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## **Mozambique's social protection system:**

an overview of the Basic Social Subsidy Programme (PSSB),  
the Direct Social Action Programme (PASD), the Productive Social  
Action Programme (PASP) and the Social Assistance Services (PAUS)

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**MOZAMBIQUE'S SOCIAL PROTECTION SYSTEM:  
AN OVERVIEW OF THE BASIC SOCIAL SUBSIDY PROGRAMME (PSSB),  
THE DIRECT SOCIAL ACTION PROGRAMME (PASD),  
THE PRODUCTIVE SOCIAL ACTION PROGRAMME (PASP)  
AND THE SOCIAL ASSISTANCE SERVICES (PAUS)**

Pedro Arruda<sup>1</sup>

## **1 INTRODUCTION**

Mozambique is a low-income, Southern African nation with an estimated population of 28 million people, 67 per cent of whom live in rural areas. Women comprise 51 per cent of the population, and 45 per cent of the population are under 15 years old (World Bank 2015).

The 4<sup>th</sup> National Poverty Evaluation (*Ministério de Economia e Finanças* 2015), based on data from the Household Income and Consumption Survey (*Inquérito ao Orçamento Familiar—IOF*) 2014-2015, estimates the incidence of poverty at between 40 per cent and 46 per cent. In absolute terms, some 10.5 million to 11.3 million people are thought to be living below the poverty line. The variation in estimates reflects the underreporting of consumption and the different methodologies that can be used to calculate the figure. The country distinguishes between food poverty (insufficient access to food) and total poverty (insufficient access to food and non-food goods). The difference between these two established poverty lines is upwards of 30 per cent. However, there are no recent figures for food poverty alone. Data from the IOF seem to indicate that there was a significant reduction in poverty between 1996-1997 and 2002-2003. This reduction slowed down between 2002-2003 and 2008-2009, and gradually sped up afterwards.

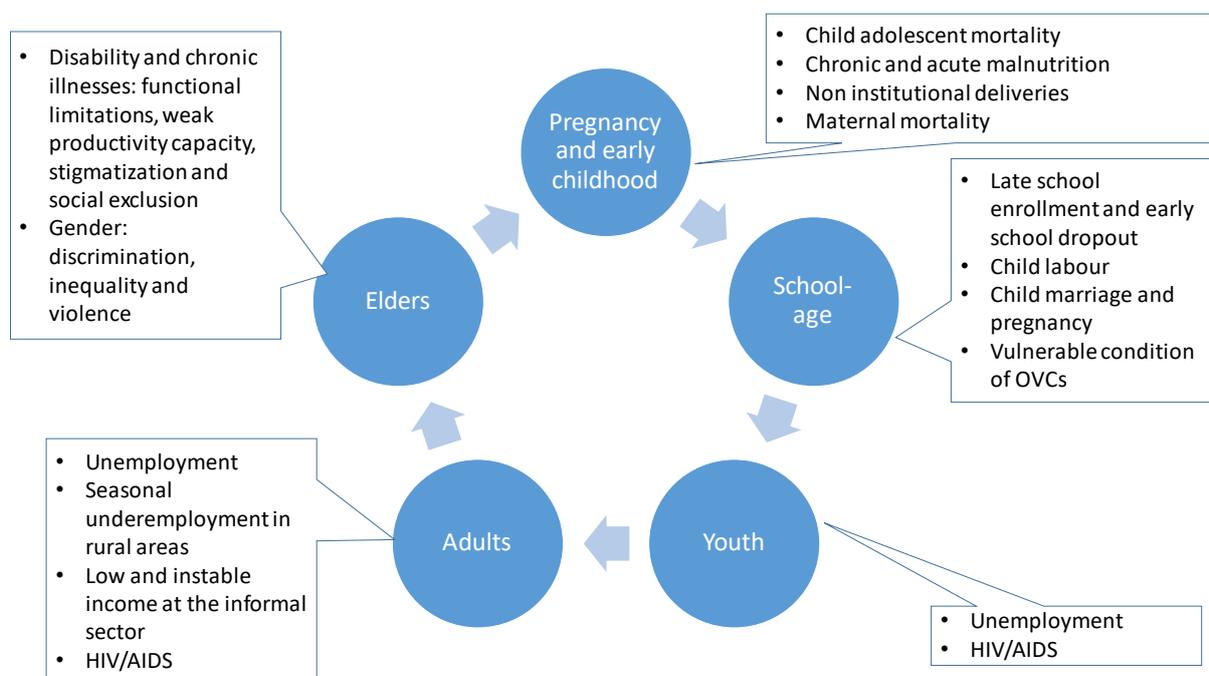
The same evaluation also calculates multidimensional poverty indicators such as the Alkire-Foster index, which looks at multiple aspects such as income, education, possession of durable goods and access to basic services (water, sewage, electricity etc.). From this perspective, there have been improvements since 1997. Taken individually, most development indicators also show a trend of consistent improvement. Poverty is more prevalent and severe in rural areas than in urban ones, and in the southern provinces compared to the northern ones.

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1. International Policy Centre for Inclusive Growth (IPC-IG).

The country's core policy document on social protection, the National Basic Social Security Strategy (*Estrategia Nacional de Seguranca Social Basica—ENSSB*) II 2016–2024, identifies the main drivers of vulnerability during each stage of the life cycle (see Figure 1).

FIGURE 1

**Vulnerability to risks according to stages in the life cycle**

Source: Government of Mozambique (2016).

Mozambique has four main social protection responses in place, including a cash transfer programme (the Basic Social Subsidy Programme—PSSB), a food voucher and in-kind transfer programme (Direct Social Action Programme—PASD), a public works programme (Productive Social Action Programme—PASP), and a set of institutional care services for vulnerable adults, elderly people and children without a home (Social Assistance Services—PAUS).

We open this brief with an analysis of relevant social protection policies in Mozambique, followed by a description of the institutional set-up of the Mozambican social protection system. The following section discusses the core features of each of the country's four flagship social policies, assessing the scale of these programmes and how they relate to each other. In the conclusion, we recall previous critiques regarding the excessive amount of categorical criteria mediating eligibility for these Mozambican social protection initiatives. We make the case for expediting the implementation of the recently developed management and information system—e-INAS—in the hope that it will integrate the databases of the flagship social protection initiatives and increase their reach. Most importantly, we question whether the active search for beneficiaries by health workers contributes to the equity of the PASD, and propose impact evaluation studies for the country's flagship social programmes, which can lead to a rational revamping of the entire social protection system.

## 2 RELEVANT POLICY-LEVEL FEATURES OF SOCIAL PROTECTION IN MOZAMBIQUE

Mozambique's social protection initiatives date back to the early 1990s, when a policy unit dedicated to social protection (the Administrative Office for the Assistance to Vulnerable People—GAPVU) was created to coordinate the country's flagship cash transfer—the Food Subsidy Programme (PSA), launched in 1990 (Selvester et al. 2012; Kula 2014; Pellerano 2014). Despite its name, the PSA was a cash transfer granted with the recommendation that households spend it on food (but without any conditionalities attached). In 1996-1997, the GAPVU was shut down, and, in its place, the National Institute of Social Action (INAS) was established within the Ministry of Gender, Children and Social Action (MGCAS) to manage numerous social protection initiatives. This shift was followed by the transformation of the PSA into the current Basic Social Subsidy Programme (PSSB) in 2010, which was intended to enhance the social transfer features of the initiative, prompting it to go beyond a food subsidy programme (Selvester et al. 2012; Kula 2014).

It was only in 2007, however, that the country started building a policy and legal framework to back social protection initiatives and enhance the comprehensiveness of its developing social protection system. In that year, the government approved a Social Protection Law that structured social protection around three pillars that Cunha et al. (2013) described as:

- **basic social security**, consisting mostly of non-contributory or almost non-contributory social solidarity initiatives funded mostly by the State, and mostly subject to the coordination, and often management authority, of the MGCAS;
- **obligatory social security**, comprising contributory, mandatory social insurance mechanisms, which are mostly managed by the *National Institute of Social Security* (INSS) under the tutelage of the Ministry of Labour. This pillar covers several benefits such as old-age, survival, invalidity, sickness and maternity benefits, hospitalisation, and allowances for burial expenses (Mausse and Cunha 2011); and
- **complementary social security**, meant to regulate complementary, contributory social security initiatives that people can choose in addition to the mandatory ones. The assessment by Cunha et al. (2013), however, indicates that no specific regulations or mechanisms for that purpose have been put in place.

To set guidelines, principles and standards for the social assistance pillar of the Mozambican social protection system, the country enacted the first ENSSB, covering the period from 2010-2011 until 2014. In practice, however, this document served as a reference until February 2016. At that point, a second version was enacted, the ENSSB II, set to cover the period from 2016 to 2024. From the first ENSSB the Basic Social Security of Mozambique was arranged with four main initiatives, which Cunha et al. (2013) described as:

- **the Basic Social Subsidy Programme (PSSB)**: a cash transfer programme targeting extremely poor households in which no adult is able to work, and with features such as being headed by an elderly person or having household members with a disability or who are chronically ill and incapable of working;

- **the Productive Social Action Programme (PASP):** an initiative set to promote public works projects for building or upgrading infrastructure in poor and vulnerable communities while providing beneficiaries with training and other educational opportunities. These projects operate through self-selection mechanisms, though there is an emphasis on prioritising vulnerable households with one or more members with working capacity;
- **the Direct Social Action Programme (PASD):** an inter-sectoral initiative between the MGCAS and the Ministry of Health (MISAU) set to provide child-headed households and households with sick, food-insecure and malnourished people with food vouchers. It also has a stream to benefit households affected by short-term shocks. Different streams of the programme provide benefits for different time spans, varying from short- to medium- and long-term support; and
- **Social Assistance Services (PAUS):** residential care and institutional support for vulnerable and abandoned children and elderly people, victims of violence and homeless people who require intensive care services.

According to Falange and Pellerano (2016), between 2010 and 2014 the number of households benefiting from programmes run by the INAS increased from 254,000 to 427,000. The values disbursed by the PSSB, for instance, tripled in real terms between 2007 and 2014. As a result, government expenditures on INAS-run initiatives grew from 0.22 per cent of gross domestic product (GDP) in 2010 to 0.51 per cent of GDP in 2014.

Falange and Pellerano (2016) note that Cunha et al. (2015) identified the following shortcomings and challenges of the ENSSB I:

- low coverage of the eligible population;
- a lack of basic social protection instruments for some vulnerable groups, particularly children;
- challenges in the implementation of the PASP;
- an absence of reliable and efficient operational procedures for programme implementation (payment delivery, case management, monitoring and evaluation);
- a lack of coordination among ministries responsible for the delivery of basic social protection;
- challenges in the coordination between the MGCAS and the INAS regarding the provision of social welfare services; and
- an absence of INAS offices in most districts, contributing to high administrative costs.

To improve such perceived weaknesses, the ENSSB II proposed the adoption of many policy and programme measures, of which Falange and Pellerano (2016) highlighted:

- the redesign of the PSSB with the gradual introduction of an old-age grant, a disability grant and a three-pronged child grant, and the adoption of a targeting approach aiming to exclude those who are not poor nor at risk of poverty;

- the introduction of a dedicated programme for the delivery of multipurpose social welfare services at community level;
- a gradual increase in the value of social transfers; and
- the strengthening of the institutional, human, physical, technical and financial capacity of the INAS and the MGCAS, including the decentralisation of INAS personnel at district level and the roll-out of the recently developed e-INAS management information system (MIS), replacing the Lindex MIS.

Falange and Pellerano (2016) also note that the ENSSB II aims to increase the coverage of its programmes from almost 500,000 people in 2015 to 3.4 million people by 2024. This expansion is meant to be covered mostly by the PSSB child grant component (yet to be launched), which is expected to cover 1.4 million beneficiaries by 2024. The old-age component of the PSSB is expected to cover 1 million beneficiaries by then. As a result of this expansion, expenditures on INAS-run social protection initiatives should increase to 2.2 per cent of GDP.

Proposing ways to revise the ENSSB, Pellerano (2014) suggested making the strict PSSB eligibility criteria regarding labour constraints more flexible. This is because the current criterion limits benefits to households with no members who are fit for work, therefore excluding households with one or two members who are fit for work, even if they are the sole providers for many household members who are unfit for work. Instead, Pellerano proposed that targeting should be based on households with high dependency ratios, though the author understands that this would imply a vast expansion of coverage, with costs estimated at 0.4 per cent of GDP.

Pellerano quoted data from Cunha et al. (2013) that showed the PSSB's bias against eligible households with higher dependency ratios, since beneficiary households had, on average, 1.08 indirect beneficiaries in 2010, and 1.06 in 2014. It is important to note, however, that this average was expected to be around 1.22 indirect beneficiaries per household.

Cunha et al. (2013) and Pellerano (2014) estimate that, at a maximum, the current targeting criteria can cover 10 per cent of the country's households, and less than 15 per cent of the households in the first two poverty quintiles. This means that over 40 per cent of poor elderly people and 75 per cent of poor people with chronic illnesses and illnesses that compromise labour capacity are excluded from the PSSB. Nevertheless, none of the recommendations were incorporated into the ENSSB II.

### **3 INSTITUTIONAL SET-UP OF THE MOZAMBIKAN SOCIAL PROTECTION SYSTEM**

As previously mentioned, the MGCAS is responsible for coordinating the four initiatives that comprise the ENSSB. The actual operation of these initiatives is conducted primarily by the INAS, which has decentralised offices in all provinces of the country. The decentralised INAS teams, however, are not prepared to undertake social assistance case management roles such as identifying potential beneficiaries, collecting data from households claiming the benefit, or maintaining communication with beneficiaries regarding payment days. Rather,

the decentralised INAS offices have administrative mandates and capacities. Their work involves tasks such as transmitting information from the districts to the headquarters and vice versa, as well as overseeing the work of social workers (Selvester et al. 2012).

Another major limitation of the INAS highlighted by Selvester et al. is that its local offices are not necessarily members of district councils. This makes it difficult for them to adequately liaise with local government and even local community-based organisations (CBOs). It is even more limiting if one considers that the mandate to coordinate joint social initiatives between the government and the CBOs lies with the District Services of Health, Women and Social Action (SDSMAS), which is a decentralised organ of the Ministry of Health (MISAU).

The core social assistance work within the MGCAS/INAS is performed by so-called *permanentes*. They are responsible for pre-selecting eligible candidates for many INAS social protection initiatives. Most notably, they undertake such a role for the PSSB, in addition to also supporting communication with beneficiaries, including communication on pay days and pay points for delivering the benefits. *Permanentes* are very active for the PSSB, but less so for the other ENSSP initiatives, such as the PASD and the PASP. Selvester et al. (2012) point out that, by 2012, there were some 2,000 *permanentes* working with the INAS, each receiving an incentive payment of MZN600 (USD149.20 PPP 2011)<sup>2</sup> per month (not a salary, but rather a daily subsistence allowance).

Another key decentralised structure of relevance to the country's social protection system is the SDSMAS. As we will see in the next chapter, they are supposed to facilitate the referral to the INAS of patients found by health workers to be potentially eligible for the PASD. In practice, however, it is rare that the SDSMAS and the INAS cooperate or that the SDSMAS has members working at INAS offices. The two institutions work in isolation because they are based on different data management tools, with no integration between them. As a matter of fact, Selvester et al. (2012) point out that the SDSMAS staff are poorly informed about the initiatives run by the INAS, including the PASD and the PSSB. They could potentially contribute to the PASD and PSSB by facilitating referral from health workers to social workers in situations where eligibility criteria depend on a medical confirmation of health status.

In terms of the comprehensiveness of the social protection system, the country has no single registry nor standardised poverty assessment thresholds or procedures. Pellerano (2014) stresses that social benefits such as health and education fee waivers require poverty certification issued by local governments, and not necessarily following the INAS guidelines. Overall, there is very little information that is monitored, and even less integration of distinct databases.

#### **4 THE ENSSP PROGRAMMES: PSSB, PASD AND PASP**

In this chapter, the key programmes of the ENSSB are presented in further detail, highlighting their specific eligibility criteria, benefit formulae and overall operational features. The PAUS is the sole programme that is not described in detail here, because it consists of several specialised services, provided by different stakeholders. All the other initiatives (PSSB, PASD and PASP) are presented below, and their main features are summarised in Table 1.

TABLE 1  
Key features of the PSSB, PASD and PASP

| The Direct Social Action Programme (PASD) |   |  |  |   |  |   |  |
|---|---|--|--|---|--|---|--|
| Eligibility criteria                      | 1. Poor child-headed households with members suffering from malnutrition  | 2. Poor households with members suffering from malnutrition, whose breadwinner is temporarily unable to work | 3. Poor households with members suffering from malnutrition, whose breadwinner is permanently unable to work | 4. Poor households with HIV and TB patients suffering from malnutrition | 5. Poor households with children between 6 and 59 months recovering from acute and severe malnutrition | 6. Poor households with children between 0 and 24 months in need of substitutes for maternal milk | 7. Occasional support to households affected by idiosyncratic shocks |
| Selection process                         | <p>Health workers are meant to refer eligible patients to the INAS offices, which already works for attesting they fulfil the health requirements of the programme. The INAS is then responsible for assessing whether they meet the sociodemographic and poverty criteria to benefit from the programme.</p> <ul style="list-style-type: none"> <li>• INAS staff can also actively seek for eligible persons by, for instance, going to hospitals. However, this hardly ever happens in practise.</li> </ul> |  |  |   |  |   |  |
| Benefit formulae                          | <p>Food kit/voucher, allowing for the purchase of the following staples, comprising a total of MZN985 (USD154.10 PPP 2011): 6kg of rice; 6 kg of maize; 1 litre of oil; 2 kg of sugar; 3 kg of groundnuts; 2 kg of beans; 1 kg of salt; 1 dozen eggs .</p>  |  |  |   |  |   |  |
| Duration of the benefits                  | Until head of the household turns 18  | 6 months plus the pregnancy period (if it is the case)   | Undetermined   | 6 months  | 6 months   | Until the child completes 24 months   | Occasional, often one-off  |
| Benefit delivery frequency                | Monthly   |  |  |   |  |   | Occasional, often one-off  |
| Number of beneficiaries                   | 57,400 households   |  |  |   |  |   |  |



|                            |   | <b>The Basic Social Subsidy Programme (PSSB)</b>   |  | <b>The Productive Social Action Programme (PASP)</b> |  |
|----------------------------|---|--|--|--|--|
| Eligibility criteria       | <p>1. Poor households with elderly people and with-out any members of working-age and fit to work</p> <p>2. Poor households whose working-age members are permanently unfit for work due to disability or chronic degenerative diseases.</p>  | Poor households with at least one fit-to-work member.  |  |  |  |
| Selection process          | <ul style="list-style-type: none"> <li>• Permanentes identify potential beneficiaries within the community, and collect information used by INAS staff to run a PMT and validate that they match the categorical eligibility criteria.</li> <li>• Some decentralised INAS offices are often not equipped to run the PMT; in such cases the decision of permanentes is enough to determine a household as being poor.</li> </ul> | Each project follows a specific selection process, often with the participation of INAS staff. Despite the self-selection nature of the workforce programme, the PASP sets for priority enrolment of female headed households, households with elderly, disabled or chronically ill members; households with malnourished children; households with high dependency ratios; and foster families. |  |  |  |
| Benefit formulae           | 1/3 of the poverty line for the main beneficiary, plus 25% of the main benefit for each dependent household member, up to 4 dependents. By 2013, this meant a grant of MZN259 (USD45.07 PPP 2011) + MZN60 (USD10.44 PPP 2011) per dependent (up to a four).   | Cash-for-work, with a maximum of 63 work hours per month. The household poverty line is meant to be the benchmark for minimum payment.   |  |  |  |
| Duration of the benefits   | Undetermined amount of time   | In rural areas, beneficiaries can enrol for the programme for 4 months per year, whereas in urban areas this period can be extended to 6 months per year.  |  |  |  |
| Benefit delivery frequency | Bimonthly   | Monthly  |  |  |  |
| Number of beneficiaries    | 366,000 households  | 57,400 households  |  |  |  |

Source: Author's elaboration based on various sources referred to elsewhere in this text. Coverage data from O'Brien et al. (2016).

The PSSB significantly limits its capacity to target households with members with chronic illness or a disability, since it only benefits households with no members who are fit for work. Coverage analysis also reveals that there is a bias against eligible households with too many dependents. Pellerano (2014) estimated that some 50,000 secondary beneficiaries were missing in 2014. This bias is not due to the programme's design. Rather, it most likely occurs because authorities at the local level prefer to concentrate the limited budget on as many households as possible, as opposed to covering fewer households but with more members per household which are subsequently entitled to higher grants.

Because these initiatives operate without the support of a strong MIS, nor a strong monitoring and evaluation mechanism, public access to coverage figures is quite limited, especially for figures disaggregated by programme stream or selection criterion. This limitation is particularly felt by the PASD, since the implementing partners (the World Food Programme—WFP—and the government) each produce coverage reports limited to the units they administer.

Data on coverage by the PASD for the first semester of 2014 (excluding the components funded by the WFP) indicate that several groups have the lowest rates of coverage, including the streams that cover people living with HIV (PLWHIV), people temporarily incapacitated and unfit for work, and households with children aged 0–24 months in need of a substitute for maternal milk (Pellerano 2014).

In the face of those challenges, it seems reasonable that the ENSSB programmes should undergo some sort of simplification of the eligibility criteria, as well as a reduction in the overlapping targeting of many categories that define eligibility for one or more programmes. A prudent idea would be to shift the eligibility criteria towards covering households with high dependency ratios. This could very likely maintain the eligibility of many households currently benefited by the PSSB, while at the same time facilitating an understanding of the programme and also enrolling other vulnerable households currently not eligible under the present design of the programme.

It is very likely, however, that this would have significant impacts on the programme's budget, as more people would become eligible, and this is probably the reason why the ENSSB II did not follow this route. Nevertheless, even the budgetary problem could be solved if, for instance, the shift in the eligibility criteria also included reducing the proxy means test (PMT) eligibility threshold to compensate for the new households that would qualify due to their high dependency ratio. Instead, the ENSSB II chose to create yet another targeting category for poor households with children aged 0–2 years old, which may make the programme even more complex.

Many of the eligibility criteria for the PSSB, PASD and the PASP depend on the assessment of a potential beneficiary's health status, but the referral mechanism between health and social workers is still very inefficient. This holds true even though the country has decentralised structures related to both the MISAU and the MGCAS that are supposed to cooperate with each other but in reality work very separately (Selvester et al. 2012).

Mozambique stands out as being one of the few countries that use health workers as spearheads to actively identify potential beneficiaries of social assistance initiatives. In the context of the PSSB, this is often not the case, as potential beneficiaries are usually first approached by *permanentes* and INAS staff. They then instruct people to obtain a doctor's note stating that they have a disability or are unfit for work due to a chronic or degenerative illness, in support of their request for enrolment (WFP 2014).

In the context of the PASD, however, health workers are responsible for identifying potential beneficiaries and then referring them to the INAS. The INAS is responsible for checking that the health-related eligibility criteria are matched by other socio-economic criteria and that the household falls within the eligibility threshold of the PMT. Despite the potential of this *modus operandi* to strengthen inter-sectoral activities between health and social assistance, in reality the vast number of eligibility criteria, a lack of clear guidelines and a lack of joint activities and coordination between the MISAU/SDSMAS and the Ministry of Women and Social Welfare (MMAS)/INAS (including the lack of a shared MIS) results in an inefficient and merely passive referral service (Selvester et al. 2012; Pellerano 2014). Thus, one can even question the equity of an enrolment strategy that depends on people accessing health services to then be referred to social assistance, since it is common that the very poorest members of society tend to have less access to public services to start with.

Although the PASD expects health workers to play a fundamental role in facilitating enrolment, the programme provides them with no training, incentives or payment for doing so. In districts where the PASD operates in partnership with the WFP, there tends to be a better referral service from the health centres to the INAS, but this is limited to the enrolment process and does not include any provision of ongoing support to eligible households facing chronic disease or disability (Pellerano 2014).

#### 4.1 THE PSSB

The main programme of the ENSSB is the Basic Social Subsidy Programme (PSSB), an unconditional cash transfer that targets poor households with no members who are fit for work and which are headed by either elderly people or people permanently incapacitated due to disability or chronic degenerative illness. By 2016, this programme had reached out to 366,000 households, yielding a basic benefit of MZN259 (USD45.07 PPP 2011), and an additional MZN60 (USD10.44 PPP 2011) per dependent member of the household up to a maximum of four (O'Brien et al. 2016).

The PSSB derives from the former PSA, which at its time was described as a food subsidy, rather than a cash transfer, even though it granted beneficiaries cash transfers. As for the PSSB, categorical criteria played a significant role in defining eligibility for the PSA, though some categorical criteria used by the PSSB are very different from those used by the PSA. To be eligible for the PSA, in addition to being poor, households had to have a member who met one or more of the following categorical criteria (Kula 2014):

- a malnourished child under 5 years old;
- a malnourished pregnant woman;
- an elderly household member (over 60 years old);
- a person with disabilities who is unable to work;
- a female head of household; or
- a household member with a chronic illness.

The PSSB targets poor households without any members who are fit for work, and headed by either an elderly person or someone with a disability or chronic illness. Its selection process starts by *permanentes* undertaking household visits and collecting a basic set of information. They take this information to identify a group of potentially eligible beneficiaries to the INAS local office.

The INAS local office is meant to undertake a second household visit to collect more in-depth information to both confirm that households match the categorical eligibility criteria and assess whether they are poor through a simple PMT that assesses the quality of housing, access to water and sanitation and household assets. In many cases, however, the INAS does not have the necessary staff to undertake this second household survey, nor do they have access to the system that runs the PMT. Hence, the selection of the beneficiaries ends up being largely influenced by the discretionary decision of the *permanentes* (Selvester et al. 2012).

The PSSB ends up mostly covering elderly people, and functioning largely as a non-contributory old-age pension. Another major problem for the programme is that it seems to have a coverage bias that excludes eligible households with higher dependency ratios. This results in privileging benefits to households headed by elderly people but without many children and other dependents who are unfit for work (Pellerano 2014).

Aware of these problems, the ENSSB II has called for more clarity regarding the categorical criteria that determine eligibility for the PSSB, the provision of better training for the *permanentes*, the recruitment of Social Welfare Auxiliary Agents and the launch of a new MIS to replace the Lindex system. Lindex is very limited. It keeps track of a scant amount of socio-economic information on PSSB beneficiaries and potential beneficiaries. In its place, the ENSSB II recommends the introduction and use of e-INAS, an MIS that, once in place, should be expanded to serve multiple other social protection services.

Another reaction in the ENSSB II to the perceived problems of the PSSB is the call to launch a programme stream to cover households with children aged 0–2 years old. Though not yet operational, this new stream is expected to lead the expansion of social protection coverage for the period of the strategy. By 2024, 0.92 per cent of GDP is expected to be destined for the Child Allowance, with the remaining streams of the PSSB expected to receive 0.78 per cent of GDP. The number of children between 0 and 17 years living in households that receive social transfers is expected to increase from 400,000 in 2014 to 8.3 million by 2024 (Government of Mozambique 2016).

The PSSB's payment system is also found to be very burdensome, as it takes 15 working days per month for the INAS local offices to notify beneficiaries of the pay days and pay points and oversee the transport of the money and the disbursement to beneficiaries (Selvester et al. 2012). The ENSSB II proposes resolving this problem by outsourcing the payments to a private company. Ideally, it would do so by using bank cards and/or smartcards. This too, however, has not yet been implemented.

## 4.2 THE PASD

The Direct Social Action Programme (PASD) was first launched in 2011, originally as an in-kind food benefit to people in situations of malnourishment and food insecurity. At first, the programme aimed to mitigate situations of short-term shocks, often through short-lasting benefits and *ad hoc* selection mechanisms. With time, however, the following six additional streams were established as part of the PASD (Pellerano 2014):

- **child-headed households:** providing benefits until the head of the household reaches 18 years of age;
- **households whose breadwinner is temporarily incapacitated and unable to work:** providing benefits for six months, and exceptionally for six months plus the term of a pregnancy if the mother is the household breadwinner;

- **poor households with PLWHIV or TB patients suffering from malnutrition:** providing benefits for six months;
- **households whose breadwinner is permanently incapacitated and unable to work:** providing benefits for long, undetermined periods;
- **households with children between 6 and 59 months recovering from acute and severe malnutrition:** providing benefits until the children reach 59 months of age; and
- **households with children between 0 and 24 months of age in need of substitutes for maternal milk:** providing benefits until the children reach 24 months of age.

It is worth noting that, between 2007 and 2011, the provision of food to poor, malnourished PLWHIV and TB patients used to be delivered by the MISAU. At that time, the programme was called *Programa Cesta Básica* (Food Basket Programme). The transfer of this initiative to the PASD occurred in 2011, following the 2010 enactment of the MISAU's Nutritional Rehabilitation Programme, which decided that the MISAU would only handle the supply of specialised nutritious food at health facilities, whereas a more basic basket of foods would be distributed under the PASD (WFP 2014).

Kula (2014) criticised the shift of responsibility for the nutrition security of PLWHIV from the MISAU to the MGCAS/INAS without a subsequent transfer of know-how, stating that it very abruptly distanced the MISAU from the process.

The stream that targets households whose breadwinner is permanently incapacitated and unable to work should be an additional benefit to people under the PSSB, since its socio-demographic and income-related eligibility criteria are the same. But since the programmes use different administrative records, keeping track of the people who actually receive both benefits is not a trivial task. Estimates from qualitative analyses suggest that there is little comprehensive coverage of those households eligible for both the PSSB and the PASD stream for permanently incapacitated households (Pellerano 2014). Hence, they most often end up receiving either one or the other benefit, but usually not both.

All seven streams of the PASD deliver a voucher worth MZN985 (USD154.10 PPP 2011) per month, which can be exchanged in designated shops for the following products: 6 kg of rice, 6 kg of maize meal, 1 litre of oil, 2 kg of sugar, 3 kg of groundnuts, 2 kg of beans, 1 kg of salt and a dozen eggs (WFP 2014). The stream that targets households with malnourished children in need of substitutes for maternal milk also delivers specific food supplements, whereas the stream that delivers short-term support also offers more *ad hoc*, additional benefits that include death and transportation expenses, material for rebuilding houses and even layettes for households with newborn babies (Pellerano 2014). Kula (2014) points out that the basic benefit of the PASD is the highest of all the ENSSB initiatives.

The selection of beneficiaries is processed by the local INAS teams, although they seldom promote active searches for beneficiaries. Rather, eligible and potentially eligible beneficiaries are referred to the INAS office by health workers, who already fill in a form attesting that the patient's health status matches the categorical eligibility criteria (i.e. unfit for work, malnourished children, HIV or TB) (Kula 2014). Many analysts, however, note that the referral of vulnerable people from health to social centres is not efficient (Selvester et al. 2012; Kula 2014; Pellerano 2014).

With the exception of areas where the PASD is run in partnership with the WFP, there are no referral tools nor protocols for the referral (Kula 2014; Pellerano 2014; Selvester et al. 2012). Kula (2014), however, highlights that in areas where the programme is run in partnership with the WFP, such as the district of Matola, INAS and WFP staff visit health centres once a week to support health workers to promote this referral. Kula (2014) perceives that a major barrier to better involving health workers in the PASD selection process is the fact that they receive no remuneration for the extra responsibilities they end up assuming.

The same report also criticises the PMT used by the INAS to ascertain whether people are poor, since it allegedly places too much importance on the ownership of housing assets. Such assets are often inherited by widows when their husbands die, even in situations where they are left without any source of income. This is reportedly the case in districts such as Chibuto, where there are many widows of mine workers.

Kula (2014) also criticises the PASD's use of vouchers and suggests that PLWHIV would be better off receiving cash benefits, since they tend to struggle to access the designated shops. This difficulty is presumed, since qualitative analysis reveals that PLWHIV tend to organise themselves in communities so that, each time, one or a few of the members can collect antiretroviral drugs for everyone in the group.

Pellerano (2014) found the coverage of the programme to be very small, reaching less than 40,000 households. More recent data from O'Brien et al. (2016) indicate that this coverage had grown to 54,000 households by 2016. Pellerano's figures from 2014 are limited to districts where the PASD is not run by the WFP. However, they suggest that the PASD stream with the highest coverage is the one that targets children aged 5–59 months recovering from acute and severe malnutrition (which accounts for 23.7 per cent of all PASD beneficiaries). This is followed by the streams that target poor child-headed households with malnourished members and poor households with permanently incapacitated members (each accounting for 19 per cent of all PASD beneficiaries).

The ENSSB II has called for the punctuality of PASD support to be improved by enhancing the cooperation between the INAS and the National Crisis Management Institute (INGC). It has also called for clearer guidelines for defining the eligibility criteria, as well as for the improvement of the referral mechanisms connecting health and social workers. Kula (2014) mentions that there are ongoing discussions among programme stakeholders to change the benefit formulae so that the vouchers can provide access to more products for larger households. This has not been mirrored in the ENSSB II.

### 4.3 THE PASP

The Productive Social Action Programme (PASP) is a productive programme in which people are offered to participate in public works initiatives to deliver infrastructure and services of interest to the community, while at the same time being referred to other productive programmes such as the Strategic Programme for the Reduction of Urban Poverty (PERPU), microcredit and credit initiatives, and skills training programmes. The PASP works according to a graduation model; hence enrolment in the programme is limited to three years. The initiative is based on self-selection, though preference is given to households with the following characteristics (Government of Mozambique 2012):

- headed by women;
- with people with a disability or a chronic illness or who are elderly;

- with malnourished children;
- with high dependency ratios; or
- foster families for orphans and vulnerable children in a situation of poverty and vulnerability.

Priority is also given to households from the following geographical areas:

- those with the highest poverty levels;
- those with the highest food insecurity levels; and
- those considered to be more vulnerable to natural shocks due to extreme weather and other environmental factors, with an emphasis on arid and semi-arid areas.

The remuneration for participating in the public works provided as part of the PASP should be equal to or higher than the daily poverty line (the monthly poverty line divided by the days of the month). Since remunerations vary with the kind of project, there is no standard value. To avoid creating disincentives to work, the public works are only meant to take place during the off-season in rural areas; hence the opportunities are only offered for four months of the year. In urban areas, the projects can be offered for up to six months every year. In both cases, people can only work up to four days per week, as they are expected to look for sustainable jobs and improve their skills on the other days.

The PASP is administered by the MGCAS/INAS in partnership with the Ministry of State Administration (MAE) and municipal councils. Most productive programmes to which PASP beneficiaries are expected to be referred are administered by the Ministry of Agriculture (MINAG) and the National Institute for Job Promotion and Professional Qualification (INEFP). The World Bank is a major partner, as it provided seed funds of USD50 million to boost the initiative in 2013.

The active search for potential beneficiaries is meant to be undertaken by the *permanentes* in conjunction with community leaders (locality chiefs), though the specific arrangements tend to vary from project to project.

The 2012 reference document for the PASP states that its beneficiaries are meant to be referred to the PSSB and PASD, though it does not specify how exactly this is meant to occur (Government of Mozambique 2012). In addition, this possibility contradicts the PSSB's own guidelines, since it is only meant to select households without any members who are fit for work—which is not the case for households with one or more members who are able to participate in a public works programme.

#### 4.4 THE PAUS

As previously mentioned, the Social Assistance Services (PAUS) refers to a set of institutional care services for vulnerable adults, elderly people and children without a home. The list of such initiatives is too vast to be presented here, as it includes institutions administered by all levels of government. There have been policy calls to enhance the comprehensiveness of these initiatives and to mainstream gender and sexual and reproductive health measures among these institutions. This is supposed to be achieved by the gradual shift of the social units to the INAS, and by the expansion of the INAS to all the districts of the country.

## 5 CONCLUDING REMARKS

The core challenges faced by Mozambique in terms of enhancing its social protection system relate to the excessive number of categorical criteria determining eligibility for the PASD and, to a lesser extent, to the PASP and the PSSB. Reports on Mozambique's social protection programmes also point out that the PMT used by the PSSB relies on too many assets that can be inherited but are nevertheless not necessarily related to a household's income-generating capacity. The targeting-related challenges faced by the PASD, PASP and PSSB derive from the fact that they do not use efficient databases, and that their MISs, where they do exist, are not linked to each other nor to other programmes. Therefore, even though the PASD, PSSB and PASP are presented as initiatives that operate very close to each other, in practice they have very few linkages. Completing the transition from the PSSB's former MIS (Lindex) to the new one (e-INAS) will be a major step to overcome this challenge.

Once the e-INAS becomes operational in most districts, it will also reduce the social workers' selection bias that compromises the comprehensiveness of the social protection system. This is particularly due to the fact that many districts currently do not have the means to run the PMT stage of the selection process; hence community and social workers end up making the decision. This bias refers not only to social workers' predisposition to distribute social services among as many households in their community as possible (instead of concentrating such services on the most vulnerable households); it also refers to their likely predisposition to favour the enrolment of smaller households, presumably as a way of maximising the number of households that can be covered with the available funds, since the PSSB provides additional benefits to each dependent member of the household.

In contrast to what is recommended here, and to what assessments of the ENSSB I have recommended, the ENSSB II might have aggravated problems related to, for instance, the excessive number of categorical criteria determining eligibility to certain programmes. This is because the PSSB will launch a new stream to cover households with children under 2 years old. Nevertheless, the ENSSB II is less limiting about the PASD than the PSSB; hence stakeholders could push for a simplification of its selection process. Our analysis strongly advises the adoption of a single categorical criterion, in addition to the PMT, based solely on the household dependency ratio, instead of adopting a vast list of eligible households that ultimately could be identified by the dependency ratio. One feature of the PSSB which was kept by the ENSSB II, and against which previous reports and this text strongly advise, is the limitation of targeting to households without any member who is fit for work, instead of targeting households with high dependency ratios.

Like many sub-Saharan African countries, Mozambique's social policies face severe challenges due to the low availability of social assistants, which leads to volunteers and poorly trained staff being responsible for performing crucial tasks. An alternative currently being adopted by the PASD involves using health care workers to enrol people in the programme. This makes sense from the perspective that health care workers should certify that people meet the health criteria that determine programme eligibility. Nevertheless, this raises questions about the equity of the programme's enrolment process, since the very poorest members of society tend to have less access to health services to start with. It would, therefore, be advisable for social workers and even peer-to-peer volunteer groups to complement this by actively searching for potential beneficiaries by visiting them at their homes and eventually offering them support so that they can attend health centres or receive home-based care if needed.

It is strongly advisable that the PASD, PASP and PSSB, or at least some of their streams, undergo impact evaluation studies, since they have never been analysed in this way. It is unlikely that, for instance, all seven streams of the PASD could be subjected to a scientific or quasi-scientific impact evaluation study. Nevertheless, some of the core streams could be subjected to this evaluation. The Mozambican social protection system clearly needs an urgent revamping exercise, and the best way to plan it is by undertaking an impact evaluation of its core programmes.

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## NOTES

2. All values presented in USD PPP 2011 derive from the following methodology. The amount of benefits in USD PPP 2011 is the value of the benefits converted to international dollars using the purchasing power parity conversion factor (PPP). Calculated by the World Bank and available in the World Development Indicators (WDI) database, the PPP for private consumption is "the number of units of a country's currency required to buy the same amounts of goods and services in the domestic market as US dollar would buy in the United States", thus measured in Local Currency Units (LCU) per international dollar. The last PPP has a reference date of 31 December 2011; therefore, the annual Consumer Price Index (CPI) series of the WDI database was used to deflate the nominal benefit values to their real value at the price levels at the end of 2011, before the conversion to the international dollar:

$$\text{Benefit in international \$} = \text{Benefit\_LCU} * \text{CPI\_2011} * 1 / (\text{CPI\_REF\_YEAR} * \text{PPP})$$

To define the reference year of the benefit value, the following rules were applied:

1. If the programme started before 2011, the reference year is 2011;
2. If the programme started after 2011 and since its start there has been no change in benefit value, the reference is the first year of the programme;
3. If the programme benefit value changed after 2011 or its start, the reference date is the year of the last change.



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