Rome Wasn't Built in a Day

The accessibility of social protection for informal workers: a mapping of 5 West African countries

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Preface

This study was commissioned to the African Studies Centre (ASC) by CNV Internationaal, the international affiliate of the Dutch trade union CNV (*Christelijk National Vakverbond*). The report serves as a background document for the new four year programme (2013-2016) of CNV Internationaal funded through the Trade Union Co-Financing Programme (TUCP) of the Dutch Ministry of Foreign Affairs.

In preparation of the 2013-2016 TUCP programme CNV Internationaal held consultations with their partners during which the accessibility of social protection was mentioned as a priority area, specifically by West African trade unions. Building on these consultations CNV Internationaal decided to assist their partners in Niger (CTN), Guinea (CNTG), Togo (CSTT), Benin (CGTB & COSI) and Senegal (UDTS) in lobbying, advocating and networking for the extension of national social protection schemes to informal workers. The ASC was subsequently asked to conduct a mapping of the availability of social protection in these five countries, in particular focusing on the accessibility of informal workers to old age pensions, health care and insurance for occupational accidents and illness.

The study comprised of field work, carried out by four local researchers between 7 and 18 April 2014, and a desk study conducted by one junior and two senior researchers at the ASC. The ASC was in charge of the overall coordination of the research, the development of the questionnaires which formed the basis of the interviews and data collection on the ground, as well as the writing of the final research report. The field work encompassed interviews with CNV Internationaal's partners in each country, data collection through various governmental and non-governmental institutions and semi-structured interviews with key stakeholders (representatives of relevant Ministries, local NGOs and FBOs, informal workers organisations, the ILO country office and, in the case of Togo, the ITUC-Africa headquarters). The findings from the field were presented in five country reports drafted by the local researchers which have been integrated in this final report. As you will see the depth of the data differs from country to country, this is due to the difference in the availability of data on social protection in the countries under study.

The desk study entailed a literature review of key academic publications and reports of relevant (inter) national organisations, as well as a screening of relevant statistical data from the ILO and ISSA. An extensive bibliography is included in the annex.

Several persons contributed to the study, first and foremost the local researchers: Muhammed Ba (Senegal), Alpha Barry Bacar (Guinea), Issa Younoussi (Niger) and Pierre Zanou (Togo & Benin). Ms. Zjos Vlaminck (MSc), political scientist and research assistant at the ASC was in charge of coordinating the local research partners, conducting the literature review and writing the final report. Dr. André Leliveld and Dr. Marleen Dekker both economists and senior researchers at the ASC coordinated the study on behalf of the ASC and ensured the quality control of the report, while Ursula Oberst, information and documentation specialist at the ASC Library, provided literature searches and the bibliography.

For the issues raised in this report, we did not only consult the documents that were provided to us, but we benefited as much from interviews with representatives of ministries, trade unions, IWOs and civil

society such as NGOs and FBOs. We are very thankful for their inputs and comments. For the complete list of interviews per country we refer to annex 2 in this report.

We equally thank Ms. Marjolein Groenewegen, programme officer, responsible for the social protection theme at CNV Internationaal and Uzziel Twagalimana, CNV Programme Advisor for Africa and WSM Continental Programme Coordinator, for their support and advice.

Contents

Acronyms

AEO	African Economic Outlook
AFD	Agence Française de Développement
APE	Agents Permanents d´Etat Benin
ASC	African Studies Centre
AU	African Union
CADEMS	Cellule d'Appui au Développement des Mutuelles de Santé, Niger
CCPF	Caisse de Compensation des Prestations Familiales, Guinea
CGTB	Confédération Générale des Travailleurs du Bénin
CNSS	Caisse Nationale de Sécurité Sociale
CNTG	Confederation Nationale des Travailleurs de Guinee
CNV Internationaal	National Christian Trade Union, International
CMU	Couverture Maladie Universelle
COSI	La Confédération des Organisations Syndicales Indépendantes du Bénin
CSOs	Civil Society Organisations
CPI	Consumer Price Index
CPS	Centres de Promotion Sociales Benin
CPS	Caisse de Prévoyance Sociale Benin
CRT	Caisse de Retraite du Togo
CSTT	La Confédération Syndicale des Travailleurs du Togo
CTN	Conféderation Nigerienne de Travail
DAS	Direction de l'assistance sociale Senegal
DGPSSN	Délégation Générale de Protection Sociale et de Solidarité Nationale
DWA	Decent Work Agenda
ECOWAS	Economic Community of West African States
FBO	Faith-Based Organisation
(F)CFA	West African Franc
FGA	Fonds de Garantie d´Accident Benin
FNV	
FNR	Fond National de Retraite Senegal
GDP	Gross Domestic Product
GESS	Global Extension of Social Security
HDI	Human Development Index
HDR	Human Development Report
ICLS	International Congress of Labour Statisticians
IFIs	International Financial Institutions
ILC	International Labour Conference
ILO	International Labour Organisation
INAM	Institute National d'Assurance Maladie
INAMO	l'Institut National d'Assurance Maladie Obligatoire
IMF	International Monetary Fund
IPM	Instituts de Prévoyance Maladie Senegal
IPRAO	West African Social Insurance and Pensions Institute

IPRES	Institut de Prévoyance de Retraite du Sénégal
ISSA	International Social Security Association
ITUC	International Trade Union Congress
IWOs	Informal Workers' Organisation
MDGs	Millennium Development Goals
MSSB	Mutuelle de Sécurité Sociale au Benin
MFNS	Ministry of Family and National Solidarity Benin
NASSIT	National Social Security and Insurance Trust Sierra Leone
NHIS	National Health Insurance Scheme Ghana
NGO	Non-Governmental Organisation
PDS	Plan de Développement Sanitaire, Niger
PEST	Pre-Existing Systems Transition
PRIMA	Projet de Recherche sur le Partage de Risque Maladie
PRSP	Poverty Reduction Strategy Paper
PSSP	Productive Social Safety Nets Programme
RAMU	Régime de l'Assurance Maladie Universelle Benin
RSPC	Régime Simplifié pour le Petit Contribuable
SAPs	Structural Adjustment Plans
SMIG	Salaire minimum interprofessionel garantie
SNITT	Social Security and National Insurance Trust Ghana
SNECRM	Stratégie nationale d'extension de la couverture du risque maladie
SNDES	Stratégie nationale de développement économique et social
SNPS	Stratégie Nationale de Protection Sociale
SPF	Social Protection Floor
SPF	African Union Social Policy Framework
SRM	Social Risk Management
SSS	Services Sociaux Spécialisés Benin
ToR	Terms of Reference
TSP	Transformative Social Protection
TUCP	Trade Union Cooperation Programme
TUs	Trade Unions
UDHR	Universal Declaration of Human Rights
UDTS	Union Démocratique des Travailleurs de Sénégal
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations
WAMEU	West African Monetary Union
WFP	World Food Programme
WIEGO	Women in Informal Employment : Globalising & Organising
WO	World War
WSM	Wereld Solidariteit Mondiaal

Introduction

In March 2014 the ASC was commissioned by CNV Internationaal to conduct a mapping of the accessibility of social protection schemes for informal workers in five West African countries: Niger, Togo, Benin, Guinea and Senegal. This report is the result of this analysis. The terms of reference indicated that the study should answer the following questions:

1) Which social protection systems are in place in each country?
    - What is covered by the social protection schemes in the country?
    - Are these systems providing social protection for formal and/or for informal workers?
    - What number of informal workers has access to social protection?
    - Is there a legislation which permits informal workers to join the national social protection systems?
    - Is there a lobby at national level going on to make social protection accessible for informal workers?
    - What is the mechanism which is used: through Mutual Health Insurances (private) or through National (Government) Social Security Schemes (*caisses nationales*)?
    - Are there already linkages between Mutual Health Insurances and the national Social Security System?
    - Are there best practices of national Social Security Schemes covering informal workers? How does this work (mechanisms)?
    - Are there best practices of other social protection schemes which informal workers can access?
2) What is the role of CNV Internationaal's partner organisation in this scheme?
    - Are they a board member of the national social security system?
    - Or involved in (tripartite) dialogue concerning functioning of these schemes?
    - Which strategies/activities do they adopt to extend the accessibility of social protection?
3) Which (international and national) actors do lobby at national level to make social protection more accessible for informal workers in the country?
    - With which actors could we join forces in the coming future?
    - Are there institutions which offer funding for these initiatives?
4) Are there (research) documents which provide best practices regarding this theme (studies from ILO, ITUC, FNV, ACV, WSM) and which may orient us in the development of a (lobby) strategy for each country? This will include also studies in Ghana and Rwanda, two countries where strategies have been developed to open up the national Social Security System to informal workers.
    - Recommendations to improve the accessibility of the existing schemes for informal workers in each of the five case study countries.

To avoid confusion it is necessary to briefly classify the different social protection regimes that exist, before moving on to the specific interests of this report.

Depending on the definition of social protection that is adopted a wide variety of classifications can be found. The table below is therefore not the one-and-only categorisation, but hopes to serve as guide for understanding the social protection terminology that will be used throughout the report.

Table 1: Social Protection Regimes

Name	Description	Contributory/non-contributory	Beneficiaries
Social Assistance	Social assistance comes in many forms, such as social safety nets (e.g. exemption of medical fees for the most vulnerable groups); public work programmes and in-kind or cash transfers. They can be state-organized or by NGOs or international institutions.	The common dominator of social assistance schemes is that they are non-contributory. The schemes are funded by the state based on tax-revenues or by donors such as the World Bank which funds many social assistance programmes in Africa	Most social assistance programmes are targeted to specific population groups through means tests, which are developed to identify the most vulnerable people. These tests have different criteria depending on the social assistance programme. Some social assistance programs are however universal (e.g. all children between 0 and 5 have access to free health care in Senegal).
Social Insurance/social security	Social insurance schemes are organized by the state and controlled by public law and build on an employer-employee relationship. Most social insurance schemes protect the employee against loss of income due to life-cycle changes such as old age, maternity, illness, etc.	Social insurance schemes are contributory and in many African countries mandatory for private and public sector workers. Contributions are paid to the scheme by the employer (which for public enterprises is the state) and the employee.	Most social insurance schemes (although often open to informal workers) only reach public employees and workers in the formal economy because registration is generally based on a contract between an employer and an employee, which most informal workers lack.
Private Insurance	Private insurance schemes are organized	Private insurance schemes are based on	Private insurance schemes are on paper

	by private insurance companies or banks within a legal framework developed by the state. They are often complementary to social insurances schemes and provide protection against life-cycle changes or other risks.	voluntary contributions from the person who wishes to insure him-/herself against a certain risk (insurance companies are profit making enterprises so contribution rates are often high).	open to everyone (workers in formal/informal, private/public enterprises) but in Africa generally only reach a small group of wealthy individuals who can afford to pay the high contributions. Some insurance companies are however developing micro-insurance schemes in order to reach out to informal workers (see Senegal case).
Community-based/ or informal social protection	These schemes operate alongside solidarity networks based on principles of reciprocity within social networks, based on kinship, neighborhood, friendship, religious affinity, and so on. Common examples are funeral insurances, ROSCAs or *Tontines.*[1].	Members pay dues to the informal schemes on a voluntary basis and can count on solidarity mechanisms in times of need (community-based schemes are generally non-for-profit enterprises and have lower contribution rates).	Community-based schemes in general are accessible to a larger group than social or private insurance schemes. In Africa most informal workers rely on these types of schemes for social security. Membership is organized across family, community, occupational lines.
Les mutuelles de Santé	*Mutuelles* or mutual health insurance schemes are a mixed-category. They are community-based and	Beneficiaries pay contributions to the *mutuelles* in return for health care and benefits in the form of	In many African countries the *mutuelles* fill in the gap left behind by national health insurance schemes, which mainly

[1] *"Rotating savings and credit associations (roscas) or Tontines in French speaking countries are one of the most prevalent forms of informal financial institution in developing countries. The basic principle of roscas is almost the same everywhere. A group of people gather for a series of meetings. At each meeting, everybody contributes to a common pot. The pot is given to only one member of the group. This member is then excluded from receiving the pot in future meetings, while still contributing to the pot. This process is repeated until every member receives the pot"* (Ambec, 2013: 2).

	generally only provide health insurance.	subsidized medicines for instance. Some mutuelles also are supported by government/donor funding.	cover formal workers. They have a wider accessibility and in some instances informal workers' organizations have formed their own *mutuelles* (see e.g. Transvie).

Source: compiled by author

The aforementioned classification depicts the wide variety of social protection systems available.

Because CNV Internationaal wishes to assist their partners in "*reinforcing the national social protection systems by strengthening the role of trade unions as a watchdog and a partner in social dialogue in matters regarding the accessibility of social protection for informal workers",* this study will focus on national social insurance as well as schemes that have the potential of being scaled up and supported by government institutions (at national, regional or local level).

The ToR further instructed to focus on three issues which are particularly relevant for the world of work: old age pensions, insurance for occupational accidents and illness and health care.

In sum, the study will look into the schemes mentioned in the matrix below and forms the basis for the development of a lobby and advocacy strategy, for CNV Internationaal's partners in Niger, Senegal, Benin, Togo and Guinea, towards more accessible social protection.

Table 2: Priority Areas

	Social Assistance	Social Insurance	Private Insurance	Community-based/informal social protection[2]	Mixed-schemes [3]
Old age pensions					
Occupational accidents and illness					
Health care					

[2] The study will focus on those schemes that have the capacity to be scaled-up beyond the initial target group through the support of government institutions. Therefore, small scale family-based/kinship based social protection schemes fall beyond the scope of this study. This however does not mean that they are unimportant safety nets for many people in Niger, Guinea, Togo, Benin and Senegal (see Devereux & Getu, 2013).

[3] Mixed schemes combine elements from different social protection schemes (social-assistance, private/public insurance or informal).

***Best practices/* other schemes that are relevant for informal workers**					

Source: compiled by author

Based on the forgoing this report will be structured as follows. Chapters one and two will allow for a common understanding of informal workers and social protection, respectively. The chapters will entail a brief description of the different views on informal workers, as well as social protection in Africa, based on the history of interpretations of both concepts. Subsequently, the report is divided into chapters per country with the following sub-sections: socio-political and economic context, existing social protection schemes, old age pensions, insurance for occupational accidents and illness, health care and conclusions and recommendations. Chapter 6 provides insights from social protection schemes in Ghana, Rwanda as a reference point. The last chapter will draw general conclusions and recommendations for improving the accessibility of social protection for informal workers and the role of CNV Internationaal's partners therein.

1. Informal Employment

1.1. Defining informality

Since the concept of informality was coined by Keith Hart in 1972 it has been attributed a plurality of meanings (Sindzingre, 2006). Depending on the theoretical lens that is adopted informality may refer to anything between an illegal economic activity (il-legalist school), a survival strategy (dualist school), a structural element of the capitalist economic system (structural school) or a micro-entrepreneur's choice of avoiding cumbersome bureaucratic procedures (legalist school) (WIEGO, 2014). A distinction can also be made between definitions which take an employment approach, and those based on enterprise characteristics; the latter being most often used. Scholars now widely agree that there is no linear relationship between informal and formal economies. Rather there exists a complex, fluid dynamic between both, with articulations of the formal economy in the informal economy and vice-versa (Sindzingre, 2006). People increasingly engage in both spheres simultaneously, based on their own preferences and incentives, or as a coping mechanism (Siegmann & Schiphorst, 2014). The informal economy therefore is a vibrant part of economy and society, covering a diversity of activities and actors - ranging from big entrepreneurs to small self-employed, and from quasi-formality to extreme informality (Sindzingre, 2006).

Due to its wide acceptance and conceptual clarity we have opted to follow the ILO's comprehensive definition of informality, which captures the diversity of informal employment. According to the definition an informal worker is someone who "*carries out a job which is not subject to national legislation or income taxation and has no entitlements to social protection or employment benefits, in a*

formal sector enterprise, informal sector enterprise or household" (ICLS, 2003 in Hussmanns, 2003). Hence informal workers can thus be understood as anyone classified in groups 1 to 10 in table 3 below.

Table 3: Conceptual Framework Informal Employment (ICLS, 2003)[4]

Production units by type	**Jobs by status in employment**								
	Own-account workers		Employers		Contributing family workers	Employees		Members of producers' cooperatives	
	Informal	Formal	Informal	Formal	Informal	Informal	Formal	Informal	Formal
Formal sector enterprises					1	2			
Informal sector enterprises (a)	3		4		5	6	7	8	
Households (b)	9					10			

Source: ICLS, 2003 in Hussmanns (2003)

1.2. The state of informality in Africa

In many Sub Saharan African countries, including West-Africa, the informal economy constitutes more than 80 % of the workforce, a figure that has steadily increased over the last three decades. Fine et al. (2012) estimate that over the past ten years, Africa's labour force has expanded by 91 million, but only 37 million of the new entrants were employed in wage-paying jobs. Two million joined the ranks of the unemployed, and the majority—some 52 million people—turned to subsistence activities to earn an income. The growth of the informal economy in Africa can be related to the structural adjustment plans of the 1980s (SAPs) which lead to mass redundancies in the public and private sector and budget cuts in governments' social spending. More recently, increased casualization, flexibilization and global and African market restructurings – informed by neo-liberal policies – have contributed to above developments, further blurring the divide between formal and informal work. Several investigations in various African countries observe a rising trend in non-standard and non-permanent employment relations such as temporary work, fixed term contracts, seasonal work and outsourcing or subcontracting (Theron, 2011).

[4] a) As defined by the Fifteenth International Conference of Labour Statisticians (excluding households employing paid domestic workers). (b) Households producing goods exclusively for their own final use and households employing paid domestic workers. Note: Cells shaded in dark grey refer to jobs, which, by definition, do not exist in the type of production unit in question. Cells shaded in light grey refer to formal jobs. Unshaded cells represent the various types of informal jobs (ILSC, 2002)

So, the assumption that informality is a characteristic of economically less-advanced countries which will fade away once higher levels of economic development are reached, has been refuted by the reality on the ground (Heintz & Valodia, 2008). Informality seems to be here to stay.

Due to the fact that informal workers constitute the majority of the labour force in Africa and will most probably continue to do so for a long period of time, trade unions increasingly acknowledge that they need to address labour issues of informal workers as well. Literature also suggested that the legitimacy of African trade unions depends on their ability to reach out to workers in informal employment (Booner & Spooner, 2011). This not only strengthens their bargaining power towards the government, as informal workers represent an important electoral mass (TUCP 2013-2016), but also allows them to enhance their connections with grassroots, clearing their reputation as "representatives of the formal few" (Mosoetsa & Tshoaedi, 2013). Expanding services, such as social protection, to informal workers has been promoted as an effective way of attracting new members, as well as a moral obligation following the solidarity principles on which the global union movement is based (Kalusopa et al.,). Service delivery activities however frequently face financial problems due to the low amount of membership fees that informal workers can provide and the limited budget African unions generally have (Kalusopa, et al, 2012). Faced by these challenges some unions have sought alternatives, opting for cooperating with service delivery NGOs for instance (Spooner, 2007). Others believe it is the government's responsibility to provide basic social protection for its population. The mapping in this report focuses on the latter of both alternatives and aims to investigate how and to what extent unions can push their governments to take up responsibility and provide social protection for their population which – according to article 22 of the Universal Declaration of Human Rights – is their universal right.

The report thus focuses on the third pillar of the Decent Work Agenda or the right of all workers, formal and informal, to social protection (ILO, 2002). In the following chapter we will elaborate on this concept, its interpretations, significance and trends in Africa.

2. Social Protection

2.1. Defining Social Protection: a literature review

Similar to the concept of informality, social protection has been attributed a fair share of interpretations and meanings over the last three decades (Holmes & Lwanga-Ntale, 2012). Depending on the development mantra of the time it has been promoted as a way to cushion the externalities of the SAPs (Jacob, 1987), a tool for poverty reduction (Holzmann & Jorgensen, 2001), a prerequisite for decent work (Coleman, 2011) and, most recently, an instrument to achieve societal change (Devereux & Sabatas-Wheeler, 2004; Adesina, 2012). This diversity of definitions has to a certain extent hollowed out the concept and consequently, problematized the operationalization of social protection (Devereux & Sabatas-Wheeler, 2004). To enable a better understanding of how social protection is framed in this study we will briefly discuss the four previously mentioned approaches.

Adjustment with a human face

In the late 1980s social protection gained wide attention as part of the Social Dimension of Adjustment or "adjustment with a human face", coined in the 1987 UNICEF annual report (Jacobs, 1987). By that

time the International Financial Institutions (IFIs), as well as the UN, had come to recognize the detrimental social consequences of structural adjustment programmes (SAPs) in developing countries and by 1986, the then just retired IMF-director, Jacques Larosiere stated that "*adjustment that pays attention to the health, nutritional and educations requirements of the most vulnerable groups in society is going to protect the human conditions better than adjustment that ignores them* (in Jacobs, 1987), hereby acknowledging that a sole focus on budget deficit management and macro-economic stabilization was not going to improve the lives of the poor. Social protection was put forth as a cushion for the detrimental social effects left behind by the SAPs in many developing countries. However, instead of restructuring the orthodox foundations of structural adjustment, adjustment with a human face was promoted and "*involved the use of safety nets to address the social costs of adjustment*" (Adesina, 2012: 456). Furthermore social protection was based on strict targeting of the "deserving poor" (Devereux & Sabatas-Wheeler, 2004: 3). In practice social protection took the form of safety nets for those failing to become "economically-active", and increased public spending on education and health. Poverty was perceived to be residualist, or a condition that would be automatically resolved once a certain level of economic growth was reached, so in the meantime the "deserving poor" were supported through free health care and education programmes (Holmes & Lwanga-Ntale, 2012: 13).

Poverty reduction and Social Risk Management

In the early 2000s Social Risk Management (SRM) emerged as the new way of approaching social protection and was actively promoted as such by key development institutions, the World Bank in particular (Devereux & Sabatas-Wheeler, 2004). Holzmann & Jorgensen's (2001: 530) define social protection as "*public interventions to (i) assist individuals, households and communities to better manage risks and (ii) provide support to the critically poor".* Unlike the earlier conceptualizations of social protection, SRM takes into account preventive measures or as Holzmann & Jorgensen (2001: 530) phrase it, "*spring-boards for the poor*". Poverty is interpreted as vulnerability to shocks (Adesina, 2012: 457), both natural and man-made, in line with the thinking of poverty as a multi-faceted problem (Holzmann & Jorgensen's, 2001: 531). The SRM framework not only enables the poor to cope with shocks but also hopes to enable the poor to become more risk-taking and "*thus provides the opportunity to gradually move out of poverty*" (Holzmann & Jorgensen's, 2001: 531). Another addition of SRM to traditional social protection thinking is the attention for non-state social protection providers, such as informal and market-based actors and institutions (Holzmann & Jorgensen's, 2001: 542). Most recently the 2014 World Development Report characterized risk management as encompassing: insurance, coping, protection and knowledge strategies. Through this comprehensive framework the World Bank hopes to provide an analytical framework to both prevent and cope with risks (World Bank, 2013).

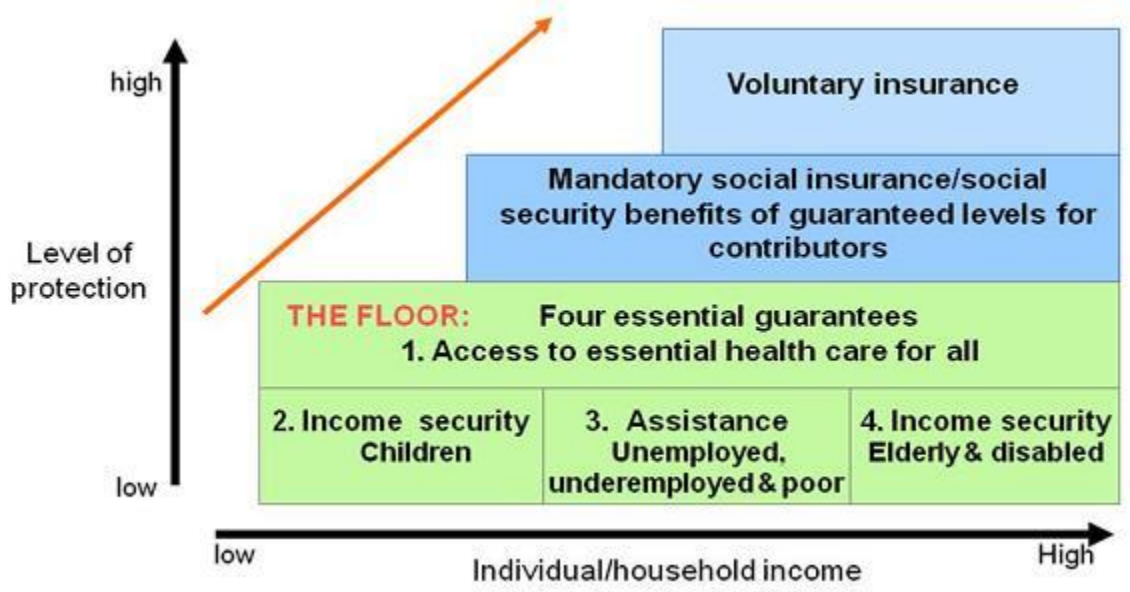
Although SRM is a welcome improvement to the narrow "targeted safety-nets" approach of the 1980s and 1990s, it has been heavily critiqued by scholars for its limited economic-conceptualization of vulnerability, its neglect of the chronic poor, its focus on public and market-based social protection strategies, the limited role of the government and its uncritical stance towards the neoliberal paradigm which "maladjusted" many African economies in the first place (Devereux & Sabatas-Wheeler, 2004: 6-8; Mkandawire, 2005 in Adesina, 2012: 459). Despite these shortcomings donors still very much push

SRM and it is remarkable how well African government officials speak the SRM-lingo when discussing issues of social protection (Devereux & Sabatas-Wheeler, 2004:6).

Social protection as a sine qua non for Decent Work: A rights-based approach

In the meanwhile the International Labour Organisation (ILO) followed a parallel path when it comes to social protection policies. In 1952 social security was enshrined as one of the core labour standards through the adoption of convention 102, following article 22 of UDHR, which states that each member state should provide basic social security in the form of: medical care, illness benefits, unemployment benefits, old-age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits and survivor's benefits (C102, ILO 1952). The ILO thus actively supports a rights-based approach to social protection wherein the state is obliged to guarantee social protection for its citizens and citizens in return can claim their rights and entitlements (Holmes & Lwanga-Ntale, 2012: 13). Initially, social protection was geared towards (formal) work and income related risks and limited to social security and social insurance schemes, which aren't adapted to the reality in many developing countries with a largely informal labour force. The ILO made a shift in 2004 with a milestone report "Economic Security for a Better World". Although the title might suggest the opposite the authors promote a comprehensive conceptualization of security, which goes beyond income security and encompasses labour market security, employment security, security of work and skills, job security and finally voice representation security (ILO, 2004). Another shift came about due to the Decent Work agenda (DWA), which is applicable for all workers including those in informal employment. The DWA thus accentuated the need to expand the conceptualization of social protection and so the ILO became an active promoter of the social protection floor (SPF) initiative which was endorsed by the United Nations Chief Executive Board in 2009. The SPF was officially adopted by ILO members during the International Labour Conference (ILC) in June 2012 and has a two dimensional strategy: (1) providing a universal minimum level of income security and basic health care for all and (2) progressively higher levels of security based on ILO social security standards. Much emphasis is placed on the role of the government as the primary provider of social protection and the importance of social dialogue as a way to ensure its effectiveness. Furthermore the extension of social protection does not proffer a one-size-fits-all approach, but leaves the operationalization of both dimensions to the respective governments (ILO, 2012).

Figure 1: Social Protection Floor



Source: Extending Social Security to All. A Guide through challenges and options, ILO, Geneva, 2010

Transformative Social Protection

Most recently, a progressive interpretation of social protection has emerged which does not only address the symptoms of fluctuating incomes but tries to understand and mitigate the root causes of economic, and more importantly, social vulnerabilities. Transformative Social Protection (TSP) therefore places much emphasis on empowerment and "*policies that relate to power imbalances in society that encourage, create and sustain vulnerabilities*" (Devereux & Sabatas-Wheeler, 2004: 9). According to Devereux & Sabatas-Wheeler's (2004: 9) TSP framework "*social protection is the set of all initiatives; both formal and informal, that provide: social assistance to extremely poor individuals and households; social services to groups who need special care or would otherwise be denied access to basic services; social insurance to protect people against the risks and consequences of livelihoods shocks; and social equity to protect against social risks such as discrimination or abuse"*. Building on SRM, transformative social protection takes into account a broad range of interventions which can be categorized as protective, preventive, promotive and transformative. A recent World Bank study considers the objectives and functions of social protection in terms of equity (protecting against destitution), resilience (insuring against impacts of different risks) and opportunity (promoting human capital and access to productive work) (World Bank, 2012), whereby 'opportunity' reflects the promotive and transformative functions of the TSP framework.

Adesina (2012) argues that Devereux & Sabatas-Wheeler, and in extension the latest World Bank framework, stopped at a half way build house by refraining from critically questioning the neoliberal paradigm in which their approach is vested. According to Adesina (2012), social protection cannot and should not be seen as an isolated intervention towards inclusive development, rather it is part and parcel of a set of social policies which according to him should be vested in equality and solidarity in

order to achieve societal change. Although Adesina's (2012) perspective is normative he does make an important link between social protection and inclusive development, which will be elaborated below.

2.2. Social protection and inclusive development

In the last decade many African economies have shown unprecedented growth rates, which have raised optimism about Africa's economic future and its ability to raise the standards of living of its people. Between 2001 and 2012 the top 10 of fastest growing economies contained 6 African countries, namely Angola, Niger, Ethiopia, Chad, Mozambique and Rwanda. These figures however say little about the distribution of wealth, social development and inclusiveness. In fact, 6 out of 10 of the most unequal economies are also located in Africa, notably, South Africa, Namibia, Angola, Lesotho, Central African Republic and Sierra Leone (AfDB, 2012). Due to the global economic crisis, the fragility of economic growth and income security has been accentuated, boosting a renewed interest in social protection as a means "*to protect household incomes and stabilize aggregate demand"* (Coleman, 2011: 7). After a period as *lonely neighbours,* wherein there was little dialog between both policy spheres, it seems that scholars and policy makers alike have come to realize that inclusive growth and social protection go hand in hand. In fact, social protection is increasingly perceived to be an important, though challenging, stimulator of inclusive development, especially in times of recession (Coleman, 2011 & Kalusopa et al., 2012). Social protection can lead to inclusivity in the short term by reducing income and non-income poverty, decreasing inequality and increasing access to labour markets and basic services. In the long term, it can support economic growth by stimulating domestic demand and productivity, may improve the quality of governance by building stronger institutions and may decrease intergenerational poverty (Szirmai, 2012). These processes pass through various transmission channels at a household, community or national level (Barrientos, 2012). These dynamics have changed the general perceptions of social protection, as more and more governments view social protection as an investment rather than a cost (Videt, 2014).

2.3. Global and African initiatives to boost Social Protection

The last decade has seen a proliferation of initiatives, memoranda, conventions and institutions concerned with the extension of social protection schemes. The following table presents some of the key initiatives and declarations relevant for Africa.

Table 4: Social Protection Initiatives

Name	Date	Initiators	Description
Conférence Interafricaine de la Prévoyance Sociale (C.I.P.R.E.S.)	1993	Ministries of Finance of the francophone West-African countries	CIPRES was installed to function as governing body of all National Social Security Schemes (CNSS). 11 West African countries ratified the treaty.

Global Campaign for the extension of social protection	2001	ILO	At the ILC in 2001 ILO member-states reaffirmed the importance of SP as a human right and in 2003 the global campaign for the extension of SP was launched.
Ouagadougou Declaration and Plan of Action on Employment Creation and Poverty Alleviation	2004	AU	The Ouagadougou Declaration and Plan of Action (POA) have the overall aim to empower people, open opportunities and create social protection and security for workers through building a people-oriented environment for development and national growth.
Livingstone Call for Action	2006	AU	Social protection programmes, including social transfers and cash transfers, when combined with other social services, directly reduce poverty and inequality. Importantly it was agreed that a sustainable basic package of social transfers is affordable within current resources of governments and with support from development partners.
Social Policy Framework for Africa	2008	AU	The SPF focuses, in no particular priority, on 18 key thematic social issues: population and development; labour and employment; Social Protection, health; HIV/AIDS, TB, malaria and other infectious diseases; migration; education; agriculture, food and nutrition; the family; children, adolescents and youth; ageing; disability; gender equality and women's empowerment; culture; urban development, environmental sustainability, the impact of globalisation and trade liberalization in Africa and good Governance, Anti-Corruption and Rule of Law.
Declaration for Social Justice and Fair Globalization	2008	ILO	At the ILC in 2008 all member-states acknowledged the right to a basic income and other objectives of the Philadelphia Declaration.
Africa Platform for	2008	CSOs	The APSP's main objective is to support the

Social Protection			development of effective national social protection policies and programmes and thereby contribute to the achievement of the Millennium Development Goals and the goals of the African Union Social Policy Framework (SPF).
Social Protection Floor Initiative	2009	UN (with WHO and ILO leading the initiative)	The Chief Executive Board of the UN adopts the SPF as a one of the Joint Crisis Initiatives.
Yaoundé Tripartite Declaration	2010	ILO	During the 2nd African Decent Work symposium the member-states adopted the Yaoundé Tripartite Declaration on the Implementation of the SPF.
Vancouver Commitment	2010	ITUC	Trade unions committed themselves to support the ILO in their efforts to achieve SPF for all.
World Bank Social Protection Strategy 2012-2022	2012	World Bank	The strategy provides a unified vision for social protection and informs the choice of instrument, financing mechanisms and institutional arrangements for social protection.
SPIREWORK	2013	ECOWAS & AU	In 2013 ECOWAS and the African Union (AU) committed itself to create a Social protection plan for workers in the informal economy and those in the rural areas by formalizing existing institutional frameworks and establishing a legislative or regulatory structure based social protection for various sector.

Source: compiled by author based on Kalusopa et al. (2014)

2.4. The state of Social Protection in Africa

Similar to historical social protection systems in the rest of the world, Africans traditionally relied on their extended family to provide assistance for income reduction or loss due to life cycle changes such as old age, disability or illness (Kalusopa et al., 2012).

Due to the increased intensity of globalization and urbanization, traditional family ties – which did not provide universal coverage – are fading and institutionalized social protection systems have, as of yet, not been unable to fill in the gap, a situation which Sen (1981: 31) labeled the *pre-existing systems*

transition or PEST[5]. These shortcomings were further aggravated by the implementation of social protection schemes by the colonial bureaucracies which were copies of the schemes the colonial powers were accustomed to at home. So, French colonies inherited mandatory contributory social insurance schemes which provided work injury, family and child benefits, as well as old age pensions, disability and survivor grants and health-care. The English colonies on the other hand were left with social security institutions which covered a reduction of income due to retirement, disability or death. These schemes were based on the prerequisite of a labour market with a large number of salaried workers, as was the case at the time in France and the United Kingdom. Needless to say, this was not the reality in the African colonies, were salaried work was an exception and most people were own-account or family workers (Diop, 2003).

Pension schemes in Francophone West Africa

The labour code, which was ratified by the French Government in 1952, allowed the creation of The West African Social Insurance and Pensions Institute (IPRAO) in former French West Africa by 1958. The voluntary scheme was open to all private-sector employees by collective agreement between employers and workers' organizations. After independence some members withdrew from the IPRAO but in Senegal it survived and was renamed IPRES in 1978 (Diop, 2003; Gruat, 1990).

Despite increased recognition of the importance of social protection – exemplified by the various initiatives mentioned above – coverage is low, benefits insufficient, administration troublesome and the share of government budgets allocated to social protection unsatisfactory (Kalusopa et al., 2012). In comparison, many Latin American countries have since the debt crises in the 1980s and 90s, developed broad-based social protection schemes such as the Bolsa Familia program in Brazil, which covers about 44 million Brazilians (Ferreire & Robalino, 2010). In what follows we will briefly discuss the main challenges related to social protection in Africa.

Low coverage

In Sub-Saharan Africa the overall coverage rate of social security schemes is about 6%, compared to a global average of 25% (Forteze et al., 2010 in Kalusopa, 2012: 31). Parallel to the shrinking formal economy, coverage rates are declining in many countries as national social security schemes are based on mandatory contributory schemes inherited from colonial bureaucracies. According to the literature, several factors make the contributory social insurance schemes incompatible with the African reality and specifically the large and growing informal labour force (Kalusopa, 2012). First, they are based on an employer-employee relationship, wherein both parties pay fees to the scheme. Most informal workers

[5] PEST is "*the phase of economic development after the emergence of a large class of wage labourers but before the development of social security arrangements is potentially a deeply vulnerable one"* (Devereux & Sabates-Wheeler, 2004: 15).

however are self-employed and therefore have to carry the burden of both contributing parties (Ginneken, 2003). Second, the fees are often too high for informal workers; most make such small profits that they are not able or willing to invest in social insurance from which no immediate benefits will be derived (Ginneken, 1999). Thirdly, the flexible and highly mobile nature of informal employment make it difficult to install a well-functioning insurance system as it makes collecting contributions as well as paying benefits cumbersome. Lastly, the fact that informal workers have volatile employment statuses and change jobs quite often poses challenges for the transmission of insurance from one employment to another. Many African countries do not have the administrative capacity to make this possible. In this study we will investigate whether these challenges ring true in the five case study countries we have studied.

Due to these difficulties some scholars argue that non-contributory social assistance systems are better equipped to reach out to informal workers (Leliveld et al., 2010), this however poses financial and targeting problems, which will be discussed below.

Benefits

When it comes to social protection benefits ISSA's 2011 report on Africa mentions two key features: adequacy and quality. Both are important indicators of a programme's effectiveness and can possibly enhance popular support for social protection programmes. Adequacy is often measured in monetary terms and in that sense refers to the sufficiency of a cash benefit to foresee in a decent standard of living. This however is a rather narrow approach as some benefits come in the form of in-kind services, such as food subsidies and others serve longer term goals, such as increasing gender equality, which cannot be measured on a monetary scale. Each social protection programme must thus come with an appropriate adequacy measure. In Kalusapo's et al. (2012) review of social protection systems in Africa most countries offer low benefits which are insufficient to provide a decent living.

The ISSA 2011 Africa report mentions three levels on which the quality of social protection programmes can be analysed: the legal framework, the national political strategy and the strategic approach towards quality insurance at the level of social security institutions. All levels can be measured through client satisfaction. Haddad et al. (1998) conducted a study in two communities in Guinea in which they aimed to capture local perceptions on the quality of health care. According to their respondents the following criteria are important measures of quality (1) technical competence of the health care personnel; (2) interpersonal relations between the patients and care providers; (3) availability and adequacy of resources and services; (4) accessibility and (5) effectiveness of care (Haddad et al., 1998: 381).

In conclusion we can state that quality should not only be measured in material terms but also personal relationships between health care providers and patients are important. Quality management and customer satisfaction inquiries across all these scales must be upgraded in most African countries in order to increase the effectiveness of health services.

At present the quality of services are often not up to standards – health care centers for instance do not always have enough medicine and medical equipment to provide professional treatment – attributing to public skepticism regarding the usefulness of social insurance schemes (Kalusapo et al., 2012).

Administration and management of social security schemes

In most African countries public trusts manage the public schemes. Francophone countries typically have a CNSS, managed by a governing body with a tripartite structure with representatives from the government, employers' associations and trade unions. Anglophone countries have similar institutions such as SNITT in Ghana and NASSIT in Sierra Leone. In some countries private funds exist next to the public ones and public-private partnerships are also on the rise. Enterprise-based provident funds on the other hand are managed by trade unions or an elected team. Kenya for example has a well-developed infrastructure of brokers, fund managers and insurance companies (Kalusopa et al., 2012: 39-40).

As indicated above, African social protection schemes are characterized by weak administrative performance generally caused by poor record keeping, lack of incentives for board members and corruption. The high administration costs are another important obstacle for sound management. In some countries, such as Ghana, up to 20 % of the contributions are spent on overhead costs. The lack of up-to-date data hampers the processing of claims and delays payments. Although the ILO and ISSA continue to support African governments in implementing sound administrations the road is long and the challenges significant (Kalusopa et al., 2012: 40-41).

Government's social spending

The political commitment to social protection can be measured on the basis of national social protection expenditures. Although the World Social Security Report 2010-2011 stated "*there are practically no systematically collected data which would indicate not only the expenditure on such schemes, but also numbers of beneficiaries and effective coverage in terms of percentages of target groups reached*" (ILO, 2010: 74 in Holmes & Langa-Ntale, 2012: 19), the ILO's Social Security Inquiry (SSI), allows us to compile data on public social expenditures as a percentage of GDP as shown in the table 5 below[6]. These figures include spending on health care and education. According to the SSI data the majority of the countries reach the social expenditure standard, of 4.5 %, set by the African Union in the 2008 Social Policy Framework for Africa. Furthermore the large differences between countries and regions are noteworthy; in general North African countries have higher levels of social spending as a percentage of their GDP and on average West African countries score worst. If we only look at the social protection expenditure on benefits for working age population, as shown in table 6, the picture is less rosy. Firstly, data on social protection expenditure is only available for a select number of counties. Secondly, the amount spent on social protection for the working age population is low. Southern African countries, South-Africa, Angola and Botswana are amongst the five highest spenders and Cote d'Ivoire, perhaps surprisingly, ranks the best of all Sub Saharan African countries. The table 7 presents public expenditure on old age and survivor pensions. In general these are higher than spending of social protection for the

[6] The SSI was developed by the ILO in 2005 to *collect, stores and disseminates comparable statistical data on social security worldwide* (see http://www.ilo.org/dyn/ilossi/ssimain.home?p_lang=en to access the entire database). The data in table 6 has been compiled based on the figures mentioned in the worldwide overview (See http://www.ilo.org/dyn/ilossi/ssimaps.mapIndicator2?p_indicator_code=E-1c). For more statistics on social protection schemes, laws and rgulations visit http://www.ilo.org/dyn/sesame/ifpses.socialdbexp .

working class population. No general trends can be derived from the figure, no region scores particularly better then another.

Table 5: Public Social Expenditure in Africa

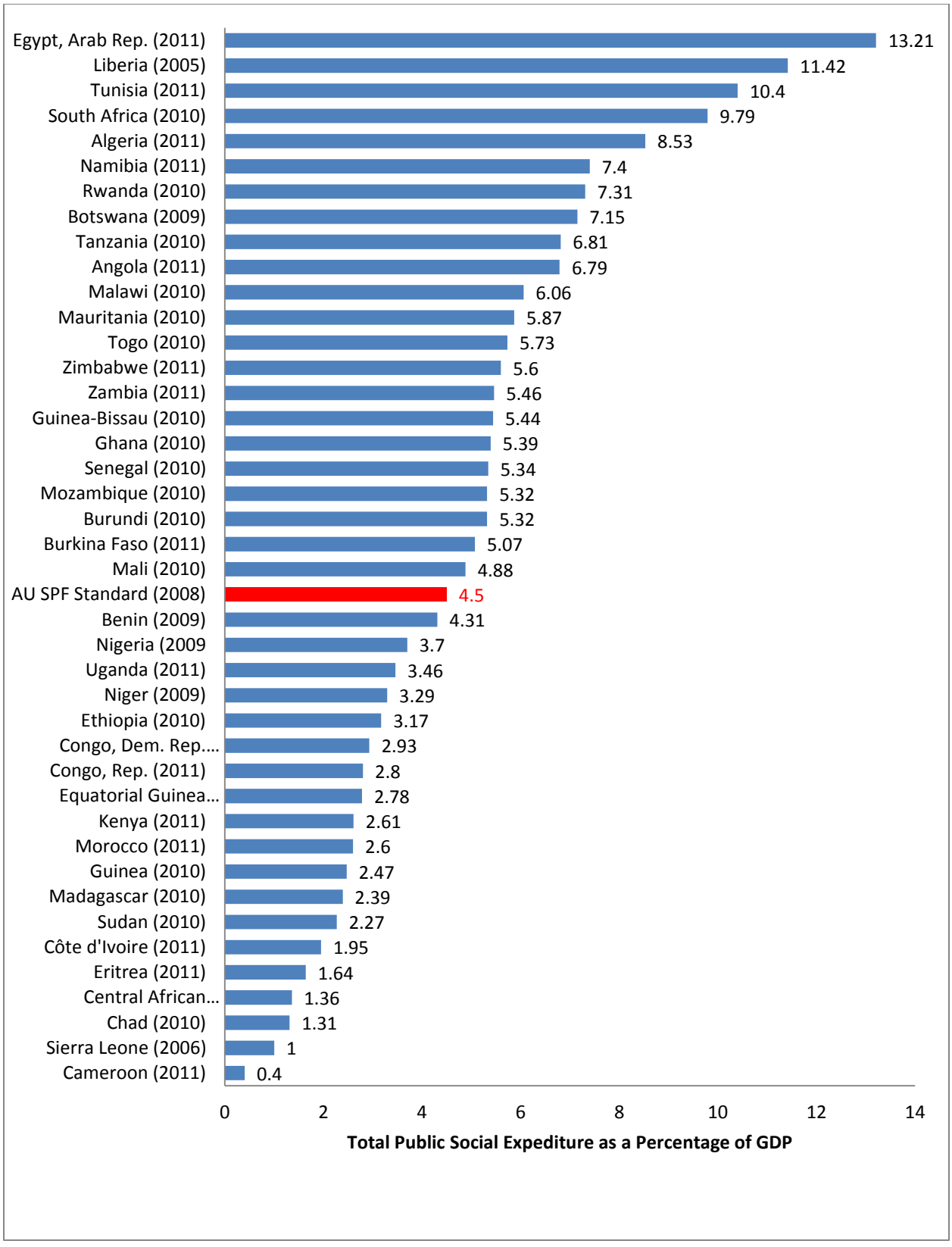
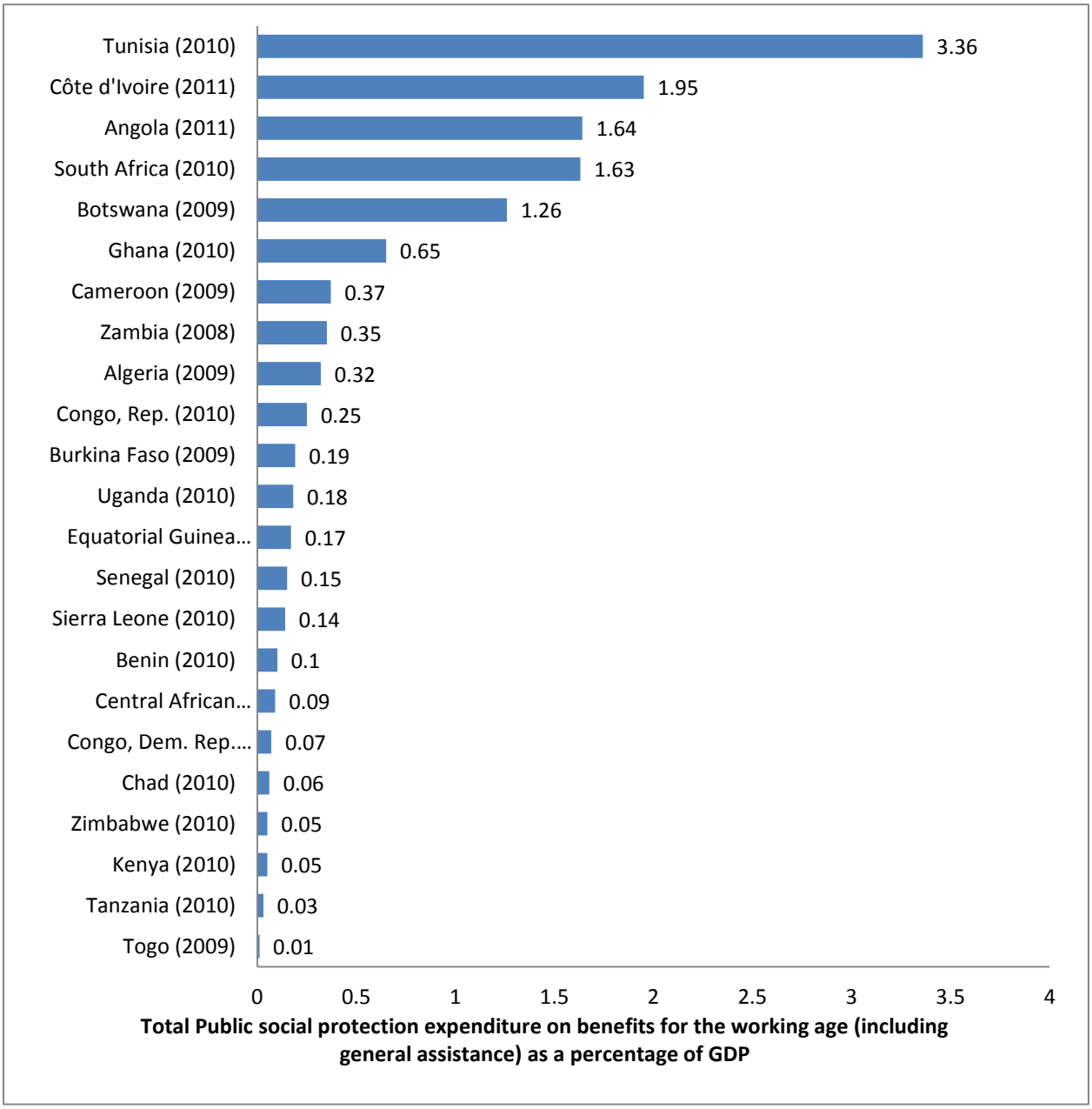
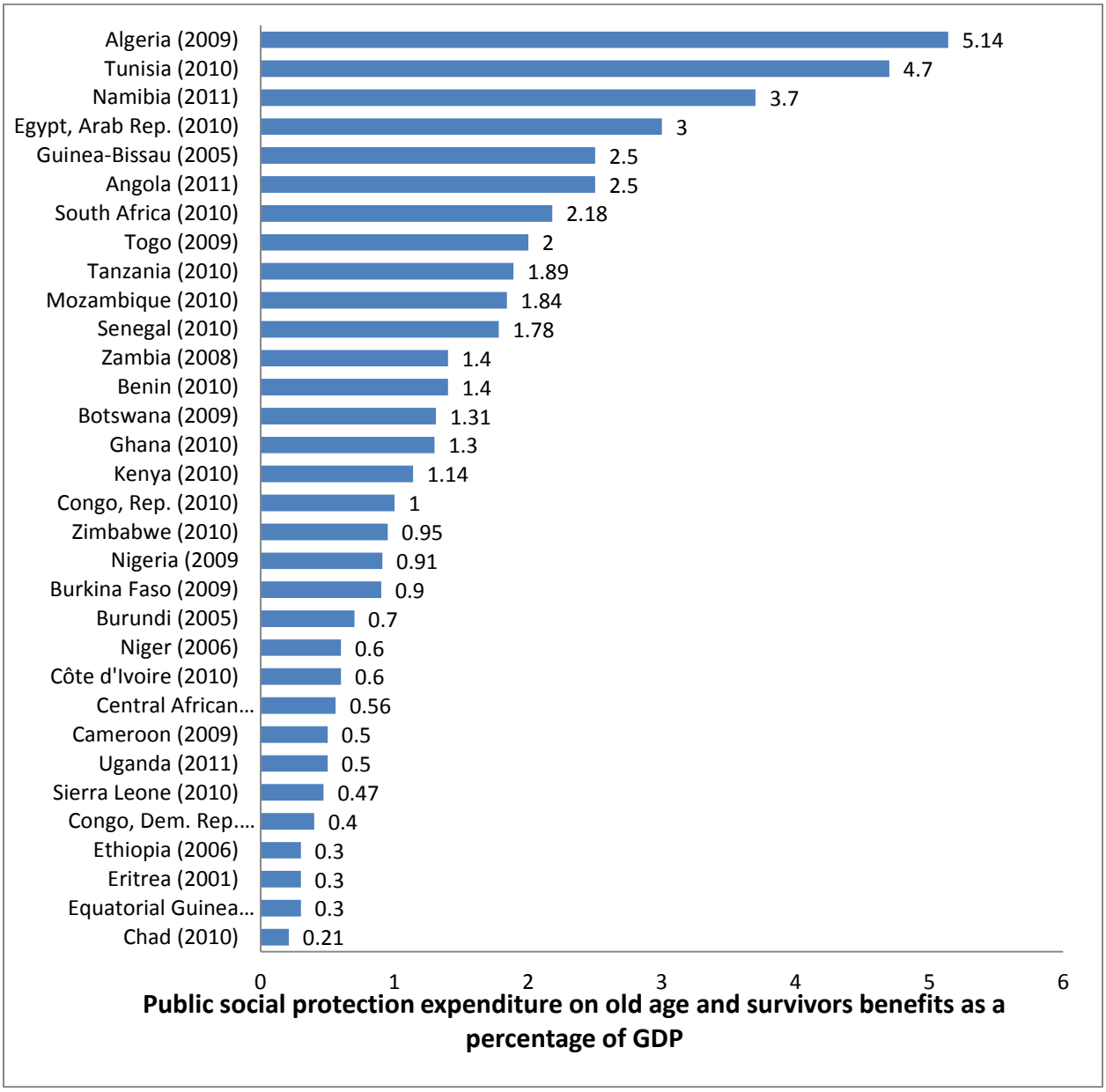

Egypt, Arab Rep. (2011) 13.21
Liberia (2005) 11.42
Tunisia (2011) 10.4
South Africa (2010) 9.79
Algeria (2011) 8.53
Namibia (2011) 7.4
Rwanda (2010) 7.31
Botswana (2009) 7.15
Tanzania (2010) 6.81
Angola (2011) 6.79
Malawi (2010) 6.06
Mauritania (2010) 5.87
Togo (2010) 5.73
Zimbabwe (2011) 5.6
Zambia (2011) 5.46
Guinea-Bissau (2010) 5.44
Ghana (2010) 5.39
Senegal (2010) 5.34
Mozambique (2010) 5.32
Burundi (2010) 5.32
Burkina Faso (2011) 5.07
Mali (2010) 4.88
AU SPF Standard (2008) 4.5
Benin (2009) 4.31
Nigeria (2009 3.7
Uganda (2011) 3.46
Niger (2009) 3.29
Ethiopia (2010) 3.17
Congo, Dem. Rep.... 2.93
Congo, Rep. (2011) 2.8
Equatorial Guinea... 2.78
Kenya (2011) 2.61
Morocco (2011) 2.6
Guinea (2010) 2.47
Madagascar (2010) 2.39
Sudan (2010) 2.27
Côte d'Ivoire (2011) 1.95
Eritrea (2011) 1.64
Central African... 1.36
Chad (2010) 1.31
Sierra Leone (2006) 1
Cameroon (2011) 0.4
0
2
4
6
8
10
12
14
Total Public Social Expediture as a Percentage of GDP

Table 6: Total Public social protection expenditure on benefits for the working age



Source: compiled by author based on ILO's Social Security Inquiry

Table 7: Expenditure on old age and survivor pension



Source: compiled by author based on ILO's Social Security Inquiry

3. What this report is about

In conclusion, despite the long tradition of social protection in Africa and the numerous policies and frameworks that have been developed, African governments are still struggling to create social protection programmes that are accustomed to the characteristics of African labour markets. Despite the efforts of the African Union to create a social policy framework (SPF, 2008) and stress the importance of extending protection to informal workers (SPIREWORK, 2013), the political efforts of most African governments have not exceeded making paper commitments to the cause. In similar vein,

Holmes & Lwanga-Ntale (2012), argue that the social protection agenda is very much driven by international donors, with their own priorities; In order to secure funding, African governments try to please each donor and therefore most African countries lack a coherent national social protection strategy (Ethiopia is one of the few countries that has been able to harmonize donor priorities through a national social protection strategy). Although, in general, significant progress has been made with regards to health care and education, other social protection branches such as insurance for occupational accidents and illness are paper commitments with little tangible results. African countries should furthermore increase their efforts in compiling up to date labour market data, as specifically workers in informal employment are often not found in national statistics. In order to develop tailored social protection strategies, which can reach out to the majority of African workers in informal employment, having a statistical picture of the labour force is essential.

Building on these insights, the remainder of this report will entail 5 case studies in which we will discuss social protection landscapes in Guinea, Niger, Senegal, Togo and Benin. To recapitulate we will focus on three focal themes, namely, old age pensions, insurance against occupational accidents and illness and health care provided by five types of social protection schemes: social assistance, social insurance/security, private insurance, communal/informal schemes and *mutuelles de santé* (see Table 1 above for a description of the various schemes).

CHAPTER 1: Guinea

1. Setting the scene

1.1. Socio-political context

Guinea is an illustrative case of a country which has not managed to transform its natural wealth into sustainable inclusive growth, whereby a decent living for the entire populations can be ensured. This chapter will briefly discuss Guinea's political climate in relation to the Guinean labour market and trade unionism. For a detailed depiction of the Guinean political history and socio-economic landscape we kindly refer to the CNV Internationaal context study, "Guinea at the Crossroads: A labour rights perspective", writing by Kaag et al. (2013).[7]

Guinea gained independence from France in 1958, two-years prior to its Francophone counterparts, after an abrupt and violent decolonization. Sékou Touré, a unionist and founder of the first West African trade union centre, led the decolonization struggle and founded a single-party socialist state. Touré's dictatorship, which ended with his death in 1984, was characterized by ethnic conflicts, violent oppression (approximately 50 000 people died during his regime), economic deterioration and diplomatic isolation. Conté, who took over power in 1984 installed a liberal economy (in line with two SAPs, notably in 1996 and 1998) but was far from politically liberal and ruled in similar vein as Touré. After a two year military junta, between 2008 and 2010, led by Moussa Dadis Camara, the first elections were held in 2010. Although the elections – won by Alpha Condé, leader of the opposition party *Rassemblement du peuple de Guinée* (RPG) – marked the end of approximately 50 years of dictatorship, Guinea is a long way from being a consolidated democracy (Kaag et al., 2013). The relatively free and fair parliamentary elections in 2013 however have raised hopes for sustained political stability (AEO Guinea, 2014).

As political actors the Guinean trade union movement also suffers from the political instability. The leaders of CNTG, CNV Internationaal's partner, have been the victims of intimidations and oppressions during 2011 and 2012. These are clear violations of the International Labour Organisation's (ILO) core conventions 87 and 98 on the freedom of association and collective bargaining ratified by Guinea. Nonetheless, negotiations of the social partners have resulted in the instalment of a general minimum wage for workers in Guinea on 14 December 2012, which is a first step towards a more significant role for Guinean unions in policy making proceses (Kaag et al., 2013).

[7] For a more detailed depiction of the socio-economic and political context of Guinea see Kaag et al. (2013).

Trade Union Rights

Right to Organise: Guinean workers have the right to organize and there is an anti-union discrimination law which prohibits discrimination against unions but the law does not foresee any measures to insure this.

Right to strike: Although on paper unions are allowed to strike in practice the law encompasses several restrictive requirements: many sectors are described as "essential services" are thus prevented from striking. Many strikes are also called unlawful because their objective is not recognized a lawful reason for holding a strike.

(ITUC, Survey of Violations of Trade Union Rights, 2010a)

1.2. Economic analysis: Huge potential, limited returns

Guinea is one of the richest West African countries when it comes to mineral resources, namely bauxite, iron ore, gold and diamonds. It also has a highland fertility but the returns on this natural wealth have been piecemeal. The capital insensitive extraction industries create little job opportunities and the revenues are not invested into social expenditures, which have become increasingly important in light of Guinea´s demographic changes (Manlan, 2014). The population has experienced rapid growth between 2007 and 2012, with an average annual growth rate of 3,1%. There is also a considerable youth bulge, 22% of women and 23% of men are between 15 and 19 years of age.

Since 2009 progress has been made in macro-economic terms but the GDP growth dropped from 3,9% in 2012 to 2% in 2013, due to the political unrest caused by the postponement of the parliamentary elections and a decrease in mining investment (see table 8). Furthermore, the government has not been able to address the budget deficits which raise questions about the stability of the economy. For the majority of Guineans the situation remains destitute as 55,2% of the people live in poverty (Manlan, 2014). The social problems can also be measured through the low score on the HDI. Guinea is ranked 178 out of 187 countries and makes very little progress on all indicators (HDR, 2013).

Table 8: Macro-economic indicators Guinea

	2012	2013(e)	2014(p)	2015(p)
Real GDP growth	3.9	2	4.2	4.3
Real GDP per capita growth	1.3	-0.5	1.7	1.8
CPI inflation[8]	15.2	11.9	9.9	6.8
Budget balance % GDP[9]	-3.2	-5.2	-2.5	-0.4
Current account balance % GDP[10]	-33.9	-20.2	-18.3	-24.7

Source: estimates (e) and projections (p) based on authors' (Manlan, 2014) calculations

[8] CPI Inflation measures the inflation based on the Consumer Price Index: a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and service.

[9] Budget balance is the overall difference between government revenues and spending.

[10] Current account balance compares a country's net trade in goods and services, plus net earnings, and net transfer payments to and from the rest of the world during the period specified. These figures are calculated on an exchange rate basis.

Kaag et al. (2013) state that: "*in 2011 the Guinean workforce is depicted to be 4.6 million. Around 45,8 % of the Guinean workforce is estimated to work in the agricultural sector. The industry and commerce sector is estimated to be 18% and services 6%. The informal economy is the largest economic sector, and it is estimated to cover about 65 to 85% of the Guinean workforce and to account for 45% to 65% of the Guinean GDP. Informal work is most common in the agriculture sector (agriculture, livestock, fishing, and forestry), wholesale and retail trade, passenger transport and construction. Working conditions in the informal sector are extremely poor; most workers do not have contracts, have little job security and no protections under the law"* (Rio Tinto Simandou, 2012 in Kaag et al., 2013: 14). Against this backdrop developing effective social protection systems is essential. The natural treasures, such as bauxite, furthermore create an opportunity for financing national social security systems. The following section will zoom in on the state of social protection in Guinea. Which systems are in place and how well do they reach out to informal workers?

Table 9: Employment figures Guinea

	2002			**2007**			**2012**		
Employment									
	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Public employee	18.8	1.1	4.9	13.3	1.0	4.0	16.4	1.4	5.4
Microbusiness employee	5.5	0.3	1.4	5.9	0.4	1.8	9.5	1.3	3.5
Employer	1.8	0.8	1.0	1.3	0.4	0.7	2.0	0.8	1.1
Independent agriculture	4.8	51.9	41.9	6.4	60.0	46.7	10.0	58.6	45.8
Independent non-agriculture	66.2	8.7	20.9	53.1	9.4	20.3	49.5	9.2	19.8
Other dependent	2.9	37.2	29.9	20.0	29.8	26.5	12.6	28.7	24.4
Total	100	100	100	100	100	100	100	100	100

Source: INS 2012 (Calculations based on EIBEP-2002, ELEP-2007 and ELEP-2012) in Kaag et al. (2013)

2. Social Protection

In the following we will discuss the state of social protection in Guinea, followed by a mapping of the existing social protection schemes in the field of old age pensions, occupational accidents and illness and health care. For an overview of the available social security statistical data as well as key legislation and the ratification of key ILO conventions, please see annex 2.

2.1. The state of Social Protection in Guinea

Compared to other African countries there is a lack of information on social protection in Guinea. Most documents on social protection in general are ILO programme reports or evaluations or reports on the progress made with regards to the Bamako initiative, which will be discussed in more detail below. The following is therefore to a large extent based on the context study by Kaag et al. (2013) as well as the field data collected by Alpha Barry Bacar, our local research partner.

As discussed in the introduction statutory social security in many West African countries find their roots in the *Code du Travail des Territoires Français d'Outre Mer* – or the Overseas Labour Code – which was developed by the French government in 1952. In Guinea the law resulted in the creation of the *Caisse de Compensation des Prestations Familiales* (CCPF). In the beginning the CCPF only provided family benefits for employers of state-led enterprises and the colonial administration. Benefits in case of work-related accidents or illness were added in 1959. Finally, in 1960 the *Caisse nationale de sécurité sociale* (CNSS) was created and old age pensions, disability benefits, as well as health care were added.

The CNSS still exists today and is the sole provider of formal social security in Guinea. It is administrated by an Administrative Council (*Conseil d'administration*) consisting of 10 members: two members representing the Ministry of Social Affairs, one representative of the Ministry of Finance, one representative of the Ministry of Health, three members representing the employers' organisations, and three members representing the trade unions (CNSS website in Kaag et al., 2013)[11].

The CNSS is a mandatory contributory social insurance scheme, which includes eight out of the nine minimum social security standards indicated in the C102 ILO convention, namely: old age benefit, disability benefit, occupational accidents benefit, illness benefit, maternity, child care, health care and survivors benefit. Unemployment benefits are not provided by the CNSS. The scheme is financed through employer and employee contributions. About 23% of a wage is paid to the CNSS with a maximum of 200 000 GNF per month.

The CNSS covers all employees in the public and private sector registered in the labour code, which in theory is open to formal and informal workers. The labour code however adopts a narrow definition of labour and workers can only be registered if they can prove a contractual employer-employee relationship. The labour code therefore discriminates against most informal workers who either are own-account workers or have an employer but no legal contract to prove it. To a certain extent this shortcoming was addressed by specifically including domestic servants, workers in agriculture, as well as apprentices, interns, and students at technical schools, as target beneficiaries of the CNSS (ISSA website country profile Guinea). Nevertheless, only approximately 3% of the Guinean population is covered by formal social protection schemes.

Table 10: Social Protection Schemes in Guinea

[11] http://www.cnss.org.gn

	Old age	Survivor	Disability	Occupationnal accidents and illness	Child benefits	Maternity benefits	Health care	Unemployment	Cash/in-kind transfers
CNSS	x	x	x	x	x	x	x		
Mutuelles							x		
PSSP								x	x

The weaknesses of the CNSS have been drawn up by the ILO, which evaluated the statutory social security schemes of CNSS in 2001. The evaluation (ILO, 2002) came to the following conclusions:

- The CNSS is incapable of increasing its coverage despite a growing population.
- The administrative costs have increased to 20% of the contributions, leaving fewer funds available for the payment of benefits.
- There have been problems with the payment of benefits due to a lack of effective control mechanisms
- The pension fund has large deficits, mainly caused by an unfavourable demographic composition (the dependency ratio is 86% (GESS country profile Guinea) [12])
- Unnecessary and corruption-strife medical evacuations[13] have furthermore put a strain on the health care budget

The general inefficiency of the CNSS led to a significant lag on the payments of benefits at that time (2001) and despite recommendations of the ILO the CNSS was not able to improve its functioning[14]. Kaag et al. (2013) identified similar obstacles adding that the "*scheme shows a lot of difficulties: administrational, legal, statutory and normative shortcomings leading to bad governance practices, financial problems, a feeble service level, and the exclusion of a substantial part of the salaried workers".*

Due to the political instability Guinea has witnessed since its independence, the social assistance programs are less developed than in other countries with a more stable political history. There is one social safety nets programme worth mentioning, namely the Productive Social Safety Nets Programme (PSSP) financed by the World Bank and approved in May 2012[15]. As the name of the programme indicates, PSSP does not only provide protection against income loss but also hopes to generate asset creation. The programme encompasses three strategies: *(i) implement a labour intensive public works*

[12] Population aged 14 or younger plus population aged 65 or older, divided by population aged 15-64.
[13] There have been examples of local doctors demanding unnecessary evacuations which entail large costs (transport, flights, etc.).
[14] For more details of the ILO evaluation please consult the evaluation report "*Guineé : rapport du gouvernement : évaluation actuarielle du régime géré par la Caisse nationale de sécurité sociale au 31 décembre 2001*. Geneva, BIT (2004).
[15] For more details on the PSSP please see World Bank 2012

program (LIPW) and life skills development in urban areas targeted at youth to rehabilitate and construct critical urban infrastructure and create short term employment; (ii) pilot a cash transfer project to improve human capital in rural areas; and (iii) strengthen the institutional capacity of the government to design and coordinate social safety net interventions. The programme targets 200.000 urban youths in the country's regional capitals and costs approximately 25 million dollars (World Bank, 2012). Yet, it must be noted that PSSP is very donor driven as none of the respondents interviewed by Alpha Barry Bacar mentioned its existence.

2.2. Recent Reforms

According to Kaag et al. (2013) the recently drafted National Social Protection Policy (*Politique nationale de protection sociale*) is an improvement of the institutional framework as it explicitly targets the informal sector. Among its aims are organizing and supporting of the informal sector in developing income generating activities, among other things through microfinance programmes. In addition, putting in place health insurance schemes, to which, within 5 years' time, 50% of the informal sector should adhere, with an enlargement of coverage to 80% in 10 years' time (*Projet de document de Politique nationale de protection sociale 2012*). In general, the social protection coverage should be extended to the entire Guinean population by 2025 (Kaag et al., 2012). In the new policy document, special attention is also devoted to particularly vulnerable groups, such as children, elderly, people with a physical or mental handicap, chronically ill people, including those with HIV/AIDS.

The latest poverty reduction strategy paper (PRSP) also accentuates the necessity of social protection as a means to increase households´ resilience (PRSP III 2013-2015). The fourth strategic axis of the PRSP III deals with social services and social protection. According Alpha Barry Bacar (2014) specific attention is giving to safety nets and employment policies (e.g. Youth Employability).

It is also worth mentioning that a new labour code was adopted by the government in 2014 and, most recently in April 2014, a general strike was held in order to pressurise the government in issuing a decree which would stipulate the attribution, organisational structure and management system of the *l'Institut National d'Assurance Maladie Obligatoire* (INAMO), which would provide health insurance for civil servants.

Despite these promising policy initiatives, Kaag et al. (2013) conclude that "*in a state in which basic human and legal security and democratic rights are not assured, it is difficult to see how the extension of social protection to all categories of the population is feasible and even a real priority for the government, other than for winning votes".*

2.3. Financing Social Spending

It is clear that the implementation of the aforementioned National Social Protection Policy necessitates the increase of financial resources destined to social protection, both at the level of the state and at the level of the population. Its implementation was therefore explicitly considered in the framework of the Poverty Reduction Strategy Paper (PRSP) II and III, which leading principles is the promotion of economic growth on the basis of a solidarity economy, in other words: inclusive economic growth (Kaag et al.,

2012). Nevertheless social spending, including health and education in Guinea only amounts to 2,47% GDP in 2010 (see table 5).

Pal (2005) calculated that universal basic social protection is affordable for Guinea. According to his modeling exercise the Guinean government could finance a basic social protection package (universal old age and disability pensions, health care, child benefits and basic education), entirely based on domestic revenues by 2032 if it were to spend one third of its national budget on social protection (Pal, 2005: 22). Although interesting from a hypothetical point of view, Pal's (2005) study does not take into account the political economy of social protection schemes. At the end of the day the government has to have the political will to prioritize social protection, an issue that will be discussed in more detail below.

3. Focal Themes

In what follows we will zoom in on the three focus themes outlined in the ToR: old age pensions, insurance for occupational accidents and illness and health care, respectively. The analysis is largely based on the data collected by our local research partner Alpha Barry Bacar, recent academic literature on these subjects is limited.

3.1. Old Age Pensions

The CNSS provides a bulk-sum old age benefit for all public and private sector workers registered under the labour code, which have at least worked 15 years. Employees who have worked more than 30 years can receive an old age pension. The benefits, however, are very low which makes a number of civil servants turn towards private insurance companies for an old age pension insurance. For most employers this is out of the question as their low salaries do not allow complementary insurance. Additional shortcomings of the formal pension schemes provided by the CNSS include the irregularities of payments, the long waiting hours for receiving the pension (particularly inconvenient for old people who are often not in good health), and the fragmentation of payments. In addition, the non-functional tripartite Administrative Council of the CNSS decreases the potential of improving the pension schemes. In sum, we may say that the old age pensions in Guinea do not offer sufficient security for loss of income due to old age for the majority of Guineans.

Most Guineans thus rely on community, kin or family ties at old age. It is generally so that younger generations take care of the older ones but these traditional systems have not been institutionalised and *mutuelles* do not specifically address old age pensions, although their health care services are of course accessible for people of old age as well. While elderly people (over 65 years) only constitute 4,5% of the population, or 508,500 people, they need extra attention as they are often a marginalised and neglected category. Explicit attention should be given to their risks and needs in formal and informal social protection schemes.

3.2. Occupational Accidents and Illness

The CNSS provides benefits for work related injuries and illness for all public and private sector workers registered under the labour code. However – partly due to the discriminatory nature of the definition of a worker according to the law – only 3% percentage, of the active population in Guinea has access to

formal social insurance schemes for these risks. In addition the level of protection provided by the CNSS is piecemeal. There is a lack of medical infrastructure, a shortage of medication and an absence of re-education programmes and assistance after severe work-related injuries or illness. Nonetheless Alpha Barry Bacar, argues that the availability of an institutional framework at least provides a basis for rebuilding a more inclusive formal social insurance system for work related accidents and injuries.

In practice, Guineans mostly count on traditional solidarity mechanisms or mutual health insurance schemes when confronted with occupational accidents or illness. A good example of such a *mutuelle* is the Mutuelle Hadja Rabiatou Sérah Diallo.

Mutuelle Hadja Rabiatou Sérah Diallo

This *mutuelle* was created in 2006 and holds the name of the retired Secretary General of the CNTG. The *mutuelle* has approximately 3845 members and 32 service points (Noyau de solidarité) which offer services to workers affiliated to transport and mechanics union of the Ratoma community in Conakry. The *mutuelle* is entirely financed by the members, who pay a contribution of 1500 GNF (or 0,16 euro) each month. Affiliates include drivers, mechanics, sheet metal workers, painters, traders and street-sellers which sell their goods near to stations or garages. Although the mutual insurance scheme lacks a sound judiciary framework the *mutuelle* has been able to provide significant social services, specifically when it comes to occupational accidents and illness. In addition help is also provided for loss or reduction in income due to marriage, decease or children. At present the *mutuelle i*s also building a health clinic.

3.3. Health care

Formal health care systems through the CNSS

As we mentioned above, the CNSS only provides health care for private and public employees which are registered under the labour code. Furthermore the benefits for civil servants provided by the CNSS are very low according to Kaag et al. (2012). Public servants therefore create *mutuelles de santé* per ministry, professional group or office location, such as the *mutuelle nationale des douanes, to which* 600 families in Conakry and 1200 in the whole country are subscribed (ISSA country profile Guinea in Kaag et al., 2012), because subscription is based on registration in the labour code the mutuelle in the public sector are in practice not accessible for informal workers.

Due to the limitations and the small coverage of the CNSS most Guineans rely on alternative systems, such as solidarity among kin and within the village or urban neighbourhood, and support through religious and professional networks. They may also participate in communal informal organizations such

as credit and savings associations (tontines) or in communal health insurance initiatives. The *mutuelles* are based on five principles: voluntary admission, solidarity amongst members, non-for-profit organization, democratic management and the self-sustainability and independence. Because research has indicated that *mutuelles de santé,* are the most important providers of health insurance for informal workers in Guinea we will zoom in on their strength and weaknesses.

The Bamako Initiative and the importance of community ownership

Studies on health care in Guinea have mostly been conducted throughout the 1990s in relation to the Bamako initiative[16]. These studies mainly focus on the effectiveness of community financing of basic health care (Levy-Bruhl et al., 1997) and local perceptions of the quality of health care centers (Haddad et al., 1998). Regrettably, there is little known about the "Bamako" health centers at present. Based on interviews with key stakeholders, Alpha Barry Bacar, concludes that the *mutuelles* are not equipped to provide health care services to the entire Guinean population (regrettably data on coverage and contributions was not available). There is an urgent need for more sensitization, income generating activities and the training of health care providers.

The Bamako Initiative

The Bamako Initiative which was adopted by African ministers of Health in 1987 aimed to increase access to primary health care, through the implementation of integrated minimum-health-care packages by community health centres. The focus was on meeting the basic health needs of communities through access to drugs and regular contact between health-care providers and communities. Communities were directly involved in the management and funding of essential drug supplies through village committees. Community financing was implemented to capture a fraction of the funds households were already spending in the informal sector and combine them with government and donor funding to revitalize the health services and improve their quality (UNICEF).

Out of interest in the reasons behind the declining membership to community-financing schemes for health centres – as promoted by the Bamako initiative – the Institute of Tropical Medicine in Antwerp conducted an insightful action research project, PRIMA—*Projet de Recherche sur le Partage de Risque Maladie,* between 1996 and 2000. PRIMA followed the set-up and implementation of a *Mutuelles de*

[16] http://www.unicef.org/sowc08/docs/sowc08_panel_2_5.pdf

Santé from start to finish in order to gain understanding of the influencing factors for subscription to a *mutuelles de Santé.*

Criel et al., (2002) concluded that in contrast with the general assumptions, African people are not per definition risk-averse. PRIMA identified the bad quality of services as the main reason for the limited subscription to *mutuelles.* The study argued that beneficiaries understand and appreciate the idea of insurance schemes and the benefits of solidarity mechanisms across traditional lines. According to Criel et al. (2002) the problem however arises during the implementation of these mutual insurance schemes. Respondents mentioned that the core reasons for non-subscription are: the mistrust in the management system – in particular if the *mutuelles* was perceived to be linked to the state; the lack of resources and the poor quality of care. Another finding relates to the importance of community-ownership. People in general appreciated the *mutuelles* established by PRIMA because of its genuine participatory set-up. From the start the communities were involved and the intensive preparation phase of more than a year was highly valued. It gave the community members a sense of ownership. This lack of sense of ownership has been identified as one of the core causes of the failure of the Bamako health centers which were created throughout the 80s and 90s. Although the Bamako Initiative is based on the principle of participation, the scheme was so centralized and institutionalized, that it hampered local creativity and many people withdrew from the schemes because they didn´t feel respected or heard within the health care system by the state or health care providers. Against this background private *mutuelles* are a welcome alternative but Criel et al. (2002) clearly state that *mutuelles* are also not magic bullets which automatically lead to increased health care accessibility. The schemes must be implemented and controlled in close cooperation with local communities, in order to ensure well-functioning quality services and attract many subscribers (Criel et al., 2002).

4. Conclusions and recommendations

It is easy to lose focus when reading all the initiatives and policy documents issued by the Guinean government related to social protection. It seems that social protection is at the centre of the political debate and it is recognized that a profound restructuring is necessary to make the existing schemes compatible with characteristics of the Guinean labour market. If we place these political statements against the socio-economic reality for most Guineans the commitments become rather unrealistic. The aforementioned labour rights violations and the fragile (according to some researchers, e.g. Docking 2002, collapsed) state institutions depict a political-economy which does not place social protection, in particular for informal workers, high on the political agenda. In practice the contributory social security schemes managed by the CNSS are not accessible to informal workers and the majority of workers resort to traditional safety nets within their family or *mutuelles* if they are confronted with a loss of income due to old age, work related accidents or health problems.

Nevertheless, hope can be derived from the recent success booked by trade unions in setting a minimum wage. This exemplifies that unions have not entirely been placed outside the political playing field despite the general oppressive climate. Building on these achievements and the paper

commitments of the government, we recommend Guinean unions to take into account the following recommendations:

- *First things first.* The primary step that could be taken by Guinean unions is lobbying the government to change the definition of "labour" in the labour code, which forms the basis of the eligibility criteria of the statutory social insurance schemes. Labour is limited to an employer-employee relationship, which for the majority of workers in the informal economy (own-account workers) does not hold true. The ratification of C102 on the minimum social security standards could also be an important lobby point for Guinean unions and the CNTG, specifically.
- *Thinking large, acting incrementally.* Although the *Politique nationale de protection sociale* and the PRSP III indicate progress in the development of a comprehensive social protection framework they do not sufficiently address interlinked themes such as redistribution and the quality of care (see recommendations below). The first step for trade unions might therefore be to pressure the government to develop a framework, in cooperation with all relevant partners (unions, *mutuelles*, employers' organizations, ect.), that adopts a systems' approach (see Robalino, et al. 2012). Many countries (e.g. Niger, Senegal) have developed social protection strategies in a participatory manner and these processes could serve as examples. It is however of primary importance that the framework has a well-designed phased plan in which the most important needs are addressed first.
- *Picking your battles.* Due to the fact that Guinea is a low income country and ranks amongst the 10 lowest countries on the HDI it is important to prioritize in social expenditure. Trade Unions could play a role in defining the priorities based on the needs and perceptions of their constituencies[17].
- *Redistributing revenues gained from mineral resources.* The policy papers and academic articles and reports do not link the social protection agenda with the economic potential of the extractive industries. Trade unions could lobby to put this issue on the political agenda. The revenues gained from the extraction of Bauxite for example – which according to AEO 2013 will increase significantly over the following years – could serve as a financial base for social expenditures (health, education, …).
- *Working with the grain.* In relation to the *Politique nationale de protection sociale* – which hopes to achieve 80% health insurance coverage in 10 years' time – unions could stress the importance of working with and building on the *mutuelles* that are already in place. The example of Rwanda (which will be discussed later on) has indicated that harmonizing and centralizing the management systems of existing *mutuelles* increases coverage and is more cost-efficient then installing an entirely new set of insurance schemes. In addition, Criel et al.'s (2002) study has shown that local ownership is important and that government installed systems are generally mistrusted due to the Guinea's history of 50 years of dictatorship.

[17] Based on our own assessment we recommend prioritising health care.

- *Investing in quality*. In addition, also building on Criel et al.'s (2002) study, unions could equally stress the importance of the quality of health care and other social protection benefits. Increasing coverage to insurance schemes is namely related to the quality of the benefits that one receives in return for his/her contribution.
- *Taking initiative*. Alternatively, in light of the unstable political situation of Guinea, trade unions could opt to take measures into their own hands following the example of the *mutuelle* in the transport sector. In other sectors where informal workers are relatively well organized such an approach could be advisable. In sectors were the informal workers are not yet well organized, unions could increase their efforts in organizing informal workers.
- *Joining Forces.* The field data in Guinea has identified no other local actors who are involved in social protection. The ILO is the most active and well-known promoter of social protection in Guinea and although the multi-actor analyses (see annex 1) mentions civil society actors, no specific actor is mentioned and there seems to be no harmonized approach to social protection within Guinean civil society. Trying to find the most relevant partners for CNTG in the field of social protection could be taken up more specifically in a future study.

The role of CNV Internationaal in these endeavours could take the form of: organizing exchange events between Guinean unions and those in countries which met similar obstacles and found ways to overcome them; supporting the improvement of lobbying and advocacy skills; and supporting a local awareness raising campaign. An awareness raising campaign in the Netherlands about the misuse of the revenues of natural resources, such as Bauxite, might also assist their partners in pressuring the Guinean government into spending the gained revenues in a more equitable manner.

CHAPTER 2: Senegal

1. Setting the scene

1.1. Socio-political context

In what follows we will briefly discuss the political and economic landscape of Senegal, before moving on to the state of social protection. For a more detailed overview of the socio-political and economic context we kindly refer to the CNV context study conducted by Kaag et al. (2009), *"Le syndicalisme au Sénégal: Une analyse du context"*, as well as the updated study which will be completed later this year (Kaag et al., 2014).

Compared to Guinea, Senegal's political history since independence has been rather stable, with no coup d'états, no ethnic conflicts or significant rebellions. Between 1960 and 2000 the country was governed by two socialist presidents from the *Parti Socialiste (PS).* Léopold Senghor (PS) ruled from 1960 to 1980 and installed a single-party system[18]. Senghor was able to remain in power due to favorable economic conditions which allowed him to uphold clientelistic ties and through the support of the three main Islamic brotherhoods. In the late 1970s the economy however deteriorated – due to the falling prices for peanuts and droughts – and soon after, in 1980, power was abdicated in favour of Abdou Diouf (PS). Diouf, the second socialist president, installed a multi-party system and ruled until 2000, largely through a government of national unity. In 2000 Abdoulaye Wade, leader of the *Parti Démocratique du Sénégal (PDS),* became the first liberal president and marked *l'Alternance*. Lots of hope was placed in Wade's hands but the political climate under his power was in fact characterized by increased corruption and manipulation of the law. The constitution was furthermore altered several times in an attempt to secure Wade's power. In 2007 Wade was reelected but, due to allegations of fraud, opposition parties had withdrawn from the race, leaving the entire parliament and senate to representatives of Wade's party, the PDS (Kaag et al., 2009). In 2011 yet another constitutional amendment was made allowing Wade to run for president for the third time. This however sparked massive popular protest boosted by youth movements such as M23 and *Y en a Marre*. The 2012 election were won by the opposition candidate Macky Sal of the Alliance for the Republic and Wade's acknowledged his defeat and peacefully handed over power. The new government has committed itself to ensure good governance and better management of public resources. However, the liberalization of the Senegalese economy has made it vulnerable to fluctuations in world commodity prices and to the economic crisis in Europe and political crisis in neighbouring Mali. Recurrent internal challenges are natural risks such as floods and other climatic shocks and the slow reform of the road and infrastructure programme, especially of the energy sector (Gassama et al., 2014). Finally, 2012 was marked by numerous strikes by state teachers. The 2011/12 school year was saved by agreements reached between the new authorities and teachers' unions.

[18] See Kaag 2001 for a critical study on the decentralization process.

Trade Union Rights

Right to Organise: the law makes it difficult to create a union (long bureaucratic process & prior authorisation by authorities)

Right to Collective Bargaining: The state arbitrate the collective agreements between employers and employees

Right to Strike: Excessively long notice is needed to hold a legal strike, unions must first go through an arbitration process before being to call a strike, the law also allows forcible requisitioning of workers strikers

(ITUC, Survey of Violations of Trade Union Rights, 2010b)

1.2. Economic analysis: a booming tertiary sector but worrying levels of youth unemployment

In contrast with Guinea, Senegal has little natural resources, but due to its favorable geographical position, the French chose it as the capital of their West-African colony. After independence in 1960 the country therefore had a relative good infrastructure as well as well-trained civil servants. It however also inherited an exploitative economic structure mainly geared towards the export of groundnuts and cotton and the import of secondary goods as well as staple foods such as rice. On the HDI Senegal ranked 154 out of 187 in 2013 and in 2011 46,7% were living under the poverty threshold (HDR 2013 and Gassama et al., 2014).

The Senegalese economy is further characterized by an important tertiary sector (transport and telecommunications, commerce, services, finance, real estate and business services) which comprises approximately 60% of the GDP in 2012 (AEO Senegal, 2013). The primary sector (agriculture, livestock and fishery) contributes relatively little to the GDP, approximately 16,7 % in 2012, compared to other countries in the region, but employs 54% of the population (AEO Senegal, 2013). The secondary sector (agro-food processing, mining, textile and chemistry), mostly run by government enterprises, is good for another 20% of the GDP. It is estimated that the informal economy contributes 60% to the GDP and employs up to 90% of the population (Ndour 2007 in Kaag et al., 2009).

Since 2011 the economy has slowly recovered and in 2013 a growth rate of 4% GDP was measured, compared to 3,4% in 2012. The inflation has been contained but the government still has significant deficits on its budget balance (-5,9% in 2012) as well as its current account balance (-10,3% in 2012) (see table 11, Gassama et al., 2014). The prospects for 2015 and beyond are dependent on the *Plan Sénégal Emergent* (PSE), the new development strategy looking ahead to 2035. "*It seeks to pull together the country's public development policies and has three dimensions: structural transformation of the economy and growth; human capital, social protection and sustainable development; governance, institutions, and peace and security"* (Gassama et al., 2014). It must be noted however that the implementation of PSE has not yet reached the wider public or government officials because none of the respondents interviewed for this study, were aware of its existence. This is worrisome seeing that one of

its core pillars is social protection and several social protection stakeholders were questioned throughout the fieldwork conducted by Ba in April 2014. Another important policy document is the National Strategy for Economic and Social Development (SNDES) for 2013-2017 which was approved in November 2012 and encompasses three areas of action: growth, productivity and wealth creation; human capital and sustainable development; and government, institutions, peace and security.

Table 11: Key macro-economic indicators

	2012	2013(e)	2014(p)	2015(p)
Real GDP growth	3.4	4	4.8	5.3
Real GDP per capita growth	0.5	1.1	1.9	2.5
CPI inflation	2.1	0.7	1.3	1.7
Budget balance % GDP	-5.9	-5.4	-5.3	-5.1
Current account balance % GDP	-10.3	-9	-8.4	-9.3

Source: estimates (e) and projections (p) based on authors' Gassama et al. (2014) calculations.

If we look at the labour market we can discern a similar situation to Guinea. From a total population of 13,11 million, 53,3% forms part of the active population, resulting in a dependency ratio of 88% (ISSA, 2014). Less than 20% of the population works in the formal sector, of which one third is employed by the state and two thirds in private companies. The majority of the workforce works in the informal economy (which grew significantly since the SAPs of the 1980s). Agriculture remains the largest sector in terms of employment, followed by services and industry. Youth unemployment is a huge challenge and was an important agenda point during the 2012 elections. Although the government has initiated several projects such as the Accelerated Growth Plan and the New National Employment Policy (2010-2015), and created specified government institutions such as the National Fund for Youth Unemployment and the National Agency for Youth Employment, in order the tackle the problem, 43,9% of people aged 15 to 24 in Senegal end up finding a job in the informal economy (Diene, 2012). The official unemployment rate is 11,7 % in Dakar and 14 % for the entire country. If we however include hidden unemployment the figure is estimated to fall between 28,7 % en 55,5 % (CNV/Mott Macdonald, 2008 in Kaag et al., 2009)[19].

2. Social Protection

In the following we will discuss the state of social protection in Senegal, followed by a mapping of the existing social protection schemes in the field of old age pensions, occupational accidents and illness and health care. For an overview of the available social security statistical data as well as, key legislation and the ratification of key ILO conventions, please see annex 2.

[19] For a more detailed description of Senegal´s labour market please see the CNV context studies by Kaag et al. (2009 & 2014, forthcoming).

2.1. The state of social protection in Senegal

Senegal not only inherited an export-oriented economic structure from its colonial rulers but also a mandatory-contributory social insurance system following the French example, based on the assumption of a large salaried working class (Diop, 2003). Social security was developed in parallel with the labour legislation after the Second World War and cemented through the adoption of the Overseas Labour Code in 1952, after a 24hours general strike of all trade unions in former French West Africa (Diop, 2003). The management structure of social security systems in Senegal came about after consultations between the social partners and was characterized by autonomy of management and institutional pluralism, implying that several schemes could co-exist, in contrast with Guinea for instance where the CNSS has a monopoly over formal social security schemes (Diop, 2003).

The Senegalese social protection system covers eight out of nine social risks which are part of the ILO´s basic social security standards (C102 ILO, 1952), with unemployment being the exception (see table 9).

Table 12: Social Protection Schemes in Senegal

	Old age	Survivor	Disability	Occupationnel accidents and illness	Child benefits	Maternity benefits	Health care	Unemployment	Cash/in-kind transfers
IPRES : RGC and RCC	x	x			x		x		
FNR / State budget[20]	x	x	x		x		x		
CSS				x	x	x			
IPM							x		
Mutuelles							x		
Private Insurance Companies	x						x		
Sésame							x		
DAS (targeted)									x
OVC (targeted)									x
PAP (universal)									x
CMU (not yet functional)							x		
RSPC (not yet functional)	x						x		

[20] For some civil servants the benefits are directly paid out of the state treasury, whilst others are paid through contributions to the FNR.

Food & basic goods subsidies									x

Source: fieldwork report (Ba, 2014)

According to Thiam (2009), only 7,5% of the Senegalese population has any form of social protection. The UN-DESA (2011) mentions that 11,4% of the population is covered by social protection in 2007, stipulating the lack of accurate data on the issue. GESS indicates that although only 6% of the population is covered – notably the salaried private and public workers – their spouses and children indirectly benefit as well, increasing the coverage to approximately 13% (ILO GESS website country profile Senegal in Kaag et al., 2014). At present, in 2014, the local data collection done for this study stipulates an overall coverage of approximately 20%. Social protection of workers in the formal private sector is provided by several institutions, namely the *Caisse de Securité Sociale* (CSS) for family benefits and employment injury compensation and prevention, the *Institut de Prévoyance de Retraite du Sénégal* (IPRES) for old age pensions and the *Instituts de Prévoyance Maladie* (IPM) for health insurance. In the public sector there are two social insurance schemes: the *Fond National de Retraite* (FNR), covering old age, and a component of the state budget through the Ministry of Finance (UN-DESA 2011), which covers family benefits, professional injury benefits, and health costs (Kaag et al., 2014).

The five schemes mentioned above are all mandatory and contributory and based on the notion of salaried employment in which contributions are deducted from wages in addition to contributions from employers. In other words, salaried workers pay a part of their salary to the funds in return for benefits. The employers' organizations and the trade unions are represented in the administrative council of the IPRES and the CSS (Kaag et al., 2014).

If we look at the quality of benefits offered by the three formal social protection institutions (CSS, IPRES and FNR), inequality exists in terms of the adequacy of benefits. In general, public servants receive better services for comparable risks, as the pensions paid by the FNR and the CSS are far greater than the minimum wage or *salaire minimum interprofessionel garantie* (SMIG), whereas pensions paid by the basic IPRES scheme is less than the SMIG. "*In fact, the difference in the average benefit paid by the FNR and CSS, on the one hand, and the IPRES, on the other hand, increased from 66% in 2003 to 83%in 2006*"(Thiam, 2009: 8).

In addition, non-contributory social assistance schemes targeted to the most poor and vulnerable exist. For example, universal cash transfers are provided to children from birth up to five years of age as part of the poverty alleviation programme (PAP) (Thiam, 2009: 3). The newly established family security grant also gives in kind or cash transfers to the most poor and Sésame, which will discussed in more detail below, provides benefits for the elderly. The *Direction de l'assistance sociale* (DAS) furthermore provides assistance to the destitute through cash transfers and the OVC scheme exempts the most poor from school fee and organizes professional training of orphans and vulnerable children (Kaag et al., 2014). The CMU, which will be elaborated on below, is also an example of social assistance provided by the state. Lastly, generalized subsidies of certain food products and fuel are also categorized as social assistance schemes (ILO GESS website country-profile Senegal, in Kaag et al. 2014).

Despite these initiatives the coverage however still remains relatively low (approximately 20% according to the local data collection). This has spurred the creation and expansion of various voluntary mutual insurance schemes or *mutuelles*, mostly to help meet the financial costs of health-care expenditure for workers (Thiam, 2009: 3). In the formal economy, mainly in the public administration, mutual health organizations offer different services to their members. In the informal economy and rural sector, community-based or socio-professional mutual health organizations play an important role in securing affordable health care for its members (Kaag et al., 2014).

2.2. Recent reforms

The Senegalese government increased its commitment towards the extension of social protection in 2005 when it developed the *Stratégie Nationale de Protection Sociale* (SNPS). The plan was primarily focused on health-care and medical insurance and aimed at increasing coverage to 50% in 2015. The *Stratégie nationale d'extension de la couverture du risque maladie* (SNECRM) supplemented the SNPS in 2008 but regretfully, in 2014, it is clear that this target will not be reached with coverage of 20%. The core cause of the failure of both plans was the lack of coordination between the many stakeholders (several Ministries, including those of Economy and finance; Labour; Health; Women etc., as well as technical agencies and civil society organizations) resulting into scattered and incoherent implementation (Kaag et al., 2014).

In 2010, the government gave a new impetus towards the protection of vulnerable groups through *Sugali Jaboot*, or the National Initiative for the Social Protection of Vulnerable Groups. The programme aimed to help alleviate poverty, vulnerability and social exclusion amongst the most vulnerable groups for which better targeting methods would be developed. *Sugali Jaboot* was part of the Poverty Reduction Strategy Paper and the SNPS and included the introduction of core community schemes to provide good-quality services; local guidance for vulnerable groups; capacity building for institutional actors and partners; better access for vulnerable groups to core infrastructure and social services (particularly health and education) and to risk prevention and management schemes. In addition, the programme aimed to ensure wider access for vulnerable groups to money transfers and direct financial products and lastly, better monitoring and assessments of community-based projects for vulnerable groups. The initiative is based on a comprehensive, integrated, decentralized and participatory approach and was developed through partnership between the State, local authorities, civil society, civil society and technical and financial partners. The project has a budget of 30 billion CFA and will be jointly financed by the Senegalese state (10 billion CFA) and the technical and financial partners (20 billion CFA) (ISSA country profile Senegal, 2014). During the fieldwork conducted for this case study none of the respondents mentioned the system, which could either indicate that it has not been implemented or that is very much donor driven and little local stakeholders have been involved.

More recently, the *Stratégie nationale de développement économique et social* (SNDES 2013-2017) has reinforced the priority given to social protection in previous poverty reduction strategy papers and builds on the aforementioned policies. The *Délégation Générale de Protection Sociale et de Solidarité Nationale* (DGPSSN) was established as part of the SNDES by the government in May 2012, and was responsible for reporting to the president "*with the aim of establishing a reference and action*

framework for more consistency, better integration, and a more visible impact of the interventions" (Kaag et al., 2014).

The latest reform regarding social protection is the commitment of the current government to work towards a universal health scheme (*Couverture Maladie Universelle* - CMU), which will be discussed in more detail below.

2.3. Financing social security

These initiatives need to be financed and require a significant budgetary commitment of the government. The 5,34% GDP that is currently spend of social expenditures (including health and education) will not be sufficient. If we only take into account expenditure on benefits for the working age population the situation is much more grim, with an average spending of 0,15% in 2010. Spending on old age pensions was 1,78% GDP in 2010 (see tables 5, 6 and 7). Pal (2005) calculated that a comprehensive social protection package encompassing, universal old age and disability pensions, health care, child benefits and basic education, could be financed entirely by the state by 2022 if it were to spend one third of its GDP on social protection (Pal, 2005: 25). Such as in the case of Guinea, we should however be weary of these estimations. Social spending is highly influenced by government´s priorities and the political economy of the country in general. The study does however indicate that effective social protection schemes for developing countries are not per definition financially impossible.

3. Focal themes

3.1. Old age pensions

The elderly account for 7 per cent of the Senegalese population or about 750 000 individuals. According to the ILO Country Programme for the Promotion of Decent Work (2012), basing itself on a study from 2008, only 16,6% of the elderly of 65 years or older receive a pension. Free basic health care for the elderly has however been provided from 2006 onwards, through the so-called Plan *Sésame*, which is currently in the process of being updated (Kaag et al., 2014).

Sésame

All Senegalese elderly, of 65 years or older have access to free basic health care from 2006 onwards through the so-called Plan Sésame. The scheme provided basic health care for all elderly with a legitimate Senegalese passport and covers all costs related to medical care in a public hospital. Sésame was financed by the state and IPRES but has ceased to function due to the debt of the government to the hospitals. Before Sésame the number of older people supported by IPRES and FNR was approximately 30% of the workforce. The remaining 70% did not receive any coverage before the programme (UN-DESA, 2011). A grant of 700 million CFA (approx. 1.065.617 EUR) was raised from the internal budget to finance this system of solidarity (Diagne et al., 2011).

There are three national pension schemes in Senegal. The *Fonds National de Retraite* (FNR) was established by law no° 61-35 of 15 June 1961, amended in 1964 and 1981 and 2002. The FNR is managed by the state, more specifically the Minister of Economy and Finance and is a social insurance system that provides old age pensions, and disability benefits, survival benefits as well as child benefits for civil servants and military and para-military state officials. It is financed by employee contributions and the national budget.

The *institut de prévoyance retraite du Sénégal* (IPRES), based on law n° 75-50 of 3 April 1975 manages both other schemes, the *Régime Général de Retraite* (RGR) and *Régime Complémentaire au profit des Cadres* (RCC). IPRES falls under the supervision of the Ministry of Labour and the Ministry of Economy and Finance, and is managed by a joint commission of employers' and workers' organisations. The *Régime Général de Retraite* (RGR) is a mandatory pension scheme for all private sector workers and the staff of public enterprises. The *Régime Complémentaire au profit des Cadres* (RCC) is a complementary scheme for senior executives. Based on 2012 data in total IPRES counts 16 814 affiliated enterprises, 204 807 affiliated workers, 68 284 retired people and 43 623 widows.

The level of pensions is calculated differently under FNR and IPRES. Pensions which are granted through FNR are based on the last earned salary. Whilst in the case of IPRES, a system of points is used. More specifically an employee must have saved 400 points, based on the years of remuneration, in order to be able to receive a minimum pension, however exemptions exists for casual workers (day-workers and seasonal workers) and domestic workers who have to present proof of 5 years of employment in order to receive a pension without having to have paid contributions. In practice most day-workers and seasonal workers can hardly present such proof as they generally do not receive a contract.

The government has recently announced that they will reform the IPRES scheme and will increase the pensions, so that they will reach the SMIG and will intensify their extension-efforts specifically towards liberal professions and informal workers. Furthermore, steps have been taken towards the creation of a universal pension scheme following the recommendations made during the 202 International Labour Conference (ILC) with regards to the social protection floor. The government intends to install a minimum old age pension for all people of tertiary age who have not or cannot contribute to IPRES.

Another initiative is the *Régime Simplifié pour le Petit Contribuable* (RSPC), which is still in the preparation phase and supported by ILO. The target beneficiaries of RSPC are non-salaried workers who are not covered by the IPRES, CNSS and the IPMs. The ILO however envisages a system in which the universal minimum pensions co-exist next to the RSPC. Private pension schemes exist but only a very small portion of the population makes use of them. Informal pension schemes are non-existent in Senegal according to the field data gathered for this study.

3.2. Occupational accidents and illness

Only 5,5% of the workers are covered by an insurance for work injuries and profession-related illnesses (ILO Country Programme for the Promotion of Decent Work, 2012). The CNSS is responsible for the organisation of occupational accidents and illness benefits, following the law n° 73-37 of 31 July 1973 and n° 97-05 of 10 March 1997. The scheme is financed by employers contributions, which depending on the risks involved in the job, can vary from 1, 3 or 5% of the salary, with a maximum of 63 000 CFA (aprox. 96 EUR). Employers are mandated to pay the contribution according to the Senegalese law.

In theory informal workers may access the scheme but in practice this has proven to be difficult. Especially the heterogeneity of the sector, with regards to type of employment as well as level of risks makes it hard for the CNSS to define the percentage of contributions that need to be paid. Due to the uncertainty of their employment it is also difficult for informal workers to pay the dues.

In the past the government has tried to increase the coverage of the occupational accidents schemes to informal workers. The most often cited example is that of the extension towards craftsmen in 1996 (see Box). All government efforts are however geared towards extending the CNSS to the informal economy. Informal schemes which provide benefits for accidents and illness at work through communal or occupational schemes are not incorporated in the government's extension plans regarding to occupational accidents and illness.

Extending social security to craftsmen

The project aimed at provided insurance against accidents and illness for 450.000 craftsmen connected to 78.000 crafts enterprises, as well as 160.000 apprentices in 129 skill centres. The pilot, implemented in eight villages in 1996, however failed due to distrust amongst the craftsmen, who saw the initiative as a hidden strategy of the government to formalize the sector and impose taxes.

3.3. Health Care

Health care is enshrined in the Senegalese constitution. Article 7 states that the state must protect and respect all human beings and declares amongst other rights that all individuals have the right to physical integrity. Article 25 declares that it is a state prerogative to ensure sanitary and humane working conditions and declares that workers have the right to determine their working conditions and to benefit from social security. These constitutional declarations have also been translated into numerous laws and regulations regarding the provision of health care (see table for an overview of all laws related to social protection). Regardless of this elaborate legislative and juridical structure less than 20% of the Senegalese population has health insurance.

Private sector employees can rely on the *Instituts de Prévoyance Maladie* (IPM) for health insurance. The IPM was created in 1975 and is organized at enterprise level. All enterprises with at least 300 employees must create an IPM, if the enterprise has less than 300 permanent staff they must link-up with an existing IPM of another enterprise. Both employers and employees pay contributions to the equivalent of 4-15% of a month's salary with a maximum of 250.000 FCFA. The IPM initially only covered the permanent workers and their family but since 2012, non-permanent workers can also be covered by IPM. In 2012, 120 000 salaried workers were covered by the IPM out of 400.000.

In article 2 of the Labour Code of 1997 workers are defined as "all persons that are engaged in a professional activity, receive a remuneration and under the management of another person, physically or mentality, public or private". This implies that most informal workers, who are own-account workers, do not fall under the category of workers according to the law, similar to the situation in Guinea. This also implies that the government is not forced by law to ensure social protection to these groups of workers. Therefore informal workers have started their own health care systems, the *mutuelles* – community or occupational based health schemes based on voluntary contributions from members. According to the 2013 AEO there were 217 community schemes and 20 *mutuelles* in Senegal providing coverage to around 609 000 people in 2011. "*Nevertheless, the coverage rate remains low, targeting is not done correctly, resources are insufficient and action taken lacks coordination* (AEO Senegal, 2013: 10). An often cited example is the health care system of the transport sector, "*Transvie*" (see box).

Transvie

Tranvie is the occupational health care system set-up by workers in the transport sector in Senegal. According to the general director Transvie has 3000 members, who can benefit from reductions up to 90% for hospital expenses, 70% in health care centres and 30% in private pharmacies. In return, members are expected to pay monthly contributions of 7200 CFA (or 11 EUR). The *mutuelle* is so effective that is has expanded to include railway officials as well as workers in the marine transport sectors.

The *couverture maladie universelle* (CMU) was launched in 2013 by the government following the social protection floor initiative of the ILO. The annual fee for adherence is 7000 CFA (appr. 10,70 euros) per person, 50% of which is subsidized by the State and paid in total for the 20% most poor households (Jeune Afrique, 2013 in Kaag et al., 2014). The aim of the CMU is to increase health care coverage to 75% in 2017. To this end the government will improve and increase the number of community health schemes (*mutuelles de santé communautaires*), which should go from the actual existing 250 to 500. An annual fee of 7000 CFA (appr. 10,70 euros) per person is expected, 50% of which is subsidized by the State and paid in total for the 20% most poor households (Jeune Afrique, 2013 in Kaag et al., 2014). The CMU is managed by multiple Ministries: The Ministry of Health and Social Action, The Ministry of Public Administration, Work, Social Dialogue and Professional Organisations and The Ministry of Economy and Finance. This multitude of actors raises questions about the coherent implementation of the initiative as in the past the cooperation between several ministries have proven to be difficult (see e.g. SNPS).

The implementation of the CMU is based on three pillars:

- Mandatory health insurance through de IPMs for workers in the private sector and civil servants
- Voluntary health insurance through the *mutuelles* and private health insurance companies.
- Medical assistance through free health care and subsidies for vulnerable groups.

Informal workers will fall under the second and third tier. The ambitious CMU will be financed by the *Caisse Autonome de Protection Sociale Universelle* (Capsu), which still needs to be created, but its financial sustainability is not yet assured. In addition, the programme requires institutional capacity building, and the lack of health staff might pose additional problems (Kaag et al., 2014).

Since October 2013, all children between 0 and 5 years have free access to basic health, i.e. the costs for consultation, vaccination and hospitalization of these children is free in the health posts and health

centres, which are the basic health infrastructure in the country, as well as consultations at First Aid Posts in the hospitals (Kaag et al., 2014). The elderly have access to free basic health care from 2006 onwards through the so-called Plan Sésame (see box).

Trade unions are actively engaged in providing health services for informal workers in cooperation with private health care institutions. UNACOIS for instance cooperating with the private health care institution Eksina. This *mutuelle* is especially beneficial for informal workers as the medical officers go to the work places of the informal workers, who often have difficulties with travelling to receive medical care. Market women for instance cannot leave their stall unattended. Other unions work together with medical cabinets such as the UDTS and the Alioun Sow cabinet.

Private health insurance companies have recently also started a programme specifically targeting larger informal businesses, which have more than 50 employees, through the provision of micro-insurances for socio professional groups. The contributions range between 5.000 (approx. 7,6 EUR) and 31.000 CFA (approx.. 47 EUR) per year per person.

The RSPC, which was already mentioned above will also have a health care branch specifically for informal workers. Through the RSPC the government, following the recommendations of the ILO, wishes to formalize the informal sector. At present it is debatable whether the health insurance under RSPC should be voluntary or mandatory but the ILO's feasibility study indicates that a voluntary system would be more opportune.

4. Conclusion and recommendations

Social protection in Senegal is in a transition phase wherein the extension of services is a key aspect. At present many social protection schemes are under construction and the future will have to tell whether the planned reforms will foster the expected results. The main obstacles are establishing coherence between the various involved ministries and actors as well as the financial sustainability of the ambitious CMU and RSPC.

The trade unions have important roles to play due to their position in the boards of IPRES and CNSS. If RSPC is successfully implemented, Muhammed Ba, who conducted the field work for the Senegalese case, believes it could be beneficial for informal workers and their formalization. He however raises the concern that the government and the ILO, who seems to be the driving force behind the initiative, should be sure to engage informal workers in the planning and implementation of RSPC, not to run against the same difficulties as the 1996 reform and extension towards artisanal craftsmen. The CMU could provide a solution for the most vulnerable groups but financing this ambitious scheme and securing quality services could be problematic. Lastly, the UDTS indicated that the main obstacle for extension to informal workers is the fact that their revenues are low and the administrative processes of applying for social security are often complicated and cumbersome, discouraging informal workers from registering.

In comparison to Guinea the political and socio-economic situation in Senegal is more favourable for union action towards the extension of social protection. In sum, there is more to start from, both in

relation to the existing national social security schemes, as in light of the "institutionalized" informal regimes. Building on these observations we recommend taken into the account the following issues.

- *First things first.* The primary step that could be taken by Senegalese unions is lobbying the government to change the definition of "labour" in the labour code, which forms the basis of the eligibility criteria of the statutory social insurance schemes. Labour is limited to an employer-employee relationship, which for majority of workers in the informal economy (own-account workers) does not hold true.
- *Increasing coherence.* As mentioned above, there is more to start from in Senegal but this also implies that the multitude of programmes, strategies and projects need to be streamlined. Trade unions could play a watchdog role towards the effective functioning of the *Délégation Générale de Protection Sociale et de Solidarité Nationale* which has been created by the government in 2012 to this effect. Placing the benefits of a system's approach, which takes into account matters of redistribution as well (see Robalino et al., 2012), on the political agenda might allow the development of a social protection framework that addresses Senegal's inequalities.
- *Delineating tasks and responsibilities.* Unions could advocate installing a clear division of labour between all relevant actors in the social protection landscape in Senegal. Specifically the multitude of ministries which are involved requires well-defined responsibilities in order to increase coherence and complementarity.
- *Picking your battles.* Although Senegal is performing better economically, it remains important to prioritize in social expenditure. Developing a coherent framework is the first step but developing an incremental approach is the next. Rome was not built in a day. Trade Unions could play a role in defining the priorities based on the needs and perceptions of their constituencies[21].
- *Redistributing.* The policy papers and academic articles and reports do not link the social protection agenda with the increased inequality in many African countries. Income inequality has not changed over the last decennia in Senegal. Although inequality is lower compared to other countries in the region "*the richest two deciles of the population consume about half the goods and services in the country, roughly the same amount as the seven bottom deciles of the population, suggesting a substantial level of income disparity and inequality*" (Kireyev, 2013:9). Trade unions, therefore could lobby to put redistribution on the political agenda: the revenues gained from key industries could serve as a financial base for social expenditures (health, education, …)
- *Putting your action where your mouth is.* Unions have an important role to play in ensuring that the CMU will materialize. By monitoring the evolution of the implementation of the CMU, they could act pro-actively when obstacles arise, pressuring the government to stick to its made commitments.

[21] Based on our own assessment we recommend prioritising health care.

- *Investing in quality*. In addition, building on Criel et al.'s (2002) study and likewise to the recommendation for Guinea, unions could equally stress the importance of the quality of health care and other social protection benefits for that matter. Increasing coverage to insurance schemes is namely related to the quality of the benefits that one receives in return for his/her contribution. Once the CMU is officially started unions could monitor its progress and the support customer satisfaction inquiries. They could also play an important role in ensuring that the poorest and most vulnerable groups in society are not left out.
- *Taking initiative*. Alternatively, trade unions could increase their efforts in establishing cooperation with *mutuelles* or medical cabinets. Specifically with regards to the extension to informal workers creating work-place health care points or supporting "flying doctor" which move to the market-place or other informal workers' hubs to provide medical care, are initiatives that could be scaled-up. In sectors were the informal workers are not yet well organized, unions could increase their efforts in organizing informal workers.
- *Joining Forces.* The multi-actor analyses of Senegal (see annex 1) identifies a variety of international partners but, besides the *mutuelles de santé,* no other local actors with whom could be cooperated in the field of social protection. This stipulates the donor-driven social protection agenda. The international partners are UNICEF, ILO, UNDP, World Food Programme (WFP), USAID and *Agence Française de Développement* (AFD) as mentioned in the introduction this amalgam of actors creates problems with regards to coherence and harmonization. The cooperation with *mutuelles de santé* could be scaled-up as the UDTS is already experienced in working with them.

The role of CNV Internationaal in these endeavours could take to form of: organiszng exchange events between unions and *mutuelles* which have adopted "informal-workers-friendly" (e.g. Eksina); supporting the improvement of lobbying and advocacy skills; and supporting a local awareness raising campaign specifically if the CMU is implemented.

CHAPTER 3: Niger

1. Setting the scene

1.1. Socio-political and economic context

The following is primarily based on the CNV context study, "Trade Union Movement in Niger: The Future Depends on the Present", by Keja and Zanou (2012). For a more detailed overview of the socio-political and economic context we kindly refer to this report.

The history of Niger since independence can be divided into two periods: between 1960 and 1990 Niger was ruled by a single party regime for 14 years followed by a military regime for 16 years. From 1990 onwards the country became a multi-party democracy in which several political parties compete for power (Keja & Zanou, 2012). Hamana Diori became the first president of independent Niger in 1960 and was leader of the first Nigerien political party, the *Parti Progressive Nigérien* (PPN). A single-party regime wherein political opposition, notably the Sawaba and Tuareg movements, were oppressed was installed after his inauguration. Corruption in the food aid sparked mass protests and in 1974 Diori was overthrown by a bloody coup d´état led by Lieutenant-Colonel Seyni Kountché (Keja & Zanou., 2012). Under Kountché a military regime was installed and the general assembly was suspended. Although economic growth picked up, through the exploitation of uranium mines in the North, popular support for the regime was negligible. In 1991 a multi-party democracy was installed after a national peace conference and a transition government paved the way to the first general election in 1993. Up until 2011 the country was characterized by political instability caused by three coup d'états in 1996, 1999 and 2010, respectively.

The elections of In January 2011 were won by the *Parti Nigerien pour la Democratie et le Socialisme* (PNDS) and Mamadou Issoufou was inaugurated as president in April 2011 (Keja & Zanou, 2012). In the last couple of years the economic situation in Niger has improved but the regional situation, more specifically the war in Mali, the Boko-Haram in Nigeria as well as the volatile situation in Libya, threatens to disrupt the internal stability. The crises along the Nigerien borders have significantly augmented government military spending in 2012 and 2013 to the detriment of capital investments and social spending. The ruling MNR (*Mouvement pour la renaissance du Niger*) coalition provides relative political stability but there are sustainability of the coalition if questioned due to the increased critics of the second strongest party towards the government (Ndoye & Ndiaye, 2014).

The trade union movement in Niger is characterized by high coverage (both in the formal and informal sector), high fragmentation and little political power. In addition throughout the country's history and long periods of dictatorships, trade unions have been constantly politicized and partisan. The internal democracy within unions and external struggles between unions also pose significant challenges for their effectiveness. Nevertheless, among a poorly developed civil society unions are still important organized interest groups (Keja & Zanou, 2012)

1.2. Economic Analysis: High growth rates and little social returns

Niger is amongst the poorest countries in world. 61% of the population lives on less than 1 dollar a day and the median hourly wage in 2012 was 2887 FCFA (0,3 EUR) (Keja & Zanou, 2012). Niger ranked the lowest country in the HDI of 2012, with a HDI of 0.304. Remarkably, Niger's GDP grew with 11,1% in real terms in the same year, one of the highest levels recorded in Africa. This spectacular growth was boosted by a good harvest and an exceptionally dynamic secondary sector, which grew by almost 38% driven by the extractive industries. Yet, the growth rate was a one shot wonder, as the GDP growth fell to 3,6% in 2013 and is expected to increased slightly to 6% in 2014. Reducing the national debt, tackling the significant current account balance deficit (-15,2 in 2013) and most importantly investing the increased national income in a sustainable, social and productive way remain huge challenges. In 2010 only 3,29% of the state's budget was devoted to social spending (including health and education), which is below the target set by the Social Protection Framework of the African Union.

Table 13: Macro-economic indicators Niger

	2012	2013(e)	2014(p)	2015(p)
Real GDP growth	11.1	3.6	6	6.2
Real GDP per capita growth	7.3	-0.3	2.1	2.3
CPI inflation	0.5	1.9	2.5	1.3
Budget balance % GDP	-1.1	0.1	-1.8	-1.7
Current account balance % GDP	-15.1	-15.2	-15.3	-15

Source: estimates (e) and projections (p) based on authors' Ndoye & Ndiaye (2014) calculations.

Due to huge investments in oil and mining sectors the country's development is encouraging but there are severe management deficits in the natural resource sector (Ndoye & Ndiaye, 2014). In order to protect the Nigerien population from climate shocks, with which it is frequently faced, the country would benefit if the revenues from the extractive industries would be used to increase social spending and support social protection (Ndoye & Ndiaye, 2014). The African Economic Outlook (2013) states that economic diversification as well as the development of agri-businesses is necessary to generate inclusive growth.

Labour statistics are notoriously unreliable in Niger but the following figures were presented in the study of Keja and Zanou (2012): in 2010 the active population was estimated to be 7 million on a total of about 15 million people. The unemployment rate is 16%, 25% for women and 12% for men. Youth unemployment is particularly high at an estimated 15%. Under-employment is stated to be between 30% and 35%. The majority of the people work in the agricultural sector (between 80 and 85%), followed by commerce, restaurants and hotels in the tertiary sector (8,5%). Charwick in Roos & Zanou (2012) estimated that 50,000 workers are employed in the formal sector amongst which 44,000 are government employees (Keja & Zanou, 2012).

The informal economy is dominant in Niger and more than 80% of the labour force gains his or her income through informal work. The majority of these people work in the agro-pastoral sector, petty-

trade and commerce. As in other countries informal work is characterized by precarious working conditions and instable revenues (Keja & Zanou, 2012).

2. Social protection

In the following we will discuss the state of social protection in Niger, followed by a mapping of the existing social protection schemes in the field of old age pensions, occupational accidents and illness and health care. For an overview of the available social security statistical data as well as, key legislation and the ratification of key ILO conventions, please see annex 2.

2.1. The state of Social Protection in Niger

Social protection is enshrined in the Nigerien constitution of 25 November 2010 and was also an important part of the PRSP (2008-2012). In extension there are numerous sector and multi-sector policies and strategies which relate to the issues of social welfare. There is however no coherent strategy and therefore the multiplicity of strategies and projects are not able to create positive synergies. According to Issa Younoussi, the local researcher who conducted the fieldwork for the Nigerien case, formal social protection systems only exist on paper for formal workers and therefore are unable to address the poverty and inequalities in the country. In what follows we will discuss the state of social protection in Niger zooming in on the three focal themes: old age pensions, protection against occupational accidents and illness and health care.

According to Robalino et al. (2012) Niger has a fragmented, poorly designed social protection system which has low coverage. Formal social protection in Niger has several dimensions which can be categorized in two types of regimes.

On the one hand there are non-contributory schemes in the form of cash or in kind transfers to vulnerable groups. These schemes can be labeled as social assistance and account for 0,68% of GDP. 77% of the budget for social assistance comes from donors such as the European Union, the World Food Programme, USAID and international NGOs, 12% is financed from the HIPC programme and 11% is contributed by the Nigerien government (World Bank, 2010). Most attention and financial commitment has gone to the provision of emergency assistance, particularly in times of food crises. These social assistance programs offer cash transfers, school meals and other in-kind support through the schools, nutritional or health centres (Robalino et al., 2012). Although these programmes offer relief in times of crises (in 2001, 2005, 2008, and 2010, respectively) they do not address the chronic food insecurity. In response to this the World Bank initiated a Safety Net programme in 2010 (see box).

World Bank Safety Net Project

The development objective of the project is to establish and support an effective safety net system which will increase access of poor and food insecure people to cash transfers and cash-for-work programs. The project has three components: (i) Safety Net System, (ii) Cash Transfers, (iii) Cash for Work.

The first will focus on the investment of management information systems in order to improve targeting as well as monitoring and evaluating the progress made. The second component aims to reach 80.000 poor households in four years' time through monthly cash-transfers of 10 000 FCFA per household. Beneficiaries receive a card with their details and the amount they have received (Robalina et al., (2012) suggest to expand the social assistance administration building on this first identification). The third component will provide an income for 60 days for approximately 15.000 people annually, during the lean season.

This programme will specifically target those rural communities experiencing an unusually higher than average level of food insecurity (World Bank, 2010). The last component raises some questions from a labour perspective as it institutionalizes temporal work. The beneficiaries will benefit for a period of 60 days a year but their employment status is not structurally addressed. Research will have to show whether beneficiaries benefit in the long term from such programmes.

On the other hand there are contributory regimes, which are based on contributions of the beneficiaries and managed by the CNSS. Social security in Niger covers all basic life-cycle risks mentioned in the ILO C102 convention on social security (see table 11). The main organizing body is the *Caisse National de la Securite Sociale* (CNSS) which provides old age, survivor and disability pensions, as well as benefits for work related accidents and illness, sick leave, child care, maternity leave and health-care. Although the constitution of 2010 specifically states that social protection should be provided to all workers in reality the CNSS does not reach out to workers in informal employment. The field data collected for this case study suggests that the reason for the low coverage amongst informal workers is their mistrust in state systems. They believe the CNSS to be a hidden strategy of the government to enforce taxes on them, for which they will get little in return. At the present the labour code to boot does not make reference to informal workers making it difficult for trade unions and other activists to pressure the government to extend social protection to informal workers. The CNT added that the low organization rate amongst informal workers also influence the low social security coverage. If more informal workers were to be organized in cooperatives for example, the cooperatives could pay the employer contributions to the social security schemes. In addition the cumbersome administrative procedures and requirements discourage many informal workers from registering to the CNSS.

As is the case in Senegal the *Fonds National de Retraite* (FNR), which has been renamed *Caisse de Retraite du Niger (CARENI)* provides old age pensions for government officials but also family allowances. The CARENIis financed by the state treasury. The CNSS and CARENI only cover a tiny portion of the labour force, 3%, at a cost of 0,7% of GDP.

Due to the low coverage and similar to the situation in most West-African countries, the majority of Nigeriens, in particular those working informally, resort to community-based solidarity mechanisms when confronted with life-cycle shocks, such as the death of a spouse, old age or changes in the family composition. These informal social protection mechanisms are however relatively less institutionalized, in comparison with Senegal, for instance. Finally, private insurance companies are also present in the country but only the small elite can afford to rely on their services. The table below indicates that most of the benefits are provided by the CNSS. In what follows we will take a closer look at three branches of interest for this study.

Table 14: Social Protection Schemes in Niger

	Old age	Survivor	Disability	Occupational accidents and illness	Child benefits	Maternity benefits	Health care	Unemployment	Cash/in-kind tranfers
CARENI	x				x				
CNSS	x	x	x	x	x	x	x	x	
Mutuelles							x		
Private Insurance Companies	x								
Safety Net Programme								x	x

Source: fieldwork report (Younoussi, 2014)

2.2. Recent Reforms

The Nigerien government recognized the need for a comprehensive social protection strategy and embarked on a long policy-making process in 2008, with a reflection day between several stakeholders, such as relevant ministries, NGOs, the trade unions and employers' organizations. The reflection day was followed by a field visit to Ghana and workshops at regional level. This participatory approach indicates the governments' commitment to developing a locally embedded social protection strategy. A committee was installed in 2009 under the management of the Ministry of Population and Social Reforms, renamed the Ministry of Population, the Promotion of Women and Protection of Children, in 2010. In 2011 a first draft was written, which was presented at regional levels during workshops in order to enrich the document. After these local consultation rounds the ILO and other financial and technical partners made some revisions, where after the strategy was presented to parliament in 2011. Although

the law on social protection was adopted in August 2011 it has yet to be translated in effective policies and programmes. According to Robalino et al. (2012) this lag could also be an opportunity because it creates room for the Nigerien government to develop a genuine systems-approach to social protection, wherein "*interconnected programs achieve interrelated functions"* (Robalino et al., 2012:1). They argue that "*social protection programs could perform better if interactions between them were exploited"* (Robalino et al., 2012:2).

3. Focal Themes

3.1. Old Age Pensions

Several laws regulate statutory pension schemes in Niger (see table Key Social Protection Indicators). All laws however date from 1967 and 1968 and have not been revised since. The legal texts furthermore do not include informal workers. 0,6% of the state budget is spend on old age pensions in 2006. The implementation of the old age pensions for formal private sector workers and staff of government institutions (such as nurses and teachers) is organized by the CNSS. The CARENI is in charge of old age pensions for civil servants. Both schemes are based on contributions made by the employers and the employees. In the case of CARENI the employer dues are directly financed by the state treasury. Although trade unions are part of the governing board of the CNSS and participate in social dialogue they have not been able to make the existing systems more inclusive.

Apart from these social security pension schemes, several social assistance programs and safety nets which target the most vulnerable groups in society and give in-kind or cash benefits have been implemented, such as the Safety Net Programme financed by the World Bank in 2010, mentioned above. These safety nets generally provide assistance in times of food crises caused by natural disasters, such as droughts. Although the elderly can receive assistance they are not specifically targeted by the existing social assistance schemes. Robalino et al. (2012) argue that these schemes could form the foundation for a more comprehensive social protection system. The authors stipulate that the cash transfer programmes can be used to set-up basic systems for identification, targeting, record keeping, and benefits payment. Building on this platform other programs – such as social insurance, active labour market programmes and voluntary savings arrangements – could be gradually connected. According to Robalino et al. (2012) the Nigerien government should primarily focus on the rationalization of assistance programs and improvement of targeting mechanisms, which will lead to investments in basic administrative infrastructure that could be used for the development of more effective social insurance schemes in the future (Robalino et al., 2012: 23-24).

Next to the statutory schemes many community-based schemes exist as well. These schemes are based on traditional solidarity mechanisms rooted in family, clan or occupational networks. Members give voluntary contributions to the schemes and can benefit from them when in need for instance in the case of marriage, funerals or baptisms. Community-based regimes which are specifically designed for the provision of old age pensions do not exist but community based regimes could of course be used if an elderly person is in need of social assistance. The interviews conducted by Issa Younoussi, did not provide examples of the community-based solidarity mechanisms that have the potential to be scaled-

up. As aforementioned this is partly due to the weaker institutionalization of such solidarity mechanism in Niger.

3.2. Occupational accidents and illness

There is a legislative framework for insurance against occupational accidents and illness in Niger (see table Key Social Protection Indicators). The CNSS is the governing body and provides benefits in the case of occupational accidents and illness to its members in return for contributions (due to the poor administrative and records keeping capacity and fragmentation between the different branches of the CNSS statistical data on contribution, coverage etc. is not available). As mentioned above the CNSS however does not include informal workers amongst its beneficiaries. As is the case for old age pensions, informal workers can in theory resort to traditional safety nets based on family of kin ties when in need of financial help due to work related injuries. Specific informal schemes which provide protection against these types of risks do however not exist in Niger.

Social assistance schemes moreover do not provide protection against loss of income or compensation for work-related accidents or illness. Notwithstanding it is worth mentioning that international pressure has intensified for incorporating and ensuring workers' rights in all World Bank projects, in particular their cash-for-work projects, such as the one mentioned above[22]. The Global Union Federations (GUFs) have been successful in their lobbying strategies in some cases (e.g. Building and Woodworkers International's lobby resulted in the adoption of social security provisions for contract workers in World Bank construction project in Iraq)[23]. If the safety net projects of the World Bank and other donors are to contribute to a comprehensive social protection strategy in the future, basic social security standards (C102, ILO 1952) must be provided and ensured. The cash-for-work programmes miss an opportunity to enhance workers' income security if benefits for occupational accidents and illness are not granted to the beneficiaries of these social assistance schemes.

Trade unions are actively raising awareness amongst informal workers to subscribe to the CNSS so that they can be able to access the benefits but informal workers are reluctant to join as they perceive it to be an indirect way of imposing taxes on them for which they will, in their eyes, receive little in return. The low levels of organization amongst informal workers in Niger also make it difficult to access protection for risk, in particular occupational accidents and illness. This, on the one hand, leads to little leverage over policy-making processes dealing with social protection and, on the other, limits the potential of developing informal insurance schemes. The example of Transvie in Senegal, for instance, implicates that a level of organization amongst informal workers, is one of the factors which enable the creation of *mutuelles*.

[22] The ITUC for instance issues an official statement which urged the IMF and World Bank to protect workers' rights in all their development interventions.

[23] For more information on this care see http://www.equaltimes.org/behind-the-world-banks-projects-in-iraq#.U2yhSIF_t2g

3.3. Health care

Health care provisions in Niger can be divided into three groups: statutory health care through the CNSS, social assistance in the form of waivers for the most vulnerable groups and children under 5 and the *mutuelles de Santé.*

The new 2010 constitution includes legislation concerning the rights to health and the labour code of 1996 also obliges employers to protect the health and life of their workers and control health hazards and risk as well as allow medical consultation (L'ordonnance n° 96-039 du 29 juin 1996). The *Plan de Développement Sanitaire* (PDS 2011-2015), provides another institutional framework for health care in Niger. The PDS has the following strategies:

- Increase the coverage of health care
- Increase the quality of reproductive health services
- Improve human resources and competences of health providers
- Ensure permanent availability of medicines, vaccines, and medical equip[met
- Decrease prevalence of diseases by an integrated monitoring system
- Improve the governance and leadership of the Ministry of Public Health
- Promote health related research

Granting all this, it is regrettable that the 95 page document not once mentions informal workers. The document starts with a list of international guidelines and recommendations such as the Millennium Development Goals and the PRSP to which it is bound, but has neglected the labour perspective of health care (PDS, 2011-2015). In what follows we will discuss the existing health care systems and the necessity of developing a strategy that explicitly targets informal workers.

Statutory health care is managed by the CNSS and is accessible for private and public sector workers. In similar vein to the pensions scheme, during the fieldwork Issa Younoussi was not able to obtain data on the coverage, contributions etc. due to the inefficient functioning of the CNSS. There is no central statistical service which keeps records of CNSS schemes, beneficiaries, contributions etc., and the desks of the various branches of the CNSS often did not have up to date data either. The research did indicate that many formal workers have additional health insurance through *mutuelles*, which are often formed on occupational lines. In contrast with other countries, informal workers do not have access to these mutual insurance schemes, as they require registration under the labour code, which for most informal workers is problematic.

In 2008 the ILO supported the creation of a specific health insurance scheme for civil servants and granted 1 million FCFA to the Nigerien government for the development of a *Cellule d'Appui au Développement des Mutuelles de Santé* (CADEMS). There was conflict amongst several ministries over the authority of CADEMS, which according to Younoussi is due to "*political tensions"*. Finally, the directorate fell under the responsibility of the Ministry of Public Affairs and since 2011 the Ministry of Public Affairs and the Ministry of Public Health jointly manage the CADEMS. The health care scheme for civil servants is not functional up to this day.

Although unions have been trying to convince informal workers to subscribe to the labour code, in order to receive health care through the CNSS or *mutuelle*s, their efforts up till now have been in vain. For the most vulnerable groups the state has installed a social assistance scheme in which free health care is offered for certain diseases. Informal workers might be selected but the scheme does not specifically target them. Informal workers are reached by universal social assistance schemes related to health, which were created in 2005 such as, free medical care for children up until 5 years of age, pregnant women and free care for caesarians, family planning and gynecological cancers. These initiatives are to a large extent financed by the World Bank and the IMF. Data on the coverage, effectiveness and quality of these projects is not available. In conclusion the majority of informal workers "*doivent se débrouiller*" (have to fend for themselves) according to Younoussi, by relying on family- or kin-ties in case of health related costs.

4. Conclusion and recommendations

Compared to the previous cases, Guinea and Senegal, Niger has a much less developed social protection system. Due to the high poverty incidence and in some regions extreme vulnerability to food and environment crises, social protection in Niger primarily takes the form of emergency relief or ad hoc social assistance for targeted groups. Against this backdrop the World Bank's Safety Nets Project aims at reducing chronic food vulnerability but fails to address important vulnerabilities related to labour. The contributory social security scheme is not adjusted to the Nigerien labour market and in reality most informal workers resort to traditional safety nets, such as family and kin ties when confronted with loss of income. The economic growth the country has witnessed in 2011 is however a window of opportunity for taking a new approach towards social protection. The economic growth, albeit centralized in the mining industry, has increases the government's budgets and this could be used to finance social services and social protection schemes. This could decrease the dependency on international donors and allow for a more country-owned approach, instead of designing schemes for the sake of attracting donor funds. Building on these insights we would like to recommend the following focus areas and strategies.

- *First things first.* The primary step that could be taken by Nigerien unions is lobbying the government to include informal workers in the labour code as well as key policy documents related to social protection such as the *Plan de Développement Sanitaire* (PDS 2011-2015). The silence of informal workers is a negation of the reality of the Nigerien labour market. The deadlock in the implementation of the Social Protection bill, voted in 2011, could be an opportunity for trade unions to re-open the discussions, specifically stressing the importance of the incorporation of informal workers in the laws and regulations on social protection as well as the development and implementation of social protection programmes.
- *Picking your battles.* Niger ranked the lowest in the HDI in 2012 and has a poverty incidence of 59,5%[24] (World Bank, 2014) making it extremely important for the government to prioritize in social expenditure. This, to a certain extent goes against the systems approach which has been advocated to be a realistic path for Niger by Robalino et al. (2012), but might be preferable in

[24] http://data.worldbank.org/country/niger

the context of Niger, with particularly weak state institutions and services. Trade Unions could play a role in defining the priorities based on the needs and perceptions of their constituencies[25].

- *Redistributing revenues gained from mineral resources.* The policy papers and academic articles and reports do not link the social protection agenda with the economic potential of the extractive industries. Trade unions could lobby to put this issue on the political agenda. The revenues gained from the extraction of Uranium and Gold for example – which according to AEO 2013 will increase significantly over the following years – could serve as a financial base for social expenditures (health, education, …). The striking fact that the country's GDP growth was over 13% in 2012, whilst it ranked as the lowest country on the HDI in the same year, could be used as a lobbying tool.
- *Taking initiative.* Instead of trying to convince informal workers to register with the labour code in order to be allowed to access social protection through the CNSS, it might make more sense if unions think about alternative strategies. The CNSS is the only, slightly institutionalized, provider of social security in Niger and therefore has been the aim of union's awareness raising activities, but our findings indicate that there are multiple reasons obstructing informal workers from registering, most notably the mistrust in the government. Unions could consider developing their own *mutuelles* for health care for example.
- *Ensuring decent work.* Unions could play an important role, in cooperation with the GUFs and ITUC, in pressuring the government and international donors, such as the World Bank, to include workers' rights and social protection guarantees in the set-up of social assistance programmes, in particular in cash-for-work projects.
- *Joining Forces.* The multi-actor analysis of Niger has identified a number of possible partners for CNT in their actions related to social protection (see annex 1). The field data suggest two relevant groups of actors: the *Associations de défense des droits de l'homme,* or those organizations which operate on human rights issues, and the platform of civil society actors, NGOs and associations, which has been created to advise the government on issues regarding social protection. The main challenge, according to the fieldwork, is the lack of harmonization and the un-institutionalized nature of both groups, which incapacitates the political leverage they have.

The role of CNV Internationaal in these endeavours could take to form of: organizing exchange events between Nigerien unions and those in countries which met similar obstacles and found ways to overcome them; supporting the improvement of lobbying and advocacy skills; and supporting a local awareness raising campaign. An awareness raising campaign in the Netherlands about the misuse of the revenues of natural resources, such as uranium and gold, might also assist their partners in pressuring the Niger government into spending the gained revenues more equitably . Furthermore assisting the GUFs and ITUC in their lobby efforts towards the World Bank towards the

[25] Based on our own assessment we recommend prioritising health care and food security.

inclusion of basic labour rights in all their development projects would increase the political leverage of local unions in their struggle.

CHAPTER 4: Togo

1. Setting the Scene

1.1. Socio-political and economic context

The following is primarily based on the CNV context study, "Words cannot be eaten, but they can give hope: perspectives for the trade union movement in Togo", by Keja et al. (2011). For a more detailed overview of the socio-political and economic context of Togo we kindly refer to this report.

Togo, former German colony turned French and English protectorate after WOI, gained independence in 1957 (West-Togoland became part of the independent state of Ghana) and 1960 (French Togo became the Republic of Togo).

The contemporary political history of Togo can be divided into three periods: the short and violent rule of Olympio from 1961 to 1963, followed by the short presidency of Grunitzky between 1963 and 1967 and the long and oppressive dictatorship of Gnassingbé Eyadéma of the *Rassemblement du Peuple Togolais* (RPT) from 1967 until 2005, and the succession by his son Faure Essosimna Gnassingbé. Gnassingbé installed some reforms but still primarily uses his father's divide-and-rule tactics to remain in power. In sum Togo's turbulent post-colonial history was marked by neo-patrimonial practices, oppression of opposition and a series of paper-elections in which the ruling party consequently ended up competing against itself due to persistent boycotts by the opposition (Keja et al., 2011).

The overhaul of the political landscape in 2012 has been a source of tension and much debate. The Togo People's Rally (RPT), the ruling party created in 1969, was dissolved in April 2012 in order to form a new party, the Union for the Republic (UNIR). The 50 RPT representatives formed a parliamentary majority group (GMP) and succeeded in maintaining the RPT majority obtained during the legislative elections of October 2007 (the National Assembly has 91 seats). In response to the postponement of elections scheduled for 2012, six opposition parties joined together in the Rainbow Coalition in August 2012. For similar reasons, the Let's Save Togo Movement (CST), comprising seven opposition parties and civil society organisations, has held protests which have often degenerated into confrontation with police forces. In this new political environment, the government has opened negotiations with the opposition regarding institutional and constitutional reforms, in order to determine the length of the president's term in office and to set electoral districts. The extent to which the upcoming legislative elections unfold peacefully will be a determining factor in maintaining calm in the country (AEO Togo, 2013).

Trade Union Rights

Right to Organise: the law prohibits anti-union discrimination but some categories of workers are prohibited from organising (e.g. police and workers in Expert Processing Zones)
Right to Strike: Public servants are not allowed to strike (including health workers)
(ITUC, Survey of Violations of Trade Union Rights, 2010c)

1.2. Economic Context

Togo is among the poorest countries in the world. Real GDP per capita barely changed between 1960 and the end of the 1990s, though recent years have shown some better performance (Keja, et al., 2011). Togo ranks 159 out of 187 on the HDI with a score of 0,459 and has a GINI coefficient of 39,3 in line with the average of low HDI countries (HDR, 2014).

Togo holds considerable mineral reserves most notably it is one of the largest phosphate producers in Africa. It also has significant iron ore reserves and large deposits of marble and calcareous rock. Regrettably, similar to the situation in Niger and Guinea, the returns from the extractive industries have not been reinvested in the country's overall development. The strength of the Togolese natural resource sector is that it has the potential of creating employment due to processing industries linked to the extraction of phosphate and cement for instance. In addition the sector is more diversified then for instance Guinea that heavily depends on the extraction of Bauxite (AEO Togo, 2013).

Nevertheless, there is little economic transformation and diversification and in 2012 the primary sector contributed 38% to the GDP, ahead of the tertiary sector (23%) and secondary sector (21%). Agriculture is an important sector and is good for 27% of the GDP. Interestingly, Togo's growth is also stimulated through public works, such as the construction of roads, (which is counted as a form of social protection by some classifications). Together with cotton, phosphate, and construction sectors, estimated growth for 2012 was 5.9%. Despite relatively stable growth (on average 5% 2011-2014) and inflation rates, extreme poverty rose from 28.6% to 30.4% between 2006 and 2011 (Ntagungira, 2014).

Table 15: Macro-economic indicators

	2012	2013(e)	2014(p)	2015(p)
Real GDP growth	5.9	5.6	6	6.3
Real GDP per capita growth	3.3	3.1	3.4	3.7
CPI inflation	2.6	1.8	2.3	1.6
Budget balance % GDP	-5.8	-4.6	-5.3	-4.4
Current account balance % GDP	-11.9	-11.7	-13.3	-13.8

Source: estimates (e) and projections (p) based on authors' Ntagungira (2014) calculations.

If we look at the Togolese labour market, the huge youth unemployment and underemployment poses many challenges. Togo's population is very young; with 60% aged under 25 and 8.1% of the youth is unemployment, whereas the percentage of underemployment is 20.5% (Ntagungira, 2014). Child labour also poses significant challenges as 55% of children between 5 and 14 are engaged in work. Children are moreover most vulnerable to fall into poverty (World Bank, 2012).

Most employment is in subsistence agriculture in rural areas or in the urban informal sector, where services dominate. Agriculture accounts for almost 60% of national employment. Commerce and trade

in urban areas is the largest source of employment, accounting for 22% of national employment. There has been a marked shift in sector employment, with a rising share in services, a falling share for industry, and little change in the dominance of agriculture. With the rise in the share of services in GDP, there has been a dramatic fall in productivity in this sector. In addition, the sector with the highest productivity – industry – has shown the least growth in employment. Thus, there has been a relative shift in the sector composition from high productivity industrial employment to lower productivity service sector jobs. This has led to a decrease in overall labour productivity in the economy. The figures below show that in fact the Togolese economy is largely informal (Keja et al., 2011).

Table 16: Wage and self-employment status by sector

Sector	Wage/piece-rate earner	Self-employed/family helper	Total
Agriculture	0.9%	58.0%	58.9%
Mining	0.2%	0.4%	0.6%
Manufacturing	0.5%	3.2%	3.7%
Construction	0.6%	1.2%	1.7%
Transport	1.1%	1.5%	2.6%
Commerce and Trade	1.3%	20.2%	21.5%
Education/ Health	2.0%	0.6%	2.6%
Administration	0.8%	0.1%	0.9%
Financial Services	1.7%	4.4%	6.1%
Other Services	0.3%	1.1%	1.4%
Total	9.4%	90.6%	100.0%

Source: World Bank 2010 in Keja et al., 2011

2. Social Protection

In the following we will discuss the state of social protection in Togo, followed by a mapping of the existing social protection schemes in the field of old age pensions, occupational accidents and illness and

health care. For an overview of the available social security statistical data as well as, key legislation and the ratification of key ILO conventions, please see annex 2.

2.1. The state of Social Protection in Togo

Togo has no national social protection strategy but the country does have several social protection schemes and institutions and a number of laws and regulations that regulate different aspects of social protection:

- Social Security Code, managed by the CNSS (law 2011-006 of 21 February 2011)
- Law N° 2011/0031 of 18 February 2011, regarding the mandatory regime of health insurance
- Ordinance N°68-16 of 5 June 1968, regarding the pension schemes
- The Public Health Code
- Law N° 2008-003 of 26 May 2008, which fixes the age of admission for pensions (60 years) for the private and public sector
- Interministerial arrest N°002/2012, which fixes the modalities of the list of professional illnesses
- Arrest N° 12/92/MBES-SN of 1er September 1992, regarding the *Agence de solidarité Nationale*.

Al these laws and regulations do not explicitly mention informal workers, except the pension branch and family benefits branch of the Social Security Code, in which informal workers are specifically mentioned but the extension has not been implemented yet.

This amalgam of laws is complemented with an equally diverse set of involved ministries. The following ministries are active in the field of social protection: Ministry of Work, Employment and Social Security; Ministry of Social Protection and National Solidarity; Ministry of Education; Ministry of Health; Ministry of Agriculture, Livestock and Fishing; Ministry of Finance; Ministry of Planning; and Ministry of Community Development, Handicraft, Youth and Youth Employment (World Bank, 2012). There is general lack of harmonisation and coordination of tasks amongst all these government institutions which leads to sub-optimal service delivery.

The World Bank in cooperation with other donors such as UNICEF, ILO, and UNDP, have since 2011 supported the Togolese government with the creation of social protection strategy which will allow a more coherent approach (World Bank, 2012).

AWorld Bank report (2012) on the state of social protection in Togo discusses two types of regimes, social assistance in the form of safety nets for the most vulnerable people and contributory schemes. The former fall under the responsibilities of the Ministry of Social Protection and National Solidarity and since 1992 the implementation is managed by the *Agence de Solidarité Nationale.* Social assistance primarily comes in the form of in-kind transfers of food through school feeding, nutrition supplements and food aid programmes. But cash transfers, temporary employment through labour intensive public works, and waivers for services (free caesarean sections or school fee waivers) are also provided in

Togo. Most safety net programs target highly vulnerable groups and coverage is limited, with the exception of universal programs like fee waivers for primary education. The share of GDP spend on safety nets is quite low and most spending goes to emergency measures in response to a specific crisis. The state budget and financial assistance from donors finance the social assistance interventions. Additionally the World Bank report mentions a trade-off between coverage and intensity. Some programmes have a wide coverage but the benefits are so low that the project has little impact on the livelihoods of people. Targeted programmes on the other hand have problems with regards to identifying the indigents, as health care centres do not apply a uniform approach (see World Bank, 2012 for an overview of all safety programmes, coverage and budgets).
Based on the field data collected by Pierre Zanou for the Togo case, social assistance in Togo has the following limitations:

- The governance is characterised by slow decision making and the administrative burdens between the Ministry in charge and the ones who provide the finances.
- There is a perpetual conflict between the people in charge of the Ministry and the trade unions
- There is a lack of financial, material and human resources. The Agency for National Solidarity for example only has 18 executives for the entire country.
- The notoriously unmotivated staff of the Ministry and the Agency for National Solidarity

Despite the limitations mentioned above the political will which lead to the creation of a Ministry, which oversees National Solidarity, as well as the initiatives taken by this Ministry to enrol certain solidarity actions are signs of a commitment by the government towards social assistance.

The mandatory contributory social insurance scheme for all private sector employees and government-employed staff is managed by the CNSS, which is divided into three branches: the family and maternity branch (child care, maternity leave, etc.), the pension's branch (old age, survivors and disability pensions), and the professional risks branch (benefits for occupational accidents and illness). Unlike most Francophone West African countries the CNSS does not foresee health insurance and health care and unemployment benefits are also not provided. Salaried workers pay 4% of their salary to the CNSS and employers pay the other 16.5% (see World Bank, 2012 for an overview of all contributory programmes, coverage and budgets). The CNSS is managed by a tripartite board but CSTT, CNV Internationaal's partners, is not part of the CNSS board, although they are part of the governing board of INAM). The *Caisse de Retraite du Togo* (CRT) provides pensions, disability, survivor pensions, and family allocations to civil servants based on contributions of 7% of base salaries and a state contribution of 20%.

In 2011 the first steps towards statutory health care were made with the creation of the *"Institute National d'Assurance Maladie*" (INAM) which provides health insurance coverage for the public sector, including the central administration, local administration , para-public agencies, and retired public sector workers. The financing base of INAM is 7% of base salaries, paid in equal amounts by the employee and the state.

INAM might present an improvement of the social insurance system in Togo yet several limitations can be discerned based on the interviews conducted for this care study:

- The mandatory insurance scheme of the CNSS only covers 10% (in 2012 the World Bank stated that the coverage was 5%) of the population or approx. 4.000.000 people
- There is a lack of transparency in the governance of the CNSS
- The management is centralised and there are cases of clientelism
- The social dialogue which should supervise the functioning of the CNSS is not effective
- The extension to the informal workers has not been implemented despite the adoption of the Social Security Code in 2011.

Table 17: Social Protection Schemes in Togo

	Old age	Survivor	Disability	Occupational accidents and illness	Child benefits	Maternity benefits	Health care	Unemployment	Cash/in-kind tranfers
CRT	x	x	x		x	x			
CNSS	x	x	x	x	x	x			
Mutuelles							x		
Agency of National Solidarity									X
INAM							x		

Source: fieldwork report (Zanou, 2014)

2.2. Recent reforms

The Government of Togo has made important advances in the area of social protection, over the last several years, and aims to achieve universal social protection.

In 2011 the Togolese Government has identified the general objective for social protection as, "to protect the Togolese population against vulnerabilities and social risks". Building on this the World Bank (2012) suggests considering the following strategic objectives:

1) Develop and extend a reliable and financially sustainable contributory social insurance system that addresses the risks of old age, death and disability to all households able to participate.
2) Ensure access to health services, improve health outcomes and mitigate the adverse effects of health shocks by developing contributory mechanisms of health insurance.

3) Prevent destitution and build human capital of the most vulnerable through an integrated system of safety net interventions that address the needs of the chronic poor, those affected by shocks and the needs of specific vulnerable groups.
4) Promote employability and access to jobs and income and safe working conditions among groups likely to be excluded from the labour market

The World Bank (2012) furthermore argues for the adoption of a *"systems approach which reduces fragmentation, promotes harmonization and can enhance both the performance of individual programs and the overall functions of social protection in creating opportunities, providing resilience and promoting equity"* (World Bank, 2012: iv). In sum a systems approach involves actively seeking linkages between existing programs, like Robalino et al. (2012) proffer as well.

In 2011 a new Social Security code was adopted by the government (law n. 2011-06 of February 2011 on the social security code). The code foresees the extension of social insurance coverage through the CNSS and CRT to informal workers. According to the World Bank (2012: 29) "*this can however only be successful if the credibility and reliability of the CNSS and CRT is addressed"*. The World Bank also argues that the government must take traditional voluntary savings mechanisms or other forms of mutual insurance via professional associations into account (World Bank, 2012: 29).

3. Focal Themes

3.1. Old Age Pensions

The old age pensions are managed by the CNSS for workers with a formal contract. Employees who have reached the age of 60 and can prove they have worked and paid contributions to the CNSS for at least 180 months and have stopped receiving a salary have the right to a pension (article 42 of the Social Security Code). From 55 years onwards workers have the right to a pension if he or she is physically or mentally incapable of doing their job. The pensions are reduced with 5% every year the pension is granted before 60 years. If the conditions mentioned above are not respected people can receive allocations for old age, the decease of a spouse or invalidity. Although the CNSS on paper is extended to informal workers the implementation of this commitment has been subject to discussion amongst the involved ministries, the CNSS and other partners since 2011.

As mentioned above civil servants are affiliated to the CRT which has 20 000 affiliates. There are two important shortcomings worth mentioning concerning the CRT: it does not offer protection against work related injuries or illness and has a chronic budget deficit.

Similar to the country case studies discussed above, the majority of workers rely on traditional solidarity mechanisms at old age. Institutionalized informal pension schemes nonetheless do not exist and many individuals are particularly vulnerable at old age. This implies that they could be targeted by the aforementioned social assistance schemes, but these safety nets are at present not specifically designed to reach people at old age. Private insurance is only a possibility for those who have sufficient financial means.

3.2. Occupational Accidents and Illness

Benefits for work related accidents and illnesses are managed by the CNSS, more specifically by the branch of professional risks. According to the social security code a victim of a work related accident is entitled to:

- Medical care (consultations, medical/surgical care, medical tests, check-ups at the hospital/health centre, work related illnesses)
- A compensation for the days incapable of working
- A invalidity pension in case of permanent invalidity caused by the accident at work
- The funeral costs and a survivors pension are is paid to the family if the worker died at work or as a cause of a work related injury
- Benefits are also paid to the family if the worker is declared to be handicapped for more than 66%

Compensation for work related illnesses is granted by decree and according to a list of professional illnesses which is regularly revised by the Ministry of Health and Work.

Without repeating ourselves, it is clear that most informal workers in Togo do not have any protection against occupational accidents and illness, except for traditional forms of solidarity. The government has to a certain extent missed an opportunity by not including the branch of professional risks in their commitment to extend social security to those in informal employment. Whereas the pension and family and maternity branches of the Social Security Code make reference to informal workers, protection against occupational accidents and illness have not been included.

3.3. Health care

Health care in Togo, like in many other Sub Saharan Countries *is characterized by medical plurality, ranging from local traditional healers to national hospitals and everything in between* (Leliveld et al., 2010: 256). Although health care systems in Togo date back to missionary posts, the system has underwent significant changes over the last decades, according to Leliveld et al. (2010: 256), due to the monetization of the medicines as well as treatment. Against this backdrop, scholars and policy makers have argued that community-based health insurance schemes could increase the accessibility to professional healthcare. Leliveld et al. (2010) however conclude that these initiatives might not be sufficient for increasing health care services to the poorest, because the contribution fees to community-based health insurance schemes cannot be paid by the most vulnerable groups. Equitable access to health services could be achieved through fee waivers or lower premiums for vulnerable groups, such as children or the very poor, although the feasibility of such options needs further investigation. According to a World Bank study (2012) an estimated 6% of the population is covered by some type of health insurance, of which 4% by the INAM regime.

According to Zanou, there are some 30 m*utuelles* in Togo with an estimated 600.000 beneficiaries. Some *mutuelles* function on the basis of microcredit schemes whilst other are based on the principle of solidarity. The functioning of *mutuelles* has been described previously and they work in similar fashion in Togo. The Togolese *mutuelles* however only have agreements with health centers and not with hospitals

which creates problems when people have severe injuries or diseases, which requires medical care that cannot be provided in a health centre. The CSTT has its own *mutuelle,* MUSA, which has been created for agricultural workers, workers in the transport sector and artisans. As mentioned above the *mutuelles* primarily offer health care insurance[26].

The Shortcomings of the *Mutuelles*

- Bad governance and lack of expertise in managing risks
- Lack of financial resources for repaying medical care
- Declining spirit of solidarity (nationally and internationally)
- Lack of respect for the UEMOA standards
- Dependency on international donors: many mutuelles collapse when the external funding dries up (e.g. Belgian support which dried up)
- The government mistrusts the mutuelles and refrains from actively supporting them
- Lack of regulatory framework to govern the mutuelles
- Incoherence between different implementing agencies (religious groups, NGOs, community-saving schemes, occupational groups)

As previously discusses the CNSS does not provide health care. In 2009 the government did take initiative to create and health insurance scheme for public sector workers and installed the INAM. INAM is a mandatory, contributory health insurance scheme which covers the following public workers:

- Staff of the Public Administration
- Civil Servants
- Magistrats
- Professional military-staff (customs, fire-fighters, prison guards, forest guards)
- Local authorities
- Retired public servants

The Togolese government has expressed that INAM is a first step in creating a universal health insurance scheme as promoted by the ILO's social protection floor initiative. But the scheme already has delays in payment of benefits and in general the Togolese government and the administration is not yet ready for the delivery of universal health care according to the respondents interviewed for this case study.

[26] Please see http://www.coopami.org/fr/countries/countries_partners/cote_ivoire/social_protection/pdf/social_protection03.pdf for more the reglementation of the UEMOA regarding *Mutuelles*

4. Conclusion and recommendations

In conclusion, there are several factors which inhibit informal workers to access social protection in Togo: the uncertainty of their income and the fact that their income is not formally registered; the absence of a focal point or ombudsman for informal workers; the lack of statistical data on informal employment; The deficit of the pension branch of the CNSS; The fact that the social security code has not extended the protection for work related accidents and illness to informal workers; and the fact that many informal workers cannot meet the obligation of regularly contributions to the *mutuelles* (therefore many *mutuelles* build up debts). Building on these insights we recommend the following priority areas for Togolese unions in their struggle for more accessible social protection.

- *First things first.* The primary step that could be taken by Togolese unions is lobbying the government to include informal workers in all branches of the Social Security Code that was adopted in 2011. The enforcement of the C102 into national law could also be an important lobby point for Togolese unions and CSTT, specifically.
- *Putting your action where your mouth is.* Unions have an important role to play in ensuring that the Social Security Code, which at present remains a paper commitment, will materialize. The aspirations to expanding INAM to a universal health insurance code could also be monitored. If the government seems to take this commitment seriously unions should lobby for its participatory preparation and implementation.
- *Addressing unequal governing structures.* Although the governing board of the CNSS is not effective at the moment it is important that CSTT is included in its structure.
- *Increasing coherence.* As mentioned above, the multitude of programmes, strategies and projects need to be streamlined. Trade unions could put pressure on the government to develop a system's approach, based on the complementarity of social protection schemes (see Robalino et al., 2012). Although the Social Security Code tries to encompass the different formal schemes a systems approach entails including informal mechanisms as well as redistribution.
- *Delineating tasks and responsibilities.* Unions could advocate installing a clear division of labour between all relevant actors in the social protection landscape in Togo. Specifically the multitudes of ministries which are involved require well-defined responsibilities in order to increase coherence and complementarity. Trade unions could take up their watch-dog role and raise awareness about illicit practices or corruption in the field of social protection.
- *Picking your battles.* In similar vein to the recommendations for the other case studies it is important to prioritize in social expenditure. The Togolese national budget is limited and needs are many. Trade Unions could play a role in defining the priorities based on the needs and perceptions of their constituencies[27].
- *Redistributing.* The policy papers and academic articles and reports do not link the social protection agenda with the increased inequality in many African countries. Income inequality is increasing in Togo and 62% of the Togolese live below the absolute poverty line (GIZ, n.d.).

[27] Based on our own assessment we recommend prioritising health care.

Trade unions, therefore could lobby to put redistribution on the political agenda: the revenues gained from key industries could serve as a financial base for social expenditures (health, education, …)

- *Investing in quality*. In addition, building on Criel et al.'s (2002) study and similar to the recommendation for Guinea, unions could equally stress the importance of the quality of health care and other social protection benefits. Increasing coverage to insurance schemes is namely related to the quality of the benefits that one receives in return for his/her contribution.
- *Taking initiative*. Alternatively, trade unions could increase their efforts in establishing *mutuelles,* to the example of MUSA. CSTT could investigate if and how MUSA could be scaled-up to other sectors which employ many informal workers. In sectors where the informal workers are not yet well organized, unions could increase their efforts in organizing informal workers.
- *Joining forces.* In Togo there are few actors besides the Trade Unions who are working on the issue of social protection. The multi-actor analysis (see annex 1) does indicate that the *Ligue des Droits de l'Homme, l'Association des Consommateurs,* could be an interesting partner for CSTT, as they have influence on legislative processes. At the time of the research they were not directly involved with the issue of social protection but they work on the topic of human rights in general and in this sense they could support a rights-based approach to social protection.

The role of CNV Internationaal in these endeavours could take to form of: supporting the scaling-up of MUSA to other sectors; supporting the improvement of lobbying and advocacy skills; and supporting a local awareness raising campaign.

CHAPTER 5: Benin

1. Setting the Scene

1.1. Socio-political landscape

The following is primarily based on the CNV context study, "*Impossible n'est pas Beninois*: The economic and social context of the Trade Union Movement in Benin", by van Westen & Zanou (2010). For a more detailed overview of the socio-political and economic context of Togo we kindly refer to this report.

Benin, the former French colony Dahomey, became independent in 1960 and went through a decade of political instability which was characterized by coup d'états and ethnic strife. The insecurity ended in 1972 with the inauguration of Mathieu Kérékou, who initiated a socialist regime which lasted for two decades.

In 1979, the CNR was dissolved, and Kérékou arranged show elections in which he was the only candidate. Establishing relations with the People's Republic of China, North Korea, and Libya, he put nearly all businesses and economic activities under state control, causing foreign investment in Benin to dry up. In 1989, riots broke out after the regime did not have money to pay its army and the banking system collapsed. Eventually Kérékou renounced Marxism and a convention forced Kérékou to release political prisoners and arrange elections. Marxist-Leninism was also abolished as the nation's form of government. The name of the country was officially changed to the Republic of Benin on 1 March, 1990, once the newly formed country's constitution was completed. In 1991, Kérékou was defeated by Nicéphore Soglo, and became the first black African president to step down after an election. Kérékou returned to power after winning the 1996 vote. In 2001, a closely fought election resulted in Kérékou winning another term, after which his opponents claimed election irregularities.

On 5 March 2006 an election was held that was considered free and fair. The runoff election was held on 19 March, and was won by Boni, who assumed office on April 6. The success of the fair multi-party elections in Benin won praise internationally. Boni was reelected in 2011, taking 53.18% of the vote in the first round, becoming the first president to win an election without a runoff since the restoration of democracy in 1991. There were, however, some social tensions in 2012, including a long teachers' strike for higher wages and economic tensions between the president's office and an important economic operator who virtually controlled the two key sectors of the economy, namely cotton and port activities. Municipal and local elections in the first quarter of 2013 mobilised a good part of the country's political leaders and population.

Trade Union Rights

Freedom of Association: The unions must deposit their statutes with the competent authorities, including the Ministry of the Interior, to obtain legal recognition, or face a fine or prosecution.

Right to Collective Bargaining: Workers have the right to collective bargaining, with the exception of merchant shipping employees.

Right to Strike: Authorities or employers may unilaterally deem a strike illegal; civil servants prevented from striking and the length of a strike must be indicated in advance

(ITUC, Survey of Violations of Trade Union Rights, 2010d)

In line with Benin's socialist political history the country has a strong trade union movement. The transition to democracy in 1990 was for example supported by the unions and at present, unions continue to actively pressure the government to implement reforms to the benefit of their constituencies. The most recent example is the prolonged union struggle in the education sector. Unions have been in recurrent strikes to force the government to increase teachers´ wages in 2014. One of the main weaknesses is the fragmentation of the trade union landscape; the 7 federations are more often working against than in cooperation with each other.

1.2. Economic Analysis

After a period of stagnated growth in 2008-2009 caused by the global economic crisis, which lead to a significant decrease in Benin's export sector, the country seems to be recovering since 2011. The growth rate of the real economy increased from 2.6% in 2010 to 5,4% in 2012 (see table 18). The economic growth is primarily based on the revival of agriculture (in particular the cotton sector), which benefitted from good rainfall, as well as the port activities.

The government announced an administrative modernization in 2013 and 2014 with a threefold objective: to further mobilize its domestic resources; to make public spending consistent with its poverty-reduction strategy; and to improve the country's business climate in order to develop the private sector. In reality the emphasis has been placed on the last goal. According to van Westen & Zanou (2010) the Beninese government is obsessed with the business climate, to the detriment of labour. Nonetheless poverty reduction deserves to be prioritized, as more than 36% of the Beninese population is still living below the poverty line and serious backlogs in reaching the Millennium Development Goals (MDGs) remain huge challenge. The government's current account balance deficits (-8,5% in 2012) should also be tackled in order to sustain macro-economic stability.

Table 18: Key Economic indicators Benin

	2012	2013(e)	2014(p)	2015(p)
Real GDP growth	5.4	5	4.9	5.3
Real GDP per capita growth	2.7	2.3	2.3	2.7
CPI inflation	6.6	2.6	2.3	2.9
Budget balance % GDP	-1.3	-1.2	-1.1	-1.2
Current account balance % GDP	-8.5	-8.2	-7.9	-7.8

Source: estimates (e) and projections (p) based on authors' Ndoye & Fall (2014) calculations

Cotton is the most important crop in Benin and contributes up to 13% of the GDP and is good for 45% of the tax revenues. From a global perspective however Benin is a small player and agricultural diversification therefore remains important. The second important sector is trade. The port of Cotonou is an important import hub for the region and Benin's long border with Nigeria has resulted into vibrant trading activities. Aid is the third significant contributor to the economy and provides 10% of the GDP.

The informal economy contributes 49,1% to the GDP of Benin (2010) and approx. 93% of men and 97% of women, work in the informal economy. We should note however that these figures are approximations. Statistics often depart from a binary perspective on the informal and formal economy whereas the reality is much more complex. The data does show us that the majority of workers in Benin are informally employed. Most informal enterprises are part of the artisanal and commerce sector, 49,4% and 43,1% respectively, and 9 out of 10 businesses are set up in the informal economy (Ale, 2013). The informal sector is getting well established on the labour market. The trade union movement has therefore started to organise informal workers and self-employed, which for UNSTB has meant that the due paying membership has increased from 18,000 to 51,290 in a few years.

2. Social Protection

In the following we will discuss the state of social protection in Benin, followed by a mapping of the existing social protection schemes in the field of old age pensions, occupational accidents and illness and health care. For an overview of the available social security statistical data as well as, key legislation and the ratification of key ILO conventions, please see annex 2.

2.1. The state of Social Protection in Benin

Social protection in Benin – as in the other countries previously discussed in this report – has two historical lineages. On the one hand, traditional solidarity mechanisms which go back to pre-colonial times and are based on social capital, family or kin ties. On the other hand, Benin has inherited a mandatory social security system from its colonial rulers, based on contributions made by employers and employees.

In 1990 social protection was back on the political agenda, in line with the new constitution which guaranteed respect for the rights of the most vulnerable citizens. Social protection became a key component of several policy documents such as *Bénin 2025 Alafia, les Orientation Stratégiques du Développement* (ODS), PRSP (2007-2009) and the *Politiques et Stratégies Nationales de Protection Sociale* 2004-2013(PSNPS). These documents nevertheless lack concrete policy measure and represent a list of objectives and aspirations but no clear mechanisms for reaching these goals. In addition, none of the documents present a coherent framework in which different risks and social protection schemes are presented in a complementary way. The PDNPS for example only focuses on the social actions, or targeted solidarity actions of the state towards vulnerable groups (such as health care waivers for the most vulnerable).

In their review of social protection systems in Benin, Hodges et al. (2010) mention six types of schemes (we will discuss only four types based on the definition of social protection we have adopted). The first, social insurance, is built on the French model and is managed by the CNSS for private sector workers and the FNR for the public sector. Together they cover only 10% of the population. Both do not cover unemployment benefits and the CNSS, like in Togo, also does not offer health insurance. The other minimum standards of C102 of the ILO have been translated into a social security code by the Beninese government, which was altered in 2003, including a specific reference to the extension of social security to informal workers.

The CNSS in Benin has three branches. A family benefits branch that covers prenatal care, child care allowances and in-kind benefits for women in labour. A pensions branch which provides old age, disability and survivor benefits and a professional risks branch that offers income security in case for occupational accidents and diseases. Contributions are paid by the employer (5,4%) and employee (3,6%). CNSS has an tripartite administration and is managed by a Directory General, who is appointed by the government (although according to the ISSA this should be done by the Governing Board). The Governing Board has a tripartite structure in which employers, employers and the state are represented. The interviews conducted in Benin suggest that the viability of the CNSS only exists on paper (see box).

Shortcomings of the CNSS

- Only 24% of the contributions are collected
- Despite the investment of 800 million FCFA in improving the data collection and monitoring of the payment of benefits, sound information management has not yet materialized
- The insurance files of employers are not up to date
- The internal governance is not transparent
- The discussions between the General Director and the Governing Body on the amount of funds (from the contributions) that should be placed in the bank exemplify the internal conflicts
- Political interference in the management of the CNSS
- The fragmentation of trade unions which are presented in the CNSS mark the fragility of its functioning
- The social dialogue that should manage the CNSS is not functional
- Although the salaries of the staff and executives of CNSS have increased the services have not improved
- The extension of social protection to informal workers is perpetually in a state of reflection
- Lack of competent staff who can identify the level of one´s disability
- The CNSS has not conducted any studies on the current situation in reference to its future aspirations.

The *Mutuelle de Sécurité Sociale au Benin* (MSSB), created in 2011, in order to reach out to informal workers, also resorts under the social insurance scheme. The MSSB offers old age pensions and health insurance but covers only 5000 beneficiaries in 4 provinces, according to COSI. In general many people do not even know of its existence. In response to these shortcomings and following the Bamako initiative *Mutuelles de Santé* proliferated during the 1980s and 90s. Nevertheless only 1,8% of the population was registered by a *Mutuelle* in 2009.

The second social protection mechanism Hodges et al. (2010) mention are the social assistance schemes. According to them social assistance, or non-contributory social protection, is little developed in Benin. The Ministry of Family and National Solidarity (MFNS) does offer assistance to the most vulnerable groups but in 2008 only 1802 people were reached. Other examples are school feeding programs in disadvantaged areas or support for HIV/AIDS patients. In general we can say that these mechanisms have a limited impact and do not allow vulnerable people to structurally address their precarious situation. Although Hodges et al. (2010) place free education up until primary school and free health care for HIV/AIDS, tuberculosis and cesareans, under a separate category, according to our

definition these measure are also forms of social assistance. In similar vein, adopting our definition, the subsidies for food stuff also resort under social assistance, in contract with Hodges et al. (2010). Benin has presented subsidies for imported food, to poor families during the price spikes in 2007-2008. These subsidies yet mostly aided the upper classes as the subsidized goods were not part of the alimentary basket of poor households. In 2006 the government announced free health care for children up to 5 years of age but has not implemented the law as of yet.

A third form of social protection, identified by Hodges et al. (2010) in Benin, is the so-called "social actions". These include assistance in cases of abuse, violence, exploitation or orphanage shelters for instance. A multitude of actors are engaged in offering social assistance to vulnerable people such as NGOs and faith-based organizations (FBOs). The state has created, 84 *Centres de Promotion Sociales* (CPS) and 25 (SSS), across the country. The CPS offers assistance with problems in the localities whereas the SSS are linked to the hospitals. Both, notwithstanding, have chronic budget deficits and lack human and material resources to be able to carry out their responsibilities.

The fourth and last set of social protection measures discussed by Hodges et al. (2010) is the employment and revenue building strategies. In particular micro-finance institutions are well developed in Benin. In fact Hodges et al. (2010) argue they are the most development of the West African Monetary Union (WAMEU), with approx. 978.341 clients (about 20% of the active population) in 2008. It must be noted though that the extremely poor cannot access micro-credits and it is questionable whether micro-credits can fall under social protection schemes according to COSI representatives. Lastly, Employment policies are often short term projects which offer little support for the large number of youth in unemployment.

Table 19: Social Protection Schemes in Benin

	Old age	Survivor	Disability	Occupationnel accidents and illness	Child benefits	Maternity benefits	Health care	Unemployment	Cash/in-kind transfers
CNSS	x	x	x	x	x	x			
FNR	x						x		
MFSN									x
MSSB	x						x		
Social Actions							x		x
Micro-credit								x	
Mutuelles							x		

RAMU[28]							x		

Source: fieldwork report (Zanou, 2014)

2.2. Recent Reforms

An important shift was made in the social protection provisions of the state in 2011 with the proclamation of a *Régime de l'Assurance Maladie Universelle* (RAMU) a state-lead universal health insurance system. After a participatory process RAMU was adopted in 2013 and aims to increase the coverage of health care and create affordable medical care for all. The initiative was supported by the ILO, the World Bank, OMS, and the French and Swiss bilateral cooperation. The CNSS and FRN are also part of the institutional framework on which RAMU is founded and which has the following cornerstones:

- The level of contributions is based on one's respective capacity and the most vulnerable people are exempted from paying contributions
- Inter-generational and economical solidarity
- The state is responsible for the legal framework
- Equality of access
- Participatory management (trade unions for instance are part of the governing body)

RAMU is of particular interest for this study as it explicitly mentions informal workers as a key target group (RAMU, 2013). According to the website RAMU is supposed to offer the following benefits:

- Medical consultations and care
- Hospitalization
- Medicines and blood transfusions
- Laboratory examination, radiology and other medical imaging
- Mandatory vaccines (except those which are already offered for free)
- Equipment necessary for the recovery of the patient
- Transportation of the sick towards the hospital or medical centre
- Costs related to pregnancy and childbirth

Withal there are important challenges to be overcome regarding the implementation of RAMU, more specifically the financing, the management and accreditation mechanisms of this ambitious plan still raise questions. The programme was launched in 2011 by the president without knowing how it would be implemented and without a legislative and regulative framework. This last pitfall has led to the temporary suspension of the activities, even before RAMU kicked-off. In other words, the absence of a legal structure has inhibited RAMU from being executed. Trade unions and other members of civil society warned the government for this situation during the drafting of the initiative but fell on deaf ears. The open dialogue between all concerned partners (such as the federations) has been reinstalled and at this moment the law which will allow its implementation is being debated. .

[28] RAMU has of yet not been operationalised

2.3. Financing Social Spending

These ambitious plans of course cannot function on commitments alone; financial, material and human resources have to be in place to allow RAMU, and the other schemes mentioned above to be effective. Due to the plurality of mechanisms and actors the efficient allocation of resources is a core challenge for social protection in Benin according to Hodges et al. (2010). The diversity should initiate exchange of expertise and complementarity but in practice it often leads to incoherence and un-transparency. In addition, due to the freeze on the recruitment of government staff in the 1980s, following SAPs´ prescripts, there is a lack of civil servants. In 2010, 451 agents were employed by the MFSN, whereas 1286 people are needed to manage the programmes effectively (Hodges et al., 2010). The financial resources invested in social protection are also not up to standard, in 2009 6.39 million FCFA was spend, or 0,9% of public expenditure equivalent to 0,2% of GDP.

3. Focal Themes

3.1. Pension Schemes

There are two contributory and mandatory pension schemes in Benin: the CNSS for private sector workers and the FNR for permanent state employees (*Agents Permanents d´Etat* (APE)). The latter provides old age pensions but also family benefits and medical care (4/5 of hospital costs are covered by the FRN). Government staff have a right to a pension if they have reached the age of 60, have served for at least 30 years or if their medical or mental condition inhibits them from performing their job (note that there are specific categories of government personnel for whom other requirements count). In the case of the inability to work, a pension allowance will be granted but not an entire pension. Only 5,6% of the total Beninese population is covered by the FNR and that the pension branch has chronic deficits (the family and medical branch on the other hand have a surplus). The level of pensions granted can be altered by the government, if the SMIG increases or if the Statute of APE´s changes. At present the FNR is being restructured so that it can become an independent institution, which can manage its funds autonomously.

The CNSS provides pensions for salaried workers who have paid contributions to the scheme for at least 180 months and are 60 years or older. From 55 years of age, workers have a right to a proportional pension. Contributions are fixed and paid by the employer and employee. Some salaried workers voluntarily subscribe to the CNSS and in this instance pay both the employee and employer contributions in order to receive a retirement pension.

Table 20: Beneficiaries of the CNSS and FNR pension schemes

Year	2008	2009	2010	2011
Public Sector (FNR)	9467	9567	9767	1674
Private Sector (CNSS)	21073	22073	23860	23867

Source: fieldwork report (Zanou, 2014)

There are no pension schemes for informal workers albeit the provision in the social security code. The *mutuelles* governed by the Ministry of Labour (which will be discussed further on) are planning to

expand their services and specifically target informal workers. For most informal workers, traditional solidarity mechanisms are the safety nets whereupon people fall at old age.

3.2. Occupational accidents and illness

There is only one formal contributory security scheme which covers risks related to occupational accidents and illness, the CNSS. Civil servants and other government staff who fall under FNR, thus, do not have protection against work related accidents or illness. The following groups of salaried workers fall under the CNSS scheme and have a right to benefits related to occupational accidents and illness:

- Managers companies with limited liability
- Salaried executives of corporations
- Students of professional schools
- Interns
- Apprentices
- Members of cooperatives

The contributions are entirely paid by the employer and all costs are reimbursed for the following expenses:

- Surgical and dental medical assistance
- Radiological and laboratory examinations and analyses
- Medical care
- The funeral costs in case of decease
- If the person is disabled (for less than 20%) due to a work related injury he or she will receive a bulk disability benefit
- If the person is disable for more than 20% a disability pension will be granted

Benefits for occupational illnesses are granted on the base of a list of eligible illness developed by the state.

Informal workers are not protected against work related accidents and therefore CGTB, CNV International´s partner, as well as other trade unions such as the CSA and UNSTB put a large effort into raising awareness amongst informal workers about preventive measures, especially in high risk sectors such as transport for example. They have also been involved in the set-up of the *Fonds de Garantie d´Accident* (FGA) which is regrettable not functioning any more (see box below).

The Fonds de Garantie d´Accident

The FGA is a *mutuell*e who covers medical care in public hospitals and health centers for victims on the basis of an agreement between the service providers. However the FGA does not function accordingly and several obstacles prevent informal workers from accessing the FGA:

- The government has not yet made the funds available to allow for the subsidized health care
- There is not enough technical competence with regards to risk managing to allow the FGA to function properly
- The different institutions are politicized
- The trade unions do not have enough expertise and pedagogic training to influence the government in taking action and implementing the made commitments

Comparable to the case of old age pensions in Benin, informal workers fall back on solidarity mechanisms amongst family, kin or community members for work related injuries or illness. Because their income and survival depends on their ability to set up shop (in case of market women), or sell their goods on the street, many informal workers only seek medical care at critical moments; when they had such a bad injury that they cannot work or if they are so sick that they´re unable to stand on their own feet. This of course is to the detriment of their health and accentuates the need for protection against loss of income due to illness or accidents. Creating health centers that are near to the workplace of informal workers (such as in markets like in Accra or near transport stations like in Niamey) would increase the tendency of informal workers to seek medical aid sooner.

3.3. Health care

Health care in Benin is provided by a variety of actors, albeit only 8,4% of the population has health insurance: 5,6% through the FNR, 1,9% through the m*utuelles* and 0,9% through private insurance companies. The CNSS does not have a health care branch. In the private and semi-public sectors the health insurance schemes are created on the basis of collective agreements at enterprise level. These agreements generally lead to an insurance scheme for the workers as well as their families (with a limit of 6 children up to 21 years) and are financed by contributions of the employer (60%) and employee (40%).

In Benin there are two types of m*utuelles,* the *Mutuelle de Sécurité Sociale au Benin* (MSSB) which falls under the Ministry of Labour (see box) and *mutuelles* that are formed on the basis of community or occupational groups.

Mutuelle de Sécurité Sociale au Benin

The MSSB provides health care and old age pensions for informal workers (in particular artisans, artistes, farmers, fishers, cattle holders, traders and other professional associations) and was installed already in 1999. MSSB was installed with the technical and financial support of the ILO (STEP programme) and the Belgian Technical Cooperation and is based on a monthly fee of 2000 FCFA and is a voluntary scheme. The coverage is howver low with approximately 5000 beneficiaries in 4 provinces (Chadare, 2014) and the MSSB faces a number of structural problems:

- The lack of political will to provide the necessary subsidies
- The increase of the contribution to the detriment of the beneficiaries
- The administration's lack of human resources and expertise
- The role of every institution and branch is not clearly defined
- The monitoring is left to the managing authority (the Ministry of Labour)
- The misuse of funds

In 2013, under pressure of the ILO, reforms were initiated and the creation of a *Caisse de Prévoyance Sociale* (CPS) was announced. The governing structures have been ratified by decree in 2012 but up to date the institutions are not functioning. Furthermore the stated reforms, notable an increase of the contributions to 3000 FCFA for individuals and 7000 FCFA for a group membership, have not been implemented.

The traditional mutual insurance schemes have existed in Benin for several decennia, like in other West-African countries. In the beginning the *mutuelles* only provided health insurance but recently many are restructuring and diversifying their services. They are based on the principle of solidarity and usually have a contributory set-up. The beneficiaries are all households, specifically those who are vulnerable. It must be noted that expenses related to chronic diseases are in general not covered by the *mutuelles*¸ as well as, medical evacuations from or to hospitals abroad. The *mutuelles* in Benin have considerable political weight and are consulted during the drafting of new strategies and policies related to social protection. They are projected as community based organizations yet the field data suggests that they are confronted with problems related to organizational structure, registration, recognition and representation. Furthermore, the lack of a national legislative framework poses problems and many *mutuelles* do not follow the UEMOA guidelines, in particular those related to uniting and decentralizing. UEMOA argues that the *mutuelles* should form national confederations (similar to trade unions) but should also be managed in a decentralized fashion to avoid the concentration of power in the hands of a small elite. These initiatives should decrease corruption and increase harmonization and transparency amongst the *mutuelles* and their beneficiaries.

Both types of *mutuelles* make agreements with hospitals and health centers regarding the costs that need to paid. Payments are made directly to the hospital or health centre and can be recovered afterwards through the *mutuelles.* Honest cooperation between the *mutuelles* and health centers is important to insure the correct functioning of this type of health care system.

There are a few private insurance companies in Benin but, due to the high rate of contributions, only a small elite has private health insurance.

In Ale´s (2013) research on three informal sectors in Benin (namely catering, trade of unofficial petrol and agro-processing) not one *Mutuelle* was identified amongst the more than 60 economic-unites investigated. This suggests that workers´ organisations in the informal economy in Benin do not create their own *mutuelles*, in contrast with the examples we discussed above in Senegal (e.g. Transvie).

4. Conclusion and recommandations

In fear of repeating ourselves, Benin has witnessed a wave of policies related to social protection. The most significant ones in relation to the extension of social protection are the MSSB and RAMU. In this respect, the respondents interviewed for this study mentioned that the state must first and foremost execute the strategies it has adopted and respect the laws it has signed. In fact there is no lack of social protection mechanisms in Benin but an overload of fragmented approaches without a clear legal and policy structure which results into sub-optimal outcomes. For example, it is not clear how RAMU and the CPS will complement each other, although both intend to provide health insurance for informal workers. Trade unions in Benin are well organized and have made relative progress in reaching out to the informal economy. They therefore can play a significant role in the following areas of importance for the future development of social protection in the country.

- *First things first.* It is advisable for the Beninese government to ratify the core ILO convention on minimum standards of social protection, C102. Unions could lobby for this to be taken up by the government.
- *Putting your action where your mouth is.* Unions have an important role to play in ensuring that the RAMU and the reforms of the MSSB (now CPS), which at present remain paper commitments, will materialize. Unions could have an important role as watchdogs over the future implementation of both schemes.
- *Increasing coherence.* As mentioned above, the multitude of programmes, strategies and projects need to be streamlined. Trade unions could put pressure on the government to develop a system's approach, based on the complementarity of social protection schemes (see Robalino et al., 2012).
- *Delineating tasks and responsibilities.* Unions could advocate installing a clear division of labour between all relevant actors in the social protection landscape in Togo. Specifically the multitudes of ministries which are involved require well-defined responsibilities in order to increase coherence and complementarity. Trade unions could take up their watch-dog role and raise awareness about illicit practices or corruption in the field of social protection.

- *Picking your battles.* In similar vein to the recommendations for the other case studies it is important to prioritize in social expenditure. The Beninese national budget is limited and needs are many. Trade Unions could play a role in defining the priorities based on the needs and perceptions of their constituencies. Building on the initiatives taken with regards to health care (RAMU and CPS) seems logical.
- *Raising awareness*. Unions play important roles in raising awareness about the importance of health insurance and other forms of social protection. If RAMU and CPS are effectively implemented unions could specifically try to convince their members into subscribing to these schemes (MMSB in the past has for instance been quite effective in attracting members amongst informal workers).
- *Redistributing.* The policy papers and academic articles and reports do not link the social protection agenda with the increased inequality in many African countries. In terms of the inequality adjusted HDI Benin loses up to 35,8% on the HDI due to inequality (HDR, 2013). Trade unions, therefore could lobby to put redistribution on the political agenda: the revenues gained from key industries could serve as a financial base for social expenditures (health, education, …)
- *Investing in quality*. In addition, building on Criel et al.'s (2002) study and likewise to the recommendation for the other countries, unions could equally stress the importance of the quality of health care and other social protection benefits for that matter. Increasing coverage to insurance schemes is namely related to the quality of the benefits that one receives in return for his/her contribution.
- *Joining forces.* In Benin there are few actors besides the Trade Unions who are working on the issue of social protection. The multi-actor analysis (see annex 1) does indicate that the *Ligue des Droits de l'Homme et du Citoyen,* could be an interesting partner for CGTB and COSI. At the time of the research they were not directly involved with the issue of social protection but they work on the topic of human rights in general and in this sense they could support a rights-based approach to social protection.

The role of CNV Internationaal in these endeavours could take the form of: organizing exchange events between Beninese unions and unions in other countries which have met the same obstacles and have overcome them; supporting the improvement of lobbying and advocacy skills; and supporting a local awareness raising campaign.

CHAPTER 6: Examples from other countries

As mentioned in the introduction social protection in Africa has witnessed a boost over the last decade with multiple countries taking initiatives regarding the extension of protection to and the accessibility for informal workers. In this chapter we will briefly discuss the examples of social protection schemes in Rwanda and Ghana, as a point of reference, which have made relative progress with regards to extension of social protection to the informally employed. There are, of course, other countries which are worth mentioning as well; Ethiopia for instance, who – as one of the only countries in Africa – managed to developed a nationally owned social protection agenda to which donors must align (Holmes & Langwa-Ntale, 2012); and South Africa, with its three-tier old age pension scheme which has enabled an almost universal coverage (Van Zyl, 2003).

Before we present the integrated system of *mutuelles* in Rwanda and the National Health Insurance Scheme (NHIS) in Ghana, it is necessary to say that there have been multiple studies on both schemes, presenting pro's and con's, weaknesses and failures, but for the purpose of this report we will be slightly more positive and stress the lessons that can be learned for our case study countries (Guinea, Senegal, Niger, Togo and Benin). Those interested in a more nuanced in-depth reflections on the social protection systems in Ghana and Rwanda are invited to consult the extensive bibliography in annex which includes numerous references to these cases.

1. *Mutuelles* in Rwanda: Extending Coverage

The Rwandese government has since 2005 increased its commitment towards Social Protection. After the elaboration of a social protection policy in 2005 and a Public Expenditure Review (PER) in 2006 social protection was adopted as one of the priority sectors in the Economic Development and Poverty Reduction Strategy of 2007, by the government. Rwanda has an elaborate set of social security schemes for the private and public sector, well-functioning labour market programs (the Umurenge Programme) and of particular interest for this report *mutuelles de Santé* that in 2010 covered 91% of the population (Ruberangeyo et al., 2011). An absolute milestone in comparison with the coverage rates of the West African countries discussed in this study. What are the reasons behind the success of the *mutuelles* in Rwanda?

The guiding principles of the Rwandese *mutuelles* are similar to those in Guinea, Togo, and the other case studies that are discussed in this report, namely: pre-payment (once a year); solidarity; risk pooling; subsidization of most vulnerable/poor people through targeting mechanisms; and supplementary to other health insurance schemes (Ruberangeyo et al., 2011). But what then explains the success of the Rwandese *mutuelles* in terms of coverage?

- First of all, vulnerable groups are supported through the creation of financial mechanisms. Support can come from the state, NGOs or other civil society organisations but the process is managed by national policies and regulations in order to ensure coherence.

- Contributions are relatively low (RF 1000 or approx. 2 US dollars a year) and equal for everyone. The government matches these funds to cover the costs of higher care levels.
- The member must pay a small co- payment at the health-care facility (a fixed amount or a percentage depending on the level of care).
- There is a strong political commitment on all levels (national, regional, district,…).
- There is a Global mobilization in favour of CBHI (local authorities, health facilities, etc.).
- There are numerous awareness campaigns through media and community meetings.
- These campaigns have help to support local ownership of the initiative thanks to the understanding of the concept.
- The PER has made it possible to develop a sound financial plan, making the system financially affordable.
- There is a *mutuelle* at every public health-care center.
- Lastly, all levels of health care are accessible (health-care center, district hospital and referral hospital).

On top of these strengths there are a few structural factors which have supported the implementation of the national system of *mutuelles:* a good functioning network of health facilities in the entire country; universal coverage is a political priority (strong political willingness); the health interventions are coordinated at national level; traditional community targeting mechanism are used to identify poor and indigents; and decentralization has led to representation of authorities close to the population (Ruberangeyo et al., 2011). Overall the *mutuelles* in Rwanda have made the following achievements (Ruberangeyo et al., 2011):

- The rate of use of health services has increased significantly (0.86 in 2009)
- High coverage rate of the population (91% as of June 2010)
- Monthly reporting from all *mutuelles* at a decentralized level through a national database;
- Coverage of the poorest people.

In sum, we can state that the integrated system of *mutuelles* in Rwanda has been effective in providing health care insurance for the majority of its people and could be used as an increasing the coverage in. Building on the Rwandese example the following lessons can be drawn for Guinea, Senegal, Niger, Togo and Benin.

Lessons Learned

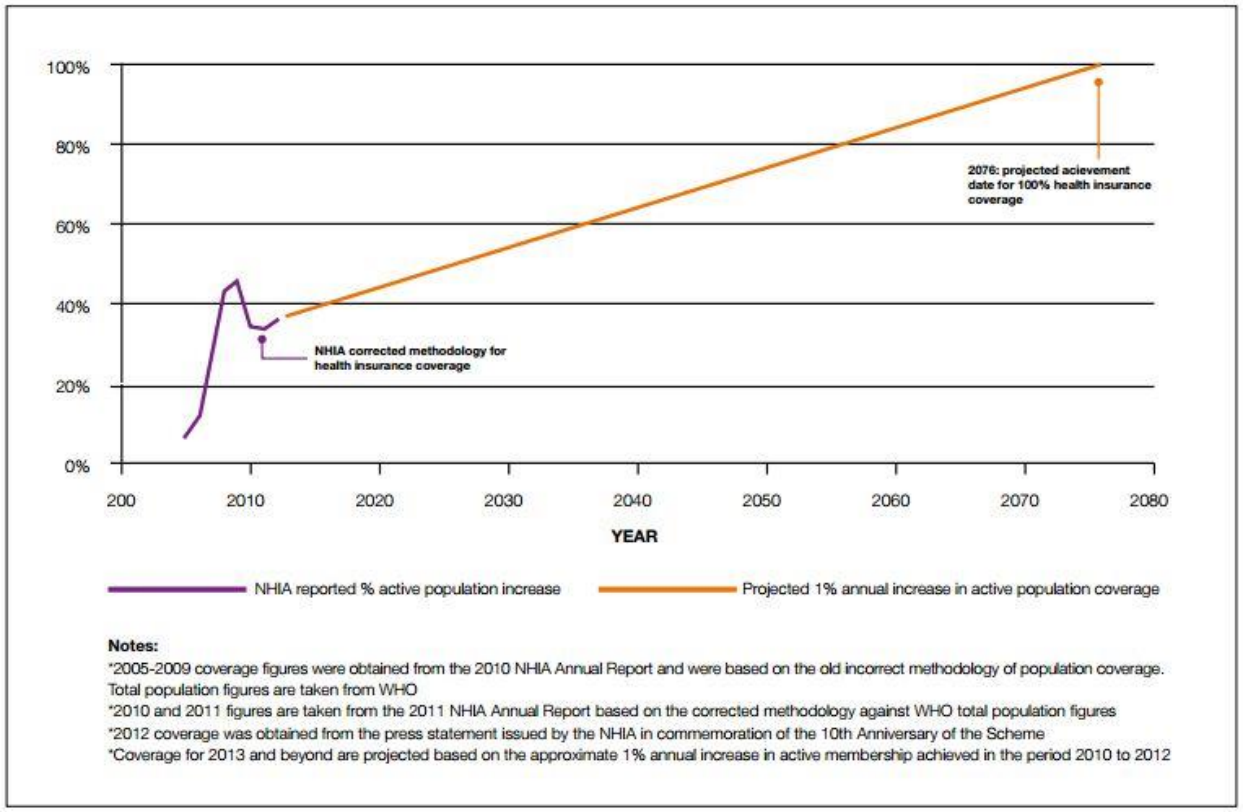
- Lobby the government to make social protection a genuine priority
- Develop a strategy for harmonizing the existing *mutuelles*
- Develop a locally embedded and broad based media campaign to raise awareness of the benefits of health insurance and understanding of the concept
- Use traditional community-targeting mechanisms do identify the poor and vulnerable
- Create a solidarity fund to subsidize health care of the poor and vulnerable
- Centralize the coordination and management of the *mutuelles*
- Invest in data management and develop a well-functioning data base of all *mutuelles*

2. Ghana's National Health Insurance Scheme

In 2003 Ghana passed a National Health Insurance Law following an election promise by former president John Kufuor. The law created the National Health Insurance Authority which licenses, monitors and regulates the operation of health insurance schemes and mandated the establishment of district-wide mutual health insurance schemes (DMHIS). The NHIS is a contributory scheme based on a minimum premium of 8 dollar per adult for registration (formal workers subscribed to the Social Security and National Insurance Trust, SSNIT, are automatically lined through a deduction from their salary). Witter & Garshong (2009) however argue that between 70% and 75% of NHIS is financed through taxation and only 20-25% from formal sector contributions and 5% from contributions from the informal sector.

Children up until 18 years old as well as people over 70 are exempted from paying. On paper enrollment is mandatory but in practice non-compliance is rather high because informal workers are not captured by any database making enforcement difficult. Some formal workers furthermore reject to pay the subscription fee (which they need to pay on top of the deduction from their salary). There has nonetheless been a significant increase in enrollment between 2005 and 2008, rising from 6,6% to 45% in three years' time (Witter & Garshong, 2009:4). In 2010 a new (more accurate) calculating methodology was adopted which resulted in an enrollment rate of 34% in 2010 (see figure below).

Figure 2: Enrollment to the NHIS



Source: Universal Access to Health Care Campaign Coalition (2013: 11)

In return a pre-defined package of benefits that coves 95% of the disease burden in Ghana is granted. Services include medical consultations, essentials drugs, shared accommodation, maternity care (normal and caesarian delivery), eye care, dental care and emergency care. The DMHIS contracts accredited providers (pubic, private and church-based) to deliver services to its members and reimburse them after submission of claims for services (Jehu-Appiah, 2012).

The NHIS however has been confronted with a number challenges the most significant being the poor quality of health services (especially in the Northern regions) and the inequity of enrollment. Jehu-Appiah (2012: 61) concludes that there is a lower enrollment amongst the poorest segments of society. An interesting finding however is the fact that indigent people have a relative higher enrollment rate then the poor. This suggests that the exemption strategy of the NHIS, which waivers registrations fees for those targeted as indigent, has been quite effective. In line with what Criel et al. (2002) suggests the contribution fee and insurance-against future risks set-up are not the main reasons for non-subscription. Perceptions about the quality of services again seem to be important factors determining the choice of admission (Jehu-Appiah, 2012: 61).

The Universal Access to Health Care Campaign Coalition (2013: 3) identified the following strengths in their report in honour of the 10th year anniversary of NHIS:

- Establishment of 145 autonomous schemes in 2003 and further expansion as new districts were created
- Introduction of the Free Maternal Care Program in 2008
- Commencement of a legal review process of Act 650, which led to the passage of Act 852
- Establishment of a Claims Processing Centre (CPC) in 2010
- Implementation of a Clinical Audit in 2010
- Establishment of the Consolidated Premium Account (CPA) in 2011;
- Establishment of the NHIS Call Centre in 2012

The scheme is currently issuing instant ID cards through a pilot biometric registration program and is reviewing capitation payment arrangement for healthcare service providers.

In conclusion, we can state that the NHIS has been quite effective in providing health care insurance for a large part of its population but time will tell if NHIS will be able to overcome the challenges it faces with regards to reaching out to the poor and increasing its coverage rate. Building on the Ghanaian example the following lessons can be drawn for Guinea, Senegal, Niger, Togo and Benin.

Lessons Learned

- Hold governments to their electoral commitments (many governments make promises they fail to fulfill after they won the ballot)
- Develop a strategy that builds on the existing health care providers whether they are public, private or church-based
- Good "indigent" targeting mechanisms and exemptions to registration fees can increase enrollment amongst the most vulnerable in society
- Create a tax-based solidarity fund to subsidize the health care of the poor and vulnerable
- Centralize the coordination and management of the health insurance scheme
- Invest as much in the quality of enrollment than in the expansion of coverage
- Address local perceptions on insurance systems, fees are not the most important reasons for non-enrollment
- Invest in data management and develop a well-functioning data base to support the registration of informal workers

CHAPTER 7: Concluding remarks

In this study the conclusions and recommendations have been presented at country level, because in the end it is at country level where social protection policies are to be implemented and strategic actors, including trade unions, play their role. In the following we will briefly present some concluding remarks which point at some similarities and cross-cutting findings among the five countries when looking at their social protection policies and schemes in relation to informal workers.

A first cross-cutting finding is that coherence in policies and programmes poses a major challenge to the stakeholders involved. Various reasons can be thought of that may lead to incoherence and therefore less effective social protection policies and programmes. In the countries under study politics is a major hindrance to collective action because serving self-interests often prevails over serving public welfare. This does not only include party politics at national level but also politics among the stakeholders involved in influencing, formulating and implementing social protection policies and programmes. This prevents that the social protection of the informal economy is high on the national agenda, and political fragmentation makes it hard for trade unions and representatives of informal workers' organizations to become part of a national discussion and become agenda setting.

In addition, in all five countries national ownership of social protection policies seems to be missing, which in turn also leads to a lack of coherence. The rationale behind existing policies and programmes reflects a patchwork of ideas which can be traced back to the several international organizations and donors that are involved in social protection and offer their assistance to the countries under study. The overview of the lines of thinking on social protection presented in the first chapter of this study already shows that a 'social protection pluralism' exists. Countries where formal social protection policies and schemes have been almost non-existent run the risk of being confronted with the 'fashion of the day', over time leading to a patchwork of policies, governmental and executive bodies involved in social protection. This does not promote coherence. Countries that have been (partly) successful in gaining national ownership over their social protection agenda, such as Ethiopia, Ghana and Rwanda, show that this may lead to more coherence and more effectiveness. National ownership may also lead to downward accountability (to the people for whom the social protection schemes are set-up) instead of upwards (to the donors that often provide money and technical assistance to set up the schemes). The former may allow for a more active role of trade unions and informal workers representatives in terms of negotiating space and being a countervailing power.

Successful examples from other countries (Ghana, Rwanda, and Ethiopia) show that political commitment to setting-up an effective social protection structure that includes also informal workers is an important prerequisite for any scheme or programme to be successful. And besides this commitment the focus on the most urgent needs is also a major characteristic. Instead of striving for a comprehensive and full coverage for all sorts of risks and destitution, the successful countries focus on one or two major areas first. Health insurance seems the most obvious among these risks, also because many surveys have pointed out that health risks / illness are among the most cited risks by respondents for falling (back) into poverty. Health insurance schemes can be set-up in numerous ways, which are less or more accessible for people in the informal sector as well. Ghana has set-up an obligatory national health

insurance scheme, partly based on previously existing mutual health organizations, Rwanda is in the process of doing the same, building on the *mutuelles de santé*. As explained in the chapter on these Ghanaian and Rwandan examples, the schemes are not perfect, but at least succeed in attaining a higher coverage than social security schemes for the formal sector usually do in other countries.

Still, it should also be recognized that the set-up and implementation of social protection schemes is expensive. In societies where tax collection is very low due to a large informal economy, it can be highly questioned whether a full blown national social protection system is feasible and realistic. Partly, the political economy of redistribution plays a role here. Countries with high windfall profits from minerals and other natural resources could in theory chose to invest in social protection policies and institutions as well. Political systems that are mainly meant to be a vehicle for the elite to seek and capture rents, however, offer very little scope for redistributive policies. Notwithstanding, for the countries we are talking about the possibilities to finance a social protection scheme are also very limited. This, again, emphasizes the need for setting priorities in which risks will be covered first and which risks should be covered in a later stage. A Catch 22 situation may arise. For extending a social protection system to the informal economy more tax income may be needed, but the same, often large informal economy limits the tax income base in many African countries to do so.

Even if a country succeeds in setting up a social protection scheme it is not said that it will help the people. Often effective social protection requires actions in other policy areas too. Health insurance will only be beneficial when there is a well-functioning health care system that ensures that people can receive adequate and effective treatment. This explains to a large extent why in some countries under study, including Togo, Guinea and Niger, participation in existing health insurance schemes is so low. Therefore low coverage figures on social protection may also be an indication that existing schemes lack a comprehensive 'system approach' in which other policy areas relevant for adequate risk management are also included. In addition, sound macroeconomic policies are equally important here. Old age pensions may certainly help elderly to survive but under high inflation rates the amounts they receive may evaporate without inflation correction (as often is the case, not only in the developing world). In sum, social protection policy is an integral part of wider social (including health) and economic policies. The issue of coherence also becomes the more urgent here as well.

Last but not least a general, cross-cutting conclusion can be that much exists on paper, but far less has been implemented. Ratification, legislation, policy plans, they may all exist on paper but very little has become reality. Governance and institutional problems are main reasons for failing to convert paper into action and into effective social protection policies and schemes. And if schemes are there they are often plagued by weak management and governance. For example, in all countries under study the governing boards of the CNSS are 'tigers on paper'. CNV trade union partners are member of the governing boards (except for Togo), but the boards only existing on paper does imply that trade unions have very little political leverage within these boards. In most countries we speak of in this report the trust of workers in social protection provisions is therefore also very low.

Do these cross-cutting issues also have implications for the agenda of trade unions? Several recommendations have been given in each country chapter. We are not going to repeat them here.

What we would like to put forward here is the discussion whether in countries with weak institutional and governance structures it would be such a good idea to advocate that informal workers should be included in formal social protection schemes? Perhaps it is more important for trade unions to raise discussion within the country how social protection schemes can be set up that are tailored to the needs of informal sector workers, without looking too much at the schemes that have been set up for the formal sector. For informal workers it might be that we need more innovative, alternative schemes that go beyond the strict international definitions of what social security and social protection is or should be. These might be schemes set up without state involvement but set up by other stakeholders within an economic sector or among a specific group of workers. The degree of formality of these schemes would probably be less than schemes set up for the formal sector, but this would reflect most likely the conditions currently prevailing in the informal economy.

The extent to which trade unions can reach informal workers is a huge debate and issue of concern for trade unionists. By working more closely together with informal workers' representatives and organizations on the topic of social protection trade unions might be able to play a pivotal role in advocacy and service delivery regarding innovative social protection schemes. It could be one way to reach the informal workers whose risk exposure and vulnerability are notoriously high and critical. Trade unions could strengthen their role as partner of informal workers organizations, and with their strong networks with stakeholders in the formal sector, trade unions have a comparative advantage and added value in strengthening the political leverage of informal worker organization with regard to social protection issues.

Rome wasn't built in a day, it took centuries actually. The urgency of the problem of lack of social protection for informal workers is more urgent though. It will take more than one day to solve this problem but with much resourcefulness and political commitment a lot can be reached within one generation, as the successful cases in Rwanda, Ghana and Ethiopia, as well as the good examples from the five countries presented in the country chapters, show.

References

Adesina, J.O. (2011) Beyond the social protection paradigm: social policy in Africa's development, *Canadian Journal of Development Studies*, 32 (4): 454-470.

AfDB (2012) Income Inequality in Africa, *Briefing Note*, 5, Addis Ababa: African Development Bank.

Ale, A. (2013) Economie Informelle et L'Emploi au Bénin: Cadre et Pratiques de l'Economie Informelle dans 3 secteurs d'activités à Cotonou**,** Geneva: International Labour Office.

Ambec, S. & Treich, N. (2003) Roscas as Financial Agreements to cope with social pressure, *Working Paper*, Grenoble:Labaratoire d'Economie Appliquée de Grenoble.

Barrientos, A. (2012) social transfers and growth: What do we know? What do we need to find out?, *World Development,* 40 (1): 11-20.

Booner, C. & Spooner, D. (2011) Organizing in the Informal Economy: Challenge for Trade Unions, *International Politics and Society*, IPG 2: 87-105.

Chen, M. (2008). Informality and social protection: theories and realities, *IDS bulletin*, 39 (2): 28-27.
Coleman,R. (2011) *Realising Decent Work and Social Protection for All:How civil society organisations are creating change,* London: Solidar.

Criel, B., Noumou Barry, A., & Von Roenne, F (2002) Le projet PRIMA en Guinée Conakry : une expérience d'organisation de mutuelles de santé en Afrique rurale*, Medicus Mundi*, Belgium: Institut de médecine tropicale.

Devereux, S. & Getu, M. (2013) *Informal and formal social protection systems in Sub-Saharan Africa,* Kampala, Fountain Publishers.

Devereux, S. & Sabatas-Wheeler, R. (2004) Transformative social protection, *IDS Working Paper 232,* Sussex: Institute of Development Studies.

Diop, F. & Ba, A. (2010) *Mutual health insurance, scaling-up and the expansion of health insurance in Africa,* USAID.

Diop, A.Y. (2003) Governance of social security regimes: trends in Senegal, *International Social Security Review*, 56 (3-4):17-23.

Docking, T. (2002) Responding to War and State Collapse in West Africa, *United States Institute of Peace Special Report,* Washingtong: USIP.

Dutch Ministry of Foreign Affairs (2013-2016), *Trade Union Co-Financing Programme: VMP 2013-2016.* Den Haag.

Ferreire, F. & Robalino, D. (2010) Social Protection in Latin America: Achievements and Limitations *Policy Research Working Paper,* 5305, Washington: World Bank.
Gassama, K., Houeninvo, T., Traoré, B. (2014) Senegal 2014, *African Economic Outlook*, retrieved from http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2014/PDF/CN_Long_EN/Senegal_EN.pdf

Finn D., van Wamelen, A., Lund, S., Cabral, A., Taoufki, M., Dörr, N., Leke, A., Roxburgh, C., Schubert, J. & Cook, P. (2012) *Africa at Work: Job Creation and Inclusive Growth*, McKinsey Global Institute.

Ginneken, W.v. (1999) Social security for the excluded majority: a new challenge for the developing countries*l, International Social Security Review*, 52 (1): 46-69.

Ginneken, W.v. (2003) Extending social security:Policies for developing countries*, International Labour Review*, 142 (3): 277-294.

Haddad, S., Fournier, P., Machouf, N., & Yatara, F. (1998) What does quality mean to lay people? Community perceptions of primary health care services in Guinea, *Social Science & Medicine*, 47 (3): 381–394.

Heintz, J. & Valodia,I. (2008) Informality in Africa: A review, *Working Paper*, 3, Cambridge: WIEGO.
Hodges, A (2010) *UNICEF: Etude sur l'état des lieux et les perspectives de protection sociale au Bénin,* Oxford Policy Management, retrieved from http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=23024

Holmes, R. & Lwanga-Ntale, C.(2012) *Social protection in Africa: a review of social protection issues in research: policy and programming trends and key governance issues in social protection,* Nairobi: PASGR.

Holzmann, R. & Jorgensen, S. (2001) Social Risk Management: A New Conceptual Framework for Social Protection, and Beyond, *International Tax and Public Finance*, 8: 529–556.

Hussmanns, R. (2003) *Defining and measuring informal employment*, Geneva: ILO.

ILO (2004) *Economic security for a better world*, Geneva: International Labour Office.

ILO (2012) R202 - Social Protection Floors Recommendation, *ILO recommendations*, 202, Geneva: International Labour Office.

International Labour Office (2002) Decent Work and the Informal Economy, *Report VI ILC 90th Session*, Geneva: International Labour Office.

ISSA (2011) *Africa: A new balance for social security*, Geneva: ISSA

ITUC (2010a) Survey of Violations of Trade Union Rights, retrieved from http://survey.ituc-csi.org/Guinea.html?lang=en

ITUC (2010b) Survey of Violations of Trade Union Rights, retrieved from http://survey.ituc-csi.org/Senegal.html?lang=en
ITUC (2010c), Survey of Violations of Trade Union Rights, retrieved from http://survey.ituc-csi.org/Togo.html?lang=en#tabs-2

ITUC (2010d) Survey of Violations of Trade Union Rights, retrieved from http://survey.ituc-csi.org/Benin.html?lang=en

Jacob, D. (1987) *UNICEF Annual Report*, Washington: UNICEF.

Jehu-Appiah, C. (2012*) Reaching the poor in Ghana's National Health Insurance Scheme; Equity aspects and strategies to improve enrolment*, Nijmegen 29 August 2012.

Kaag, M. & Wade, B. (2009) *Le syndicalisme au Sénégal: Une analyse du context,* Utrecht: CNV Internationaal.

Kaag, M., Keja, R. & Bacar, A.B. (2013) *Guinea at the Crossroads: A labour rights perspective*, Utrecht: CNV Internationaal.

Kalusopa, T., Dicks, R., & Osei-Boateng, C. (2012) *Social protection in Africa:* African Labour Research Network.

Keja, R., Leliveld, A. & Zanou, P. (2011) *Words cannot be eaten, but they can give hope: perspectives for the trade union movement in Togo*, Utrecht: CNV Internationaal.

Keja, R. & Zanou, P. (2012) *Trade Union Movement in Niger: The Future Depends on the Present*, Utrecht: CNV Internationaal.

Leliveld, A., Dekker,M., 't Hart, C. & Gnimad, J. (2010) Can't buy me health: financial constraints and health-seeking behaviour in rural households in central Togo, in Dekker, M. & van Dijk, R.A. *Markets of well-being: navigating health and healing in Africa,* Leiden: Brill: 255-281.

Levy-Bruhl, D., Soucat, A., Osseni, R., Ndiale, J.-M., Dieng, B., & de Bethune, X., et al. (1997) The Bamako Initiative in Benin and Guinea: Improving the effectiveness of primary health care, *International Journal of Health Planning and Management*, 12(Suppl. 1): S49–S79.

Manlan, O. (2014) Guinea 2014, *African Economic Outlook*, retrieved from http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2014/PDF/CN_Long_EN/Guinee_EN.pdf

Mkandawire, T. (2005) Maladjusted African Economies and Globalisation, *Africa Development*, 30(1-2): 1-33.

Mosoetsa, S. & Tshoaedi, M. (2013) COSATU Retreating to the Workplace in Post-apartheid South Africa: What about Community Struggles?, *Rethinking Development and Inequality*, 2: 28-46.
Ndoye, D. & Ndiaye M. (2014) Niger 2014, *African Economic Outlook*, retrieved from http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2014/PDF/CN_Long_EN/Niger_ENG.pdf

Ndoye, M. & Fall, E.H. (2014) Benin 2014, *African Economic Outlook*, retrieved from http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2014/PDF/CN_Long_EN/Benin_EN.pdf

Ntagungira, C. (2014) Togo 2014, *African Economic Outlook*, retrieved from http://www.africaneconomicoutlook.org/fileadmin/uploads/aeo/2014/PDF/CN_Long_EN/Togo_EN.pdf

Pal, K. (2005) *Can low income countries afford basic social protection? : first results of a modelling exercise,* Geneva: ILO.

Robalino, D.A., Rawings, L., Walker, I. (2012) Building Social Protection and Labor Systems: Concepts and Operational Implications, *Social Protection and Labor Discussion Paper*, 1202, Washington: World Bank.

Ruberangeyo, T., Ayebare, C. & de Laminne de Bex, A. (2011) Rwanda, Social Protection: An Ongoing Process, in ILO *Sharing Innovative Experiences, Volume 18: Successful Social Protection Floor Experiencies*, Geneva: ILO: 333-360.

Sen, A. (1981: 31) *Poverty and Famines: An Essay on Entitlement and Deprivation*, Oxford: Clarendon Press.

Sindzingre, A. (2006) The Relevance of the Concepts of Formality and Informality: A Theoretical Appraisal, in Guha-Khasnobis, B., Kandbur, R. & Ostrom, E. *Linking the formal and informal economy: Concepts and Policies*, Oxford: Oxford University Press.

Spooner, D. (2007) Trade Unions and NGOs: the need for cooperation*, Development in Practice*, 14 (1-2): 19-33.

Szirmai, A. (2012) Proximate, Intermediate and Ultimate Causality: Theories and Experiences of Growth and Development, *UNU-MERIT Working Paper Series, 032,* Maastricht: UNU-MERIT.

Taylor, V. (2009) *Social protection in Africa: an overview of the challenges: a study commissioned by the African Union,* Addis Ababa: African Union.

Theron, J. (2011) Non-standard workers, collective bargaining and social dialogue: The case of South Africa, *Working Paper*, 28, Geneva: ILO.

Theron, J. (2010) Informalization from Above, Informalization from Below: The Options for Organization, *African Studies Quarterly*, 11(2&3): 87-105.

Thiam, B. (2009) Study on extending social protection in Senegal, *Working Paper,* 3, Geneva: ISSA Universal Access to Health Care Campaign Coalition (2013) *Ten years of the National Health Insurance Scheme in Ghana A civil society perspective on its successes and failure*, Ghana: UAHCCC.

Van Zyl, E.(2003) Old Age Pensions in South Africa, *International Social Security Review,* 56 (3-4): 101-120.

Videt, B. (2014) *Social protection for inclusive growth: How welfare schemes might contribute to economic growth*, retrieved from http://thebrokeronline.eu/Articles/Social-protection-for-inclusive-growth.

Westen*, G.v & Zanou, P.* (2010) *Impossible n'est pas Beninois*: *The economic and social context of the Trade Union Movement in Benin,* Utrecht: CNV Internationaal.

WIEGO (2014) *History and Debates*, retrieved from http://wiego.org/informal-economy/history-debates.

Witter, S. & Garshong, B. (2009) Something old or something new? Social health insurance in Ghana, *BMC International Health and Human Rights*, 9(10): 1-13

World Bank (2012) *Togo: Towards a National Social Protection Policy and Strategy,* Washington: World Bank.

World Bank (2012) *Project Information Document (PID) Appraisal Stage: Safety Net Project*, Washington: Word Bank.

World Bank (2012) *Project Appraisal Document on a Proposed Grant in the amount of SDR 16, 2 Million (US$ 25,0 million equivalent) to the Republic of Guinea for a Productive Social Safety Net Project,* Washington: World Bank.

World Bank (2013) *World Development Report: Jobs*, Washington: World Bank.

ANNEX 1: Multi-Actor Analyses

1. Guinea

Nom	Description	Forces	Faiblesses	Partenaire	Partenaire Potential
CNTG	CONFEDERATION SYNDICALE DES TRAVAILLEURS DE GUINEE. Principal centrale syndicale du pays	- Vaste couverture interprofessionnelle et territoriale. - Structure affiliée assez indépendante - Grande - Expérience avérée dans la constitution des mutuelles de santé - Participation au conseil d'administration de la CNSS - Participation au CA des futures	- insuffisance des moyens techniques et financiers dans la promotion de la protection sociale - Absence d'une politique nationale de protection sociale	- Ministère du Travail - CNSS - Ministère de l'action sociale - CNV - BIT	- INAMO - Caisse de prévoyance sociale - Mouvement syndical -

		institution de protection sociale			
Ministère du Travail	Département ministériel en charge de promouvoir la politique de travail de la Guinée	- Connaissance acceptable du secteur de la protection sociale - Présence de quelques instruments juridiques: code du travail, code de la protection sociale, décret INAMO et de Caisse de prévoyance sociale - présence de l'inspection Générale du travail - connaissance relative sur la protection sociale	- faiblesse des textes dans la couverture de tous les travailleurs de Guinée - faible capacité technique dans le montage, le suivi et l'évaluation des projets	- BIT - Mouvement syndical - Société civile - Gouvernement	- Mutuelles professionnelles exerçant dans la protection sociale - secteur prive (employeurs et operateurs prive de la protection sociale)
CNSS	Etablissement public	- Expérience dans la	- couverture limitée dans les	- Ministère de	Ministère de l'économie et du

	administrative charge de la gestion du régime général de sécurité sociale en Guinée	couverture multisectorielle des travailleurs du secteur mixte et prive - Autonomie de gestion -	prestations sociales aux travailleurs - couverture exclusive des travailleurs du secteur formel. - Lenteur dans la prise en charge des cas d'accident de travail et maladie professionnelles - Lenteur dans la prise en charge médicale des retraites	l'action sociale - Ministère du Travail - CNTG - Association internationale de la sécurité sociale	plan - institution internationales couvrant la sécurité sociale - BIT - Société civile
Ministère action sociale	Département Ministériel charge de l'élaboration et de la promotion de la politique de promotion sociale du pays	- Existence de divisions spécialisées dans l'action sociale - couverture nationale - encrage institutionnel de la CNSS -	- faiblesse des textes dans la couverture de tous les travailleurs de Guinée - faible capacité technique dans le montage, le suivi et l'évaluation des projets	- CNSS - Partenaires sociaux - Système des nations Unies - société civile	- BIT - Association international de la sécurité sociale - société civile
BIT	Agence des	- Longue	- Faible présence	- Gouvern	Société civile

	Nations unies spécialisées sur les questions de travail	expérience dans l'élaboration et la promotion de programme, projet de promotion sociale dans les pays membre de l'ONU - Plus grande assiette de partenaires technique et financiers - Plus grande capacité de mobilisation de ressources	en Afrique de l'ouest et pas de bureau a Conakry - Faible intérêt pour le secteur informel - Faible connaissance empirique sur le secteur informel	ement - Autres agences du Système des Nations unies - Mouvement syndical	
Ministère de la santé publique	Département ministériel en charge de la promotion de la santé et de l'hygiène publique	- Expérience dans la politique de gestion de la santé et l'hygiène publique en Guinée	- Faiblesse des capacités de communication - Faible capacité d'élaboration et de gestion de projets et programme dans le secteur de la santé. - Faible capacité	Autres départements ministériels - OMS - ONG internationales specialisees en santé publique	- Ministères de la santé de la sous région - Organisme internationaux de protection sociale

			de couverture médicale et pharmaceutique des populations - Faible capacitives techniques et matériels pour la prise en charge des personnes du 3eme âge.	- Communauté rurales de développement - Collectivités locales	- Société civile - Structures mutualistes du secteur informel

2. Senegal

Nom	Description	Forces	Faiblesses	Partenaire	Partenaire Potential
Fonds nationals de Retraite	Il s'agit d'un régime d'assurance sociale qui fournit les prestations de retraite, d'invalidité et de survivant, d'une part et d'autre part, les prestations d'allocations familiales aux agents fonctionnaires (civils, militaires et paramilitaires) de l'Etat. Il est financé par les cotisations et le budget de l'Etat.	-Pension de retraite plus convenable, car calculée sur le pourcentage des salaires. -	-Ne concerne que les travailleurs fonctionnaires de l'Etat, soit ….% -problème de financement : risque de déficite à cause de l'accroissement du nombre de retraités avec un faible nombre de cotisant et des réformes en 2002 (Loi N. 2002-08)	Il n'y a pas de relations du point de vue institutionnel entre les syndicats et le FNR	

Institut de prévoyance de retraités du Sénégal (IPRES	Régime d'Assurance sociale pour la retraite des salariés du secteur privé, des employés de maison, des agents contractuels ou décisionnaires de l'Etat, des agents des collectivités locales et des établissements publics, du personnel des sociétés d'économie mixte. L'IPRES a un régime obligatoire général et un régime complémentaire pour les travailleurs cadres. Les prestations suivantes sont fournies : pension de retraite, allocation de réversion, allocation de solidarité et le fonds social	-Dispositions pour les travailleurs domestiques et journaliers à pouvoir bénéficier de ses prestations. -disposition d'un fond social	-calcul des pensions : système de pointage, désavantageux par rapport aux retraités du FNR. -le plafond du salaire de base pour le calcul des cotisations ; - la faiblesse du taux de couverture de la population (environ 12% de la population active et 5 à 7% de la population totale) - des contraintes juridiques et techniques qui freinent la prise en charge des activités non salariées.	Les syndicats sont membres du conseil d'administration	
Caisse de Sécurité Sociale (CSS)	Institut de prévoyance sociale qui a en charge les branches de la sécurité sociale que sont : les allocations familiales, de maternité et les accidents de travail et de maladies professionnelles. Sa population cible est les travailleurs régis par le code du travail et de la	Elle couvre tous les travailleurs du secteur privé formel .	-ne prend pas en compte une grande partie de la population qui évolue dans l'économie informelle et leur famille. - loi 73.37 du 31.7.73 portant Code de Sécurité Sociale n'intègre pas les autres branches	Les syndicats sont membres du conseil d'administration	

	marine marchande et des journaliers et autres pour la branche accident de travail et maladies professionnelles uniquement.		de sécurité sociale. -		
Instituts de prévoyance maladie (IPM)	Crées par un décret de 1975, elles sont des régimes d'assurance pour la branche « santé et soins médicaux) de tous les travailleurs du secteur privés. Toute entreprise ayant au moins 300 employés est tenue de créer une IPM, si elle en dispose moins, alors elle est tenue de s'inscrire dans une IPM inter-entreprises. Le financement est assuré par une cotisation mensuelle patronale et salariale de 4-15% appliquée sur une assiette de 250 000 f CFA maximum. La prise en charge peut aller de 50 à 80%.	Couverture des travailleurs du secteur formel et des membres de leurs familles.	-exclusion d'une forte partie de la population active. -faible niveau de couverture 24% et risque d'évasion sociale -absence de coordination entre IPM -exclusion des travailleurs de l'économie informelle ;	Pas de relation, les IPM sont gérées par les employeurs au sein des entreprises	
Les mutuelles de Santé	Elles constituent un régime d'assurance maladie volontaire,	Accessible aux travailleurs de l'économie	-Faible capacité contributive des membres (pour les	L'UDTS à sa propre mutuelle et peut en travailler avec	

	contrairement à l'IPM qui est un régime obligatoire. Leur mise en place peut être le fait des travailleurs d'une entreprise du secteur formel ou de l'économie informelle. Au Sénégal, la Transvie, qui regroupe des transporteurs, est l'une des mutuelles illustrative de l'économie informelle.	informelle.	mutuelles de l'économie informelle) -problème de gouvernance des mutuelles ; -faible adhésion des travailleurs (27% de la population couverte)	d'autres.	
Bureau international du travail	Organisme international en charge de la question de l'organisation et de la supervision du respect des conditions de travail par rapport aux conventions ratifiés par le Sénégal.	-expertise dans la mise en œuvre des nouvelles politiques pour la sécurité sociale. -pilotage du programme d'extension de la protection sociale			oui
Ministère du Travail (Direction de la protection sociale)	Ministère de tutelle des inspecteurs du travail. Il a en charge, d'une manière générale, la question de la protection sociale et de l'exécution de son programme de protection sociale, en partenariat avec le BIT.	-pilotage des réformes sur l'extension de la protection sociale			Oui
Ministère de la santé publique	Ministère en charge des questions de prévention et	-l'expertise sur la question de la CMU	-faible niveau de coordination avec les		Oui

(cellule d'Appui à la Couverture Maladie Universelle)	de santé de la population. Elle dispose pour ce qui est de l'extension de la couverture maladie, d'une cellule qui a en charge cette question, en plus de ses exercices en gratuité des soins et de l'appui aux mutuelles de santé.	(couverture maladie universelle)	autres ministères qui ont en charge la question de la protection sociale.		
Ministère de l'économie et des finances (MEF)	Ministère en charge du programme de la stratégie nationale de la protection sociale (lancé en 2005). L'objectif de ce programme est de permettre un meilleur accès des groupes vulnérables aux systèmes de protection sociale et aux mécanismes de prévention des risques majeurs et de gestion des catastrophes. Il partage aussi le programme de l'exécution du socle de protection sociale avec le ministère du travail.	Expertise de la situation économique du pays, et particulièrement sur l'état financier et budgétaire de l'Etat.	-Lenteur dans l'exécution des programmes. -instabilité ministérielle. - faible niveau de coordination avec les autres ministères qui ont en charge la question de la protection sociale.		Oui
Comité national du Dialogue social (CNDS)	Comité mis en œuvre par le gouvernement suite aux concertations nationale, en 2002, qui ont amendé la charte nationale sur le dialogue social. Il est une	-Médiation entre le patronat et les employés. -rapport de facilitation entre le secteur formel et	-absence d'une politique nationale de promotion du dialogue social ; - carence de la législation sociale ;	Organisme triparti, donc partenaire de l'UDTS	

	structure tripartie qui a pour mission « la prévention et la régulation des conflits ». Le CNDS intervient aussi dans les recommandations en termes de travail décent et de protection sociale surtout dans l'économie informelle.	l'économie informelle ;	-absence de coordination entre les différentes institutions ; -absence de régulation du champ du dialogue social ; absence de dentition des domaines d'intervention de chaque institution		
UNICEF	Organisme international de l'ONU pour l'éducation et la culture. Avec l'Etat du Sénégal, il a engagé un programme qui s'étend de 2012 – 2016 portants sur l'initiative du socle de protection sociale.	-Santé pour les enfants -éducation inclusive (80% des enfants auront accès à l'éducation de base d'ici 2016) -D'ici 2016, objectif de protection accrue contre les violences, l'exploitation, les abus et les pratiques socioculturelles néfastes des enfants les plus vulnérables ; - D'ici 2016, les enfants les plus vulnérables, bénéficient d'une prise en charge	-définition du critère de ciblage ; -la non prise en compte du travail des enfants, dans l'économie informelle notamment ou en tant que employés domestiques[2]		Oui

		accrue de leurs besoins, de protection sociale et des politiques sociales			
PNUD	Il s'agit d'une institution de l'ONU qui s'occupe des questions de développement humain. En matière de protection sociale au Sénégal, le PNUD s'active en accord avec le ministère de la santé sur l'assurance maladie.	Expertise sur le développement humain Rapport annuel de développement humain du Sénégal	Absence d'intervention dans les autres branches de la protection sociale.		oui
PAM (Programme d'Alimentation Mondiale)	Organisme d'aide alimentaire de l'ONU. En matière de protection sociale, le PAM met plus l'accent sur l'assistance alimentaire.	Assistance alimentaire (petit-déjeuner et déjeuner) aux 475.000 élèves des écoles primaires et institutions préscolaires, 40% des écoles primaires; -Assistance aux communautés rurales pour augmenter la résilience communautaires pendant la période de soudure; - Stabilisation du prix	-programmes essentiellement destinés aux milieux ruraux, non prise en compte du risque de malnutrition en milieu urbain, du fait de l'absence de ressource et de la promiscuité dans la vie familiale ; L'expertise locale pour savoir ce dont les populations ont besoin comme aliment nutritionnel		oui

		des céréales pendant la période de soudure;			
USAID	Agence du gouvernement américain en charge de la question du développement économique et de l'assistance humanitaire. Au Sénégal en matière de protection sociale, l'USAID a contribué à la mise en place de certaines mutuelles de santé, surtout pour l'économie informelle.	Expertise en matière d'études sur le développement Assistance technique aux acteurs de l'économie informelle (avec l'UNACOIS)	-Insuffisance dans les accomplissements par rapport à l'étendue de l'économie informelle. -Absence d'étude descriptive sur la composition de l'économie informelle		oui
Agence Française de Développement (AFD)	Agence de développement économique et social du gouvernement français. Dans les pays de l'UEMOA, l'AFD définit un programme de renforcement du système de la protection sociale, en matière de couverture maladie universelle.	Mise en place d'un programme de 2012 à 2014 de 5 milliard d'euros pour l'extension de la couverture contre le risque maladie.	Absence d'analyse descriptive de l'économie informelle		Oui

3. Niger

Nom	Description	Forces	Faiblesses	Partenaire	Partenaire Potentiel
Etat et différents départements ministériels	Ministère de la santé publique, Ministère de la promotion de la Femme et de l'Enfant, Ministère du Travail et de l'Emploi, Ministère de l'Education Nationale. Ces différents ministères ont en charge l'élaboration de la politique et la stratégie nationale en matière de protection sociale	Leurs forces résident dans la capacité de promouvoir une politique nationale de protection sociale. De même, ils ont en charge de tracer le cadre législatif et réglementaire de cette politique	Leur faiblesse se trouve dans la mise œuvre de la politique et dans l'absence de fédération des activités sectorielles	Le CNV international ne coopère pas avec l'Etat les différents départements ministériels	Mais le CNV international est un partenaire potentiel de l'Etat
CNSS[29] et FNR[30]	Il s'agit des 2 institutions nationales en charge des régimes formels de retraites et de sécurité sociale des travailleurs salariés au Niger	Leur force réside dans la capacité à élaborer des textes législatifs et réglementaires qui régissent les régimes formels des pensions et des retraites au profit des travailleurs du secteur formel au Niger	Leur plus grande faiblesse se situe dans l'absence de perspectives en matière de sécurité sociale au profit des travailleurs de l'économie informelle	Le CNV international ne coopère pas avec la CNSS et le FNR	Mais le CNV international est un partenaire potentiel pour ces deux institutions international
Syndicats	Il s'agit des organisations	Leur principale	Leur faible se situe	Le CNV	Les autres

[29] Caisse Nationale de Sécurité Sociale
[30] Fonds National de Retraite

	des travailleurs qui œuvrent en faveur de la protection sociale de leurs membres tant dans le secteur formel que dans le secteur informel.	force se situe dans leur capacité de mobilisations et de défense des droits sociaux des travailleurs. Elles organisent des formations et sensibilisent au profit des travailleurs tant du secteur formel que du secteur informel	essentiellement dans le manque d'initiatives concrètes en vue de la prise en compte travailleurs informels en matière de protection sociale	international coopère déjà avec la CNT	organisations syndicales sont des partenaires potentiels du CNV international
Associations de défense des droits de l'homme	Il s'agit des structures fondées sur le principe de la défense et de la promotion des droits humains	Leur force réside dans les formations qu'elles offrent aux populations par rapport à leurs droits et devoirs de citoyens	Leur faiblesse se situe dans la faiblesse de la couverture des actions qu'elles offrent en matière de protection	Le CNV international ne coopère pas avec les associations de défense des droits humains	Mais le CNV international peut est un partenaire potentiel des associations des droits de l'homme
Mutuelles et assurances privées	Il s'agit des structures mises en place par les employés et employeurs sur la base de régimes contributifs. Elles offrent des prestations d'assurance sociale aux travailleurs salariés	Leurs forces résident dans la capacité de promouvoir les régimes formels de sécurité sociale	La faiblesse est l'absence d'initiatives envers les travailleurs sus secteur informel en matière de politique d'assurance sociale	Le CNV international ne coopère pas avec les mutuelles et les assurances privées	Mais le CNV international peut est un partenaire potentiel des mutuelles et des assurances privées
Plate forme des organisation de la société civile, ONGs et	Il s'agit des organisations qui accompagnent l'Etat dans la mise en œuvre de la politique de protection	Leurs forces résident dans la capacité de plaidoyer auprès	La faiblesse se situe dans le manque de fédération des initiatives et des	Le CNV international ne coopère pas avec organisations	Mais le CNV international est un partenaire potentiel de ces structures

associations	sociale	des partenaires en faveur de la protection sociale	actions en matière de protection sociales		
Autres partenaires de la protection sociale au Niger (BIT, OIT, CSI[31] monde et CSI Afrique, Fondation wage Indicator	Il s'agit des autres partenaires qui participent à promouvoir la protection sociale au Niger. Beaucoup appuient l'Etat dans sa politique en accordant les financements nécessaires.	Leur force réside dans les moyens financiers conséquents dont ils disposent pour appuyer l'Etat et peuvent infléchir sur sa politique nationale	Leur faiblesse se situe au niveau du manque de fédération des actions	Le CNV international coopère déjà avec certaines de ces organisations qui n'ont pas de représentations nationales ici au Niger	

4. Togo

Nom	Description	Forces	Faiblesses	Partenaire	Partenaire Potential
Etat **Ministères** **Départements** **Communes**	Le Togo est un Etat unitaire situé en Afrique de l'Ouest entre le Ghana et le Bénin. Il est divisé en 4 grandes régions avec un taux de croissance de 3,2% (2011). La population est de 5 millions environs. Le Ministère du Travail et de la Fonction Publique, Le Ministère de la Santé Publique, le Ministère de la Protection	Dispose de : - un fichier des acteurs de l'économie informel urbain ; - un Institut de l'assurance maladie des fonctionnaires et des retraités de l'Administration publique ; - une Agence de solidarité	Absence d'un document de politique nationale de protection sociale Absence de loi organique du Régime d'Assurance Maladie Universelle (RAMU)	Il n'existe pas une coopération entre CNV-International et l'Etat Togolais ni avec les Ministères	Les différents Ministères sont des partenaires potentiels

[31] Confédération syndicale Internationale

	sociale et de la solidarité Nationale, interviennent dans le domaine de la politique sociale. La Délégation à l'organisation du secteur informel rattachée à la Présidence de la République a pour mission de recenser d'identifier les acteurs du secteur informel au Togo. Le ministère du Travail et celui de la Santé assure la tutelle de la CNSS et l'INAM (Institut National de l'Assurance Maladie.	nationale ; Il existe une volonté politique de promouvoir la protection sociale et d'élaborer les textes législatifs et réglementaires .			
CNSS	La CNSS est un établissement public à caractère social, chargé de la gestion du régime de sécurité sociale. Elle gère les assurés du secteur formel et les membres de leurs familles	La CNSS fournit les prestations de : - vieillesse (pension aux travailleurs retraités aux survivants) ; - maternité et allocations familiales ; - risques professionnels ; . assure la formation des cadres . procède aux	Le régime général de sécurité sociale ne couvre que les travailleurs du secteur formel privé. Le retard dans la mise en œuvre du code de sécurité sociale modifié en faveur des travailleurs de l'économie informelle.	CNV-International ne coopère pas avec la CNSS	La CNSS Togo peut être un partenaire potentiel

		études ; . élabore des projets de textes législatifs et réglementaires ; . gère les travailleurs migrants			
Syndicats	Les Syndicats sont des organisations représentatives des travailleurs opérant dans le secteur formel notamment. Ils sont chargés de la défense des intérêts des travailleurs et de l'amélioration de leurs conditions de vie. La CSTT, la CNTT sont les Syndicats les plus représentatifs.	Ils constituent un acteur du dialogue social et de la négociation collective de travail. Ils sont membres du Conseil d'Administration de la CNSS, des commissions nationales tripartites. Ils participent à l'élaboration des textes à caractère social et économique. Ils élargissent leur base syndicale par l'adhésion des travailleurs de l'économie	- ils manquent d'experts en matière de protection sociale ; - ils n'ont pas une autonomie financière pour entreprendre des études sur l'extension de la sécurité sociale. La Gouvernance des mutuelles de santé des syndicats n'est pas performante. Ils ont des difficultés à recouvrer les cotisations des membres et à rembourser les frais des prestataires.	La CSTT est partenaire à CNV-International	- CSTT - Devoir Dignité (ONG) - Ministère de la Protection Sociale et de la Solidarité Nationale - Délégation de l'organisation du secteur informel (rattachée à la Présidence de la République)

		informelle. Les syndicats bénéficient d'appui des partenaires et de la subvention de l'Etat.			
FNR	Il s'agit d'une Caisse des retraités, structure rattachée au Ministère des Finances. Elle gère les pensionnés de l'Administration publique et les militaires.	Le Fonds National de Retraite assure les pensions de vieillesse, les allocations familiales et de maternité. Les survivants bénéficient de pension ou d'allocation de survivants. - gère les différents fichiers.	Le Fonds National de Retraite est déficitaire. Il n'assure pas des prestations aux travailleurs de l'économie informelle ni celles des risques professionnels	Ne coopère pas avec CNV-International	FNR Ministère des Finances
Associations de défense des Droits de l'Homme	Ce sont des organisations légalement reconnues. Leur mission est la défense des Droits de l'Homme y compris celle de la protection sociale. - La ligue des Droits de l'Homme, l'Association des Consommateurs participent à l'élaboration des textes législatifs et réglementaires.	Elles développent une capacité de sensibilisation, de mobilisation des populations. - disposent des canaux de communication et d'information efficaces ; - bénéficient de l'appui de l'opinion publique.	- Absence de staff permanent de coordination nationale ; -pluralité d'associations de défense de Droits de l'Homme ; - crise de leadership et de représentativité ; - absence de programme	Ne coopère pas avec CNV-International	- Associations des Consommateurs - Ligue Nationale des Droits de l'Homme et du Citoyen

			spécifique sur le droit de la protection sociale : - difficulté de financement de leurs activités.		

5. Benin

Nom	Description	Forces	Faiblesses	Partenaire	Partenaire Potential
Etat **Ministères** **Départements** **communes**	Le Bénin, Etat unitaire, démocratique, est situé en Afrique de l'Ouest ; ayant 10 millions d'habitants dont 51% de femmes avec 27 Ministères dont - le Ministère de la Famille, des Affaires Sociales, de la Solidarité Nationale, des Handicapés et des Personnes de Troisième Age mène des actions sociales à l'endroit des personnes indigentes, handicapées, des enfants en situation difficile, des personnes de troisième âge ; - le Ministère du Travail, de la Fonction Publique et du Dialogue Social est chargé	Dispose d'un document de politique holistique de protection sociale -lance un programme d'Assurance Maladie Universelle (RAMU) -exécution de la gratuité de la césarienne ; - gratuité de l'enseignement primaire public au profit des filles ; - consultation gratuite des	- Absence d'un texte de loi et celle des textes de mise en œuvre - Absence de cohérence des actions - Existence de conflit en matière de tutelle de mise en œuvre de la politique sociale - la procédure de prise en charge des personnes indigentes est lourde et complexe (lourdeur administrative)	OMS, BIT, Coopération Suisse, Coopération Française, Canada. CNV-International n'a pas de coopération avec les Institutions publiques de l'Etat (Ministères, Départements, Communes)	Ministère de la Famille, des Affaires Sociales, de la Solidarité Nationale, des Handicapés et des Personnes de Troisième Age ; Ministère de la Santé à travers le Régime d'Assurance Maladie Universelle ; Ministère du Travail, de la Fonction Publique et du Dialogue Sociale pour l'extension de la sécurité sociale

	de l'extension de la sécurité sociale, des mutuelles de l'Etat, des travailleurs de l'économie informelle (artisans)	enfants de 0 à 5ans ; - existence du Fonds d'indigence géré par le Ministère de la Santé en collaboration avec le Ministre de la Famille			
CNSS	Etablissement public chargé de la mise en œuvre du régime général de la sécurité sociale des travailleurs du secteur formel privé. Il s'agit d'une structure autonome placée sous la tutelle du Ministère du travail. Son siège est à Cotonou	Fourniture de prestations suivantes : - pension de vieillesse et de survivants ; - prestations aux familles (allocations familiales et de maternité) - les risques professionnels (rente) ; - pratique des soins médicaux pour les membres des familles des assujettis au code de sécurité sociale (enfance, maternité). Elle dispose de structures	- gouvernance interne peu performante ; - absence d'étude actuariale pour vérifier les statistiques et l'équilibre ou le déséquilibre entre les branches chargées des prestations ; - retard dans la mise en œuvre du programme d'extension du régime de sécurité sociale aux travailleurs de l'économie informelle ; - conflit entre le Directeur Général, le Conseil	Pas de coopération avec CNV-International	La CNSS a besoin d'expertise. Elle dispose d'une capacité de cofinancement (formation des formateurs)

		départementales.	d'Administration et le Ministre		
FNR	Fonds National de Retraite (fonctionnaires et civils) est une structure administrative dépendant du Ministère des Finances	- Assure la branche pension de vieillesse et pension de survivants ; - assure les allocations familiales, les congés de maternité ; - participe aux frais médicaux pour des Agents Permanents de l'Etat ; - assure les évacuations sanitaires en Europe. - perspectives : création d'une Agence autonome (réforme en cours)	- Chroniquement déficitaire ; - La lenteur dans la liquidation des dossiers des Agents Permanents de l'Etat retraités est observée ; - le FNR ne couvre pas les prestations des risques professionnels ; les travailleurs de l'économie informelle sont exclus.	Ne coopère pas avec CNV-International ; mais coopère avec la coopération française.	- Ministère des Finances - FNR
Syndicats	Ce sont des organisations représentant notamment les travailleurs du secteur formel. Elles ont une fonction revendicative.	Ils sont très actifs au Bénin ; participent aux réformes de la politique sociale au niveau national et sectoriel. Organisent les élections sociales	- Difficultés de fidéliser les travailleurs du secteur informel ; - Absence d'experts en matière de protection sociale (gestion des risques, des mutuelles)	CNV-International Coopère depuis plusieurs années avec CGTB et la COSI Bénin	- la CGTB souhaite le renforcement de la coopération ; - la COSI Bénin souhaite un appui en matière de protection sociale ; - la Confédération des Syndicats

		en vue de déterminer la représentativité syndicale. Ils sont membres du Conseil d'Administration de la CNSS, du Conseil Economique et Social, du Conseil national du Travail et celui de la santé, sécurité. - élargissement des bases syndicales dans le secteur informel. Stratégie : développement de microcrédit, sensibilisation par les programmes de formation en matière des risques professionnels (Taxi-moto, artisans…) - ils bénéficient de la subvention de l'Etat	- gouvernance interne limitée ; - faible capacité d'autofinancement.		Autonome (CSA) également
Associations de défense des Droits	La ligue des Droits de l'Homme et du citoyen : c'est	Leur existence affaiblit les abus	Elles n'interviennent pas spécifiquement	CNV-International ne coopère pas	Risque de conflit entre les syndicats et

de l'Homme	une Association chargée de la défense des droits humains (lutte contre la torture, le droit de vote du citoyen-les emprisonnements arbitraires	des gardes à vue dans les centres de police et les traitements des prisonniers de droit commun ; - visites périodiques des prisons ; - construction de nouveaux bâtiments de prison grâce à leur effort de sensibilisation participe aux travaux des réformes sociales ; - dispose d'une grande capacité de communication et d'information sur les menaces des Droits humains.	dans le domaine de la protection sociale des travailleurs de l'économie informelle. Leur programme est limité faute de loi sur l'économie informelle	avec l'Association des Droits de l'Homme et du citoyen	les associations des droits de l'homme et du citoyen. - la double appartenance comme syndicat et comme membre de l'Association des Droits de l'Homme et du citoyen est une menace pour la coopération.
Mutuelles	Elles sont des organes associatifs à but contributif. Elles opèrent dans le domaine de la santé, de microcrédit, de pensions de vieillesse… Elles relèvent des initiatives privées pour la plupart. Certaines initiatives relèvent du Ministère du Travail ou	Leur existence complète l'action sociale de l'Etat et celle des structures formelle privées. Elles constituent une base pour le RAMU. elles peuvent servir de vecteur pour toute	- absence de loi organique ; - l'organisation des mutuelles laisse à désirer ; - Le manque de diversification de leur champ d'action ; - le taux de recouvrement des	Les mutuelles des syndicats ont comme partenaires - CNV-International ; - COSI Bénin ; - CGTB	- La mutuelle du Ministère du Travail souhaite la coopération avec CNV-International ; - la COSI-Bénin veut renforcer sa coopération en la matière

	des entreprises privées ou semi-publiques	politique sociale. Elles sont les relais de l'UEMOA en matière d'encadrement technique. Elles disposent de partenaires internationaux.	cotisations est faible, véritable cause de leur affaiblissement. La problématique de la gouvernance et de la formation en matière de risques		

ANNEX 2 : Key Social protection Indicators

1. Guinea

Country data Guinea	
1) **Population size**[32]	10,48 Million
2) GDP per Capita	498 Million
3) Population aged above 65[33]	3,3%
4) Dependency ratio[34]	85 %
5) **Percentage of people in informal employment**[35]	90%
6) Percentage of people covered by social protection[36]	3% is covered by formal social security (CNSS)
7) Old age contributors ratio (% working age)[37]	11,1% (2006)
8) Old age pension beneficiaries ratio total (incl. mean-tested | periodic benefits)[38]	8,8% (2009)
9) Employment Injury to economically active protection ratio (contributors)	Nd
10) Employment Injury recipient ratio total (incl. means-tested | periodic benefits)	Nd
11) Total public social expenditure as a percentage of GDP[39]	2.47%
a. Public social protection expenditure excluding health benefit in kind as a percentage of GDP	Nd
b. Total Health expenditure (public and private) as percentage of GDP[40]	6.0% (2011)
c. Public Health expenditure as percentage of GDP[41]	1.6% (2011)
12) Percentage/number of informal workers covered by social protection	Nd
13) Key Legislation	Law No. 94/006 of 14 February 1994, on the Social Security Code

[32] ISSA Country Profile Guinea
[33] ISSA Country Profile Guinea
World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm
34 ISSA Country Profile Guinea
[35] ASC Map: Selected decent work indicators (2013)
[36] ISSA Country Profile Guinea
[37] http://www.ilo.org/dyn/ilossi/ssimaps.mapIndicator2?p_indicator_code=CP-1b+OA
[38] http://www.ilo.org/dyn/ilossi/ssimaps.mapIndicator2?p_indicator_code=CR-1f+OA
[39] http://www.ilo.org/dyn/ilossi/ssimaps.mapIndicator2?p_indicator_code=E-1c
[40] http://www.ilo.org/dyn/ilossi/ssimaps.mapIndicator2?p_indicator_code=H-1a
[41] http://www.ilo.org/dyn/ilossi/ssimaps.mapIndicator2?p_indicator_code=H-1b

14) Ratified (relevant) ILO Conventions[42]	C017, C018, C121

2. Niger

Country data Niger	
1) Population size[43]	17 200 000
2) Population aged 15-64[44]	7564 (47,6%)
3) Dependency ratio[45]	110%
4) **Percentage of people in informal employment**[46]	90-95%[47] (1995)
5) Percentage of people covered by social protection[48]	3% of the population is covered by formal social security (CNSS and FNR)
6) Old age contributors ratio (% working age) [49]	nd
7) Old age pension beneficiaries ratio total (incl. mean-tested | periodic benefits)	nd
8) Employment Injury to economically active protection ratio (contributors)	nd
9) Employment Injury recipient ratio total (incl. means-tested | periodic benefits)	nd
10) Total public social expenditure as a percentage of GDP[50]	3.29% (2009)
a. Public social protection expenditure excluding health benefit in kind as a percentage of GDP	nd
b. Total Health expenditure (public and private) as percentage of GDP	nd
c. Public Health expenditure as percentage of GDP[51]	2.9 % (2011)
11) Percentage/number of informal workers covered by social protection	nd
12) Legislation [52]	

[42] The most important ILO conventions with regards to social security are: C017 (Workers' compensation, accidents), C018 (Workers' compensation, illness), C102 (minimum standards), C121 (employment injury benefits), C130 (medical care and illness), C155 (Occupational Safety and Health), C161 (Occupational Health Services), C168 (Protection against unemployment)

[43] ISSA Country Profile Niger

[44] Population aged 15-64 in 2010 (Medium variant). Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat,
World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm

45 Population aged 14 or younger plus population aged 65 or older, divided by population aged 15-64 Medium variant World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm

[46] ASC Map: Selected decent work indicators (2013)

[47] http://www.ulandssekretariatet.dk/sites/default/files/uploads/public/PDF/LMP/niger_2013_final_web.pdf

[48] BTI 2012

[49] Secsoc does not have data for Niger

[50] http://www.ilo.org/dyn/ilossi/ssimaps.mapIndicator2?p_indicator_code=E-1c

[51] http://www.ilo.org/dyn/ilossi/ssimaps.mapIndicator2?p_indicator_code=H-1b

a. **Old Age pensions**	Law n° 67-016 18 March 1967 ; law n° 65-23 25 May 1967 ; decree n° 67-025 of 2 February 1967 ; arrest n° 477/MFP/T of 2 March 1968 ; and decree n° 67-025 of 2 February 1967
b. **Occupational accidents and illness**	Decree n° 65-117 of 18 August 1965
13) Ratified (relevant) ILO Conventions	C018, C102, 155, C161

3. Senegal

Country data Senegal	
1) **Population size**[53]	13,11 Million
2) **Population aged 15-64**[54]	6 899 (53.3%)
3) **Dependency ratio**[55]	88 %
4) **Percentage of people in informal employment**[56]	89,67 % (M=80,2% F=92,4)[57]
5) **Distribution of informal workers, by sex:**	
a. **Sectors (agriculture, industry manufacturing, trade, construction & energy, transport, other services, …)**	68.9% of the informal sector is constituted by commerce[58]
b. **type of work (employer, employee, own-account, casual worker, family workers, etc.)**	nd
c. **education**	nd
d. **rural/urban**	nd
6) **Percentage of people covered by social protection**[59]	20%[60]
7) **Old age contributors ratio (% working age)** [61]	5% 2008

[52] Data field work (Younoussi, 2014)
[53] ISSA Country Profile Senegal
[54] Population aged 15-64 in 2010 (Medium variant). Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat,
World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm
55 Population aged 14 or younger plus population aged 65 or older, divided by population aged 15-64 Medium variant World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm
[56] ASC Map: Selected decent work indicators (2013)
[57] Decent Work Indicators in Africa
[58] https://liveatlund.lu.se/intranets/LUSEM/NEK/mfs/MFS/194.pdf
[59] ISSA Country Profile Benin
[60] http://www.ids.ac.uk/files/dmfile/SocialProtectioninSubSaharanAfrica.pdf
[61] Data derived from secsoc
http://www.ilo.org/dyn/ilossi/ssiindic.viewMultiIndic2?p_lang=en&p_geoaid=204&p_show_descs=Y

8) **8) Old age pension beneficiaries ratio total (incl. mean-tested | periodic benefits)**	0.7% 2007
9) **Illness employment protection ratio (affiliated)62**	2,8% 2001
10) **Total public social expenditure as a percentage of GDP**	5.34% 2010
a. Public social protection expenditure excluding health benefit in kind as a percentage of GDP	2.06% 2010
b. Total Health expenditure (public and private) as percentage of GDP	6.0% 2011
c. Public Health expenditure as percentage of GDP	3.5 % 2011
11) **Percentage/number of informal workers covered by social protection**[63]	nd
a. By sex	nd
b. By age	nd
c. By sector	nd
12) **Key Legislation**	The law of 15 June 1961 on Social Security for Civil Servants ; Law n° 73-37 of 31 July 1973 ; Law n° 97-05 of 10 March 1997 ; Law n° 73-37 of 31 July 1973 ; law n° 91-33 of 25 June 1991 and lastly law n° 75-50 of 3 July 1975.
13) **Ratified (relevant) ILO Conventions**	C102, C121

4. Togo

Country data Togo	
1) **Population size**[64]	6,28Million
2) Population aged 15-64[65]	55,2%
3) Dependency ratio[66]	81,2%
4) **Percentage of people in informal employment**[67]	More than 90%

[62] No. of working age affiliates to a illness benefit scheme see http://www.ilo.org/dyn/ilossi/ssiindic.viewMultiIndic?p_lang=en&p_indicator_code=CP-2a%20SI&p_geoaid=686

[63] http://www.ilo.org/gimi/gess/ShowWiki.action?wiki.wikiId=809

[64] ISSA Country Profile Togo

[65] Population aged 15-64 in 2010 (Medium variant). Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat,
World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm

66 Population aged 14 or younger plus population aged 65 or older, divided by population aged 15-64 Medium variant World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm

[67] http://www.ulandssekretariatet.dk/sites/default/files/uploads/public/Afrika/Landeanalyser/labour_market_profile_2012_-_togo_web.pdf

5) Percentage of people covered by social protection[68]	5 %
6) Old age contributors ratio (% working age) [69]	3.1% (2009)
7) Old age pension beneficiaries ratio total (incl. mean-tested | periodic benefits)	16.7% (2009)
8) Employment Injury to economically active protection ratio (contributors)	2.3% (2009)
9) Employment Injury recipient ratio total (incl. means-tested | periodic benefits)	0.0% (2009)
10) Total public social expenditure as a percentage of GDP	5.73% (2010)
a. Public social protection expenditure excluding health benefit in kind as a percentage of GDP	2.31% (2010)
b. Total Health expenditure (public and private) as percentage of GDP	8.0% (2011)
c. Public Health expenditure as percentage of GDP	4.2% (2011)
11) Percentage/number of informal workers covered by social protection[70]	Nd
12) Key legislation	Law N°2011-006 of 21 February 2011
13) Ratified (relevant) ILO Conventions	C102 will enter in force in June 2014

5. Benin

Country data Benin	
1) **Population size[71]**	9.35Million
2) Population aged 15-64[72]	5 107 (53.7%)
3) Dependency ratio[73]	86 %

[68] ISSA Country Profile Togo
[69] Data derived from secsoc http://www.ilo.org/dyn/ilossi/ssiindic.viewMultiIndic2?p_lang=en&p_geoaid=204&p_show_descs=Y
[70] http://www.ilo.org/dyn/ilossi/ssiindic.viewMultiIndic2?p_lang=en&p_geoaid=768&p_show_descs=Y
[71] ISSA Country Profile Benin
[72] Population aged 15-64 in 2010 (Medium variant). Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat,
World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm

4) Percentage of people in informal employment[74]	98,2% (M=97,2%, F=99,2)
5) Percentage of people covered by social protection[75]	Less than 10 % (238 138 formal sector workers were covered by the CNSS in 2009)
6) Old age contributors ratio (% working age) [76]	5.2% (2009)
7) Old age pension beneficiaries ratio total (incl. mean-tested | periodic benefits)	0.2% (2005)
8) Employment Injury to economically active protection ratio (contributors)	4.0% (2006)
9) Employment Injury recipient ratio total (incl. means-tested | periodic benefits)	0.0% (2005)
10) Total public social expenditure as a percentage of GDP	4.31% (2009)
a. Public social protection expenditure excluding health benefit in kind as a percentage of GDP	1.5%(2008)
b. Total Health expenditure (public and private) as percentage of GDP	4.6% (2011)
c. Public Health expenditure as percentage of GDP	2.4% (2011)
11) Percentage/number of informal workers covered by social protection[77]	200 000 people covered by *mutuelles de santé*
12) Key Legislation	Law No. 98-019 of 21 March 2003, on the Social Security Code, with 2007 amendment (Law No. 2007-02 of 26 March) and 2010 amendment (Law No. 2010-10 of 22 March).
13) Ratified (relevant) ILO Conventions	C018, C61

73 Population aged 14 or younger plus population aged 65 or older, divided by population aged 15-64 Medium variant World Population Prospects: The 2012 Revision, http://esa.un.org/unpd/wpp/index.htm

[74] ASC Map: Selected decent work indicators (2013)

[75] ISSA Country Profile Benin

[76] Data derived from secsoc http://www.ilo.org/dyn/ilossi/ssiindic.viewMultiIndic2?p_lang=en&p_geoaid=204&p_show_descs=Y

[77] http://www.ilo.org/gimi/gess/ShowWiki.action?wiki.wikiId=809

ANNEX 3: List of Respondents and Documents Consulted During the Fieldwork

1. Guinea

Interviews

1. Monsieur Amadou Diallo, Secretaire Generale de la Confederation Nationales des travailleurs de Guinee
2. M. Bandia Gorogna, point focal CNV a la CNTG
3. M. Louis Mbemba Soumah, Secretaire Generale du Syndicat Libre des enseignants et chercheurs de Guinee (SLEG) - USTG
4. Monsieur Elhadj Mamadou Mansare, President du Conseil d'Administration de la Caisse Nationale de Securite Sociale de Guinee
5. Madame Dogomet Barry, Inspectrice Generale du Travail en Guinee
6. Dr. Alia Camara, Inspecteur General adjoint du Travail en Guinee
7. M. Doumbouyah, conseiller au Ministere de travail
8. Elhadj Mamadou Yaya Balde, Secretaire General du Syndicat du transport et mecanique generale de Ratoma
9. Dr. Mamadouba Camara, consultant specialist des organisations mutualistes
10. Hadja Mariama Barry, charge des projets de mutualite aupres de la CNTG

List of consulted documents

- ✓ Code de de la securite sociale de la Guinee
- ✓ Code du travail de la Guinee
- ✓ Decret du President de la Republique instituant l'institut national de l'assurance Maladie Obligatoire INAMO

- ✓ Le troisieme document de Strategie de reduction de la pauvrete en Guinee DSRP III.
- ✓ www. CNSS

2. Senegal

Interviews

11. Mme Rosalie, Ministère du travail, chef de division chargée des CMU à la direction de la de la protection sociale, ministère du travail (l'immeuble Yoro Lam), 9/04/2014 (23 min)
12. Assane Diop, Chargé des programmes l'UTS / Syndicat du BTP, l'hotel King Fahd Place, 15/04/2014 (26 min)
13. Abriel Pino, Expert du OIT sur la protection sociale, King Fahd Place, 15/04/2014 (10 min)
14. Dr Pape Babou Ndiaye, Chargé d'étude à l'IPRES, King Fahd Place, 14/04/2012 (17 min)
15. Abdoul Azize Sy, Chargé du secteur informel à l'UDTS, à Pikine, 07 & 20/04/2014 (32 min)
16. Dr Ousseynou Diop, Ministère de la santé, économiste de la santé, cordonnateur du CAPSU (caisse d'assurance pour la sécurité sociale universelle), king Fahd Place, 14/04/2014 (12 min)
17. Ibrahima Seck, Caisse de Sécurité sociale Directeur prestations familiales et sociales, CSS, 17/04/2014 (15 min)
18. Ibrahima Diop, Secrétaire permanent de l'UNACOIS JAPPO (syndicat des travailleurs de l'informel), l'UNACOIS Jappo (colobane), 16/04/2014 (1h27 min)

List of consulted documents

- ✓ Rapport d'Atelier d'identification de l'existant et des lacunes dans la mise en œuvre d'un socle national de protection sociale au Sénégal, octobre 2012.
- ✓ Document de la Stratégie Nationale de Protection Sociale, Ministère de l'économie et des finances, 2008
- ✓ Rapport d'enquête nationale sur l'économie informelle, Agence Nationale de la Statistique et de la démographie, 2010-2011.
- ✓ Etude technique sur l'administration du Régime simplifié pour les petits contribuables (RSPC) au Sénégal, BIT Janvier 2014
- ✓ Etude technique sur la branche retraite du Régime Simplifié pour les Petits Contribuables (RSPC) au Sénégal, BIT Janvier 2014
- ✓ Etude technique sur la branche santé du Régime Simplifié pour les Petits Contribuables (RSPC) au Sénégal, BIT Janvier 2014
- ✓ Juliette Alenda (2012), Évolution de l'assurance maladie au Sénégal : de l'exclusion à l'inclusion du secteur informel, working paper.
- ✓ Caisse de Sécurité Sociale, recueil de textes fondamentaux de la CSS du Sénégal
- ✓ Rapport sur l'extension de la protection sociale à l'économie informelle : vers un Régime simplifié pour les petits contribuables (RSPC) au Sénégal, BIT Mai 2013.
- ✓ Code de la Sécurité Sociale du Sénégal
- ✓ Code du travail du Sénégal
- ✓ Document sur L'analyse des prestations et des indicateurs de résultats de la protection sociale Préparé par Pascal Annycke, BIT, mai 2008

3. Niger

Interviews

19. Mamane Zaroumeye Yacoubou, chargé des affaires syndicales et statistiques à la CNT, lieu de l'entretien siège CNT, date de l'entretien 08/04/2014, durée de l'entretien 3 heures
20. Ibrahim Hamidou Koda, chargé des affaires sociales et de la lutte contre le sida à la CNT, chef service à la CNSS, lieu de l'entretien siège CNT, date de l'entretien 09/04/2014, durée de l'entretien 2 heures
21. Laouly Issoufou, Secrétariat Confédéral aux Activités Sectorielles à la CNT, lieu de l'entretien siège CNT, date de l'entretien 10/04/2014, durée de l'entretien 30 minutes
22. Gado Sanda, président du syndicat des conducteurs de taxi (SYNCTAXI), affilié à la CNT, lieu de l'entretien siège du syndicat, date de l'entretien 11/04/2014, durée de l'entretien 1heures 30 minutes
23. Abdou Litini, président du syndicat des vendeurs de café et thé (SYVEDICAF), affilié à la CNT, lieu de l'entretien quartier château 9 Niamey, date de l'entretien 11/04/2014, durée de l'entretien 1 heures
24. Mme Zeini Hadiza, présidente du syndicat des restauratrices (SYNARESNI), affilié à la CNT, lieu de l'entretien médiature de la république, date de l'entretien 14/04/2014, durée de l'entretien 30 minutes
25. Mme Thérèse Hubert, présidente du syndicat des coiffeuses (SYNACOIFNI), affilié à la CNT, lieu de l'entretien atelier de coiffure, date de l'entretien 14/04/2014, durée de l'entretien 25 minutes
26. M. Alzouma Traoré, secrétaire exécutif de l'ONG SOS Femmes et Enfants victimes de violences familiales, lieu de l'entretien siège de l'ONG, date de l'entretien 15/04/2014, durée de l'entretien 20 minutes
27. Mr. Insa Youssa Maiyaki, président du syndicat des travailleurs bois et constructions, lieu de l'entretien ancien siège de la CNT, date de l'entretien 16/04/2014, durée de l'entretien 20 minutes
28. 1Mr. Oumarou Boubacar Maiga, Secrétaire Général du syndicat des travailleurs bois et constructions, lieu de l'entretien ancien siège de la CNT, date de l'entretien 16/04/2014, durée de l'entretien 20 minutes
29. Mme. Oumou Sabiou Dicko, directrice de la caisse nationale de sécurité sociale, lieu de l'entretien à la CNSS (bureau), date de l'entretien 17/04/2014, durée de l'entretien 15 minutes
30. Mr. Idé Zarmakoye, coordonnateur national de la Plate-forme des Organisation de la Société Civile (OSC) sur la protection sociale, lieu de l'entretien siège de l'ONG, date de l'entretien 17/04/2014, durée de l'entretien 30 minutes
31. Mr. Illa Samaila, chargé du plaidoyer au niveau de la Plate-forme des Organisations de la Société Civile (OSC) sur la protection sociale, SG du regroupement des ONG et associations du secteur de la santé, lieu de l'entretien siège de l'ONG ROSEN, date de l'entretien 18/04/2014, durée de l'entretien 1 heures

32. Mr. Abdou Galo Karim, chef de division financement à la Direction des Etudes et de la Programma (DEP) du ministère de la santé, lieu de l'entretien Ministère de la Santé Publique (MSP), date de l'entretien 18/042014, durée de l'entretien 25 minutes
33. Mr. Ali Idé, président du comité de gestion de la mutuelle de la Société Nigérienne de Télécommunication (SONITEL), lieu d'entretien bureau de l'infirmerie, date de l'entretien 22/04/2014, durée de l'entretien 30 minutes
34. Mme Dibril Bintou, directrice de la solidarité nationale au Ministère de la Promotion de la Femme et de la Protection de l'Enfant (MPFPE), leu de l'entretien ministère, date de l'entretien, 22/04/2014, durée de l'entretien 25 minutes.

List of Consulted Documents

Règlements UEMOA sur la mutualité

- ✓ Règlement n°07/2009/CM/UEMOA portant réglementation de la mutualité sociale au sein de l'UEMOA
- ✓ Règlement d'exécution n°002/2001/COM/UEMOA déterminant les modalités de procédures de constitution d'argent et d'immatriculation des mutuelles sociales et leurs structures faitières
- ✓ Règlement d'exécution n°003/2001/COM/UEMOA relatif aux règles prudentielles portant sur les risques courts, aux mécanismes de garantie et au contrôle du fonctionnement des mutuelles sociales et de leurs structures faitières

Textes de lois nationaux et rapports

- ✓ La constitution du 25 septembre 2010
- ✓ La Politique Nationale de Protection Sociale (PNDS), ministère de la population, de la protection de la femme et de l'enfant
- ✓ Loi n° 95-015 du 3 juillet et son décret d'application n°96-224 du 29 juin 1996 portant généralisation des couts de santé
- ✓ Loi n° 2003-033 du 5 août 2003 instituant une catégorie d'établissement publics dénommés « établissements publics à caractère social » (EPS) ont pour objectifs l'exercice d'une activité sociale visant l'amélioration des conditions de vie des populations dans les domaines de la santé, protection de la femme et des enfants, personnes handicapées et/ou âgées, l'éducation sociale, formation professionnelle, sécurité alimentaire, sécurité sociale, santé et sécurité des travailleurs, promotion de l'emploi
- ✓ Loi n° 2003 du 3 août 2003 portant création de la CNSS
- ✓ La loi n° 65 du 15 mai 1965 relative au contentieux de la sécurité sociale
- ✓ La loi n° 67-016 du 18 mars 1967 déterminant les conditions d'application du régime des retraites de la loi n° 65-23 du 15 mai 1965 relative au contentieux de la sécurité sociale

- ✓ Décret n°62-127 révisé en 1996 pour aboutir au décret 96-456 règlementant les prestations fournies par les hôpitaux stipulant la prise ne charge des frais hospitaliers pour les fonctionnaires à 80%
- ✓ Décret n° 65-116 du 18 avril 1965 portant déterminant les règles de gestion du régime des prestations familiales
- ✓ Décret n° 2005-064/PRN/MFP/T du 11 mars 2005 portant approbation des statuts de la CNSS
- ✓ Décret n° 65-117 du 18 août 1965 portant détermination des règles de gestion du régime de réparation et de prévention des accidents de travail et maladies professionnelles
- ✓ Décret n° 65-116 du 18 août 1965 portant détermination des règles de gestion du régime des prestations familiales par la CNSS
- ✓ Décret n° 67-025 du 2 février 1967 portant détermination des règles de gestion du régime des retraites
- ✓ Arrêté n° 477/MFP/T du 2 mars 1968 pris en application du décret n° 67-025 du 2 février 1967 portant détermination des règles de gestion du régime des retraites
- ✓ Décret 2005-064/PRN/MFP/T du 11 mars 2005 portant approbation des statuts de la CNSS
- ✓ Code de travail ordonnance n°96-039 du 29 juin 1996
- ✓ Plan de Développement Sanitaire (PDS) 2005-2009, MSP, Niamey, 2005-2009
- ✓ Rapport d'analyse des politiques du fonctionnement de la santé au Niger

4. Togo

Interviews

35. Le Secrétaire Général de la CSTT
36. Le Secrétaire Général de la CSTT, 1er Adjoint
37. MATEPEY, chargé de l'information au Conseil National du Patronat du Togo
38. Madame N'DJOME, Assistante de la Directrice Générale de l'INAM (Institut National d'Assurance Maladie)
39. Directeur Général du Travail et des Lois sociales
40. Directeur de la Protection Sociale, Monsieur BIGNANDI Palakimyèm
41. Monsieur SAMAROU, chargé des maladies ordinaires des agents de l'Etat
42. Monsieur HANNOUKOPE, Secrétaire Permanent de la Conférence Internationale de la Prévoyance Sociale, intérimaire
43. Monsieur Dossou, Directeur de SADD
44. Monsieur MOUKENGUE ETOTA Adolphe Gabriel, Inspecteur Régional de la Prévoyance Sociale, Docteur en droits fondamentaux de l'Université de Nantes
45. Monsieur OROU BANGNA, Directeur de la Délégation du secteur Informel/Présidence de la République
46. Docteur DOGBE kokou, Directeur Général de la Santé Publique
47. Docteur BABA Bibiane, Directrice des Etablissements de Soins, membre du Conseil d'Administration de l'INAM
48. Monsieur DOSSOU yves, Directeur de l'ONG SADD (Solidarité, Développement Durable)
49. Monsieur le Directeur des Programmes chargé des Droits de l'Homme

50. Monsieur AGBO François, Coordonnateur National des Syndicats du secteur informel
51. Monsieur ADOME Dogi, Directeur Exécutif de la Mutuelle de santé CSTT
52. Madame SAIZONOU Ghislaine, Coordonnatrice des mutuelles au Togo, Département ITVC-Africa-Lomé
53. Madame SANNY Reine, Assistante de Direction à la CNSS
54. Monsieur AGBOKOU, Directeur des Affaires Administratives à la CNSS
55. Monsieur AKOUE Adrien, Secrétaire Général CSI-Afrique
56. Monsieur GBETOULA Sylvestre, Secrétaire général Adjoint de l'Administration Publique
57. Monsieur A. AKOLLY, Administrateur de l'ONG Devoir Dignité
58. Madame DOSSOU Mirianne, Directrice de l'INAM (Institut National d'Assurance Maladie)
59. Monsieur ABALO, représentant du BIT
60. Monsieur Kossi Dodzi ABOEYABA, Assistante Juridique et chargé de projet-ONG-SADD

List of Consulted Documents

Les textes de loi et de règlement

- ✓ Loi N° 2011-006 du 21 février 2011 portant code de sécurité sociale
- ✓ Loi N° 2011-003 du 18 février 2011, instituant un régime d'assurance maladie des Agents Publics et assimilés
- ✓ Décret N° 2011-034/PR portant statut de l'Institut National d'Assurance Maladie (INAM)
- ✓ Décret N° 2011-035/PR fixant le régime du partenariat entre l'Institut National d'Assurance Maladie (INAM) et les formations sanitaires
- ✓ Décret 2011-032 fixant les taux et modalités de paiement des cotisations au régime obligatoire d'assurance maladie du 02 mars 2011
- ✓ Document sur la présentation générale d'assurance maladie (présenté par le Directeur des prestations de l'INAM)

Les documents d'informations générales

- ✓ Rapport 2012 sur la situation des Droits de l'Homme au nord Togo-juin 2013
- ✓ Fiche d'informations sur la protection sociale : un droit fondamental de l'ONG-SADD (solidarité et action pour le développement durable)
- ✓ Fiche d'information sur la sécurité sociale - ONG-SADD (volume1)
- ✓ Fiche d'informations sur les prestations familiales et de maternité - ONG SADD (volume3)
- ✓ Communication sur la protection sociale : un mécanisme pour un développement inclusif (Milieux économique et sociaux UE-Afrique-par Adrien B. AKOUETE, Secrétaire Général Adjoint CSI-Afrique-mars 2014)
- ✓ Document sur les missions de l'ONG- Devoir-Dignité : prévention sanitaire et suivi médical des personnes de troisième âge
- ✓ Articles de presse sur l'atelier de sensibilisation sur la protection sociale dans le secteur informel Togo ¨Presse N°9047 du jeudi 30 mai 2013-BIT Ministère du Travail.

5. Benin

Interviews

61. Monsieur DJAGOU Ernest, Directeur Général du Travail ;
62. Monsieur NATABOU Emile, Directeur de la mutuelle de sécurité sociale (Ministère du Travail et de la Fonction Publique) ;
63. Monsieur ATIOGBE Urbain, chargé des mutuelles du secteur informel-COSI-BENIN (Confédération des Organisations Syndicales Indépendantes du Bénin) ;
64. Monsieur CHADARE Noel Secrétaire Général de la COSI-BENIN ;
65. Monsieur ZOUNON Emmanuel, Secrétaire Général UNSTB (Union Nationale de Syndicats des Travailleurs du Bénin) (initiative sur le secteur informel) ;
66. Monsieur HOUNGUEVOU Paul Secrétaire Général Adjoint, chargé du secteur informel-micro crédit CSA (Confédération des Syndicats Autonomes) ;
67. TODJINOU Pascal, Secrétaire Général de la CGTB (Confédération Générale des Travailleurs du Bénin) ;
68. Uzziel Twagalimana, représentant continental de l'ONG Solidarité Mondiale, programme officer CNV ;
69. Monsieur DAGA, Directeur des prestations à la caisse nationale de sécurité sociale (CNSS) ;
70. Monsieur ABDOU Mohamed Bachirou, Chef Cellule de la Statistique et de la Coopération à la CNSS ;
71. AHISSOU Constant, statisticien, stagiaire (CNSS).

List of Consulted Documents

Textes de lois nationaux et rapports

- ✓ Le document de politique holistique sur la protection sociale au Bénin

Les textes de lois et de règlements

- ✓ Loi N° 98-019 portant code de sécurité sociale au Bénin du 21 mars 2003 et la loi 2007-02 du 26 mars 2007 modifiant la loi ci-dessus.
- ✓ Loi 2010-10 du 22 mars 2010 portant code de sécurité sociale du 22 mars 2010.
- ✓ Loi N° 86-013 du février 1986 portant statut général des Agents Permanents de l'Etat.
- ✓ Loi 2004-27 modifiant le statut général des Agents Permanents de l'Etat
- ✓ Loi N° 86-014 du 26 septembre 1986 portant code des pensions civiles et militaires de retraite.
- ✓ Arrêté interministériel N° 2005-743/MFE/MSP/CAB/SP du 13 juin 2005 relatif à la mise en place du mécanisme d'utilisation du Fonds sanitaire des indigents.
- ✓ Arrêté N° 2011-008/MS/DC/SGM/DRFM/SA du 4 janvier 2012, relatif au fonctionnement du comité technique chargé de l'élaboration de la mise en œuvre des actions stratégiques en vue de l'ouverture effective des droits aux prestations de l'assurance maladie universelle au Bénin 1er avril 2012.

Documents généraux d'informations

1- <u>Etudes</u>

- ✓ étude relative à la branche de l'assurance maladie selon la mutuelle de sécurité sociale par Monsieur ATIOGBE (COSI-BENIN) ;
- ✓ projet de création d'une mutuelle de santé des agents de l'Etat ;
- ✓ tableau des statistiques sur la mutuelle de santé du Ministère du Travail (document partiel) ;
- ✓ étude comparative des systèmes de protection sociale au Rwanda et au Burundi ;

2- <u>Les ouvrages</u>

- ✓ les acteurs de l'économie informelle, les atouts pour le développement durable, réalisée par l'UNSTB sur la protection sociale (2011) ;
- ✓ actes du séminaire continental sur la place des mutuelles de santé dans les politiques d'assurance maladie universelle, réalisé par WMS – soutien Coopération belge, 2011 ;
- ✓ revue du BIT N° 146-147-2077, renforcement des syndicats : le rôle de l'éducation ouvrière.

ANNEX 4 : Bibliography

1. Benin

Social security

Ale, A. 2013. *Économie informelle et l'emploi au Bénin : cadre et pratiques de l'économie informelle dans 3 secteurs d'activités à Cotonou.* Geneva, ILO.
http://www.ilo.org/wcmsp5/groups/public/---ed_emp/documents/publication/wcms_218874.pdf

2010. *Loi no. 98 - 019 du 21 mars 2003 portant code de sécurité sociale ; Loi no. 2007-02 du 26 mars 2007 portant modification des dispositions des articles 10, 89, 93, 94, 95 et 101 de la loi no. 98-019 du 21 mars 2003 portant Code de sécurité en République du Bénin.* [Cotonou], Editions Geocy.

Ahouansou, C. 2010. *Questions directes, ou, Le manifeste social.* Cotonou, CAAREC Editions.

Diop, F. & Ba, A. 2010. *Mutual health insurance, scaling-up and the expansion of health insurance in Africa.* USAID.
http://www.healthsystems2020.org/content/resource/detail/2523/

Hodges, A. 2010. *UNICEF: Etude sur l'état des lieux et les perspectives de protection sociale au Bénin.* Oxford Policy Management.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=23024

2009. *Les stratégies de survie à Cotonou.* Cotonou, Centre de Recherche d'Étude et de Créativité Compagnie de Jésus au Bénin.

Munib, N. 2008. Social security schemes for the marginalized groups in the informal sector in a few developing countries : a comparative analysis. *Asian economic review*, vol. 50, no. 3, p. 511-522.

2007. *Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA.* Bureau international du travail, (BIT).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1250

2007. *Mutuelle de sécurité sociale de Cotonou : rapport de suivi 2006.* Bureau international du travail, (BIT).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1271

Régent, S. 2007. *Developing a legal framework for mutual organizations in WAEMU Member States: a participatory process.* ILO.
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1950

2006. *Atelier régional de concertation sur les avant-projets de règlement sur les mutuelles sociales dans les Etats membres de l'UEMOA : rapport final.* Bureau international du travail, (BIT) ; Union Economique et Monétaire Ouest Africaine, (UEMOA).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=973

Audibert, M., Mathonnat, J., & Roodenbeke, E.d. 2003. *Le financement de la santé dans les pays d'Afrique et d'Asie à faible revenu.* Paris, Editions Karthala .

Tovo, M. & Bendokat, R. 2000. *Contribution pour une stratégie de protection sociale au Bénin.* World Bank.
http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2001/05/08/000094946_01041906223564/Rendered/PDF/multi0page.pdf

Ginneken, W.v. 1999. *Social security for the excluded majority : case-studies of developing countries.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/1999/99B09_222_engl.pdf

Ginneken, W.v. 1997. *Social security for the informal sector : investigating the feasibility of pilot projects in Benin, India, El Salvador and Tanzania.* Geneva, Social Security Dept., ILO.
http://www.ilo.org/public/libdoc/ilo/1997/97B09_103_engl.pdf

Health protection

Ridde, V. & Jacob, J.P. 2013. *Les indigents et les politiques de santé en Afrique : expériences et enjeux conceptuels.* Louvain, Academia-L'Harmattan.

Turcotte-Tremblay, A.-M., Haddad, S., Yacoubou, I., & Fournier, P. 2012. Mapping of initiatives to increase membership in mutual health organizations in Benin. *International Journal for Equity in Health*, vol. 11, no. 1, p. 74.

Ahouansou, C. 2010. *Questions directes, ou, Le manifeste social.* Cotonou, CAAREC Editions.

Diop, F. & Ba, A. 2010. *Mutual health insurance, scaling-up and the expansion of health insurance in Africa.* USAID.
http://www.healthsystems2020.org/content/resource/detail/2523/

2009. *Renforcer la protection sociale par l'institutionnalisation des mutuelles de santé au Bénin : rapports sur les droits économiques, sociaux et culturels.* Alliance nationale des mututalités chrétiennes (ANMC) ; Solidarité Mondiale (WSM).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=17917

2007. *L'accès à la protection sociale et aux soins de santé pour tous: STEP en Afrique.* [Genève], ILO.
http://www.ilo.org/public/libdoc/ilo/2007/107B09_112_fren.pdf

2007. *Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA.* Bureau international du travail, (BIT).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1250

2007. *Mutuelle de sécurité sociale de Cotonou : rapport de suivi 2006.* Bureau international du travail, (BIT).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1271

Dimechkie, K. 2007. *Mutuelle de Sécurité Sociale du Bénin (MSS) - FAQ.* BIT.
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=4052

Labie, M., Nyssens, M., & Wéjé, P. 2007. Microfinance et micro-assurance santé : réflexions sur des articulations possibles à partir de quelques expériences au Bénin et au Burkina Faso. *Mondes en développement*, vol. 35, no. 139, p. 57-71.

Régent, S. 2007. *Developing a legal framework for mutual organizations in WAEMU Member States: a participatory process.* ILO.
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1950

2006. *Atelier régional de concertation sur les avant-projets de règlement sur les mutuelles sociales dans les Etats membres de l'UEMOA : rapport final.* Bureau international du travail, (BIT) ; Union Economique et Monétaire Ouest Africaine, (UEMOA).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=973

2004. *L' amélioration de l'accès aux soins en Afrique francophone : le rôle de l'assurance : rapports des 14 pays d'Afrique francophone.* Paris, ESPAD.
http://www.ces-asso.org/Pages/defaut_fr.htm

2004. *Inventaire des systèmes d'assurance maladie en Afrique: synthèse des travaux de recherche dans 11 pays.* La concertation.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=82

Audibert, M., Mathonnat, J., & Roodenbeke, E.d. 2003. *Le financement de la santé dans les pays d'Afrique et d'Asie à faible revenu.* Paris, Editions Karthala .

Atim, C. 2000. *Contribution des mutuelles de santé au financement, à la fourniture et à l'accès aux soins de santé: synthèse de travaux de recherche menés dans neuf pays d'Afrique de l'Ouest et du Centre.* Genève, LO Strategies and Tools against Social Exclusion and Poverty Programme.

Old age benefits

Occupational accidents insurance

Arouna, B. 2003, "Tendances actuelles dans la prévention et l'assurance contre les accidents du
Houessou, R. 2007. *Organization of the prevention of occupational hazards in Benin: good practices and challenges.*

Arouna, B. 2003, "Tendances actuelles dans la prévention et l'assurance contre les accidents du travail en Afrique : l'expérience du Bénin," *In Les défis que les régimes de sécurité sociale ont à relever en Afrique*, pp. 263-270.

2. Guinea

Social security

Pal, K. 2005. *Can low income countries afford basic social protection? : first results of a modelling exercise.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/2005/105B09_269_engl.pdf

2004. *Guineé : rapport du gouvernement : évaluation actuarielle du régime géré par la Caisse nationale de sécurité sociale au 31 décembre 2001.* Geneva, BIT.
http://www.ilo.org/public/libdoc/ilo/2004/104B09_384_fren.pdf

Boulliung, P. 1989. *Republique de Guinée: reorganisation administrative de la caisse nationale de securite sociale; resultats du projet et recommandations en decoulant.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/1989/89B09_414_fren.pdf

1987. *Republique de Guinée: reorganisation administrative de la caisse nationale de securite sociale; resultats du projet et recommandations en decoulant.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/1987/87B09_422_fren.pdf

Health protection

Carlson, C. 2005. *Improving the delivery of health and education services in difficult environments: lessons from case studies.* Department for International Development ; Health Systems Resource Centre.
http://www.dfidhealthrc.org/shared/publications/SDDE/SDDE%20summary_revised%2021feb.pdf

2004. *L' amélioration de l'accès aux soins en Afrique francophone : le rôle de l'assurance : rapports des 14 pays d'Afrique francophone.* Paris, ESPAD.
http://www.ces-asso.org/Pages/defaut_fr.htm

2004. *Inventaire des systèmes d'assurance maladie en Afrique: synthèse des travaux de recherche dans 11 pays.* La concertation.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=82

Criel, B., Noumou Barry, A., & Von Roenne, F. 2002. *Le projet PRIMA en Guinée Conakry : une expérience d'organisation de mutuelles de santé en Afrique rurale.* Medicus Mundi, Belgique ; Institut de médecine tropicale.

Camara, M.T. 2001. Mutuelle de santé : une nécessité incontournable pour nos pays. *Horoya* no. 5602, p. 3.

Carrin, G. & Evlo, K. 1995. *A methodology for the calculation of health care costs and their recovery : Guinea : technical paper.* WHO.

1994. *République de Guinée : caisse nationale de securite sociale; etude actuarielle.* Geneva, ILO. http://www.ilo.org/public/libdoc/ilo/1994/94B09_52_fren.pdf

Camen, U. & Carrin, G. 1994. *Macroeconomic evolution and health sector : Guinea : country paper.* WHO.

Old age benefits

1994. *République de Guinée : caisse nationale de securite sociale; etude actuarielle.* Geneva, ILO. http://www.ilo.org/public/libdoc/ilo/1994/94B09_52_fren.pdf

Occupational accidents insurance

Camara, M.T. 2001. Médecine d'entreprise : organismes paritaires pour la prévention des accidents du travail et des maladies professionnelles. *Horoya* no. 5677, p. 4.

Camara, M.T. 2001. Sécurité sociale : évaluation de l'incapacité en cas d'accident du travail ou de maladie professionnelle. *Horoya* no. 5578, p. 5.

Camara, M.T. 2000. Les trois principes de la protection du travailleur. *Horoya* no. 5485, p. 5.

Camara, M.T. 2000. De l'importance de la CNSS dans la répartition des risques professionnels. *Horoya* no. 5443, p. 3.

1993. *Prévention des risques professionels.* Ministère de la réforme administrative; de la fonction publique et du travail; Caisse nationale de sécurité sociale.

3. Niger

Robalino, D.A., Rawlings, L., & Walker, I. 2012. *Building social protection and labor systems concepts and operational implications.* Washington, D.C., World,Bank. http://hdl.handle.net/10986/13554

2007. *Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA.* Bureau international du travail, (BIT). http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1250

Régent, S. 2007. *Developing a legal framework for mutual organizations in WAEMU Member States: a participatory process.* ILO. http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1950

2006. *Atelier régional de concertation sur les avant-projets de règlement sur les mutuelles sociales dans les Etats membres de l'UEMOA : rapport final.* Bureau international du travail, (BIT) ; Union Economique et Monétaire Ouest Africaine, (UEMOA). http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=973

1993. *Recueil des textes.* Caisse nationale de sécurité sociale.

Dayina, M., Nathan, R., & Kieffer, R. 1993. *République du Niger : note technique au gouvernement du Niger sur l'analyse financière du régime de sécurité sociale du Niger : annexe au rapport d'évaluation actuarielle.* BIT ; UNDP.

Dayina, M., Nathan, R., & Kieffer, R. 1993. *République du Niger : rapport du gouvernement du Niger sur l'analyse actuarielle du régime de sécurité sociale du Niger.* BIT ; UNDP.

Salle, G. 1970. *Rapport au gouvernement de la republique du Niger sur l'administration de l'assurance-pension.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/1970/70B09_381.pdf

Health protection

2007. *Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA.* Bureau international du travail, (BIT).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1250

Régent, S. 2007. *Developing a legal framework for mutual organizations in WAEMU Member States: a participatory process.* ILO.
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1950

2006. *Atelier régional de concertation sur les avant-projets de règlement sur les mutuelles sociales dans les Etats membres de l'UEMOA : rapport final.* Bureau international du travail, (BIT) ; Union Economique et Monétaire Ouest Africaine, (UEMOA).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=973

2004. *Inventaire des systèmes d'assurance maladie en Afrique: synthèse des travaux de recherche dans 11 pays.* La concertation.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=82

2004. *L' amélioration de l'accès aux soins en Afrique francophone : le rôle de l'assurance : rapports des 14 pays d'Afrique francophone.* Paris, ESPAD.
http://www.ces-asso.org/Pages/defaut_fr.htm

Old age benefits

Salle, G. 1970. *Rapport au gouvernement de la republique du Niger sur l'administration de l'assurance-pension.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/1970/70B09_381.pdf

Occupational accidents insurance

Balla Souley, E.I. 1996. L'enquête d'accident du travail. *Dialogue social* no. 5, p. 7-9.

4. Senegal

Social security

Diop, F. & Ba, A. 2010. *Mutual health insurance, scaling-up and the expansion of health insurance in Africa.* USAID.
http://www.healthsystems2020.org/content/resource/detail/2523/

2009. *Fiscal space for strengthened social protection : West and Central Africa.* UNICEF.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=16132

McGillivray, W. 2009. *Strengthening social protection for African migrant workers through social security agreements : background report prepared for the Extension of social security coverage to African migrant workers (MIGSEC) project.* Geneva, ILO.

Annycke, P. 2008. *Sénégal : l'analyse des prestations et des indicateurs de résultats de la protection sociale.* BIT.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=6271

2007. *Members making a difference.* ICMIF.
http://search.ilo.org/gimi/RessShowRessource.do?ressourceId=3910&longTitle=Members+making+a+difference&author=ICMIF&ressYear=2007

2007. *Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA.* Bureau international du travail, (BIT).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1250

Régent, S. 2007. *Developing a legal framework for mutual organizations in WAEMU Member States: a participatory process.* ILO.
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1950

2006. *Atelier régional de concertation sur les avant-projets de règlement sur les mutuelles sociales dans les Etats membres de l'UEMOA : rapport final.* Bureau international du travail, (BIT) ; Union Economique et Monétaire Ouest Africaine, (UEMOA).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=973

Diop, A.Y. 2006. *Assurance contre les risques professionnels: renforcer les liens entre les systèmes de financement et la gestion du risque: rapport du Sénégal.*

Pal, K. 2005. *Can low income countries afford basic social protection? : first results of a modelling exercise.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/2005/105B09_269_engl.pdf

Riondel Besson, G. 2005. Le développement des mutuelles de santé au Sénégal : quels enjeux ? *Cahiers genevois et romands de sécurité sociale* no. 34, p. 27-41.

Fall, A. 2004. Protection sociale et bonne gouvernance : pour une sécurité sociale plus forte. *Infos Sécurité Sociale* no. 4, p. 9-11.
http://www.secusociale.sn

Diop, A.Y. 2003. Governance of social security regimes : trends in Senegal. *International Social Security Review*, vol. 56, no. 3-4, p. 17-23.
http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291468-246X

Fall, C. 2002. *Etendre l'assurance santé au Sénégal : possibilités à travers les régimes statutaires et les organisations mutualistes.* BIT.
http://www2.ilo.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=5814

Armengaud, P. 2001. Aperçus de la Caisse de Sécurité Sociale du Sénégal. *Documents et synthèses* no. 17.

Bockstal, C. & International Social Security Association Meeting of Directors of Social Security Institutions in French Speaking Africa L'extension de la protection sociale: expérience du projet "micro-assurance santé pour les femmes et leurs familles", STEP/UNF, pp. 49-67.

Hempel, M. 2001. *Actes du Forum national sur la réforme de la protection sociale au Sénégal.* [Dakar], Dép. de la coopération internationale, Bureau de Dakar.

Diallo, A. & Ndiaye, P. B. 2000, "Les régimes de pension en Afrique : l'expérience de l'institution de prévoyance retraite du Sénégal," *In La sécurité sociale en Afrique: nouvelles réalités*, Genève: AISS.

1992. *Sénégal : rapport au gouvernement sur la situation actuelle et les perspectives d'évolution de la protection sociale.* BIT.

Issa-Sayegh, J. 1992. *Le droit sénégalais de la sécurité sociale.* Dakar, Les nouvelles éditions africaines du Sénégal.

Sooth, C.P. 1992. *Entstehungs- und Entwicklungsbedingungen staatlicher Systeme sozialer Sicherung in Afrika : Senegal, Kamerun, Mauritius und Gabun im Vergleich.* Hamburg, Institut für Afrika-Kunde.

Kaufmann, O. 1983. Le droit de la sécurité sociale au Sénégal. *Jahrbuch für afrikanisches Recht* no. 3, p. 137-156.

Thomas, J. 1969. *Rapport au gouvernement de la republique du Senegal sur l'organisation administrative et la mecanisation de la caisse de compensation des prestations familiales et des accidents du travail.* Geneva, ILO.

Health protection

Ridde, V. & Jacob, J.P. 2013. *Les indigents et les politiques de santé en Afrique : expériences et enjeux conceptuels.* Louvain, Academia-L'Harmattan.

Diop, F. & Ba, A. 2010. *Mutual health insurance, scaling-up and the expansion of health insurance in Africa.* USAID.
http://www.healthsystems2020.org/content/resource/detail/2523/

2007. *L'accès à la protection sociale et aux soins de santé pour tous: STEP en Afrique.* [Genève], ILO.
http://www.ilo.org/public/libdoc/ilo/2007/107B09_112_fren.pdf

2007. *Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA.* Bureau international du travail, (BIT).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1250

Asfaw., A. & Jütting, J.P. 2007. The role of health insurance in poverty reduction : empirical evidence from Senegal. *International journal of public administration*, vol. 30, no. 8-9, p. 835-858.

Régent, S. 2007. *Developing a legal framework for mutual organizations in WAEMU Member States: a participatory process.* ILO.
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1950

2006. *Atelier régional de concertation sur les avant-projets de règlement sur les mutuelles sociales dans les Etats membres de l'UEMOA : rapport final.* Bureau international du travail, (BIT) ; Union Economique et Monétaire Ouest Africaine, (UEMOA).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=973

Scheil-Adlung, X., Carrin, G., Jütting, J., & Xu, K. 2006. *What is the impact of social health protection on access to health care, health expenditure and impoverishment? : a comparative analysis of three African countries.* Geneva, International Labour Office.

Jütting, J. 2005. *Health insurance for the poor in developing countries.* Hampshire, Aldershot.

2004. *L' amélioration de l'accès aux soins en Afrique francophone : le rôle de l'assurance : rapports des 14 pays d'Afrique francophone.* Paris, ESPAD.
http://www.ces-asso.org/Pages/defaut_fr.htm

2004. *Inventaire des systèmes d'assurance maladie en Afrique: synthèse des travaux de recherche dans 11 pays.* La concertation.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=82

Jütting, J.P. 2004. Do community-based health insurance schemes improve poor people's access to health care? : evidence from rural Senegal. *World development*, vol. 32, no. 2, p. 273-288.

Fall, C. 2002. *Etendre l'assurance santé au Sénégal : possibilités à travers les régimes statutaires et les organisations mutualistes.* BIT.
http://www2.ilo.org/gimi/gess/RessourceDownload.action?ressource.ressourceId=5814

Fall, C. 2002. *Extending health insurance in Senegal : options for statutory schemes and mutual schemes.* Geneva, International Labour Office.

Jütting, J.P. 2002. *Social protection in rural areas of developing countries : investigating the impact of community based health insurance in rural Senegal.*
http://purl.umn.edu/24803

Bockstal, C. & International Social Security Association Meeting of Directors of Social Security Institutions in French Speaking Africa L'extension de la protection sociale: expérience du projet "micro-assurance santé pour les femmes et leurs familles", STEP/UNF, pp. 49-67.

Jütting, J.P. 2001. *The impact of health insurance on the access to health care and financial protection in rural developing countries : the example of Senegal.* Washington, DC, World Bank.

Atim, C. 2000. *Contribution des mutuelles de santé au financement, à la fourniture et à l'accès aux soins de santé: synthèse de travaux de recherche menés dans neuf pays d'Afrique de l'Ouest et du Centre.* Genève, LO Strategies and Tools against Social Exclusion and Poverty Programme.

Old age benefits

2000. *Perspectives d'évolution des opérations de retraite de l'IPRES, 2000-2012.* Institution de prévoyance retraite du Sénégal.

Diallo, A. & Ndiaye, P. B. 2000, "Les régimes de pension en Afrique : l'expérience de l'institution de prévoyance retraite du Sénégal," *In La sécurité sociale en Afrique: nouvelles réalités*, Genève: AISS.

Thomas, J. 1969. *Rapport au gouvernement de la republique du Senegal sur l'organisation administrative et la mecanisation de la caisse de compensation des prestations familiales et des accidents du travail.* Geneva, ILO.

Occupational accidents insurance

Ndiaye, M. 2007. *L' importance de la formation: cas de la Caisse de sécurité sociale du Sénégal.*

Diop, A.Y. 2006. *Assurance contre les risques professionnels: renforcer les liens entre les systèmes de financement et la gestion du risque: rapport du Sénégal.*

Thomas, J. 1969. *Rapport au gouvernement de la republique du Senegal sur l'organisation administrative et la mecanisation de la caisse de compensation des prestations familiales et des accidents du travail.* Geneva, ILO.

Bouchoou, A. 1966. *Rapport au gouvernement de la republique du Senegal sur l'amelioration du fonctionnement de la caisse de compensation des prestations familiales et des accidents du travail.* Geneva, ILO.

5. Togo

Social security

2012. *Togo : towards a national social protection policy and strategy.* Washington, DC, World Bank. http://hdl.handle.net/10986/11871

2007. *Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA.* Bureau international du travail, (BIT). http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1250

2007. *Members making a difference.* ICMIF. http://search.ilo.org/gimi/RessShowRessource.do?ressourceId=3910&longTitle=Members+making+a+difference&author=ICMIF&ressYear=2007

Régent, S. 2007. *Developing a legal framework for mutual organizations in WAEMU Member States: a participatory process.* ILO. http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1950

Bendokat, R. & Tovo, M. 1999. *A social protection strategy for Togo.* Washington DC, World Bank. http://www-

wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2000/08/19/000094946_00081905493527/Rendered/PDF/multi_page.pdf

Almeida, D.N. 1995. La protection de la mère et de l'enfant au regard des prestations familiales de sécurité sociale au Togo. *Penant*, vol. 105, no. 819, p. 308-324.

Mignot, A. 1977. Les relations entre la France et le Togo en matière de sécurité sociale. *Penant*, vol. 86, no. 758, p. 450-485.

Health protection

Leliveld, A. 2010, "Can't buy me health: financial constraints and health-seeking behaviour in rural households in central Togo," pp. 255-281.

2007. *Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA.* Bureau international du travail, (BIT).
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1250

Régent, S. 2007. *Developing a legal framework for mutual organizations in WAEMU Member States: a participatory process.* ILO.
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1950

2004. *L' amélioration de l'accès aux soins en Afrique francophone : le rôle de l'assurance : rapports des 14 pays d'Afrique francophone.* Paris, ESPAD.
http://www.ces-asso.org/Pages/defaut_fr.htm

2004. *Inventaire des systèmes d'assurance maladie en Afrique: synthèse des travaux de recherche dans 11 pays.* La concertation.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=82

Atim, C. 2000. *Contribution des mutuelles de santé au financement, à la fourniture et à l'accès aux soins de santé: synthèse de travaux de recherche menés dans neuf pays d'Afrique de l'Ouest et du Centre.* Genève, LO Strategies and Tools against Social Exclusion and Poverty Programme.

Old age benefits

Ryba, M. 1998. *The role of the International Labour Organization and the World Bank with pension reforms in Africa.* ILO.

Audibert, J. 1996. *Togo : rapport au gouvernement sur la caisse de retraite des fonctionnaires.*
http://www.ilo.org/public/libdoc/ilo/1996/96B09_356_fren.pdf

1990. Establishment of a complementary pension fund for officials of parastatal bodies. *African News Sheet*, vol. 9, p. 22-24.

Occupational accidents insurance

Borne, F. 1967. *Rapport au gouvernement de la republique du Togo sur l'assurance des risques professionnels.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/1967/67B09_96_fren.pdf

6. Ghana

Social security

2014. *Rationalizing social protection expenditure in Ghana : consolidated version: draft for comments.* Geneva, ILO.

Wodon, Q. 2012. *Improving the targeting of social programs in Ghana.* Washington, D.C., World Bank. http://hdl.handle.net/10986/13082

Kpessa, M.W. 2011. A comparative analysis of pension reforms and challenges in Ghana and Nigeria. *International Social Security Review*, vol. 64, no. 2, p. 91-109.

Diop, F. & Ba, A. 2010. *Mutual health insurance, scaling-up and the expansion of health insurance in Africa.* USAID.
http://www.healthsystems2020.org/content/resource/detail/2523/

2009. *Fiscal space for strengthened social protection : West and Central Africa.* UNICEF.
http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=16132

McGillivray, W. 2009. *Strengthening social protection for African migrant workers through social security agreements : background report prepared for the Extension of social security coverage to African migrant workers (MIGSEC) project.* Geneva, ILO.

Yaw Baah, A. 2009. *Legal and social protection for informal economy workers in Ghana : a guide for trade organisers and educators.* Accra, Ghana Trades Union Congress.

2008. *Ghana : report to the Government: peer review of the fifth triennial actuarial valuation of the social security and national insurance trust as at 31 December 2005.* Geneva, ILO.

Arun, T. & Steiner, S. 2008. *Micro-insurance in the context of social protection.* Brooks World Poverty Institute.
http://www.seed.manchester.ac.uk/medialibrary/bwpi/publications/working_papers/bwpi-wp-5508.pdf

Twerefou, D.K., Ebo-Turkson, F., & Kwadwo, A.O. 2007. *Labour market flexibility, employment and income insecurity in Ghana.* Geneva, ILO.

Weiss, H. 2007. *Begging and almsgiving in Ghana : Muslim positions towards poverty and distress.* Uppsala, Nordiska Afrikainstitutet.

2006. *Republic of Ghana: technical note: financial assessment of the National Health Insurance Fund.* Geneva, ILO.

Boatin, K. & Nyarko, E. 2006. *Social and economic investments of social security funds: trends of social and economic investment policies and practices in social security organizations.*

Dorkenoo, D.K. 2006. Réforme de la sécurité sociale et des retraites au Ghana: le rôle des syndicats. *Education ouvrière*, vol. 145, no. 4, p. 57-63.

Kwabla Dorkenoo, D. 2006. The role of trade unions in reforming social security and pensions in Ghana. *Labour education* no. 145, p. 53-60.
http://www.ilo.org/public/libdoc/ilo/P/09707/09707(2006-4)53-60.pdf

2004. *Fishing for standards : a collection of articles on ILO's proposed comprehensive standard on work in the fishing sector.* S.l., International Collective in Support of Fishworkers.

Osei, K. 2004, "Extending social security coverage: the Ghanaian experience," *In Current social security issues in English-speaking Africa*, pp. 71-86.

Audibert, M., Mathonnat, J., & Roodenbeke, E.d. 2003. *Le financement de la santé dans les pays d'Afrique et d'Asie à faible revenu.* Paris, Editions Karthala .

Cichon, M. 2003. Linking community initiatives to national institutions : Ghana. *International Social Security Review*, vol. 56, no. 3-4, p. 59-71.
http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291468-246X

Kumado, K. & Gockel, A. 2003. *Social security in Ghana : a study.* [Accra], Friedrich Ebert Foundation.
http://library.fes.de/pdf-files/bueros/ghana/50022.pdf

Barr, A.M. 2002. The functional diversity and spillover effects of social capital. *Journal of African Economies: (2002), vol.11, no.1, p.90-113 : graf., tab.*, vol. 11, no. 1, p. 90-113.

Goldstein, M.P., Janvry, A.d., & Sadoulet, E. 2002. *Is a friend in need a friend indeed? : inclusion and exclusion in mutual insurance networks in Southern Ghana.* UNU/WIDER.

Arhinful, D.K. 2001. *"We think of them" : how Ghanaian migrants in Amsterdam assist relatives at home.* Leiden, African Studies Centre.

Allotey-Pappoe, J.E. 1997. *The role of public information activities : the transformation of provident fund into social insurance schemes : the experience of Ghana.*

Amartey-Vondee, E. & Owusuh-Ansah, M. 1997. *Social security and national insurance trust report.*

Dei, H.G. 1997. Meeting the challenge of conversion : Ghana's provident fund becomes a pension scheme. *International Social Security Review*, vol. 50, no. 2, p. 63-71.
http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291468-246X

Cassels, A. & Janovsky, K. 1996. *Reform of the health sector in Ghana and Zambia : commonalities and constrasts.* WHO.

Dei, H.G. 1995. *The role of public information activities : the transformation of provident fund into social insurance schemes : the experience of Ghana.*

Dei, H.G. 1994. The impact of structural adjustment programmes on social security in English-speaking West African countries. *Social Security Documentation.African Series* no. 15.

Dei, H.G. 1994. Experience gained in the conversion of a provident fund to a social insurance scheme : the experience of the Social Security and National Insurance Trust of Ghana. *Social Security Documentation.African Series*, vol. 14, p. 13-27.

Butare, T. 1993. *Ajustement structurel, croissance et réduction de la pauvreté en Afrique subsaharienne: Ile Maurice et Ghana.* BIT.

1992. *Twenty-five years of the Ghana social security scheme (1965-1990).* National Social Security and Insurance Trust.

Health protection

Boateng, D. & Awunyor-Vitor, D. 2013. Health insurance in Ghana: evaluation of policy holders' perceptions and factors influencing policy renewal in the Volta region. *International Journal for Equity in Health*, vol. 12, no. 1.
http://dx.doi.org/10.1186/1475-9276-12-50

Kotoh, A.M. 2013. *Improving health insurance coverage in Ghana : a case study.* Leiden, African Studies Centre.
http://hdl.handle.net/1887/20951

Kotoh, A.M. 2013. *Improving health insurance coverage in Ghana : a case study.* Leiden, African Studies Centre.

Ridde, V. & Jacob, J.P. 2013. *Les indigents et les politiques de santé en Afrique : expériences et enjeux conceptuels.* Louvain, Academia-L'Harmattan.

Nguyen, H., Hong Wang, & Rajkotia, Y. 2012. The financial protection effect of Ghana National Health Insurance Scheme : evidence from a study in two rural districts. *International Journal for Equity in Health*, vol. 10, no. 4.
http://dx.doi.org/10.1186/1475-9276-10-4

Saleh, K. 2012. *A Health sector in transition to universal coverage in Ghana.* World Bank.
http://www-wds.worldbank.org/external/default/main?pagePK=64193027&piPK=64187937&theSitePK=523679&menuPK=64187510&searchMenuPK=64187511&entityID=000386194_20120306000453&cid=3001

Saleh, K. 2012. *World Bank study : a health sector in tansition to universal coverage in Ghana.* Washington, DC, World Bank.

Schieber, G., Cashin, C., Saleh, K., & Lavado, R. 2012. *Health financing in Ghana.* Washington, DC, World Bank.
http://hdl.handle.net/10986/11977

Akazili, J., Gyapong, J., & McIntyre, D. 2011. Who pays for health care in Ghana? *International Journal for Equity in Health*, vol. 10.
http://dx.doi.org/10.1186/1475-9276-10-26

Carbone, G. 2011. Democratic demands and social policies: the politics of health reform in Ghana. *The Journal of Modern African Studies*, vol. 49, no. 3, p. 381-408.

Diop, F. & Ba, A. 2010. *Mutual health insurance, scaling-up and the expansion of health insurance in Africa.* USAID.
http://www.healthsystems2020.org/content/resource/detail/2523/

2009. *Health insurance matrix for selected sub-Saharan African countries : Ethiopia, Ghana, Liberia, Nigeria, Kenya, Rwanda, Tanzania, and Uganda.* USAID.
http://www.healthsystems2020.org/content/resource/detail/2380/

Mazzucato, V. 2009. Informal insurance arrangements in Ghanaian migrants' transnational networks : the role of reverse remittances and geographic proximity. *World development*, vol. 36, no. 6, p. 1105-1115.

Assensoh, A.B. & Wahab, H. 2008. A historical-cum-political overview of Ghana's National Health Insurance Law. *African and Asian Studies*, vol. 7, no. 2/3, p. 289-306.

Grüb, A. 2007. *Ghana : social security schemes for health.* GNEMHO.
http://search.ilo.org/gimi/RessShowRessource.do?ressourceId=4872&longTitle=Ghana+-+Social+Security+Schemes+for+Health&author=A.+Gr%FCb&ressYear=2007

Hsiao, W.C. & Shaw, R.P. 2007. *Social health insurance for developing nations.* Washington, D.C., World Bank.

Rosa, J.d.l. & Scheil-Adlung, X. 2007. *Enabling transition to formalization through providing access to health care: the examples of Thailand and Ghana.* Geneva, International Labour Office.

2006. *Republic of Ghana: technical note: financial assessment of the National Health Insurance Fund.* Geneva, ILO.

2005. *Improving social protection for the poor : health insurance in Ghana : the Ghana Social Trust pre-Pilot Project: final report.* Geneva, International Labour Office.

Awoonor-Williams, J.K. 2005. *Bridging the gap between evidence-based innovation and national health-sector reform in Ghana.* Population Council.
http://www.popcouncil.org/uploads/pdfs/wp/191.pdf

2004. *L' amélioration de l'accès aux soins en Afrique francophone : le rôle de l'assurance : rapports des 14 pays d'Afrique francophone.* Paris, ESPAD.
http://www.ces-asso.org/Pages/defaut_fr.htm

Arhinful, D.K. 2003. *The solidarity of self-interest : social and cultural feasibility of rural health insurance in Ghana.* Leiden, African Studies Centre.

Arhinful, D.K. 2003. *The solidarity of self-interest : social and cultural feasibility of rural health insurance in Ghana.* [S.l., s.n.].
http://dare.uva.nl/document/71020

Audibert, M., Mathonnat, J., & Roodenbeke, E.d. 2003. *Le financement de la santé dans les pays d'Afrique et d'Asie à faible revenu.* Paris, Editions Karthala .

2001. *Contribution of mutual health organizations, to financing, delivery, and access to health care Ghana case study.* Geneva, ILO Strategies and Tools against Social Exclusion and Poverty Programme.

Atim, C. 2000. *Contribution des mutuelles de santé au financement, à la fourniture et à l'accès aux soins de santé: synthèse de travaux de recherche menés dans neuf pays d'Afrique de l'Ouest et du Centre.* Genève, LO Strategies and Tools against Social Exclusion and Poverty Programme.

Old age benefits

Kpessa, M.W. 2011. A comparative analysis of pension reforms and challenges in Ghana and Nigeria. *International Social Security Review*, vol. 64, no. 2, p. 91-109.

2008. *Ghana : report to the Government: peer review of the fifth triennial actuarial valuation of the social security and national insurance trust as at 31 December 2005.* Geneva, ILO.

Kwabla Dorkenoo, D. 2006. The role of trade unions in reforming social security and pensions in Ghana. *Labour education* no. 145, p. 53-60.
http://www.ilo.org/public/libdoc/ilo/P/09707/09707(2006-4)53-60.pdf

Osei, K. Risk management : the experience of the Social Security and National Insurance Trust, pp. 313-337.

Dei, H.G. 1997. Meeting the challenge of conversion : Ghana's provident fund becomes a pension scheme. *International Social Security Review*, vol. 50, no. 2, p. 63-71.
http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291468-246X

Dei, H.G. 1994. Experience gained in the conversion of a provident fund to a social insurance scheme : the experience of the Social Security and National Insurance Trust of Ghana. *Social Security Documentation.African Series*, vol. 14, p. 13-27.

1992. Le Ghana adopte le régime de pension. *Nouvelles africaines de sécurité sociale*, vol. 10, p. 15-16.

1992. Ghana goes pension. *African News Sheet*, vol. 10, p. 13-14.

Occupational accidents insurance

7. Rwanda

Social security

Andrews, C. 2012. *Social protection in low income countries and fragile situations: challenges and future directions : background paper for the World Bank 2012-2022 social protection and labor strategy.* Washington, D.C., The World Bank.
http://www.ilo.org/public/libdoc/igo/2012/469522.pdf

2011. *Rwanda : national social protection strategy.* Minister of Local Government.
http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=23208

Barya, J.J. 2011. *Social security and social protection in the East African Community.* Kampala, Fountain Publishers.
http://www.asclibrary.nl/docx/336/388/33638808X.pdf

Diop, F. & Ba, A. 2010. *Mutual health insurance, scaling-up and the expansion of health insurance in Africa.* USAID.
http://www.healthsystems2020.org/content/resource/detail/2523/

Hagen, K. 2009. *The "Livingstone call for action": a critical analysis.* Utrecht, University of Utrecht.
http://igitur-archive.library.uu.nl/student-theses/2009-0320-201600/ Scriptie_January_2009.pdf

McGillivray, W. 2009. *Strengthening social protection for African migrant workers through social security agreements : background report prepared for the Extension of social security coverage to African migrant workers (MIGSEC) project.* Geneva, ILO.

2008. *Rationalising delivery of social security benefits services to be delivered under one institution.* Ministry of Finance and Economic Planning. Republic of Rwanda. http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=10470

Umulisa Shamsa, S. 2005. *Les prestations de sécurité sociale et leur ajustement : cas de la caisse sociale du Rwanda.* Université libre de Kigali.

Niyitegeka, J.P. 2004. La couverture sociale pour tous : pari du gouvernement rwandais. *Solidarité* no. 20, p. 8-9.

2003. Social security in Rwanda : overcoming indifference. *International Social Security Review*, vol. 56, no. 3-4, p. 11-16. http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291468-246X

Kamwenubusa, T. 2000. *Rapport au Gouvernement : analyse actuarielle de la Caisse sociale du Rwanda : version préliminaire.* BIT.

Ngabonziza, J.B. 1997. Reflexions sur les cotisations sociales et leur recouvrement. *Solidarité* no. 10, p. 35-47.

Gayabazi, P.C. 1980. Les recours de la victime et de la caisse sociale contre le tiers responsable de la réalisation d'un risque professionnel. *Revue juridique du Rwanda*, vol. 4, no. 3, p. 333-368.

Health protection

Brinkerhoff, D., Williamson, R., Squires, J., Ravishankar, N., & Fox, L. 2014. *Rwanda health governance assessment.* USAID. http://www.healthsystems2020.org/content/resource/detail/2780/

Ridde, V. & Jacob, J.P. 2013. *Les indigents et les politiques de santé en Afrique : expériences et enjeux conceptuels.* Louvain, Academia-L'Harmattan.

Turcotte-Tremblay, A.-M., Haddad, S., Yacoubou, I., & Fournier, P. 2012. Mapping of initiatives to increase membership in mutual health organizations in Benin. *International Journal for Equity in Health*, vol. 11, no. 1, p. 74.

Ahouansou, C. 2010. *Questions directes, ou, Le manifeste social.* Cotonou, CAAREC Editions.

Diop, F. & Ba, A. 2010. *Mutual health insurance, scaling-up and the expansion of health insurance in Africa.* USAID. http://www.healthsystems2020.org/content/resource/detail/2523/

2009. *Renforcer la protection sociale par l'institutionnalisation des mutuelles de santé au Bénin : rapports sur les droits économiques, sociaux et culturels.* Alliance nationale des mututalités chrétiennes (ANMC) ; Solidarité Mondiale (WSM). http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=17917

2007. *L'accès à la protection sociale et aux soins de santé pour tous: STEP en Afrique.* [Genève], ILO. http://www.ilo.org/public/libdoc/ilo/2007/107B09_112_fren.pdf

2007. *Mutuelle de sécurité sociale de Cotonou : rapport de suivi 2006.* Bureau international du travail, (BIT). http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1271

2007. *Appui à la construction d'un cadre régional de développement des mutuelles de santé dans les pays de l'UEMOA.* Bureau international du travail, (BIT). http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1250

Dimechkie, K. 2007. *Mutuelle de Sécurité Sociale du Bénin (MSS) - FAQ.* BIT. http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=4052

Labie, M., Nyssens, M., & Wéjé, P. 2007. Microfinance et micro-assurance santé : réflexions sur des articulations possibles à partir de quelques expériences au Bénin et au Burkina Faso. *Mondes en développement*, vol. 35, no. 139, p. 57-71.

Régent, S. 2007. *Developing a legal framework for mutual organizations in WAEMU Member States: a participatory process.* ILO. http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=1950

2006. *Atelier régional de concertation sur les avant-projets de règlement sur les mutuelles sociales dans les Etats membres de l'UEMOA : rapport final.* Bureau international du travail, (BIT) ; Union Economique et Monétaire Ouest Africaine, (UEMOA). http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=973

2004. *Inventaire des systèmes d'assurance maladie en Afrique: synthèse des travaux de recherche dans 11 pays.* La concertation. http://www.socialsecurityextension.org/gimi/gess/RessShowRessource.do?ressourceId=82

2004. *L' amélioration de l'accès aux soins en Afrique francophone : le rôle de l'assurance : rapports des 14 pays d'Afrique francophone.* Paris, ESPAD. http://www.ces-asso.org/Pages/defaut_fr.htm

Audibert, M., Mathonnat, J., & Roodenbeke, E.d. 2003. *Le financement de la santé dans les pays d'Afrique et d'Asie à faible revenu.* Paris, Editions Karthala .

Atim, C. 2000. *Contribution des mutuelles de santé au financement, à la fourniture et à l'accès aux soins de santé: synthèse de travaux de recherche menés dans neuf pays d'Afrique de l'Ouest et du Centre.* Genève, LO Strategies and Tools against Social Exclusion and Poverty Programme.

Old age benefits

Ngarambe, F.-X. 2002. Réforme du régime des pensions : bilan et perspectives. *Solidarité* no. 16, p. 20-23.

Mugenzi, L.M. 1989. La protection du travailleur contre les accidents du travail en droit social rwandais. *Revue juridique et politique*, vol. 43, no. 3/4, p. 568-579.

Occupational accidents insurance

Mugenzi, L.M. 1989. La protection du travailleur contre les accidents du travail en droit social rwandais. *Revue juridique et politique*, vol. 43, no. 3/4, p. 568-579.

8. Africa in general

2013. *Study on social protection in Sub-Saharan Africa : final report.* European Commission. http://capacity4dev.ec.europa.eu/public-employment-social-protection/document/study-social-protection-sub-saharan-africa-final-report

2013. *Social security programs throughout the world : Africa, 2013.* Washington, U S Govt. Print. http://www.ssa.gov/policy/docs/progdesc/ssptw/2012-2013/africa/ssptw13africa.pdf

Devereux, S. & Getu, M. 2013. *Informal and formal social protection systems in Sub-Saharan Africa.* Kampala, Fountain Publishers.

Kalusopa, Trywell, Dicks, Rudi, and Osei-Boateng, Clara 2012. *Social protection in Africa.* Accra, Ghana, African Labour Research Network.

Hinz, R. 2012. *Matching contributions for pensions: a review of international experience.* Washington, D.C, World Bank.

Holmes, R. & Lwanga-Ntale, C. 2012. *Social protection in Africa : a review of social protection issues in research : policy and programming trends and key governance issues in social protection.* Nairobi, PASGR.

Kangas, O.E. 2012. Alte Theorien in neuer Umgebung auf die Probe stellen : Der Zeitpunkt für erste Gesetze der sozialen Sicherheit in Afrika. *Internationale Revue für soziale Sicherheit*, vol. 65, no. 1, p. 81-107.

Sharma, N. & Koseki, S. 2012. *The path to universal coverage in Africa : focus on community-based health insurance.* USAID. http://www.healthsystems2020.org/content/resource/detail/104166/

2011. *Evaluation of retirement systems of countries within the Southern African Development Community.* Oxford Policy Managment. http://www.ilo.org/gimi/gess/RessShowRessource.do?ressourceId=23884

Adesina, J.O. 2011. Beyond the social protection paradigm: social policy in Africa's development. *Canadian Journal of Development Studies*, vol. 32, no. 4, p. 454-470.

Dicks, R., Lwanda, G., & Brockerhoff, S. 2011. *Achieving a decent work agenda in South Africa : finding synergies between public employment schemes and social security interventions within a new growth strategy.*

Olivier, M. 2011. Informality, employment contracts, and social insurance coverage : rights-based perspectives in a developing world context. *International journal of comparative labour law and industrial relations*, vol. 27, no. 4, p. 419-433.

Sanfilippoi, M. & Giovannetti, G. 2011. *Social protection in Sub-Saharan Africa : learning from experiences.* Vox Europa.
http://www.voxeu.org/index.php?q=node/6041

2010. *Health insurance handbook : how to make it work.* World Bank ; USAID.
http://www.healthsystems2020.org/content/resource/detail/2697/

Fouomene, E. 2010. L'introduction de la sécurité sociale dans les Etats francophones d'Afrique Noire. *Cahiers genevois et romands de sécurité sociale* no. 44, p. 39-68.

Ron, A. 2010. Faire des soins de santé une prestation de sécurité sociale approches institutionnelles de l'extension de la couverture. *Revue internationale de sécurité sociale*, vol. 63, no. 1, p. 81-102.

Verstraeten, B., Vandurme, P., Beirinckx, K., Justaert, G., Sintubin, S., Vanbelle, V., & Lesire, C. 2010. *Sociale bescherming: een kwestie van sociale verandering : de visie en strategieën van sociale bewegingen.* Brussel, Wereldsolidariteit.
http://www.wsm.be/images/stories/publications/Sociale_bescherming._Een_kwestie_van_sociale_verandering.pdf

2009. *The informal economy in Africa : promoting transition to formality : challenges and strategies.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/2009/109B09_196_engl.pdf

Schremmer, J. 2009. Extending health care coverage : potential linkages between statutory social security and community-based social protection. *International Social Security Review*, vol. 62, no. 1, p. 25-43.

Taylor, V. 2009. *Social protection in Africa : an overview of the challenges : a study commissioned by the African Union.* Addis Ababa, African Union.

Barrientos, A. Extending the coverage of social security pensions : new strategies for old-age income security in Africa, *In Regional Social Security Forum for Africa, 18-20 November 2008, Kigali*.

Chen, M. 2008. Informality and social protection : theories and realities. *IDS bulletin*, vol. 39, no. 2, p. 28-27.

2007. *Success Africa : partnership for decent work : improving peoples' lives 2nd volume.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/2007/107B09_210_engl.pdf

Kannan, K.P. 2007. Social security in a globalizing world. *International Social Security Review*, vol. 60, no. 2-3, p. 19-37.

Mendy, G. Guide to reporting on challenges relating to occupational diseases : Afican region, *In World Social Security Forum, 10-15 Sept. 2007, Moscow*, ISSA, p. -10.

Naidoo, R. & Frye, I. 2006. The role of workers' organizations in the extension of social security to informal workers. *Comparative Labor Law and Policy Journal*, vol. 27, no. 2, p. 187-205.

Kakwani, N. & Subbarao, K. 2005. *Ageing and poverty in Africa and the role of social pensions.* Washington, DC, World Bank.
http://hdl.handle.net/10986/8535

Butare, T. & Kaseke, E. 2003. Social security in Africa : inherited burdens, future priorities. *International Social Security Review*, vol. 56, no. 3-4, p. 3-9.
http://onlinelibrary.wiley.com/journal/10.1111/%28ISSN%291468-246X

Lund, F. & Nicholson, J. 2003. *Chains of production, ladders of protection : social protection for workers in the informal economy.* Durban, School of Development Studies, Univesity of Natal.

Maes, A. 2003. Informal economic and social security in Sub-Saharan Africa. *International Social Security Review*, vol. 56, no. 3-4, p. 39-58.

Mchomvu, A.S.T. 2002. *Social security.* Harare, School of Social Work.

Meessen, B., Criel, B., & Kegels, G. 2002. Institutionelle Lösungen zur gemeinschaftlichen Risikoverteilung bei Krankheit in Afrika südlich der Sahara : Überlegungen angesichts der vorgefundenen Hindernisse. *Internationale Revue für soziale Sicherheit*, vol. 55, no. 2, p. 91-119.

Arhin-Tenkorang, D. 2001. *Health insurance for the informal sector in Africa : design features, risk protection, and resource mobilization.* Washington, DC, World Bank.
http://hdl.handle.net/10986/13643

Lund, F.J. & Srinivas, S. 2000. *Learning from experience : a gendered approach to social protection for workers in the informal economy.* Geneva, ILO-STEP.
http://www.ilo.org/public/libdoc/ilo/2000/100B09_139_engl.pdf

Barbone, L. & Sanchez, B.L. 1999. *Pensions and social security in Sub-Sahara Africa : issues and options.* Washington DC, World Bank.

Ginneken, W.v. 1999. Social security for the excluded majority : a new challenge for the developing countries. *International Social Security Review*, vol. 52, no. 1, p. 46-69.

1998, "Promoting productivity and social protection in the urban informal sector : an integrated programme approach," *In African employment report 1997/98 : employment generation for poverty reduction*, Geneva: ILO, pp. 97-117.

Fultz, E. & Pieris, B. 1998. *Employment injury schemes in Southern Africa : an overview and proposals for future directions.* Harare, ILO.

Jesse, A. & Ginneken, W.v. 1998. *Social security for the informal sector : annotated bibliography on developing countries, 1990-1997.* Geneva, ILO.
http://www.ilo.org/public/libdoc/ilo/1998/98B09_174_engl.pdf

Ginneken, W.v. 1996. *Social security for the informal sector : issues, options and tasks ahead : working paper.* Geneva, International Labour Office.
http://www.ilo.org/public/libdoc/ilo/1996/96B09_156_engl.pdf

1993. *Rapport du Directeur général.* Genève, Bureau International du Travail.

9. Search strategy

Sources	Keywords[78]
ASC catalogue (http://catalogue.ascleiden.nl/)	social security, informal sector, crafts, small enterprises, self-help, market vendors, domestic workers, Guinea, Senegal, Togo, Benin, Niger, Ghana, Rwanda, family allowances, occupational accidents insurance, health insurance, pensions, unemployment insurance
Labordoc (http://labordoc.ilo.org/)	Guinea, Senegal, Togo, Benin, Niger, Ghana, Rwanda, Africa, social protection, social security, disability benefit, employment accident benefit, family benefit, old age benefit, pension scheme, social assistance, unemployment benefit, microinsurance, health insurance, informal economy, cottage industry, family enterprise, hidden economy, informal employment, informal workers, small scale industry, street vendor
Open Knowledge Repository World Bank (https://openknowledge.worldbank.org/)	[79]Guinea, Senegal, Togo, Benin, Niger, Ghana, Rwanda, Africa, informal economy, social security, informal employment, social protection, health insurance, pensions
RePec (http://ideas.repec.org/)	Guinea, Senegal, Togo, Benin, Niger, Ghana, Rwanda, Africa, informal economy, social security, informal employment, social protection, health insurance, pensions
ISSA (http://www.issa.int/document-database)	Guinea, Senegal, Togo, Benin, Niger, Ghana, Rwanda, Africa

[78] Whenever possible, thesaurus terms were used for searching (f.e. ASC thesaurus: *social protection* USE social security)

[79] Via https://openknowledge.worldbank.org/search-filter?query=health+insurance&filtertype_0=subject&filter_0=INSURANCE&filter_relational_operator_0=equals&field=subject