



Social protection in Nigeria

Mapping programmes and their effectiveness

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Abbreviations

ADSUBEB	Adamawa SUBEB
AEO	African Economic Outlook
AfDB	African Development Bank
ARFH	Association of Reproductive and Family Health
AGSP	Ambassador's Girls' Scholarship Program
AOON	Association of OVC of Nigeria
ASHWAN	Association of Women Living with HIV and AIDS in Nigeria
AU	African Union
BIG	Basic Income Guarantee
CBHIS	Community-based Health Insurance Scheme
CBN	Central Bank of Nigeria
CCT	Conditional Cash Transfer
CDA Stars	Child Development Account: Savings, Training and Rewarding Savers
CDC	Centers for Disease Control and Prevention
CDC	Community Development Committee
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGS	Conditional Grants Scheme
COPE	In Care of the Poor
CPRC	Chronic Poverty Research Centre
CRC	Convention on the Rights of the Child
CRR	Center for Reproductive Rights
CSO	Civil Society Organisation
CWAE	Centre for Women and Adolescent Empowerment
DFID	UK Department for International Development
DHS	Demographic Health Survey
ESSPIN	Education Sector Support Programme in Nigeria
EU	European Union
FCT	Federal Capital Territory
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FHI-GHAIN	Family Health International Global HIV/AIDS Initiative Nigeria
FMOH	Federal Ministry of Health
FMWA&SD	Federal Ministry of Women Affairs and Social Development
FSW	Female Sex Worker
GDP	Gross Domestic Product
ICAP	International Centre for AIDS Care and Treatment Programs
ILO	International Labour Organization
IMF	International Monetary Fund
KII	Key Informant Interview
LCDA	Local Council Development Area
LEEDS	Local Economic Empowerment Strategy
LGA	Local Government Area
M&E	Monitoring and Evaluation
MARP	Most-at-risk Population
MCH	Maternal and Child Health Care Programme
MDAs	Ministries, Departments and Agencies
MDG	Millennium Development Goal
MDGs-DRG	MDG Debt Relief Gains Fund
MSM	Men Who Have Sex with Men
MSS	Midwife Service Scheme
NAPEC	National Poverty Eradication Council
NAPEP	National Programme for Poverty Eradication
NAPTIP	National Agency for the Prohibition of Trafficking in Persons
NBS	National Bureau of Statistics
NDE	National Directorate of Employment
NEEDS	National Economic Empowerment Strategy
NGO	Non-governmental Organisation
NHIS	National Health Insurance Scheme
NLSS	Nigeria Living Standards Survey
Norad	Norwegian Agency for Development Cooperation

NPC	National Planning Commission
NPHCDA	National Primary Health Care Development Agency
NSPC	National Social Protection Commission
NSITF	Nigeria Social Insurance Trust Fund
NWCSS	National Working Committee on Social Security
ODA	Official Development Assistance
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
OSA	Office of the Special Advisor
OSSAP-MDGs	Office of the Senior Special Assistant to the President on the MDGs
OVC	Orphans and Vulnerable Children
PATHS	Partnership for Transforming Health Systems
PHC	Primary Health Care
PPP	Purchasing Power Parity
PRAI	Poverty Reduction Accelerator Investment
PRB	Population Reference Bureau
RIDA	Rural Infrastructure and Development Association
SAVI	State Accountability and Voice Initiative
SEEDS	State Economic Empowerment Strategy
SIGI	Social Institutions and Gender Index
SMEDAN	Small and Medium Scale Enterprise Development Agency
SMOH	State Ministry of Health
SPAG	Social Protection Advisory Group
SUBEB	State Universal Basic Education Board
Triple F	Food, Fuel, Financial
UBE	Universal Basic Education
UK	United Kingdom
UN	United Nations
UNAIDS	Joint UN Programme on HIV/AIDS
UNDP	UN Development Programme
UNFPA	UN Population Fund
UNGASS	UN General Assembly Special Session
UN-HABITAT	UN Human Settlements Programme
UNICEF	UN Children's Fund
US	United States
USAID	US Agency for International Development
VPF	Virtual Poverty Fund
VVF	Vesicovaginal Fistula
WAPA	Ministry of Women Affairs and Poverty Alleviation
WARDC	Women Advocates Research and Documentation Centre
WHO	World Health Organization

Executive summary

Nigeria has experienced strong economic growth over recent decades. However, at the same time, the country has seen extremely high and rapid increases in the poverty rate (doubling in a 20-year period and exacerbated by the recent food, fuel and financial (Triple F) crisis), high inequality and a concurrent threat of instability. These challenges are of significant concern for the country's development.

Social protection is increasingly being seen by the international community, regional bodies (e.g. the African Union (AU)) and national governments as a policy tool to address such development challenges. Recent regional and global imperatives to invest in social protection argue that social protection policy and programming can support a more equitable pro-poor growth model (especially, as in Nigeria, where strong growth economic is not benefiting the poor) by supporting both economic and social development.

This report examines the current status of social protection policy and programming in Nigeria and finds that it is falling significantly short as a policy response to address the needs of the poor. It then makes a number of policy and programming recommendations for the government and development partners to strengthen the nascent agenda.

Mapping social protection policy, programming and actors

Expenditure on health, education and social welfare (e.g. child protection) by the government of Nigeria is low. In addition, within these sectors, as well as in the economic and agriculture sectors, a key criticism of the government has been its limited prioritisation of the poor. However, there has more recently been recognition that focusing on the supply of services has not been adequate in reaching the poor, and that there needs also to be a simultaneous focus on addressing the barriers that the poorest face in accessing services. This has resulted in financing from the Debt Relief Gains (DRG) Millennium Development Goals (MDGs) fund of three federal government-led social protection programmes. Current expenditure on the social protection sector is very low, however, representing only 5% of the DRG-MDGs fund (excluding state contributions) and 1.4% of government expenditure.

Social protection policy has been discussed since 2004 at both national and also regional (AU) levels in Nigeria, but this has not resulted in policy traction beyond three small-scale federal government-led programmes, despite a chapter being committed to social protection in the implementation plan of Vision 20: 2020 (the national policy document). Documents on social protection take a lifecycle and gender approach to risk and vulnerability (recognising both economic and social risks, such as job discrimination and harmful traditional practices), and organise social protection around four main themes: social assistance, social insurance, child protection and the labour market. However, in practice, implementation is extremely narrow, *ad hoc* and most often state specific. There is currently no realistic social protection policy or strategy driving the social protection agenda in the country.

A mapping of the current social protection landscape in Nigeria finds that a number of actors are involved in funding and implementation, including government, donors, international non-governmental organisations (NGOs) and civil society. The three federal government programmes are the conditional cash transfer (CCT) In Care of the Poor (COPE), a Maternal and Child Health (MCH) health fee waiver for pregnant women and children under five and the Community-based Health Insurance Scheme (CBHIS) (being re-launched this year after problems with programme design). Other social assistance programmes are implemented in an *ad hoc* manner, by government ministries, departments and agencies (MDAs) at state level. These include child savings accounts, disability grants, health waivers, education support and nutrition support. Programmes led by donors include a CCT for girls' education in three states. Some programmes on HIV and AIDS and orphans and vulnerable children (OVC) include social protection subcomponents, such as nutrition, health and education support. Labour market programmes include youth skills and employment programmes and there are also state

agricultural subsidies/inputs – but these are not necessarily targeted at the poor, and are often implemented at the discretion of the state rather than as part of a coordinated response.

Social equity legislation passed – which can be seen as part of the transformative social protection agenda – includes the Civil and Political Rights Covenant, the Economic, Social and Cultural Rights Covenant, the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child (CRC). Only the CRC has been domesticated, and this not by all states. Implementation is weak at best. There is limited, if any, conceptual link between the broader regulatory policies of equality and rights and social protection policies.

The multiplicity of actors at federal, state, local, donor and NGO levels means that social protection programming is currently *ad hoc* and uncoordinated. The National Planning Commission (NPC) is responsible for coordinating the sector, but weak institutional capacity, high staff turnover and limited coordination structures are key challenges. The sustainability of the social protection agenda post-DRG-MDGs funding is of critical concern. There is currently no clear institutional leader with the required political authority to coordinate between MDAs as well as to foster political and financial commitment to social protection.

Social protection programme performance

In a context of high levels of poverty and inequality, Nigeria's existing social protection approach faces a number of significant challenges. The key challenges include low coverage of existing programmes which only reach a fraction of the poor, the implementation of only a narrow set of social protection instruments, and the fragmentation of approaches and projects across the country. States have been given the responsibility for expanding interventions through the Conditional Grants Scheme (CGS), which requires them to match federal expenditure. Given that state budgets are contracting, only a third of all states have committed to co-funding the COPE programme, and coverage is estimated at less than 0.001% of the poor. Low coverage of existing programmes, coupled with low transfer values (exacerbated by the recent Triple F crisis) and short programme participation (COPE beneficiaries receive support for one year only), restricts the potential effectiveness of social protection to address poverty and vulnerability.

In addition, limited discussion of the appropriateness of different types of social protection programmes has resulted in programmes addressing only a narrow set of risks and target groups. In the case of COPE, while the objectives are multiple (health, education, investment), the programme's design is not necessarily well suited to the needs of households (especially if they are labour constrained as a result of HIV or because they are single headed). Moreover, despite some programmes incorporating a gender- and child-sensitive focus in their conceptual design, a concerted approach to addressing equity is missing.

Social protection actors and programmes also remain fragmented and *ad hoc* – government, development partners and NGOs all contribute to the uncoordinated and projectised nature of social protection across the country. Moreover, concerns over service delivery and availability of other infrastructure (e.g. financial infrastructure, banking for the poor) have been raised and identified as another key challenge in taking social protection to scale throughout Nigeria's states. Overall, achieving this objective would require addressing institutional, governance and financing constraints to delivering programmes and promoting coordination and efficiency among a variety of actors.

Policy implications

The report discusses a number of policy implications for the government and development partners, which focus on the following areas:

- Developing an overarching social protection policy framework to provide clear institutional roles and responsibility and guide social protection design and implementation at the federal and state level;
- Supporting and generating political commitment to social protection at the federal and state level;

- Allocating resources to scale up social protection programmes;
- Increasing investment in service delivery;
- Integrating an equity focus into the design and implementation of programmes;
- Strengthening governance features of social protection programmes.

1 Introduction

Despite strong economic growth in Nigeria, 54% of the population remains living in poverty. Of significant concern is the fact that, despite recent forecasts that poverty may be reducing slightly, the poverty rate has doubled in the past 20 years. Nigeria is also highly unequal: the Gini coefficient was 43.8 as of 2005 (Ortiz and Cummins, 2011). Approximately 20% of the population owns 65% of the national wealth (UNDP, 2009).

Income inequality is just one dimension of poverty in Nigeria. Poverty and vulnerability are also highly influenced by social and other factors, including geography, ethnicity, age and gender. For instance, a low gender equality ranking reflects the inequalities in human capital, political representation and economic participation between women and men. Meanwhile, with over 60% of the population below 18, children are represented disproportionately in poor households. Nigeria's under-five mortality and maternal mortality rates for the poorest are among the highest in the world, and poverty and deprivation exacerbate child protection issues, including trafficking, prostitution and abuse.

Patterns of poverty vary by geographic location and are also influenced by socio-cultural and religious norms and prevalence of conflict and instability, as much as by economic environment. High prevalence rates of HIV and AIDS are a key concern, especially for particularly vulnerable groups. High rates of unemployment and limited availability of livelihood opportunities in rural and urban areas also continue to restrict the economic opportunities available to men and women, and youth, preventing a route out of poverty.

In recent years, the government of Nigeria and its development partners have sought to develop social protection instruments as a mechanism to tackle high rates of poverty and vulnerability in the country and to support progress in both the economic and the social spheres. As such, social protection is emerging as a policy objective.

This report is part of a project that aims to support the government of Nigeria in realising its overarching development strategy (Vision 20: 2020) and in developing a national social protection strategy. The project aims to address gaps identified in national policy in terms of social assistance provision for orphans and vulnerable children (OVC) and children under the age of five, as well as for the disabled, the elderly and those without access to social protection support. Through five thematic reports (this one on social protection mapping and effectiveness, and reports on cash transfers, HIV and AIDS, child protection and fiscal space), it aims to provide policy-oriented research-based evidence to inform an implementation plan for these national strategies mentioned above.

This report focuses on mapping existing social protection programmes and analysing their effectiveness in addressing poverty and inequality. It is organised as follows. The following section outlines the methodological approach. Section 3 presents the social protection conceptual framework which guided the research project. Section 4 discusses the poverty, vulnerability and inequality profile of Nigeria. Section 5 examines existing social protection policy and programming in the country. Section 6 discusses the impacts of programmes where data permit, and the gaps and challenges related to the effectiveness of social protection programmes and policies. Section 7 concludes and offers policy implications to the government of Nigeria and its development partners to strengthen social protection in the future.

2 Methodology

This report draws on both primary and secondary research carried out between January and June 2011. A comprehensive review of the literature on social protection in Nigeria was carried out, including an analysis of policy and strategy documents, social protection programme documents, impact evaluations and other grey literature, covering the period from approximately 2004-2011.

Key informant interviews (KIIs) were undertaken with stakeholders at the national and state levels (including relevant government, donor, international and national non-governmental organisation (NGO), civil society and academic actors) (see Appendix 1). Focus group discussions (FGDs) were carried out at selected sites at the state level with adult and adolescent beneficiaries of the In Care of the Poor (COPE) programme (see Table 1 for site selection rationale and Appendix 2 for COPE research questions). We also draw on findings from the Triple F (food, fuel and financial) crisis study being carried out by the Overseas Development Institute (ODI) and the UN Children’s Fund (UNICEF).

The case studies were carried out in four states – Adamawa, Benue, Edo and Lagos – chosen based on previous and current implementation of COPE; prevalence of HIV and AIDS (at least two were to be in high prevalence states) and specific child protection vulnerabilities;¹ general state poverty profile and susceptibility to shocks and stresses; and geographical spread across the northern and southern regions (two in the north and two in the south), to maximise synergies with the ODI/UNICEF Impacts of the Triple F Crisis project (see Table 1).

Table 1: Site selection

State	General poverty profile	COPE implementation
Adamawa	Adamawa, North East, was selected for its high poverty rate	Matched funding for Phase 3
Benue	Benue, North Central, was selected for its high levels of social vulnerability, its position as the nation’s food basket and its declining trade opportunities	Not matched funding
Edo	Edo, South South, was selected to represent the landlocked centre of Nigeria; although income poverty rates are reportedly not as high as in other states, social vulnerabilities such as child trafficking and labour are significant	Not matched funding
Lagos	Lagos, South West, was selected because of its position as the economic centre of Nigeria and its urban density	Matched funding for Phase 3

At the state level, a wide range of government, NGO and civil society stakeholders working on HIV, child protection and social protection were invited to an initial stakeholder meeting.² The aim of the meeting was to i) explore the range of programmes being implemented at the state level and ii) guide the choice of programmes to be explored in more depth and choose the areas/communities in which the case studies would take place.

As such, the workshop aimed to generate information on:

- The kind of social protection programmes government and CSOs currently work on;
- The beneficiaries and the level of reach of these programmes;

¹ Case studies for the child protection and HIV reports were carried out in the same states.

² Courtesy calls were paid to permanent secretaries of government ministries and agencies and NGOs and other relevant organisations. Formal invitation letters and reminders were dispatched and confirmation visits were carried out to ensure participation.

- The impact these programmes have had so far; and
- The major challenges faced in implementation.

Despite attempts to provide a comprehensive mapping of programmes and their impacts, a number of limitations were encountered, in terms of the availability of secondary data and impact evaluations, and with regard to limited participation at the workshop, which restricted the ability to ensure the representation of all programme activities in each state. We sought to overcome this by following up with individual meetings but, overall, we recognise that gaps do remain in this overall mapping.

3 Conceptual framework

Social protection is most commonly conceptualised as a set of interventions which aim to address poverty, vulnerability and risk. Such interventions may be carried out by the state, by non-governmental actors or the private sector, or through informal individual or community initiatives.

In this report, we take as our starting point the need to apply both an economic and a social analysis lens to poverty and vulnerability in order to support the development of appropriate social protection policies and programmes in Nigeria. We draw on Devereux and Sabates-Wheeler's (2004) transformative social protection framework, which takes into consideration both economic and social sources of risk and is based on a framework whereby social protection promotes social equity as well as economic growth.

3.1 A gender and lifecycle approach to poverty, vulnerability and inequality

It is increasingly recognised that poverty and vulnerability are multidimensional, and that vulnerability to risk includes not only economic and environmental dimensions, but also social and lifecycle features. Of the five poverty traps identified by the 2008-9 Chronic Poverty Report, four were non-income measures: insecurity (ranging from insecure environments to conflict and violence); limited citizenship (lack of a meaningful political voice); spatial disadvantage (exclusion from politics, markets, resources, etc., owing to geographical remoteness); and social discrimination (which traps people in exploitative relationships of power and patronage) (CPRC, 2008).

Distribution and intensity of poverty, risk and vulnerability are likely to be experienced differently at the community, household and individual level depending on a number of factors, including stage in the life-course (infant, child, youth, adult, aged), social group positioning (gender, ethnicity, class) and geographic location (e.g. urban/rural), among other factors. For children in particular, the experience of risk, vulnerability and deprivation is shaped by four broad characteristics of childhood poverty and vulnerability (Jones and Sumner, 2007):

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

Gender inequality also cuts across both economic and social dimensions of poverty, vulnerability and inequality (Holmes and Jones, 2010a). The differential distribution of resources (financial, social, human and physical capital) between men and women, as well as differential social roles and responsibilities, means the options available to men and women to respond to macro- and micro-level shocks and stresses as well as to long-term chronic poverty are likely to vary (*ibid.*). Household members' vulnerability is also likely to vary, according to household composition (e.g. dependency ratio, sex of household head, number of boys and girls); individual/household ownership and control of assets (land, labour, financial capital, livestock, time); access to labour markets, social networks and social capital; and levels of education.

3.2 Social protection framework

The term 'social protection' has evolved differently in different socioeconomic and political contexts. In high- and middle-income countries, many interventions are embedded in broader social policy frameworks. Interventions are increasingly being adopted in low-income countries too, as social protection is seen as an effective mechanism to support poverty reduction as well as to protect the poor/near poor from falling into, or further into, poverty.

A common definition of social protection is one which includes all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalised. The overall objective is to reduce the economic and social vulnerability of poor, vulnerable and marginalised groups and, in particular, to support the poor to overcome the demand-side barriers which prevent them from accessing basic economic and social services. Such interventions may be carried out by the state, non-governmental actors or the private sector, or through informal individual or community initiatives.

As such, social protection interventions often aim to tackle extreme poverty; given the depth and breadth of poverty and inequality in a country like Nigeria, it is increasingly important that approaches adequately address the multidimensionality of poverty at the intra-household, household and community level, as described above.

For this report, Devereux and Sabates-Wheeler's (2004) transformative social protection framework offers the most relevant conceptual approach, as its analytical view goes beyond safety nets and encompasses the following four social protection measures:

- *Protective* (protecting households' income and consumption, which includes social assistance programmes such as cash transfers, in-kind transfers, fee waivers to support access to basic and social services);
- *Preventative* (preventing households from falling into or further into poverty, including, for instance, health insurance programmes, subsidised risk pooling mechanisms);
- *Promotive* (promoting household's ability to engage in productive activities and increase incomes, for example through public works employment schemes, agricultural inputs transfers or subsidies); and
- *Transformative* (addressing social inequalities and discrimination, which includes, for example, core social protection programmes which tackle gender inequality and promote child rights and linkages to awareness-raising programmes or tackling discrimination) (see Table 2).

The transformative perspective is particularly useful in understanding and addressing societal power imbalances that encourage, create and sustain poverty and inequality – extending social protection to arenas such as equity, empowerment and economic, social and cultural rights (Devereux and Sabates-Wheeler, 2004; Holmes and Jones, 2010a; UNICEF, 2010). Taking this approach also allows for a better conceptual understanding of the dimensions of poverty and vulnerability and of the fact that the distribution of resources is influenced by factors at the community, household and intra-household level.

Taking a transformative approach may be reflected in the core design of social protection interventions and/or in linkages with complementary programmes and services. Indeed, maximising the effectiveness of social protection requires complementary measures, which may not be considered a core component of social protection, but are necessary to ensure an effective enabling environment to achieve social protection objectives. These include complementary services (basic social services such as quality health, education and social welfare services, as well as economic services including infrastructure, functioning markets and opportunities for financial inclusion such as microcredit and microfinance) as well transformative programmes (such as sensitisation and awareness-raising campaigns to

transform public attitudes and behaviour along with efforts to change the regulatory framework to protect marginalised groups from discrimination and abuse) (see Table 3).

Table 2: Transformative social protection approach

Type	Poverty-focused social protection intervention	Types of instrument
Protective	Social assistance	Cash transfers, food transfers, fee waivers for social services, school subsidies, school feeding
Preventive	Social insurance	Health insurance, premium waivers, subsidised risk-pooling mechanisms
Promotive	Productive transfers, subsidies and work	Agricultural inputs transfers, fertiliser subsidies, asset transfers, public works programmes
Transformative	Social equity measures	Equal rights/social justice legislation, affirmative action policies, asset protection

Source: Adapted from Devereux and Sabates-Wheeler (2004).

Table 3: Complementary measures and programmes

Complementary pro-poor measures	
Complementary social services	Health, education, social welfare, child protection
Complementary economic services	Financial inclusion, agricultural extension, infrastructure, markets, microcredit, microfinance

A child-sensitive approach to social protection (see Box 1) can include social protection measures which benefit children without explicitly targeting them (e.g. pensions, household grants, public works programmes), or those which benefit children directly (e.g. child grants or targeted fee waivers). Making social protection more child sensitive has the potential to benefit not only children but also their family and community and national development as a whole.

Marcus and Perezniето (2011) emphasise an important conceptual clarification between child protection and social protection. UNICEF defines child protection as 'preventing and responding to violence, exploitation and abuse and unnecessary separation from family' (UNICEF, 2011). Social protection helps to build a protective environment for children by 'reducing the socio-economic barriers to child protection' (ibid.) through policies that contribute to economic security, ensure access to basic social services and contribute to preventing violence and exploitation.

Given that many ministries of social welfare play a coordinating role in social protection, there are opportunities for synergies between these and social protection programmes, including mechanisms for awareness raising and referral. As part of a stronger social protection system, there are opportunities and a number of possible entry points for strengthening linkages so as to address children's vulnerabilities in a more integrated way. Such opportunities include, for example, linking cash transfer beneficiaries to complementary supportive programmes, including preventative and responsive social welfare services (e.g. measures to tackle harmful forms of child labour or human trafficking), where necessary (Jones and Holmes, 2010a).

Box 1: Principles of child-sensitive social protection

- Avoid adverse impacts on children, and reduce or mitigate social and economic risks that directly affect children's lives.
- Intervene as early as possible where children are at risk, in order to prevent irreversible impairment or harm.
- Consider the age- and gender-specific risks and vulnerabilities of children throughout the lifecycle.
- Mitigate the effects of shocks, exclusion and poverty on families, recognising that families raising children need support to ensure equal opportunity
- Make special provision to reach children who are particularly vulnerable and excluded, including children without parental care, and those who are marginalised within their families or communities due to their gender, disability, ethnicity, HIV and AIDS or other factors.
- Consider the mechanisms and intra-household dynamics that may affect how children are reached, with particular attention paid to the balance of power between men and women within the household and broader community.
- Include the voices and opinions of children, their care givers and youth in the understanding and design of social protection systems and programmes

Source: DFID et al. (2009).

4 Poverty and inequality in Nigeria

Nigeria is a middle-income country, with high dependence on oil revenues, although in recent years the non-oil economy – especially agriculture and services – has been growing (AfDB et al., 2009). Nigeria is socially and culturally diverse, with over 250 ethnic groups. Muslims and Christians take up around half of the population each.

Nigeria reinstated a democratic regime in 1999 after over 30 years of military rule. Government corruption remains a major challenge to development. Institutionally, Nigeria has a decentralised political system which consists of a three-tier government (federal, state and local), consisting of 36 state governments and 774 local government areas (LGAs). Sub-national governments have autonomy over economic development policy, budget regimes and expenditure patterns (Norad, 2010). States and Local Government Areas (LGAs) range considerably in size, population and resources, resulting in huge variation between states.

This section outlines the key poverty, vulnerability and inequality statistics in Nigeria, paying particular attention to income poverty, health and education, HIV and AIDS, gender inequality and child protection deprivations. It then discusses the impact of the Triple F crisis on the poor drawing on findings from Gavrilovic et al. (2011).

4.1 Poverty and inequality

Income poverty

The majority of the Nigerian population lives in poverty, despite the wealth in the country. Despite indications that poverty may be declining (AfDB et al., 2009; NPC, 2010), of significant concern is that, between 1980 and 2004, both rural and urban poverty more than doubled, from 28.3% to 63.3% in rural areas and from 17.2% to 43.2% in urban areas (UNDP, 2009). Nigeria's national poverty line states that 54% of the 140 million population lives in poverty (approximately 75 million people) (NPC, 2010), of whom 22% were defined as 'core poor' in 2004 (UNDP, 2009). This is a huge challenge in terms of development and poverty reduction.

High population growth and rural to urban migration mean Nigeria has become increasingly urban, with 47% of the population now living in towns and cities (PRB, 2010).³ While discussions of the experiences of the rural poor dominate the literature, given the depth and severity of poverty as well as its higher incidence in rural areas,⁴ several authors, including Osinubi (2003), argue that policymakers should be paying more attention to urban poverty, as the number of urban poor and the depth of poverty in urban areas are increasing.

Inequality in income and asset distribution, unequal access to basic infrastructure and services and social-cultural norms are key drivers of poverty, vulnerability and inequality in the country (see UNDP, 2009). Indeed, Nigeria has one of the most unequal societies in the world (AEO, 2010). According to the UN Development Programme (UNDP, 2009), inequality increased between 1985 and 2004 (from 0.43 to 0.49), although others suggest it has been decreasing (from 0.491 in 1990 to 0.438)⁵ (Ortiz and Cummins, 2011): overall, however, it remains high. When adjusted to reflect inequality, Nigeria's Human Development Index value drops significantly, from 0.423 to 0.246 (UNDP, 2010).

This is around the average in relation to the region (the sub-Saharan African average was 44.2 in 2008⁶) (ibid.); internationally, it is higher than in Ethiopia and India, but lower than in Brazil and Madagascar (AfDB et al., 2009). Meanwhile, figures mask a large disparity among states, with the belt of states across the middle of the country having the highest levels of inequality

³ In 2000, Nigeria had 438 cities with a population over 10,000 – the highest in West Africa (UN-HABITAT, 2010).

⁴ Nsikakabasi and Ukoha (2010); Ojowu et al. (2007); Okuneye (2004); Okunmadewa et al. (2005); Rural Poverty Portal (2010).

⁵ Where 0 represents complete equality and 1 represents complete inequality

⁶ Unweighted average values based on Solt (2009).

(ibid.). This is a factor of a rapidly increasing population and a growing poverty gap, whereby a greater proportion of Nigeria's wealth is concentrated in the hands of the wealthiest: approximately 20% of the population owns 65% of the national wealth (UNDP, 2009). The benefits of the wealth generated by oil production are not distributed among the Nigerian population (Okunmadewa et al., 2005), the poor rarely feel poverty reduction measures (ibid.) and the decentralised nature of the political system means state expenditure on pro-poor activities is most often subject to political will.

Despite the fact that Nigeria is a lower middle-income country and has experienced robust, high levels of economic growth since 2005 (growth rates remained strong over the economic crisis, in part because of the buffer provided by Nigeria's large level of international reserves as well as low debt (IMF, 2010)), the country remains highly reliant on oil revenues. For instance, according to a key informant from the International Monetary Fund (IMF), the agriculture sector accounts for 40% of the economy but does not drive growth,⁷ (KII with IMF), although the sector has grown over recent years⁸ (AfDB et al., 2009). Of the almost half of the population in this sector, 80% are subsistence farmers (ActionAid, 2010). Data from the 2003 Nigeria Living Standards Survey (NLSS) shows that, among all occupational groups, agriculture has the highest poverty incidence rate, at 62.7% (Ojowu et al., 2007). Stronger growth in this sector (and overall in the non-oil economy) may have contributed to falling poverty rates since 2003. Data from the 2009 NLSS have not yet been analysed (AfDB et al., 2009).

Limited growth and economic opportunities in agriculture sector are key challenges for poverty reduction,⁹ as is the high proportion of the population (at least 75%) working in the informal sector (NHIS, 2010) and the huge unemployment rate. The official unemployment rate as of February 2011, 19.7%, is likely to be hugely underestimated, according to a key informant from the Ministry of Labour and Productivity, and reports suggest an estimated 50 million youths are unemployed (Aigbokhan, 2008; World Bank, 2010). According to one source, Nigeria will need to create 15 million new jobs over the next 10 years just to keep employment at current levels; to halve unemployment, it will need to create 24 million new jobs, expanding the labour market by almost 50%; and to bring unemployment to 7% by 2030, the labour market needs to nearly double in size, with almost 50 million jobs created (Next Generation Nigeria, 2010). Unemployment is a concern not only in terms of rates of poverty and inequality, but also in relation to the country's security:

'large cohorts of unemployed or underemployed young people destabilise their societies, fuelling crime and creating conditions where civil conflict becomes more likely. Instead of collecting a dividend, a country that is not well prepared to make the most of its baby boom generation can find itself in the midst of a demographic disaster' (ibid.).

Education, health and nutrition

Poverty incidence is highly correlated with educational attainment in Nigeria. Households headed by individuals with little or no education experience the highest poverty incidence, depth and severity (Ojowu et al., 2004; OSSAP-MDGs, 2010). Nigeria has made improvements

⁷ With 5% projected growth for crop production.

⁸ The non-oil sector provides a livelihood for the majority of Nigerians. Driven by agriculture, manufacturing, minerals and telecommunications, it has grown at more than 8% per year, accelerating to over 9% in 2007-2008. Improved fiscal management has been responsible for most of the recent macroeconomic improvements (AfDB et al., 2009).

⁹ Despite a land mass of 923,768 km², a huge amount of forest (12.2%), arable (35.1%) and irrigated (0.7%) land (Oriola, 2009; Rural Poverty Portal 2010) and a wealth of natural resources, numerous factors restrict farmers to subsistence farming and limit the potential of the agriculture sector. These include a lack of rural infrastructure, including roads and markets; lack of access to new technology; limited land (ibid.; ActionAid, 2010; Ogunlela and Ogunbible, 2006; Rural Poverty Portal, 2010); environmental problems (associated with high export production (of oil and gas) and mining in the Niger Delta, which has been responsible for deforestation, desertification and flora and fauna depletion (UN, 2002)); high levels of disease; the successive military rule and agricultural and economic policies of governments prior to 1999 (AfDB et al., 2009; Ogunlela and Ogunbible, 2009); rapid population growth and over-population; and conflict and insecurity (economic development and poverty reduction in Nigeria is thwarted by ethnic and religious tensions and conflict, particularly in the Niger Delta, where environmental degradation and trade in stolen oil fuels violence (see AEO, 2010).

in net enrolment in primary school: 9 out of 10 eligible children are now in school as a result of Universal Basic Education (UBE) interventions and enrolment in private schools (NPC, 2010). However, this figure masks the fact that disadvantaged groups are still excluded and education quality remains poor: the country still has more than 7 million children out of primary school, of whom girls constitute about 62% (ibid.). It also masks attendance: the 2008 Demographic Health Survey (DHS) shows that net attendance at primary is 62.1% (NPC and ICF Macro, 2009). Approximately 15 million children under 14 are working to support their family and pay their school fees (UNICEF Nigeria, 2006).

A higher proportion of boys than of girls enrol in both primary and secondary school. Nigeria missed the 2005 target of gender parity in education, although enrolment of girls in school rose from 78% to 85% between 2000 and 2008 (NPC, 2010). The gross enrolment ratio has been consistently over 10% higher for boys than for girls. At secondary level, although enrolment of both boys and girls has risen, it has been higher for boys than girls. Dropout rates for girls tend to be significantly higher in schools that do not have separate toilet facilities for boys and girls (ibid.). Unsurprisingly, all this also means that literacy rates are higher for males than for females, at 82.5% and 64.3%, respectively, for 15-24 year olds. Meanwhile, although there has been an increase in young women's educational attainment since the 1990s (UNGASS, 2010), there is still a significant gender gap in certain regions. The North West and North East have the highest proportion of persons with no education – roughly 7 in 10 women and half of men – whereas the South South has the lowest percentage of those who have never been to school (15% among females and 8% among males) (NPC and ICF Macro, 2009).

As in the education sector, there have been improvements in health outcomes over the past few years, although there is still cause for significant concern. The under-five mortality rate has improved, from 201 deaths per 1,000 live births in 2003 to 157 in 2008 (NPC, 2004; 2009, in NPC, 2010). Similar improvements have been made on infant mortality,¹⁰ which reduced from 100 deaths per 1,000 live births in 2003 to 75 in 2008 (NPC, 2010). Nevertheless, Nigeria remains 18th out of 193 countries ranked in terms of under-five mortality rate and, despite being the wealthiest country in the West and Central Africa region, its under-five mortality rate is above the average (of 150) (UNICEF, 2011).

Rates differ substantially between rural and urban areas, geographic zones and wealth quintiles. For example, the under-five mortality rate is 121 deaths per 1,000 live births in urban areas, compared with 191 in rural areas (NPC and ICF Macro, 2009). It ranges from 89 in the South West to 222 in the North East (infant mortality is also lowest in the South West, at 59 deaths per 1,000 births, and highest in the North East, at 109 (ibid.)). Under-five mortality rates are lowest for children in households in the highest wealth quintile (87 deaths per 1,000 live births); the rate for the lowest wealth quintile is 219. Maternal mortality fell from 800 deaths per 100,000 births in 2003 to 545 in 2008 (NPC, 2010). This falls far short of the Millennium Development Goal (MDG) target of 136.

Malnutrition is also a serious risk among the poor. Despite the nutritional status of children remaining fairly constant between 2003 and 2005 (NPC and ICF Macro, 2009), stunting and wasting rates for children under five remain a key concern. Stunting¹¹ has long-term effects: 41% of children under five are stunted and 23% are severely stunted (ibid.) (the West and Central African average is 40% (UNICEF, 2011)). Rural children are more likely to be stunted (45%) than urban children (31%), and zonal variation in the nutritional status of children is substantial, with stunting highest in the North West (53%) and lowest in the South East (22%) (NPC and ICF Macro, 2009). Wasting¹² rates are also of concern, and higher than the West and Central African average of 10% (UNICEF, 2011): 14% of children under five are wasted. Children in the South East are the least likely (10%) to be underweight, whereas children in the North East and North West are the most likely (35% each) (NPC and ICF Macro, 2009).

¹⁰ Probability of dying before the first birthday.

¹¹ Height for age.

¹² Weight for age.

Health care expenditure in Nigeria is low in comparison with that in other countries. Per capita government expenditure on health care (purchasing power parity (PPP) international US\$) was \$50 in 2009 (WHO, UD), which equated to 5.8% of gross domestic product (GDP), up from 4.6% in 2000 (ibid.). This is less per person than spent by most other governments in Africa (Save the Children UK, 2008).

The World Health Organization (WHO, 2009) suggests the main challenges affecting delivery of health services in Nigeria are inadequate decentralisation of services (and the separation of responsibilities for provision of health care among the country's three tiers of government); dilapidated health infrastructure (buildings and equipment); and weak institutional capacity (no effective system for supervision of health services in the public and private sectors). Where there is service delivery, it is hugely over-subscribed. In 2003, there were 0.3 physicians per 1,000 people (Rural Poverty Portal, 2010), which means traditional medicine still plays an important role in meeting the health needs of the population (Antai, 2010).

With reference to maternal health, between 2000 and 2009 antenatal coverage of at least one visit was 58%; this fell to 45% for coverage of at least four visits (WHO UD). Only 38.9% of births in 2008 were attended by skilled personnel in 2008 (ibid.), and this was higher in urban (65%) than in rural (28%) areas (NPC and ICF Macro, 2009). There are huge variations in terms of wealth quintiles: 37% of the poorest quintiles have access to antenatal care, compared with 96% of the richest quintile; in the richest quintiles, 85% of births are attended by skilled personnel – this drops to 13% in the poorest quintiles; the poorest quintiles also have a higher fertility rate: 6.5 compared with 4.2 (World Bank, 2008).

A number of factors affect the demand side in terms of accessing health services. First, the introduction of fees has had a negative impact. One survey (Nanda, 2002, in Sharma et al., 2005) shows a 46% decline in the number of deliveries at the main hospital in the Zaria region as a result of the introduction of user fees. Second, low quality health care provision (lack of staff, basic equipment and medicines) also affects health-seeking behaviour: only 24% of people are satisfied with the quality of their health care (UNDP, 2009). Third, social and cultural norms as well as gender inequality play an important role. For instance, almost 75% of married women in the lowest wealth quintile do not make their own decisions with regard to their own health care, varying from around 80% in the North West (not disaggregated by wealth quintile) to around 30% in the South West (NPC and ICF Macro, 2009).

Finally, lack of information, fear of side-effects and mothers' educational attainment also affect health service utilisation – and influence the coverage of child immunisations. In 2008, while 23% of children aged 12-23 months received all basic immunisations (up from 13% in 2003), there was also an increase in the percentage of children not receiving any immunisations at all, from 27% to 29%. Coverage was found to be higher in urban areas of the south than in rural areas in the north; full immunisations are higher in the South East (42.9%) and lowest in the North West (6%) (NPC and ICF Macro, 2009). A total of 61% of children whose mothers achieved above secondary school level education are fully immunised, compared with 7% of those whose mothers received no education (ibid.). Meanwhile, according to Jones et al. (2008), for those not receiving any basic immunisations, there is a consistent bias towards boys in the poorest quintile, with a ratio of coverage between girls and boys of 1:2.

HIV and AIDS¹³

Although Nigeria's HIV prevalence appears to have stabilised in the past 10 years, the epidemic still remains a major public health challenge. The sheer size of the population means that Nigeria is second only to South Africa in terms of numbers of people affected by HIV and AIDS. Indeed, with an estimated 3.3 million people living with HIV, Nigeria bears nearly 10% of the global burden of HIV (UNAIDS, 2010). While the HIV and AIDS epidemic can be framed as a generalised epidemic, there are concentrated epidemics among high-risk groups or most-at-risk populations (MARPS). Vulnerable groups in Nigeria include youth (mainly young women), pregnant women, OVC and the elderly. Such groups are particularly vulnerable

¹³ This section draws on the HIV report for this project (Samuels et al., 2011).

because of socioeconomic, age and gender characteristics as well as their location. MARPs, who include female sex workers (FSWs) and men who have sex with men (MSM), are at a higher risk of HIV and other sexually transmitted diseases because of behaviours or occupations that place them at risk of unsafe sex; the above more demographic, locational and structural vulnerabilities are also likely to affect them.

There is significant variation in HIV prevalence rates among regions, states and localities. At the regional level, HIV prevalence ranges from 2% in the South West up to 7% in the South South (FMOH, 2010). Prevalence at state level ranges from 1% in Ekiti in the South West zone to 10.6% in Benue in the North Central zone (ibid.). However, the highest prevalence rate (22%) has been recorded in the LGA of Bwari in the Federal Capital Territory (FCT) (Rhodes and Simic, 2005). There are also marked differences among urban and rural areas. HIV prevalence is higher in urban (3.8%) than in rural (3.5%) areas (FMOH, 2009). However, access to antiretroviral therapy is significantly lower in rural areas of Nigeria, with 3% of rural health facilities providing services in comparison with 20% in urban areas. This gap in service provision is further widened by the fact that there are already fewer health facilities in rural areas, even though most Nigerians are living in rural locations (Amanyewe et al., 2008).

As a result of HIV and AIDS, households have reduced levels of income and declining agricultural production and family assets. Other impacts include increasing numbers of widows and orphans and increases in elderly- and child-headed households. High numbers of OVC have led to an increase in dependency ratios: 90% of poor households in Nigeria are composed of 20 or more individuals (UNDP, 2009). Another impact of HIV and AIDS, affecting women and OVC disproportionately, is disinheritance and the loss of property. Moreover, with an estimated 3.3 million people living with HIV in Nigeria, the number of individuals requiring health services is increasing, implying a significant rise in the patient-to-health centre and patient-to-health professional ratios, as well as an increased workload for health providers.

Gender inequality

According to UNDP (2009), Nigeria exhibits poor equality between men and women in terms of achieving basic capabilities as well as the extent to which women and men are able to participate actively in economic and political life and in decision making. These inequalities have significant regional variations, strongly influenced by cultural, religious and traditional norms. Higher inequality is present in the northern region, particularly the North West and North East.

Women lag behind on most socioeconomic development indicators (Ajani, 2008). They face consistent inequalities in terms of access to and control over land, credit facilities, technologies, education and health. Poverty therefore often affects women more intensely than men (Social Watch, 2005). In rural communities, female-headed households tend to be the poorest, given cultural norms which inhibit women from inheriting land – traditionally, on the death of her husband, a widow is dispossessed of all her husband's property (Rural Poverty Portal, 2010). Incidence of food insecurity is also higher for female- than for male-headed households – 49% compared with 38% – although women improve household food and nutrition security by spending more of their income on food (Ajani, 2008).

Despite women's significant role in the production, processing and marketing of food crops (Rural Poverty Portal, 2010), their potential is restricted by low ownership of land (38.1% of men compared with 7.2% of women) and credit (11.6% of men and 9.8% of women) (NBS, 2009). Men continue to control farm decisions and productive resources (Ajani, 2008). Similarly, microcredit opportunities are more available for men (79.2% compared with 29.8% for women) (NBS, 2009).

Women's labour market participation rate is 39.5% compared with 74.8% for men (UNDP, 2009). Employment in non-agriculture specifically stands at 67.5% of men compared with 32.5% of women (NBS, 2009). Again, there is significant state variation, with Akwa-Ibom and Ondo (South South and South West) the highest, at 59.5% and 56.5% of women, respectively, and Jigawa and Zamfara (North East and North West) the lowest, at 4.3% and

3.7%. Women also receive a smaller proportion of non-agricultural wages: 67.7% for males, 32.3% for females.

Social risks and vulnerabilities are also significant for women. According to the 2008 DHS, 28% of females questioned had experienced violence since the age of 15; this was higher in urban areas (30%) than in rural areas (26%). The indigenous practice of female genital mutilation/cutting (FGM/C), which carries significant physical and psychological health risks for women, is also widespread (Mbakogu, 2004; PRB, 2010). FGM/C is practised by approximately 33% of all households across ethnic and religious groups in all parts of the country, although there is a higher prevalence in the eastern and southern regions. FGM/C is most commonly performed on girls between the ages of 4 and 18, although ages vary. In 2008, 29.6% of women aged 15-49 had been exposed to FGM/C (PRB, 2010).

Although the government publicly denounces FGM/C, no legal action has been taken to eradicate the practice (Mbakogu, 2004). Indeed, although discrimination on the grounds of gender is prohibited in the Nigerian constitution, because Nigeria is a federal republic each state has the authority to draft its own legislation. The combination of federation and a tripartite system of civil, customary and religious law makes it very difficult to harmonise legislation and remove discriminatory measures. Based on its Social Institutions and Gender Index (SIGI) value of 0.21991, Nigeria ranks 86th out of 102 non-Organisation for Economic Co-operation and Development (OECD) countries.¹⁴

Child protection deprivations¹⁵

As the median age in Nigeria is only 17.1 years (UNDP, 2010), and over 17% of the population is under the age of six (NPC and ICF Macro, 2009), poverty has tremendous impacts on children's protection needs. It threatens the survival of many Nigerian children, reflected in high rates of child and infant mortality; high prevalence of malnutrition; and often limited educational opportunities. Nigerian children are highly vulnerable to income poverty but also to a wide variety of other economic and social factors. These include urbanisation and migration; health shocks; environmental degradation; domestic violence and family fragmentation; broader societal violence and conflict; social exclusion and discrimination; harmful traditional practices based on cultural values; and orphanhood and loss of family.

15 million children under the age of 14 are working across the country (UNICEF Nigeria, 2006). Working often long hours in semi-formal and informal businesses, they are frequently exposed to dangerous and unhealthy environments for little pay. Child labour interferes with children's schooling and their physical and psychosocial health, and feeds Nigeria's trafficking problems, as many child labourers are controlled by highly profitable syndicates.¹⁶ Early marriage is also prevalent in the country. A quarter of all girls are married as adolescents, with negative implications for their human capital development as well as their intra-household bargaining power and access to resources.¹⁷ Coupled with customary laws that fail to protect the rights of women and girls, and cultural practices such as fosterage, Nigeria's girls are particularly vulnerable to child protection deficits (ibid.). Accusations of child witchcraft are also common, and may result in abandonment and death (Cimpric, 2010).¹⁸

4.2 Impacts of the Triple F crisis on the poor

According to Gavrilovic et al. (2011), the recent Triple F crisis had a number of effects on the poor which have exacerbated existing patterns of poverty and vulnerability. These include reduced employment opportunities, decreases in the real value of wages, more people seeking informal work and a reduction in household income through the devaluation of the naira, in a

¹⁴ <http://my.genderindex.org/>.

¹⁵ This section draws on the child protection report for this project (Jones et al., 2011).

¹⁶ According to a key informant from the National Agency for the Prohibition of Trafficking in Persons (NAPTIP).

¹⁷ Aronowitz (2006); Dottridge (2002); NPC and ICF Macro (2009); Okojie (2003).

¹⁸ Witchcraft is deeply rooted in traditional belief in Nigeria, especially in the South South (Akpan and Oluwabamide, 2010). Suspected children can be beaten, ejected from their homes and left to fend for themselves.

context of increased food and fuel prices and inflation, limited job opportunities, reduced remittances and limited informal lending channels.

At the household level, these effects have resulted in a number of adverse effects on the poor, especially as formal support to help households cope has been limited. Food insecurity has increased as food price rises have resulted in growing food insecurity (particularly in urban areas), which has been linked to sustained declines in food production as well as reduced household budget allocations towards food. For some, food and fuel shocks have led to the modification of consumption, including the purchase of cheaper and less nutritious food staple substitutes, cutting back on meals and, in dire circumstances, scavenging and/or going hungry. The costs of staple food items have also increased as a result of fuel shocks, mainly via a rise in transport costs, with both net food consumers and producers negatively affected.

Effects on health and access to health care and education are also key concerns: while high costs and low utilisation of medical services predate the crisis, the crisis has exacerbated this. Diminishing household purchasing power has in some cases led to an inability to pay for increasing drug and treatment costs. Fuel shocks also play an important role in health care access, with transport costs deterring some women from even attempting to reach antenatal facilities. Women living with HIV and AIDS (and the children they support) are unable to pay for essential medication owing to lack of an adequate income. Health problems associated with malnutrition are also reportedly on the rise.

Likewise, in terms of education, rises in school dropouts and absenteeism are resulting from growing difficulties affording school costs and transportation fees, especially in rural areas. In many states, children are seen as an essential workforce, and the opportunity costs of education for poor families are high in this context of increasing financial hardship. In contrast, states more dependent on fuel-related consumption experience a less severe drop in school retention when domestic petrol prices increase, pointing to the ability of more affluent states to maintain their children's education in the face of fuel shocks.

Traditional views with regard to children's roles in assisting with family income, as well as expectations according to gender and age, also affect education. A strong gender bias has been evidenced across states, with girls often withdrawn from school to ensure boys' or younger siblings' education. Quantitative evidence suggests that being a girl increases the probability of early dropout.

At the intra-household level, the impacts of the crisis have implications for gender roles, women's rights and children's development in particular. Evidence shows that financial stress is reshaping gender and intra-household relations, with women (and often children) assuming increased responsibility for the household economy, with resultant challenges to traditionally patriarchal household decision making. Changes in the consumption of varied and necessary amounts of food are also disproportionately affecting children's nutritional and health status, and changes in the provision of health care and consumption capacity have particularly affected maternal and child health. As we have seen, the crisis has also compounded educational deprivations among girls and rural children especially, with evidence of school withdrawals and increased child work. The quality and availability of care for children have been diminishing.

At the community level, existing traditional forms of support have been eroding, with some community-based lending groups disbanding when members cannot afford to repay their debts. Even support from friends was perceived to be weakening in some states as a result of financial hardship.

5 Social protection policy and programmes in Nigeria: An overview

This section looks at the evolution of social protection policy in Nigeria over the past few years, then analyses current policy and maps out key programmes and the main actors involved in funding, designing and implementing these. It is important to note that this mapping may not capture small-scale state-level social protection programmes.

5.1 Social protection policy

Nigeria's social protection policy has, to a large extent, developed in parallel with broader economic and social sector policies and strategies. This has created a disjuncture between the wider development planning agenda and the role that social protection can play in supporting these broader pro-poor objectives. Indeed, the majority of current poverty eradication efforts (which have entailed limited policy and programming guidance/strategies from the federal level, according to a key informant from UNDP) have focused more on supply-side projects in education, health, infrastructure and microcredit for empowerment. While these are important strategies, there remains much more scope for policy to focus on the poor's inability to access these facilities (the demand side) through social protection interventions.

Evolution of social protection policy

'Social protection' in Nigeria used to refer to contributory social security benefits for formal sector/government workers before the turn of the century. While formal social security still accounts for approximately two-thirds of social protection expenditure (Hagen-Zanker and Tavakoli, 2012), with the return of democratic governance in Nigeria in 1999 and a reorientation of policy towards growth and development, the government has taken several steps to extend social protection measures beyond the formal sector to address poverty and vulnerability. Most significantly, in 2004, a draft Social Protection Strategy was developed by the Social Protection Advisory Group (SPAG), made up of representatives of the National Programme for Poverty Eradication (NAPEP), the National Social Protection Commission (NSPC) and the World Bank. The draft lays out the foundation for a lifecycle approach to social protection in Nigeria, discussing the key interventions in existence and a vision for social protection for the country. Its mission is as follows (SPAG, 2004):

'To liberate human potentials of Nigerians and promote equality of opportunity by helping households and communities sustain their livelihoods in the face of shocks and risks, by allowing for households to achieve basic education, health and nutrition, and, ensuring that all households have the wherewithal for basic human development thereby ensuring skilled and productive workforce and finally providing an environment in which individuals and households can adapt and change livelihood strategies without fears of calamity should such strategies fail'.

The strategy reviews existing social protection programmes and identifies the different types of risks and vulnerabilities the Nigerian poor face, using a lifecycle and gender lens. However, it has had limited policy traction and has failed to stimulate a more strategic and comprehensive approach to social protection: it has not evolved into a costed or implementable plan.

Box 2: Key features of the 2004 Social Protection Strategy

In the draft policy, priorities and interventions are grouped according to lifecycle stages.

- Priorities in the **0-5** age group include child health and early childhood education. Proposed interventions include nutrition supplementation, establishment of child care development centres, a national immunisation programme and civic registration.
- Priorities in the **6-14** age group include improving the quality of primary education, reducing late entry to school and grade repetition and addressing child labour, early marriages and vesicovaginal fistula (VVF) through scholarship/return to school incentives and school feeding programmes.
- Priorities in the **15-24** and **25-64** age group include increasing human capital, reducing health risks and addressing unemployment and underemployment, teenage pregnancy, early marriage, violence and substance abuse, etc. Proposed interventions include expanding school scholarship programmes and providing reproductive health education and counselling, interventions against drug abuse and violence, skills acquisition programmes, unemployment insurance, income support programmes, active labour market policies and public works programmes.
- Finally, the priority for the **65 and above** age group is to manage the risk of income loss and poor health, through interventions including income transfers and a non-contributory pension.

Source: SPAG (2004).

The draft Social Protection Strategy (which “came to a halt” – key informant interview with NSITF), was followed up by a National Study on Targeted Safety Net Interventions, which formed the basis of the MDGs-Debt Relief Gain (MDGs-DRG) fund’s Social Safety Nets Scheme, under the Office of the Senior Special Assistant to the President on the MDGs (OSSAP-MDGs). This recommended the NAPEP take the lead on cash transfers if the country was serious about meeting the poverty MDGs by 2015 (KII with NAPEP). In particular, conditional cash transfers (CCTs) came to be seen as an appropriate social protection instrument after the SPAG was influenced by the South American experience of these. Interventions intended as stepping stones to a more comprehensive policy were identified and resources were made available through the MDGs-DRG (OSSAP-MDGs, 2007).

At the same time, regionally, there has been a concerted effort in sub-Saharan Africa by governments and the international community to foster commitment to social protection within national poverty reduction agendas and to develop costed social transfer plans. This resulted in the African Union’s (AU’s) Conference of Ministers of Social Development adopting a Social Policy Framework in October 2008 that included a ‘minimum package’ of social protection measures, and AU Heads of State endorsing this in early 2009, noting that ‘social protection has multiple beneficial impacts on national economies, and is essential to build human capital, break the intergenerational cycle of poverty, and reduce the growing inequalities that constrain Africa’s social and economic development’ (Regional Experts Meeting on Social Protection, 2008). AU Member States will be called on to develop financial plans of action for the design and rollout of the minimum package; Nigeria has been a main player in the AU since 2006 but, like many other countries, has not yet done this.

More recently, in 2009, a national Social Protection Bill – the National Social Security Policy for Inclusiveness, Solidarity and Sustainable Peace and Prosperity – was drafted by the National Working Committee on Social Security (NWCSS), led by the Nigeria Social Insurance Trust Fund (NSITF), and submitted to the National Assembly (KII with OSSAP-MDG Office). This aims to integrate a formal social security framework with social protection mechanisms for informal sector workers and the poor. The goal will be to ‘promote and protect human dignity, in particular through measures that mitigate vulnerability to risks arising from poverty, unemployment, job loss, ill-health, loss of the breadwinner, old age or other disabilities’ (NWCSS, 2009). The overall objective is to make the ‘social security sector a net contributor to the growth of the national economy and human wellbeing, the strengthening of social cohesion and harmony and the enhancement of both political stability and national security’ (ibid.).

The draft policy states the need to critically examine the gaps that exist in social assistance for children under five years of age, OVC, physically and mentally challenged persons, the elderly with no employment history/pension and those who are unable to join a contributory social security scheme. However, it has not yet been passed as a bill, and key informant interviews suggest that it has very limited political support, largely because of concerns over the leading institution's role in taking it forward.

Despite the presence of two draft social protection strategies, then, there is as yet no comprehensive approach to social protection, despite safety nets having been identified as a 'policy thrust' in the two recent national development plans (the National Economic Empowerment Strategy (NEEDS) and Vision 20: 2020). In 2004, in response to widespread poverty and inequality, the administration of President Olusegun Obasanjo consolidated development efforts, bringing them under NEEDS 2003-2007,¹⁹ which was then translated into state and local government strategies (SEEDS and LEEDS, respectively). The NEEDS document had a section dedicated to safety nets (NPC, 2004). The interventions were quite broad and would not all necessarily be considered core social protection interventions (programme responses included agricultural extension services, incentives to use alternative energy sources and a children's parliament, for instance). Meanwhile, many of the core social protection interventions would likely exclude the poor, as they are based on contributions (unemployment insurance, health insurance, contributory pensions). Nevertheless, the vision for social protection was a step towards setting out ways to protect the poor and vulnerable against a number of important risks and vulnerabilities, including those related to natural, environmental, labour, social, gender, lifecycle, conflict and macroeconomic shocks and stresses. It also suggested targeted interventions for the rural and urban poor, such as improved agricultural inputs, public works programmes and scholarships. However, social protection was not well integrated into sectoral goals, with one reference to HIV: 'ensure that 5 percent of communities affected by HIV/AIDS will have programmes designed to provide social safety nets for people living with HIV/AIDS by 2005, and increase the proportion of communities with such programmes to 15 percent by 2007' (ibid.).

Social protection in current policy

As Vision 20: 2020 replaced NEEDS, the focus on safety nets and social protection for the poor was 'lost', according to a key informant from the World Bank. The overarching document has only one explicit reference to a specific social protection instrument – the National Health Insurance Scheme (NHIS) and the Community-based Health Insurance Scheme (CBHIS) – to provide free health services to vulnerable groups including women and children across the country. Reference to social protection is implicit at best. As the World Bank (2011, KII) notes, the diagnostics underpinning Vision 20: 2020 do not include a risk and vulnerability analysis, hence there is little appreciation of the 'poverty trap'; the variety of the sources of risk and their impact (as articulated in NEEDS, for instance) are largely underplayed, resulting in a limited 'social policy thrust'. Critically, the document prioritises the supply side, and assumes the population has the capability to access publicly provided services. This does not sit well with Nigeria's relatively high poverty incidence and inequality, which illustrates the importance of looking at the document and its implementation plan through a social protection lens (ibid).

However, the First National Implementation Plan (2010-2013) document, 'Volume II: Sectoral Plans and Programmes', dedicates a chapter to safety nets under human capital and social development, and identifies 'facilitating social security and safety nets' as a policy thrust (NPC, 2011). N186.1 billion has been proposed for social protection over the plan period. Safety nets are seen as part of efforts to reach the goal of economic growth: 'the Federal Government is aware that effective social protection policy environment is a political, economic and social imperative, for sustainable economic growth and development'. The vision is to,

'Institutionalize universal social protection for all Nigerians to motivate workers in the public and private sector to increase productivity and free them of domestic

¹⁹ The four priority areas of NEEDS included youth empowerment, rural infrastructure development, social welfare and natural resource development and conservation.

worries. The goal is to increase productivity and income, reduce poverty and vulnerability by diminishing people's exposure to risk and enhancing their capacity to protect themselves against hazards and loss of income'.

In particular, social protection will contribute to reaching the poverty reduction target from 65% to 50% by 2013.

The document draws heavily on the NEEDS conceptualisation of social protection programmes to address lifecycle risks, and aims to expand social protection by,

- Harmonising the provision of social protection measures in the country;
- Formulating a comprehensive social protection policy and strengthening the mechanism for coordination of social programmes;
- Diversifying social security measures to cover more people, those employed in the formal and informal sector as well as the unemployed; and
- Establishing a data management system for different categories of vulnerable group and workers in the formal and informal sector.

It also aims to diversify and provide comprehensive social protection for different categories of the population by,

- Sustaining and strengthening the NHIS to cover both private and public sector workers;
- Developing and implementing social transfer programmes for the elderly, persons with disabilities and the poorest quartile of the population;
- Supporting comprehensive community response programmes for vulnerable groups (OVC, widows, the elderly, ethnic minorities) in partnership with civil society;
- Providing entrepreneurial, employable and adolescent life skills to youth outside school, alongside start-up kits; and
- Providing social protection for abused and neglected children and babies who are in need of care and protection. To achieve this, a collaboration mechanism would be designed between government and civil society organisations (CSOs).

Despite the inherent linkages between social protection and other sectors, safety nets are discussed in only two other sector strategies. First, the NHIS is integrated in the health sector implementation plan (but there is no detail on the CBHIS); and secondly, under women's affairs and social development, there is a note to 'formulate policies and develop strategic frameworks for provision of appropriate social and economic safety nets to foster sustainable livelihood for women, children, elderly and other vulnerable groups'.

In sum, social protection as both a conceptual and a practical approach to addressing economic and social risks in Nigeria has made some progress at the policy level. However, it remains compartmentalised in the current national development strategy, Vision 20: 2020, with little evidence of policy traction among key policymakers to translate policy commitment into implementation. The 2004 Social Protection Strategy was a good starting point to build on for a future social protection strategy, but it has not enabled more than a programmatic focus on cash transfers, health insurance and health fee waivers. Meanwhile, despite its attempt at a multi-sectoral approach, the 2009 National Social Security Policy for Inclusiveness, Solidarity and Sustainable Peace and Prosperity has failed to garner broad political support, partly because NSITF is not seen as the most appropriate institute to lead on it. It is not clear whether the bill will be passed and, if it is, whether it will result in implementation.

This leaves a big gap at the federal level, and thus at the state level, where existing small-scale social protection programmes are left to be implemented in an *ad hoc* manner without any overarching strategic objective or long-term plan. A federal-level overarching strategic framework for social protection in Nigeria could lay out numerous options for social protection in the country, facilitate dialogue and knowledge exchange on the different types of interventions suitable in the context and promote inter-sectoral and federal-state coordination.

This could support policymakers at the state level to identify appropriate context-specific interventions based on critical assessment around the following key questions (the '6 As'):²⁰

- 1 Is it *appropriate* (is the instrument appropriate to achieve its goals and objectives of reducing poverty and vulnerability?)
- 2 Is it *achievable* (are there adequate resources, institutional capacity and services to ensure that this instrument will work?)
- 3 Is it *acceptable*? (is there popular and government support for this type of social protection instrument?)
- 4 Is it *affordable* (what are the implications of this instrument for cost and affordability?)
- 5 Is it *adequate* (e.g. the value of the transfer?)
- 6 Does it *add* value (does it complement other programmes, and are complementary programmes and services in place?)

5.2 Social protection programmes

Social protection programmes have existed in Nigeria since political independence, but have become more visible since the 1980s as a component of the government's development policy, following structural adjustment, prices subsidies and income allowances. They have focused primarily on contributory forms of social security allowances. The 2004 Social Protection Strategy aimed to map the status of social protection policy and programming at that time across the country. However, many of the policies and programmes discussed had not been fully implemented, or subsequently stopped. This section therefore aims to provide an up-to-date account of the main social protection programmes (government and non-government, federal and for selected states) currently being implemented in Nigeria. It is worth reiterating here that this project conducted a rapid diagnostic of the sector and, while all attempts have been made to generate a comprehensive account of current social protection programming, limitations in the data remain, especially at state level.

Currently, Nigeria has two types of social protection programming, split between the formal and the informal sectors. Provision is mostly to those in formal sector employment, both private and public, despite the fact that this covers only around 25% of the labour force (Alayande and Alayande, 2004). Programmes for formal sector employees do not reach the poor and are based on contributions. There are both public and private sector social security programmes. While these are not the focus of this report, the main initiatives are briefly discussed below.

The **NHIS** was established in 1999 and was officially launched in 2005, with three main social health insurance programmes: formal sector, urban self-employed and rural community. Since then, a further five programmes have been initiated: mothers and children under five years old, permanently disabled persons, prison inmates, those in tertiary institutions and those in the armed forces, police and other uniformed services. The formal sector programme is mandatory for all organisations with 10 or more employees and is based on a 10% employee and 5% employer contribution, which entitles the employee and four children to health care including family planning, immunisations, maternity care and outpatient care. In comparison, the urban self-employment and community programmes require membership of a user group of at least 500 participants, who pay a flat rate monthly contribution towards premiums (under 10%) with the funding shortfall made up by donor contributions (Kannegiesser, 2009).²¹

While poor data systems have hindered evaluation of the NHIS, it appears that, out of these three initiatives, the formal sector programme has been the only one that has taken off to any extent, and even this has been limited significantly with regard to coverage at state level. A total of 5.3 million beneficiaries (3.73% of the population) are said to have enrolled after five years of NHIS operation. These consist largely of formal public sector workers. A total of 95% of the federal government workforce and their families are now covered, but only two states –

²⁰ Developed by Rachel Slater of ODI.

²¹ See also www.nhis.gov.ng/.

Bauchi and Cross River – have fully endorsed the scheme for their government staff (only at state level, not LGA level).

The **National Pension Commission** currently implements the formal pension scheme (reformed in 2004), which covers central public service and is based on the Chilean social pension model (according to a key informant from NSITF). Out of the states, Lagos has joined, but other states still have their own pay-as-you-go schemes (ibid.). Coverage is low, at approximately 4-5% of the formal labour force.

The 2011 **Employers Compensation Bill** is run by NSITF and covers nine branches of social security, including accidents, occupational diseases and death at the workplace/in the course of work. It covers the entire public sector and the organised private sector (in total about 10 million employers). The contribution is a 1% payroll tax (employers) (ibid.).

In comparison with formal sector contributory social security programmes, social protection programmes in Nigeria are targeted to the poor and do not require financial contributions. This definition also separates out social protection programmes – which aim to support the demand side in accessing social services and economic opportunities – from broader social policies, such as universal basic education, the provision of basic health care services and broader economic programmes, such as long-term employment opportunities, vocational training, agricultural extension services and agricultural reforms.

The following sections present the information available on federal-led social protection programmes, and refer to state-level programmes where information is available.

Protective social assistance

Social assistance programmes in Nigeria consist mainly of cash transfers, targeted education and health waivers or subsidies and targeted nutrition programmes.

Conditional cash transfers

COPE is a CCT which started as a pilot in 2007 and is now in its third phase. The objective is to break the intergenerational transfer of poverty and reduce the vulnerability of the core poor in society to existing socioeconomic risks, and to improve the capacity for human contribution to economic development in the community, state and nation.

The programme's design draws on the Latin American model. Beneficiary households receive a monthly Basic Income Guarantee (BIG) for one year and then a lump sum Poverty Reduction Accelerator Investment (PRAI). The BIG ranges from \$10 to \$33, depending on the number of children in the household; a further \$50 per month is withheld as compulsory savings, which is provided as the PRAI (up to \$560) to the head of the household. Entrepreneurship and life skills training are provided to beneficiaries to maximise the PRAI. Payments are based on households meeting two key conditions: the enrolment and retention of children of basic school age in basic education (Primary 1 to junior secondary education), where a child must maintain at least 80% school attendance, and participation in all free health care programmes. According to a key informant from NAPEP, COPE is effectively the same across the country, even though the name might be different.²²

Targeting is guided by national policy and initially included a combination of geographical, community-based and household targeting²³ (NAPEP, 2007). COPE is targeted at households with children of basic school age with the following characteristics: headed by poor females; aged; physically challenged; VVF patients; HIV and AIDS patients. A community development committee (CDC) coordinates the identification of beneficiaries; this usually includes a district

²² For instance, in Cross River state, COPE is called Comfort. In Niger state, local committees are called village social assistance committees, not communities.

²³ Initial geographical targeting included North Central – Kogi (88.55%), Kwara (85.22%); North East – Bauchi (86.28%), Gombe (83.5%); North West – Jigawa (95.07%), Kebbi (89.65%); South East – Ebonyi (43.33%), Enugu (31.12%); South South – Delta (45.35%), Cross River (41.61%); and South West – Ekiti (42.27%), and Lagos (63.58%) (NAPEP, 2007). Current funding is dependent on states' own financial commitment.

head, a social welfare officer, a health assistant, a headmaster of a primary school, a women's leader, a councillor representing the ward and religious leaders (one imam and one pastor).

The programme started as a pilot in 12 states and became compulsory across all states in the second phase. It is currently in its third phase, with state governments required to match funding. In this third phase, the programme is subject to state commitment to its implementation. A total of 12 states have committed funding: Katsina and Kebbi (North West); Bauchi and Adamawa (North East); Kogi and Niger (North Central); Bayelsa and Cross River (South South); Anambra and Abia (South East); and Osun and Lagos (South West).

Programme coverage is extremely small. NAPEP's own estimates suggest that COPE has now reached approximately 22,000 households. Dijkstra (2011b) find that 18,750 households have been trained by COPE. This results in coverage of less than 0.001% of the poor.²⁴ Rollout has been uneven and currently, even with matched funding, resources to reach a wider population are constrained. For instance, in Jigawa, COPE reaches 50 households in 17 LGAs, covering 850 households in total (even though there is currently a proposal to cover about 2,800 households in all 27 LGAs) (KII with Budget and Economic Planning Directorate). The population of Jigawa is over 4 million and the poverty rate is 90%. In Adamawa, 50 households in 10 LGAs (out of 21) have been targeted, reaching 500 households in total so far.

COPE was designed at the national level by NAPEP, OSSAP-MDGs and state representatives (including those from State Ministries of Education), with support from the World Bank, and is implemented through state governments. In 2010, under the third phase, OSSAP-MDGs announced that state governments would take control of the CCT through the Conditional Grants Scheme (CGS) in order to improve sustainability. The CGS has a number of thematic areas, including education, health, water and cash transfers, and its criteria for approval for CCTs include that there must be an implementing agency, the state must be conversant with CCTs and they must have a supply side in place (tied to school enrolment, primary health care (PHC), schools) (according to a key informant at OSSAP-MDGs). At the state level, COPE is implemented mainly by NAPEP in collaboration with the Small and Medium Scale Enterprise Development Agency (SMEDAN) and the National Directorate of Employment (NDE).

The programme is funded from the MDGs-DRG (and now also by state counterpart funding, as seen above). In Phase 1, it cost N1 billion (NAPEP, 2007), with N2.4 million allocated to each of the 12 states and the FCT.²⁵ In Phase 2, funding of N2.3 million was provided to cover the remaining 24 states and FCT.

Three other **CCT** programmes are currently being implemented in Nigeria – in Kano, Bauchi and Katsina – to reduce girls' dropout as a result of early marriage, specifically in the transition period from primary to secondary school.²⁶ The pilots are running for three years, from 2011 to 2014. The cash transfers are transferred to beneficiaries on a regular basis (every two months). In Kano, two benefit levels are being tested: N5,000 (approximately \$32) and N2,500 (approximately \$16), according to a KII with a representative of the Education Sector Support Programme. Receipt of the income transfer is conditional on girls' 80% attendance at school. In Katsina, the design also focuses on creating linkages with other programmes and institutions. As such, the CCT includes a 'referrals' component, where beneficiaries are referred to a specialised institution when necessary (KII with respondent from Ayala Consulting).

In Kano, there are around 12,000 beneficiaries, but the aim is to extend the programme to all rural girls in the eligible LGA/catchment areas. The pilot covers one cohort moving through the schooling cycle, through Primary 5 and 6 and Junior Secondary 1 of selected schools. Targeting is determined primarily by the availability of schools supported by the Education Sector

²⁴ Calculation based on the assumption of 54% poverty rate, population 140 million and mean household size of 4.4 (NPC and ICF Macro, 2009).

²⁵ According to a key informant from the World Bank, in each state, N30 million was allocated for BIG; N42 million for PRAI, and N2.4 million for NGO paymasters (funding for beneficiaries in the FCT was half that for the states, but paymasters received the same). Coordination and monitoring was N 131.8 million.

²⁶ In early primary school years, there are no huge differences in school attendance by gender.

Support Programme in Nigeria (ESSPIN),²⁷ so that the supply side is guaranteed. In rural areas, the programme management unit is selecting schools in poor areas; in urban areas, however, schools are selected using proxy means testing (according to a key informant from ESSPIN). In Katsina, stakeholders (Office of the Special Advisor (OSA), UNICEF and the State Universal Basic Education Board (SUBEB)) selected nine LGAs for the pilot, with 7,000 households/9,000 girls as beneficiaries. Like in Kano, there is the expectation, based on impact evaluation results, that the cash transfer will be scaled up to all 36 LGAs (KII with Ayala Consulting).

The CCTs in Bauchi and Katsina were conceptualised and funded by UNICEF and the World Bank, which offer technical support, with Ayala Consulting providing support to design and implementation. Consultants are based at the state level and liaise with state education and programme management counterparts. In Katsina, OSA adopted the programme and started its design and implementation with key technical assistance from UNICEF Kaduna office. In Kano, the CCT is funded partially by the UK Department for International Development (DFID) through ESSPIN. DFID funds three LGAs and the states should fund nine; as they did not have the funds, a World Bank loan was reallocated (KII with respondent from ESSPIN).

Aside from these CCTs, there are few other cash transfer programmes targeted at the poor. There has been some discussion internationally on an **Oil to Cash** proposal in the Niger Delta (KII with respondent from the World Bank).²⁸ Bayelsa state has recently introduced the **Bayelsa Child Development Account: Savings, Training and Rewarding Savers** (CDA Stars), designed by Columbia University and the Global Assets Project at the New America Foundation.²⁹ CDA Stars will open seeded bank accounts for 1,000 junior secondary students from public schools spanning eight LGAs. The students and the schools are selected by lottery, however, not through eligibility-based targeting.

In Jigawa, the governor has initiated a social security allowance (cash transfer) consisting of a monthly payment of N7,000 (approximately \$46) to physically disabled persons as provided under Law 6 of 2007 (KII with respondent from the Budget and Economic Planning Directorate). The allowance covers 5,000 families (respondent from the State Accountability and Voice Initiative (SAVI)).

School subsidies/fee waivers

There is universal free primary education in Nigeria, but in many states there are still costs associated with attending school. There are some targeted school subsidy and fee waiver programmes run by states, donors and NGOs. Adamawa SUBEB (ADSUBEB), for instance, distributes **free uniforms** to female children in primary schools across the state at the commencement of the academic year.

The **Ambassador's Girls' Scholarship Program (AGSP)**, funded by the US Agency for International Development (USAID) was set up in 2004 and will run until 2011 with the aim of improving girls' and boys' access to and retention in schools.³⁰ Scholarships cover school fees, textbooks, exercise books, book bags, uniforms, socks and sandals. In addition, each girl is mentored and encouraged in her educational pursuits while participating in activities that focus on HIV and AIDS mitigation and prevention, community participation and democracy.

A total of 1,250 girls in 13 states have been supported since inception. Beneficiaries are chosen by community leaders, school principals and facilitating NGOs based on the following

²⁷ ESSPIN works on education reform, mainly on a state level, in six states (three in the north, three in the south), in the hope of replication across the whole country in the long run. Supply-side work consists of improving the capacity of states to deliver planning and budgeting (human resources and collecting, processing and using data); governance; and delivery (higher quality services, head teacher support, more effective supervision and infrastructure, especially water and sanitation). On the demand side, it engages with communities by helping to develop/strengthen school-based management committees, e.g. through training (KII with respondent from ESSPIN).

²⁸ See <http://blogs.cgdev.org/globaldevelopment/2011/01/oil-to-cash-an-idea-to-fight-the-resource-curse.php> and Zimmerman and Holmes (2011).

²⁹ See www.bayelsacdstars.com.ng/.

³⁰ See <http://nigeria.usaid.gov/programs/education/projects/ambassadors-girls-scholarship-program-agsp-0>.

criteria: economic status; physical ability; family status (i.e. orphaned); and HIV and AIDS status of the student or family member. Many of the recipients, who are typically from poor families, are physically disadvantaged or HIV positive. They are sponsored over a period of four to five years, through primary and junior secondary schooling. The 10 partner NGOs that are helping to implement the programme are receiving capacity and institutional support from World Education, which funds the project in collaboration with USAID.

A number of **HIV and AIDS programmes for OVC include school fee waivers and support the indirect costs of schooling** as part of their overall programming (which also includes nutritional, livelihoods and social support) (see Samuels et al., 2012). The 2004 National Plan of Action for OVC, for instance, identifies school scholarships to OVC to cover fees, books, uniforms, exam registration, school meals and transportation, etc., as a priority action (FMWA&SD, 2004). Although more recently there has been a focus on strengthening the welfare system to address the vulnerabilities children face (rather than the symptoms through, for example, school scholarships (KII with respondent from Save the Children UK)), many NGOs continue to provide small-scale education support in the context of HIV (see Box 3).

Box 3: HIV programmes supporting access to education

In Adamawa, programmes include the Centre for Women and Adolescent Empowerment's (CWAE's) indirect cash transfer programme, which pay schools fees for orphans for 12 years of primary and secondary education. Approximately seven children are currently sponsored. CWAE also receives funds from BAOBAB (a NGO) which it utilises to sponsor underprivileged female children throughout their primary and secondary education. At the moment, two girls are benefiting from this, currently enrolled in a private school in Yola. Another programme, run by the Association of OVC of Nigeria (AOON), also has a programme which pays school fees for OVC throughout primary and secondary education. AOON also provides in-kind transfers such as school materials like books and blankets, etc. (Adamawa Workshop Report).

In Benue, which has high HIV prevalence, a number of programmes include social protection-type components in their broader HIV approach. For instance, a positive media support group under the Association of Women Living with HIV and AIDS in Nigeria (ASHWAN) includes fee waivers for social services and savings; International Centre for AIDS Care and Treatment Programs (ICAP) and Centers for Disease Control and Prevention (CDC) funding through the Association of Reproductive and Family Health (ARFH) includes education support (provision of school materials, etc.) and food transfers. However, overall, coverage remains very small (900 OVC) (Benue Workshop Report).

In Edo, Girls' Power Initiative, a youth development organisation, provides educational support (e.g. school materials) to 1,868 people living with HIV and AIDS who dropped out of school to enable them to return, in collaboration with Edo State Population Commission. The Women Enhancement Organization (WEO) seeks to cater to children who are orphaned as a result of HIV and AIDS and to help eradicate poverty in poor and isolated communities in Etsako West. Working with Family Health International Global HIV/AIDS Initiative Nigeria (FHI-GHAIN), Christian Aid and other stakeholders, it provides 65 OVC with educational materials such as school fees, sandals and books and educates the public, schools and the private sector on prevention, stigma and discrimination. It also provides nutritional support to OVC households, distributing food items such as rice, groundnut oil and beans. It also pays hospital bills for OVC. The Rural Infrastructure and Development Association (RIDA) has provided educational waivers to 265 OVC, which precludes them from any form of payment of school fees, charges or fines for the duration of their course on the condition that they remain in the school (Edo Workshop Report).

Unlike in many other countries, there is no government-led **school feeding programme** in operation in primary or secondary schools, beyond those for boarding students (FMWA&SD, 2008). There are, however, a number of small-scale school feeding programmes at the state level and implemented by development partners. For instance, ADSUBEB and the Post-primary Education Board report that ADSUBEB has a feeding programme for pupils and students of the Special Education Centre in Jada, which is for children with disabilities (Adamawa Workshop Report). In 2004, the Lagos State Ministry of Health (SMOH) commenced a school milk programme for Primary 1 pupils in a bid to improve the nutritional status of children in poor communities. Under this programme, a sachet of milk is given to each pupil every Tuesday and

Thursday. At present, 927 public schools with a population of 61,182 pupils benefit from the programme (Lagos Workshop Report).

UNICEF is supporting school feeding programmes in Osun state, with a small pilot in Oyo state and one under design in Delta state (KII with UNICEF). The Osun Home Grown School Feeding Programme started in 2006 and covers all public primary schools in the state (1,359). One meal a day is provided to children including those from kindergarten up to Primary 2 (a total of 129,318 pupils). It costs about N30 to feed one child per day. The programme was initially funded by the federal government but funding now comes from the state and LGAs. However, there are no links with OSSAP-MDGs, for example, or with the CGS running in the state. Nevertheless, although an evaluation has not been carried out, findings suggest the programme has included an increase in enrolment, retention and completion; improvements in the health of the children; empowerment of cooks; and improvements in the local economy (the programme purchases at least 130,000 eggs every week from poultry farmers).

Health subsidies/fee waivers

The **Maternal and Child Health Care programme** (MCH) is part of the NHIS and started in 2008 to accelerate achievement of MDGs 4 and 5. It provides free PHC for children under five and primary and secondary care (including for birth complications and caesarean sections) for pregnant women up to six weeks after childbirth. While it is not specifically targeted at the poor, it is included in this social protection mapping given high rates of child and maternal mortality disproportionately affecting the poor.

The programme is being implemented in the country in phases. In 2006, one state from each zone and six LGAs in each of these states were chosen for Phase 1 (KII with respondent from NHIS). At this time, no disaggregated health data beyond broad regional groupings were available. Phase 1 started in September 2008 and included Bayelsa, Gombe, Niger, Imo, Oyo and Sokoto states. In 2008, national health data were published, disaggregated by state. Phase 2, which started in September 2009, added six states, this time on the basis of need (*ibid.*): Bauchi, Cross River, Jigawa, Katsina, Ondo and Yobe. Reports from the NHIS (2010) show that Phase 1 was to cover 621,386 people (100,000 enrollees per state). By December 2009, a total of 69,000 pregnant women and 175,000 children had been provided with services – well below the targeted enrolment rate (in Gavrilovic et al., 2011), but by June 2010 a total of 615,101 (98.9%) had reportedly been covered (NHIS, 2010). For Phase 2, out of 452,296 people targeted, a total of 236,097 (52%) had been covered as of June 2010. There are plans to scale the programme up to cover additional states and LGAs, and funding has been secured to cover an additional 12 states (personal communication with NHIS).

Only public health facilities can be accredited for the scheme (except in Oyo state, where private facilities may also be accredited but had not been by January 2010). Health management organisations enrol participants and receive fixed capitation payments of N622 per enrollee per month, of which they keep N36 as an administration fee. N36 is retained as a capitation payment for secondary care (whether it is a child or pregnant woman) and N550 is passed on to the health provider (Gavrilovic et al., 2011).

The programme is funded by the DRG-MDGs. The budget for Phase 1 was N5.0 billion (as a grant) and for Phase 2 N4.25 (NHIS, 2010). By the end of 2009, it was estimated that around N2 billion of Phase 1 funding had been disbursed (Gavrilovic et al., 2011). Each state must now provide matching funds of 50% of the amount disbursed; funding has now finished and states have not provided counterpart funding for the scheme so far.

Some states have implemented their own fee waiver systems. For instance, the State Drug Revolving Fund Programme in Jigawa has a Deferral and Exemption Component, under which certain social groups, usually those living in abject poverty, have free access to drugs and medical treatment (KII with respondent from Budget and Economic Planning Directorate). Katsina has targeted health services for children (measles vaccination) (KII with respondent from Ayala Consulting). In Adamawa, there is a medical fee waiver for children 0-5 years, and pregnant women can access free medical services from public health centres and hospitals in the state. Children receive free immunisation and SACA gives free medical services to people

living with HIV (Adamawa Workshop Report). In Edo, WEO caters to children orphaned by HIV and AIDS and helps eradicate poverty in poor and isolated communities in Etsako West. One component of the programme involves paying hospital bills for OVC (Edo Workshop Report). In Ifedore district in Ondo state the Abiye programme provides maternal health waivers and medical support during pregnancy (World Bank, 2011c).

Targeted nutrition programmes

There is no nationally led targeted nutrition programme, despite the severity of malnutrition in the country, especially for young children. NGOs have tended to focus more on emergency nutrition. and HIV/AIDS-related programmes tend to include nutritional supplements in their broader programming. For instance, Save the Children is leading an emergency nutrition programme to treat moderate and severe acute malnutrition with plumpy nut on an outpatient basis, with inpatient care for those with complications. While this is primarily a health response, there is recognition that the programme is not addressing the chronic, cyclical root causes of food insecurity (KII with Save the Children UK). The programme started in Katsina, given its chronic malnutrition status, and subsequently expanded to six states: Yobe, Jigawa, Kebbi, Katsina, Zamfara and Sokoto (all in the north). In Katsina, the programme is operating in four LGAs and has treated 7,000 people in seven months (ibid.).

Meanwhile, like school support, HIV and AIDS-related programmes tend to include nutritional supplements as part of their programming. In Benue, where HIV prevalence is very high, there are a number of programmes providing therapeutic food for malnourished children, e.g. through the USAID MARKETS project. Recently, Benue's SMOH facilitated the urgent distribution of ready-to-use therapeutic foods to moderately/severely malnourished under-five children and lactating mothers. Vitamin A supplements are given to children 6-59 months every six months. Iron folate for pregnant women and de-worming of children 12-59 months are also available in the state (Benue Workshop Report). In Edo, Girls' Power Initiative offers nutritional services to OVC as well as carrying out de-worming exercise for them every three months. Community volunteers are trained to help mobilise participants to access these services. Similarly, WEO provides nutritional support to OVC households, distributing food items such as rice, groundnut oil and beans (Edo Workshop Report).

Preventative social insurance: health insurance

The CBHIS aims to protect the informal sector and marginalised groups against the burden of high out-of-pocket health expenditures (PATHS2, 2010) by pooling risks within a community.

Community-based health insurance programmes have previously been implemented in Nigeria but with little success (although see Box 4 on Lagos state's CBHIS), because of the mismanagement of funds by community members (KII with respondent from the NHIS) and poor and rushed design (PATHS2, 2010). The new CBHIS model is based on learning from previous pilots and from Uganda and Mexico's health schemes. The pilot will be implemented in 12 states to provide a safety net for at least 60,000 people in the informal sector. When fully rolled out, it is expected to cover 112 million Nigerians in the informal sector (ibid.).

The core benefit package has been designed to ensure relevance to potential beneficiaries, so as to ensure high levels of enrolment and use of services, as well as to contribute to the achievement of national and international targets such as the MDGs and the National Strategic Health Development Plan (NHIS, 2011). It is recognised that the package may differ by geographic area, given the different epidemiologic profiles of the different zones of Nigeria. Confirmation of the different benefit packages for the different geographic zones will be decided after consultations with stakeholders. The core package covers essential cost-effective maternal, neonatal and child health services and control of highly prevalent diseases that contribute to the high disease burden in Nigeria (ibid.).

Key features relating to implementation include the following: communities will be pooled to spread risks, at least at LGA level; fund management will be recruited and there will be checks on finances; as the cost of health varies across regions, the flat contribution rate will be by community; communities will choose their benefits package, which will then be costed; every community has to pay a minimal contribution – if their package is deemed too expensive for

them to pay for, it will be cross-subsidised or they will have to reduce it; and there will be a co-payment of 10% at the point of service (KII with NHIS).

Box 4: Community-based Health Insurance in Lagos

Policies supporting child survival in Lagos state include the pilot CBHIS implemented by the state government since 2009. The subsidised benefit package offers enrolees and their dependants prepaid basic outpatient care at Olowora Primary Health Centre (treatment of common ailments, provision of prescribed essential medicines, immunisation, maternity care, health education and short stay admissions and access to economic empowerment). A key component is enterprise promotion in the form of skills acquisition programmes, via collaboration with the Ministry of Women Affairs and Poverty Alleviation (WAPA). Enterprise development agencies/microfinance institutions provide economic empowerment for the new WAPA-trained enrolees, selected members of the community, community groups and selected subsidy beneficiaries, and provide microcredit for providers, communities and selected beneficiaries. The initiatives work in tandem to improve/provide economic empowerment for community members to increase their earning power, thereby bolstering programme sustainability (Lagos SMOH, 2011).

The scheme takes place in Ikosi-Isheri local council development area (LCDA) and is targeted at the peri-urban Olowora community, which has an estimated population of 70,000, most of whom are informal sector workers. It was designed for very poor families, and especially women and children (antenatal women, nursing mothers and children under the age of five years), although, since government funds are committed to the programme, its services are not restricted and charges are standard. Over 65% of those enrolled are very poor households, defined as those with incomes of less than N2,000 per month (KII with Board of Trustees). Beneficiaries were located through community development associations, market groups and schools, and later community outreach sessions, word-of-mouth referrals and periodic awareness-raising campaigns. Target coverage was initially set at 5,000 people or 833 families, which comes to 7% of the population. It currently has 9,120 registered members, as of February 2010 (SMOH, 2011). There has been an annual growth rate of between 10% and 23% (KII with Board of Trustees). At a recent meeting with Lagos SMOH, the commissioner of health indicated that there were plans to scale up the community health plan to all 57 LGAs/LCDAs in the state towards the end of the year (KII with Board of Trustees).

The programme is run by a Board of Trustees headed by LCDA officials and community representatives. The Board of Trustees engages private health management organisations (HMOs) to provide medical personnel and drugs. The administrative component is managed by community representatives, known as Ikosi-Isheri Health Association, who register clients for the programme as well as carrying out the administrative tasks associated with implementing the programme.

Quality control for medical services is coordinated by Lagos SMOH through its Primary Health Care Department. There is also existing collaboration between the Ikosi-Isheri Primary Health Programme and Gbagada General Hospital for referrals and follow-up care.

The programme is subsidised by Lagos state government through SMOH. In addition, each beneficiary pays a monthly premium of N800 for a family of six (father, mother and four dependants). Each year, approximately N100 million is generated from premiums. Community donations are also involved: the LCDA donated the land on which Olowora Primary Health Centre is built. The centre's complex was built by the Lagos state government.

The NHIS and the National Primary Health Care Development Agency (NPHCDA) will be working together to implement the programme (KII with NPHCDA). It is seen as particularly important to implement the CBHIS where there are simultaneous supply-side initiatives in place to enhance effectiveness. For instance, the scheme would have a high chance of succeeding where the Midwife Service Scheme (MSS) is present to address supply/service deficits. The MSS should cover 23,000 PHC facilities. There is currently discussion about adding on other interventions, for example to address HIV, although it is recognised that SMOH will need to post additional staff to do this (ibid.).

The total budget for the CBHIS is currently unclear. The NHIS is looking for ways to cross-subsidise the informal sector using the formal sector, but it is recognised that this will entail a funding gap, as the poor will not be able to afford sufficiently high contribution rates. This gap will be plugged with the National Health Insurance Safety Fund, with the following financing sources (KII with NHIS):

- Under the National Health Bill, currently under discussion in Parliament, currently proposed at 2% of government expenditure/ revenue where 1% will be spent on NHIS and 1% on primary health funding and part of the latter 1% for the CBHIS. The worst six (northern) states will be covered using the 1% of the National Health Bill, as an incentive to get them to join the CBHIS;
- Corporate social responsibility payments from financial, oil and GSM companies;
- Donor support, which may be in the form of technical assistance (DFID, UNICEF, UN Population Fund (UNFPA), USAID, World Bank).

Productive transfers, public works and subsidies

Public works programmes

Although social protection policy in Nigeria has been articulated to contribute to economic growth and development, and documents have identified employment and skills as priority themes, Nigeria lacks an overarching strategy for the role of public works in social protection.³¹ In December 2010, the President announced a massive job creation programme, to be kick-started with seed funding of N50 billion – the National Job Creation Scheme – to ‘create thousands of new jobs in our urban and rural communities’ across the 36 states and the FCT (Akogun and Nzeshi, 2010). Some of these labour-intensive public works would be funded by conditional grants and targeted at sectors critical to achievement of the MDGs.

However, the status of the scheme is currently unclear and, overall, there is little in the way of public works programmes in Nigeria (KII with ILO). The NDE has Special Public Works (which combine direct labour projects and education) (Lagos Indicator, 2011), but these have declined recently as a result of the general drop in social spending (KII with NSITF).

The Ministry of Works is more involved in machine-intensive and contractor-conducted works. The new national procurement directive reports that new contracts need a certain percentage of labour inputs (KII with NSITF), but it is not clear that this would be a public works-type programme in the sense of social protection. However, the International Labour Organization (ILO) is encouraging the Ministry of Works and the Ministry of Labour and Productivity to conduct labour-focused public works (rather than infrastructure-focused works led by foreign contractors) (KII). Other international organisations draw on community labour to implement programmes. For example, UNDP’s Local Development Programme works with LGAs in Ando and Bajesa states, based on a community-driven approach to identifying needs which are then provided with the assistance of local people (KII). However, the labour component of such programmes tends to be a secondary objective.

Reports suggest that a number of states invest in direct employment or job creation schemes, e.g. Lagos, Edo and Ekiti (World Bank, 2011a). Other states, such as Lagos, have implemented their own public works-type programmes: recent reports suggest that over 2,000 people have been employed through the state Rice for Job Scheme, the Agric-Yes Scheme and the Lagos Ignite Enterprise Programme. It is not clear whether such programmes are poverty targeted.

Targeted subsidised inputs

Agricultural subsidy policy in Nigeria has been subject to significant changes since the 1970s. Most recently, a federal policy provides a 25% subsidy under the Fertiliser Market Stabilisation Programme, and state governments implement various fertiliser subsidies levels to augment these (Eboh et al., 2006).

Adamawa, for instance, subsidises agricultural inputs and implements. However, this is not done through any coordinated government programme. Subsidised fertiliser comes through

³¹ Skills training programmes are not included here, although a variety of such programmes are operational at the state level, especially through the NDE and local NGOs. In Adamawa, for instance, in 2009, the NDE started a training scheme for physically challenged persons and those with special needs, in collaboration with NGOs. At the end of the training, the NDE gives N20,000 to each graduate to help in establishing a small business (Adamawa Workshop Report). In Benue, the NDE works with First Step to provide skills acquisition for orphans who receive nine months of training by experts in welding or tailoring. Constraints include the failure of the NDE to pay N2,000 for travel allowances and difficulties encountered opening a bank account to transfer money (Benue Workshop Report).

the Ministry of Agriculture and a hiring programme of agricultural implements is sometimes implemented through CSOs. For instance, the National Council of Women Societies received fertiliser for distribution at subsidised rates to female farmers (Adamawa Workshop Report).

In Benue, the Ministry of Agriculture, funded by the state government, provides farm inputs to the public at a subsidised price. This covers 28 LGAs state wide, with the objective of increasing yield. However, anecdotal evidence suggests that farming associations and poor farmers do not tend to benefit from the inputs, which go to better-off farmers or are sold. There are also problems with the timeliness of disbursement (Benue Workshop Report).

In Edo, the Ministry of Agriculture works towards income generation, poverty reduction and job creation, and mainly by organising fertiliser supply and distribution programmes to reach the rural poor in the state. Between 2007 and March 2011, 350,000 farm families in Edo state received fertilisers from the ministry at subsidised rates (Edo Workshop Report).

Other small programmes exist at the state level. For instance, the Millennium Development Village project operates in two villages in Kaduna and Ondo state providing agricultural support (seeds/fertiliser subsidies).³²

Training, grants and savings

Savings schemes and productive transfers in the form of grants or loans linked to training skills are popular at the state level. In particular, HIV and AIDS programming links these livelihoods objectives in their broader approaches. BENPLUS, for instance, is a network of people living with HIV and AIDS in Benue, with funding from ActionAid. NAPEP is an implementing partner in the skills acquisition programme, whereby 20 people living with HIV and AIDS have been trained in knitting and carpentry and provided with equipment. A number of other HIV programmes conduct income-generating activities, including seed storage and exploitation of market price increases to make a profit (through support networks and groups) and provision of revolving grants to parents to support small businesses (Benue Workshop Report). RIDA in Edo state includes a Household Economic Strengthening programme on the basis that a financially strong household is better placed to provide uninterrupted and complete services to the children under its care. RIDA has established nine savings and loans associations which enable care providers to save money and then borrow and establish business ventures to help them to cater to the needs of children. A total of 315 household heads are involved in this aspect of the programme (Edo Workshop Report).

Social equity/transformational social protection

The government of Nigeria has passed a number of progressive international laws providing the basis for equality and human rights for its citizens. These include the Civil and Political Rights Covenant (443), the Economic, Social and Cultural Rights Covenant (444), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (445) and the Convention on the Rights of the Child (CRC) (446) (CRR and the WARDC, 2010). The government is therefore obligated under international law to protect the rights guaranteed by these instruments. Of these, Nigeria has domesticated only the CRC. A draft Child's Rights Bill aimed at enacting the principles enshrined in the CRC and the AU Charter on the Rights and Welfare of the Child was passed into law by the National Assembly in July 2003 (now known as the Child's Rights Act 2003) (UNICEF Nigeria, 2007). Despite this, not all states have passed the law, rendering it ineffective as a legal tool in those states.

Although an active civil society has advocated for the passage of the CEDAW Bill, there has been failure in this regard, not least because of opposition to the bill as both 'anti-religion' and 'foreign'. In addition, Nigeria attempted to pass the text of CEDAW 'wholesale', rather than the way other countries have done it, for example, by passing principles, affirmative action, regulation of conflict of laws, customised text (Imam, 2010). A women's rights bill, which includes rights in both CEDAW and the AU Women's Protocol, must be Nigeria specific, with issues that need particular attention including reproductive rights; equality of rights of women and men within marriage; rights, responsibilities and duties of and over children; equality

³² See www.ng.undp.org/projects/mvp.shtml.

before the law; definition of the terms 'equality' and 'equity'; women as leaders; and age of marriage (ibid.).

In addition to the problems associated with passing bills at the national and state level, and the subsequent challenges of practical implementation, there is limited, if any, conceptual link between the broader regulatory policies of equality and rights and social protection policies.

At the programmatic level, there are some signs that equality has been incorporated into the limited social protection interventions to date, at least at the conceptual level (not taking into account the severe challenges facing these programmes in terms of scale and implementation). The government of Nigeria, by targeting the poorest of the poor through COPE, has gone some way towards recognising the inequalities the extreme poor face in access to services, promoting livelihood opportunities and providing a basic consumption safety net. Similarly, the CBHIS and the MCH programme aim to provide basic coverage of essential services to those most excluded to date. The three CCTs go a step further by recognising and addressing gender inequalities specifically related to education and by incorporating community sensitisation issues and referral mechanisms. However, only the CBHIS has the vision and plan to scale up to a national level to cover all of the poor.

While HIV programming has not been primarily social protection-focused (see Samuels et al., 2012), this is a key area where economic and social risks are addressed in a more integrated way, for instance by linking safety nets (e.g. nutrition) and livelihood promotion (e.g. microcredit and income generation) with anti-discrimination and social capital interventions. However, despite these initial and tenuous linkages, the transformative and social equity potential of social protection remains very weak. Perhaps this is unsurprising, given the nascent state of social protection development in the country. It also means opportunities exist for strengthening these dynamics as social protection evolves in the country.

5.3 Mapping social protection actors³³

Social protection is a cross-cutting sector and therefore requires the involvement of numerous ministries, departments and agencies (MDAs) from different sectors, as well as support from donors, NGOs and civil society in terms of the funding, design and implementation of emerging programmes. At the same time, social protection requires strong coordination (between the federal and state (vertical) levels as well as between MDAs and other agencies (horizontal)), led by one ministry, to ensure the effectiveness of policy and programmes.

Currently, numerous actors are working in different capacities within or at the fringes of the emerging social protection sector in Nigeria. A lack of coordination means that programmes are currently fragmented and *ad hoc*. With no clear structure, institutional roles are confused, weak and often overlapping. This is particularly symptomatic of social protection, but such institutional challenges also go beyond this sector, with the root causes often found in the overall governance structure of the country (discussed in more detail below).

Federal- and state-level government institutions

The **National Planning Commission** is responsible for coordinating social protection programmes in the country and, as such, has a strategic role in social protection. In 2004, with support from other institutions, it led the first Social Protection Strategy. The Social Services Department is responsible for social policy, which includes programmes ranging from national health insurance to housing and the minimum wage. The NPC is seen as best placed to lead on social protection, but it suffers from weak capacity (KII with UNICEF). At the state level, some states have social services ministries and others handle social protection through their social welfare ministries.

The **Office of the Senior Special Assistant to the President of Nigeria on the MDGs** is a funding body initiated as a result of the MDGs-DRG, which funds the two main government-led social protection programmes in the country – COPE and the MCH programme. OSSAP-MDGs

³³ This section draws mainly on KIIs.

funds line departments at the state level by working bilaterally with the lead state authority (whichever ministry is responsible). More recently, funding for COPE, for instance, has been operating through the CGS as a way to promote financial sustainability when MDGs-DRG funding ends, with OSSAP-MDG reviewing applications and disbursing matching funding. The MCH is a partnership between the NHIS (discussed below) and OSSAP-MDGs, benefiting states and local government, using NHIS social health insurance structures (NHIS-accredited public (and private) health care providers in benefiting states).

The **National Poverty Eradication Programme** was established in 2001 by President Olusegun Obasanjo, with a mandate to coordinate and monitor all of government's poverty eradication programmes in the country. NAPEP is the apex policymaking body for poverty eradication in Nigeria. It is headed by a national coordinator who is also the Senior Special Assistant to the President on Poverty Eradication. The National Poverty Eradication Council (NAPEC), chaired by the President, with the Vice President as the vice chair, has the membership of all ministers of federal ministries whose activities have a direct impact on poverty eradication. The Secretary to the Government of the Federation is NAPEC's secretary. At the state level, NAPEP is headed by a state coordinator (a political post), but all administrative works are carried out by a state secretary.

The aim of NAPEP is to build strong partnerships across the board, from the public to the private sectors, to provide an enabling platform for the delivery of poverty eradication programmes. It aims to do this in the following ways: help generate mass participation in the economic reform process, through catalytic partnerships and intervention; help state and local governments develop direct anti-poverty programmes that include microcredit and microfinance; build strategic public and private sector partnerships that provide information to the disadvantaged; and cause political action against poverty to centre on providing confidence and stable markets for the goods and services of poor people.

NAPEP has been charged to provide technical expertise and limited financial support to states and LGAs in the implementation of COPE by fostering joint implementation, structured around state implementation units to facilitate communication between federal and state level.

The **Ministry of Women Affairs and Social Development, the Ministry of Youth Development, the Ministry of Education and the Ministry of Health** are important players in social protection directly (e.g. through health fee waivers and insurance, cash transfers) and indirectly (e.g. through child protection, OVC and HIV support). However, there is limited visibility of their role at the federal level in social protection discussions. In particular, the Ministry of Education and Ministry of Health are absent from the NSITF-led Social Security Committee, although they are more involved in implementation committees (e.g. COPE) and in the CGS at state level, (KII with OSSAP-MDG Office) as well as in funding and working with NGOs and CBOs in the states.

Likewise, the **Ministry of Agriculture** is not visible in social protection at the federal level, but in the states it plays an important role in providing agricultural subsidies and inputs and creating jobs (although a key challenge is the pro-poor nature of these programmes).

The **Ministry of Labour and Productivity** oversees a number of departments, including the Labour Inspectorate, and a number of parastatals, including the NDE, NSITF and the Pension Commission, which are semi-independent and have some flexibility with regard to their work. The ministry currently covers the formal sector only, but wants to extend coverage by organising informal worker groups to improve their working conditions and eventually mainstreaming them. The ILO (discussed below) is encouraging the Ministry of Works and the Ministry of Labour and Productivity to conduct labour-focused public works.

The **Labour Inspectorate** works mainly on employment and wage policies and certification of skills. The director was also involved in the design of the draft NSITF social protection policy and the Employer Compensation Act that NSITF will implement.

To mitigate the large and growing numbers of unemployed citizens, the federal government in 1986 established the **National Directorate of Employment**. The NDE is a fully funded

federal government agency with offices in the 36 states. It has a vision of 'jobs for all' and a mission to design and implement job creation programmes that will 'promote attitudinal change, employment generation, poverty reduction and wealth creation aimed at combating mass unemployment'. Specifically, it has a national mandate to carry out vocational and technical training to able Nigerians, including youths and retired persons, under four broad thematic areas: training in skills acquisition; entrepreneurship; enterprise creation; and training in labour-based work.

In addition, the NDE is expected to maintain a databank on employment and vacancies in Nigeria with a view to acting as a clearing house to link job seekers with vacancies. It aims to collaborate with communities, state governments, NGOs and any other organisation that are interested in its core objectives. Of importance is the existing collaborative relationship with Members of the National and State Houses of Assembly, largely to facilitate implementation of their constituency projects. In 2009, the agency was reinvigorated through partnership and collaborative relationships with other government agencies, including the National Youth Service Corps, the Nigerian Agricultural, Cooperative and Rural Development Bank, the National Bureau of Statistics (NBS), NAPEP, Nigeria Employers' Consultative Association, ILO, the Nigerian Railway Corporation and UNDP to deepen implementation of its activities.

The **Nigeria Social Insurance Trust Fund** (which started as the National Provident Fund in 1961, with a compulsory fund for private sector employees and some civil servants) is a relatively new player in social protection policy for the poor. The secretariat led the multi-sector submission of the draft national social security policy in 2009.

The **Pension Commission** has been the supervisory and regulatory agency of the contributory pension scheme since 2004. It makes guidelines and supervises pension fund administrators and pension fund custodians. The latter hold the contributions and make payments; there are four of them, to promote diversification, and they are privately managed (KII with Pension Commission).

The **National Health Insurance Scheme** has a regulatory role but, when the MDG programmes started, it took on an implementation role. It is said to have an ambiguous role and to have weak institutional capacity, which development partners are helping to improve (KII 15). The NHIS is part of the committee that developed the 2009 social security policy led by NSITF.

Development partners

A small number of the government's development partners have played a key role in the development of social protection in Nigeria to date. A Social Protection Development Partners Group has been convened (SPAG is no longer in existence), comprising DFID, UNFPA, UNICEF, WHO and the World Bank.

DFID is keen to examine the potential for unconditional transfers in the country. In addition, it provides funding to Phase II of the Partnership for Transforming Health Systems (PATHS 2), which has provided technical support to the NHIS in designing a study to gather evidence to support decisions on the location, management and structure of the CBHIS (PATHS2, 2010).

UNFPA's potential interest in social protection includes a strong focus on gender and health. The agency would be keen to see social protection focus on high maternal mortality rates; low contraception prevalence; high poverty; and targeting of existing interventions. As part of its social protection-related work, UNFPA has mapped community-based health insurance initiatives with a maternal and child health focus. Along with UNICEF and WHO, it is currently developing a work plan to support social protection mechanisms that facilitate access to health services (Social Protection Development Partners Group, 2010).

UNICEF currently convenes the Social Protection Development Partners Group and, as well as providing technical assistance to the CCTs in Katsina and Bauchi, is involved in activities outlined by WHO on social protection for access to health services.

WHO is a member of the NHIS Board of Trustees and has been involved in inter-agency support to the NHIS to define the CBHIS package and its costing; to review implementation and training manuals; to conduct social vulnerability profiles across selected states; and to assess the MCH schemes (Social Protection Development Partners Group, 2010).

The World Bank has been a key player in social protection in Nigeria. In 2004, it assisted in the development of the draft Social Protection Strategy and continues to support the NPC to put a social protection strategy in place. It has also provided technical assistance to COPE and now, with DFID and UNICEF, provides technical support to the CCT schemes. The Bank is also involved in the new Youth Employment Programme that the government aimed to launch pre-election to generate employment for youth through public-private partnerships.

Other development partners may not be directly involved in social protection programming, but are interested in supporting the development of the sector in the future (e.g. UNDP). Some are involved indirectly, with social protection components as secondary objectives, as in the cases of HIV-focused funding agencies such as ARFH, FHI-GHAIN and USAID, for instance.

Non-governmental organisations

The majority of international and national NGOs in Nigeria do not work directly on social protection. Rather, social protection-type instruments, such as the provision of school materials/waivers, medical fee waivers and food transfers, are often subcomponents of their broader programme of work on specific issues, including rural livelihoods, child protection and HIV and AIDS, as well as broader education and health support and efforts to build a stronger civil society.³⁴ For instance, Save the Children works on HIV and AIDS and nutrition. Oxfam's focus is on strengthening the capacity of small-scale farmers through i) helping them access markets and information; ii) training on better farming methods; iii) inputs; and iv) helping them access existing subsidies. It also works on women's rights and with the National Emergency Management Agency on planning emergency responses (Round table with CSOs/NGOs).

Many international NGOs work directly with local organisations to implement their programmes. For example, Oxfam gives mainly technical support and works through other NGOs. There are also huge numbers of local CSOs working on behalf of the poor, addressing both economic and social risks and the vulnerabilities of adults and children. These include the SOS Children's Villages through their Family Strengthening Programme, which helps children at risk of losing parental care by strengthening family support through essential services as well as food and educational and health support. These types of activities integrate both social protection mechanisms and broader social and economic goals, but their reach is limited to a few states with only a few hundred beneficiaries in each. For instance, SOS Children Villages works in Abuja, Lagos and Ogun and reaches approximately 200-300 beneficiaries in each state. Similarly, the Empowering Women and Youths programme combines HIV, child protection and social protection elements, by supporting women and youths, in particular orphaned children and widows, to access PHC, education and social amenities. It also provides awareness raising on HIV and AIDS and encourages street children back into school. However, it works only in Abuja, reaching 72 women and 12 children while working with the community as a whole. At the state level, organisations include ASHWAN, CWAE, Girls' Power Initiative and RIDA.

³⁴ For instance, funding women to become involved in politics, helping the poor access credit and subsidies, training and microfinance for care givers, advocacy (e.g. campaigning on a sexual exploitation bill), social work, getting street children off the street and into school by replacing earnings for three months, etc. (KII 29).

6 Impacts, gaps and challenges in social protection programming

The mapping of policy, programmes and institutional actors above highlighted the emerging key priorities in social protection for government and its development partners. These include alleviating the short-term symptoms of chronic poverty (e.g. through cash transfers) and addressing longer-term poverty (e.g. by building human capital in education and health or promoting economic opportunities through lump sum cash transfers linked with training). The target groups of the most recent cash transfer programmes have primarily been the poorest, on the assumption that categorical group targeting by headship, age and HIV status, for instance, correlates efficiently with extreme poverty (Holmes et al., 2012) and that the community successfully targets such households on the basis of this criterion. Other programmes, such as the MCH programme, the CBHIS and labour-based activities, have not specifically targeted the poor, although poor communities and households may benefit.

The social protection mapping also illustrated the highly fragmented and small-scale nature of social protection at both the federal and the state level. This next section therefore examines existing evidence on the effectiveness of social protection programmes in the country (where data is available), and goes on to discuss the programme design and implementation challenges these programmes face, as well as the key governance, institutional, financial and political factors influencing the potential for future social protection development in the country.

6.1 Effectiveness of social protection programmes

Given the relative newness of social protection programmes in Nigeria, there is currently little empirical evidence on their impacts and effectiveness at a local or aggregate level. To date, programme evaluations have tended to focus on outputs (e.g. number of households reached, effectiveness of service delivery) rather than impacts; and while this is an important component of a monitoring and evaluation (M&E) strategy, outputs tell only one side of the story (see Box 5 for current M&E approaches in safety net programmes). As programmes start, it is vital, in order to assess their *impacts* on poverty, that they include baseline data and control groups – so it will be possible to assess attribution of poverty reduction to specific programmes and to collect and analyse data disaggregated by sex, age and ethnicity.

Box 5: Current M&E approaches in safety net programmes

COPE's M&E mechanisms comprise a layered structure to ensure programme delivery:

- NAPEP conducts a baseline survey to provide a reliable benchmark for tracking progress in implementation.
- Periodic reviews are carried out at all levels to keep track of progress in implementation.
- NAPEP employs various research tools, including participatory M&E, to monitor access to, utilisation of and satisfaction with services among households.
- OSSAP-MDGs monitors NAPEP's compliance in the utilisation of funds.

KIIs at the federal and state level suggest challenges in implementing this M&E structure in practice. The Management Information System is problematic because the database is held at central level. Meanwhile, a respondent in Jigawa suggested it would be more appropriate to develop a common M&E framework, to aggregate COPE impacts at a state and national level.

Donor-supported **CCTs** entail an M&E/planning department at the implementation unit, responsible for carrying out evaluations, monitoring training and evaluating data. The latter include baseline data on students currently attending school, disaggregated by sex and geographical location.

Monitoring indicators for the MCH programme include political (commitment); community indicators (e.g. number of households benefiting, changes in awareness and attitude towards MCH services); service utilisation (number); and maternal and health indicators.

Dijkstra et al. (2011a; 2011b) recently conducted an evaluation of MDGs-DRG, which presents findings on some general poverty trends to which programmes under the Poverty Reduction Fund (focused on both the supply and the demand side of services) have contributed. Between 2004 and 2008, primary enrolment increased, as did the ratio of girls to boys in primary education, which the authors assert probably owes mainly to UBE, promoted since the beginning of the decade. Between 2006 and 2008, the proportion of the population that visited a health facility increased dramatically, as did the proportion of children immunised. However, access to antenatal care decreased in the same time period and trends in the proportion of births attended by skilled health staff remained erratic. From this, the authors conclude that the effects of the increased number of midwives trained and deployed under the MDGs-DRG are not yet visible in 2008 figures.

With specific reference to COPE, Dijkstra et al. (2011a; 2011b) report that the target population in Nigeria is still too small for the programme to make a palpable impact and that, since the most recent income poverty data are from 2004, it is as yet impossible to examine eventual effects. They do suggest that COPE has helped to retain over 100,000 children who would have dropped out of school as a result of poverty (Dijkstra et al., 2011b). Reports on the micro-level impacts of COPE have mainly been anecdotal. Box 6 highlights key findings from our FGDs and KIIs, which indicate that, despite the small size of the transfer, the income has helped households meet their immediate needs in terms of consumption and, to some extent, to cover school and health costs. However, the transfer is inadequate, especially for large families, which is particularly problematic for polygamous households in the north for instance, but also for smaller families. A review of COPE in 2009 found that beneficiaries suggested increasing the amount to between N11,850 and N18,200 (World Bank, 2009).³⁵ COPE currently transfers a maximum of N5,000 per family per month.

³⁵ The per capita monthly expenditure of COPE beneficiaries in four states (Cross River, Enugu, Niger and Yobe) was N3,700, of which 49% on average was spent on food.

Box 6: Effects of COPE at household level

Findings suggest that COPE's largest impact has been to support households in meeting their daily consumption needs and, to some extent, has increased access to health and schooling for children.

'We bought food items. The money brought about a change in our economic situation. I was able to respond better to the needs of the children and my wives' (adult male, Adamawa).

'We used to eat garri [from cassava tubers] four times daily before because that was the only food we could afford' (Edo).

'We use money for school fees, health, housing and feeding' (Benue).

'I used to buy drugs from patent medicine stores. But now I go to hospital whenever the kids are sick and there is improvement in the food in-take of children' (widow, Edo).

However, while the transfer is an important part of poor households' coping strategies, its level is insufficient to make a sustainable difference to household poverty.

'I have a large family and the money was not enough to cater for our needs. It has helped us to feed while the money lasted but it was not enough' (adult male, Adamawa).

'The monthly transfer often lasted three weeks because as soon as I receive it, I buy food in bulk' (widow, Adamawa).

Some households have made investments in small-scale productive activities which have enabled future income generation. Many others have not received guidance on their lump sum payment, meaning sustainable graduation from the programme within one year is unrealistic.

Of the indirect benefits, while there seems to be a general assumption that COPE will lead to women's empowerment, there is no evidence to support the notion that transfers have led to a change in unequal relationships or power at the household level.

'It has not changed the behavioural pattern in my home. Our relationships remain the same' (adult male, Adamawa).

Source: Holmes et al. (2011a).

This study also found that COPE did not appear to have been successful in enabling households to graduate from the programme through its economic promotion component (PRAI), highlighting the timeframe of the programme (one year) as inadequate and suggesting at least four years of programme participation. International research on lump sum investment transfers finds that large transfers without continuous support are largely consumed rather than invested in productive activities (Slater and Farrington, 2009).

Holmes et al. (2012) argue that, in Nigeria's context of high levels of poverty and constrained institutional capacity and resources (discussed in more detail below), maximising the effectiveness of cash transfers in particular will entail Nigerian policymakers and development partners considering the relative importance of and the budget currently allocated towards the conditional features of cash transfers, as against reallocating expenditure towards, for example, scaling up the programme to cover a larger proportion of the poor; increasing the value of the transfer; increasing the length of participation; improving the delivery of transfers so they are regular and predictable; creating awareness among beneficiaries to utilise services through 'soft conditions'; and improving basic service delivery for access to complementary programmes and services.

Data on the impacts of the two other government-led social protection initiatives are even sparser. There is no information available on the impacts of the CBHIS. One USAID evaluation of the MCH programme estimates that up to 470 women's lives and 1,070 children's lives may have been saved under the first 15 months of Phase 1 of the programme, and that the project has had a positive benefit-cost ratio of 6.4 (USAID, 2010, in Gavrilovic et al., 2011). However, given that in 2009 there were an estimated 4.2 million pregnant women at any given time, with a population of 25.3 million children under five, this represents only a tiny fraction of the potential beneficiary population (Gavrilovic et al., 2011). Dijkstra et al. (2011a; 2011b) confirm a lack of real progress on antenatal care access in the country.

In the context of the Triple F crisis, Gavrilovic et al. (2011) finds that the most common response to the impacts has been to draw on informal coping mechanisms – many of which are resulting in adverse and potentially severe longer-term consequences. The main coping strategies are distress selling of critical assets and engaging in risky and/or illegal activities (particularly among young people), such as drug selling and child trafficking. Commercial sex work and early marriage among children were reported in all states. For children in particular, this has resulted in increased levels of child labour to the detriment of schooling and health; increased strain on relationships with parents and children as a result of stress; increased exposure to physical and sexual abuse; and higher risks of teen pregnancy and HIV or other sexually transmitted infections.

6.2 Gaps and challenges in social protection programming

Design

Equity and reaching the poorest

A key challenge in achieving Nigeria's goal to promote economic growth and reduce poverty is the extent of inequality in the country. The Gini coefficient remains at a persistently high level. Inequality is found not only in income disparities, but also in basic education and health outcomes, as we have seen. Evidence suggests that well-designed social protection can support broader equity objectives by channelling resources to disadvantaged poor areas and expanding access for vulnerable populations who are excluded from services (UNICEF, 2010).

COPE prioritises a small subsection of the extreme poor. Geographically, in the first year of implementation, the programme allocated 70% of funds to the two poorest states in each geopolitical zone and 30% to special groups (NAPEP, 2007). The CBHIS and MCH indirectly support the poor by providing free/subsidised services to pregnant women and children under five – those who suffer from the worst health outcomes, although coverage of these programmes is, to date, negligible (see Table 5 below). Gender inequalities are recognised in the design of CCTs, which support girls' transition to secondary school, and in the MCH, by providing free health services to pregnant women.

Despite the broader lifecycle and gender risk and vulnerability approach taken in social protection policy – which includes tackling child protection issues and gender inequalities – this has not translated into practice. Meanwhile, although social protection to date has focused on young children both directly (free health services) and indirectly (maternal care), and a small proportion of households with school-age children, key gaps remain in terms of addressing the risks facing adolescents and youth, poor economically active households and poor elderly people.

The COPE programme aims to address inequality by targeting the poorest in communities on the basis of a number of characteristics thought to be most associated with extreme poverty, has made inroads into the policy agenda to tackle extreme poverty and theoretically could support households out of poverty (e.g. there is a logical sequencing between beneficiaries receiving COPE and graduating to other income-generating activities). However, there are a number of challenges associated with COPE's design. These include the small size of the transfer (especially in the context of rising food prices and inflation); absence of skills training for participants; and an expectation that COPE participants will graduate from the programme onto a trajectory out of poverty after just one year (KII with Budget and Economic Planning Directorate, Jigawa state). Under the CGS system, graduation is not expected, but households continue to be enrolled in the programme for one year only.

There is little discussion on the *ability* of targeted households to take advantage of the productive investment lump sum (regardless of whether they receive the trainings), given that these households are often labour-constrained, in terms of either the number of working adults (e.g. single female-headed households) and/or the effects of ill-health (e.g. HIV and AIDS) or disability – even though they have been targeted based on these specific characteristics. Evidence from similar social protection programmes in other parts of the world which combine

protective and promotive objectives suggests that a significant investment in addressing both the economic and the social risks facing households is needed. This includes investing both finances and programme staff time in developing beneficiaries' skills, capacities, confidence and empowerment as well as tackling broader community inequalities (such as exclusion and limited social capital) (Holmes et al. 2008).

Child-sensitive social protection

The extent to which emerging social protection is child sensitive in Nigeria can be assessed by looking at how current programmes respond to the different deprivations and risks children face; how they address the different vulnerabilities at different ages; whether they support families and care givers to care for and nurture their children; and whether they take children's perspectives into account (see Table 4 for an overview of Nigeria's child-sensitive approach to social protection). As Marcus and Perezniето (2011) note, not all child-sensitive social protection interventions need to be targeted at children. Most social protection interventions work primarily at the household level, and their child sensitivity can be analysed with respect to how programme design ensures that benefits reach children. Indeed, as shown in our conceptual framework, a child-sensitive approach can be enhanced either through core programme design (e.g. through the choice of target group or type of benefit) or through strategic linkages with complementary services and programmes that can benefit children.

The development of social protection in Nigeria has taken a child-sensitive approach in a number of ways (see Jones et al., 2012): targeting children or households with children to build children's human capital development through health and education; supporting care givers in particularly vulnerable households (orphaned/widowed); and promoting household expenditure on children by attaching conditions to cash transfers targeted at the household. However, the target is a very specific and narrow group (children under five and in primary/secondary education) and two very specific risks (health and education and, to some extent, income poverty). As our conceptual framework showed, poverty combines economic and social risks, most often intertwined, and children often face heightened risks and vulnerabilities which go beyond income poverty.

The CCTs in Bauchi, Kano and Katsina are addressing girls' early marriage by targeting a specific age group (those transitioning to secondary school) but are also providing community sensitisation components on the importance of sending girls to school, thereby recognising not only the income-related demand-side deficit in accessing services, but also the role of socio-cultural barriers. In addition, these CCT programmes include a system to support institutional referrals when needed.

The multitude of risks and vulnerabilities facing children across the different life stages, and the complex causes of these, are discussed more fully in the child protection report (Jones et al., 2012). Social protection programmes can play a stronger role in addressing these, either through core interventions (e.g. addressing youth unemployment through public works) and/or by linking more strategically to complementary programmes and services, such as community sensitisation in cash transfers on child marriage or trafficking or linking employment opportunities and skills training to public works programmes.

Table 4: Child-sensitive approach to social protection in Nigeria

Child-sensitive approach	Addressed in programming?	Examples
Reduction in household income poverty	Limited	COPE cash transfer (government)
Support to access basic services (education and health)	Limited	CCTs (health and education), free health care to pregnant women and children under five, CBHI, support to OVC (NGOs)

Child and maternal nutrition	Limited	HIV-related nutrition programmes (NGOs)
Supporting families' child care role	Limited	Cash transfers
Reducing child labour	No	
Increasing household access to income or employment	Limited	Some state-level employment schemes, agricultural inputs/subsidies
Preparing adolescents for future livelihood	Limited	Some youth employment and training schemes
Preventing and responding to abuse and exploitation	Limited	Laws in place (e.g. CRC) but poor implementation
Addressing gender inequality	Limited	CCTs (girls' education)
Responsiveness to children's perspectives	No	

Coverage of social protection instruments

One of the key concerns regarding the current status of social protection in the country is the limited coverage and reach of existing programmes. This is reflected in the small reach of programmes run by government and those supported by development partners (international agencies and NGOs). In the case of the MDGs-DRG safety net, the federal nature of Nigeria means that programme development begins with a targeted, federal government-funded pilot project on a relatively small scale, which is followed by national scaling-up under the responsibility of individual states. However, in the current global economic climate, with lower-tier government budgets contracting significantly, relying on state and local governments to provide adequate funding for the expansion and effective operation of programmes is an approach fraught with difficulties, as shown by the increasing difficulty of securing counterpart funding for the CGS (Gavrilovic et al., 2011). This is reflected in the COPE programme: in Phase I and II, approximately 22,000 households benefited (Dijkstra et al., 2011a) – only a fraction of the estimated number of core poor households in Nigeria. Only 12 out of 36 states have committed counterpart funding for Phase III; in these states, while the CGS has been a catalyst for scaling up cash and other social protection programmes, the proportion of households reached remains extremely small in the context of high rates of poverty (see Box 7).

Box 7: Coverage of social protection in Jigawa

In Jigawa, where the state has a relatively high commitment to social protection in comparison with other states, COPE was initially implemented in only 10 LGAs. Subsequently, when given the opportunity to apply for funding under the CGS, the programme was scaled up to the remaining 17 LGAs (KII with Budget and Economic Planning Directorate). However, one of the key challenges identified by KII is the small scale of all three safety net programmes (COPE, MCH programme and a social security allowance for the disabled). The cash transfer programme under the CGS currently covers only 50 households in the 17 LGAs, although there are plans to scale it up to cover 2,800 households (in a proposal submitted under the 2011 CGS). It is also planned to expand the MCH programme to all major health facilities in all 27 LGAs (KII 45). However, even where political will to commit pro-poor funding to social protection is available, as in Jigawa, resource constraints and limited capacity of implementing agencies are key challenges (ibid.).

Table 5 highlights the extremely limited coverage of existing social protection programmes. Only the CBHIS has the explicit vision to reach 100% of the poor (in the informal sector). This may be linked to the presidential mandate given to the NHIS to achieve universal health

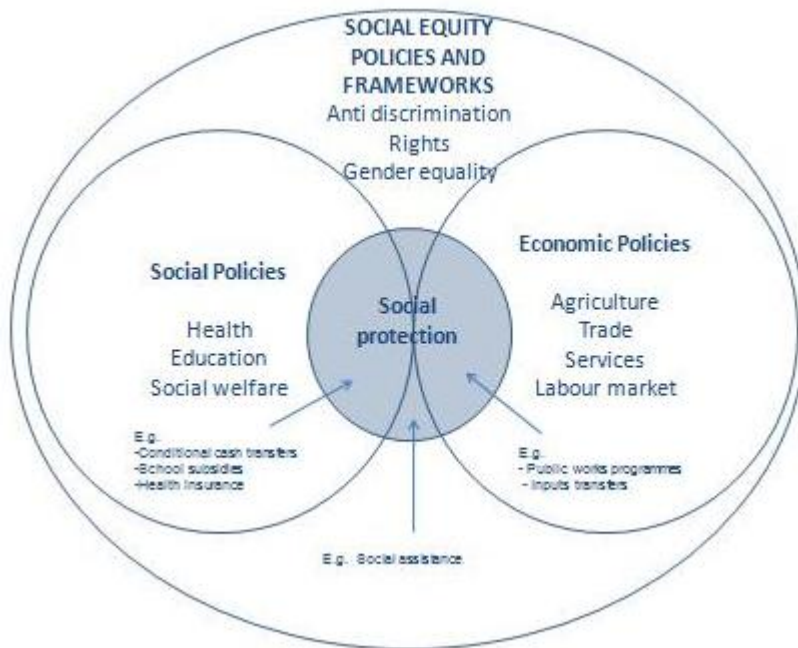
insurance coverage and access to health care for all Nigerians by 2015 (NHIS, 2010). However, the executive secretary of the NHIS has admitted there are enormous financial difficulties in extending such a scheme to the huge number of informal workers and those living in poverty, as well as challenges relating to the poor state of health infrastructure and human resource capacity within the health system, a lack of public awareness of the scheme and weak coordination and reluctance of state governments and LGAs to engage with the scheme (The Guardian, 2010, in Gavrilovic et al., 2011).

Table 5: Coverage of social protection programmes

Programme	Projected coverage: number of households/% of poor	Actual coverage: number of households/% of poor
COPE		22,000 households/less than 0.001% of poor households nationally (NAPEP, NPC and ICF Macro, 2009)
CCT girls' education	Kano – scaling up to all eligible girls in LGAs where CCT is implemented	12,000 girls, Kano/0.002% of poor people in Kano (9.2 million population; poverty incidence approx. 60%) 7,000 girls, Katsina / 0.001% of poor people in Katsina (6 million population; poverty incidence approx. 70%)
MCH		851,198 women and girls June 2010 (Phase 1: 615,101, Phase 2: 236,097)/less than 0.01% of the poor (assumption 75 million poor; poverty rate 54%)
CBHIS	100% informal sector workers (when fully rolled out, expected to cover 112 million Nigerians in informal sector (PATHS2, 2010)	Currently unavailable

The approach is also very limited in terms of the different types of social protection interventions that could be appropriate to address poverty and inequality in Nigeria. Despite a long list of social protection activities mentioned in the draft Social Protection Strategy and in the Vision 20: 2020 implementation plan, in practice only a few interventions are being driven from the federal level – cash transfers, health fee waivers and CBHI. The federal government and development partners could play a much stronger role in relation to strengthening awareness of the appropriateness of different types of instrument from a social protection package that would respond to needs at state level (see Figure 1 for an illustration).

Figure 1: Social protection instruments



Source: Holmes and Jones (2010).

Governance

The governance environment of Nigeria has critical implications for the development and delivery of social protection policy and programmes. At the federal and state level, it is fraught with challenges. State-level governments have autonomy over economic development policy, budget regimes and expenditure patterns: they are responsible for the delivery of public services and are able to interpret national policies (for example, they can operate their own version of UBE and set up SUBEBs to implement this (Eldon and Gunby, 2009)). However, many sub-national governments lack the capacity and/or the political will to effectively provide key services for their residents. This issue is often compounded by independence and mistrust of higher government, as well as a lack of transparency and accountability.

The federal government is responsible for monitoring the actions of sub-national governments but, aside from a few pilot schemes (e.g. the CGS, discussed in more detail below) and increased high-level political recognition of the importance of monitoring, it lacks the capacity to do so. This results in a lack of upward accountability. Moreover, sub-national governments do not often make publically available their revenue allocations and budgets; this lack of information and the fact that few people are engaged in any way with local government (few states collect tax effectively, for example, citizens have limited knowledge on government activities and there are few mechanisms for citizens to hold local government's accountable) lead to a lack of downward accountability from sub-national government to residents.

Corruption is a challenge across all levels and sectors of government (Freinkman, 2007). It has been suggested that inter-governmental transfers – both from federal to state and state to local – are a main source of corruption (Norad, 2010); every day the electronic and print media report cases corruption (Social Watch, 2009). Vision 20: 2020 identifies corruption and lack of transparency in the administration of social protection programmes as a key challenge.

Weak governance is therefore a significant challenge, not only in terms of promoting a healthy economic climate but also in addressing poverty and reducing vulnerability. Concerns about channelling development aid through the government have also often led to a preference to disburse aid 'closer to the people' at the state and LGA level (according to KIIs), hence to work with particular pro-poor state governors rather than across states on structural issues. This has meant that pilot programmes and donor interventions often centre around the same few

states (Eldon and Gunby, 2009). It is unsurprising that donors choose to work in states that appear the most likely to adopt responsive behaviour in governance and service delivery in order to provide best practice examples. In reality, though, it is problematic, as the underlying challenges in the majority of states are not addressed or resolved appropriately to make it possible to scale up projects to reach a larger proportion of the poor.

The Nigerian government has attempted to address governance issues since the return to democracy through a series of reforms and by establishing anti-corruption bodies. The CGS, through which COPE is now being implemented, is one of these initiatives. Its aim is to improve efficiency, increase accountability and improve governance dimensions of service delivery by building on the resources, knowledge and capacity existing at sub-national level. It is also closely aligned with the national development agenda (which follows the MDGs).

The CGS relies on states putting forward programmes that fit into pre-decided categories that map onto the MDGs, with grants conditional on states and their programmes meeting minimum requirements and agreeing to sign and abide by written guidelines (Phillips, 2009). Programmes must respond to community need. The conditionality of the scheme contributes towards sub-national capacity by placing responsibility on state governments as well as increasing accountability and communication between federal and state level. The conditions address many of the issues that hinder the delivery of basic services and also aim to promote state ownership. They insist on accountability and financial responsibility through M&E, with an emphasis on inter-governmental cooperation and support.

The CGS has been successful in many ways. In 2007, reports from states suggested an average project completion rate of 96%, significantly higher than federal or most states' budget implementation performance. There are also reports that accountability had improved (Phillips, 2009), although this depends on the M&E provided to the Virtual Poverty Fund (VPF) by a combination of professional experts and civil society (*ibid.*) (see Box 8). There have also been issues within the CGS. Necessary policy reforms and the introduction of electronic payments have caused delays in implementation. The popularity of the scheme has placed a large burden on the federal level, whose responsibility it is to monitor and evaluate programmes. From 4,000 projects in 2007, the scheme had expanded to 10,000 in 2008, which compromised M&E and so weakened the stringency with which conditionality is enforced – a factor which may compromise the effectiveness of the CGS as it gains popularity (*ibid.*).

Box 8: Institutionalising monitoring systems through the Virtual Poverty Fund

The MDG VPF (through which COPE and the MCH programme are funded) has put in place a budget tracking system and also a decentralised M&E framework for monitoring outputs and outcomes in which the private sector and civil society are involved. As projects are implemented through MDAs, and also through states (since 2007) and LGAs (since 2010 or starting in 2011), the VPF has sought to institutionalise these practices more broadly (Dijkstra et al., 2011a). Currently, while the VPF M&E system is widely seen as good practice, federal agencies and states are not (yet) applying it for other expenditure (*ibid.*). However, there seems to have been some influence on project formulation and planning, as MDG costing exercises are becoming more common and these exercises are integrated into medium-term sector strategies. It is hoped that these changes will lead to more effective government spending and thus to better service delivery in the future (*ibid.*).

These challenges highlight the need to institutionalise and build on appropriate accountability and transparency mechanisms within the systems through which social protection programmes are being implemented. It will also be important to encourage bottom-up systems of accountability – programmes such as SAVI are working on these issues. As social protection programmes are rolled out, households and communities must be aware of their entitlements (and also why they may not be entitled) so they can hold implementers accountable. In addition, grievance mechanisms must be put in place, as has been done in other social protection programmes in India and Ethiopia, for example.

Institutional coordination and capacity

The Vision 20: 2020 document identifies institutional coordination as the major constraint to social protection in Nigeria. This was echoed in KIIs, which emphasised that social protection in Nigeria is not yet well structured (KII with NPC): it lacks a clear definition agreed on by multiple stakeholders; and different MDAs at the federal, state and local level assume responsibilities for policymaking, financing, coordination and implementation, and do not communicate well, leading to duplicated efforts, inefficiencies and limited cost effectiveness (KII with NHIS). Despite this recognition of the need for improved coordination, there is no clarity on which institution is best placed to take a leading role in coordinating social protection at the national level.

At the federal level, while the NPC Social Services Department is responsible for the coordination of social protection, the NPC itself envisages a relatively long process to develop an appropriate structure that would ensure other ministries' buy-in. A recent restructuring within the NPC may give the Social Services Department greater influence.

Moreover, there are various overlaps in terms of functions between different teams within the NPC, which create problems for effective coordination. For instance, development partners who are influential and support social protection at the national level are required to 'go through' the International Cooperation Department³⁶ within the NPC, as well as sectoral and technical teams. The weak positioning of the Social Services Department is a key challenge in relation to driving social protection forward at the national, state and local levels.

As social protection interventions have developed both within and outside the government, the role of development partners – and their relationship with government in the context of social protection – has changed. For instance, despite initial coordination between development partners and the government on COPE, DFID, UNICEF and the World Bank have subsequently set up parallel structures at the state level to implement CCTs. This issue will need to be resolved, as there is consensus that the government needs to take the lead on social protection for it to be sustainable; while parallel structures may be needed in the short term to ensure effectiveness, transparency and efficiency, in the long run there should be convergence and development partners should prioritise supporting social protection systems, not projects. There are examples of positive coordination on other social protection interventions: in the case of the CBHIS, for instance, international agencies such as DFID, UNFPA and WHO are providing technical assistance through design and scoping study initiatives (PATHS2, 2010).

Development partners need to support both the federal government and state governments. At the federal level, they need to help in developing an overarching policy on social protection which can provide guidance at the state level on different types of instruments – including different cash transfers – that can be adapted to state needs. Strengthening coordination among sectors will also be important, given the cross-cutting nature of social protection. At the same time, technical assistance is needed for states to be able to interpret the most appropriate and feasible social protection interventions and to deliver them, building on existing capacity, structures and actors. Indeed, technical assistance should support existing delivery channels where possible, as well as inter-sectoral coordination at the state level.

Improved coordination between sectors could also support opportunities to address multiple vulnerabilities and risk and to integrate gender, OVC, child protection and HIV issues into social protection activities. For instance, forums exist for strategic partners to share on issues such as OVC response, including the Development Partners Forum, which meets on a quarterly basis; the National Steering Committee, which brings together different agencies and partners, including poverty alleviation-focused agencies such as SMEDAN; and a National Technical Coordinating Meeting (KII with FMWA&SD). Identifying a social protection focal point to be represented in these meetings and on these bodies could be beneficial. This is also true at the state level. In Katsina, for instance, a key problem identified by the CCT team is that, although there has been a focus on education service delivery, little prioritisation has been given to the

³⁶ This department monitors development partners and tracks official development assistance (ODA) and contains national experts sponsored by the European Union (EU).

financial inclusion of the most vulnerable families or supporting their access to credit markets. In other words, up until the implementation of the CCT, there had been a focus on supply but not on the demand side of accessing services. More coordination at state level is therefore seen as an urgent priority in providing this type of service to the community (KII with Ayala Consulting). In Jigawa, the CGS is being implemented by the Directorate of Economic Empowerment, but an inter-ministerial committee coordinates this, with membership from Education, Health, Budget and Economic Planning and Local Governments (KII with Budget and Economic Planning Directorate).

Coordination is not only an issue horizontally at the national and state levels. The federal nature of Nigeria, with its state autonomy and LGAs, further adds another complex layer in terms of promoting institutional coordination, transparency and accountability. Learning from other sectors could generate ideas to take across to the emerging social protection sector. For example, in the health sector, the NPHCDA reports directly to federal level on technical issues, which ensures quality in an otherwise vertically autonomous structure (KII with NPHCDA). It might also be possible to build on the successes of the CGS, where it has worked (states committing additional funds).

Institutional coordination challenges are plagued by problems associated with the lack of structures to facilitate and incentivise cross-institutional working (e.g. working groups, such as the old SPAG, which supported the development of the initial 2004 draft Social Protection Policy). They are also a result of a weakness in institutional capacity associated with high turnover of staff in ministries and posts, limited technical expertise of appointed staff, low levels of commitment and low staff numbers. The NPC in particular identified current recruitment problems, restructuring and the movement of staff from other departments as a key constraint, although there was a desk officer for social services post was planned for the near future, which would help address some of these challenges.

Institutional capacity also affects implementation of existing social protection programmes on the ground. While state and LGA staff have been trained at the federal level, capacity challenges are identified as one of the key constraints. This is highlighted by Omar (2009): particularly sub-national level staff are 'under-skilled and under-qualified'. In COPE in Jigawa, for instance, there are challenges in terms of human resources and technical capacity in the implementing agency, and capacity gaps, particularly in terms of implementation and monitoring to ensure achievement of the ultimate objective of breaking intergenerational poverty transfer, need to be filled (KII with Budget and Economic Planning Directorate). Differing capacity in different states makes it difficult to scale up nationally and simultaneously (KII with OSSAP-MDGs).

While there are short-term mechanisms through which to address these capacity gaps (e.g. training), there is a longer-term challenge in terms of capacity weaknesses in the systems needed to implement effective social protection – for instance in the capacity of the welfare state, where there are huge gaps in the social worker system, in regulation and in coverage at the community level (KII with Save the Children UK). In the health sector, federal level agencies (National Primary Health Care Development Agency, Head of Health Financing and Health Economics section) have tried to overcome some of the challenges of retaining staff by making agreements with state governments that the federal level will provide salaries for two years, while the state provides top-up and accommodation (KII with NPHCDA).

On-the-ground implementation is also supported by numerous international and local NGOs, faith-based organisations and communities themselves. Many organisations approach pro-poor development by working specifically with communities rather than individuals, to enhance buy-in (e.g. community builds a gate for a school) and sustainability (e.g. Save the Children UK). Other organisations use a block grant approach (e.g. Catholic Relief Services and Christian Aid) (KII with Save the Children UK). Key challenges include the fact that communities see themselves as beneficiaries and not partners; that it is difficult to get and retain volunteers without paying them; that community-based organisations require significant monitoring and supervision; and that communities do not always equally share out benefits (KII with NGOs/CSOs).

Donors could play a key role in addressing capacity gaps through technical assistance. Building the capacity of implementing units and sharing knowledge and lessons learnt have been a major component of CCTs in Bauchi, Kano and Katsina (KII with Ayala Consulting).

In other countries, such as Brazil and India, institutional incentives are put in place to support improved accountability, coordination and capacity. India's national public works programme, for instance, penalises state- or village-level governments if they do not provide employment within 15 days of the demand for a job. In Brazil, a number of institutional reforms were enforced when Bolsa Família was consolidated from a number of small state-led CCTs into a federal-driven programme, including a single registry, performance-based financial incentives to states and implementing partners and the promotion of knowledge sharing (see Box 9).

Box 9: Experience of Brazil's Bolsa Família in building accountability, institutional coordination and capacity

Bolsa Família is managed centrally by the Ministry of Social Development, yet numerous other agencies, both centralised and decentralised, are involved in the implementation of the programme. The development of the single registry system has enabled beneficiaries to access additional programmes and services – such as health, primary education and social assistance – as well as enhancing both horizontal (between sectors) and vertical (across different government levels) coordination among institutions. This is a significant departure from a historically fragmented social policy institutional framework in Brazil. The single registry system, initially started in 2001, has been identified as 'the single most important management tool' available to Bolsa Família: the single social assistance database is based on a system of unique identification numbers, to serve as a targeting and monitoring instrument to reduce both duplicate registrations and administrative costs, to monitor eligibility requirements, to improve efficiency and to ensure horizontal coordination between social policies (ILO, 2009).

However, the relatively complex institutional structure is also associated with a number of complex challenges. These include managing third party implementers to ensure quality implementation by actors other than the federal government, namely, the 5,564 municipalities responsible for registration in the single registry system, monitoring of conditionalities and making payments.

Administrative and financial capacity and levels of political commitment to delivering the programme vary vastly across the thousands of municipalities. In addition, given the multiple array of municipal-level programmes, sub-national CCTs mean Bolsa Família faces an additional challenge in relation to potential duplications (Lindert et al., 2007).

A number of solutions have been put in place to try to overcome these key challenges. These include:

- Establishing formal joint management agreements between the Ministry of Social Development and all municipalities in order to formalise municipal implementation roles and responsibilities, setting up minimum standards for programme operation and carrying out audits (Lindert et al., 2007).
- Developing an Index of Decentralised Management to assess municipal quality of implementation, in order to enable provision of performance-based financial incentives (administrative cost subsidies) and better quality implementation (Bastagli, 2008). Targeted training and capacity building is given to municipalities with low scores (Lindert et al., 2007).
- Agreeing performance-based contracts, e.g. with the Caixa Econômica Federal, which is also subject to audits under the oversight and controls network (Lindert et al., 2007).
- Agreeing joint cooperation contracts with other sub-national programmes in order to avoid duplications and to enable the facilitation of vertical integration and/or linking Bolsa Família beneficiaries to complementary services (Lindert et al., 2007).
- Knowledge sharing across municipalities to promote an exchange of municipal experiences, including field visits as part of the awards process for good practices (Lindert et al., 2007).

Source: Holmes et al. (2011b).

Service delivery

Delivering any type of services in Nigeria faces constraints and challenges. The social protection sector – which is dealing with relatively new types of instruments such as cash

transfers and different health financing mechanisms – faces a number of specific delivery challenges. At the same time, given that it focuses on increasing the demand side of accessing services, is also dependent on the effective delivery of other basic services and infrastructure. Indeed, for social protection in Nigeria to achieve its goals to support better outcomes in education, health, child poverty, gender inequality and livelihoods, programmes are reliant on these sectors to deliver social and economic services effectively. There is already recognition of the importance of these linkages, particularly in health and education, given the MDG framework, less so in terms of child protection, women’s empowerment and economic services. A number of other schemes funded by the MDGs-DRG seek to create these synergies specifically between safety nets and other sectoral initiatives, such as the Midwife Service Scheme (see Box 10), the CBHIS and the MCH (KII with Save the Children UK).

However, service delivery remains poor, despite investments and improvements in recent years, particularly in the health sector. Phillips (2009) notes that interventions to improve service delivery in Nigeria have traditionally taken a top-down approach, which has prioritised tertiary and secondary facilities at the expense of primary ‘front-line’ facilities. This approach has done little to improve primary facilities or to engage actors at sub-national levels who do not have responsibility for tertiary facilities and are not consulted with reference to possible improvements at the levels they are responsible for (ibid.). As noted above, the division of roles and responsibilities between the federal and the local levels means LGAs provide services with logistical support from the state government. The federal government is responsible for forming national policy and building infrastructure. This allocation of responsibility means local government – the tier with the least resources (both financial and human) as well as the least capacity – is responsible for providing essential basic services (ibid.).

Box 10: The Midwife Service Scheme

The MSS was designed to address the shortage of skilled birth attendants at PHC level in Nigeria – a key factor in high maternal mortality – and is a collaborative effort between the Federal Ministry of Health (FMOH) and core partners in MCH efforts, funded under MDGs-DRG. A total of 2,608 midwives have been deployed to 652 PHC facilities in 332 LGAs in all 36 states and the FCT. The programme is implemented by the NPHCDA and provides antenatal, delivery, postnatal and family planning services, and community-based outreach services, to contribute to attainment of MDGs 4 and 5.

The MSS serves an estimated 10,711,532 women of reproductive age (15-49) in 36 states and 2,463,652 in the FCT. The estimated travel distance to take part in the scheme is 23 km (range 7-47 km), which is above the recommended distance of 5-10 km, but this varies between states.

An evaluation study found that a high proportion of MSS PHC facilities (77%) and designated referral hospitals (86%) were assessed as ‘fair/good’. However, between June and July 2009, 30-70% of the 652 MSS PHC facilities had no midwives, mainly in the North Central, North East and North West zones; 20-30% of facilities had one midwife, mainly in the South South, South West and South East zones. No facility had four midwives.

Most of the women who use the service are petty traders, farmers or housewives. A total of 60% live on more than N5,000 a month (average \$1 a day). Between July and December 2009, there were 27,977 deliveries (28,021 in the preceding six months). A total of 220 women died. The facility-based mortality ratio is 789/100,000 from pregnancy and associated factors. The neonatal mortality ratio in MSS facilities is 10.97/1,000 (306).

The evaluation recommended that initiatives to enhance the quality of services are put in place and that non-regular supervision visits are made to PHCs. It is also necessary to identify training needs and deliver training for MSS midwives.

Service delivery challenges are compounded by the fact that both the health and the education budgets are significantly lower than international best practice standards. The public education system in Nigeria, for instance, is often described as failing. It is unable to meet demand for primary and secondary education; there are huge regional-, gender- and income-based disparities with regard to access; there is a shortage of teachers – many of whom are under-qualified and under-motivated; and there is a lack of investment (Eldon and Gunby, 2009).

Similarly, the health sector is plagued with problems, such as low efficiency and effectiveness; poor budgetary allocations; ineffective use of resources in running the health system; and unbalanced and inequitable distribution of resources (skilled personnel, health care providers, etc.), largely in favour of urban elites (NHIS, 2010). The National Health Strategy Plan costed a minimal package to prioritise five childhood diseases at \$37 per capita annually. Even if funding were available, however, it could not be delivered, as a result of poor supply, and in practice the cost would be much higher (KII with UNICEF). With budget allocations to health low (approximately 6.1% of government expenditure), the cost of drugs and equipment is borne by donors, with the government paying only for childhood vaccines. The bulk of health costs are borne by individuals and the bulk of services are provided by the private sector (approximately 60% in the south and about 20% in the north (ibid.)). On average, out-of-pocket health expenditures amount to 67% (ibid.).

A study in 2008 found that 50% of households in Nigeria lived within 30 minutes' walking distance of the nearest community health facility and 9.8% lived within 3 hours' walking distance. However, more rural households took less than 30 minutes (56.1%) than urban households (37.6%) (FMWA&SD, 2008). Distances to referral centres (the next level of health care) were longer: 54.2% of households covered a distance of more than 4 km to reach the nearest health referral centre within the locality; 11.7% covered less than 1 km. Around 65% of rural dwellers travelled more than 4 km, but only 33.2% of urban dwellers covered the same distance (ibid.). The same study highlighted a lack of adequate trained personnel in nearly all medical institutions surveyed, coupled with gross inadequacy of drugs (ibid.).

Similar challenges are found in the child protection sector, especially as it is not a priority for policymakers and government agencies charged with working on it are among the most marginalised. There are very few professional personnel, such as social workers, particularly at local levels, and little attention goes to strengthening the child protection system. Coordination is low, programming and planning fragmented, data limited and budgets inadequate and vulnerable. Reliance on international agencies for funding and implementation is very high, with local Nigerian NGOs occasionally serving as intermediaries. This situation exacerbates fragmentation and makes sustained systematic programming difficult. Only 10% of children aged 0-4 are registered at birth, and this varies significantly by region: 30% of children in the South West are registered compared with 2% in the North Central (FMA&SD, 2008).

Financing social protection

Economically, Nigeria is a middle-income country with a high dependence on oil revenues although there has also been growth in the non-oil economy in recent years. Significant variations in budgets and expenditures across states are found due to the fiscal decentralisation structures in the country. Unlike in other countries, Nigeria's federal level does not allocate resources equitably to the states: around 50% of the allocation from the federal account is distributed evenly, regardless of states' size or population. Around a third reflects derivations of oil payments, meaning that in 2005 just four states (Delta, Rivers, Akwa Ibom and Bayelsa) received an extra \$2 billion between them (Freinkman, 2007). A further 2.5% is distributed according to local revenue effort – which penalises poor states which lack the capacity to generate their own income through taxation while and rewards the better-off. All this has led to huge inequality between states. Between 2001 and 2005, the difference in per capita transfers between the poorest and the richest states increased by between 9 times and 17. Four states (with around 11% of the population) received a quarter of all transfers in 2001; this had risen to a third by 2005 (ibid.). In June 2010, the state with the highest allocation was Akwa Ibom, an oil-producing state in the Niger Delta, with N14 billion. Lagos received N7 billion, Bauchi and Kaduna N3 billion and Adamawa, Benue, Ado and Enugu N2 billion each. Abia state received the least, at N2.07 billion (Federal Ministry of Finance, 2010).³⁷

³⁷ Note also that, as most states rely almost totally on federal transfers for revenue, they are vulnerable to changes within the Nigerian economy and the fluctuating price of oil.

Government expenditure in the social sectors has typically been very low by international standards. Hagen-Zanker and Tavakoli (2012), taking a broad definition of social protection, find similarly low government expenditure on the sector, estimated at 1.4%.³⁸ Of this, social assistance (excluding civil service schemes) is at 0.4% of GDP. This is much lower than other social sectors: education has the highest budget share out of all social sectors, taking an average of about 12% of government expenditure; health expenditure takes around 7% on average (ibid.). Even compared with other African countries, the government's allocation to social protection is low.³⁹ Social spending has also been declining as a proportion of government expenditure in the context of the recent Triple F crisis. Gavrilovic et al. (2011) finds that estimated expenditure on education and health in 2009 showed a decline, both in the amount allocated to the social sectors (N466 billion) and in their share of total federal expenditure (14.19%) (CBN, 2009). Since the lower tiers of government rely heavily on these allocations, particularly for the delivery of essential social services, declines in federal revenues in 2008-2009 led to a contraction in the resources available for the state governments and LGAs.

The Vision 20: 2020 implementation document mentions allocations to social protection for 2010-2013 at N186 billion. However, the budget does not define the type of social protection programmes this will be allocated to. Indeed, there is no costed plan with regard to implementing a social protection package in Nigeria, or particular types of cash transfers. In practice, the MDGs-DRG has secured allocations to the social sector, dictated by conditions attached to the debt relief gains. Most of the \$750 million provided since 2006 has been allocated to strengthening PHC, primary education and providing access to water and sanitation. Smaller shares (around 5% each) have been allocated to social safety net projects and to improving rural infrastructure (Dijkstra et al., 2011a). However, a key concern is the sustainability of funding of social protection activities after MDGs-DRG funding ends.

A geographically targeted benefit to reach all households with children under five years in Jigawa and Kogi (two of the poorest states in Nigeria) equivalent to the current low COPE benefit – N2,500 per month – would cost N17 billion per year (based on the NLSS 2003 demographic profile).⁴⁰ This represents approximately 0.05% of Nigeria's 2010 GDP and would reach 57% of the poor in these two states (based on the moderate poverty line), or 2% of all households in Nigeria. Errors of inclusion would be very low – around 91% of beneficiaries would be poor. However, such a benefit would cost almost 30% of the total allocation to social protection per year in Vision 20: 2020 (the N186 billion is budgeted over a three-year period).

In this context, competing investment needs, stretched resources (particularly at the state level) and inefficiencies in expenditure are likely to reduce financial commitment to social protection. The CGS was initiated as a way to address this issue, alongside issues relating to financial sustainability and stimulate state funding. In addition, the MCH programme is designed so that states scale up counterpart funding over time while MDG funding scales down. By 2015, state governments are expected to take over funding completely (NHIS, 2010). However, despite the allocation of N150 billion in funds from MDGs-DRG (KII with OSSAP-MDGs), actual spending has been below budgeted allocations, with money not spent on the intended purpose within a year having to be returned (Dijkstra 2011b). Finally, only a third of state governments have committed to matching funding in the recent third phase of the COPE programme.⁴¹ As such, despite international evidence indicating that well-designed

³⁸ Nigeria's federal structure and the absence of a computerised budget system mean it is extremely difficult to obtain comprehensive budget data (both budgeted and actual) for the country on a federal, state and local level. To compensate for data gaps, the authors utilise estimation techniques to present a complete picture. The data sources, methodology and limitations are now discussed in more detail in the full report. Social protection includes all expenditure on women, poverty and social development affairs (Hagen-Zanker and Tavakoli, 2011).

³⁹ Nigeria spends a significantly lower share of government expenditure (0.9% in 2006-2007) on social protection than much poorer countries (Ethiopia, Kenya, Malawi, Mozambique and Uganda spent an average of 1.4% in the same year (Hagen-Zanker and Tavakoli, 2011)).

⁴⁰ See cash transfers report for the simulation (Holmes et al., 2011a).

⁴¹ For instance, Niger state promised a N1.7 billion contribution to Phase 1 but this did not materialise because of worsening economic conditions, according to state officials, which raises concerns around the feasibility of the 50% state counterpart funding in Phase 2 of the scheme (USAID, 2010, in ODI, 2010).

interventions can be cost-effective and instrumental in reducing poverty and vulnerability, more action is needed to make the case for social protection as part of a poverty reduction package to garner increased fiscal commitment to such programmes.

Hagen-Zanker and Tavakoli (2012) suggest that the greatest scope for increasing fiscal space for pro-poor social protection lies in three options: i) mobilisation of domestic resources; ii) possible increases in ODA specifically targeted at social protection; and iii) improving the public financial management of public expenditure (see Hagen-Zanker and Tavakoli, 2012, for a more detailed discussion on fiscal space for social protection in Nigeria).

Political commitment

Development programmes, including social protection programmes, are highly political, and in Nigeria have tended to be limited to the lifespan of governments. Programmes have in the past been used as tools to gain political support (Aigbokhan, 2010), and also have a tendency to be state specific rather than nationally led. As highlighted above, social sector spending, and social protection spending in particular, is low in Nigeria. This is not just a financial issue but also a political economy issue. Despite DRG-MDGs being a significant factor driving the commitment to, and development of, safety nets in the country, financial commitment at the state level has remained low. As pointed out in interviews with key informants, current spending patterns at the federal and some state levels prioritise more visible projects such as infrastructure/electricity projects.

Recent Drivers of Change research carried out by SAVI in five states (Enugu, Jigawa, Kaduna, Kano and Lagos) identified the key developmental issues of importance to the people and stakeholders in each state. Social protection was referred to briefly only in Lagos (providing safety nets for the vulnerable by mobilising funds from taxes to support economic growth (SAVI, 2009a)) and Jigawa (an enabling environment to support girls' education and high interest to address this through a CCT (SAVI, 2009b)). In order to understand the factors which influence commitment to social protection, as well as those which block it, in a more meaningful way, applying a Drivers of Change or political economy analysis to social protection may be beneficial.

In Jigawa, for instance, the pro-poor agenda of the current governor is reflected in the state's broader interest in and commitment to social protection programmes. The state has a disability grant and has passed Law 6 of 2007 to guarantee the payment of social security allowances to the most vulnerable groups among the poor (including the disabled). This regulatory framework also requires LGAs in the state to be part of the initiative (KII with Budget and Economic Planning Directorate). The current administration is particularly concerned that Jigawa has one of the highest poverty incidences in Nigeria and in the North West zone, which has prompted it to pursue poverty alleviation and economic empowerment programmes.

Meanwhile, state ministries are responsible for state-level expenditure decisions, but the centre has largely dictated the design of safety nets. While in some states this has not been a problem (e.g. Jigawa), for others the conditions attached to cash transfers, for instance, may have affected political commitment. For instance, South West zone states have very low school dropout rates, so states' level of commitment is lower. In the north and east of the country, however, getting more children into education is a top priority. State governments have been more interested in the CCT and have much to gain by getting children back into school.

Finally, despite the proposed variety of safety nets discussed in various policy documents, in practice limited discussion on the different instruments that might be appropriate in Nigeria has resulted in a very narrow approach to CCTs. Obtaining political influence for social protection will be a complex process, and will require a coordinated approach from champions in the government at national and state levels, development partners and civil society as well as evidence on the role that social protection instruments can play in supporting Nigeria's broader development and growth objectives. This should include a focus beyond the MDG and DRG agenda, and prioritise advocating social protection to influential ministries such as the Ministry of Finance; leveraging the power of stronger sectoral ministries, such as Education and Health, at the federal level; putting social protection on a high political agenda (as with

the presidential mandate given to the NHIS to achieve universal health insurance coverage and access to health care for all Nigerians by 2015); advocating to the National Assembly, which can challenge individual budget items and add projects; mobilising the Governors' Forum to lobby the President or National Assembly, for instance drawing on states with pro-poor governors proven to be responsive to social protection issues; and implementing a state-level peer review mechanism, which will give some incentives for state public financial management reform to provide political incentives to release funds and provide services, particularly in health and education.⁴²

⁴² These incentives include encouraging states to release more budget documentation, expenditure monitoring and other information into the public domain to create an entry point for civil society actors to lobby. Incentives for state governors to take part in public management reform include being seen as credible and progressive. Such a mechanism will be piloted soon with DFID support (KII with DFID).

7 Conclusions and policy implications

Over 50% of Nigeria's population lives in poverty and, coupled with its large population (155 million), this poses significant challenges for the pro-poor and poverty reduction agendas in the country. At the same time, however, Nigeria is classified as a lower-middle-income country. While the economy is highly dependent on oil (and thus is vulnerable to economic risks), the future economic outlook is one of growth, offering opportunities for the government to support the development of the country financially.

Nigeria has a very high Gini coefficient, reflecting high inequality throughout the country, despite improvements over the past two decades. An increasing urban population (almost 50%) means that both rural and urban poverty urgently need to be addressed. Furthermore, although improving, basic health and education outcomes are low, especially for the poorest, quintiles with high rates of maternal and child mortality. Malnutrition and food insecurity also affect a large proportion of the population, in particular pregnant women and young children. HIV and AIDS affect an estimated 3.3 million people: Nigeria bears nearly 10% of the global burden of HIV, with prevalence rates varying significantly by geographic regions.

Poverty is influenced not only by income also by economic and social risks, which result in gender inequalities and child protection deprivations. Women's human capital development, economic participation, voice and agency (e.g. political representation) at the national, community and household level are significantly lower than men's, which leads to suboptimal development and economic growth outcomes, but also represents a violation of women's basic human rights. Children also face severe deprivations which, like gender inequality, are often driven by poverty alongside socio-cultural and religious norms which vary by and within regions and states. Girls' early marriage, trafficking and child labour are particular concerns.

The Triple F crisis has heightened these existing vulnerabilities at the household level. In particular, rising food prices, falling remittances, high unemployment and increased vulnerability to environment shocks have resulted in households working longer hours in dangerous jobs and pulling children out of school (Gavrilovic et al., 2011). This has had severe detrimental effects on consumption, access to health and education and child protection.

In the context of Nigeria's strong growth rates but high poverty rate, and the threat of instability that this raises, social protection can be seen as one policy tool to address the development challenges the country faces. Recent regional and global imperatives to invest in social protection argue that social protection policy can support a more equitable pro-poor growth model (especially in the case of Nigeria, where strong growth economic is not reaching the poor) by supporting both economic and social development. As shown below, however, this report finds that the social protection agenda is currently limited and, as such, is not yet adequate to address these challenges. After this summary, we present a number of policy implications for the government and development partners to help strengthen this agenda.

7.1 Policy responses

A key criticism of the Nigerian government has been its limited prioritisation of the poor within the health, education and social welfare (e.g. child protection) sectors (as well as in the economic and agriculture sectors). More recently, there has been recognition that focusing on the supply of services has not been adequate in reaching the poor – there also needs to be a simultaneous focus on addressing the barriers that the poorest face in accessing services. This has resulted in funding from Debt Relief Gains-MDGs (DRG-MDG) fund of COPE (focused on health, education and economic empowerment) and the Maternal and Child Health Care Programme (MCH) fee waiver programme. Current expenditure on social sectors in general and the social protection sector in particular is very low, however, and represents only 5% of the DRG-MDGs (excluding state contributions) and 1.4% of government expenditure

Social protection policy has been discussed since 2004 at both national and also regional (AU) levels, but this has not resulted in policy traction beyond the three small-scale government-led programmes (COPE, MCH and Community-based Health Insurance Scheme (CBHI)) despite a chapter committed to social protection in Vision 20: 2020's implementation plan. Policy documents on social protection take a lifecycle and gender approach to risk and vulnerability (recognising both economic and social risks including e.g. job discrimination and harmful traditional practices) and arrange social protection around four main themes: social assistance, social insurance, child protection and the labour market. However, in practice, implementation of social protection instruments is extremely narrow.

7.2 Social protection programming

Current social protection programming in Nigeria is funded and implemented by a range of government, donor, international NGO and CSO actors. Government-led safety nets programming consists of the three programmes above (social assistance and social insurance): the COPE Conditional Cash Transfer (CCT), the MCH health fee waiver and CBHI (to be re-launched this year after problems with programme design). Other social assistance programmes are implemented in an *ad hoc* way, run by government ministries at federal and state level. These include child savings accounts, disability grants, health waivers, education support (e.g. free uniforms) and nutrition support. Programmes led by donors include the CCT for girls' education in three states. Some programmes include social protection subcomponents (not as the primary objective), such as HIV and AIDS and OVC programmes which incorporate nutrition support and support for health and education.

Labour market programmes include federal- and state-level agricultural subsidies/inputs and youth skills and employment programmes. These are not necessarily targeted at the poor, and are often implemented at the discretion of the state rather than as part of a coordinated response to unemployment and underemployment and constraints to agricultural productivity.

Social equity laws and legislations which can be seen as part of the transformative social protection agenda have included the passage of the Civil and Political Rights Covenant, the Economic, Social and Cultural Rights Covenant, CEDAW and the Convention on the Rights of the Child (CRC). However, only the CRC is domesticated, and even this not by all states, with implementation of all laws weak at best. There is limited, if any, conceptual link between the broader regulatory policies of equality and rights and social protection policies.

7.3 Actors and institutions

While there are a number of institutions directly and indirectly involved in social protection at the national, state and Local Government Authority (LGA) levels, only a few Ministries Departments Agencies (MDAs) and donors at the federal level are currently and actively driving social protection forward (e.g. OSSAP-MDGs, NAPEP, NSITF; DFID, UNFPA, UNICEF, WHO, World Bank). Other MDAs are involved in social protection but have less presence in federal-level discussions on social protection (e.g. Women Affairs and Social Development, Health, Education, Labour and Productivity, Works, Agriculture), although they tend to have more visibility and presence at the state level (for instance as part of COPE state social assistance committees). There are also a range of NGO and CSO actors at the local level involved in implementing social protection programmes directly and indirectly (especially in terms of child rights and HIV programming).

The multiplicity of actors at federal, state and LGA levels means that programming is currently *ad hoc* and uncoordinated. While the NPC is responsible for coordinating social protection, weak institutional capacity, high staff turnover and limited coordination structures are key challenges. OSSAP-MDGs has been spearheading the social protection agenda within the MDG framework, but the sustainability of this post-MDG and DRG funding is of critical concern. As such, there is currently no clear institutional leader with the required political authority to coordinate between MDAs as well as to foster political and financial commitment to social protection.

Moreover, despite the convening of the Social Protection Development Partners Group to facilitate information sharing between actors, the focus of both development partners and NGOs in the country is reinforcing the projectised approach being taken to the sector.

7.4 Effectiveness of existing social protection programmes

The lack of impact data on current social protection limits the extent to which it is possible to evaluate the effectiveness of programmes. Moreover, as some programmes are relatively new (the CBHIS and CCTs for girls' education), M&E data are often not yet available. A wider concern is that, for existing programmes, M&E has focused on programme *outputs* (e.g. numbers of households reached, effectiveness of service delivery) and not *impacts*.

FGDs and KIIs conducted for this project suggested that, despite the small size of the transfer given to households in COPE, this has been important in helping households meet their immediate needs in terms of consumption and school costs. However, the transfer is not sufficient, especially for large families (COPE is designed based on a family of five, although 90% of the poor live in families of around 20, particularly the case in northern regions with polygamous households) but also for smaller-size families, to meet monthly household needs. The COPE programme also appears to have been less successful in enabling households to graduate through its economic promotion component (PRAI). These findings corroborate results from existing data, which indicate some initial small-scale impacts at the household level: Dijkstra et al. (2011a; 2011b) report that COPE's target population in Nigeria is still too small for the programme to make a palpable impact and that, since the most recent income poverty data are from 2004, it is as yet impossible to examine an eventual effect of the social safety net programme.

It is estimated that the first 15 months of Phase 1 of the MCH programme saved up to 470 women's lives and 1,070 children's lives, with a positive benefit-cost ratio of 6.4 (USAID, 2010, in Gavrilovic et al., 2011). However, given that it is estimated that in 2009 there were a total of 4.2 million pregnant women at any given time and a population of 25.3 million children under five, the scheme represents only a tiny fraction of the potential beneficiary population.

Social protection programmes for the poor are making steps towards addressing inequality and poverty, to some extent – in conceptual design at least – by means of a child-sensitive approach. The government, by targeting the poorest of the poor through COPE, has gone some way to addressing the severe inequalities the extreme poor face in access to services and promoting livelihood opportunities and a basic consumption safety net. Similarly, the CBHIS and the MCH programme aim to provide basic coverage of essential services to those most excluded from these to date. The three girls' education CCTs go a step further by recognising and addressing gender inequalities specifically related to education and also by incorporating community sensitisation on the risks of early marriage.

7.5 Gaps and challenges in the social protection sector

The social protection sector faces numerous challenges. Actors and programmes remain fragmented and *ad hoc* – government, development partners and NGOs contribute to the uncoordinated and projectised nature of the sector. The scale of programmes is extremely small, reaching a maximum of a third of all states, and coverage is estimated at a tiny fraction of the poor. Low coverage is a result of a combination of constraints, including political, financial and capacity limitations. Coupled with the low value of transfers, this restricts the potential effectiveness of social protection to address poverty and vulnerability, especially in the context of increasing vulnerabilities as a result of the Triple F crisis.

Social protection programmes also remain focused on a narrow set of risks and target groups. In the case of COPE, while the objectives are multiple (health, education, investment), the design is not necessarily well suited to the needs of households (especially if they are labour constrained). There is scope to increase the range and improve the sequencing of targeted social protection instruments: for instance, within the MDG-driven social protection agenda,

there has so far been little attention to the role of productivity-enhancing instruments and, despite attention to gender- and child-sensitive social protection in some programmes' design, a concerted approach to addressing equity has to date been limited.

There is also scope to include referral mechanisms between services to support programmes to address a wider range of risks, although this would entail addressing the supply side of services (in terms of quality and quantity). Indeed, concerns over service delivery and other infrastructure (e.g. financial infrastructure, banking for the poor) have been raised and identified as another key challenge if social protection is to be scaled up throughout Nigeria.

Meanwhile, it is important to note that the geographic coverage of social protection programmes is determined largely by state-level political determinants, that is, the existence of political will and capacity within the state, especially now, given that COPE and the MCH are newly reliant on states matching government funding. Overall, scale-up would require addressing institutional, governance and financing constraints to delivering programmes and promoting coordination and efficiency among a variety of actors.

7.6 Policy implications

In light of progress made to date in social protection and the challenges that lie ahead in developing the sector in Nigeria, we discuss six key policy implications here.

1. Develop an overarching social protection policy framework to provide clear institutional roles and responsibility which guides social protection design and implementation at the federal and state levels

A overarching federal-level social protection strategic framework for social protection in Nigeria would clarify institutional roles and responsibilities, lay out numerous options for social protection in the country, facilitate dialogue and knowledge exchange on the different types of interventions suitable in the Nigerian context and promote inter-sectoral and federal-state coordination.

Such a framework would seek to support an institutional leader to drive forward social protection at the Federal level, beyond the MDG funding cut-off. This one institution needs to coordinate and provide oversight and guidance to the social protection strategy at federal level, while also being accountable and responsive to state needs. If the National Planning Commission (NPC) is to fulfil this role, institutional coordination structures should be put in place or strengthened, including linkages with development actors, and capacity to take on this role developed (e.g. through placement of a donor-sponsored national within the NPC Social Services Department). Nigeria could learn from other countries, such as Brazil and India, in terms of providing institutional incentives to promote improved coordination and capacity in the social protection sector.

Development partners, given their mandate to support and strengthen institutions in Nigeria, can play a key role here, for instance supporting institutional coordination mechanisms by facilitating an inter-ministry working group (including Women Affairs and Social Development, Education, Health, Agriculture and Finance, for example).

The framework should also aim to facilitate the federal government and development partners to provide more information about potential social protection interventions, beyond a narrow focus on cash transfers and health financing mechanisms. This would include supporting the states to consider a broader range of instruments to address poverty and vulnerability, in both rural and urban areas for the range of lifecycle risks, especially in the context of the Triple F crisis. This would include consideration of instruments that aim to reduce poverty and inequality and also to strengthen household resilience to future shocks and stresses. Regional/state context specificities in the design of social protection programmes should be encouraged.

Indeed, an overarching social protection strategy at the national level should allow states the flexibility to build on existing priorities, institutional structures and actors (e.g. strengthening

linkages to the Lagos Yellow Card programme; promoting synergies between HIV programming in Benue), recognising that states have different levels of capacity and commitment. Development partners can provide technical support and capacity building according to different requirements at the state level – focusing on developing and strengthening systems rather than following a projectised and compartmentalised approach.

Social protection instruments should be considered at the state level, based on the extent and patterning of poverty and vulnerability, existing structures, capacity of actors and fiscal availability and could include the following:

- Scaling up cash transfers – but with consideration of
 - Index-linked values of transfers/increases in transfer values;
 - Simultaneous investment in supply-side capacity (health, education but also HIV and child protection services);
 - Investment in rural financial infrastructure (banks) and capacity for people to access them;
 - State-specific additional components (cash 'PLUS') – e.g. nutrition, HIV focus;
 - Consideration of food transfers or mixed cash and food (especially where food prices have increased);
 - Lengthening programme participation;
 - For the PRAI, consideration of the appropriateness of household labour capacity (e.g. female-headed households, HIV), better investment in labour/skills/market analysis and other factors which affect investment (e.g. household health, resilience to disasters, longer-term subsistence support);
- Employment-based public works programmes (rural and urban), considering
 - Level of unemployment in the state;
 - Possible works to be undertaken (infrastructure, community work, health and child care);
 - Equitable wages for men and women;
 - Linkages to skills training;
- Agricultural inputs targeted at poor farmers;
- Nutrition programmes, which could include transfers targeted to at-risk groups – in particular children under five;
- A continued focus on, for example, education scholarships and subsidies and access to free health services for women and children.

As such, providing knowledge and information on a wider variety of potential social protection interventions could support policymakers at the state level to identify appropriate context-specific interventions, based on a critical assessment around the following key questions (the "6 As"⁴³):

- 1 Is it *appropriate* (is the instrument appropriate to achieve its goals and objectives of reducing poverty and vulnerability?)
- 2 Is it *achievable* (are there adequate resources, institutional capacity and services to ensure that this instrument will work?)
- 3 Is it *acceptable*? (is there popular and government support for this type of social protection instrument?)
- 4 Is it *affordable* (what are the implications of this instrument for cost and affordability?)
- 5 Is it *adequate* (e.g. the value of the transfer?)
- 6 Does it *add* value (does it complement other programmes, and are complementary programmes and services in place?)

⁴³ Developed by Slater, R. (ODI)

2. Support and generate political commitment to social protection at the federal and state levels

Currently, political commitment to social protection is very variable, at both the federal and the state level. Ways to ensure the sustainability of social protection have so far concentrated on devolving responsibility to the state level, which has led to some states taking up social protection initiatives through the CGS and others not. Encouraging broad-based political commitment to social protection needs to be built at both the federal and the state level, given the relationship between the two in terms of designing, funding and implementing programmes. Entry points to consider include the following:

- Invest in gathering state and local data on poverty and vulnerability profiling – especially social vulnerability profiling, disaggregated by age, sex, wealth and ethnicity;
- Support the provision of evidence to the Ministry of Finance, Budget Office and National Assembly as well as state-level governors on the benefits of social protection in reducing poverty, supporting economic growth and contributing to stability;
- Support the Governors’ Forum to influence the budget on social protection and leverage it to share information across states on social protection;
- Support a state-level peer review mechanism to incentivise public financial reform in weaker performing states;
- Encourage linkages between government, development partners and civil society to champion social protection – especially through a equity lens;
- Improve M&E systems and dissemination of good practices by designing M&E indicators and systems to measure impacts, disaggregated by sex and age. Development partners could support the development of a common M&E framework to allow for comparisons across programmes or states and to enable aggregation up to state level and to national level;
- Consider the promotion/support of state-level regulatory frameworks, for example in Jigawa, to support LGA commitment to and implementation of social protection;
- Commission a political economy analysis of the drivers of change in social protection.

3. Allocate resources to scale up social protection programmes

Options for increasing fiscal space will need to put in place systems and mechanisms for scaling up pro-poor social protection beyond small standalone projects. Of particular concern is limited funding to existing social protection from the DRG-MDGs fund and limited commitment to social protection through the CGS. Development partners could play a role in supporting the inclusion of social protection in a medium-term financing plan before DRG funding ends. Hagen-Zanker and Tavakoli (2012) also suggest that increasing fiscal space could include i) mobilisation of domestic resources (future growth); ii) possible increases in ODA specifically targeted at social protection (e.g. the sovereign fund); and iii) improving the public financial management (efficiency) of public expenditure (federal and state level). Development partners could support the use of recently developed financing tools to plan future expenditure priorities in social protection, for example the ILO/UNICEF Rapid Assessment Protocol and UNICEF’s Social Protection Floor Costing Tool.

4. Increase investment in service delivery

As social protection has developed in Nigeria, so has the focus on improving service delivery – in part because of the focus on the MDGs in linking the two. Social sector expenditure remains very low, however, and delivery of services remains a weak link in the potential scale-up and expansion of social protection. Simultaneous investment in the supply side of services in both the social and the economic spheres will be vital to maximise the effectiveness of social protection programmes.

5. Integrate an equity focus into the design and implementation of programmes

All social protection programmes must be age and gender sensitive. This could occur explicitly, through programme design which recognises both economic inequalities (e.g. labour market) and social inequalities (for instance public works ensuring women receive equal pay for labour-intensive works and sufficient child care, given their additional domestic/reproductive responsibilities; cash transfers ensuring that women's time poverty is not exacerbated). Or it could occur by creating linkages and referrals to programmes such as those addressing child protection issues and by sensitising communities to address social risks such as early marriage, child labour and trafficking (see Holmes and Jones, 2010b toolkit for a gender-sensitive approach to social protection).

Development partners can support awareness raising on the importance of integrating an equity approach to social protection by providing evidence and strengthening M&E systems and activities which collect and analyse data disaggregated by sex, age, ethnicity and geographical location.

An equity approach is particularly important in the context of findings on the Triple F crisis, which have demonstrated harmful coping strategies at both the household and the intra-household level, especially in terms of higher rates of informal work, exacerbation of women's time poverty and heightening of child protection deprivations, including child labour and exploitation.

6. Strengthen governance features of social protection programmes

Learning from other sectors in terms of strengthening governance will also be important as social protection develops in the country. Of particular importance will be putting in place mechanisms for accountability and transparency, which could include donor-funded technical support in MDAs and strengthening the capacity of federal and state levels to operate systems such as the CGS. It will be equally important to ensure that beneficiaries are informed about programme design and can participate in programme governance committees, for instance, and can access fair grievance procedures. This entails sensitising not only programme beneficiaries but also the broader community, so they can understand the rationale for targeting.

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Appendix 1: List of key informant interviews

Organisation and position	
1.	NAPEP, SA to Secretary of Programme
2.	National Planning Commission, Acting Director, Social Services Department
3.	National Planning commission, Chief Planning Officer, Social Development. SS dept
4.	OSSAP ⁴⁴ -MDG Office, Desk Officer, Social Safety Nets
5.	Save the Children UK, Deputy Director, Country Director
6.	Ministry of Education
7.	Ministry of Agriculture, PPAS (planning dept).
8.	UNICEF Nigeria Country Office, Chief, Social Policy,
9.	ILO, Deputy Representative
10.	Ministry of Women's Affairs and Social Development (MoWASD)
11.	UNICEF Child Protection Officer
12.	– Deputy Director of the NPHCDA – National Primary Health Care Development Agency, Head of Health Financing and Health Economics section
13.	World Bank, Social Protection Sector Leader
14.	National Social Insurance Trust Fund (NSITF), Head Special Duties and HR and Administration.
15.	WHO Nigeria and UNFPA Nigeria.
16.	National Emergency Management Agency, Assistant Director, Disaster Risk Reduction
17.	Ministry of Finance/ DFID/ UNICEF / World Bank
18.	DFID
19.	Voice & Accountability (SAVI)
20.	United Nations Development Programme (UNDP), country representative and economist, economic advisor
21.	National Aids Control Agency (NACA)
22.	National Agency for Prohibition in Trafficking in Persons and Other Related Matters (NAPTIP), research & programmes department

⁴⁴ Office of the Senior Special Assistant to the President, Millennium Development Goals (MDGs)

Organisation and position

23. National Health Insurance Scheme (NHIS), assistant general manager
24. International Monetary Fund (IMF), resident representative and economist (from Budget office)
25. Education Sector Support Programme in Nigeria (ESSPIN)
26. UNICEF, Head of Health
27. Justice for All (JFA)
28. Budget Office of Nigeria, ODI fellow and TA to Dr Bright Okogwu
29. NGOs/CSOs: Change Management; SOS; Empowering Women and Children; Oxfam and Gada
30. Ministry of Labour and Productivity, Director Labour Inspectorate, Director Factory inspectorate and Labour officer inspectorate department
31. Pension Commission (Pencom), Head research and policy unit
32. DFID Public sector reform projects, governance advisor DFID
33. Federal Ministry of Women Affairs, Assistant Director in Charge of OVC Programme
34. First Steps (CSO for OVCs) and (Jari Doo Foundation – a CSO which focuses on older OVCs)
35. SACA – Grace Ashi Wende, Executive Secretary, Benue State AIDS Control Agency
36. State Secretary, NAPEP Makurdi, Benue State Office
37. Permanent Secretary, MoWASD, Benue State
38. Director, Disease Control Unit of Edo State Ministry of Health
39. Edo State Ministry of Agriculture, Head, Veterinary Department
40. Deputy Director Department of Social Mobilization (MINISTRY OF EDUCATION: STATE UNIVERSAL BASIC EDUCATION BOARD (SUBEB))
41. Admin Manager of NAPEP
42. Representative of SPECIAL ADVISER TO EDO STATE GOVERNOR ON NON GOVERNMENTAL ORGANISATIONS (NGOs)
43. NAPEP, Federal Secretariat, Benin - Edo state
44. Secretary, Edo State NAPEP
45. Budget and Economic Planning Directorate. Jigawa State,
46. Katsina. PROJECT SPECIALIST, AYALA CONSULTING,

Organisation and position

47. CGS, in FCT

48. Accountant 2, NAPEP

49. Chairperson Board of Trustees, Ikosi-Isheri Local Council Development Area (LCDA), Lagos

50. Millennium Development Goals (MDGs)
Director, Department of Planning and Development.

51. Lagos State Ministry of Health, Gender Desk Officer

52. Education Sector Support Programme in Nigeria (ESSPIN)
State Team Leader

53. Department of International Donor Support, Cross River

54. Kano, CCT.
CCT resident consultant for Girl's Education Programme in Kano.

Appendix 2: COPE research questions

KII guide on cash transfers: state level

Questions	
Programme details	<p>What cash transfers are you aware of <i>currently</i> being implemented in the state? E.g. NAPEP, MDG office, NGO programmes?</p> <p>Please give us details about the cash transfer programme that your organisation is / has been implementing:</p> <ul style="list-style-type: none"> • The name of the programme • When the programme started and when it will be finishing • Please give us an overview of what the programme does and its objectives, e.g. What are the overall objectives and goals of the programme? How much money is transferred? How often do people receive it? Are there conditions attached to the cash transfer that households have to comply with? • The cost of the programme • Who funds the programme • Who implements the programme • Who makes the decisions about the programme funding, design and implementation • How was the value of the transfer calculated? • Why were these programme conditions chosen (e.g. if households have to send their children to school etc.)? • Were other transfers other than cash considered? E.g. in-kind? What were the reasons that cash was seen as the most appropriate transfer? • Are there any coordination mechanisms between other institutions and/or ministries/departments? • Who is the programme meant for and why (e.g. the whole household or specific members in the household – e.g. girls, boys, orphans, men, women, elderly?) • How many individuals or households have benefited from the programme? <p>Who receives or picks up the transfer? (e.g. mother, caregiver, father?)</p>
Programme effectiveness	<ul style="list-style-type: none"> • Have there been evaluations of the programme? If so, what were the results? Can you share documents with us? • In your opinion, what have been the successes of the cash transfer programme? (e.g. beneficiary improvements, implementation etc). • In your opinion, what have been the challenges of the cash transfer programme? (e.g. have there been positive or negative effects on the beneficiaries? Have there been implementation, coverage or funding problems?)
Institutional and funding arrangements	<p>How does the institutional and funding structure of this cash transfer work? For example, is the state required to match funds from the federal government to implement the programme?</p>
Political commitment	<ul style="list-style-type: none"> • Is the state government committed to poverty reduction programmes? • Has the state government committed matching funds for cash transfers? If not, what are the reasons for this? If yes, what are the reasons for this? • What are the other key priorities for the state government funds? • Are gender and child issues a priority for the state government? Please give examples.
Supply-side	<ul style="list-style-type: none"> • Is there adequate provision of supply-side services and infrastructure for cash transfers to work? E.g. are there schools, health centres, functioning markets? • Even if households have more income, what are the key challenges to them accessing basic services? E.g. distance from schools / health posts / markets • Do the poor have access to the banking system? If not, what alternatives are there for them to receive cash transfers?

Questions

Social impacts

- Given that social transfers are increasing targeted through female caregivers, to what extent do cash transfers empower women (e.g. by providing her with greater resources and decision-making power within the household) or to create an additional burden?
- Have there been any intended or unintended community effects, e.g. social exclusion, social capital, stigmatisation of people living with HIV/AIDS, or increased social cohesion and awareness?
- Have there been any intended or unintended intra-household effects of the cash transfer programme, e.g. on OVCs, relations between men and women, between parents and children

Capacity and implementation

- In your opinion, is there adequate institutional capacity and infrastructure to deliver cash transfers?
- How are cash transfers coordinated between different ministries, agencies and departments?
- Are there issues of diversion of resources? What has been put in place to overcome these challenges?

KII guide on cash transfers: community level

Questions

Programme details

Please give us details about the cash transfer programme in this community / LGA:

- When the programme started and when it will be finishing
- Please give us an overview of what the programme does and its objectives, e.g. How much money is transferred? How often to people receive it? Are there conditions attached to the cash transfer that households have to comply with?
- Who implements the programme
- Are there any coordination mechanisms between other institutions and/or ministries/departments?
- Who is the programme meant for and why (e.g. the whole household or specific members in the household – e.g. girls, boys, orphans, men, women, elderly?)
- How many individuals or households have benefited from the programme in this area?
- Who receives or picks up the transfer? (e.g. mother, caregiver, father?)

Programme effectiveness

- In your opinion, what have been the successes of the cash transfer programme? (e.g. beneficiary improvements, implementation etc).
- In your opinion, what have been the challenges of the cash transfer programme? (e.g. have there been positive or negative effects on the beneficiaries? Have there been implementation, coverage or funding problems?)
- In your opinion, has the targeting of the programme been effective? Has the programme reached the programme beneficiaries intended?

Programme design and implementation

- How much is the value of transfer? How was this calculated?
- Have all the monies been transferred to beneficiaries and were the payments on time? Did beneficiaries receive a lump sum cash transfer at the end of the programme?
- Are there additional requirements which the households must meet in order to receive the cash transfer? What are these and why were they chosen? Have households adhered to these conditions?
- Have the services and infrastructure been in place to enable beneficiaries to meet health and education conditions? What have been the key challenges associated with this?
- What are some of the challenges associated with community targeting? Is there a better way to target?

Questions

Institutional and funding arrangements

How does the institutional and funding structure of this cash transfer work? Have the funds been disbursed on time?

Political commitment

- Is the state government committed to poverty reduction programmes?
- Has the state government committed matching funds for cash transfers? If not, what are the reasons for this? If yes, what are the reasons for this?
- What are the other key priorities for the state government funds?
- Are gender and child issues a priority for the state government? Please give examples.

Supply-side

- Is there adequate provision of supply-side services and infrastructure for cash transfers to work? E.g. are there schools, health centres, functioning markets?
- Even if households have more income, what are the key challenges to them accessing basic services? E.g. distance from schools / health posts / markets
- Do the poor have access to the banking system? If not, what alternatives are there for them to receive cash transfers?

Social impacts

- Given that social transfers are increasing targeted through female caregivers, to what extent do cash transfers empower women (e.g. by providing her with greater resources and decision-making power within the household) or to create an additional burden?
- Have there been any intended or unintended community effects, e.g. social exclusion, social capital, stigmatisation of people living with HIV/AIDS, or increased social cohesion and awareness?
- Have there been any intended or unintended intra-household effects of the cash transfer programme, e.g. on OVCs, relations between men and women, between parents and children

Capacity and implementation

- In your opinion, is there adequate institutional capacity and infrastructure to deliver cash transfers? What kinds of challenges do you face in implementing the cash transfer? How could these be overcome?
- Are there issues of diversion of resources? What has been put in place to overcome these challenges?

FGD guide on cash transfers

State clearly at the start of the discussion the objective of the research study. Ask for permission to record the discussion and state clearly that participants will all be anonymous.

Questions for beneficiaries

Contextual information

- What are the main occupations/livelihoods of people here? Probe, migration, farming, business, etc.
- Who does what? E.g. men, women, children
- What are the major challenges people face here? Have these changed over the last few years? If yes, how, why?
- Has anything improved in the last few years? If so, what, and why?

Gender issues

- How much control do women have over decision-making in the community? What types of decisions? Probe education, health-seeking behaviour, older children's/young adults' choice of marriage partners? Are there major differences between different ethnic groups, regions, ages?
- Are there any women's organisations? What do they focus on (e.g. informal credit?). Are women involved in community decision making? If no, why not? If yes, in what capacity?

Questions for beneficiaries

Cash transfer details

- Have you all received a cash transfer?
- When? For how long?
- Did you receive monthly payments? How many Naira?
- Did you receive a lump sum at the end of the project? How much money was this?
- How much in total did you receive from the cash transfer programme?
- Were you required to do anything as a condition of getting the money? To what extent did you agree with these conditions, and to what extent were you able to comply with these conditions? Explain

Direct impacts of regular cash transfer

- When you received the regular cash transfer, who picked up the transfer? (e.g. husband? Wife?)
- Who decided what the transfer was to be spent on?
- What were the main items that the regular transfer was spent on?
- What have been the direct impacts of the cash transfer programme on the household? <<PLEASE ENSURE YOU ASK DETAILS FOR EACH HH MEMBER – MEN, WOMEN, GIRLS and BOYS>>

Improving economic security
 Improving food consumption (quality and quantity)
 Helping to provide better protection and care for HH members
 Improving household human capital
 Providing adequate protection from the impacts of shocks (e.g. floods, drought in the community, or household shocks such as illness and health expenses)

- Was the regular transfer sufficient to cover basic household needs?
- How would you have paid for these things if you hadn't received assistance through COPE (informal systems of support)?

Direct impact of lump sum cash transfer

- When you received the lump sum cash transfer, who picked up the transfer? (e.g. husband? Wife?)
- Who decided what the transfer was to be spent on?
- What was the lump sum cash transfer spent on? If it was invested in a productive activity, are you still making money?
- Was the transfer large enough to help you and do you feel that you no longer need to receive support?
- How would you have paid for these things if you hadn't received assistance through COPE (informal systems of support)?

Impacts of the cash transfer programme on the household

What have been the indirect impacts of the cash transfer programme on the household?

- Has participation in the programme changed men and women's relations in the household? In what way? (e.g. more or less tensions or conflict in the household? Women have more power over decision making?) What about any changes in relations between younger and older generations? In what way?
- Has participation in the programme influenced access to social capital (formal and informal)? In what way?
- What impact does the programme have on child well-being? (different children in the household, e.g. girls, boys, OVCs)
- Has participation in the programme had an impact on your access to credit services?

Questions for beneficiaries

Impacts of the cash transfer programme on the community

What have been the impacts of the cash transfer programme on the community?

- Increased access or use of community assets or basic social services, such as health or education?
- Has there been improved demand for better basic services?
- Has the targeting selection for beneficiary households created any tensions in the community? In your opinion, were the correct people targeted or do you think other people should have received the cash transfer too?
- Has the cash transfer helped people in the community who were previously excluded to be included in community activities?

Targeting

How were you contacted as a potential beneficiary? How was information about the targeting process given to you? Do you think this was a fair process?

Malpractice

Did you have any negative experiences from the cash transfer process? What have these been and what do you think the causes were? <<E.g. corruption, extortion etc.>>

Relative importance of cash transfer

How important has the cash transfer programme been in comparison to other support you have received? (e.g. family/friends support or other programmes)

Links with other programmes

Did this cash transfer enable you to link with any other support services that have been important to you and your family?

Links with HIV/AIDS

- To what extent has the cash transfer programme supported OVCs? In what way? Has it created any challenges?
- To what extent has the cash transfer programme supported PLWHA? In what way? Has it created any challenges?

Links with child protection

To what extent has the cash transfer programme helped address children's problems? (Researchers: please refer to the particular child protection issues)

Questions for non-beneficiaries

Contextual information

- What are the main occupations/livelihoods of people here? Probe, migration, farming, business, etc.
- Who does what? E.g. men, women, children
- What are the major challenges people face here? Have these changed over the last few years? If yes, how, why?
- Has anything improved in the last few years? If so, what, and why?

Gender issues

- How much control do women have over decision-making in the community? What types of decisions? Probe education, health-seeking behaviour, older children's/young adults' choice of marriage partners? Are there major differences between different ethnic groups, regions, ages?
- Are there any women's organisations? What do they focus on (e.g. informal credit?). Are women involved in community decision making? If no, why not? If yes, in what capacity?

Questions for non-beneficiaries

Cash transfer programme/coping strategies/other programme support

- Do you know why you did not receive the cash transfer?
- What do you think the benefits of receiving the cash transfer have been for programme participants?
- Have there been any benefits for the whole community of the cash transfer?
- Has the cash transfer programme created any tensions or problems in the community? What are these and why have these problems been caused?
- What are the key challenges that you face in your day-to-day lives? Have these got better or worse in the last couple of years? Why is this?
- Have you received any other government or NGO programming in the last couple of years? What are these and what have been the benefits?
- Are you members of any groups or associations? What are the benefits of this?
- Who can you turn to in times of need? Church / mosque? Your community? Friends? Relatives? What type of support do they give you?
- What type of support from the government do you think would best help you?