



**Standing Committee
for Economic and Commercial Cooperation
of the Organization of Islamic Cooperation (COMCEC)**

Accessibility of Vulnerable Groups to Social Protection Programmes in the OIC Member Countries



**COMCEC COORDINATION OFFICE
January 2016**



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This report has been commissioned by the COMCEC Coordination Office to the project team comprised of Dr. Rana Jawad, Dr. Adam Coutts and Dr. Hicham Ait Mansour. Views and opinions expressed in the report are solely those of the author(s) and do not represent the official views of the COMCEC Coordination Office or the Member States of the Organization of Islamic Cooperation. Excerpts from the report can be made as long as references are provided. All intellectual and industrial property rights for the report belong to the COMCEC Coordination Office. This report is for individual use and it shall not be used for commercial purposes. Except for purposes of individual use, this report shall not be reproduced in any form or by any means, electronic or mechanical, including printing, photocopying, CD recording, or by any physical or electronic reproduction system, or translated and provided to the access of any subscriber through electronic means for commercial purposes without the permission of the COMCEC Coordination Office.

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Glossary of Key Terms *

Social Policy: Interventions in the public sphere (encompassing all forms of social security and human rights legislation, regulations, guidelines for public and private programmes and services,) designed to enhance social and individual wellbeing. It is possible to speak of social policy in both 'narrow' and 'broad' terms depending on how much importance is placed on addressing social inequalities and the choice that is given to individuals and markets to provide the essential services required for living a decent life with dignity.

Social Protection: A government wide policy implemented through a set of intersectoral programmes which respond to the economic, social, political and security risks that poor and vulnerable people face and which will make them less insecure and more able to participate in economically and socially in society. Social protection can also be extended to members of the working population as a right of citizenship and insurance against social and economic risks.

Social Protection Floor: Nationally defined sets of basic social security guarantees that should ensure that, as a minimum, over the life course all in need have access to essential health care services and to basic income security which together provide access to goods and services defined as necessary at the national level.

Social Assistance or Social Safety Nets: Social assistance programs are non-contributory transfers in cash or in-kind and are usually targeted at the poor and vulnerable which are intended to have an immediate impact on reducing poverty and on boosting prosperity, by putting resources in the hands of the poorest and most vulnerable members of society. Some programs are focused on improving chronic poverty or providing equality of opportunity; others more on protecting families from shocks and longstanding losses they can inflict for the unprotected poor. These programmes are also known as social safety net programmes, and include cash transfers (conditional and unconditional), in-kind transfers, such as school feeding and targeted food assistance, and near cash benefits such as fee waivers and food vouchers.

Social Security or Social Insurance: Socially-supported institutional arrangements to meet conditions of adversity such as sickness, accidents and old age. May also include the social provision of a critical minimum to meet basic wants such as food health, education and housing.

Vulnerable: Individuals or groups who, due to age, poor health, minority status, or their otherwise disempowered position in society, may be open to physical, emotional, financial, or psychological deprivation or exploitation. The condition of being vulnerable may also be brought out by structural factors in the wider social environment such as discrimination, lack of job opportunities or natural disasters.

* The definitions of the glossary terms are derived from various sources, namely the ILO, World Bank, UN and various government social strategy documents in the COMCEC group of countries.

EXECUTIVE SUMMARY

The group of countries that belong to the Organisation of Islamic Countries (OIC), also referred to in this report as OIC countries consist of a variety of socially and economically diverse countries spanning the continents of Africa and Asia. They include some of the highest income countries in the world such as Qatar and Saudi Arabia as well as some of the poorest such as Sierra Leone and Afghanistan. The discussion of access to social protection programmes and vulnerability in this report reflects the social, economic and political diversity of these countries. However, it should be acknowledged that these countries do have one common feature: none can be described as traditional 'welfare states' in the Northern European sense in terms of possessing universal and comprehensive systems of social welfare and public service delivery that are based on the entitlement of all citizens to basic social rights. Existing research shows that on the whole, OIC member countries have a broad range of social assistance, social insurance and labour market programmes but coverage of the poor and vulnerable groups of society remains scattered and in some cases non-existent. This is the situation despite most OIC Member States having experienced economic growth (as measured by Gross National Product GNP) over the last twenty years although more recently lowered oil prices and associated weak fiscal positions have seen stagnation and deterioration of economic growth in a number of states.

The aim of this report is to understand the challenges and opportunities of social protection systems in OIC member countries. This is achieved by exploring the coverage of the social protection programmes at various levels or stages of economic development. The objectives of this report are to:

- i. provide a detailed audit of social protection strategies, policies and institutions in the OIC member countries
- ii. map out the social and economic situation of vulnerable groups in OIC members states
- iii. analyse where OIC member countries stand in light of the new global trends in social protection policies
- iv. highlight the main challenges facing the increased coverage of the social protection systems in these countries and to provide policy options and recommendations to help overcome these challenges.

The report uses a combination of qualitative and quantitative methods incorporating a desk-based review, statistical analysis of secondary data sets and in-depth interviews with key policy stakeholders within case study countries: Lebanon, Oman, Iran, Morocco and Sierra Leone. The desk based review and evidence is generated from research reports and empirical studies, which were accessed via United Nations agencies, academic research organisations and regional government departments. Literature and evidence searches were conducted using academic search engines.

The numerical data cited draws mainly from the ILO World Social Security Report database of 2014 and the World Development Indicators, which uses data from different sources including UNDESA, the ILO, the World Bank, WHO, UNICEF, among other sources. The main indicators included in the analysis are population structure, economic growth, GDP per Capita, out of pocket health payments (OoPP), social protection expenditure, public expenditure in social sectors such as health, education, as well as outcome indicators such as health, nutrition, education, child and maternal mortality, vulnerable employment and poverty headcount ratio.

The two guiding concepts in the analysis undertaken are vulnerability and social protection. Vulnerable groups are understood as “groups that experience a higher risk of poverty and social exclusion than the general population. Ethnic minorities, migrants, disabled people, the homeless, those struggling with substance abuse, isolated elderly people and children all often face difficulties that can lead to further social exclusion, such as low levels of education and unemployment or underemployment”.¹

Social protection is understood as including programmes for social insurance (contributory programs, principally pensions), labour markets programmes (for example job training and back-to-work interventions), and non-contributory social assistance programmes (or social safety nets) which include humanitarian and disaster relief programs, cash transfers, food stamps, school feeding, in-kind transfers, among others. Social insurance and labour market programs tend to benefit higher income groups and those with higher levels of qualifications and skills, whereas social assistance programs generally (but not exclusively) focus / target the most poor and vulnerable”.²

Social protection has two broad aims: to manage economic risk through policies or services that protect against the sudden loss of income from life events such as accidents and the need for urgent health care. And secondly to promote social mobility through policies that affect the structural causes of social and economic inequalities. For instance via changes in legislation, land reform and taxation systems. It is hoped that this may also present political opportunities for vulnerable groups to be heard.

This report shows that there OIC Member States are made up of a variety of economic conditions and groups, from the very wealthy to the absolute poor. A diverse range of social protection policies have been implemented across OIC states. Overall four conclusions can be drawn from the analysis:

- High Income Countries (HICs) invested heavily in social safety net policies. They now face the challenge of reducing their financial and economic dependency on oil revenues to stimulate social enterprise and levels of youth employment. The key challenge for these countries is to develop human capital and effective active labour market programmes.
- Upper-Middle Income countries (UMICs) have large income inequalities to deal with and would benefit in the short to medium term from administrative reform of their social assistance and assurance schemes in order for social protection services to better coverage of vulnerable groups. A number of these countries are also experiencing political instabilities and this poses further risks to vulnerable groups.
- Lower-Middle Income Countries (LMICs) have large populations of vulnerable groups or those in vulnerable / insecure economic situations and employment. A key task for these countries is to create economic opportunities and to support economic growth in addition to introducing basic social protection policies and services.
- Low Income Countries lack basic social protection services and suffer from serious humanitarian and development issues such as drought, malnutrition, high infant mortality and illiteracy. These countries are often heavily dependent on foreign aid to

¹ European Union, 2014: 5 cited in COMCEC terms of reference for this project.

² Fiszbein, Kanbur, Yemtsov, 2013.p.1.

fund social protection and development programmes. Not all these countries are resource poor in terms of natural resources but many suffer from high levels of ineffective usage of financial resources and lack human capital resources.

The report makes a series of recommendations for the extension of social protection services to vulnerable groups. These consists of a combination of social safety nets, basic social insurance and labour market programmes. They entail: targeted social pension programmes, permanent labour intensive public works programmes, cash transfer programmes to very poor families with children; active labour market interventions including the formalisation of migrant workers and the informal workforce force in countries where national income is high. A key proposal relates to the provision of universal access to essential primary health care services.



Accessibility of Vulnerable Groups to Social Protection
Programmes in the OIC Member Countries

INTRODUCTION

Since the early 2000s, the OIC countries have shown a growing interest in the contribution of social protection policies to human development, in large part due to the impetus of the Millennium Development Goals (MDGs) and the post-2015 UN development agenda. This is also in line with a wider global development policy shift: the World Bank is increasingly in favour of cash transfer programmes and more cognisant of the rising income inequalities that are brought on by economic liberation and technological change. The ILO (2009) has succeeded in mainstreaming the idea of the Social Protection Floor (SPF) in non-OECD contexts with countries such as Jordan, Oman, Pakistan and Mauritania introducing back protection packages for vulnerable populations. These policy shifts reflect realities on the ground: the ineffectiveness of the 'growth first' approach; the persistence of extreme poverty and the protracted nature of social problems in the OIC Member States.

In the OIC countries, government rationales for social protection vary according to the types of social protection institutions that are in place and the extent to which social policies have intrinsic or instrumental value in their own right. Issues of social justice and welfare have traditionally played a subsidiary role to economic growth in the OIC countries; they have been relegated to the domain of the family via the male-breadwinner model of social protection (Jawad, 2014). The National development programmes for many OIC states make clear that the economic function of social protection is the priority. A second rationale for social protection is to ease social discontent. This has become more evident after 2011 with various Arab Gulf countries as well as Syria, Jordan and Morocco embarking on reforms or increasing social assistance services. But historically, the extension of social insurance, the introduction of public works programmes and other types of social protection policies have been initiated by concerns to promote state legitimacy. The third and least well-developed rationale for social protection in the OIC countries is the welfare function. Arguably, this is the most complex to achieve as it requires institutional and political reform. In these respects, the OIC states are characterised by the situation of social policy in the African states where the formulation of a social contract is still not a reality (Green, 2012).

In this regard, the aim of this report is to understand the accessibility of vulnerable groups to social protection systems in the OIC member countries. This is achieved by exploring the coverage of the social protection programmes at various levels or stages of economic development. The objectives of this report are to:

Provide a detailed audit of social protection strategies, policies and institutions in the OIC member countries

Map out the social and economic situation of vulnerable groups in OIC members states

Analyse where OIC member countries stand in light of the new global trends in social protection policies

Describe the main challenges facing the increased coverage of the social protection systems in these countries and to provide policy options and recommendations to help overcome these challenges.

The battery of indicators presented in this report provides an overview of the levels of vulnerability from a macro perspective and particular populations groups who are vulnerable within OIC countries. These indicators provide an overview of the social and economic needs within countries as well as gaps in social protection coverage. The main indicators are labour



market vulnerability such as vulnerable employment, unemployment especially among youth and women and child labour. The report considers labour force participation rates and employment to population ratios in OIC Member States to provide an overall picture of the size of the productive labour force in each country income grouping before tackling the more specific indicators of vulnerability such as vulnerable employment, unemployment and child labour.

With regard to economic growth, paradoxically low-income countries achieved higher rates of economic growth compared to higher income groups. However, the level of GDP per capita has not seen any significant increase indicating the very limited transformative nature of economic development, also translated by very slow progress in reducing poverty, which remains very high in these countries. The capacity to absorb the most important factors of vulnerability in low-income countries relies heavily on the level of resources available in these countries more than expanding the productive economic activities.

In terms of demographic structure, low-income countries have large population share of young population under 14 years old and a low share of the elderly. Generally high rates of poverty and of poor quality of education and low rates of retention as well as poor training to labour transition identify children and youth as some of the main vulnerable groups. It follows that social protection policies in these countries should prioritize these groups.

Lower middle-income although they share some features with low income countries in terms of young population and the challenges they face, have an additional challenge of increasing the elderly population. In this group, the most exposed portions of the population are children and youth to a lesser extent but also the elderly without protection against illness, old age as well as appropriate medical services.

In the upper middle-income countries, the proportion of dependent elderly becomes more pronounced and is expected to increase further in the next few decades to form the most vulnerable group in this income group. In the high income countries, the elderly dependency proportion declines along with the proportions of dependent young people probably due to the small size of populations. It becomes apparent that the most exposed groups to major risks are the working age populations. The vulnerable employment and long-term unemployment rates in some of these countries reinforce this perception.

Child and maternal mortality identify the most vulnerable groups in low income countries and to a lesser extent in lower middle-income countries and much less in upper middle-income countries. High rates of maternal and child mortality, generally due to preventable risks, indicate poor social conditions that affect a wider proportion of the population beyond the figures of mortality indicators. In a related issue, undernourishment is generally correlated with poverty and vulnerability. Low-income countries are largely affected ranging from 15% to 30% with a few exceptions.

In terms of labour market, relatively high and sometimes very high employment to population ratios in all OIC countries, there exist serious vulnerabilities in this sector expressed by the rate of vulnerable employment and long-term unemployment. Except high income countries all of which have labour markets dominated by foreign labour and the majority of OIC countries suffer from high rates of insecure employment. Informal sector is predominant in many countries of the three income groups, which offer little social protection in terms of income,

health and safety and unemployment insurance. On the other hand, long-term unemployment affects many countries regardless of the income level. This range from around 30% in some high income countries to 78% in the only one low income country for which data is available for this indicator. It follows that working age population are very much affected and represent the most vulnerable. However, given the high rates of dependent young people especially in low income countries and lower-middle income countries, much wider groups of the population is also indirectly affected.

Mostly because of high informal sector, large segments of populations in the OIC countries are outside the frame of social insurance policies. Especially, unemployed able-bodied men and women, female-headed households who have care responsibilities for children, disabled family members of elderly relatives (and are unable to work), rural workers, self-employed people and street children and children in employment are vulnerable due to the inadequate social insurance policies.

The child labour indicator shows that children especially in lower-middle income countries and more severely in low income countries are the most vulnerable group of the population. Poor access to social services in the areas known to have high child labour prevalence, but social safety net programmes will not be sufficient to overcome such huge structural deficit. More transformative intervention is needed which looks holistically into the wider population and addresses the wider dimensions of vulnerability such as health, education and the labour market.

In a similar vein, amongst the main risks associated with the lack of efficient social protection systems is the challenge of very high poverty rates especially in low and lower-middle income countries. This again calls into question the efficiency of social safety nets widely applied in many of these countries which do not address the multidimensional nature of poverty starting from education and training systems, health systems as well as labour market policies.

Finally, besides poverty, which challenges the current policies in many low and lower-middle income countries and to a lesser extent some upper middle income countries, there is a major challenge of inequality which is very acute in many of these countries. The implication for vulnerability and accessibility to social protection concerns the fact that the lowest 20% of the population in the income distribution are not only deprived of access to basic social services and social protection but also occupy a weak position in terms of command over material resources. Transformative social protection are needed beyond social safety net efforts in order to promote more social cohesion and more equitable access to social protection services through education, labour and other transformative measures. Such a political choice does not consider targeting as the main intervention but only of a temporary nature, whereas the focus is put on transformative interventions in the mid and long run.

As a result, there is a need of extension of social protection services to vulnerable groups. These consists of a combination of social safety nets, basic social insurance and labour market programmes. They entail: targeted social pension programmes, permanent labour intensive public works programmes, cash transfer programmes to very poor families with children; active labour market interventions including the formalisation of migrant workers and the informal workforce force in countries where national income is high. In this regard,



- OIC countries should embark on establishing a basic social protection floor for the most vulnerable nationals and migrants within their countries.
- Targeted social pension programmes could offer a minimum income to war victims, adults with disabilities, poor female-headed households, people aged over 60 years and older people without a pension who cannot work and have no other source of income.
- Reform of existing public works programmes in some of the low-income OIC states may be needed to provide more stable for vulnerable groups, particularly those who are unable to work and those in insecure employment.
- New measures to help beneficiaries make sustainable transitions or “graduate” from active labour market and public works programmes such as skill upgrading should be considered.
- OIC countries should also establish cash transfers to very poor families with children and other dependents such as the elderly or persons with disabilities.
- OIC countries need to also promote free and universal health care coverage.
- OIC governments need to install new institutional arrangements for the monitoring and impact evaluation of the strategy and associated social protection interventions and policies.

1. CONCEPTUAL FRAMEWORK AND METHODOLOGY

This chapter addresses the following questions:

- What does the concept of social protection mean and why is it important in poverty alleviation and poverty reduction strategies? Why is the life-cycle approach to social protection relevant in this respect?
- Which population segments are defined as vulnerable to poverty from a social protection perspective?
- What is the specific importance of access to a social protection system for the vulnerable groups?
- What are the good practice examples and lessons that can be learned in relation to ensuring that social protection systems can be inclusive and can address the needs of vulnerable populations?

First, the concepts of vulnerability and social protection will be defined. Vulnerability and social protection mean two different things. Social protection refers to the set of policies and outcomes undertaken by a public body to deal with social problems, whereas vulnerability refers to a range of social and economic challenges at the individual, community and society levels that need to be addressed.

1.1. Defining Vulnerability

The European Union defines vulnerable groups as those “that experience a higher risk of poverty and social exclusion than the general population. Ethnic minorities, migrants, disabled people, the homeless, those struggling with substance abuse, isolated elderly people and children all often face difficulties that can lead to further social exclusion, such as low levels of education and unemployment or underemployment.”. Similarly, the World Bank defines vulnerable groups as “a population that has some specific characteristics that make it at higher risk of falling into poverty than others living in areas targeted by a project.³ Vulnerable groups include the elderly, the mentally and physically disabled, at-risk children and youth, ex-combatants, internally displaced people and returning refugees, HIV/AIDS- affected individuals and households, religious and ethnic minorities and, in some societies, women”.⁴ The concept of resilience is often used in conjunction with vulnerability. Hence, resilience can be understood in terms of the ability of an individual, family or system cope with and recover from the effects of a shock or stress.⁵

A key implication of this definition for the analysis and policy recommendations presented in this report is that “Vulnerability needs to be forward-looking, as it makes a prediction about future poverty (or other outcomes). Vulnerability does not simply refer to those who are likely to become poor in the future due to an unexpected shock, but also to those who will remain poor, those who will fall deeper into poverty and those who may fall into poverty due to predictable fluctuations such as seasonality. This disaggregation is important as the policy implications are very different for these different groups.”⁶

³ European Union, 2014. p.5.

⁴ World Bank, 2015.

⁵ Devreux et al., 2006:13.

⁶ Ibid, p.14.

1.2. Defining Social Protection

In this report we define social protection (following the World Bank) as “a collection of programs that address risk, vulnerability, inequality and poverty through a system of transfers in cash or in kind.”⁷ In development policy research and policy making the concept has now become synonymous with social policy. ILO was an early advocate of the concept which it used in the narrow sense of protecting workers’ rights. It has now expanded to include a minimum component for other vulnerable groups such as the elderly and children through the Social Protection Floor Framework.

For many countries expanded social protection programmes are important for assisting other development goals: conditional cash transfer programs have played a key role in achieving the health and education MDGs; and social safety nets have helped to avoid the negative impacts of crises such as hunger and extreme poverty. The growing evidence on impact of safety net programmes has facilitated their expansion into low income countries. However, expansion of social protection for the poorest and most vulnerable in a sustainable manner remains a challenge.

There are different types of social protection programmes depending on their objectives and the risks they cover. The usual classification that is accepted for the developing world includes “social protection programmes for social insurance (contributory programs, principally pensions), labour markets (for example job training), and non-contributory social assistance programs (or social safety nets) which include humanitarian and disaster relief programs, cash transfers, food stamps, school feeding, in-kind transfers, labour-intensive public works, targeted food assistance, subsidies and fee waivers. Social insurance and labour market programs tend to benefit higher income groups, whereas social assistance programs generally (but not exclusively) focus on the most poor and vulnerable.”⁸

The policy focus on social protection marks a departure from the targeted safety net approach of development policies in the 1980s and 1990s. This was a period marked by a sharp rise in poverty and vulnerability worldwide, linked in large part to the workings of the global economy, and the associated implementation of structural adjustment programs which had severe impacts on many OIC Member States. The renewed interest in social protection reflects a concern with reducing the numbers of the extreme poor and mitigating the effects of economic vulnerability. How social protection policies are designed and delivered is about the future vision that a government has of its society and population. A key feature of recent social protection policies is that they aim to generate sustainable and long term improvements for individuals and communities. The aim is not only to offer services that alleviate poverty and which may create dependency but that build capacity and enable individuals to participate economically and socially.⁹ Box 1 shows the two main orientations for considering the impact of social protection programmes

⁷ Fiszbein, Kanbur, Yemtsov, 2013. p.1

⁸ Ibid.

⁹ Sabates-Wheeler and Devereux, 2009.

Box 1: Categorizing social protection programmes for vulnerable groups

Social protection as economic risk management: policies or services that protect against risk and sudden loss of income or contingencies of the life course; can be universal or targeted; do not aim at income redistribution but can help it; also include safety nets and targeted services that do not deal with the causes of poverty or social inequalities

Social protection as social transformation: policies that affect the structural causes of social inequalities such as through change in the law, redistribution of wealth and land reform; and that might even open up political opportunities for the vulnerable groups to be heard.

Source: Sabates-Wheeler and Devereux (2009)

Social protection programmes can have *protective* effects such as providing relief from deprivation; or they can have *preventive* effects such as averting deprivation once a shock has occurred; or they can have *promotive* effects such as enhancing income and capabilities; and all of these dimensions together can have a *socially transformative* effect which would entail addressing power imbalances that create or sustain vulnerability.¹⁰ This broader view shows that policy needs to move beyond the overly economic perspective of social protection as consumption smoothing. Social protection policies should extend well beyond the transfer of cash or food and include the redistribution of assets in order to reduce the dependency of the poor on handouts and to enable them to achieve sustainable livelihood.¹¹ These policies and interventions address vulnerability not only through the transfer of financial resources but through the delivery of social services and behaviour change interventions aimed at altering the social attitudes toward socially vulnerable groups. Such social services might include support for trade unions, creation of spaces for deliberative democracy and public-awareness campaigns to support recognition of vulnerable groups.¹²

There are four main types of entitlement available to vulnerable groups in accessing social protection services (World Bank, 2012). These parameters will be applied to the county context discussions and social protection policies discussed in this report. They are as follows:

- **Universal (but not entirely free)** → food and fuel subsidises are most common; school education, health care access/
- **Employment/earnings-related** → less than half of working population qualify due to high levels of informal labour
- **Means testing** → in the NGO and charity sector, for example social care where there are contracts with the relevant ministries
- **Categorical** → in the NGO and charity sector, for example social care where there are contracts with the relevant ministries; new cash transfer programmes

The grand aim of social protection policies is to promote equity and social transformation.¹³ This refers to equal life chances. There should be no difference in outcome based on factors for

¹⁰ Sabates-Wheeler and Devereux, 2009

¹¹ Ibid.

¹² Ibid.

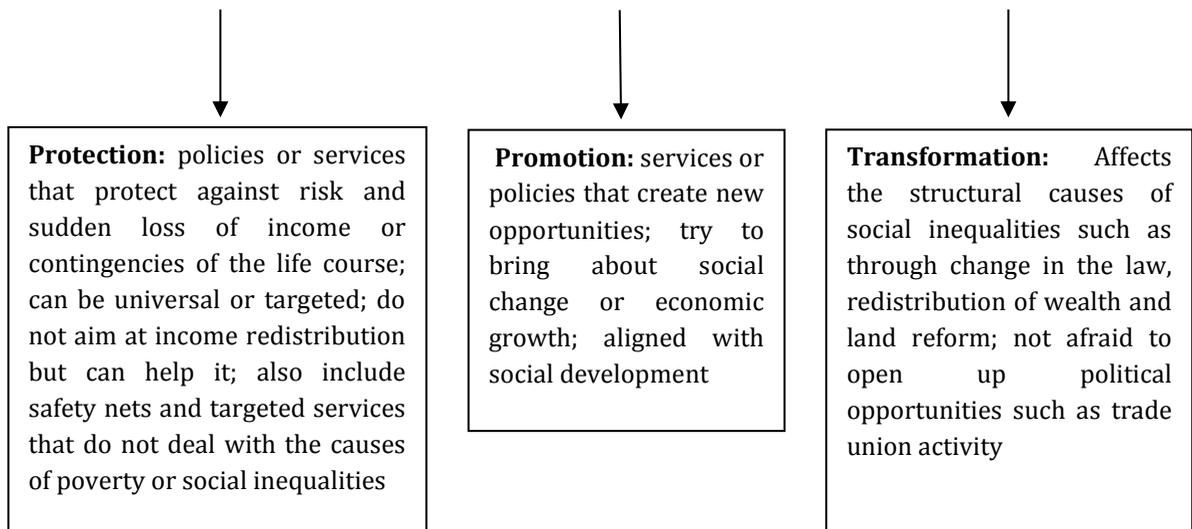
¹³ Ibid.

which people cannot be held responsible; some goods/services are matters of necessity and should be distributed proportional to people’s level of need and nothing else (equal concern for people’s needs). Positions in society and rewards should be distributed to reflect differences in effort and ability, based on fair competition (Meritocracy). Box 2 below provides an illustration of the overall framework of how social protection programmes fit together.

Box 2: Overall framework of social protection and the main types of programmes

Social Protection Programmes: consist of various policy sectors all of which can play a role in reducing social inequalities, vulnerability and poverty: Social care, Family policy, education, health, employment-based social insurance, non-contributory social safety nets, fiscal policy (taxation and government spending including subsidies). Such programmes take on three main forms:

- social insurance (contributory programs, principally pensions) - these tend to benefit higher income groups
- labour markets programmes (for example job training) – these only benefit those in formal employment
- non-contributory social assistance programs (or social safety nets) which include humanitarian and disaster relief programs, cash transfers, food stamps, school feeding, in-kind transfers, labour-intensive public works, targeted food assistance, subsidies and fee waivers – these tend to focus on the most poor and vulnerable.



1.3. Good Practice Examples from non-OIC Countries

It is useful at this point to briefly review some key examples of policy success from other countries which the OIC countries can learn from. These examples include low, high and medium income countries. On the whole, public expenditure on social services increased in the 1960s to 1980s as part of the modernisation and nation-building endeavors which many

developmental states embarked on. States in both Latin America and Sub-Saharan Africa established public schools, universities and health care networks, though these remained at first primarily skewed towards urban areas. The benefits of these initiatives can be seen by the declining rates of maternal and child mortality, and more fundamentally, they point to the importance of universal social services.¹⁴

In the developing world, various countries have provided universal social protection schemes. As part of the major social transformations that have come to mark India in the last few decades, various federal states such as Kerala, Tamil Nadu and Himachal Pradesh introduced universal provision of essential services.¹⁵ Tamil Nadu was the first Indian state to introduce free and universal midday meals in primary schools as part of its efforts to combat child undernourishment, bearing in mind that India has the highest rate of child malnutrition in the world. Tamil Nadu later became the model for the rest of India.¹⁶ In many ways, the social problems faced by India are also echoed later on in this paper in the Arab region. Undernourishment is key issue in this regard. India, has a food subsidy system in place which is a universal scheme. The scheme covers grains and essential cooking items and is part of a wider Right to Food campaign which has gained much momentum in India.¹⁷ The national feeding programmes in India have helped to improve primary school attendance and enrolment, though the wider effects on quality of education and child nutrition are yet to be seen. Indeed, the school feeding programme is not in itself sufficient in addressing the problem of underweight children since this would need multi-sectoral interventions, however these forms of universal provision help cut across divisions of religion, caste and sect in India which can bear important lessons for the OIC countries. This food subsidy programme is now under review by the World Bank which, in line with the new policy trends in favour of targeted social assistance, has recommended that India reform the program in favour of cash transfers.¹⁸

Other countries such as the Republic of Korea, Taiwan and Costa Rica have introduced universal social protection schemes.¹⁹ In Korea, the democratic transition of the late 1990s saw the introduction of reforms in health, pension and unemployment social insurance schemes as well as a Minimum Living Standard Guarantee (MLSG) – all of which increased coverage and equity of social protection. Under pressure from Trade Unions and various civil society organisations, various health insurance schemes were merged into one integrated public health scheme, under the presidency of Kim Dae-Jung. This had significant efficiency outcomes such as reducing administrative costs from 11.4% to 4.7% by 2003 but also because entitlement conditions became equalized²⁰. The MLSG and the labour insurance reforms were introduced after the Asian financial crisis of 1997-8 establishing basic living standards as civil right and adjusting benefits to a new poverty line, reaching 1.5 million people (3.19% of the population) in 2007. The labour insurance programme provided cash benefits, job training and small loans to unemployed temporary workers. Moreover, universal old-age security was also introduced after incorporating the urban self-employed in 1999. The system does not yet show signs of fiscal pressure though it is clear that the problem of under-contribution by informal sector workers will need to be addressed.²¹ This is also an issue shared by all Arab countries to

¹⁴ UNRISD, 2012.

¹⁵ Mutatkar, 2013.

¹⁶ Ibid.

¹⁷ UNRISD, *Op. Cit.*,

¹⁸ Mutatkar, *Op. Cit.*,

¹⁹ UNRISD, 2012.

²⁰ UNRISD, 2012.

²¹ Ibid.

various degrees. In Taiwan, the first universal social protection that was introduced was in 1995 in the form of National Health Insurance. The state also made financial contributions to cover for farmers, the self-employed and informal workers. These reforms occurred in a context of rising unemployment, economic downturn and structural transformation after the Asian crisis.²²

A similar story can be found in Costa Rica which has made great gains in social inclusion and social protection and brought coverage of health and maternity insurance close to 90% despite its modest levels of per capita income. The expansion of social policy from the 1950s to 1980s was driven by domestically driven economic growth in which the state had a prominent role. The Costa Rican model has relied on a strong commitment to universal education and health care as well as concerted efforts to expand pension and health care. This is achieved by expanding the number of workers contributing to social insurance schemes, while securing protection for those unable to contribute to social assistance. Brazil, which had adopted a constitution in the 1980s that had at its core the extension of social citizenship, has also made important strides in expanding coverage of key social services like education and health through a mix of public and private partnerships in health care and also a combination of state taxation and business funds for education. South Africa has a more fragmented system of universal provision.²³ After Apartheid, South Africa sought to harmonize the quality of its education system and provide a fairer allocation of resources. Regionally integrated educational departments became unified into one national system; education became compulsory and funds were allocated from the formerly white schools to the formerly African schools. The result was an equalization of funding whereby funding of African schools increased from 58% to 79%.

The country examples presented above show that constitutional reform and social policy legislation can help set the context within which new social protection agendas can emerge if they adequately reflect the will of the people. This confirms that long-term effective social transformation takes place when there is situated political change and not necessarily through the transfer of development policies.²⁴ The case studies provided in this section show that it is important to develop the social and political dimensions of citizenship for instance, through the recognition of and extension of social rights. There are various unemployment insurance schemes in place in many developing countries as in China, Brazil and South Africa. But often, they exclude certain groups such as farmers, which is also the case in the Arab region.

The successful cases of countries in East Asia like Taiwan and South Korea, as well as other countries like Costa Rica, the Indian state of Kerala and Sri Lanka are some of the key examples in the developing world which show that transformative social change can only come about through fortifying the mechanisms of social inclusion, accountability and social cohesion. Economic growth was central for the expansion of social insurance in countries like Taiwan and South Korea²⁵ but in Kerala and Costa Rica, an early commitment to universal health and education provision as well as payroll tax-funded social assistance programmes ensured higher levels of social solidarity and wellbeing in these contexts.²⁶ In the case of Costa Rica, the commitment for universalism dates back several decades.

²² Ibid.

²³ UNRISD, 2012.

²⁴ Green, 2012

²⁵ UNRISD, 2012

²⁶ Ibid.

Before the discussion moves to considering social assistance, the other key pillar of social protection in developing countries, it is important to make a note about the mix of institutional actors who can partake in universal social protection schemes. States, markets, charity and community organisations, households and donor agencies can all play a role in facilitating universal coverage. This mix will depend on the country context and policies. But some lessons are clear, many services such as education and health require significant investment in infrastructure which are therefore likely to be underprovided by market actors. Particularly when there are urban-rural disparities or regional differences, state involvement is needed. As the examples discussed so far show, the countries which have succeeded in providing wide spread coverage for their citizens have done so through direct state involvement in the financing, provision and administration of these services.

In terms of non-contributory social assistance, these schemes have by far become the most predominant trend in developing countries due to the marked weakening of universalist principles and the fiscal pressure placed on many states in funding social protection policies.²⁷ In addition, social assistance programmes are more in tune with neo-liberal policies since they adopt a targeted or means-tested approach to cash or in-kind transfers. They also promote a rationale of consumption smoothing and reactive in nature because they are given to populations who are also in need and have not been able to cope with unexpected social or economic shocks. Since the 1980s, the shift towards more neo-liberal economic principles across most of the developing world has reinforced the lack of commitment by many governments to dedicate public funds to long-term social protection and social investment. Under the pressure to liberalize, promoted by international agencies like the IMF and World Bank, some developing countries have opted for a more short-term and targeted approach of social assistance. This has in part led to the increased commercialization of social services²⁸ as well as to a greater reliance on social safety nets. The commercialization of social protection can be seen in the increased role private businesses have as mediators or providers of essential social services. This is typically the case in the health insurance market and public-private partnerships in health care as evidenced in for example the corporatization of hospitals such as in the United Kingdom or North America, the introduction of user fees; and the introduction of small scale private and unregulated provision as in some countries of South Asia and Sub-Saharan Africa. In these cases, services are often used by the poor and draw on out-of-pocket expenses²⁹. One final aspect of commercialization is in relation to the pharmaceutical sector and the increased power of multi-national companies in setting terms of trade that affect prices and restrict access to generic drugs in developing countries.

Apart from these global issues, there are a variety of experiences in relation to the targeted social assistance programmes that have come into existence in the developing world. Some notable examples are the Child support grant in South Africa, the Minimum Living Standards Scheme in China and Mexico's *Oportunidades* programme. Indeed, other examples abound in the developing country contexts where social assistance programs were introduced to avert social discontent, such as the *jefes y jefas* programme in Argentina and the *Minimum Living Standards Scheme* in China. India has introduced a rural Public Works programme following the National Rural Employment Guarantee Act which is a self-targeting programme for all rural populations.³⁰

²⁷ Ibid.

²⁸ Ibid.

²⁹ UNRISD, 2012.

³⁰ Ibid.

It is useful to consider some of these in a little more depth, focusing on China, South Africa, India, and Brazil. All of these countries have a cash transfer programme in place for vulnerable populations there. China established the Minimum Living Standards Scheme (MLSS) in 2003 which aims to provide material aid to residents and their families once their income falls below the state-defined minimum living standard.³¹ The programme has as its target population the urban poor, and over the years, it has come to provide comprehensive in-kind and in-cash support ranging from medical assistance to housing and heating allowances. The programme is now national and in May 2012 reached more than 21.6 million citizens. The rural poor in China also benefit from similar non-contributory social assistance programmes as well as a scheme known as the “five guarantees” which has been in place since 1950 and ensures that all poor people living in rural areas have access to basic life necessities such as food, clothing, shelter and even a contribution towards funeral costs. In the Chinese case, the rationale for social protection has been dominated by state concerns for political legitimacy and the availability of an adequately skilled and capable labour force to support the main goal of economic growth.³²

This rationale has in part led to ad hoc introduction of social assistance programmes which are not yet properly integrated. And yet, the government budget on social assistance is projected to grow by 16% in 2015 with the aim of the GDP share of social protection reaching 25%. But contribution-based social insurance will continue to be the largest source of social protection, in large part thanks to a large formal labour market.³³ A slightly different picture emerges in India, Brazil and South Africa where social assistance programmes are just as predominant but there are substantial numbers of informal workers and rural poor populations who are reliant on food subsidies or state social grants. Of notable importance in the literature is the *Bolsa Familia* in Brazil which has been lauded for reducing levels of inequality in Brazil by 14%. This is a monthly conditional cash transfer programme funded and coordinated by state authorities and given to families living in poverty or extreme poverty. It obliges beneficiaries to ensure their children attend school and are immunized.³⁴ Pregnant beneficiaries also have to undergo official monitoring.³⁵ From a coverage of 3.5 million families in 2003, it reached 12.7 million in 2010. South Africa also established a tax-funded, state administered social assistance scheme, of which the most prominent is the Child Support Grant which now includes 28% of the population (14.2 million) and accounts for 3.5% of total GDP.³⁶

The short-termism and distributional limitations of these cash transfer programmes are an important concern from a social protection point of view.³⁷ Reaching a wide population may also indicate high levels of dependency on these programmes with families unable to sustain themselves in the long run. This is a weakness of universal food subsidy programmes in particular. To this end, Silva et al. (2012) cite the case of fuel subsidy reform in Indonesia which introduced three social safety net programmes in 2005 to compensate for the sharp cuts in fuel subsidies. To mitigate the impact of price increases on poor and near-poor households, the government introduced an unconditional cash transfer programme which reached 18.5 million households at a cost of about 0.3% of GDP, as well as a health insurance programme and an education subsidy programme.

³¹ Zhu, 2013.

³² UNRISD, *Op. Cit.*, 2012.

³³ Zhu, 2013

³⁴ UNRISD, *Op. Cit.*, 2012.

³⁵ Gomes dos Santos, 2013.

³⁶ Mpedi, 2013

³⁷ Cook, 2013.

1.4. Data and Methodology

The report uses a combination of qualitative and quantitative methods incorporating a desk-based review, statistical analysis of secondary data sets and in-depth interviews with key policy stakeholders within case study countries. The desk based review and evidence is generated from research reports and empirical studies, which were accessed via United Nations agencies, academic research organizations and regional government departments. Literature and evidence searches were conducted using academic search engines.

The numerical data cited draws mainly from the ILO World Social Security Report database, 2014 as well as the World Development Indicators, which uses data from different sources including UNDESA, the ILO, the World Bank, WHO, UNICEF, among other sources. The main indicators addressed are population structure, economic growth, GDP per Capita, out of pocket health payments, social protection expenditure, public expenditure in social sectors such as health, education, as well as outcome indicators such as health, nutrition, education, child and maternal mortality, vulnerable employment, poverty headcount ratio, among others.

The approach followed in describing these variables for every income country group is two-fold: Outcome variables which provide overview of the vulnerable groups and risks that can hinder access to social protection and may increase the risk of vulnerability; and *policy* variables which provide an overview of the macro context as a proxy indicator for the ability of each country to address those risks and the needs of vulnerable groups in terms of providing coverage and access.

Qualitative in-depth interviews have been conducted in each case study country with key policy stakeholders. These individuals and organisations were identified via existing research networks of the report authors and also the policy networks of COMCEC focal points.

2. OVERVIEW OF OIC MEMBER COUNTRIES

This chapter will address the following issues:

- Which population segments are defined as vulnerable with respect to falling into poverty in the OIC Member Countries?
- What is the current situation related to the coverage of social protection systems?
- Is there any strategy towards increasing the inclusiveness of the social protection systems in terms of the vulnerable groups in the OIC Member Countries?
- What are the common challenges in increasing the coverage of the social protection systems for the OIC Member Countries, in reference to the income groupings?

The following section examines the current institutional context of the OIC member countries and what social protection policies are in place. Much has already been written on the social problems which these groups of countries face including the UNDP 2002-2009 Arab Human Development Reports, the UNDP Arab Challenges Development Report (2012) and more recently the UN/LAS (2013). The focus of this section is to map out how social protection is currently provided in the region. These are:

- Rationale for Social Protection Policies in OIC States
- Overview of the vulnerability in OIC member countries
- Total social protection expenditure in division of components
- Social insurance (analysis of income groups with regard to social insurance accessibility of vulnerable groups defined above)
- Social assistance and Targeted service delivery (analysis of income groups with regards to social assistance accessibility of vulnerable groups defined above)
- Employment programmes (analysis of income groups with regards to employment programmes accessibility of vulnerable groups defined above).

2.1. Rationale for Social Protection Policies in the OIC Member Countries

In the OIC countries, government rationale for social protection vary according to the types of social protection institutions that are in place and the extent to which social policies have intrinsic or instrumental value in their own right. Issues of social justice and welfare have traditionally played a subsidiary role to economic growth in the OIC countries; they have been relegated to the domain of the family via the male-breadwinner model of social protection (Jawad, 2014). The National development programmes for many OIC states make clear that the economic function of social protection is the priority.³⁸ This is especially evident in the Arab countries. For instance, Jordan's National Agenda (2006-2015) aims firstly "to improve the quality of life of Jordanians through the creation of income-generating opportunities, the improvement of standards of living....achieving an annual real GDP growth rate of 7.2%, reducing public debt from 91% to 36% of GDP, and reducing unemployment from 12.5% to 6.8%".³⁹

A second rationale for social protection is to ease social discontent. This has become more evident after 2011 with various Arab Gulf countries as well as Syria, Jordan and Morocco embarking on reforms or increasing social assistance services. But historically, the extension

³⁸ Jawad, 2014.

³⁹ Jawad, 2014, p.26.

of social insurance, the introduction of public works programmes and other types of social protection policies have been initiated by concerns to promote state legitimacy. The OIC countries are not alone in this regard. The political function of social protection has also served as a rationale for Western welfare states and other developing countries has already highlighted in this paper.

The third and least well-developed rationale for social protection in the OIC countries is the welfare function. Arguably, this is the most complex to achieve as it requires institutional and political reform. In these respects, the OIC states are characterised by the situation of social policy in the African states where the formulation of a social contract is still not a reality (Green, 2012). It is important to recognise the need for a broad governance approach for understanding the way in which the state-citizen contract can develop. Political struggle, as has been seen in Latin America or India, and now more increasingly in the Maghreb countries may be the only way forward for relations between state and society to be harmonised and for a social space to be created whereby citizens can claim their social rights. Crucially, these changes have occurred in Latin American and India not as a result of development policy transfer but of “situated political society” (Green, 2012:24).

2.2. Overview of Vulnerability in the OIC Member Countries

The macro analysis provided in this section provides an overview of the main vulnerability factors that hinder access to social protection schemes. We follow the life cycle approach and draw, within the limitations of available data, the profile of vulnerable groups within each income group. Typically, when data permits, we look at two types of vulnerability factors: those related to different age groups and those related to the overall population in general. For example:

- For children under 5 years old: child mortality and malnutrition;
- For children aged between 6 and 15 years old: inappropriate education and child labour;
- For youth aged 15-23: transition from training to labour market and unemployment;
- For adults: precarious and vulnerable employment and unemployment as well as maternal mortality;
- For the elderly: inaccessibility to medical insurance and to pension schemes
- For the general population: volatility of market prices and low economic growth, poverty, inequality, low and poor access to social services as well as high out of pocket health expenditure, etc.

It should be noted that vulnerability is idiosyncratic and context specific in character. Since the present overview is comparative and focuses on macro indicators, it only provides an approximation of the most important factors of vulnerability by income groups within OIC Member Countries. Given the importance of the structure of the population and the information it conveys toward social protection policies, this section begins with a brief overview of demographic structures of OIC member countries and economic growth rates.

2.2.1. Demographic Structure and Economic Growth in the OIC Member Countries

Demographic Structure

First, there is an apparent correlation between demographic and economic transition. Low income country (LICs) groups are characterized by large proportions (30% to 50%) of their populations being young under the age of 14 years old with high rates of youth dependency and low proportions of older people and elderly dependents (4% to 6% of total population). In this group, high rates of poverty and of poor quality of education and low rates of retention as well as poor training to Labour transition identify children and youth as the main vulnerable groups. It follows that social protection policies in these countries should prioritize these groups.

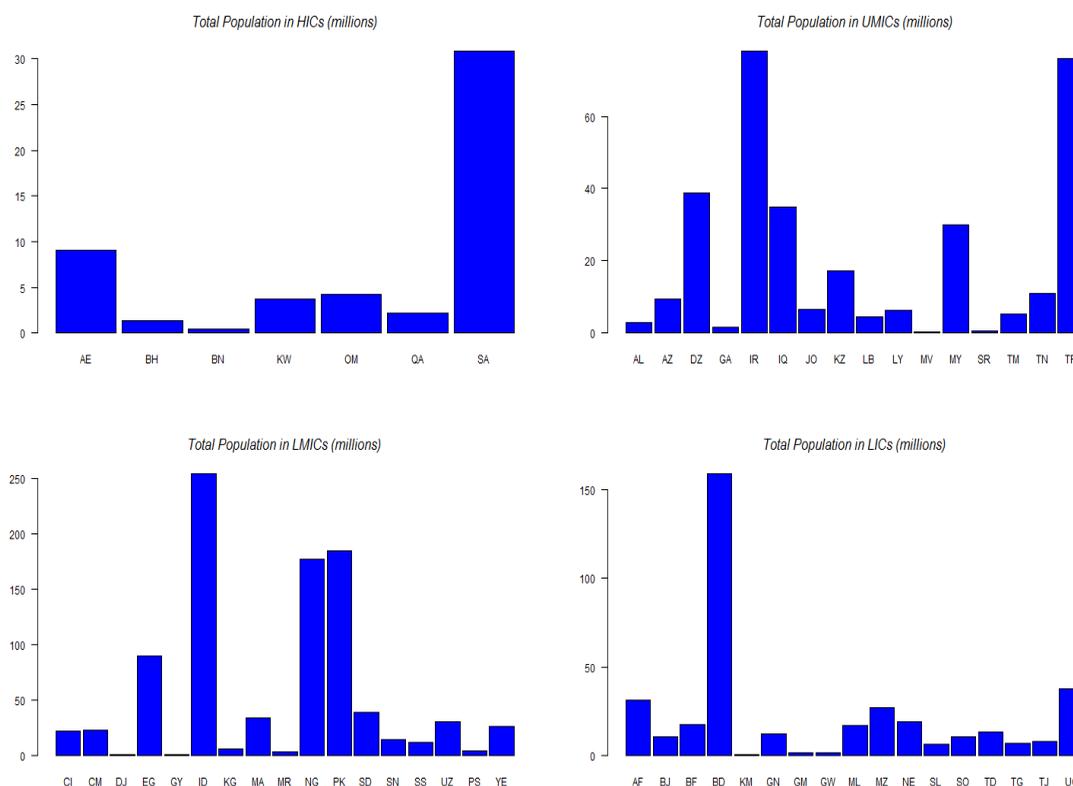
Lower-middle income countries (LMICs) still possess high proportions of young people (30% – 40%) but have slightly lower levels of youth dependency. We begin to see the increase in numbers of older people and elderly dependents given advances in medical technologies and access to health services, which has helped to increase life expectancy. In this group, the most exposed portions of the population are children and youth to a lesser extent but also the elderly without protection against illness, old age as well as appropriate medical services.

In the upper-middle income countries (UMICs) economic growth and improvements in medical technologies and health services have given rise to larger proportions of elderly dependents (5 to 15 % of total population). The dependency burden has switched from being that of the young to the old. In this group, the elderly are the most exposed group of the population to the major risks against preventable factors of vulnerability.

However, in the high income countries (HICs) the elderly dependency proportion declines along with the proportions of dependent young people. These declines may be due to the fact that the High Income OIC Member Countries have small populations.

Life expectancy is also a key demographic indicator. The overall population in Low Income Countries (LICs) is exposed to the risk of a shorter life where the mean life expectancy ranges between 45 and 60 years old with exceptions such as Morocco and Tunisia where it slightly exceeds 70. Significantly higher life expectancy is observed in UMICs where it does not fall below 60 years old and reaches 78/80. In HICs life expectancy plateaus at the average of 78 to 80.

Figure 1: Total Population in the OIC Countries (in Millions)



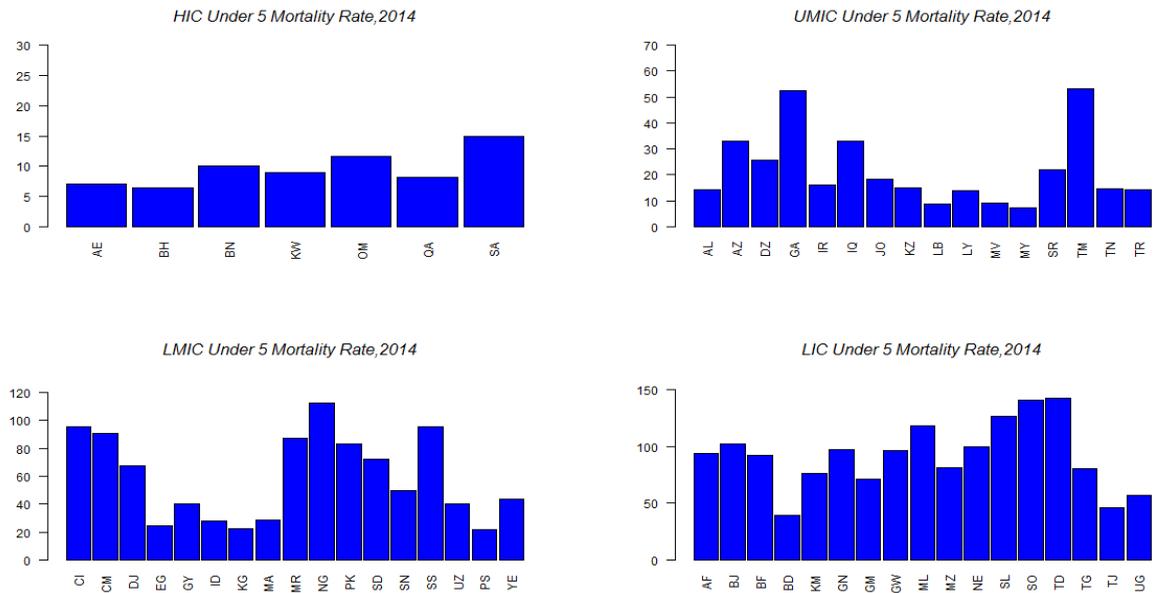
Source: World Development Indicators Database, 2014

Child and maternal mortality

Child and maternal mortality provide sensitive indicators of the levels of development and overall social, economic and civic ‘health and wellbeing’ of the population in a country. In line with levels of economic development OIC Member Countries provide a mixed picture. LICs possess high levels of child (30-150/1000) and maternal mortality (100-1200/100,000). As countries become economically developed with improved access to health care, child and maternal mortality rates drop considerably among LMICs and again further among UMICs. However, there are a number of outliers particularly in Africa such as Gabon. At the highest levels of economic development child mortality is between 5 to 15/1000 and maternal mortality 1 to 15/100000. The European average for under 5 child mortality is 11/1000 and in Africa it is 81/1000.⁴⁰ As shown in Figure 2, levels of malnutrition generally equate with levels of child mortality. It follows that the most vulnerable groups among children and women are overrepresented in the low-income countries and to a less extent in LMICs and much less in UMICs.

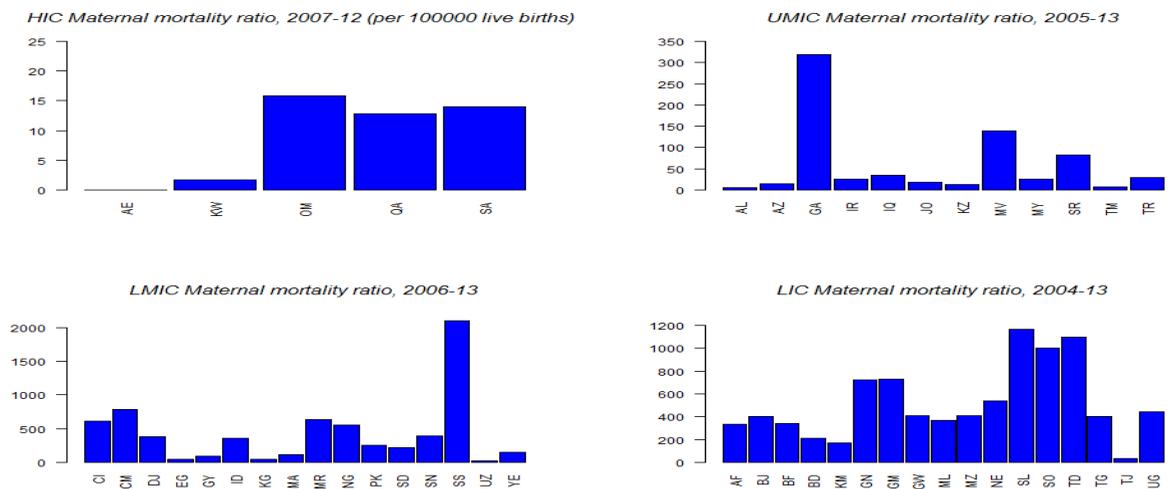
⁴⁰ http://www.who.int/gho/child_health/mortality/mortality_under_five_text/en/

Figure 2: Child mortality by income groups in the OIC Countries



Source: World Development Indicators Database, 2014

Figure 3: Maternal Mortality by Income Groups in the OIC Countries



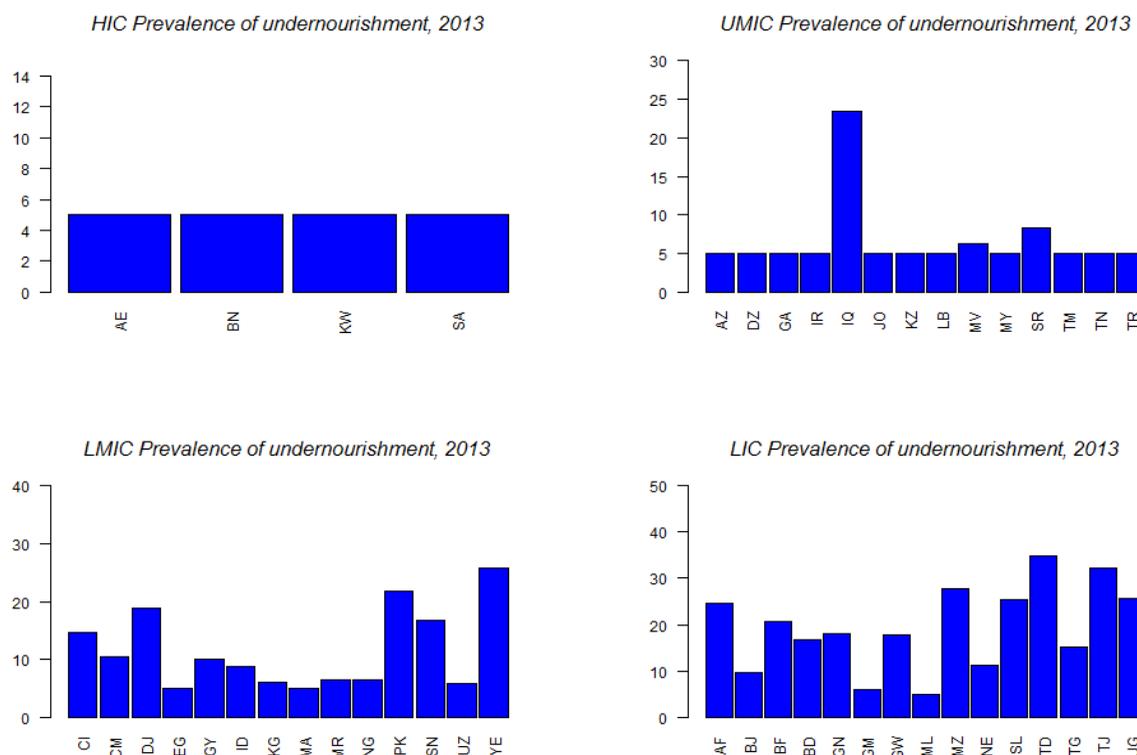
Source: World Development Indicators Database, 2014

Malnourishment

Another indicator of vulnerability that concerns the overall population is malnourishment and hunger. This refers to a situation below the minimum level of dietary energy consumption. It is expressed in percentage of the population whose food intake is insufficient to meet dietary energy requirements. The graphs below show that the lowest undernourishment rates are observed in Higher and Upper middle-income countries except Iraq in which it exceeds 20% in a similar pattern to many countries in the Lower middle-income countries such as Djibouti, Pakistan and Yemen, which display the highest rates in this income group.

As far as the lower income countries, except Benin, Gambia and Mali which display under 10% rates, the rest countries range between 15% and over 30% of the population suffering from undernourishment. The outliers in this income groups (between 20% and 30%) are Mozambique, Chad, Uganda and Tajikistan.

Figure 4: Prevalence of undernourishment in the OIC Countries



Source: World Development Indicators Database, 2014

Access to water and sanitation

Among the main determinants of vulnerability and poor health among children, besides vaccines for common preventable diseases, is the lack of access to clean and safe drinking water. As the data in Annex 7 shows LICs and LMICs significantly lack access to sanitation facilities and clean water supplies.

For Higher and Upper middle-income countries, the majority of countries have almost universal sanitation coverage, except Gabon and Turkmenistan in the latter group for which sanitation coverage is respectively around 40% and 60% only. For safe drinking water access in this group, the same pattern is observed except for Libya and again Turkmenistan, which have lower rates below 70%. As far as Lower middle-income and low income countries, Cote d'Ivoire, Nigeria and more severely Sudan and South Sudan have the lower coverage rates for the former group whereas in the latter group (LICs) the majority have severe low coverage rates except Bangladesh, Gambia and Tajikistan which have coverage above 60 % and above 80% for the latter country. Access to an improved water source is much far better than sanitation where the majority of countries regardless of income levels have coverage rates above 80% except Libya and Turkmenistan in the Upper MICs groups with a coverage rate less than 80%. The same is true for LMICs countries with Mauritania, Nigeria, Sudan, South Sudan, Palestine and Yemen also less than 80% coverage rate. In the lower income group, many countries have less than 60% coverage rate such as Afghanistan, Mozambique, Somalia and Chad (See Annex 7 for data).

Economic growth

Economic growth can be seen as one of the main policy response factors/determinant in relation to the outcome areas examined above. Average levels of economic output gives an idea of the capacity of individual countries to face the risks related to vulnerability.

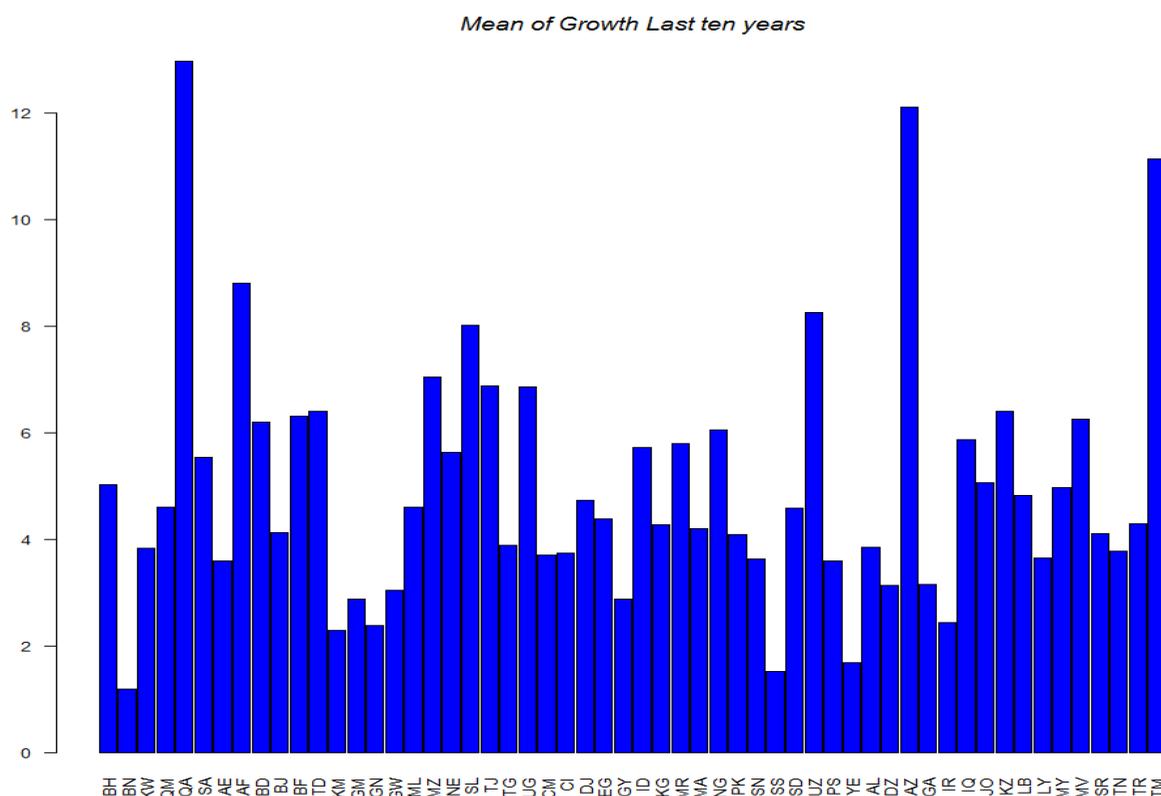
As shown in the GDP data annex 2 in the last 10 years, economic growth has been very instable, uneven, Z-like movement, in most of OIC countries, especially those whose economy depend on resource extraction. Such is the case in all HICs. In UMICs, similar patterns are observed in Iraq and Libya, whereas the rest of countries have seen unchanged severely low economic growth rates. The latter patterns are also observed in LMICs with negative growth (under zero) in both South Sudan and Yemen after 2010, before a slight take off above zero for Yemen and a surprising increase to 25% in South Sudan. For low income countries, very unstable growth rate are observed in most of countries, ranging between zero and 30% in very limited range of time. These graphs show an unstable economic growth and a huge vulnerability to market prices.

Looking at average GDP annual growth in the last ten years provides a different picture as shown in the graphs below. In high-income countries, except Qatar, which averaged around 13% growth, average economic growth has barely exceeded 5% in a Saudi Arabia and Bahrain whereas it reached around 3% in Kuwait and Emirates and only around 1% in Brunei Darussalam. More or less similar patterns are observed in upper-middle income countries to the exception of Azerbaijan and Turkmenistan, which exceeded 10% average growth whereas the lowest were Algeria, Iran and Gabon with an average growth rate between 2 and 3%. In lower middle-income countries, the lowest rates were in Guyana and South Sudan (1.5 to 3%) whereas Nigeria and Uzbekistan averaged between 6 and 8% growth rates. Lastly, the low-income countries averaged much higher economic growth in the last ten years than any other

income group. For example, Afghanistan, Sierra Leone and Mozambique averaged between 7 and 8% and a larger group such as Burkina Faso, Bangladesh, Tajikistan and Uganda averaged slightly more than 6% growth rate. Limited linkages between lower income economies and international financial markets may explain the relatively better performance of these countries compared to other income groups.

However, despite the higher economic growth rates in low income countries, the level of GDP per capita has not seen any significant increase in the same period ranging only between \$1000 and \$3000 per head per year expressed in purchasing power parity international dollar. This reflect the very limited transformative nature of economic development, also translated by very slow progress in reducing poverty, which remains very high in these countries. The capacity to absorb the most important factors of vulnerability in low-income countries relies heavily on the level of resources available in these countries. Boosting economic growth per capita and its contingent factors such as education, higher quality of training and human capital remain one of the most important areas of priority in this income group.

Figure 5: GDP average annual growth in the last ten years (2004-2014)



Source: World Development Indicators Database, 2014

2.2.2. Vulnerability Indicators of the OIC Member Countries

The battery of indicators presented in this section provides an overview of the levels of vulnerability from a macro perspective and particular populations groups who are vulnerable within the OIC Member Countries. These indicators provide an overview of the social and economic needs within countries as well as gaps in social protection coverage. The main indicators are labour market vulnerability such as vulnerable employment, unemployment especially among youth and women and child labour.

Labour market

The labour market is not only a determinant of access to social protection rights it has become a factor that shapes the identity of an individual and communities.⁴¹ Moreover, the author rightly points out that labour markets dynamics are largely responsible in developing countries for issues such as mass migration both internal and international, harsh living conditions in big cities and such alike. In this sense, unlike neo-classical assumptions, which largely consider labour as merely a commodity whose value is subject to the famous law of supply and demand, the sociology of labour market allows considering the social context in which labour plays a role in the inclusion or the exclusion of individuals from the wider society. Since stable employment theoretically provides access to the formal social protection schemes, those unemployed or facing precarious and vulnerable employment remain outside such schemes. It follows that indicators covering these aspects provide a fairly good idea of the extent of accessibility to established social protection schemes. In this section looks briefly at labour force participation rate and employment to population ratio to provide an overall picture of the size of the productive force in each income group countries before tackling the more specific indicators of vulnerability such as vulnerable employment, unemployment and child labour.

The labour force participation rate refers to the proportion of a country's working-age population that engages actively in the labour market, either by working or looking for work. According to ILO key Indicators for labour Market⁴², this indicator is useful for employment policy formulation especially in terms of drawing training needs, the expectation of accession and retirement from economic activity as well as for financial planning for social security systems. As shown in labour force data in annex 3, the labour force exceeds 80% for most of HICs for males and about or fewer than 50% for females. In UMICs, slightly lower rates are observed for males, that are between 60% and 70% whereas for some countries like Azerbaijan and Kazakhstan the rate exceeds 60% among females. However, the majority of these income group countries have female participation rates between 10 and 40%. Almost similar patterns are observed in both LMICs and LICs countries to the exception of males' participation rate, which in the majority of cases reaches or slightly exceeds 80% while females' rate ranges between 20 and 60% depending on the country. According to ILO, in developing countries labour force generally declines with economic growth because the latter is associated with expanding educational opportunities, a shift from agriculture-intensive activity to urban economic activity as well as raising earning opportunities for prime age head of households that allow other household members to choose not to work. Also, lower participation rate among youth reflects the availability of education opportunities whereas for

⁴¹ Fevre., 1992.

age groups over 55 and over 65 reflects the availability and systems of safety nets and retirement schemes. It follows that breaking the observed higher labour force participation rates in OIC countries could lead to a refined analysis of the major patterns by age groups and could inform about major potential risks. However, other indicators such as employment to population ratio, unemployment and vulnerable employment are more relevant in the context of the present study.

a. Employment to population ratio

According to ILO definition, employment to population ratio refers to the proportion of the population older than 15 that is employed. A high ratio means that the larger proportion of the population is employed. Conversely, a lower ratio means they are either unemployed or out of labour force. As shown in the employment data in annex 3, in HICs, except Emirates and Qatar which reach 80%, the other countries barely reach or slightly exceed 60%. In Upper MICS, except a couple of countries, the general pattern for the majority of countries is under 50% employment population ratio. The same is true for LMICs except Cote d'Ivoire, Cameroun and Sudan in which the ratio slightly exceeds 60%. However, in LICs countries, the opposite is true, except Afghanistan where this ratio is barely around 40%, the majority of countries between 50 and 60%. According to ILO, although a high overall ratio is typically considered as positive, the indicator alone is not sufficient for assessing the level of decent work or decent work deficits and additional indicators are needed to assess the situation of employment. Moreover, the ratio could be high for reasons that are not necessarily positive – for example, where education options are limited, young people tend to take up any work available rather than staying in school to build their human capital. When this indicator is desegregated by sex, it reveals more information on gender differences in terms of labour market activity. Except a few countries in all income groups, where the ratio is between 50 and 60, the majority of countries display a rate than ranges between 60 and 90% for male employment. However, female employment displays a skewed distribution among all income groups. For example, in HICs female employment ranges from around 16% in Saudi Arabia to almost 50% in Qatar and Brunei Darussalam. In Upper middle-income countries, except Azerbaijan and Kazakhstan where it exceeds 60%, the majority of countries range between 10 and 40%. More or less similar patterns are observed in Lower middle-income countries where only Code d'Ivoire, Cameroun, Senegal, Kyrgyz Republic and to a lesser extent Indonesia range around 50 and 60%. However, in Low Income Countries, much higher female employment rates are observed in Togo, Mozambique and Burkina Faso and Uganda above 70% and many others above 50 and 60%. The exception is Afghanistan with a 14 % female employment rate.

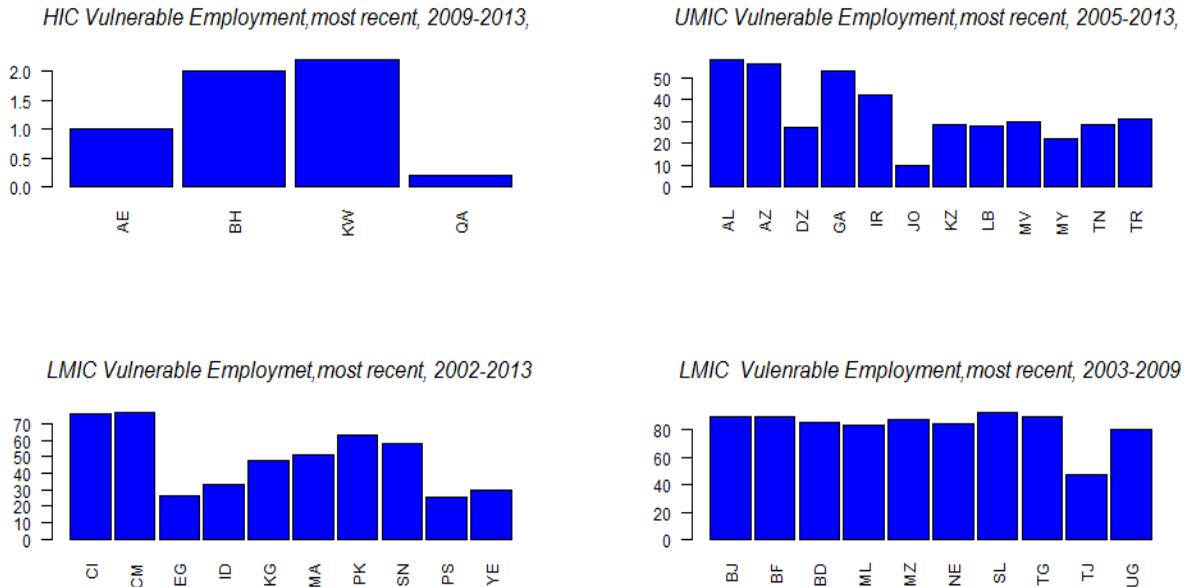
b. Vulnerable employment

Despite relatively high and sometimes very high employment to population ratios in all OIC countries, and as mentioned above, this ratio may mask serious vulnerabilities. This is the case when we look at vulnerable employment which refers to unpaid family workers and own-account workers as a percentage of total employment. Own account workers are considered to be vulnerable even if when their incomes exceed poverty and vulnerability threshold, since they are not protected against major preventable risks such as illness, pension and unemployment.

As Figure 6 shows, the extent of precarious and insecure employment across each development context. With the exception of the HICs all of which have labour markets dominated by foreign labour the majority of OIC countries suffer from high rates of insecure

employment. This is an indication of large informal sectors which offer little social protection in terms of income, health and safety and unemployment insurance.

Figure 6: Vulnerable employment in OIC Countries



Despite great variation between income groups in terms of labour force and employment to population ratio, except HICs, high employment rates in the three income groups mask huge vulnerabilities in relation to employment and hence to the related social protection schemes accessibility. Vulnerable employment is very low in HICs, ranges between 10 and 50% in UMICs, between 20 and 70% in LMICs and exceeds 80% in most of LICs countries. It follows that the greatest vulnerable segment of the population in these income groups are the working age population.

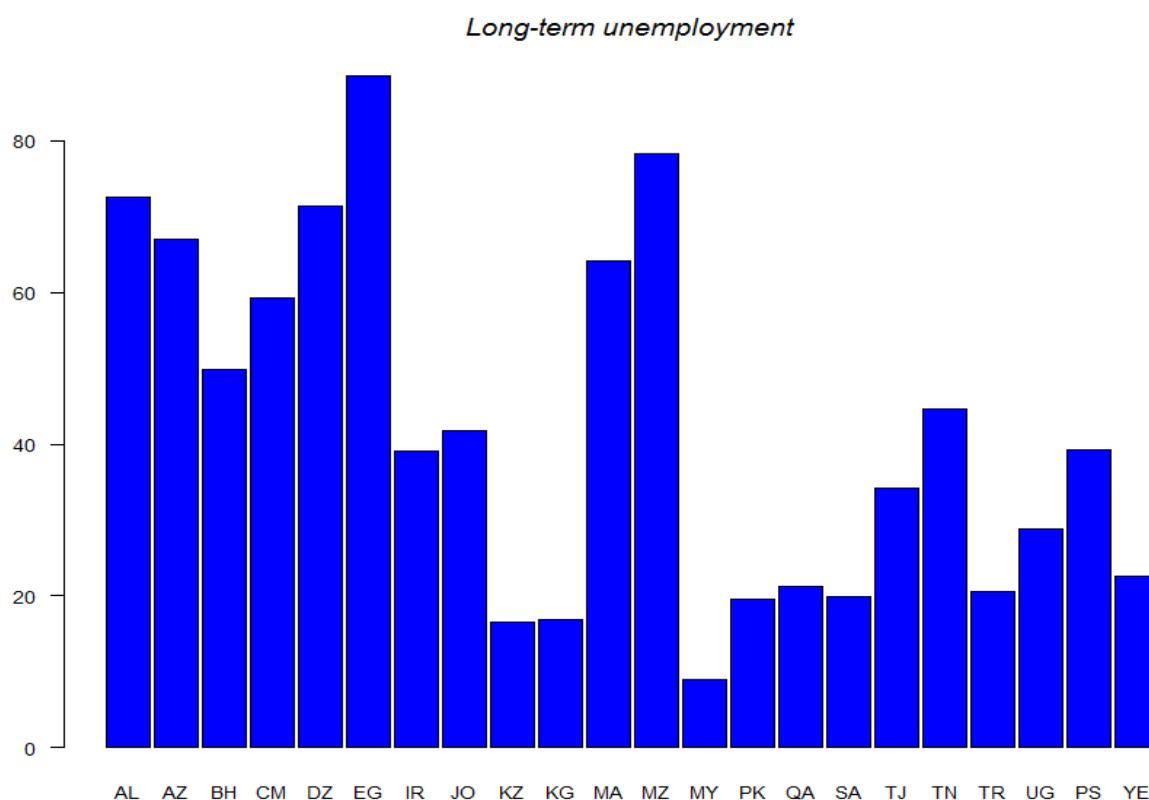
c. Total unemployment and long-term unemployment

According to ILO, the overall unemployment rate for a country is a widely used measure of its unutilized labour supply. However, ILO recommends that this indicator should not be interpreted as a measure of economic hardship or of well-being. Among the main reasons is the fact that, opposite to developed countries, developing countries lacking appropriate safety net and unemployment insurance, many individuals cannot afford to be unemployed and rather engage in any type of activity often in the informal economy. Moreover, ILO stresses that the unemployment rate does not display any information about the type of unemployment – whether it is cyclical and short-term or structural and long-term. Thus, this section only focuses on long-term unemployment as a proxy indicator for vulnerability. Along with vulnerable employment above provide a fairly good picture of the situation of labour market vulnerability and hence on the correlative social protection accessibility.

OECD defines Long-term unemployment as referring to people who have been unemployed for 12 months or more. The ratios calculated here show the proportion of these long-term

unemployed among all unemployed. As shown in the graph below, data on long-term unemployment is not available for all countries. Sources of data (whether from census or from households surveys) as well as the efficiency of national statistical systems are among factors that influence both the availability and the quality of data on highly specific indicators such as long-term unemployment. However, with only a few cases countries from each income group, we can draw an approximate picture of the long-term unemployment. Hence, in HICs, Bahrain and Qatar have 30% among those unemployed who suffered from long-term unemployment. In The UMICs countries, this figure reached 71% in Algeria, 41% in Jordan and about 30% in Turkey. In LMICs countries, Morocco reached 65% of long-term unemployment, about 20% in Pakistan and 22% in Yemen. In Low Income countries, the only country for each data is available is Mozambique with a record rate of more than 78% long-term unemployed.

Figure 7: Long-term unemployment in some OIC Countries

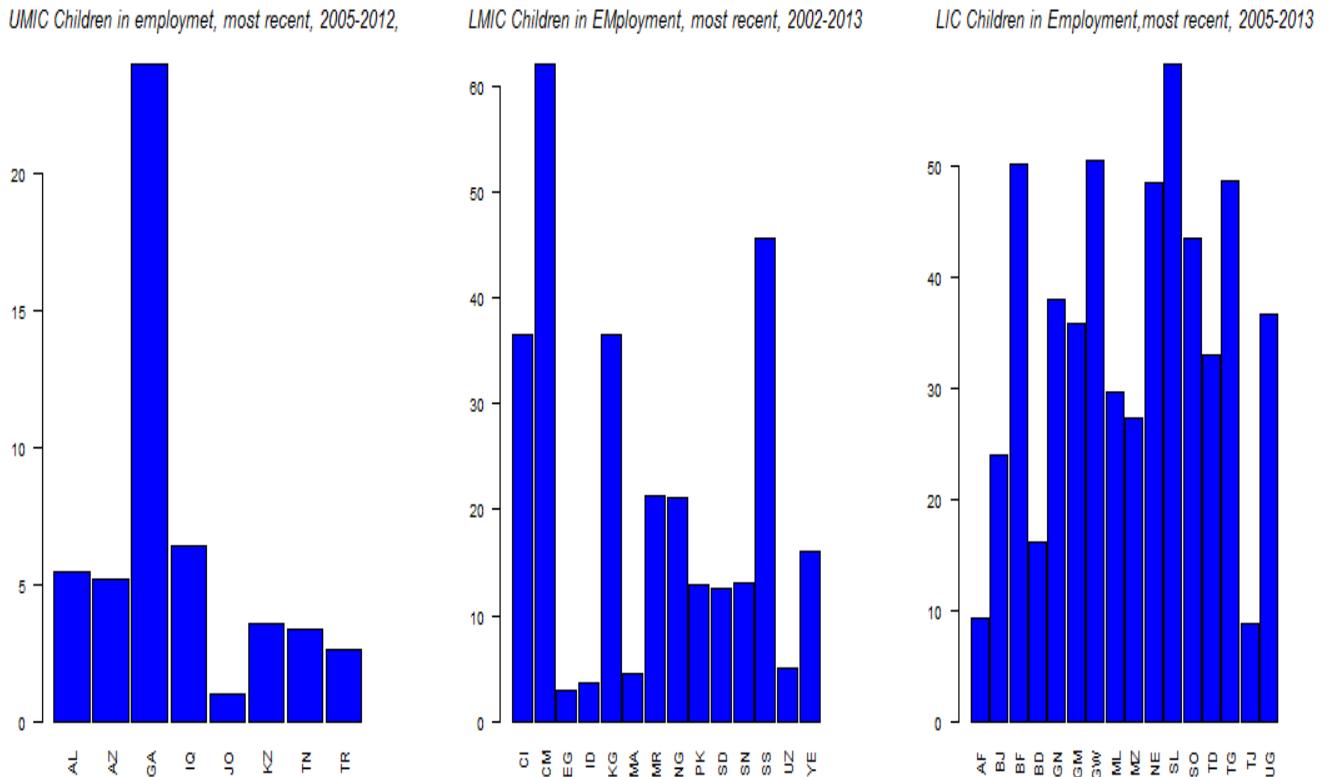


d. Child labour

Rates of child labour vary across development contexts for where data is available. Within UMICs Gabon possesses high rates of child labour (20% of children are reported as being in the labour market). Within LMICs the rates increase in the African OIC Member Countries most notably in Cameroon and Sudan. In LICs the majority of countries have over 30% of children in the labour market with over 60% in Sierra Leone. High rate of child labour in an economy is an indication of gaps in social protection and social services such as access to education for

children and child allowances. Children in these countries especially in LMICs and more severely in LICs are the most vulnerable group of the population. Social assistance programmes will not be sufficient to overcome such huge structural deficit. Transformative social protection policies are required to invest in vital areas of education, health, training and more widely the development of human capital starting from early childhood.

Figure 8: Child Labour in the OIC Countries



Poverty headcount ratio at \$2 a day (PPP) (% of population)

The World Bank poverty estimates are measured according to a shortfall in terms of financial resources (income or expenditure) below which it is not possible to meet the minimum maintenance and physical efficiency. Thus, both the previously applied poverty threshold of \$1.25 and the currently applied threshold of \$1.90⁴³ define poverty only at subsistence level. These estimates do not take into account other vital needs such as education and health care as well as other essential goods and services for wellbeing. They therefore underestimate poverty and mask its many dimensions. Given that \$1.90 estimates are missing for many countries (see the graph below for \$1.9)⁴⁴ in the World Development Indicators database we use the \$2 threshold for which data is available only in the upper middle income groups and below. Though the HICs do not experience forms of poverty at this level, regionally adapted upper-

⁴³ See the latest update here: <http://www.worldbank.org/en/topic/poverty/brief/global-poverty-line-faq>

⁴⁴ The profile of poverty does not change significantly from \$2 to \$1.9 thresholds.

bound poverty thresholds used by the World Bank may well, if applied capture some fractions of the population that are poor according to these definitions.

As shown in Figures 9 and 10 the population proportions of those living on two dollars a day largely equates to the level of economic development, that is the higher the GDP of a country the lower the proportion of those living in poverty as the figures demonstrate. There are a number of exceptions to the trend notably the LICs of Comoros and Tajikistan which have low levels of poverty compared to their country group which tends to be over 60% of the population living on two dollars a day. Among the main risks associated with the lack of efficient social protection systems is the challenge of very high poverty rates especially in Lower middle income and low-income countries. Getting out of poverty is a complex issue that might not be addressed only by social safety nets but by addressing the multidimensional nature of poverty starting from education and training systems, health systems as well as labour market policies beyond increasing the labour demand but looking at the long-term structural development factors.

Figure 9: Poverty Headcount Ratio at \$2 a day per person in OIC countries

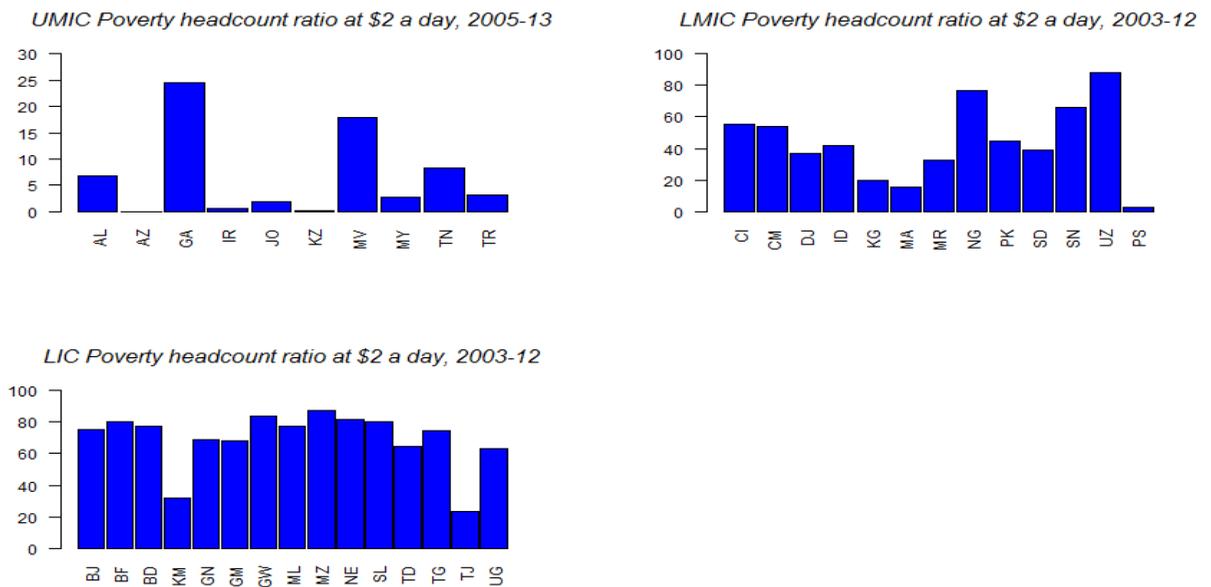
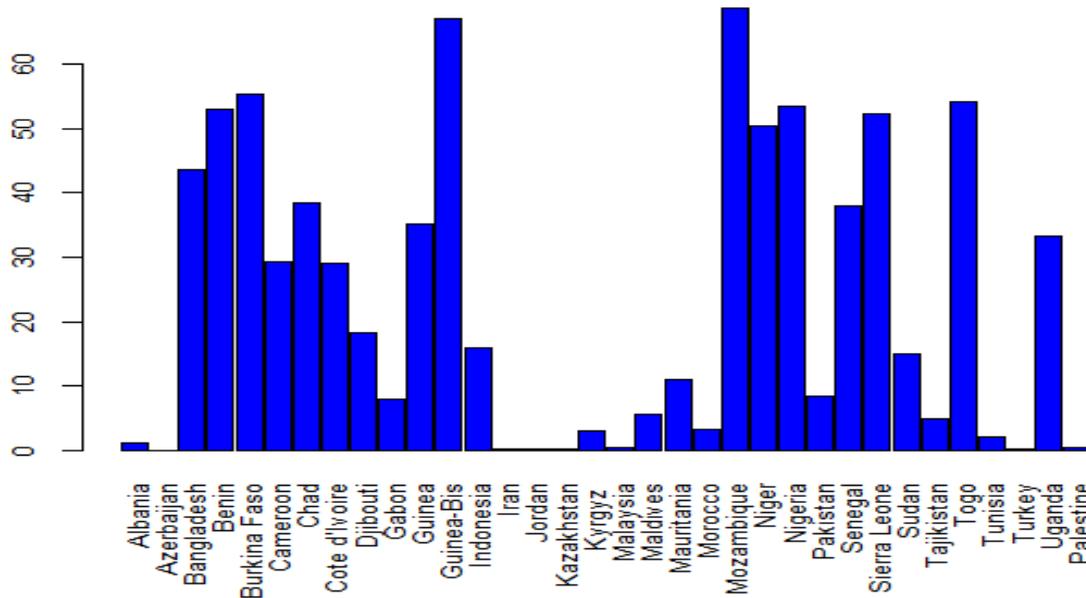


Figure 10: Poverty Headcount Ratio at \$1.9 a day per person in OIC countries



Inequality, Share of income or consumption, Lowest 20% and Highest 20%

According to the World Bank WDI database, Percentage share of income or consumption is the share that accrues to subgroups of population indicated by deciles (population divided into groups of 10%) or quintiles (divided into groups of 20%) ranked to the share of income or consumption they held in the overall income distribution. The portions ranked lowest by personal income receive the smallest shares of total income or consumption. Thus, this indicator provides an idea of the extent of inequality in each income group except for HICs for which data is not available. As the graphs in annex 5 show, we see that in UMICs, the lowest quintile held less than 12% and less than 6% in some countries compared to the highest quintile in which for the majority of countries in this group held between 30% to 50%. In the Lower middle-income and low income countries, the lowest quintile generally held less than 8% of the total income or consumption distribution (sometimes less than 5%) whereas the highest quintile accounted for more than 50% and 60% in the two income groups. Such degrees of inequality provide an idea of the level of redistribution of income and wealth in the majority of OIC countries.

The extent of inequality is also corroborated by the graphs of GINI Index⁴⁵ as shown in annex 5. Most of our countries of interest have a Gini index above 30 and some countries more than 50.

⁴⁵ Gini index measures the extent to which the distribution of income or consumption expenditure among individuals or households within an economy deviates from a perfectly equal distribution. A Gini index of zero represents perfect equality, while an index of 100 implies perfect inequality.

Concluding remarks on vulnerability indicators and vulnerable groups

In terms of demographic structure, low-income countries face challenges of low economic development besides large population share of young population under 14 years old and a low share of the elderly. Generally high rates of poverty and of poor quality of education and low rates of retention as well as poor training to labour transition identify children and youth as well as working age population in vulnerable employment as the main vulnerable groups. It follows that social protection policies in these countries should prioritize these groups.

Lower middle-income although they share some features with low income countries in terms of young population and the challenges they face, have an additional challenge of increasing the elderly population. In this group, the most exposed portions of the population are children and youth to a lesser extent but also the elderly without protection against illness, old age as well as appropriate medical services.

In the upper middle-income countries, the proportion of dependent elderly becomes more pronounced and is expected to increase further in the next few decades to form the most vulnerable group in this income group.

In the High Income Countries, the elderly dependency proportion declines along with the proportions of dependent young people probably due to the small size of populations. It becomes apparent that the most exposed groups to major risks are the working age populations. The vulnerable employment and long-term unemployment rates in some of these countries reinforce this perception.

Child and maternal mortality identify the most vulnerable groups in Low income countries and to a lesser extent in LMICs and much less in UMICs. High rates of maternal and child mortality, generally due to preventable risks, indicate poor social conditions that affect a wider proportion of the population beyond the figures of mortality indicators. In a related issue, undernourishment is generally correlated with poverty and vulnerability. Low-income countries are largely affected ranging from 15 to 30% with a few exceptions such as Mali, Gambia and Benin. A few exceptions are also observed in the upper middle-income groups such as Iraq where undernourishment affects around 20% of the population. Such exceptions call for temporary measures to close the existing gaps in such basic indicators.

Always in terms of environmental and policy factors of vulnerability, some countries in the upper middle-income groups such as Gabon and Turkmenistan which have access patterns to water and sanitation similar to low income countries, though in terms of access to water, the rates are relatively much higher regardless of income levels.

With regard to economic growth, paradoxically low-income countries achieved higher rates of economic growth compared to higher income groups. However, the level of GDP per capita has not seen any significant increase indicating the very limited transformative nature of economic development, also translated by very slow progress in reducing poverty, which remains very high in these countries. The capacity to absorb the most important factors of vulnerability in Low-income countries relies heavily on the level of resources available in these countries more than expanding the productive economic activities.

In terms of labour market, relatively high and sometimes very high employment to population ratios in all OIC countries, there exist serious vulnerabilities in this sector expressed by the

rate of vulnerable employment and long-term employment. Except HICs all of which have labour markets dominated by foreign labour the majority of OIC countries suffer from high rates of insecure employment. Informal sector is predominant in many countries of the three income groups, which offer little social protection in terms of income, health and safety and unemployment insurance. On the other hand, long-term unemployment affects many countries regardless of the income level. This range from around 30% in some HICs to 78% in the only LICs country for which data is available for this indicator. It follows that working age population are very much affected and represent the most vulnerable. However, given the high rates of dependent young people especially in LICs and LMICs, much wider groups of the population is also indirectly affected.

The child labour indicator shows that children especially in LMICs and more severely in LICs are the most vulnerable group of the population. Given the correlation between child labour, poor access to social services in the areas known to have high child labour prevalence, social assistance programmes will not be sufficient to overcome such huge structural deficit. More transformative intervention is needed which looks holistically into the wider population and addresses the wider dimensions of vulnerability such as health, education and the labour market.

In a similar vein, amongst the main risks associated with the lack of efficient social protection systems is the challenge of very high poverty rates especially in Lower middle income and low-income countries. This again calls into question the efficiency of social safety nets widely applied in many of these countries which do not address the multidimensional nature of poverty starting from education and training systems, health systems as well as labour market policies.

Finally, besides poverty, which challenges the current policies in many LICs and LMICs and to a lesser extent some UMICs countries, there is a major challenge of inequality which is very acute in many of these countries. The implication for vulnerability and accessibility to social protection concerns the fact that the lowest 20% of the population in the income distribution are not only deprived of access to basic social services and social protection but also occupy a weak position in terms of command over material resources. Transformative social protection are needed beyond social assistance efforts in order to promote more social cohesion and more equitable access to social protection services through education, labour and other transformative measures. Such a political choice does not consider targeting as the main intervention but only of a temporary nature, whereas the focus is put on transformative interventions in the mid and long run.

2.3. Overview of Social Protection Systems in the OIC Member Countries

Within regards to the Asian countries in the OIC country grouping, these are the most diverse region in the world in terms of religion, culture and economic development. It includes some of the richest countries alongside two-thirds of the global poor. This diversity has led to differing social protection systems in terms of quality and coverage. Across Asia it is generally the trend that the higher a country's GDP per capita the broader its coverage of social protection. The Asian Development Bank's Social Protection Index (SPI) provides an overall assessment of the depth and breadth of social protection programmes in each country. The SPI is an indicator that divides total expenditures on social protection by the total number of intended beneficiaries of all social protection programs. The higher the SPI figure the greater coverage and breadth of social protection a country has.

Within the upper-middle-income countries Azerbaijan has SPI value of 0.187 and spends 6.1 % of GDP on social protection policies and interventions. The same figures for Malaysia are 0.155 and 3.7, respectively. Within lower-middle-income countries Uzbekistan performs very well spending 10.2% of GDP on social protection policies (the second highest in the Asia region after Japan). In lower income countries Maldives has average spending of 3% of GDP and for Bangladesh the average spending is less than 3 % of GDP.

The countries in South Asia do not perform as well as those in Southeast Asia. This region has only one upper-middle-income country (Kyrgyz Republic SPI: 0.151; 8.0 % of GDP on social protection) and the low-income countries of Bangladesh (0.043; 1.4) and Afghanistan (0.046; 2.0). The average GDP per capita in this region is only \$1,703, the lowest among Asian countries.

2.3.1. Total Expenditure on Public Social Protection and Health Care

Since the start of the global economic crisis, spending on social safety nets in some OIC states as a whole has increased, from 10.1% of total expenditure before the crisis to 11.9% during the crisis and 12.5% afterwards (4.16%, 4.44%, and 4.59% of GDP respectively).⁴⁶ Countries in the low or lower-middle income groups like Egypt and Yemen extended eligibility criteria for subsidised food rations and cash transfers to vulnerable populations which lead to increased access by poor or vulnerable populations.⁴⁷ However, in the majority of OIC countries spending on social protection remains relatively low to very low in many cases.

According to the OECD⁴⁸, social protection is a measure of the extent to which countries assume responsibility for supporting the standard of living of disadvantaged or vulnerable groups. Benefits may be targeted at low-income households, the elderly, disabled, sick, unemployed, or young persons. Social spending comprises cash benefits, direct in-kind provision of goods and services, and tax breaks with social purposes. To be considered "social", programmes have to involve either redistribution of resources across households or compulsory participation.

When social protection expenditure does not include health care, it consists mainly of :

⁴⁶ Prasad and Gerecke, 2010; cited in ODI/UNICEF, 2011.

⁴⁷ ODI/UNICEF, 2011.

⁴⁸ <https://data.oecd.org/socialexp/social-spending.htm>

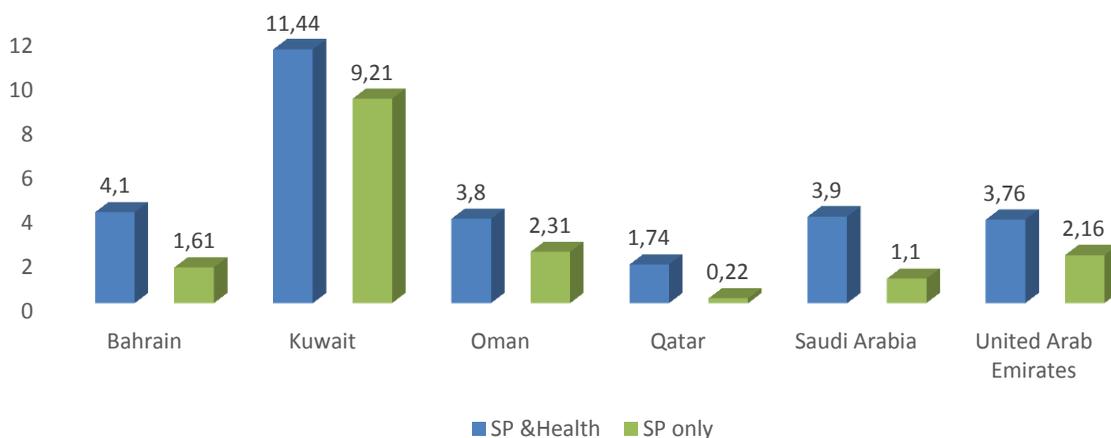
- social benefits, or transfers in cash or in kind, to households and individuals with the aim to relieve them of the burden of a defined set of risks or needs;
- administration costs, or costs of managing or administering the social protection scheme; and
- Other miscellaneous expenditure by social protection schemes (payment of property income and other).⁴⁹

In OIC countries, as shown in the graphs below, public expenditure on social protection varies greatly even within the same income group. For example, social protection in HICs excluding health care ranges from 0.22% in Qatar to 9.21% in Kuwait, the rest of countries expenditure range from 1 to 2% out of their GDP. Upper middle-income countries display higher social protection expenditure ranging between 4.11% in Kazakhstan and 10.69% in Iran, the exception being Lebanon and Malaysia with respectively only 0.36% and 1% out of their GDP. In lower middle-income countries, many countries spend around 1% or less in social protection such as Mauritania, Sudan, Pakistan, Indonesia, Nigeria and Cameroun. The highest proportion of GDP spent in social protection is Egypt with 11.73%, followed by Kyrgyz Republic with 5.75% and a few countries spending around 4% such as Morocco and Yemen. In low income countries, except Tajikistan with 4.96% and Guinea-Bissau with 3.13% the rest of countries spend less than 2% or less than 1%.

OECD social protection database definitions points out that Social protection expenditure can fall even in rich countries if there is an increase in employment so that many are enrolled in formal benefits and do not need to rely anymore on social protection for the vulnerable or the near poor. However, in most of OIC countries, given the profile of employment sector, of poverty and other relevant indicators covered in this report, it is very unlikely that such generally low public spending in social protection is due to such a transformative factor.

The graphs below show also that social protection when combined with health care spending tends to be higher. This combination sometimes obscures the actual spending in social protection, thus the two types of expenditure have been separated in the graphs.

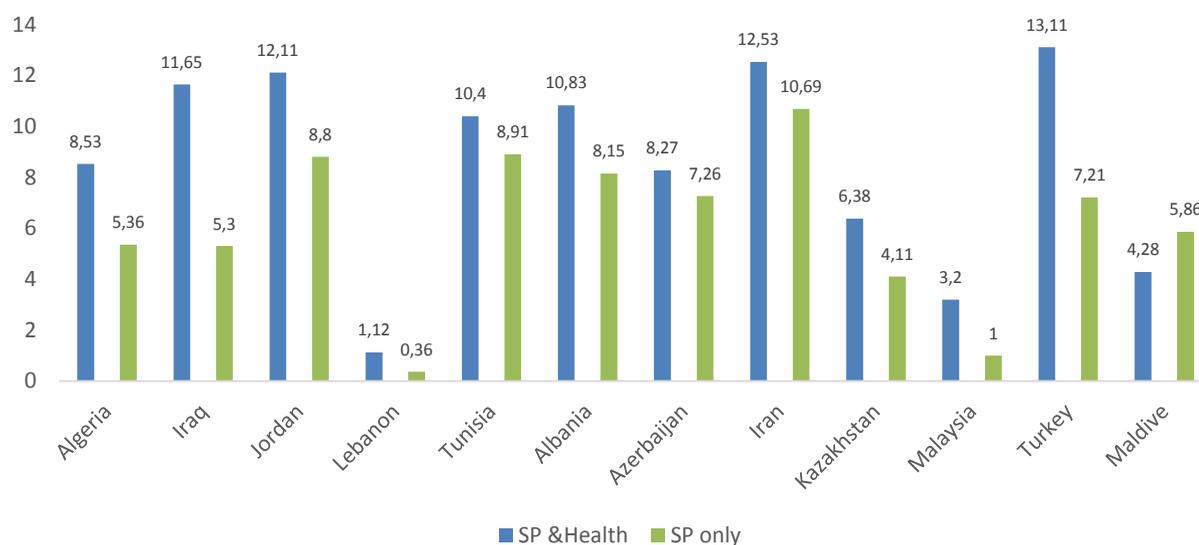
Figure 11: Total public social protection and health care expenditure, (% of GDP) in HICs



Source: World Social Security Report, ILO, 2014

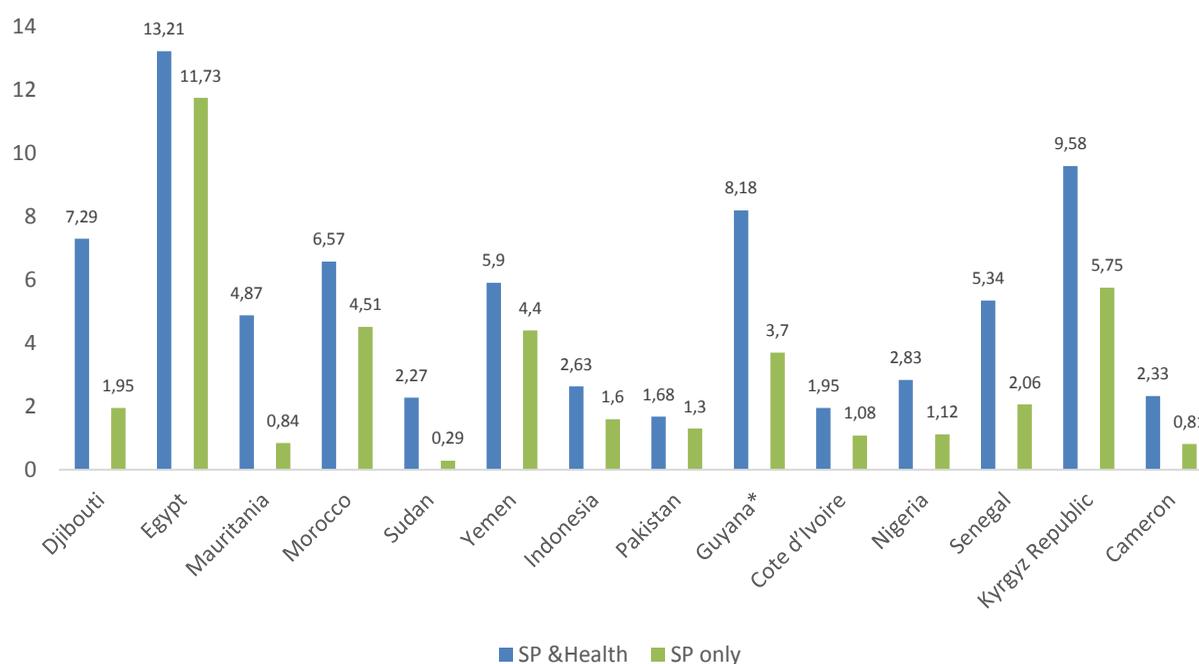
⁴⁹ http://ec.europa.eu/eurostat/statistics-explained/index.php/Glossary:Social_protection_expenditure

Figure 12: Total public social protection and health care expenditure, (% of GDP) in UMICs



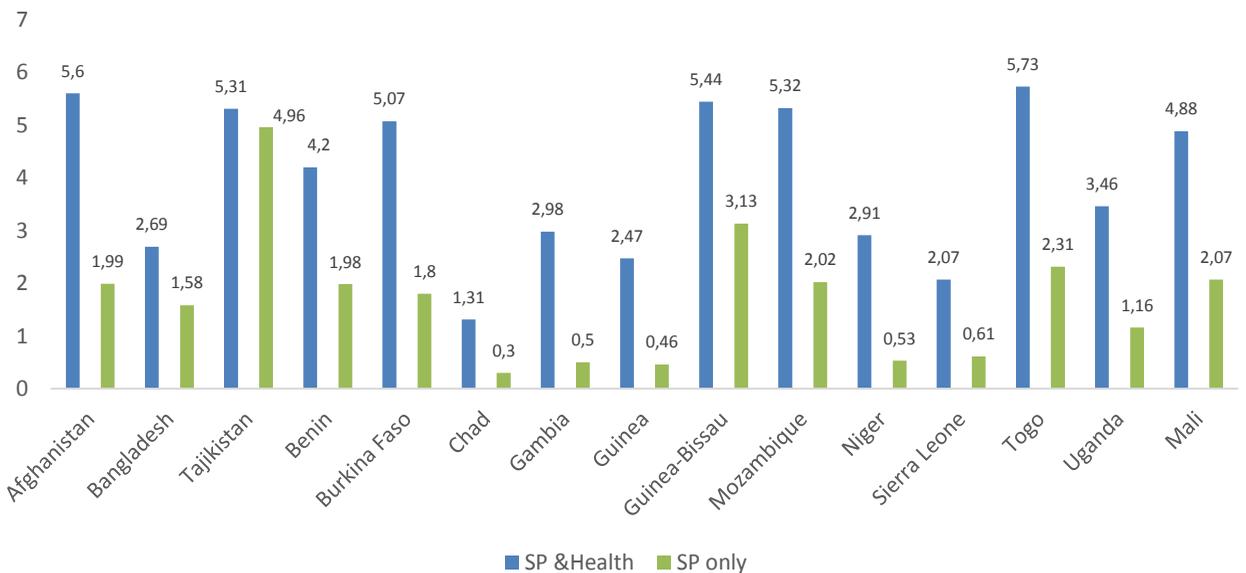
Source: World Social Security Report, ILO, 2014

Figure 13: Total public social protection and health care expenditure, (% of GDP) in LMICs



Source: World Social Security Report, ILO, 2014

Figure 14: Total public social protection and health care expenditure, (% of GDP) in LICs



Source: World Social Security Report, ILO, 2014

Out of Pocket Health payments

Despite sometimes-important government spending in health care as shown in the graphs above, across OIC countries the vast majority of people are subject to high out of pocket payments for access to health across economic contexts. As the graphs below show the level of GDP is not a determinant of the level of spending devoted to health and health care in OIC countries. For instance, a number of LICs have higher health spending than UMICs and HICs. It is apparent that social protection investments are governed by others factors rather than the traditional fiscal space available as measured by GDP.

The data and figures below are also an indication of the largely privatised healthcare systems operating across OIC countries. Large out-of-pocket expenditure requires the average citizen to pay for every expense, rendering access to health care close to impossible for those of lower socio-economic status, who simply cannot afford to either pay for private medical services much less insure against health emergencies.

The absence of affordable access to health care and prepayment schemes in many countries has compelled low-income households to pay a substantial share of their income for health services at the expense of other basic items, such as food, often subjecting them to a higher risk of being pushed deeper into poverty. These are termed catastrophic payments and can lead to families and individuals becoming further deprived due to health care costs.⁵⁰

Despite high Out of Pocket health payment, the poor risk being relegated to low care standards in often badly equipped State-run institutions or, when the prices are too high, being forced to forgo health care altogether, or not seeking the care they need until it is too late. This may lead

⁵⁰ ESCWA, 2015, Chapter 5.

people dying of what otherwise are very treatable and preventable illnesses and conditions. On a large scale this can lead to increased inequalities in health, development, and life expectancy among different social groups, obstructing any efforts towards inclusive social development in the region.

Figure 15: Out of Pocket Payments for health care in OIC countries



Source: World Development Indicators Database, 2014

2.3.2. Social Insurance

In the social insurance programmes of OIC Member States, there is a similar picture of misallocation of resources and skewed benefits of social protection towards the Middle Classes. OIC countries do not necessarily lack revenues; more than a fifth of GDP is spent on social policies in some of the low and middle incomes countries like Egypt and Jordan (Loewe, 2013). The programmes that exist limited in the range of risks which they cover, reach a small share of the population and also have limited budgets. Based on IMF (2011) estimates, OIC countries have substantial social spending ranging between 7% and 13%.⁵¹

Yet, there are significant gaps in coverage of social insurance programmes. Social insurance coverage rates vary enormously from 8% in Yemen to 87% in Libya. This is due to the structure of the labour market (for example, public or private sector) and the institutional arrangements that cover different categories of workers. It is estimated by the World Bank (in Silva et al. 2012) that only one-third of the OIC countries' populations are enrolled in formal social insurance schemes. This low rate does not correlate with the fact that two thirds of OIC countries are above the lower-middle income group banding.

⁵¹ Cited in Loewe, 2013.

In low income OIC countries like Djibouti, Sudan and Yemen, social insurance mechanisms are confined to the formal sector workforce (in the civil service, army and police). The larger share of the population who are working in the informal sector are partially covered by state provided safety nets such as food and energy subsidies or targeted programmes such as social transfers, food assistance and public works programmes (ODI/UNICEF, 2011). In the other lower-middle and upper-middle income countries such as Egypt, Morocco, Tunisia and Lebanon, the social insurance system generally covers around 30-40% of the populations as previously stated in this report. These schemes include different services, ranging from health insurance to family benefits, depending on the county. These countries also have additional mechanisms providing some coverage to informal sector workers and social assistance for disadvantaged groups. In the high income Arab countries such as the Arab Gulf countries, who are also in the highest income brackets of the OIC grouping, the state has a long tradition of social spending from oil revenue which ranges from marriage allowances to the establishment of publicly funded hospitals and schools. Oman has a system of free universal medical care for citizens, while Bahrain is the first Arab country to implement an unemployment insurance programme in 2006 (ILO/Government of Bahrain, 2010).

In Senegal, for example, formal social insurance coverage only reaches 13% of the population, including 6.2 % covered by a formal pension program, 3 % receiving social insurance administration benefits and 3 % having some form of health insurance. In particular the poor and informal sector workers have little access. In Mozambique, the Ministry of Finance's pension plans cover all public employees and therefore are classified as having high coverage, though public employees and their dependents represent less than 3 % of the population.⁵²

Indeed, OIC countries have high levels of informal workers. On average, in non-GCC Arab countries, about 67 % of the labour force does not contribute to social insurance schemes. They include agricultural workers, the self-employed in micro- and small enterprises as well as their employees. In Jordan around 50 % of the labour force did not contribute to a pension scheme in 2010; in Morocco and Syria this was around 70% in 2011 and 2008 respectively, and in Tunisia about 45% in 2008 (ESCWA, 2013). This gap in coverage is exacerbated if we take into account the low labour-force participation rates in the region which have already been alluded to (around 50%). In GCC countries, the main coverage gap concerns foreign migrant workers, who are mostly excluded from formal social insurance schemes.

The largest excluded groups from social insurance mechanism in most countries are agricultural workers, household and family workers, and foreign migrant workers (ESCWA, 2013). Only about 30% of OIC country populations are covered by formal social insurance schemes, the remainder are in the informal sector and have to seek recourse in informal ways such as through family. What we find therefore is regressive redistribution with a focus on the middle classes and much less attention to the social protection needs of the rural and urban poor.

Unequal coverage across social groups among the OIC counties is the result of differences in employment status: men are more often covered than women and the wealthier more often than the poor. In Egypt for instance, the political elite and military personnel benefit from free health care in the best state hospitals whilst the poorest have to contend with the less better equipped state hospitals that have very low standards of care (Loewe, 2013).

⁵² Marques, 2012.

In terms of redistribution, the main social insurance schemes for public and private sector employees in the region are based on the 'pay-as-you-go' (PAYG) system where current employees pay for the pensions of current retirees. This system can in principle lead to both horizontal redistribution (across age groups and employee status for example) as well as vertical redistribution (from the richer to the poorer participants).⁵³ Yet in practice, redistribution to poorer people is marginal. Governments contribute as employers, but they may also subsidize the programme if required, as happens in Iraq and Saudi Arabia. In Egypt, Jordan, Qatar and Saudi Arabia, the Government covers any deficit which the programme may incur, and in Qatar the Government fully covers the administrative costs as well.⁵⁴

An example in point relates to the pension insurance schemes which occupy the largest share of social insurance budgets among the Arab states in particular (Loewe, 2013). Their revenues range from 3 % of GDP in Egypt and Jordan to 9% in Kuwait, 5% in Tunisia and 2% in Syria. Most of them are statutory social insurance schemes with defined benefits. The pension schemes fail to reduce income differences. Most OIC states have minimum pension arrangements which entail redistribution within pension funds in favour of those covered by social insurance with the lowest incomes. However, they only benefit the urban lower middle classes since the rural populations and the urban underclass are not covered by social insurance, as has already been highlighted above. Armed forces, civil servants and private sector employees benefit the most from the system of social insurance.⁵⁵

In the public health systems of the region, a similar picture may be found with regard to the urban Middle Classes benefiting more than other groups. In the GCC states, the public health system is maintained almost entirely by the state, which ensures. Over 2% of GDP in OIC states is spent on public health but most of it also finances specialist private hospitals which benefit the urban middle classes. Much less of the state spending on health goes towards maintenance of health stations and village clinics which are need by the poor.

A similar situation of limited coverage and limited redistribution can be found in the public health care systems of the OIC states. The Lebanese health care system is the exception due to its heavy reliance on private health providers.⁵⁶ Generally, health-care services in the OIC states are provided either for a small fee or are free of charge. In addition to those universal public services, several countries have developed social health insurance systems, mainly for employees of the public sector and the formal private sector. In Egypt, Jordan and Tunisia, these insurance systems operate health care facilities for their members. In Egypt, the Health Insurance Organization, the primary insurance provider, covered around 57 % of the population in 2008/2009 (ESCWA, 2013). Coverage rates were higher in Tunisia (99 %) and Jordan (83 %). In Lebanon the Ministry of Public Health serves as the insurer of last resort for 53 % of the population, those who are not covered by employment-based or private health insurance.

Tables 1 to 4 in Annex 4 provide an up-to-date outline of the social insurance legislation in all the OIC Member States discussed in this report as well as non-contributory government social grants and similar social safety nets. They show that almost all countries have formal social insurance schemes place at it is possible to make the following conclusions at this stage:

⁵³ ESCWA, 2013, 2015.

⁵⁴ Ibid.

⁵⁵ Jawad, 2009; Loewe, 2013.

⁵⁶ Ibid, Jawad.

1. Workers in the public and private sector whose employers are making contributions to social insurance funds are the best protected.
2. Women are disadvantaged in various countries due to lack of or very little maternity insurance schemes. In the high income Arab Gulf States, only Qatar has a social insurance scheme for women in place. These states also stand out in that none of them provide family allowances.
3. Countries that do offer family allowances, this is often tied to the employment status of the eligible applicants who wishes to claim this pay.
4. With regards to unemployment, for any countries, this is in fact severance pay in case a worker is dismissed from work. This matter is not the same as unemployment insurance since it does not guarantee a minimum income or support the dismissed worker in finding new work for example, due to a redundancy.
5. In many of the old age pension schemes, this is in fact a social assistance-based service so not related to a previous work or contribution record but it raises issues of whether or not eligible applicants know about the service and if they are means-tested to qualify for the benefit.

2.3.3. Social Assistance and Targeted Service Delivery

Almost all social assistance programs in the OIC countries fail to cover even 20 % of the bottom quintile (the poorest populations), while some programmes cover a substantial proportion (up to 11–12 %) of the top quintile. As an example, Egypt's *Monthly Social Pension (or Sadat Pension)* programme covers only 8% of the poorest quintile. In Jordan, the *National Aid Fund* reaches only 16.5 % of the poorest quintile. Djibouti and Iraq's Social Safety Net programmes reach less than 2 % of the poorest quintile.⁵⁷ The highest coverage of the poorest quintile (over 50 %) is in West Bank and Gaza, where assistance is provided primarily by the United Nations (UN). In this respect, this programme compares well to the signature programmes in Europe and Central Asia or Latin America and the Caribbean (Silva et al., 2012).

Although low coverage of the poor is a key indicator that social assistance or social safety net programmes are underperforming, substantial coverage of the middle classes and richer segments of society indicates a high degree of inefficiency. High coverage rates for the poor are difficult to achieve without some leakage. However, coverage rates should decrease progressively from the poorest to the richest quintiles. Specifically, a key policy design feature is that coverage rates should have a negative slope across wealth quintiles.

The logics of categorical and geographical targeting methods which predominate in the social assistance programmes of the OIC countries work well in environments where poverty is concentrated but not where poverty is multi-dimensional in nature or geographically dispersed. Categorical and geographic targeting methods are now outdated, which means that the OIC countries that continue to use them to target vulnerable groups lag behind others that have switched to individual assessments of either incomes (through means tests) or expenditures (through Proxy Means Testing or PMT), in some cases supplemented by community-based targeting. Among the OIC countries, Jordan, West Bank and Gaza, and the Republic Yemen have begun to improve their targeting methods.

In the African countries, social safety net systems are especially weak. In Senegal, for instance, over half of households have no specific coping strategies in response to shocks. Very few

⁵⁷ Silva et al, 2012.

report receiving help from the Government or NGOs, relying on family members, savings or going into debt. The general conclusion of the Government and key international partners has been to build a better targeted safety net system as a better option than continued reliance on general subsidies. The basis for this argument can be grounded not only in equity concerns but also in direct linkages to economic growth. Social protection contributes to economic growth in multiple ways. Yet, support is often poorly targeted, with subsidies and write-offs benefitting larger rural producer and those able to participate in the formal credit system. The Senegalese government responded to the fuel and food price hikes with a series of fiscal measures, including subsidies on basic foodstuffs (rice, wheat, and milk), butane/natural gas and electricity. This ensured a quick and visible action by the Government to respond to growing social discontent and immediate needs, but proved very expensive, absorbing 2.4 % of GDP, or one-tenth of all spending in 2008. The use of subsidies during the food and fuel crises came with administrative difficulties and economic disincentive effects. More importantly, the bulk of benefits went to the non-poor. For example, only one-third of water subsidy beneficiaries were poor and only 8 % were in the poorest quintile (poorest 20 %). Similarly, 31 % of electricity subsidy beneficiaries were poor and about 7 % were in the poorest quintile. The strong majority of beneficiaries of both subsidies were urban dwellers.

A review of safety net programs in Senegal identified 12 programs under implementation by the Government in 2011. The performance of these targeting systems is mixed. Some programs are very effective at concentrating on the poorest households, like the PRN and agricultural support programs, while others reveal significant leakage to the non-poor, including educational assistance (like scholarships) and food aid. The elderly health care program benefits more the better off 40 % of households with beneficiaries concentrated in urban households.

A similar situation may be found in Mozambique where the social safety net system suffers from programme gaps, particularly programs for poor families with children, for youth at risk, and to help seasonal agricultural workers and the urban unemployed; many programs have low coverage and generosity; there is program fragmentation (i.e., various pension plans) and duplication.⁵⁸The Ministry of Finance's pensions and fuel subsidies absorb a large share of social protection expenditures and do not benefit the poor; and there is substantial room to improve targeting and beneficiary selection mechanisms and increase program cost effectiveness. Estimates of spending according to the GOM's Social Protection Framework indicate that about 44 % is spent on Basic Social Security and 56 % on Compulsory Social Security (excluding subsidies).⁵⁹

The major social assistance programs in Mozambique have low coverage relative to the number of individuals at risk, including the unconditional cash transfers (PSA) and the other INAS's programs, school lunches, HIV/AIDS programs, and food for work. INSS has low coverage as it covers less than 5 % of the labour force and 88 % of elderly have no pension. Out of the 37 programs for which some information has been obtained, 5 programs have been identified with high coverage, 1 with fair coverage, and 31 with low coverage.

The other programs with high coverage are the micronutrients programs which according to the Ministry of Health's surveillance Program cover all the "intended" target group though many children continue to suffer from malnutrition (44 % of the under five are stunted). The program classified with fair coverage is adult education, as it covers 1.1 million adults of the estimated 5.9 million illiterate adults in the country. The expenditure data and the program

⁵⁸ Ibid.

⁵⁹ Marques, 2012.

coverage data indicates that major program gaps include those for poor families with children, programs for youth, and programs for the working poor, particularly those facing recurrent weather related shocks.

In addition, the targeting accuracy of major social assistance programs is quite poor, though two caveats are in order. First, the distribution of poverty across quintiles is quite flat, therefore reaching the poorest of the poor is a greater targeting challenge in Mozambique than in countries where this group is more easily identified; secondly, the large share of population involved in informal sector and subsistence farming activities makes it also more challenging to target on the basis of income or consumption measures compared to countries with larger formal sectors and monetized economies. With these caveats in mind, the targeting accuracy of the two programs that are designed to reach the poor and for which there is information on targeting results (PSA and PASD) is quite low.

In Burkina Faso, over 92 % of the population lives in rural areas where poverty incidence is more than twice as high as in urban areas (52.3 % versus 19.9 %). In terms of regional poverty, the Center Region is among the poorest with over 50 % of its inhabitants being poor. Male-headed households, which constitute 95.6 % of poor households, tend to be poorer than households headed by females both in terms of incidence and gap. However, in many parts of West Africa Sahara, there are reasons to believe that some groups of women may be particularly poor and vulnerable (such as widows, remarried widows, divorced women, and their children). Moreover, households whose heads are illiterate or only educated to a low primary level also have a notably higher than average poverty incidence (51.0 and 41.1 % respectively).⁶⁰ However, the scope and coverage of the existing social safety net system is too limited and most interventions are fairly small in scale and designed to be only temporary interventions.⁶¹ On average, excluding fuel subsidies, spending on social safety net programs constituted only about 0.6 % of GDP between 2005 and 2009 (rising from 0.3 % in 2005 to 0.9 % in 2009), while about 20 % of the population is food-insecure and lives permanently in chronic poverty. Universal fuel subsidies are very expensive (0.7 % of GDP in 2007) and have a very limited impact on those in the poorest decile while 84 % of the benefits go to the non-poor. Of the remaining programs, food transfers are the main social safety net program in Burkina Faso, accounting for 69 % of total social safety net spending and over 80 % of all estimated social safety net beneficiaries in 2009 (excluding fuel subsidies). However, most of the financing for social safety net programs comes from external and ad hoc resources.⁶²

In terms of social indicators, health services have become more accessible as a result of a steady increase in public health expenditures as a share of the overall budget (from 7.4 % in 2004 to 9.9 % in 2006).

Government Strategy, Institutional Setup, and Expenditures for Social Safety Nets Although Burkina Faso has not yet adopted a consolidated national social protection policy, social safety net programs are playing an important role in the government's human capital development and crisis response strategies. Social safety net programmes feature in many sector-based strategies, including those for health, education, food security, and employment. Yet their potential to reduce poverty and vulnerability through income redistribution, promotion, and transformation is less often recognized in medium-term sectoral strategies. Moreover, as a result of the lack of a comprehensive strategy and the lack of an appropriate institutional setup, there is little inter-ministerial coordination on social protection and social safety nets.

⁶⁰ Ibid.

⁶¹ Cherrier, del Ninno and Razmara, 2011.

⁶² Ibid.

The government is taking several actions to address the need for more comprehensive social protection and a more effective social safety net system in particular. Currently, the social safety net programmes in Burkina can be classified in five categories: (i) cash and near-cash transfers; (ii) food transfers (subsidized food sales, targeted food distributions, nutrition programs, and school feeding); (iii) universal subsidies (food and fuel); (iv) public works; and (v) fee waivers.⁶³

Hence, what we find is that in the OIC countries therefore, social assistance and social safety net programmes do target the poor and vulnerable but the reality is that the wealthy populations tend to constitute a significant share of social safety net beneficiaries. On average, only a quarter of non-subsidy social assistance beneficiaries in the Arab region come from the poorest quintile, while about 15 % come from the richest quintile. In some programmes, such as in West Bank and Gaza, targeting has been improved since 2009 thanks to the creation of the unified Cash Transfer Program (CTP) in 2010, which uses a PMT targeting mechanism and a unified payment scheme. In contrast, in Djibouti and Morocco, the richest population quintile represents the same share of social safety net beneficiaries as the poorest quintile.

In comparison to other world regions, there is clear underperformance in the OIC countries' social assistance and social safety net programmes in terms of beneficiary incidence: in all other regions, the bottom quintile accounts for at least 30% or more of social safety net beneficiaries, with Latin America and the Caribbean leading the world at 36%. The Monthly Social Pension (or Sadat Pension) in Egypt and the Social Welfare Fund (SWF) in the Republic of Yemen each have a progressive benefit incidence, but not in significant numbers (Silva. et al, 2012). But these two countries differ in their targeting of the poor due to the differences in their respective poverty lines. Bearing in mind that the Republic of Yemen has a high poverty rate (about 35%), the share of the SWF going to the poor is 48%, whereas Egypt's poverty rate of 22% suggests that only 26% of the Monthly Social Pension (or Sadat Pension) benefits reach the poor. Morocco's conditional cash transfer (CCT) programme is also noteworthy of good practice. An impact evaluation of the pilot showed that school dropout rates decreased by 57% and the rate of return to school by dropouts rose by 37%. Moreover, between 2009 and 2011-2012, programme coverage increased from 80,000 school children to 609,000 children (within 406,000 households). The total budget also rose from US\$10 million to US\$62 million.

It is generally agreed that the most important indicator of social assistance effectiveness is the final impact on reducing poverty and inequality. This indicator draws upon an assessment of coverage, targeting, and generosity of social assistance programmes and assesses the overall effect of the presence of social assistance programmes on the welfare distribution of the country. With the exceptions of West Bank and Gaza and Jordan, social assistance programmes in the OIC states have little effect on poverty rates. Social assistance programmes in Egypt, Iraq, and the Republic of Yemen reduce poverty rates in these countries by no more than 4%. In this respect, the OIC states performs better in terms of poverty impact of social assistance programmes than East Asia but much worse than the world average or in Europe and Central Asia or Latin America and the Caribbean. A similar picture emerges for the non-subsidy social safety net impact on the poverty gap. As with the poverty rate, social assistance programmes in Jordan and West Bank and Gaza appear to have a noticeable effect on the poverty gap (reducing it by 23 % and 42 %, respectively).

⁶³ Cherrier, del Ninno and Razmara, 2011.

3. Case Studies

3.1. Iran

3.1.1. Current Legislation Covering Vulnerable Groups

The social welfare system in Iran can be classified in two major categories. Formal social insurance and support service (non-insurance services).⁶⁴ The latter services are run mainly by Iran Welfare Organization (Behzisti) and Imam Khomeini Relief Committee.⁶⁵ Their main financial source is the government's annual budget. However, Imam Relief Committee together with other foundations is accountable only to the supreme leader rather than the government. Both main organizations provide different support for the poor and vulnerable such as female headed households without any income sources, orphans and poor children, the elderly, disabled, and poor families in urban and rural areas. The support services and non-insurance programs began after 1979 Revolution in line with the Article 29 of the constitutional Law.⁶⁶ The article clearly states that the government must provide support services and financial support for all vulnerable groups and access to support is accepted as a universal right.

After the revolution, the government began to implement comprehensive subsidy programmes to provide for basic needs. In addition, according to the constitutional law of 1980, several social assistance organizations were established to support vulnerable groups mainly through state financial resources. The five five-year socio-economic development plans that were put in place since 1989 assigned to the government the duty of supporting different vulnerable populations in rural and urban areas. Parliament passed the Comprehensive Law of Social Security and Welfare in 2004 to coordinate the different organizations and their services under supervision of a newly established ministry, Iran Social Security and Welfare Ministry, which was then integrated into the Ministry of Labour in 2013. The social assistance services and non-insurance programs have been gradually developed to include all vulnerable groups since 1979. For instance, a new piece of legislation to include all disabled people to receive an allowance and permanent benefits is ready to be sent to the parliament.

3.1.2. Population Segments Defined as Vulnerable

There are different vulnerable groups such as female headed households, the elderly, disabled and orphans. They receive different services from cash benefits to medical services and allowances and income support and medical services at home or day and day care state centres. Each of these key groups is discussed in more detail in the following sections.

⁶⁴ Iran formal welfare Insurance program has provision for a very comprehensive social security system funded mainly by payroll levies with intention to provide not only income on retirement or on incurring disability, but also healthcare, together with some "unemployment" (redundancy) protection. The main scheme is administered by the Social Security Organization (SSO).

⁶⁵ There are several para-governmental organizations such as the Oppressed Foundation (the Bonyad-e Mostazafan), the war Disabled foundation (the Bonyad-e Janbazan), the Martyre foundation (the Bonyaf Shahid), the Imam Executive Command Committee (the Setad-e farman-e Ejraei-e Imam) and 15 Khordad foundation, that provide regular one off services for vulnerable groups such as new born babies, pregnant mother, women head households, and students. For instance, the oppressed foundation provide the following one-off services to the poor families in the different part of country.

⁶⁶ It should be mentioned that since 2011 the government pay each individual a monthly cash subsidy equal to 15 Dollar (450000 rial).

3.1.3. Extent of Effective Coverage

Female-Headed Household

Female-Headed households have become a major social problem for public policy and a source of disputes in the Iranian Welfare system. These women have been considered as vulnerable group in Iran welfare policy. The rising number of nuclear families, growing rate of divorce and the increasing rate of women participation in the higher education have not only weakened the structure of traditional family but also led to ever increase the rate female headed families. Besides, the increasing rate of divorce, number of drug addicts, prisons are main causes of increasing female headed households.

As Table 1 shows, between two national censuses (2006 to 2011) the number of female headed households has been increased sharply and reached near 2,500,000 households, increased 900,000 more than 2006. These types of family make 12.1 % of all households.

Table 1: Number of Iranian Household by Gender and Age of Headed Households in National Census, 2006 and 2011

	2006				2011			
	Men		Women		Men		women	
	Number	%	Number	%	Number	%	Number	%
> 15 y	2813	0.02	498	0.03	2439	0.01	1379	0.05
15-19 y	53227	0.34	6868	0.42	44203	0.24	7594	0.30
20-24 y	613245	3.90	28830	1.76	672749	3.62	35988	1.41
25-29 y	1926302	12.26	50538	3.08	2235408	12.04	74484	2.92
30-34 y	2316226	14.74	72702	4.43	2803553	15.10	115304	4.53
35-39 y	2307522	14.69	106097	6.47	2534193	13.65	145057	5.69
40-44 y	1987317	12.65	132337	8.06	2350929	12.66	192220	7.54
45-49 y	1738423	11.06	158669	9.67	1965979	10.59	214267	8.41
50- 54y	1354034	8.62	177309	10.80	1720636	9.27	264956	10.40
55-59 y	904865	5.76	165559	10.09	1304040	7.03	283902	11.14
60-64 y	709743	4.52	169414	10.32	868377	4.68	273454	10.73
65-69 y	605568	3.85	160375	9.77	634175	3.42	250753	9.84
70-74 y	570692	3.63	178674	10.89	548807	2.96	243650	9.56
75> y	621665	3.96	233174	14.21	871991	4.70	444746	17.45
Unclear	-	-	-	-	4930	0.03	318	0.01
Total	15711642	100	1641044	100	18562409	100	2548072	100

Source: Iran Statistical Center.

As Table 2 indicates men as breadwinner makes 75.37 % of all households and women 18.18 % of them. While 19.29% of men headed households are without income sources, 50.1 % of female headed households suffer from any type of income resources. This makes the government to assign the ministry in charge in the Article 39 of Five Year Development Plan (2011-2015) to arrange programme to empower these households.

Table.2 Number of the Iranian Households by Gender and Type of Activity of Headed Households in Two National Census 2006 and 2011

	2006				2011			
	Men		Women		Men		Women	
	Number	%	Number	%	Number	%	Number	%
Employed	12770396	81.28	230748	14.06	13991219	75.37	463240	18.18
Unemployed	534002	3.40	9611	0.59	1093027	5.89	35141	1.38
Student	67062	0.43	18501	1.13	95264	0.51	18329	0.72
Household(vies)	1795781	11.43	791917	48.26	39076	0.21	927940	36.42
Income without job	19003	0.12	508981	31.02	2195306	11.83	808214	31.72
Others	477521	3.04	75111	4.58	994655	5.36	271787	10.67
No response	47877	0.30	6175	0.38	153862	0.83	23421	0.92
Total	15711642	100	1641004	100	18562409	100	2548072	100

Source: Iran Statistical Center.

Female-headed households recently receive different services from cash benefit to small credit and empowerment services to support their families. Table 3-5 provides the information related to the programmes for those households.

Table 3: Female-Headed Household Supported by Imam Khomeini Relief Committee, 2011

	Number of households	Households population
Country	983209	1761980
Tehran	46612	77236

Source: Imam Khomeini Relief Committee, Annual Statistic

Table 4: Per Capita Monthly Cash Benefit of Female Headed Households 2011 (\$=1226 rial)

Household members	One-member	Two-member	Three-member	Four-member	Five and five plus-member
Amount of Benefit	400000 rial 326 dollar	450000 rial 367 dollar	550000 rial 448 dollar	600000 rial 489 dollar	750000 rial 611 dollar

Source: Imam Khomains Relief Committee, Annual Statistic, 2011

Table 5: Female Headed Households Companion group (1)

Year	2012	2013	2014
Companion groups	854	875	900

Source: Iran Welfare Organization (Behzisti)

(1) Women Headed Households Companion groups are those women who received entrepreneurial courses, micro credit in order to be empower and be self-sufficient.

As verified in interviews and also in available research, the Iran Welfare Organization (Behzisti) targets most deprived female headed household. Accordingly, this organization classifies these types of families in different groups in order to provide different support

programmes.⁶⁷ The Behzisti Organization needs closer cooperation with other organizations that provide support for these families such as Tehran Municipality and Imam Khomeini Relief Committee in order to make the programme more efficient and target the needy women headed household and avoid overlapping support in urban areas.

Disabled People and Elderly

The number of disabled people has registered at Behzisti organization are about 1,500,000. They receive different services at their home and Behzisti's day centres and day care centres. Their number has increased since 1979. In 2013, Behzisti organization supported 1,179,005 disabled people.

Table 6: Number of Disabled Supported by Behzisti

Year	2012	2012	2013
Disabled	1093855	1111694	1179005

Source: Iran Welfare Organization (Behzisti)

Table 7 provides the information on the types of services towards disabled people and the number of households receiving those services. There are also some households which are in the waiting list to receive those services.

Table 7: Number of households received Rehabilitation and Assistance allowance and the number of Households in waiting list from 2011-2013

Year		2012	2012	2013
Rehabilitation and Assistance allowance	Received households	222109	225668	294637
	Households in waiting list	-	70551	41659
Rehabilitation allowance pay to chronic mental patients	Received households	10512	10758	15895
	Households in waiting list	-	3418	2477
Rehabilitation allowance pay to chronic mental patients at home	Received households	7830	7676	8631
	Households in waiting list	-	776	549

Source: Iran Welfare Organization (Behzisti)

Table 8: Number of elderly supported by Imam Khomeini Relief Committee in rural and urban areas

Year	Total	Healthy	Disable ⁶⁸	Disabled	Mental patients	Physical patients
2013	3985429	2558667	39174	1072530	21760	293298
2014	1071042	250583	11534	736893	4567	67465

Source: Imam Khomeini Relief Committee

⁶⁷ Interview with Parviz Zarei, head of public participation section at Behzisti, 28th of December, 2015.

⁶⁸ Disable refers to people born with a disability while disabled is used for people with work related injuries which stop someone from working.

Table 9: Number of households and individuals supported within Shahid Rejaei Plan in 2013

Households					Individuals				
Total	Rural		Nomadic		total	Rural		Nomadic	
N	N	%	N	%	N	N	%	N	%
691726	686536	99.25	5190	0.75	1379489	1365819	99.01	13670	0.99

Source: Imam Khomeini Relief Committee

Shahid Rejaei Plan began in 1980 during the presidential office of Mohammad Ali Rejaei. The plan is supposed to support rural elderly over 60 with regular cash benefit. The plan has been expanded since then with providing different services other than regular cash benefit, i.e., supporting the children of family members with student loans and health care insurance and etc.

Table 10: Number of elderly and disabled people received services from day centers of Behzisti

Year	Different types of disabled people	Elderly	Total	Number of Behzisti's Day Centers
2012	32106	4379	36485	902
2013	33121	4458	37579	932
2014	31941	4177	36118	943

Source: Iran Welfare Organization (Behzisti)

Table 11: Number of elderly and disabled people received rehabilitation services in their home and Day care centers of Behzisti

Year	Different types of disabled people		Elderly		total		Number of Behzisti's Day Centers
	Day care centers	Service at home	Day care centers	Service at home	Day care centers	Service at home	
2012	30911	12545	13788	5204	44699	17749	674
2013	31978	12427	14103	5549	46081	17976	699
2014	31402	11745	13878	4428	45280	16173	688

Source: Iran Welfare Organization (Behzisti)

Orphans

As verified during interviews, in Iran the numbers of children who no longer have parents or carers have increased. This has several causes such natural disaster such as earthquake, eight years war with Iraq, the revolution itself, and urbanization and modernization of the country. These children cannot attend school, have no proper clothes or school uniform and have no other community support. Compared with other children, orphans are normally heavily underprivileged and there is a greater possibility that they are undernourished, not receive appropriated medical treatment. In Iran, helping orphans has a very special place in the social support services since Islamic revolution as the idea of helping and defending orphans is a

very significant matter in Islamic text.⁶⁹ Three organizations provide different services for orphans. As Table 12 shows, the Alavi foundation has prepared cloth and shoes, promoted their educations and taken care of pregnant women in rural areas. This organisation has regularly set up summer camps in order to support them culturally. The financial sources of this help and service have been independent from government revenues. However, the supreme leader supervises their charitable activities.

Table 12: Social services provided by the Alavi foundation

The project	Year	Number of people received services
Distribution of cloth and shoes	2013	309648
Health of pregnant women	2013	216500
Promoting education of students	2011-2012	52538
University student support fund	2012	3084
Student summer camp	2013	15071

Source: the Oppressed Foundation (*the bonyad-e mostazafan*)

Behzisti is the second organisation that provides various support programmes for orphans. One of them is to integrate orphans in different types of family ranging from childless couples to the extended family. Based on Islamic state law the legal care of orphaned should be supervised by the supreme leader (*vali faqih*) even they are integrated by the families. Therefore, the Behzisti, as a representative of the supreme leader, supervises socially the treatment of their adapted parents. Table 13 shows the number of orphans in the Behzisti home have decreased during 2012 but the number of orphans in family homes have increased. This clearly shows that the changing policy of this organisation towards using the public's participation for this service.⁷⁰ It also shows that the orphans' services have been more regulated but directed to non-state orphanages. However, the adoption prospects need to be clearer in order to absorb more access to the informal non-state sector.

Table 13: Number of Orphans supported by Orphanages in the country (1)

Year	2012	2013	2014
Number of Orphans in Total	9188	9571	9639
Orphans in State	2366	2143	2161
Behzisti homes - Non-state	6822	7428	7478
Orphans in family homes	12634	13121	13763
Orphans in Behzisti homes - state	87	83	75
Orphans in Behzisti homes - non-state(2)	437	499	500

Source: Iran Welfare Organisation (*Behzisti*)

- (1) As Orphanages (*Yatim khane*) in Persian language has a negative connotation, Behzisti uses pseudo family homes or centers. For the same reason, orphan (*yatim*) is called children without guardians.
- (2) These centers usually run by private finance and donors but under supervision of Behzisti

⁶⁹ As Mohammed, the prophet of Islam, was orphaned as a child, many scriptural citations describe how orphans should be treated.

⁷⁰ Interview with Dr Parviz Zarei, head of public participation section at Behzisti, 28 December 2015

The Imam Khomeini Relief Committee is one of the most active organisations helping orphans in Iran. As a religious charitable organisation, it supports orphans with honour in order to respect their human dignity (Table 14).

Table 14: Number Orphans of supporters and number of orphans who receive support in Ekram Plan

Number of supporters by different situation			Orphans receive supported		
Individuals	Legal entities	Total	Girl	Boy	Total
702624	6466	709090	110729	94473	205202

Source: Imam Khomeini Relief Committee

In addition to the above-mentioned vulnerable groups, poor people are also supported by the government. IKRC is the major organization to provide benefit and aid to the poor people. This service has been financed mostly by the state, i.e., the government and the office of supreme leader. IKRC recently make a supplementary scheme to give the poor on benefits more incentives to work by so called empowerment programme. This policy should be taken seriously in coming years as the universal cash subsidy programme run by the state from 2009 has become ineffective simply because the cash subsidy is more than the means tested benefit provided by IKRC.

As a whole, it seems that the services have been provided by this organization is more efficient than the government run organization in terms of administration cost, costs of determining eligibility, both in time spent gathering information from vulnerable, filing for benefits and examining claims.

Table 15: Number of Poor (*madad-jo*) Households Received Permanent Income Support

Description		2012	2012	2013
Permanent Income support	Received households	173599	171662	179695
	Households in waiting list	-	8639	7027

Source: Iran Welfare Organization (*Behzisti*)

Table 16: Number of Vulnerable Households Supported by Imam Khomeini Relief Committee

Year	Total support given to vulnerable		Case support given to vulnerable		Vulnerable in waiting list	
	Household	Individual	Household	Individual	Household	Individual
2013	1851094	3985429	811470	2020242	11159	31114
2014	1883042	4043011	753750	1893830	19109	50044

Source: Imam Khomeini Relief Committee

In addition to the above-mentioned programmes towards vulnerable groups in Iran, according to Comprehensive Law of Social Security and Welfare in 2004, the government established the Rural Insurance Fund. It covers part of health care expenditure of the rural people based on triple contribution, i.e., the fund investment, rural contribution based on their annual income and the government. However, since then the government has committed to pay all

expenditure. It seems this service is categorized as a part of social assistance and non-insurance programme.

Table 17: Number of Insurer by Iran Health Insurance Organization

Province and year	Total	State employee fund	Other people fund	Rural fund (rural insurers)	Health Public insurance	Iranian Insurance fund
2013	33762469	6123636	1854319	23173107	-	2611406
2014	39614490	5957673	1721174	22857771	8500470	577402

Source: Iran Health Insurance Organization

3.1.4. Efforts towards Increasing the Inclusiveness of the Social Protection System

In 2010, Iran began a major socio-economic plan, known as the subsidy reform plan since 2010 in order to replace the old subsidies program on food and energy, which was inherited from the Iran-Iraq war era, with targeted social assistance. It could therefore, be claimed that the country has embarked on major reform of its welfare system not only to include more vulnerable people in its social protection system but also to exclude people who are not eligible to receive subsidies. Although the program could target the more vulnerable, the government decided to follow a universal cash subsidy due to the expected social and political consequences of sharp increases in consumer and energy prices. The universal cash subsidy plan resulted in budget constraints on other social protection plans to include the vulnerable, female-headed households and people with disabilities.

Accordingly the government has started to cut cash subsidies since 2015, and at the same time to deliver in kind welfare packages in the form of food packages to those living under the poverty line. This part of program has been implemented by Imam Khomeini Relief committee in the rural areas. However, the government agencies that delivered this welfare package to urban residents in Iran seems not to have been as successful in targeting the vulnerable.

The para-governmental organizations, such as Imam Khomeini Relief Committee and Alavi foundation intend to continue their efforts in future to protect people who suffer from chronic hunger and malnutrition in rural areas and regions that are more undeveloped such the Sistan and Bulochestan and Kohkiloye and Boyer Ahmad provinces. However, there will not be an entirely inclusive social protection program due to budget constraints.

In urban areas, particularly in Tehran and Mashad, the municipalities have implemented a program to help those who have inadequate shelter, and are highly prone to many diseases with assistance of some Nongovernmental Organizations (NGOs). The program would include the street children, particularly Afghan street children who deprived of education and are particularly vulnerable to natural disasters. In 2015, the supreme leader ordered the Ministry of Education to register Afghan children. However, their families have two significant problems: first, these children are major source of family revenue and second are the tuition fees of registration in school.

The government's intention to work on a social safety net program mainly serves as protective approach rather than promotional or transformational approaches to protect the poor. Hence, the expectation is that as of 2016, the reduction of oil revenue will not only increase the number of

ultra-poor in some regions in Iran but also fail to include them from any government interventions.

Since the government implemented the universal cash subsidy plan, there has been a major effect on the Imam Khomeini Relief Committee social safety net program. This committee has recently decided to refocus attention away from a concrete social safety net program to empowering the poor and vulnerable through a small credit scheme. The IKRC argues that the objectives of the empowerment programme for the poor and vulnerable is to assist them in graduating from extreme poverty by bringing positive economic, social and aspirational changes in their lives. The programme also seeks to support them in accessing the mainstream development programmes in the country. In spite the government's optimism surrounding this new approach, past experiences would indicate that the long waiting list of application to get help will increase due to the quality of small credit scheme and empowerment poor program.

3.2. Lebanon

3.2.1. Current Legislation Covering Vulnerable Groups

Political developments since 2007 have affected progress in improving the labour governance system in Lebanon. Despite some progress in improving the policy framework for human rights protection, women's rights, refugees' rights and the rights of migrant workers, Lebanon continues to fall short of international benchmarks.

The ILO's International Programme on the Elimination of Child Labour and the Lebanese government has been active in combatting child labour since 2000. In November 2013 the President of Lebanon launched "The National Action Plan to Eliminate the Worst Forms of Child Labour by 2016" in accordance Lebanon's commitment at the Hague Global Child Labour Conference.

As for the Lebanese working population, there is no pension system in Lebanon. The present End-of-service Indemnity (EOSI) benefit administered by Lebanon's National Social Security Fund has a number of critical shortcomings. In order to strengthen social insurance protection for private sector workers, with the assistance of the ILO and the World Bank, the Government of Lebanon has taken to steps reform the EOSI scheme into a pensions scheme, providing decent pensions in case of old-age, disability and death. An estimated 2% of children aged 5-14 years were involved in child labour between 2002 and 2011. Many children work in hazardous conditions in the informal sector, including agriculture, metalwork and crafts, fishing, rock cutting and tobacco cultivation, especially in remote areas.

Lebanon hosts around 1 million registered Syrian refugees, according to Government estimates. Lebanon is not party to the 1951 Refugee Convention relating to the Status of Refugees and protection mechanisms for refugees are considered weak. In addition, many refugees who entered Lebanon in a legal manner cannot afford to renew their stay after 1 year, which potentially exposes them to arrest, detention, and restriction in freedom of movement. Syrian refugees and implications of their influx on Lebanon's labour market, the ILO developed a series of interventions as an integral part of its response to the Syrian refugee crisis in Lebanon. The interventions aim to enhance the resilience of both producers (individual and groups) as well as workers affected by the Syrian refugee crisis in Lebanon's rural areas, focusing on the Northern Akkar region. In addition, an estimated 100,000 – 150,000 Bedouins

reside in Lebanon and, although originating from Lebanon, many remain stateless. This leaves them in a highly vulnerable situation - for instance, they cannot benefit from public health services and education.

With regards to persons with disabilities, in 2000, Lebanon adopted Act No. 220 of 2000 on the rights of persons with disabilities. Under that law, the Rights and Access Program in Lebanon identifies persons with disabilities and provides a disability card that enables them to access free or subsidised services from both Government and non-state providers, including assistive devices and medical aid. However, the law is not fully implemented and access to education and health facilities remains of concern. The scale of the problem is difficult to estimate as there is a lack of updated data on the number and location of those with disabilities.⁷¹

In terms of migrant domestic women, institutional and legal protection for migrant domestic women workers remains very weak in Lebanon, and efforts to ensure decent working conditions are confined to a limited number of local organisations, international actors and activists. Since 2005, the ILO, in partnership with Lebanon's Ministry of Labour, has advocated for the protection of migrant women domestic workers, primarily focusing on the introduction of relevant legal instruments as well as the development of capacity building programmes supported by advocacy efforts. Migrant domestic workers are not covered by the labour law and often face exploitation and abuse, including underpayment or delayed payment of salaries; physical, verbal and sexual abuse; long working hours; no freedom of association; and confiscation of identity documents.⁷²

3.2.2. Population Segments Defined as Vulnerable

Lebanon's economic indicators show that the country is highly developed in many aspects, with education and healthcare, for example, being of a relatively high standard. However, the disparity between the wealthy and the poor is vast and many communities found across different parts of the country live in poverty and are under-served by government infrastructure. Even in the suburbs of Beirut, government-provided electricity is only available for 12 hours a day, forcing families to spend money on expensive generators. Economic development is hampered by political instability, ineffective usage of financial resources, lack of economic diversity and the high cost of the unreliable electricity supply. As a country that imports high per cent of goods and whose economy is reliant on service industries and tourism, it is instantly affected by any changes in the region. In Lebanon's relatively high-cost environment and with limited access to alternative financial resources, many working in low-wage jobs remain poor. Lebanese households face a decrease in income and an increase in debts to be able to meet basic needs, including food or healthcare. Table 18 shows the types of vulnerable groups in the country.⁷³

⁷¹ (Handicap International 2009, Daily Star 2013/04).

⁷² Al-akhbar, 2013/03/15; Human Rights Watch, 2012, 2010.

⁷³ LCRP, 2015.

Table: 18: Lebanon: Vulnerable populations in need

	Female	Male	TOTAL
Vulnerable Lebanese	745,875	753,938	1,500,000
Displaced Syrians	781,368	718,632	1,500,000
Palestine Refugees	162,288	159,074	321,362
TOTAL	1,689,531	1,631,643	3,321,362

Source: Lebanese Humanitarian Crisis Plan 2015-2016.

As verified during interviews, disparities in Lebanon fall along geographic lines and the Syrian and Palestinian refugee populations have, for the most part, settled in areas inhabited by impoverished and vulnerable Lebanese communities where limited or non-existent service provision is then even further stretched. The most vulnerable areas include the highly impoverished North, the Bekaa, the South and the Palestinian refugee camps across the country. Several groups, including Lebanese female-headed households, Palestinians, and Syrian refugees are the most severely affected by any deterioration of the economic situation.

Although only limited data is available, an estimated 25% of the Lebanese population live on less than USD 4 a day.⁷⁴ There are significant regional inequalities in terms of access to public services, employment and infrastructure. Unemployment rates are estimated at 10-15%, disproportionately affecting the youth and women. A significant percentage of employment is in the informal economy, which is estimated to be equivalent to 30% of GDP. Those working in the informal sector are vulnerable to exploitation and have limited access to basic rights. According to the recently launched second Lebanese Crisis Response Plan (2015) “the number of poor Lebanese, displaced people and pre-crisis refugees living inside Lebanon has risen by an estimated 110 % since 2011, to 2.7 million. Their vulnerability has been increasing, as savings are rapidly depleting and use of negative coping strategies is on the rise.”

The health sector is largely privatised with approximately 85% of clinics and hospitals being run privately.⁷⁵ While 50% of the population have medical insurance, the other half are reliant on the Ministry of Health reimbursing a share of the medical bill. Out-of-pocket costs are increasing and healthcare is unaffordable to a growing number of people.⁷⁶

3.2.3. Extent of Effective Coverage

As verified during interviews, although social spending in Lebanon has been relatively high (with over 70% coming from the private sector), investment expenditure has not matched the geographic distribution of poverty and the privatization of service delivery has resulted in exorbitant costs which has disproportionately affected the poor.⁷⁷ The substitution of welfare support and direct delivery of social assistance services by religious organisations, while

⁷⁴ World Bank (2013) Lebanon Economic Monitoring: The brunt of the Syrian conflict. Poverty Reduction and Economic Management Unit. MENA Region.

⁷⁵ Multi sector needs analysis (2014) Public health in Lebanon. Available from <https://data.unhcr.org/syrianrefugees/download.php?id=5397>

⁷⁶ Ibid.

⁷⁷ Jawad, 2009.

beneficial to the most vulnerable populations for the most part, has further weakened the ability of the state to deliver, regulate and improve the quality of social services.

Despite the important role of confessional organisations in provision of social and welfare services, it is important to note that inequalities exist even in coverage for ‘in-groups’. In many cases, service provision by confessional organisations is politically motivated and selective, implying that the most vulnerable do not necessarily benefit.

Lebanon’s social safety net system ranks among the weakest in the world (117 out of 122 in the WEF’s 2013 HCI). Lebanon, similar to the MENA region, suffers from key factors that hamper the effectiveness of social safety nets: (a) offering a multitude of small, fragmented and poorly targeted programs that do not have a significant impact on poverty or addressing inequality because of their low coverage, high leakage, and limited benefit levels—weak capacity of public institutions coupled with lack of reliable and consistent data also hampers program effectiveness; and (b) relying primarily on inefficient and pro-rich universal subsidies which crowd out more-effective interventions.

Fragmented and relying overwhelmingly on categorical and geographic targeting, Lebanon’s non-subsidy social safety net programme spending did not exceed 1% of GDP in 2013, while price subsidies (diesel, bread, and domestic production of tobacco) account for a negligible 0.03% of GDP. The 1% of GDP spent on social safety nets in 2013 did not contribute to reducing poverty or addressing inequalities and proved to be weak in protecting vulnerable Lebanese. The electricity subsidy is perceived as a social safety net for the Lebanese poor with a progressive tariff fixed in 1996. As electricity subsidies suffer from high leakage and offer a small benefit value to the poor, the programs’ efficiency as a social safety net is weak and should be replaced by better-targeted and more efficient programs.⁷⁸ Similarly, the absence of feedback mechanisms create a disconnection between the government and needs of citizens.

3.2.4. Efforts towards Increasing the Inclusiveness of the Social Protection System

There is a significant gap between the de jure dimensions of governance in Lebanon and the de facto implementation of the same laws and regulations. In the last two years, Lebanon has put in place a Crisis Response Plan (LCRP) to deal with the impact of the Syrian refugee population on public services in Lebanon. This plan serves as a transitional phase into a longer term strategic framework for 2017-2020. As in the previous year, the Government of Lebanon (GoL) and national and international partners come together to deliver integrated and mutually reinforcing humanitarian and stabilization interventions. The LCRP promotes the strategic priorities identified by GoL and partners (United Nations, national and international NGOs and donors), emphasizing the role of GoL in leading the response with the oversight of the Cabinet’s Crisis Cell. Interventions in the LCRP are aligned to national policies and strategies, and seek to complement and build on other international assistance in the country.⁷⁹ Key priority strategies in the plan aim to ensure the following:

- vulnerable children can access and learn in a quality learning environment, including by strengthening the absorption capacity of formal and non-formal education and increasing geographic coverage;

⁷⁸ World Bank, 2009c.

⁷⁹ LCRP, 2015: Executive Summary.

- the most vulnerable Lebanese and displaced Syrians can access affordable healthcare, with a focus on accessibility and quality of services and controlling disease outbreaks;
- increase in outreach to and responsiveness of community and institutional systems to protect the most vulnerable, especially children and women at risk of violence (including armed violence, abuse, exploitation and neglect) and to provide referrals and a full package of services, while providing appropriate support to survivors through a robust and coordinated national system;
- expansion of energy, safe water, sanitation and hygiene for the most vulnerable Lebanese and displaced Syrians through emergency gap-filling and by reinforcing existing services. Key sector responses include education, health, energy and water and protection.

3.3. Oman

3.3.1. Current Legislation Covering Vulnerable Groups

Oman has experienced a rapid increase in its Human Development Index over the last 40 years. GDP per capita has grown consistently at an average rate of 7% per year (2000-2014). Large scale infrastructure developments have taken place linking the country together. Women's participation in the labour market rose from 7.6% to 23% between 2003 and 2010. Enrolment rates of girls in post-basic education (grades 10-12) are now 88%. Inequality has also reduced from 0.384 (Gini coefficient) in 2006 to 0.308 in 2010. Oman has performed well on many of the Millennium Development Goals (MDGs) as the government has made a sustained concerted effort to reduce absolute material poverty.

The Government of Oman's (GoO) 'Vision for Oman's Economy: Oman 2020' expresses the commitment to tackle and enhance the country's social and economic development. According to interviewees it will be based on 'pillars'. This includes four Programme Pillars:

- a) Social Security
- b) Social Care
- c) Family Development
- d) Rights of Persons Living with Disability

and two Support Pillars:

- e) Civil Society
- f) Institutional Reform

In terms of social protection, it notes the need to improve the social protection system especially for the vulnerable segments of the population. The vision recognises and highlights the importance of data in order to develop effective development projects that can then be evaluated.⁸⁰ In addition to government statistics via the census, other studies that include relevant data include the draft Situation Analysis of Children and Women in Oman conducted in 2014 by UNICEF and the first Multiple Indicator Cluster Survey (MICS)/household survey

⁸⁰ ESCWA, 2009.

conducted jointly with the National Centre for Statistics and Information.⁸¹ According to the ILO82, social security statistics are unreliable and there is a lack of data for social insurance schemes targeting specific groups of the population.⁸³

Oman has embarked on establishing an effective social protection system. As a result, a wide range of basic services are available, such as access to insurance against old age, disability and death, maternity, health care and education. Considerable investments have led to substantial social development progress, which include significant reductions in child mortality⁸⁴ and child immunisation rates. Coverage is improving, however, as with many countries in the Arab region the system is still fragmented, poorly coordinated and remains large coverage inequality between the public and private sectors. It was reported that 12 pension funds covering the private and public sector are operating but coordination at the national level is not in place due to the absence of a regulatory body. The effects of this are that funds are unequally distributed, contributions do not correspond to the level of final benefit. The relatively generous coverage for those working in public sector also acts as a disincentive for young people to enter the private sector.

It was estimated by a number of respondents that social assistance interventions may have helped to reduce inequalities and the proportion of low income population by 30 % since 2010.

A particularly interesting aspect of recent social protection coverage in Oman is that those working in the informal economy have begun to receive assistance. Coverage has been extended to own account workers and the self-employed, agricultural workers and fishermen. This of course has significant and positive impacts on social inclusion. Despite this many workers remain outside the system and cross sector / policy links with social assistance are weak.

In relation to the coordination of protection and insurance systems several interviewees also noted that social and economic data in Oman needs to be properly collected and analysed. There remain significant data gaps and in the technical capacities of ministries to evaluate the impact and effectiveness of policy interventions. This is common across the region but Oman has the potential to act as a leader in terms of evidence base policy making and establishing impact evaluations of policies. This would particularly help in the assessment of whether CTs actually work and for who are they most beneficial. Relations between research organisations, academics, ministries and the National Centre for Statistics and Information (NCSI) need to be strengthened to take advantage of existing and future household surveys.

The Constitution of the Sultanate of Oman also known as “The White Book. The Basic Law of

81 UNICEF, 2014. See also <https://www.ncsi.gov.om/>

82 A social enquiry is being conducted

83 http://www.ilo.org/dyn/ilossi/ssimain.home?p_lang=en&p_geoaid=512

84 11 per 1000 live births < <http://www.who.int/gho/countries/omn.pdf?ua=1>>

the Sultanate of Oman”, was adopted by Royal Decree No. 101/1996 and issued on November 6th, 1996. Article 12 of the Constitutions provides: “*The State guarantees assistance for the citizen and his family on cases of emergency, sickness, incapacity and old age in accordance with the social security system. It also encourages society to share the burdens of dealing with the effects of public disasters and calamities.*”⁸⁵ Oman is a signatory to a number of Human Rights Conventions that have implications on social development. Conventions include the Convention on Elimination of Discrimination against Women (CEDAW), the Convention on the Right of the Child (CRC), and the recent Convention on Discrimination against Persons with Disabilities (CPWD).

Social spending has increased since the 2011 protests which occurred throughout the Arab region. As a response to the protests a number of changes were made. These included a ‘marriage fund’⁸⁶ to provide assistance to low-income young people, an increase of the minimum salary by 43%, a monthly allowance for individuals registered as job seekers, an increase in the monthly allowance for students at universities and vocational schools from 25 to 90 Omani Riyals (OR) and to promise to create 50,000 new public sector jobs. There was also an increase in civil servant wages, which represented a pay hike of between 5% and 42% for public-sector employees. In terms of food security, the price was fixed for essential food commodities such as rice, and subsidies products such as sugar, wheat and local produced fodder were subsidised. The economic concessions made since the start of the protests in late February were estimated to be OR1 billion.⁸⁷

According to the 2015 budget, the budgeted current and capital expenditure for the GoO Ministries were: Education (13%), Health (5%), Social Security and Welfare (4%), House (4%), Public Services (4%), Others (7%). This constitutes 37% of the total budget.⁸⁸

3.3.2. Population Segments Defined as Vulnerable⁸⁹

Building on an oil price boom around 2011, the Sultanate of Oman was able to stave off public disenchantment by creating an estimated 100,000 new jobs in the public sector, with a significant number of these being in the defence/security sectors. This was a major economic benefit for its estimated population of 2.5 million (counting only nationals; expatriates make up a further 1.9 million, about 45% of the population; officials in Oman in December, 2015, were resolute that a government plan to reduce the proportion of expatriates in their country would succeed). The possibility of a steep decline in oil prices (beginning roughly in June, 2014) has meant that the government has so far frozen the expansion of payrolls, and there is a very real prospect that social protection provisions will be affected. There was recognition amongst all Omani officials that the Ministry of Social Development had the overall prerogative of defining and identifying which vulnerable groups were classified as being in need of social protection.

⁸⁵ <http://lexarabiae.meyer-reumann.com/blog/2010-2/healthcare-in-the-sultanate-of-oman/>

⁸⁶ An amended proposal was sent to the Council of Ministers at the end of 2013. The fund aims to benefit 2,500-3,000 Omanis per annum. It provides a grant of OMR 4,000 to unmarried Omanis with a salary less than OMR800. The existing fund supports those earning less than RO600 a month < <http://www.timesofoman.com/article/44800/Oman/Marriage-fund-yet-to-see-the-light-of-the-day-in-Oman>> < <https://www.y-oman.com/2014/04/marriage-money>>

⁸⁷ Chatham House, 2013; ILO, 2011; Valeri, 2011.

⁸⁸ KPMG, 2015.

⁸⁹ This part is based on observations from interviews with key stakeholders.

Population groups which officials in several ministries defined as being vulnerable and in need of social protection were: women, broadly defined, including widows, single mothers and women estranged from their families (more on this in the complete report); “destitute” children, orphans and children living in poverty; the unemployed, where there was a particular emphasis on those who needed assistance in acquiring skills and training to find employment; individuals who had left the educational system without adequate qualifications; and the physically disabled. Social protection policies in Oman are focused on empowering the individual; the state often has avenues for dispensing monetary assistance to those it deems need it. One definitive example of this is in the realm of housing policies, where a Ministry of Housing seeks to ensure that all Omanis have adequate housing which they own. These policies are all centred on nationals of Oman and not on the 45% of the population who are expatriates; expatriate wage earners living in Oman are also legally prevented from family reunification unless they earn above a mandated minimum monthly amount, thus removing some of the burden of social protection from the state. Nonetheless, Oman has seemingly adopted a progressive, tolerant approach to “non-nationals” living within its borders: largely, nomadic and semi-nomadic groups with no proof of citizenship, or individuals who have lost citizenship for various reasons.

Health care was, as far as Omani officials were concerned, a major component of social protection. The only group identified in Oman for which social protection was a contentious issue was homosexuals: while officials at the Ministry of Health maintained that there were no homosexuals in Oman, one prominent Omani individual with whom the author spoke insisted that the inability to extend health care services to homosexual Omanis was an unfortunate oversight, particularly given that there is a very visible, indigenous gay/transgender scene in the Dhofar, in the south west of the country. It remains to be seen how this policy will be reconciled with a general objective in Oman to provide HIV treatment at integrated health care centers across the country.

In general, the officials expressed optimism in the ability of the state to continue to provide services for vulnerable groups, although the impact of a rapid decline in oil prices could not be discounted in the medium term. One possibility which officials from various ministries expounded on was for greater partnerships with the private sector, and independent philanthropists. Yet, this particular type of social protection seems particularly susceptible to the change in economic fortunes; most recently, the death of a single philanthropist, who provided an annual sum of 8 million Omani Riyals between 2009 and 2012, has made it impossible for the Ministry of Education to provide free school meals for students from limited income households.

3.3.3. Extent of effective coverage

Health⁹⁰

Oman has a system of (almost) free, universal medical care, based largely on public sector providers. Until 1996, all healthcare services were free at the point of delivery, but given the burden on the government budget, a small fee was subsequently introduced. Since then a family card has to be bought for one rial every year and consultation costs 200 baisas.⁹¹ Health spending as a percentage of GDP over the last three years was 1.7 % in 2013, 1.93 % in 2014

⁹⁰ WHO (2-11) Country Cooperation Strategy or WHO and Oman 2010-2015
http://www.who.int/countryfocus/cooperation_strategy/ccs_omn_en.pdf?ua=1

⁹¹ Valeri, 2010.

and 2.15% in). According to the IMF in 2001 Oman spent approx. 3.66% of GDP on social protection and health care. As a result, approx. 90 % of the population is covered by universal health care services (ILO, 2011). The Omani Health Vision 2050⁹² rests on the World Health Organization's framework approach. The Ministry of Health has developed a series of Five Year Health Development Plans in order to achieve it. It is planned to set up 10,000 health centres by 2050 in order to meet the requirements of a rapidly growing population.

Disability

The GoO signed the Convention on the Rights of Persons with Disabilities (CRPD) in 2008 and ratified it in 2009. Through a royal decree (No. 63/2008) a person with disabilities is given the right to preventive and rehabilitation health services (articles 5 and 6), education (article 7), vocational rehabilitation (article 8), work (article 9) and participation in social, cultural and sports activities (article 11). In 2010, it was estimated that 3.2% of the Omani population was affected by disabilities in 2010 (65,506).⁹³

Current estimates of numbers of people living with disabilities are below figures estimated by UN agencies for Oman. Estimates of disability within the population in 2010 was 3.2 % compared with expected levels of 15% based World Health Organization estimates. One interviewee noted that diagnosis of disability is delayed. Over 80 % of people diagnosed as suffering from a disability for the first time are over 12 years old. It is apparent there needs to be a greater focus screening and early intervention services. There are also major gaps in terms of psychological and psychiatric services

There are specific programmes for children such as community based rehabilitation and home visits. In addition, there are three specialist centres for the education of children with difficulties seeing, hearing or speaking and 300 schools with integrated provision for children with special needs.⁹⁴ Oman has attempted to make education more inclusive by adopting the National Strategy for the Disabled.⁹⁵

UNICEF and the GoO jointly determined two strategic areas in the Country Programme 2012-2015⁹⁶: (1) early childhood learning, care and development; and (2) child-centred, inclusive strategies and plans.

Education

Under the Royal Decree No. 22/2014, education is both compulsory⁹⁷ and free.⁹⁸ The average net enrolment rate for the academic year 2012/13 was 98.2% in State schools for grades 1 to 6, while the average net enrolment rate in the educational system for grades 7 to 9 was 95.5 % (UN General Assembly, 2015). In 2014, Early Childhood Development (ECD) standards were put in place, as part of the National Action Plan on Early Childhood Education (ECE)⁹⁹ thereby enabling Oman to promote a multi-faceted approach to early childhood.¹⁰⁰ This includes

92 <https://www.moh.gov.om/documents/16506/119833/Health+Vision+2050/7b6f40f3-8f93-4397-9fde-34e04026b829>

93 According to 2010 population census

94 ODI/UNICEF, 2011

95 In 2008, Royal Decree 63/20085 on the law of the disabled specified that individuals with disabilities have the right to education and training.

96 The GoO is the sole donor

97 Up to a basic level

98 Government schools covering grades 1 to 12

99 International evidence suggests that ECE has substantial economic and social benefits for children's future lives.

100 UNICEF, 2014.

nutrition since Oman suffers from persistent nutrition challenges in regards to young children. Its progress against global WHA targets are all currently off course.¹⁰¹ In 2011, UNICEF and the Ministry of Health launched the 'Child Nutrition Campaign' to raise awareness and behaviour change and reduce malnutrition in children under the age of five.¹⁰² A national nutrition survey will be conducted as soon as next year, which will provide an evidence base for future policy-making. Enrolment in ECE quadrupled between 2010/2011 and 2013/2014 and currently stands at 55 %. Access to quality ECE for rural and low-income children needs to be strengthened in order to enhance equity.¹⁰³

Cash transfers (CTs)

In 1984, social assistance programmes were set up to assist the vulnerable.¹⁰⁴ This group includes orphans, disabled, widows, divorced or abandoned women¹⁰⁵. In 2007, 49,500 people benefitted from such financial stipends.¹⁰⁶ Between 2010 and 2011, cash transfers doubled from 40,000 to 80,000 and reached 84,000 by 2014. The use of cash transfers in Oman have doubled from 40,000 to 80,000 between 2010 and 2011 reaching 84,000 by 2014 and the amount an individual receives has also increased. However, as a number of interviewees commented CTs have largely failed to raise people out of poverty in Oman. There is still work to be done in order to link these programmes to wider social policies such as health, education and the labour market in order to ensure people are lifted out of poverty.

Commodity subsidies

The GoO grants subsidies to producers of various essential items.¹⁰⁷ Due to a slump in oil prices, the GoO cut subsidy spending on various food items by 48 % in the first quarter of 2015. It was argued that the subsidies were ineffective because they didn't target the poor. On the other hand Petroleum product subsidies cost the government OR1.5 billion.¹⁰⁸ Other cuts are being considered. The IMF (2013)¹⁰⁹ also noted that general subsidies that disproportionately benefit the well-off need to be targeted towards the poor, in order to achieve a sustainable fiscal position.

Social insurance

Since 1992¹¹⁰, a comprehensive pension system has been in place, overseen by the Ministry of Manpower¹¹¹, which provides old age, death and disability pensions to both public and private sector employees. The administration of the private sector segment comes under the Public Authority for Social Insurance (PASI). This is a system of shared contribution between the government, employer and employee. PASI recently approved its 2016-20 plan¹¹², which aims

¹⁰¹ Global Nutrition Report, 2014.

¹⁰² [http://www.unicef.org/oman/UNICEF_-_Child_Nutrition_Campaign_Launch_PRL_\(Eng\).pdf](http://www.unicef.org/oman/UNICEF_-_Child_Nutrition_Campaign_Launch_PRL_(Eng).pdf)

¹⁰³ Ibid.

¹⁰⁴ Ministerial Decree No. 72/2014 establishing regulations for social assistance benefits

¹⁰⁵ Sultans decree (no.87/84)

¹⁰⁶ Valerie, 2009.

¹⁰⁷ This includes: petroleum products, housing loan interests, electricity, water, essential food items, including wheat flour, oil firms, housing banks, power producers, flour mills, and poultry feed manufacturers.

¹⁰⁸ <http://gulfnews.com/news/gulf/oman/oman-cuts-subsidy-spending-by-48-in-2015-1.1540377>

¹⁰⁹ <https://www.imf.org/external/np/ms/2013/051413.htm>

¹¹⁰ Established by Royal Decree No. 72/1991. This covers all citizens of Oman aged 15-59.

¹¹¹ <http://www.manpower.gov.om>

¹¹² <https://www.pasi.gov.om/en/Pages/AboutUs/5YearsPlan.aspx>

to cover the entire Omani population under social protection. Voluntary insurance was recently introduced for the self-employed¹¹³ and social Insurance coverage could be extended to non-Omani workers in the near future.¹¹⁴ In 2014, the Social Insurance System covered 14,116 employers compared to 11,130 in 2013. The number of active insurees in the Social Insurance System increased to 197,510 in 2014 from 181,860 in 2013 (PASI, 2014). An amended social insurance law by Royal Decree 61/2013 came into effect from July 2014 which increased pensions by 5 % amongst others.¹¹⁵ Oman currently has eight governmental pension funds, which consist of workers both in the government and the military.¹¹⁶

Migrants

Social protection provisions exist for temporary migrant workers. Short-term benefits include health care, work injury benefit, sick pay and maternity leave. Family benefits such as health care and allowances are non-compulsory.¹¹⁷

3.3.4. Efforts towards Increasing the Inclusiveness of the Social Protection System

The ILO's The Decent Work Country Programme¹¹⁸, which started in 2010, was recently extended till 2016.¹¹⁹ This will focus on four priorities which include – the 'omanisation'¹²⁰ of employment policies which aims to support productive work in the private sector, enhance employability of Omanis through strengthening technical and vocational education and training and reduce dependence on foreign labour. National legislation related to the Unemployment Insurance Fund will also be introduced.

The GoO has established a number of initiatives to increase SME financing. A microfinance institution (MFI) called the *Sanad* Project, targeted for unemployed youths, was established in 2001 by the Ministry of Manpower (MoM) to encourage young entrepreneurs by providing loans and network opportunities.¹²¹ Between 2001 and 2012, 3184 projects were funded. The Fund for Development of Youth was established in 1999, with a grant of RO 1 million granted by His Majesty, to encourage young Omanis to start SMEs¹²². In 2012, the Ministry of Commerce and Industry (MoCI) launched an SME Development fund (also known as *Al Namaa*), with an initial capital of OMR100 (approx US\$260m) to subsidize finance for entrepreneurs.¹²³ In 2013, as MFIs started to proliferate, all the funds were merged into one programme called the *Rafd* Fund.¹²⁴

A recent amendment to the social housing law had made it easier for low-income workers to obtain a loan. The maximum limit for interest-free loans was increased from RO20,000 to

113 <http://www.muscatdaily.com/Archive/Oman/Experts-say-Oman-must-prepare-for-social-insurance-challenges-4ein>

114 ILO, 2011.

115 United Nations General Assembly, 2015. The Decree also regulated the proportional contributions of private sector workers to the PASI and increased their pension entitlements after their retirement

116 <http://www.oman.om/wps/portal/index/cr/employment/socialinsuranceandpension>

117 Inventory of Social Protection Provisions for Temporary Migrant Workers in GCC Countries Available at <
<https://www.gfmd.org/inventory-social-protection-provisions-temporary-migrant-workers-gcc-countries>>

118 The Sultanate ratified four of the ILO's eight core conventions since its accession to the Organisation in 1994. In June 2010, Oman became the second Gulf state, after Bahrain, to sign a DWCP. <http://www.ilo.org/global/about-the-ilo/decent-work-agenda/lang-en/index.htm>

119 <http://www.ilo.org/public/english/bureau/program/dwcp/download/omandwcpextension2014-2016.pdf>

120 Operational since 1988

121 <http://www.oxfordbusinessgroup.com/analysis/small-mighty-financing-and-other-services-expand-support-smes>

122 The fund also accumulated equity from private companies

123 <http://www.arabianbusiness.com/oman-launches-us-260m-sme-development-fund-455140.html>

124 Hussein, 2014.

RO30,000¹²⁵. In 2009, a fund worth OR7 million (approx.US\$18.2 million) was set up for women involved in agriculture.¹²⁶

3.4. Sierra Leone

3.4.1. Current Legislation Covering Vulnerable Groups

Sierra Leone's main laws are the National Food and Nutrition Security Policy-2012, Optional Protocol to the UN Convention on the Rights of the Child-2002, Convention on the Rights of the Child-1990, Sexual Offences Act 2012, Persons with Disability Act 2011, Child Rights Act 2007, Domestic Violence Act 2007, Registration of Customary Marriage and Divorce Act 2007, Devolution of Estates Act 2007, Social Protection Policy 2011. There is also the African Charter on Human and People's Rights, which has been ratified by Sierra Leone. Article 15 of the Charter provides for the right of individuals to work under equitable and satisfactory conditions and to receive equal pay for equal work.¹²⁷

Sierra Leone provides the main forms of social insurance coverage for the population in formal employment. The two schemes which do not exist are social insurance for unemployment and also family allowances. Indeed, this situation particularly affects the informal labour, most notably women and children doing domestic work across the country, who are among the most vulnerable workers. The formal insurance schemes that are in place are contribution-based and therefore only benefit those in formal employment which means that vulnerable groups in Sierra Leone are exempt from them since by definition, they are not connected to members of the population who are in formal employment. Vulnerable groups therefore need to seek recourse in social safety nets and social assistance programs.

According to the World Bank (2013), National Commission for Social Action (NaCSA) and the World Food Programme (WFP) implement a number of public work programs (some of which offer cash for work and some of which offer food), with different administrative procedures and fiduciary arrangements. Also, there are many different youth programs implemented by the National Youth Commission and by development partners. At the national level, there is lack of coordination among public entities that leads to much duplication of efforts.¹²⁸

There are several programmes aimed at children, most of which are implemented by local councils. The World Bank-supported Decentralized Service Delivery Program (DSDP) is supporting the implementation by the local councils of the education devolved functions. In addition, the MEST implements a School Feeding Program with the support of the WFP and other partners. It also gives Grants-in-Aid to government-run boarding schools that are used mostly for feeding the students and Grants to Handicapped Schools. Also, together with the Ministry of Finance and Economic Development (MoFED) it runs the Girl Child Support Program, which provides tuition waivers for girls in junior secondary schools with a view to increasing girls' enrolment and retention in schools nationwide. The Ministry of Social Welfare, Gender, and Children's Affairs (MSWGCA) implements the Diets for Approved Schools and Remand Homes Program and the National Street and Other Vulnerable Kids program, which aims to get children off the streets in major urban centres.

¹²⁵ <http://www.arabianbusiness.com/oman-relaxes-low-income-housing-loan-laws-527029.html>

¹²⁶ https://freedomhouse.org/sites/default/files/inline_images/Oman.pdf

¹²⁷ Interview data, 2015.

¹²⁸ World Bank, 2013.



The Ministry of Agriculture, Forestry, and Food Security (MAFFS) is implementing a major integrated rural development program, the Smallholder Commercialization Program (SCP), which is supported by the World Bank and other partners. Component 5 of the SCP comprises three sub-components: (i) social safety nets for vulnerable groups; (ii) risk and disaster management; and (iii) productive safety nets. The overall coordination of the program is by MAFFS, while Component 5 is being coordinated by NaCSA. The social safety nets for vulnerable groups component includes supplementary feeding, nutritional support, and a school feeding program. The Productive Safety Assets sub-component is implemented with the support of the WFP and aims to augment food security by providing smallholder households with food and a limited cash transfer while also creating productive assets that will contribute to smallholder commercialization.¹²⁹ Programs for the elderly consist of a small program for the aged executed by the MSWGCA and the National Social Safety Net Program, a social pension piloted in 2007/2008 that has still not been fully rolled out by the Ministry of Labour and Social Security (MLSS).¹³⁰

Sierra Leone spent 0.5% of its GDP on social insurance (pensions) and 3.5% of its GDP on social assistance in 2011, excluding fuel subsidies (2.1% of GDP in 2011) (World Bank, 2013). The recently launched health waiver (Free Health Care Initiative, FHCI) accounts for about one-fourth of social assistance spending (0.9% of GDP). The World Bank (2013) suggests that based on available information, social protection spending in Sierra Leone (4% of GDP) is marginally lower than the average for the other African countries (4.1% of GDP). Although social insurance spending is lower in Sierra Leone than the other countries, social assistance spending is higher. In 2011, fuel subsidies (mostly in the form of reduced revenue from fuel taxes) accounted for 34.6% of total social protection spending. Social protection programs in Sierra Leone depend heavily on external financing.¹³¹

Overall, 85% of social assistance expenditures (excluding fuel subsidies) are financed by external resources. Maternal, infant, and nutrition programs (including the FHCI) rely almost entirely on external finance as do many of the programs aimed at young people and households. These estimates do not take into account the budgetary support received from the Government of Sierra Leone, which in 2011 amounted to Le 250 billion (2.6% of GDP).¹³²

3.4.2. Population Segments Defined as Vulnerable

Poverty levels in Sierra Leone have been in decline since 2003, but over one-half of the population remains poor. In addition, many Sierra Leoneans are just over the poverty line. This makes these Sierra Leoneans very vulnerable to small variations in their incomes, whether seasonal or annual. Moreover, almost half (45%) of households or 2.5 million people are food-insecure during the lean season (June to August) and 374,000 people (6.5% of total population) are severely food-insecure. Food insecurity is very seasonal, increasing in June and July every year and peaking in August. The poorest households are generally also the most food insecure, mostly those involved in agriculture, petty trade, and unskilled labour. The poor and vulnerable in Sierra Leone face a series of important risks resulting from: (i) economic shocks and consequent variations in employment, income, and consumption; (ii) social instability; (iii) natural disasters; and (iv) household conditions that expose the poorest

¹²⁹ Ibid.

¹³⁰ Ibid.

¹³¹ World Bank, 2013.

¹³² Ibid.

families to a series of adverse situations and make them vulnerable. From a life cycle approach, there are key challenges that face key age groups as follows.

The main risks that poor children under 5 year old face are low birth weight, debilitating and life threatening diseases, inadequate diet, and a lack of early stimulation. All of these risks can impair their development and perpetuate their poverty. While there has been progress in reducing maternal, infant, and under-5 mortality rates in recent years, these rates are still among the highest in the world. Sierra Leone's maternal mortality ratio of 857 per 100,000 and under-5 mortality rate of 217 per 1,000 compare to 650 per 100,000 and 130 per 1,000 for the whole of Sub-Saharan Africa. Malaria is the most common cause of illness and death among children under the age of 5 in Sierra Leone. Bed nets are the most effective method for preventing malaria. However, according to the MICS 2010, in Sierra Leone, only 32% of children under the age of 5 slept under any type of net during the night preceding the interview and only 30.3% slept under an insecticide-treated net. Child mortality can also be prevented by timely and full vaccinations with current levels of full vaccinations among children under 32 years of age being only 46.2%. Chronic malnutrition has increased since 2005 and affects nearly one-half of children under the age of five.¹³³

In the 6-17 year group, the major risks are poor school attendance which affects 26.1% of children due to "hidden and indirect costs, cultural barriers to girl-child education, child labour, and a lack of nearby schools." Indeed, SLIHS 2011 data indicate that the annual cost to extremely poor households of sending a child to central government primary and secondary schools is 2.4% and 8.6% of household food costs respectively. In the case of secondary education, it corresponds to 31 days of family food consumption. Within this age group, there are particularly vulnerable children who require special support. These include 791,000 orphaned and vulnerable children (OVC), 796,000 child 5 labourers, 349,000 children with disabilities (including war victims), 6,000 street children, and an undetermined number of abused children and child mothers. These are the most vulnerable groups in Sierra Leone and should therefore be given the government's priority attention.¹³⁴

In the 18-35 year group, which account for one-third of Sierra Leone's population, the principal risk facing young people is not having any schooling or leaving school without any skills. The civil war disrupted educational services and made it impossible for young people to remain in school, as many were combatants in the civil war. Even before the war, many youths were leaving their villages because of a lack of opportunities and seeking a better living in the mines or urban centres. It is estimated that about 400,000 youths were jobless (in other words, not working or studying) in 2011.¹³⁵

For the populations above 36 years of age, the key challenge is to securing good and stable jobs. Many are working in very low productive activities in agriculture and the informal sector because they lack basic skills and have little access to basic productive services. Many of those in the labour force in Sierra Leone work in agriculture or the informal sector in very low productivity activities and do not earn enough to cover their basic needs. These are the working poor. Indeed, in rural areas, the majority of those who work and yet are in the lowest income quintile are unpaid family workers (63.7%) and workers in family farms or businesses

¹³³ World Bank, 2013.

¹³⁴ Ibid.

¹³⁵ Ibid.

(90.1%). In urban areas, the majority of those who work and are in the poorest quintile work in a family businesses (65.7%) and work in wholesale or retail related activities (40.7%). Low-paid jobs are often associated with low endowments of both human and physical capital.¹³⁶

The 60 years and above age group accounts for 6.2% of the population. The vast majority of senior citizens have no pension when they leave the labour market and therefore have to depend on family, social assistance programs, or charity to survive. Indeed, fewer than 9% of those in the labour force are covered by the pension system, and only 7% of those aged 60 years and older receive a pension. This means that currently about 337,675 people aged 60 and older do not receive a pension.

A recent World Bank study on disability in Sierra Leone stressed the need to increase knowledge building and analysis, improve the institutional and legal framework, and increase the coverage of and financing for public and private sector programs for the disabled. The MSWGCA manages a program that provides funds to organisations for disabled people. In 2011, 86 organisations each received an average of US\$270. The World Bank (2013) estimates that there are just over 500,000 disabled people in Sierra Leone.

There are also a large number of war victims who need the support of the government because they are physically disabled and/or mentally scarred by the atrocities of the war. The country's Truth and Reconciliation Commission received 7,700 statements from victims of the war and recommended: (i) the provision of free physical and mental health care to all victims and rehabilitation and free prosthetic and orthotic services for amputees; (ii) disability pensions for permanently disabled; (iii) measures to enhance access to education; and (iv) expansion of skills training, microcredit, and micro-finance projects by the government.¹³⁷

However, few of these recommendations have yet been implemented due to lack of resources. Through the Post 8 Conflict Reparations for Victims of Sexual Violence program, NaCSA is currently supporting a fraction (650) of the 4,000 women registered as victims of sexual violence, and through the Relief and Resettlement/ Refugees and Asylum Seekers in Sierra Leone, it is supporting the 9,000 remaining Liberian refugees. Gender discrimination in Sierra Leone, in particular, violence against women is a key challenge. Often, through patriarchal and traditional practices, women, especially young women, become vulnerable to teenage pregnancy, child marriage, sexual harassment in school by peers and teachers, in the workplace by male co-workers, to HIV/AIDS, other STIs, and sexual and gender-based violence.

In sum, the main risks that Sierra Leonean households face are: falling into or being trapped in poverty, suffering from HIV/AIDS and other infectious diseases but having no access to quality health services, being disabled, suffering from the effects of the civil war, being victims of gender discrimination and domestic violence, and lacking access to basic services. Households in Sierra Leone are also exposed to natural disasters and the effects of global shocks such as food, fuel, and financial crises.

¹³⁶ Ibid.

¹³⁷ Ibid.

3.4.3. Extent of Effective Coverage

The expenditure and coverage information indicate that major program gaps remain and include the following groups: (i) war victims, the disabled, and the elderly who are unable to work and have no means of sustenance; (ii) the working poor and the seasonally or long-term unemployed; and (iii) very poor families with children. The amount spent on the fuel subsidies was nearly as large as the amount of social protection spending on the 0 to 5 year old and the 6 to 17 year old age groups combined. Excluding subsidies and contributory pensions (which absorbed 7.8% of total social protection spending), very little was spent on the 39 to 59 (0%) and the over 60 (0.2%) age groups, which account for 18.7% and 6.4% of the extreme poor population. While there is no standard, benchmark, or “correct allocation” of resources by age group, this comparison gives an indication that the elderly and adult poor population, including the victims of war and the disabled, are not being well served.¹³⁸

In addition, Sierra Leone’s major social assistance programs are very limited. The planned social pension transfer under the MLSS’s National Social Safety Net Program only covers 8.3% of the food requirements of the poorest families compared to a median of 27% for a sample of similar programs in developing countries. Similarly, the average NASSIT pension covers only 85 % the cost of the basic food needs of the poorest families. Those families with only this pension as income would be below the extreme poverty line. The Ministry of Agriculture, Forestry, and Food Security’s (MAFFS) average pension is even less generous as it covers only one-third of the food costs of the poorest families. The efficiency of targeting methods may also require improvement. Data from the 2011 Sierra Leone Income Household Survey indicates that there are some social assistance programs that benefit mostly the wealthier families. There is therefore, substantial room to increase the targeting accuracy of social assistance programs in Sierra Leone through an improved mechanism for selecting beneficiaries.

Similarly, over two-thirds of expenditures on petrol are made by the richest families; therefore not only are petrol subsidies not pro-poor but they are actually regressive and the Government of Sierra Leone may need to consider eliminating them. In terms of cost-effectiveness, the fragmentation and duplication among many different programs reduces the cost-effectiveness of the social protection system.¹³⁹ The literature indicated that the administrative costs of NaCSA’s programs are in a similar range as those for equivalent programs in other countries whereas NASSIT’s administrative costs are on the high side. Program coordination is also a major challenge. At the local level, ministries, departments, and government agencies (MDAs) and local councils are not in agreement on a mechanism to ensure that the materials needed by the front line service providers are procured and to agree on the criteria for distributing these materials among the providers in a timely and equitable manner. Very few programs share administrative subsystems or operational platforms relating to key aspects such as targeting, beneficiary registries, and payment mechanisms. This limits the ability of programs to benefit from economies of scale and avoid duplication. Monitoring and in terms of monitoring and evaluation, the government has gradually been introducing a culture of results-oriented management and a national monitoring and evaluation (M&E) system in Sierra Leone. As part of the PRSP, it has implemented performance management contracts (PMC), the Public Expenditure Tracking Survey (PETS), and participatory poverty assessments (PPAs), and other surveys. However, most of the few programs that use the M&E systems are pilot programs financed by donors. Further development of a culture of evidence-based policymaking and

¹³⁸ Ibid.

¹³⁹ Ibid.



management by results will require continued commitment and effort from the government as well as greater investment in information gathering, program M&E systems, and staff training.¹⁴⁰

At present, there is some fragmentation and duplication of social assistance programs and poor coordination between central government ministries and local councils and between both of these groups and NGOs and other service organizations. Sierra Leone continues to have one of the lowest rates of access to basic services in Africa because basic infrastructure was in a poor condition before the war which caused it to deteriorate further. According to UNICEF, the country's lack of sanitary facilities and poor hygiene is a major contributory factor to its exceptionally high maternal, infant, and child mortality rates. While a great effort has been made to rebuild basic infrastructure since the end of the war, there are 448,000 households (43%) with no access to improved sources of water, 662,500 (60%) with no access to improved sources of sanitation, and 928,000 (89%) with no access to electricity. NaCSA is implementing several programs aimed at meeting these unmet needs. These include the Sierra Leone Community Driven Development (SLCDD) Program funded by the Islamic Development Bank (IDB), the Pro-Poor Growth for Peace Consolidation Program (GPC) supported by the Federal Republic of Germany, and the Rapid Response Growth Poles: Community-Based Livelihood and Food Support Program supported by the World Bank (World Bank, 2013).

While there has been significant improvement in health services since the war ended, nearly half of the population has no physical access to health services. Also, one third of those who do use such facilities are not satisfied with the services provided. Most people in Sierra Leone seek care from health providers only once every two years, and many public health facilities are underused. The biggest barrier to accessing health care services has been cost-related. According to data from the SLIHS 2011 survey, however, about 77% of the poorest people seeking care in local government health facilities do not pay consultation. Public health spending dropped sharply between 2006 and 2008, from 1.7% of GDP to 1% of GDP, but it has since recovered to about 2.1% in 2011. However, this is still below the Sub-Saharan Africa average of 2.6%. The country's flagship health initiative is the Free Health Care Initiative aimed at pregnant women, lactating mothers, and children under 5 years of age, which started in April 2010.

In 2007, the government enacted the Domestic Violence Act, which defines domestic violence comprehensively and encompasses physical, sexual, economic, emotional, verbal, and psychological abuse. It criminalizes these acts and imposes fines and prison terms for the offenders. The Child Rights Act of 2007 set the minimum age for marriage for girls at 18 years old. The challenge now is to put the provisions of these laws into practice. The MSWGCA is coordinating the implementation of the National Gender Strategic Plan that was launched in June 2010. The UK DFID is supporting the MSWGCA and the Sierra Leone Police in strengthening national capacity to tackle gender-based violence including supporting family support units. These are specialist units attached to the police stations across Sierra Leone that have a mandate to investigate all forms of child abuse and allegations of sexual and domestic violence.

¹⁴⁰ Ibid.

3.4.4. Efforts towards Increasing the Inclusiveness of the Social Protection System

In December 2011, the President of the Republic approved new institutional arrangements for the social protection system. The main MDAs involved in social protection in Sierra Leone are the MSWGCA, NaCSA, the MLSS, NASSIT, and MoFED which provides financing. Local councils are playing a growing role in delivering services. At the same time a large number of NGOs, faith-based organisations, and other civil society organisations provide social services to the most vulnerable groups. The MSWGCA, NaCSA, the MLSS, and local councils will need to be substantially strengthened in order to manage the revamped social protection system.

Sierra Leone has many social protection programs that seek to address all of the major risks faced by the population. However, most of these programs are small and underfunded and have important gaps. There is fragmentation and duplication among these programs as many of them target similar groups but have different management and to begin addressing the issues of child poverty and vulnerability the government with the support of its development partners began implementing, in April 2010 the Free Health Care Initiative for pregnant women, lactating mothers, and children under 5 years of age. It developed a plan to upgrade the infrastructure necessary to meet the expected increase in demand, hire more workers, improve workers' incentives, and procure additional drugs and medical supplies. This initiative is implemented by the Ministry of Health and Sanitation (MOHS), which also oversees other programs that address the risks facing this age group. These include nutrition interventions, Community-based Management of Acute Malnutrition (with the support of the DFID, the EU, and UNICEF) and Caregivers of Malnourished Children and Supplementary Feeding of the Under 5s (with the support of the World Food Programme), and a program to encourage child birth registration implemented by the MOHS and local councils with the support of UNICEF.

Some recently implemented youth programs include the World Bank's cash-for-work Programs (2009-2010); UNDP's Support to Food Security Project (2004-2009); and GTZ's Employment Promotion Program (2006-2010). Currently, the World Bank is supporting the Youth Employment Support Project (YESP, 2011-2013), which has a labour intensive cash-for-works component implemented by the NaCSA, and Skills Development and Employment Support and Institutional Support and Policy Development executed by the National Youth Commission (NAYCOM); the UNDP is supporting the National Youth Employment Program and Youth Enterprise Development also executed by NAYCOM (2011-2013).

3.5. Morocco

3.5.1. Current Legislation Covering Vulnerable Groups

Morocco is a North African country, situated in the extreme north west of Africa, on the doors of Western Europe. The strait of Gibraltar separates Morocco off Spain with 13 km span of water. Morocco spans from the Mediterranean Sea on the north and the Atlantic Ocean in the west with a large mountainous areas inside the country and Sahara desert in the far south. The last population census revealed that the population of Morocco in 2014 reached almost 34 million (33,848,242), of which 60.3% live in urban areas. GDP growth in Morocco in the last 10 years averaged about 4.20 % whereas GDP per capita reached 7,606.00 USD (2014) and about the equivalent of 3000 USD using national currency an current exchange rate. As far as Human development Index is concerning, Morocco HDI value in 2014 is 0.628 which situates the

country in the medium Human Development category ranked at 126 (shared with Namibia) out of 188 country.

There is no a unified legislative definition of vulnerable groups. However, existing social protection programmes have their own legislative document delimiting eligibility criteria as well as the mechanisms of access. Despite the lack of a coherent law and/or a policy at the moment, there are ongoing efforts toward adopting a national policy in social protection area.¹⁴¹ Alternatively, one can directly refer to official statistics, which generally distinguish the poor from the non-poor according to a certain income or consumption expenditure shortfall and/or threshold, or indirectly infer such groups from the actual coverage of social protection programmes, though some exceptions are to be made on this basis. According to the High Commission of Planning, the poor in Morocco are those whose consumption expenditure is below 3834 DH per person per year in urban areas and 3569 DH in rural areas. The vulnerable population are those whose annual mean consumption expenditure is situated between poverty line and 1.5 times this threshold. Thus, the estimates of the poor are calculated according to the definition of almost \$1 per day per person whereas the vulnerable are those situated around \$2.5 per day per person using the current exchange rates.

Despite the lack of a coherent national policy in social protection- an effort that is being made in this direction since a couple of years- and despite the fragmented nature of public intervention in this area, there is a wide range of public interventions in terms of both social security and social assistance in Morocco. Like many similar countries in the income group to which Morocco belongs, the most structured programmes are contributive social security. The Dahir number 1-72-184 of 27th July 1972, as updated in 2004 through the law number 17.02 covers exclusively the public sector and private sector employees. Such a scheme ensures employees are protected against risks of illness, disability, old age, death as well as unemployment and family benefits. Public and private employees are covered through two separated funds.¹⁴²

3.5.2. Population Segments Defined as Vulnerable

The identification of vulnerable groups may be inferred from the actual coverage of social protection and social assistance programmes. This may be done through drawing the main contextual risks, which highlight the vulnerability of households and individuals. This is the approach followed by a World Bank strategic note on social protection elaborated in 2012 in collaboration with the government of Morocco. It classifies the risks into two broad categories: the risks associated with the life-cycle and groups at risks (i.e., the disabled people mainly) and risks that affect the population in general such as poverty, volatility of market prices of the basic commodities, lack of access to health care, basic infrastructures, precarious shelter and climate changes. The identified risks by age groups are more or less similar to many of those covered by the macro analysis in the second chapter of this report; they provide a fairly good idea of the depth of such risks in each country. According to the WB note¹⁴³ children under 5 years old face risks such as malnutrition, child mortality as well as low psychosocial and cognitive development. Children between 6 and 15 face inappropriate preparation to and

¹⁴¹ The Ministry of General Affairs and Governance is currently coordinating a large scale study which updates the profiles of risks, maps all existing social protection and social assistance programmes as well as proposing ways to increase coherence and efficiency in this area. At the moment of writing this report, the outcome of this process was not yet made public.

¹⁴² Public employees are covered through "la Caisse Nationale des Organismes de prévoyance sociale (CNOPS)" whereas private sector employees are covered through "la Caisse Nationale de Sécurité sociale (CNSS)".

¹⁴³ Banque Mondiale, 2011, Maroc, ciblage et protection sociale : note d'orientation stratégique

retention in schools, violence as well as child labour are also among the main risks facing children of this age group. The youth aged between 15 and 23 face risks such as low level of human capital, difficult transition from training to labour market, unemployment and risks behaviours such as drug use and adolescent pregnancy. As far as adults are concerned, they face risks such as low human capital, usually translated into low pay due to precarious and informal labour, under employment and unemployment. Maternal mortality is also a major risk for women in this age group. The elderly face increasing health risks often not covered by a medical insurance and/or a pension scheme. Lastly, one major area of risks concern the poor population with low access and poor quality of basic social services including housing, health care especially chronic diseases. The note adds that about 1.5 among Moroccan are in a disability situation, which is a major factor of vulnerability.

3.5.3. Extent of Effective Coverage

Up to very recently (mid 2000s) only public sector and formal private sector employees were entitled to social protection coverage as stated above. The scope of coverage did not exceed 20-30% of the population including all types of coverage. The remaining 70% were composed, in part, of formal liberal professions (Lawyers, Pharmacists, doctors working for their own, etc.) and of those working in the informal economy and/or in agriculture sector. If we limit the analysis to the economically active population only, according to a recent report elaborated by ILO in collaboration the Moroccan ministry of labour, only 18.1% of employed people have access to a medical insurance. When this figure is desegregated by gender and location 44% of employed women in urban areas are covered while the proportion of covered women in rural areas is only of 1.1% where the coverage rate for men in rural areas is around 5%. Moreover, the coverage rate among non-skilled workers is around 7% whereas it reaches 25% among employees with a university degree.¹⁴⁴ While the first group do not face vulnerability as well as the majority of risks outline above because high incomes, the majority of the population were left outside any significant effort to alleviate such risks. For decades, if we exclude universal fuel and some food products subsidies, which proved not to benefit the poor and the vulnerable, and is being progressively phased out since a couple of years^{145,146}, only private transfers such as remittances helped directly more than 1 million Moroccans to escape poverty.¹⁴⁷ However, since 2005, the Government of Morocco started to tackle the issue of social protection and social assistance more seriously, though not yet systematically. By 2014, the coverage rate in terms of medical insurance all schemes included reached 53% which equates to 17.5 million people.¹⁴⁸

National initiative for human development

The National Initiative for Human Development launched in 2005 consisted in geographical targeting of poverty and social exclusion. It consisted of four main components and

¹⁴⁴ Ministère de l'emploi et des affaires sociales, Bureau International du Travail, Agence Espagnole de Coopération internationale. Etude de diagnostic sur la situation de l'emploi au Maroc, Rapport Global, 2014.

¹⁴⁵ Despite it did benefit the rich more than the poor, except probably for domestic gas, the universal subsidies system was not a major issue for public finance until 2008. At the time of the economic crisis and the raise in market prices, especially fuel products, the subsidies system became a major burden on the Budget, to the point that it reached 7% of Moroccan GDP while the international mean benchmark is of 0.7%. In 2013, just before its reform was enacted, the subsidies system costed 40 billion Moroccan Dirham, that is more than investment budget of the same year.

¹⁴⁶ Salima Bennani, Directrice de la caisse, conférence à l'université Internationale de Casablanca, le 12 Mai 2015

¹⁴⁷ Soudi K, Teto A (2004), « Contribution des transferts des Marocains résident à l'étranger à la réduction de la pauvreté : analyse comparative entre différentes sources des transferts – cas du Maroc », Fifth Mediterranean Social and Political Research Meeting, Florence, 24-28 mars.

¹⁴⁸ Agece Nationale de l'Assurance Maladie, Feuille de route 2014-2018 : www.assurancemaladie.ma

programmes: urban poverty, rural poverty, a programme against precariousness and a crosscutting one consisting in issues such as capacity building, partnerships, etc. In 2013 only, the National Human Development Initiative implemented 4583 projects and 1644 activity; that is 6227 interventions, with a budget exceeding 3.9 billion DH. The total number of beneficiaries reached 1.2million individuals.¹⁴⁹ The most important share of budget in 2013 concerned the urban programme with 33.5%.¹⁵⁰ The National Observatory of Human Development undertook an impact evaluation of the initiative in 2012 covering the period of 2005-2010. It showed some important achievements, such as the increase of income of targeted rural households by 49%; though increase touched mostly the middle and upper quintiles of the population rather than the poorest; it also showed some mitigated results. Whereas, overall multidimensional poverty significantly decreased in rural targeted areas from 26.7% in 2008 to 7.8% in 2011; it slightly increased in targeted urban areas passing from 0.6% in 2008 to 0.7% in 2011; the impact evaluation showed slightly different results when each component of the multidimensional poverty index individual components.

For example, in terms of education deprivation, that the deficit decreased in the targeted rural areas compared to non-targeted areas whereas it stayed the same in the urban non-targeted areas and slightly increased in urban non-targeted areas. In terms of child mortality, it significantly decreased between the two periods in rural areas and especially in the targeted areas (passed from 6.2% to 0.9%). As far as malnutrition is concerned, it did decrease in targeted rural areas from 14.4% in 2008 to 4.3% in 2011, whereas it increased in targeted urban areas from 2.4% to 6.4% in the same period. In the Urban non-targeted areas, it reached 6.8%.¹⁵¹

The main lessons drawn from the impact evaluation were mainly that while significant positive changes have been identified they benefited mainly the lower middle class than the poorest. The conception of the projects did not take into account the needs of the poorest.

Education programmes and initiatives

In addition to non-formal education for which large-scale partnerships programmes have been implemented with NGOs since late 1990s¹⁵², Morocco implemented a few important programmes to assist poor and vulnerable children to access and stay in formal education, among which the Conditional Cash Transfer Programme called “Tayssir”. This program aims to reduce drop out of schools and increase equity in access to education for children belonging to the most vulnerable and poor households. The programme provide financial assistance for children aged between 6 and 15, that is the age for compulsory formal education. The targeted areas are those that fall within the National Human development initiative targeted areas especially those where the rate of poverty is more than 30% and drop out of schools more than

¹⁴⁹ Initiative Nationale pour le Développement Humain. Genèse et Evolution, Coordination Nationale de l'INDH, Septembre 2013, consulté le 25 Novembre 2015 : <http://www.indh.ma/pdfrapann/rap1.pdf>

¹⁵⁰ Royaume du Maroc, Ministère de l'Intérieur, Secrétariat générale, CN-INDH Bilan des réalisations de l'INDH -Exercice 2013-, Mai 2014

¹⁵¹ For more information on the results see ONDH(2012), Evaluation de l'Impact de l'Initiative Nationale du développement Humain (2005-2010).

¹⁵² Considering only 2011/2012, 64.570 beneficiaries followed the reinsertion programme, that is 31.girls and 33 boys (against only 46.119 in 2010/2011). Among the 64.570 beneficiaries, about 42% were reintegrated into the formal education scheme and vocational training, that is about 27.059 children. For more information see : Royaume du Maroc, Ministère de l'Education Nationale, Direction de l'Education non Formelle, Bilan d'activité des programmes de l'éducation non formelle, 2011-2012.

5%. The number of beneficiaries has steadily increased and ranged between 88.000 in 2012-2013 and 825.000 in 2013-2014.¹⁵³ The programme showed encouraging results, drop out of schools in targeted areas decreased from 7.8% to 3.1% among girls that is almost 5 points and 4 points for boys. A recent evaluation of the programme showed that among the shortfalls is the joint targeting with the Human development initiatives which leaves out many poor households due to geographic targeting inclusion and exclusion errors.¹⁵⁴

Employment and youth employment promotion

Like similar developing countries, Morocco faces the problem of unemployment, especially among youth. The economic activity rate among working age (15-64) reached only 51.6% in 2012. Unemployment rate reached 9.2% in 2013. Among youth in general, this rate reached 19.3% and 16.5% among young graduates. Among women, the unemployment rate reached 38%. The number of unemployed reached 1.081.000 in 2013 among which, more than half are primarily seeking employment.¹⁵⁵ Many initiatives and programmes have been designed and implemented to tackle this issue. Among these the creation of the National agency for the promotion of Employment and skills (ANAPEC). It collects jobs advertisements from employers and relate the job seekers with them. In addition, job seekers are entitled to professional advice whereas novice entrepreneurs to business advice. The agency targets young people who achieved the high school grade and beyond. It recently decided to also include those with lower education levels.¹⁵⁶

Other programs have been designed and implemented such as IDMAJ for integration into labour market and first employment¹⁵⁷, which aims at developing skills among youth graduates through a first professional experience within a company. Launched in 2006 it targets, for a duration of 18 to 24 months, those who have a high school degree or equivalent or a vocational training certificate. Among incentives, tax exemption for companies mainly the social security contributions and vocational training tax whereas job seekers are exempted from revenue tax on training allowances. These incentives are carried over for one year if the job seekers gets a full time contract. Retention rate reached 44%, though it seems companies use this programme to attract qualified workers rather than serve the purpose of promoting employment among youth. Another programme called "TAEHIL"¹⁵⁸ aims at training and skills development adapted to the needs of enterprises. It is managed by the national agency for the promotion of employment and provides training contracts of up to one year, especially in areas where enterprises have difficulty to identify trained candidates. Lastly, the programme called "Moukawalati" aims at encouraging young people to create enterprises, especially among

¹⁵³ The amounts allocated per child per months are 60 DH for the first two years of primary education, 80 DH for the following two years and 100 DH for the last two years of the primary cycle and lastly, 140 DH for lower high school. For more information see TAYSSIR-infos, Le programme « Tayssir » des transferts monétaires conditionnels : www.men.gov.ma/tayssir/.../tayssir%2017122010/Tayssir_infos1.doc

¹⁵⁵ Haut Commissariat au Plan –HCP–, enquête Activité, Emploi, Chômage, 2013

¹⁵⁶ Royaume du Maroc : Promouvoir les Opportunités et la Participation des Jeunes, Document de la banque Mondiale, 2012 : [http://www.unicef.org/morocco/french/FR_Version_du_rapport_30_avril_\(Repaired\).pdf](http://www.unicef.org/morocco/french/FR_Version_du_rapport_30_avril_(Repaired).pdf)

¹⁵⁷ Royaume du Maroc, Ministère de l'Emploi et des Affaires Sociale : <http://www.emploi.gov.ma/index.php/fr/emploi/politique-de-l-emploi/10-emploi/169-amelioration-de-l-employabilite.html>

¹⁵⁸ Royaume du Maroc, Ministère de l'Emploi et des Affaires Sociale : <http://www.emploi.gov.ma/index.php/fr/emploi/politique-de-l-emploi/10-emploi/169-amelioration-de-l-employabilite.html>

university graduates. It provides business advice to candidates as well as facilitating access to funding. It aimed for creating at less 30.000 small enterprises and about 900.000 jobs. It provides, among others, in partnerships with banks, loans as well as exempted interest loans for up to 10% of the investment funds. It also ensures unique points offering advice, mentoring and facilitating administrative procedures gathering representative of all stakeholders. Many shortfalls have been identified such as extended delays in granting loans and lack of enough qualified mentors.¹⁵⁹

Unemployment allowance

In accordance with the law N° 03-14, which modifies the law N° 1-72-184 pertaining to the organisation of social security appeared in the «Bulletin Officiel» 6290 of 11th September 2014, a loss of employment allowance entered into force the 1st of December 2014.

According to this new law, an insured employee who lost unintentionally their job may benefit from from this allowance during six months. The conditions of eligibility are as follows : being an employee of private sector, being in the process of actively searching for a job, have cumulated 780 days of contribution to social security during the last 36 months preceding the date of losing their job including 260 days during the last 12 months of the same period. The allowance will be equivalent to 70% of the net monthly salary expressed as the mean of the last 36 last months and up to the minimum salary level. The allowance also include medical insurance, family benefits and will be accompanied by a programme run by the national agency for the promotion of employment to search for a new job. A training programme will also be put in place once the beneficiary ceases to work. It should be noted that the number of private sector employees in Morocco is estimated around 3.6 million person but the number of those affiliated to the social security scheme is around 2.9 million.¹⁶⁰

Social protection for independent workers and students

The government of Morocco is the process of promulgating a law to organize and ensures that independent workers such as doctors, pharmacists, layers, etc., are covered through a contributive scheme adapted to their activity. Similarly, student aged under 30 years old starting September 2015 become eligible to medical insurance in the same standards as the employees of public sector. Students of private universities are subject to a contribution perceived along the tuition fees.

Medical insurance for the poor (RAMED)

The RAMED scheme is grounded on the principle of social assistance and national solidarity with the vulnerable and poor population. It targets the individuals who live in Morocco and are not eligible for the compulsory medical insurance. They should have an annual income below 5650 DH per person composing the household.¹⁶¹ This threshold is far above the national poverty line threshold and is close to the definition of the vulnerable to fall into poverty. That is those whose income or consumption expenditure is 1.5 times above the poverty line.

¹⁵⁹ Royaume du Maroc : Promouvoir les Opportunités et la Participation des Jeunes, Document de la banque Mondiale, 2012 : [http://www.unicef.org/morocco/french/FR_Version_du_rapport_30_avril_\(Repaired\).pdf](http://www.unicef.org/morocco/french/FR_Version_du_rapport_30_avril_(Repaired).pdf)

¹⁶⁰ See the figures provided in footnote number4.

¹⁶¹ Le régime marocain de sécurité sociale, Centre des Liaisons Européennes et Internationales de Sécurité Sociale, consulté le 27 Novembre 2015 : http://www.cleiss.fr/docs/regimes/regime_maroc.html

Health care services attached to this scheme are delivered in public hospitals. The annual contribution of vulnerable population benefiting from the scheme does not exceed 120 DH per person and is upper limited to 600 DH per household regardless of the number of people in the household. However, those whose income or consumption expenditure, that is living below 3767 DH per person per year are entitled to free coverage.

To benefit from RAMED, the article 116 and 117 of the law Number 65-00 stipulate that an eligible person should prove that they are not covered by any medical insurance scheme either as directly insured or an entitled as a family member of an insured person. They also should meet the monetary criteria mentioned above. In addition, there are directly eligible pensioners of residential care institutions, namely orphans and those living in any non-profit establishment hosting abandoned children or adults without a supporting family.

Despite the improved accessibility to health care of the vulnerable and poor population, many shortfalls have been identified. Upon the generalization of the scheme, the health sector professionals in public hospitals are faced with lack of appropriate financial and human resources. Such limits are exacerbated by an increasing demand for health care services along with excessively delayed bills recovery call for an urgent reassessment of the situation to enable the scheme to continue.¹⁶²

Support to the elderly

Between 1980 and 2010, the proportion of the elderly has doubled in Morocco and is expected to steadily increase to reach 25% by 2050.¹⁶³ The government of Morocco has adopted a national strategy for the elderly in 2009 whose main priorities were housing and living condition. However, this strategy has not been implemented.¹⁶⁴ According to the available data only one fifth of the elderly have a pension and a medical insurance scheme. For those without any family support, the Entraide Nationale has 44 centres situated in different Moroccan cities. It provides financial and human resources to NGOs hosting them. In 2011, 3224 (1627 women and 1597 men) have benefited from the services of such centres.

A recent study conducted by the Economic and social council pointed out the inadequacy of infrastructures of the centres hosting the elderly in Morocco as well as inappropriate profiles, skills and motivations of the personnel working in these centres. It advocated for a significant improvement of services including appropriate training and recruitment of qualified staff, development of gerontology, and putting in place daily care centre for the elderly.¹⁶⁵

People with disabilities

According the latest available data, about one million and half (5.12%) of Moroccans live with a disability. One household in four include at least a disabled person among its members. Also,

¹⁶² Dr M.A. HAJJI, Evaluation du Régime d'Assistance Médicale au Centre hospitalier préfectoral de Salé, Mémoire de fin d'études (2012/2014), Management des Organisations de santé, ENSP, 2014.

¹⁶³ United Nations, Department of Economic Population Prospects, The 2010 Revision, <http://esa.un.org/unpd/wpp/index.htm>.

¹⁶⁴ La promotion et la protection des droits de l'homme des personnes âgées au Maroc Conseil National des Droits de l'Homme (CNDH, Maroc), 2013 :

<http://www.ohchr.org/Documents/Issues/OlderPersons/PublicConsultation2013/MarocCNDH.doc>

¹⁶⁵ Le CESE adopte son rapport sur la situation des personnes âgées et présente son projet de budget 2016, publié le 27 Aout 2015, consulté le 02 Décembre 2015 : http://www.cese.ma/Documents/PDF/Communiqués_de_presse/2015/SO-53-31082015/CP-SO-53-31082015-VF.pdf

one in five has never visited a health care institution. Only one person in 100 has access to a medical insurance.¹⁶⁶ In addition, 71.8% of disabled people in Morocco do not have any education. The schooling rate among disabled children 32.4% against 92.6% among non-disabled children. As a result, the poverty rate is higher among disabled people and their families than the rest of the population. To deal with this catastrophic situation, the Ministry of Social Development is in the process of proposing a law that protects the rights of disabled people. The law proposes establishing a fund to promote professional integration of disabled people, help to families caring for a disabled child regardless of their age as well as the creation of a national council for disabled people, which will provide policy advice to the government on the promotion of the rights of disabled people in Morocco. These measures have not yet been implemented and are still in discussion.

A pension fund for widows and orphans

The law pertaining to direct assistance to the widows living in a vulnerable or a precarious living conditions and in charge of school-age orphans aged under 21 or living with a disability sets an amount of 350 DH per child given that the upper limit of monthly allowance should not exceed 1050 DH and without cumulating such an allowance with another transfer such as 'Tayssir', a pension or a family benefit or any kind of assistance directly provided by the government including local government or any other public institution.¹⁶⁷

Launched in February 2015, this scheme reached 10500 request, about 40.000 requests for assistance are currently under consideration. However, this allowance will concern only 300.000 widows compared the initially estimated 600.000.

3.5.4. Efforts towards Increasing the Inclusiveness of the Social Protection System

In the light of the above-mentioned programmes and initiatives, it is clear that Morocco has significantly improved access to social protection, especially for the vulnerable and for the poor population in the areas of health care, access to education, promoting employment and improving living conditions. These efforts aims to generalize social protection including pension and medical insurance, as well as maintaining purchasing power through subsidies of basic food and fuel products. Despite these efforts, the targeted results are not yet achieved. Among the major shortfalls and challenges are the fragmented nature of these initiatives and programmes lacking coherence and efficiency within a unified system. Social insurance programmes are fragmented and dispersed in many schemes and suffer from a lack of coordination. Social assistance programmes remain sectorial with diverse targeting methods (territorial such as Tayssir and INDH) and individual/household for RAMED and the widows fund. An important fraction of the population that qualify as vulnerable is not yet covered by any of existing pension and medical insurance schemes, altogether covering 17.5 million, that is 53% of the total population in Morocco.¹⁶⁸ It is well acknowledged that a knowledge management strategy is needed consolidating research and studies about social protection in Morocco especially in the light of rapid changes of the society in the last few decades. The system of targeting needs serious reconsideration in the light of the identified shortfalls and

¹⁶⁶ Royaume du Maroc, Haut Commissariat au Plan, Direction de la Statistique, Population en situation de handicap au Maroc, Profil démographique et socio-économique, Impression Editions OKAD, 2009

¹⁶⁷ Décret n° 2-14-791 du 11 safar 1436, BO n° 6318 en arabe du 18/12/2014

¹⁶⁸ Agence Nationale de l'Assurance Maladie, Feuille de route, 2014-2018, consulté le 25 Novembre 2015 : http://www.anam.ma/anam.php?id_espace=1&id_srub=109

limitations.¹⁶⁹ The last but not the least, demographic and socioeconomic data should be consolidated and improved within a national information system allowing desegregation and territorial identification and hence, appropriate services for the population.

¹⁶⁹ La convergence des politiques publiques, Op.cit.

4. CONCLUSION and POLICY OPTIONS

This report shows that OIC Member States are characterised by a variety of economic conditions and population groups, from the very wealthy to the absolute poor. In reaction a diverse range of social protection policies have been implemented across OIC states. Overall four observations and conclusions can be drawn from the analysis:

- High Income Countries (HICs) have invested heavily in social safety net policies and interventions for country nationals. They face the challenge of reducing their financial and economic dependency on incomes derived from oil revenues to stimulate social enterprise and levels of youth employment. The key challenge for these countries is to develop human capital and effective active labour market programmes that promote social mobility and reduce dependency on governmental aids.
- Upper-Middle Income countries (UMICs) have large income inequalities to deal with and would benefit in the short to medium-term from administrative reform of their social assistance and social insurance schemes in terms of coordination and coverage aspects. A number of these countries are also experiencing political instability and this poses further risks to vulnerable groups as well as increasing the number of people in poverty as well as orphans and conflict related disabilities.
- Lower-Middle Income Countries (LMICs) have large populations of vulnerable groups or those in vulnerable / insecure economic situation and employment. A key task for these countries is to create economic opportunities and to support economic growth in addition to introducing basic social protection policies and services.
- Low Income Countries lack basic social protection services and suffer from serious humanitarian and development issues such as drought, malnutrition, high infant mortality and illiteracy. These countries are often heavily dependent on foreign aid to fund social protection and development programmes. However, not all these countries are natural resource poor but many lack human capital resources to drive economic development.

Policy options

The report provides a number of options for the extension of social protection services to vulnerable groups. These consist of a combination of strengthening existing social protection systems but also introducing social insurance and labour market programmes and interventions. They entail: targeted social pension programmes, public works programmes, cash transfer programmes to very poor families with children; active labour market interventions including the formalisation of migrant workers and the informal workforce force in countries where national income is high. A key proposal relates to the provision of universal access to primary health care services.

1. All OIC countries should embark on establishing a basic social protection floor for the most vulnerable nationals and migrants within their countries. This would initially involve conducting feasibility and cost benefit analysis for particular social protection packages (as noted below). Technical assistance could be sought from the international organizations as to how best approach the implementation of a basic package.
2. Targeted social pension programmes could offer a minimum income to war victims, adults with disabilities, poor female-headed households, people aged over 60 years and older people without a pension who cannot work and have no other source of income. The Social Pension should establish close links with health services. For example, to enhance the impact, the beneficiaries of the Social Pension could be automatically eligible for access to

free public health services (and medicine). As has been shown in this report, health costs are a major burden for local populations in the OIC states and especially for the disabled and elderly.

3. Reform of existing public works programmes in some of the low-income OIC states may be needed to provide more stable for vulnerable groups, particularly those who are unable to work and those in insecure employment. Agricultural workers occupy a large proportion of this category. In low income and lower-middle income countries, programmes could be unified under one permanent national labour intensive public works programme designed to help food insecure households to cope during lean period of each year. As resources permit, the programme could then open to all adults in need. The unified program would cover both rural and urban areas as food insecurity affects households living in both types of geographical areas.
4. New measures to help beneficiaries make sustainable transitions or “graduate” from active labour market and public works programmes such as skill upgrading should be considered. Labour intensive public works should not only provide beneficiaries with predictable payments in return for their labour but also include elements of training or technical assistance so that beneficiaries can improve or develop their skills and thus move into full-time formal employment where it exists. These services could also include a savings component combined with financial literacy training after which the programme might begin to provide microcredit services to help beneficiaries to finance agricultural production or income-generating activities. The difficulties of introducing and managing these types of activities should not be underestimated, and expectations should be realistic about their potential for enabling sustained labour market entry and poverty reduction.
5. It is also recommended that OIC countries establish cash transfers to very poor families with children and other dependents such as the elderly or persons with disabilities. Priority could be given to families with orphans and vulnerable children (OVC), single earners and households that have caring responsibilities but are physically able to work. The amount of the transfer might consist of a flat transfer equal in amount to the social pension plus an additional (declining) amount for each dependent child with an upper limit of. Preference should be given to conditional cash transfers which offer incentives to families to improve the levels of health and education of its members and its children.
6. OIC countries need to also promote free and universal health care coverage. In many OIC countries health care is already provided free to the infants and to pregnant and lactating women. Children enrolled in school are also entitled to have free access to health care in public facilities, but this policy is not consistently applied. Access to good quality healthcare is a key pillar of social protection and inclusive social development as recently promoted by a number of international agencies.¹⁷⁰
7. Rationalising, strengthening and joining up existing policies and programmes are vital. Programmes that may need to be changed include education and youth employment programmes that have received priority attention and investment from the government and international development partners in recent years yet we still know very little about which interventions have worked. Youth employment programmes and vocational training programmes have mixed results across a variety of contexts. These interventions and

¹⁷⁰ See ESCWA (2015)



- policies need to be linked to education policy in general in order to meet skills gaps and employed demands in local labour markets.
8. Effective social protection policy has to be based on rigorous data and evidence showing what are the actual needs of vulnerable groups and what interventions work and why. Therefore, OIC Member States need to install new institutional arrangements for the monitoring and impact evaluation of the strategies, interventions and policies associated social protection. This would generate good quality evidence and data on policy impact and effectiveness. However, it should also be noted that there is a global evidence gap in terms of what social protection programmes and interventions work, why and for whom.

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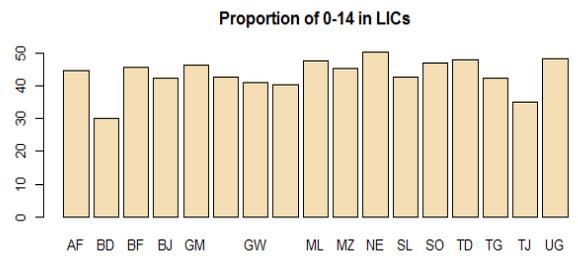
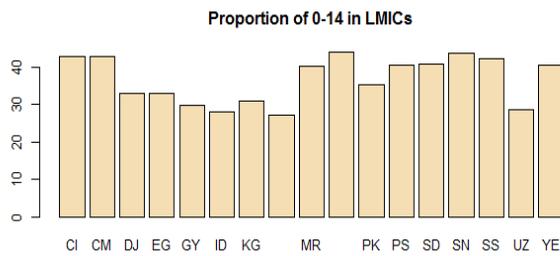
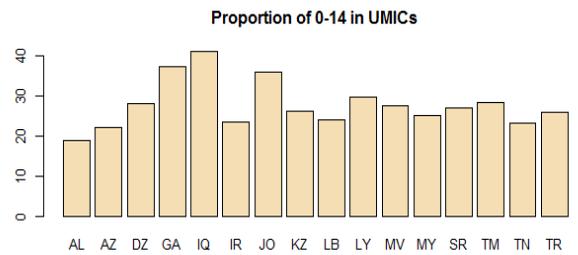
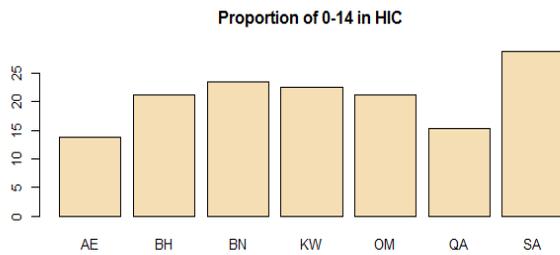
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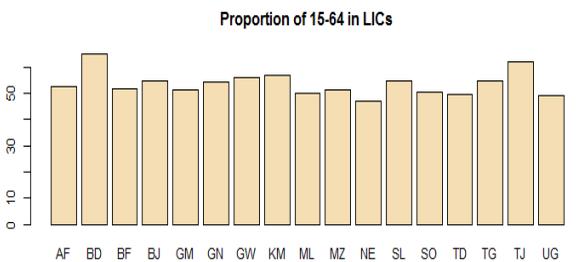
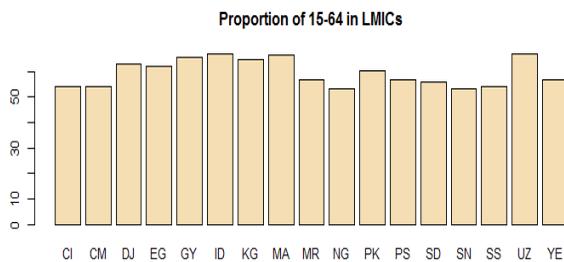
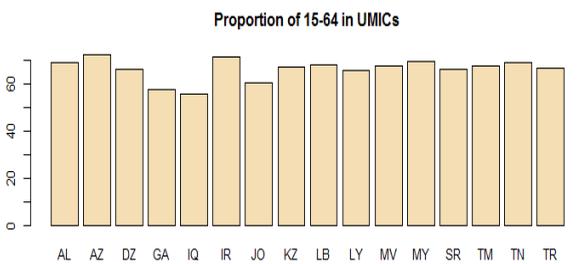
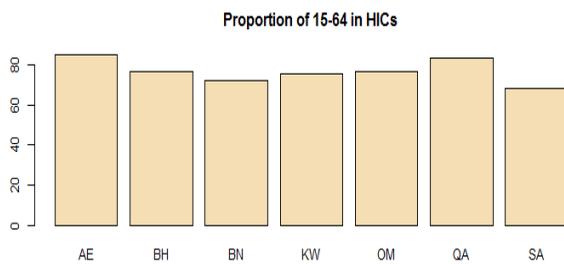
ANNEXES

Annex 1 - Detailed Demographic Indicators

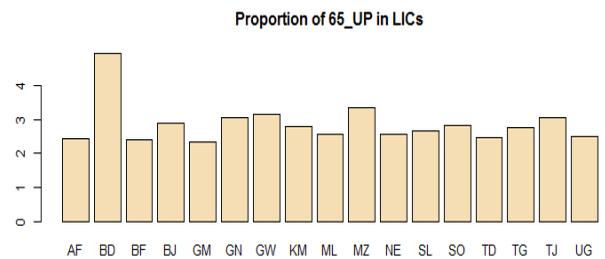
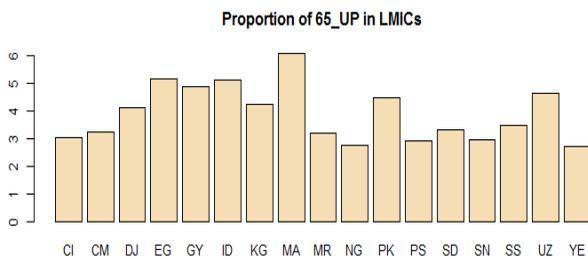
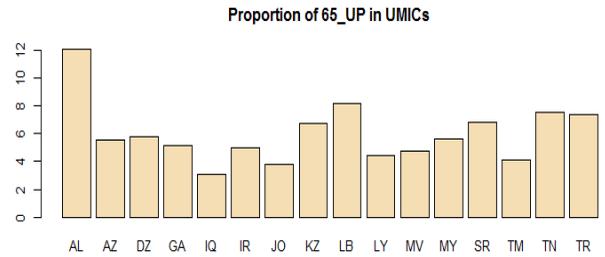
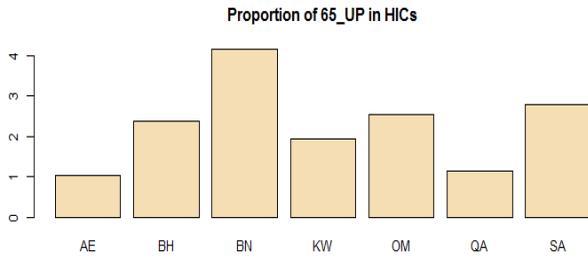
Box 1: Population Age 0-14



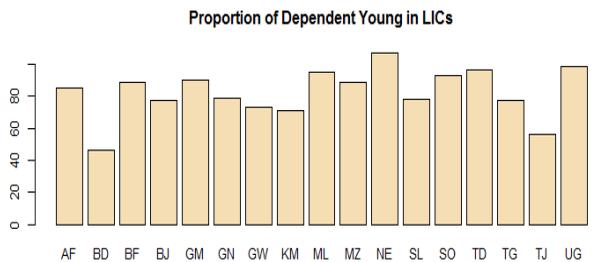
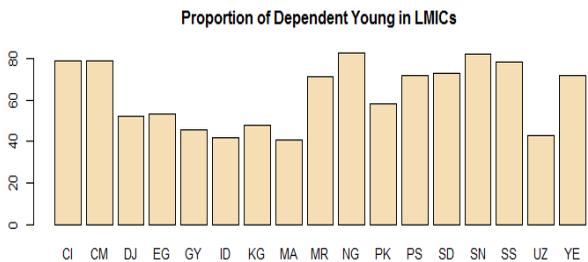
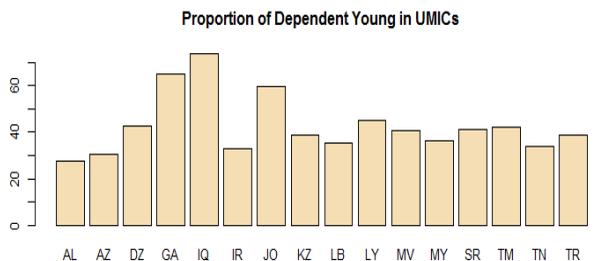
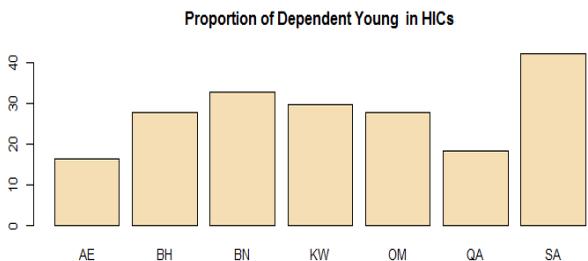
Box 2: Population 15-64



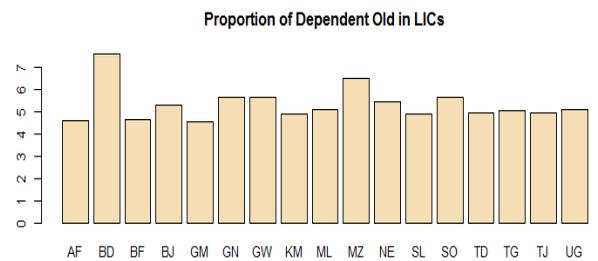
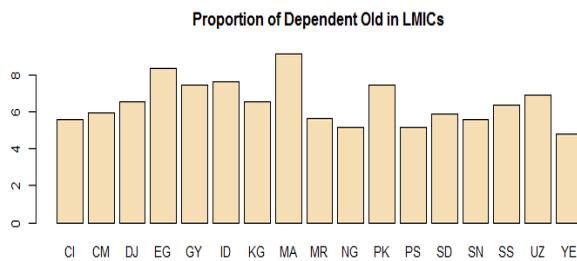
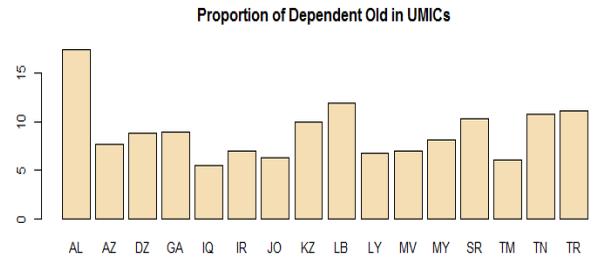
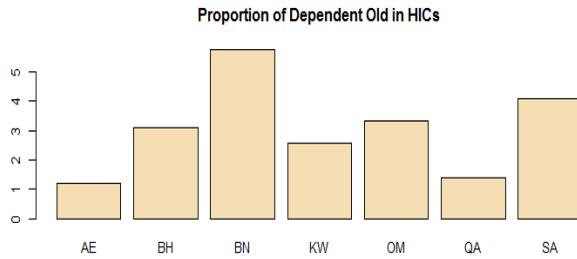
Box 3: Population 65_UP



Box 4: Dependency rate, Young

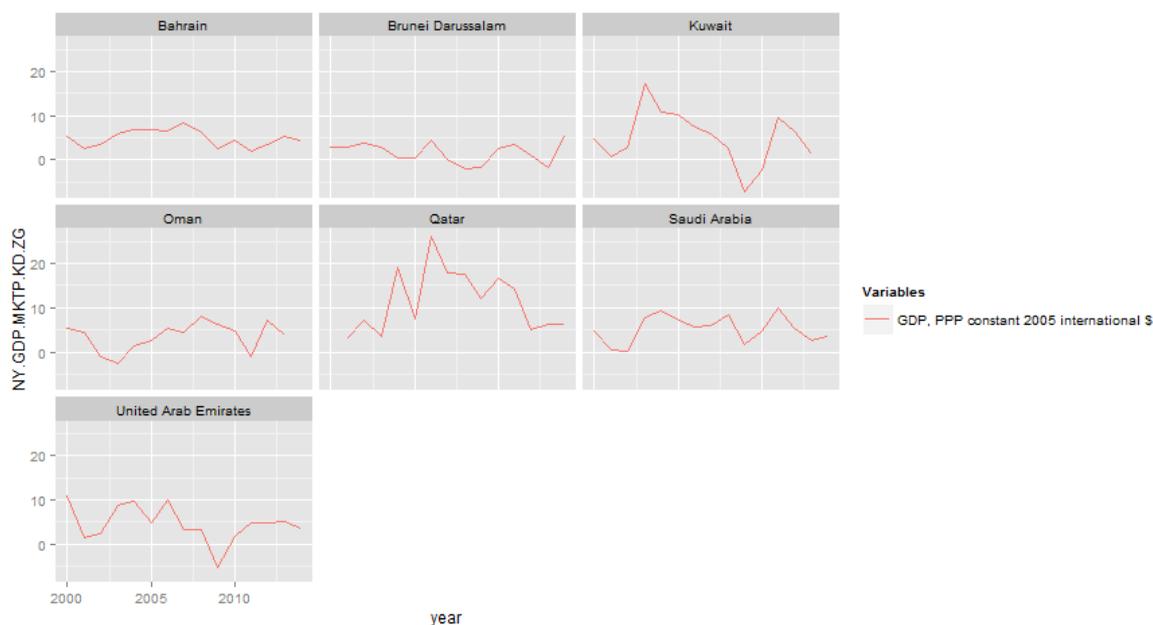


Box 5: Dependency Rate, Old



Annex 2 - GDP Levels in OIC Countries in the last 10 years

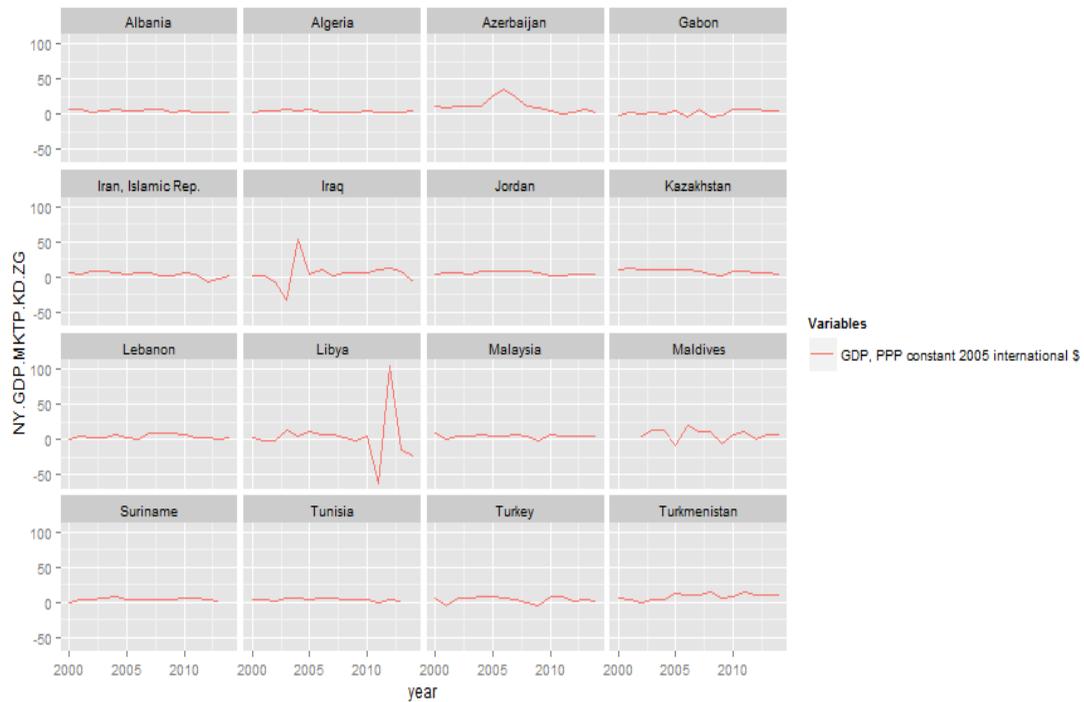
High Income countries



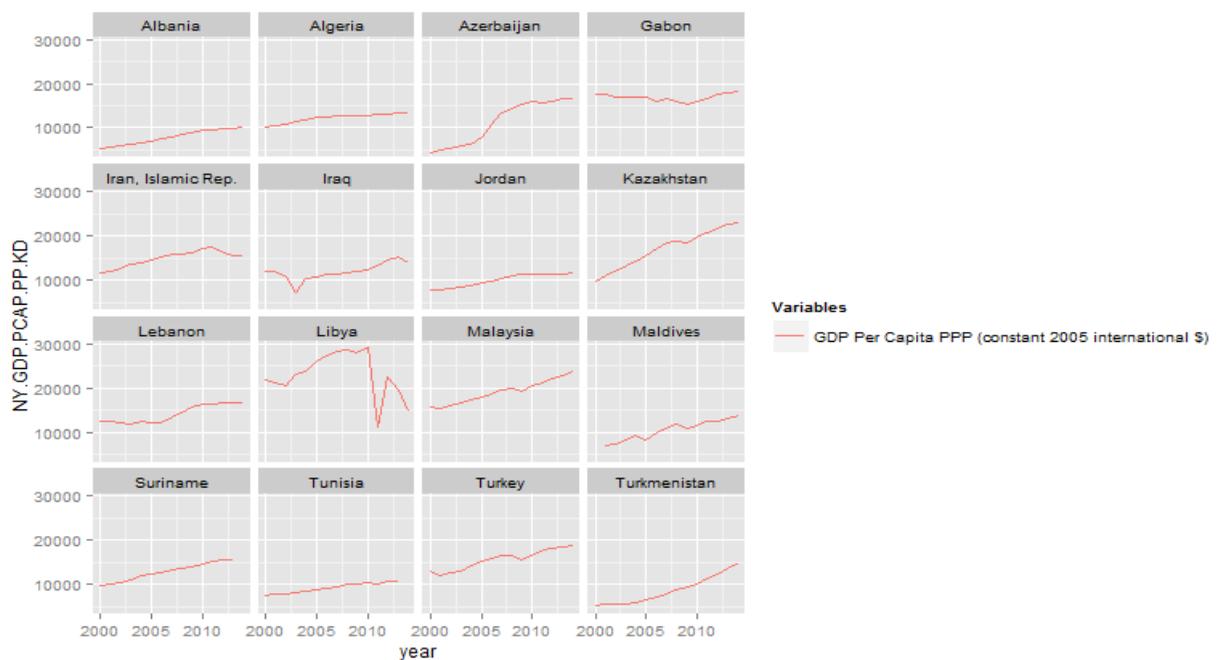
GDP Per capita expressed in PPP constants 2005



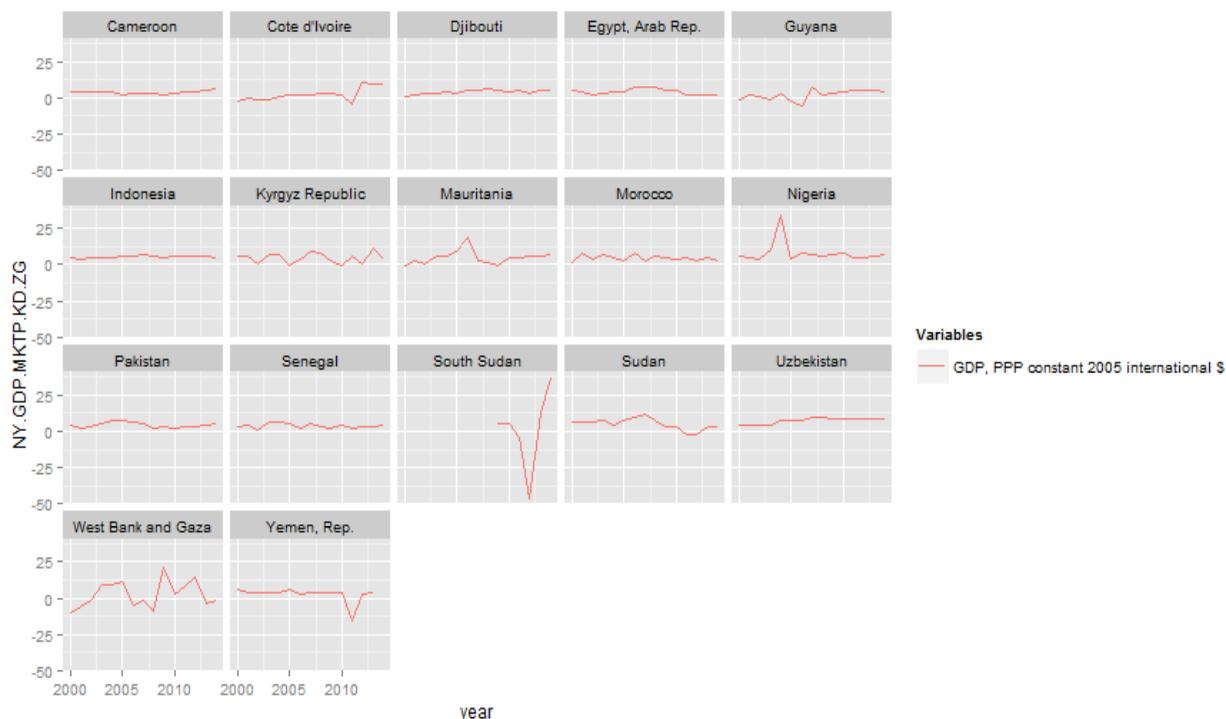
Upper Middle Income countries



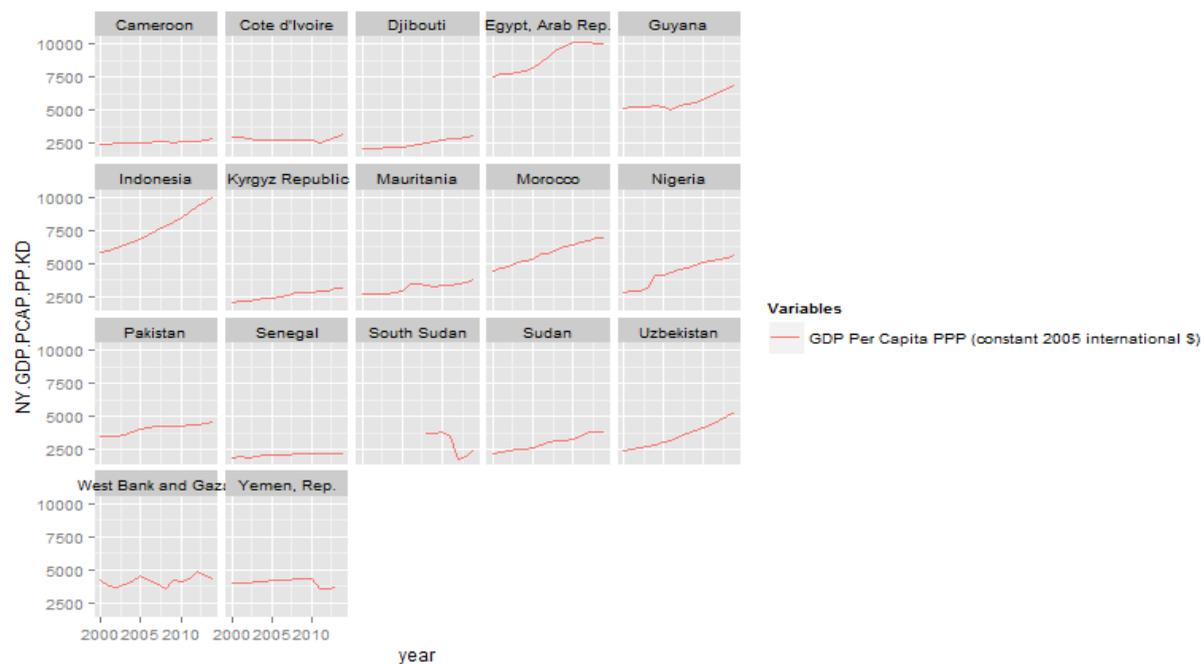
GDP Per capita expressed in PPP constants 2005



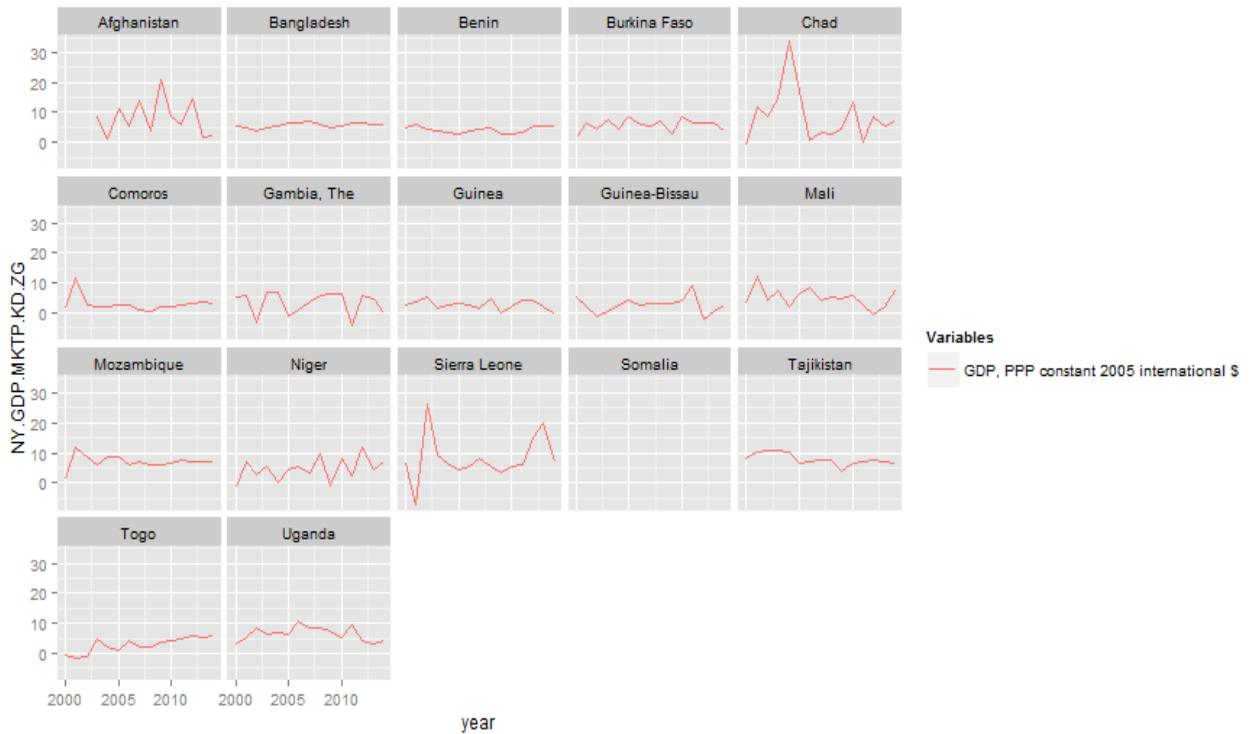
Lower Middle Income Countries



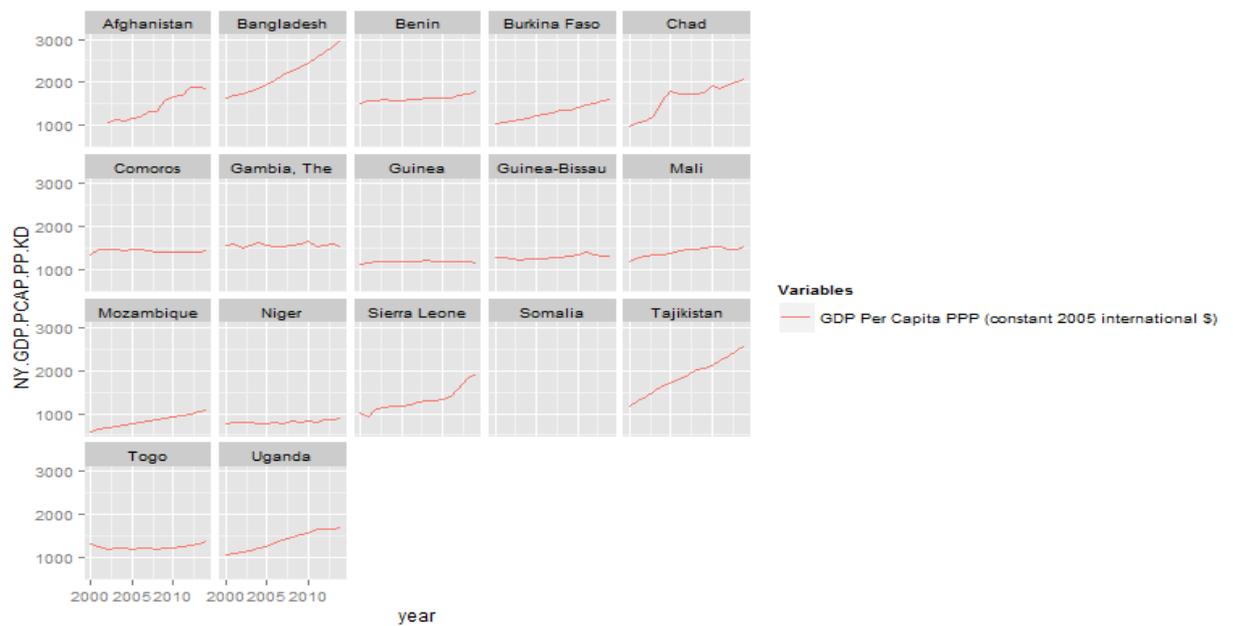
GDP Per capita expressed in PPP constants 2005



Low Income countries

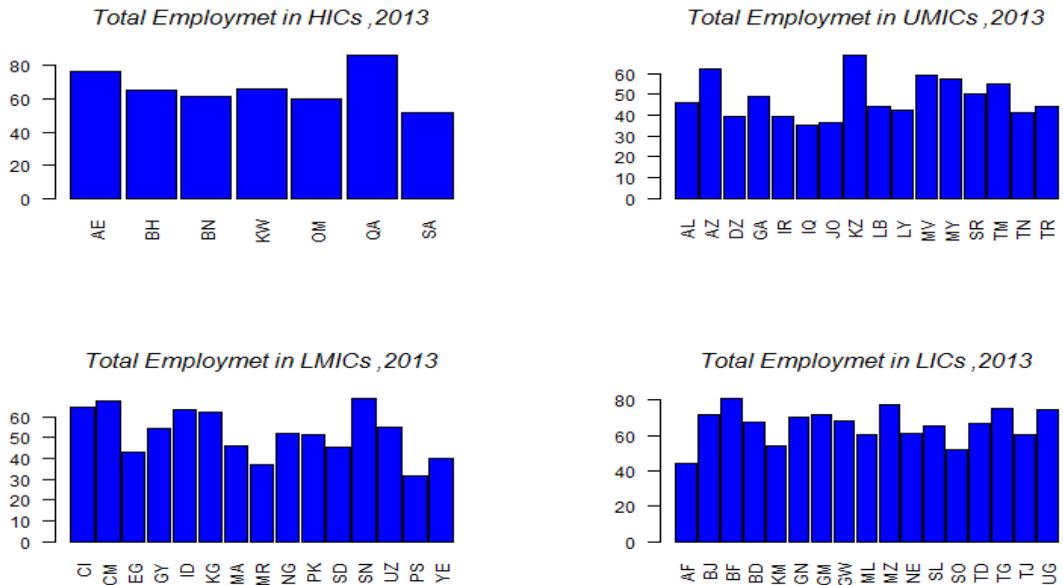


GDP Per capita expressed in PPP constants 2005

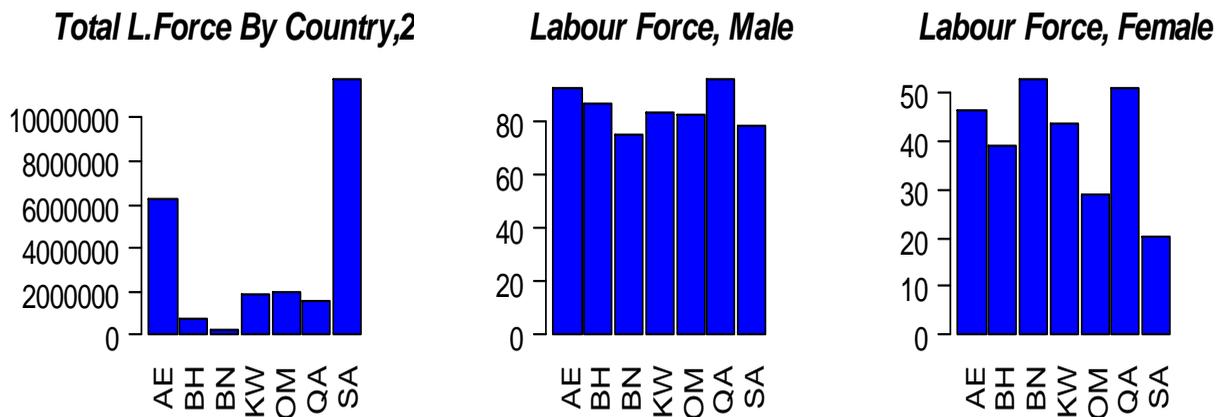


Annex 3 - Labour Market Data

Employment to population ratio

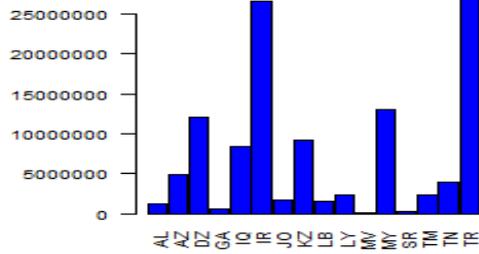


Labour Force in High Income countries

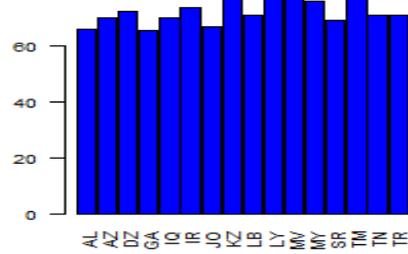


Labour Force in Upper Middle Income Countries

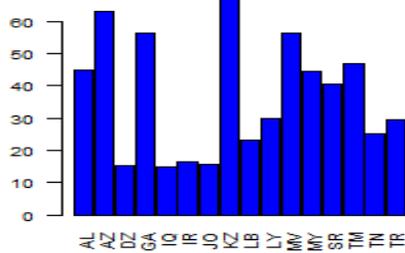
Total L.Force By Country, 2013



Labour Force, Male

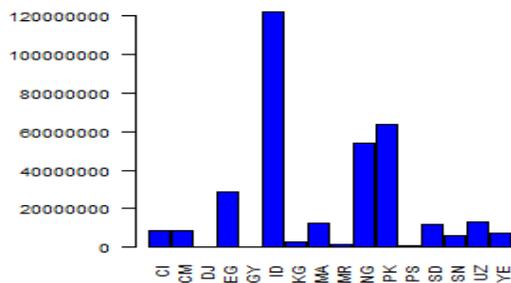


Labour Force, Female

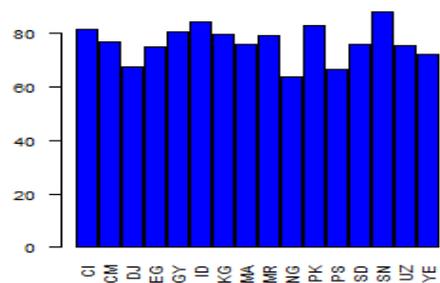


Labour Force in Lower Middle Income countries

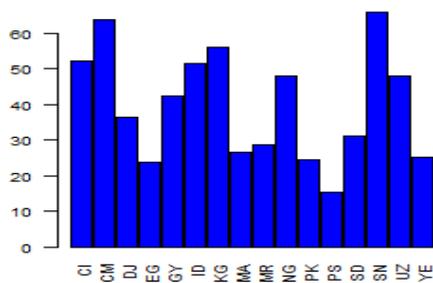
Total L.Force By Country, 2013



Labour Force, Male

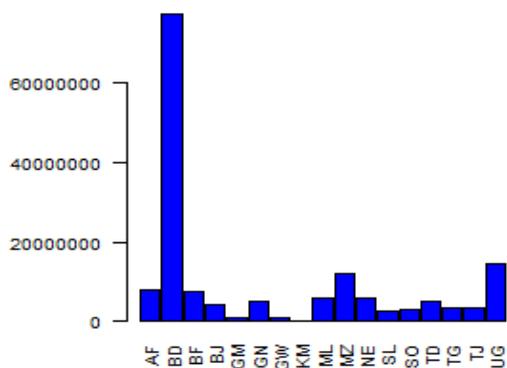


Labour Force, Female

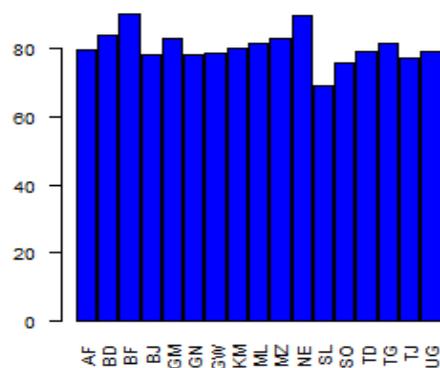


Labour Force in Low Income Countries

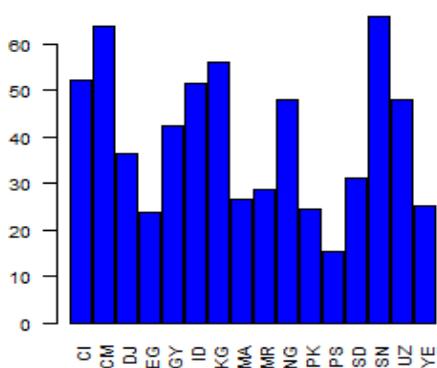
Total L.Force By Country, 2013



Labour Force, Male



Labour Force, Female



Annex 4 - Formal Social Insurance Schemes

Social Insurance Schemes in High Income Countries (mainly for Employed Persons and Public Sector Workers) (ISSA Website, Country Profiles)

Scheme Country	Old Age, Disability, Survivor	Work Injury	Unemployment	Sickness and Maternity
Bahrain	X	X	legal residents and Bahraini citizens	N/A
Brunei Darussalam	Provident Fund	X	N/A	universal
Kuwait	X	(oil sector employees only)	X	N/A
Oman	X	X	N/A	N/A
Qatar	X	X	N/A	X
Saudi Arabia	X	X	X	N/A
UAE	?	?	?	?

Social Insurance Schemes in Upper-Middle Income Countries (mainly for Employed Persons and Public Sector Workers) (ISSA Website, Country Profiles)

Scheme Country	Old Age, Disability, Survivor	Work Injury	Unemployment -	Sickness and Maternity	Family Allowances
Algeria	x	x	x	x	x
Iraq	x	x	x	x	x
Jordan	x	x	x	x	x
Lebanon	x	x	N/A	x	x
Libya	x	x	x (severance payment)	x	x
Tunisia	x	x	social assistance	x	x

Albania	x	x	x	x	x
Azerbaijan	x	x	x	x	x
Iran	x	x	x	x	x
Kazakhstan	x	x	x	x	x
Malaysia	x	x	N/A	x	x
Maldives	?	?	?	?	?
Turkey	x	x	x	x	N/A
Turkmenistan	x	x	x	x	N/A
Suriname	?	?	?	?	?
Gabon	x	x	N/A	x	x

Social Insurance Schemes in Lower-Middle Income Countries (mainly for Employed Persons and Public Sector Workers) (ISSA Website, Country Profiles)

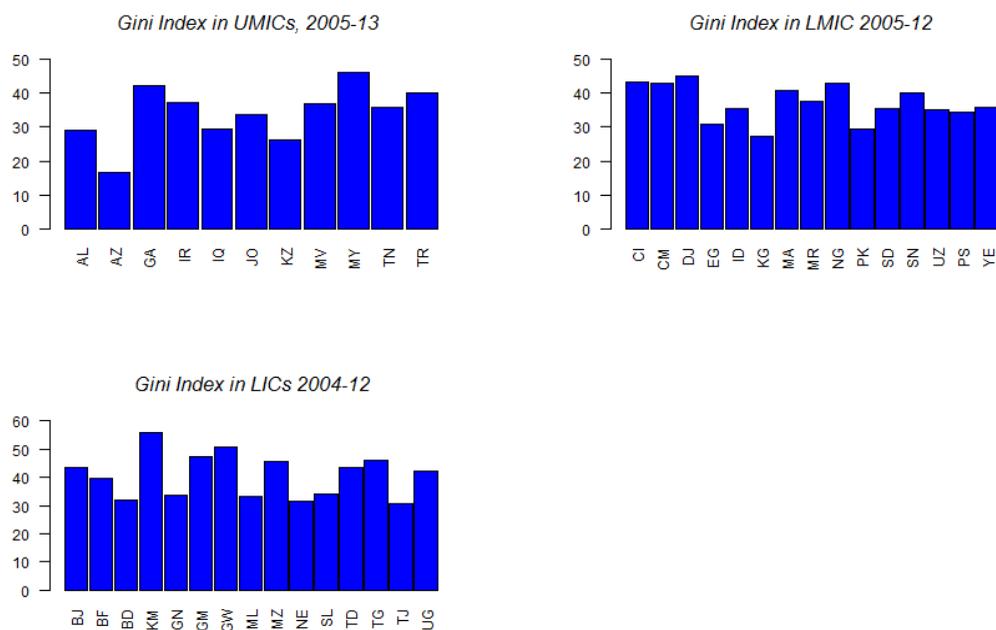
Scheme Country	Old Age, Disability, Survivor	Work Injury	Unemployment	Sickness and Maternity	Family Allowances
Djibouti	X	X	N/A	X	X
Egypt	X	X	X	X	N/A
Guyana	X	X	N/A	X	X
Cameroon	X	X	Severance pay	X	X
Mauritania	X	X	N/A	X	X
Morocco	X	X	X	X	X
Palestine	?	?	?	?	?
Sudan	X	X	Severance pay	X	N/A
Yemen	X	X	N/A	X	N/A
Indonesia	X	X	N/A	X	N/A
Pakistan	X	X	N/A	X	Social assistance
Uzbekistan	X	X	X	X	X
Cote	X	X	N/A	X	Employment

d'Ivoire					t-based
Nigeria	X	X	N/A	X	N/A
Senegal	X	X	N/A	X	Employment-based
Krygyz Republic	X	X	X	X	X

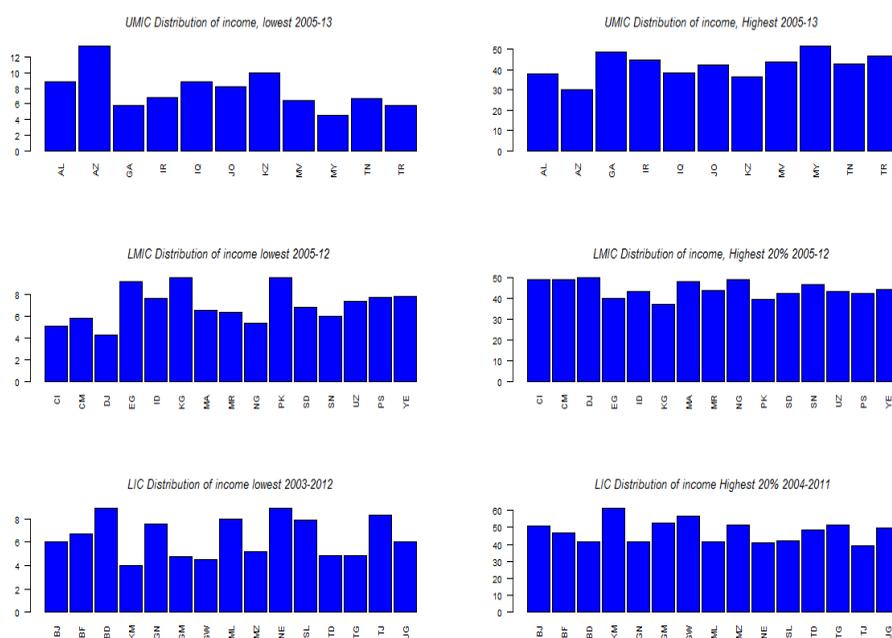
Social Insurance Schemes in Low Income Countries (mainly for Employed Persons and Public Sector Workers) (ISSA Website, Country Profiles)

Scheme Country	Old Age, Disability, Survivor	Work Injury	Unemployment	Sickness and Maternity	Family Allowances
Comoros	?	?	?	?	?
Somalia	N/A	N/A	N/A	N/A	N/A
Afghanistan	N/A	N/A	N/A	N/A	N/A
Bangladesh	X	X	N/A	X	N/A
Tajikistan	X	N/A	X	X	X
Benin	X	X	N/A	X	X
Burkina Faso	X	X	N/A	X	Employment-based
Chad	X	X	Severance pay	X	X Employment-based
Gambia	X	X	Severance pay	X	N/A
Guinea	X	X	N/A	X	X
Guinea-Bissau	Employee social insurance legislation in progress				
Mali	X	X	Severance pay	X	X
Mozambique	Old Age	N/A	N/A	N/A	N/A
Niger	X	X	N/A	X	X
Sierra Leone	X	X	N/A	X	N/A
Togo	X	X	N/A	X	X
Uganda	X	X	Severance pay	X	X

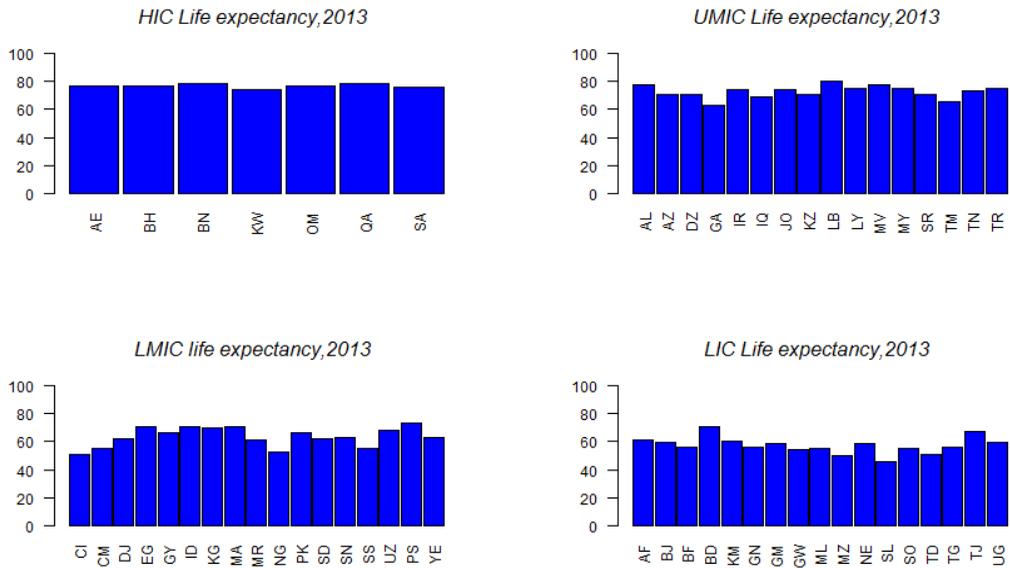
Annex 5: Gini Index and inequality in OIC countries



Inequality measured by the share of income/consumption among the highest and lowest 20% of the population

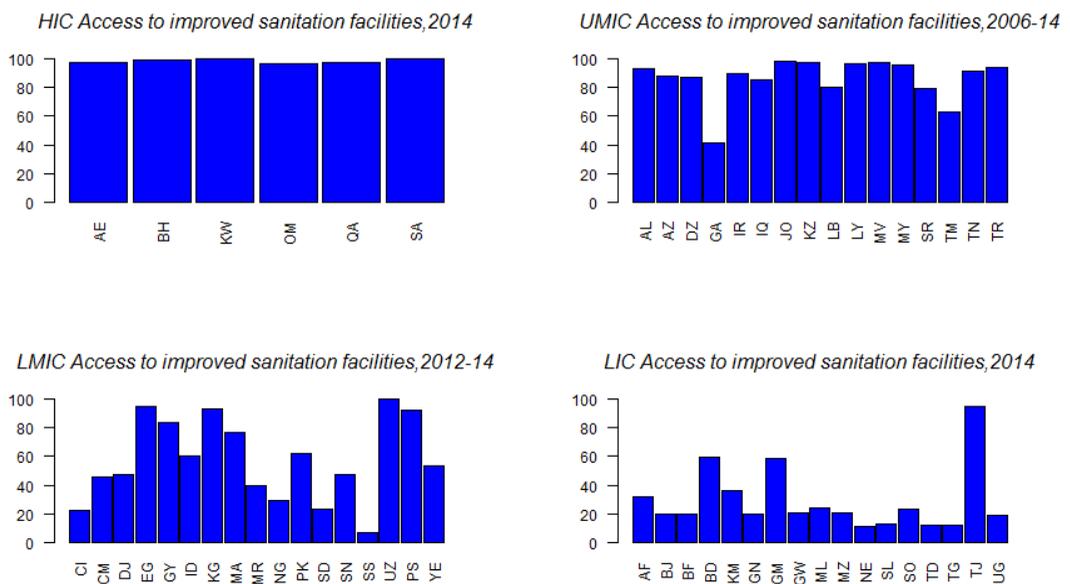


Annex 6: Life expectancy



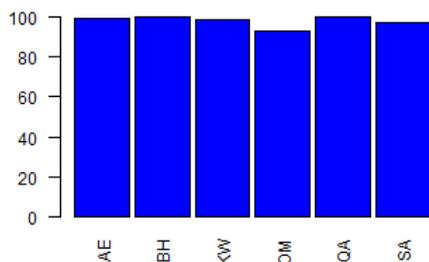
Annex 7: Access to water and sanitation

Access to Sanitation

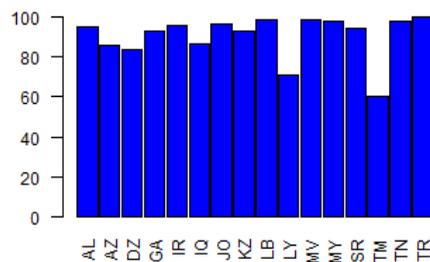


Access to Water

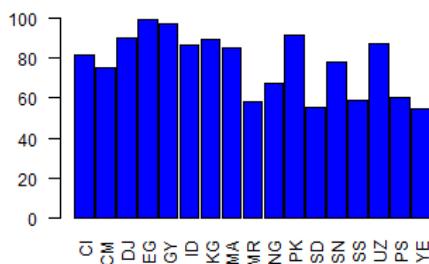
HIC Access to an improved water source, 2014



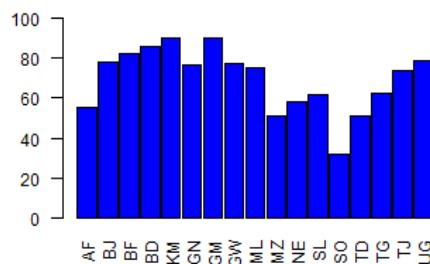
UMIC Access to an improved water source, 2014



LMIC Access to an improved water source, 2012-1



LIC Access to an improved water source, 2014



Annex 8: Country codes

High Income Countries

Bahrain	BH
Kuwait	KW
Oman	QM
Qatar	QA
Saudi Arabia	SA
United Arab Emirates	AE
Brunei Darussalam	BN

Upper-middle Income Countries

Algeria	DZ
Iraq	IQ
Jordan	JO
Lebanon	LB
Libya	LY
Tunisia	TN
Albania	AL
Azerbaijan	AZ
Iran	IR
Kazakhstan	KZ
Malaysia	MY
Turkey	TR
Turkmenistan	TM
Suriname *	SR
Gabon	GA
Maldives	MV

Lower-middle Income Countries

Djibouti	DJ
Egypt	EG
Mauritania	MR
Morocco	MA
Palestine	PS
Sudan	SD(SS)
Yemen	YE
Indonesia	ID
Pakistan	PK
Uzbekistan	UZ
Guyana*	GY
Cote d'Ivoire	CI
Nigeria	NG
Senegal	SN
Kyrgyz Republic	KG
Cameron	CM

Low Income Countries

Comoros	KM
Somalia	SO
Afghanistan	AF
Bangladesh	BD
Tajikistan	TJ
Benin	BJ
Burkina Faso	BF
Chad	TD
Gambia	GM
Guinea	GN
Guinea-Bissau	GW
Mozambique	MZ
Niger	NE
Sierra Leone	SL
Togo	TG
Uganda	UG
Mali	ML