a programme would be affordable and effective.	Maximising fiscal space opportunities necessitates not only advocating for increased budget allocations but also addressing expenditure allocation and usage inefficiencies. Civil service reform, especially in the education and health sectors (owing to a high wage bill), has been identified as a major priority. Any effort to advocate for greater investment in child-sensitive social protection should therefore be framed in accordance with these broader fiscal debates. Given the commitment to poverty reduction and human capital development in the GPRSII, there is scope for the introduction of a targeted grant to all poor children. However, advocating for a universal child grant, which would reach four children in non-poor households for every one child in a poor household, appears less politically and fiscally feasible.	MMYE and MOWAC are responsible for both social protection and children's wellbeing. It is therefore crucial that their capacities in terms of programme and budget planning and execution are strengthened. This will not only allow them to better maximise their limited available resources, through more efficient allocation and expenditure decisions, but also enable them to present a more effective case to MOFEP during budget negotiation processes. MMYE in particular will need to work with the other line ministries involved in the social protection coordination group to ensure that all ministries commit specific budget allocations for social protection programmes.	Ghana has signed the UNCRC; this commits it as a nation to the principle of progressive realisation of children's rights in line with its resource base. As Ghana continues to grow, and its poverty reduction efforts progress, it is important that CSOs hold the government accountable for allocating comparable resource increases to child-sensitive social protection. Such programmes are vital as a means to address children's rights to survival, development and protection. Supporting child budget monitoring and analysis initiatives should therefore be prioritised; findings should feed into sectoral working group and other high-level dialogue forums. They should also be reported in Ghana's submissions to the UN Committee on the Rights of the Child (both government and NGO reports). Donors, as part of their UNCRC obligations, could provide support (financial and technical) to such monitoring initiatives.

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