# Anticipatory Social Protection

## Claiming dignity and rights

*Marilyn Waring, Anit Mukherjee, Elizabeth Reid and Meena Shivdas*

**Commonwealth Secretariat**

# Anticipatory Social Protection

## Claiming dignity and rights

Marilyn Waring, Anit N Mukherjee, Elizabeth Reid and Meena Shivdas

Commonwealth Secretariat

Commonwealth Secretariat
Marlborough House
Pall Mall
London SW1Y 5HX
United Kingdom

© Commonwealth Secretariat 2013

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic or mechanical, including photocopying, recording or otherwise without the permission of the publisher.

Published by the Commonwealth Secretariat
Edited by Joan Ross Frankson
Typeset by Cenveo Publisher Services
Cover design by Tattersall, Hammarling & Silk
Printed by Charlesworth Press

Views and opinions expressed in this publication are the responsibility of the authors and should in no way be attributed to the institutions to which they are affiliated or to the Commonwealth Secretariat.

Wherever possible, the Commonwealth Secretariat uses paper sourced from sustainable forests or from sources that minimise a destructive impact on the environment.

Copies of this publication may be obtained from

Publications Section
Commonwealth Secretariat
Marlborough House
Pall Mall
London SW1Y 5HX
United Kingdom
Tel: +44 (0)20 7747 6534
Fax: +44 (0)20 7839 9081
Email: publications@commonwealth.int
Web: www.thecommonwealth.org/publications

*A catalogue record for this publication is available from the British Library.*

ISBN (paperback): 978-1-84929-095-1
ISBN (e-book): 978-1-84859-151-6

# Foreword

The Commonwealth Secretariat's social protection work arises from our mandates to address gender inequalities and inequities and work on issues affecting small states. It particularly reflects an outcome of commissioned research on the gender and policy dimensions of unpaid HIV care work. The Ninth Commonwealth Women's Affairs Ministers Meeting in 2010 highlighted the need to focus on social protection for women's empowerment and social justice given their critical role in sustaining the informal, subsistence and care economy sectors.

Commonwealth regions have experienced in varying degrees the aftermath of the 2007 global financial crisis, which triggered other crises, particularly in food, energy and social security. Ensuing budgetary cuts and increased unemployment and under-employment have seen previously paid care being consigned to the unpaid care economy, comprising largely of women carers, with the already disproportionate burden on carers increasing. The current challenges facing member states are deepening poverty, new forms of risk and vulnerability, and the expansion of informal employment. In this context, countries have struggled to meet or expand commitments on social protection.

Many Commonwealth countries have implemented a range of social protection measures over the years. These include the provision of free health care and education, pensions for government employees, as well as policy strategies on food and agriculture. Other policy responses have included expansionary fiscal and monetary stimulus, for example, a one off payment to every low-income family; an increase in indirect taxes and a cut in corporate tax rates; and 'cash for work' development programmes. At the same time, countries have also instituted key measures and programmes that go beyond cash transfers by building on informal institutions in communities and providing education and nutrition among other critical needs, including short-term employment to mitigate the impact of the crisis.

Increasingly, international and regional organisations are involved in social protection initiatives as part of their work on food security, vulnerable groups, human rights, HIV and AIDS, and humanitarian crises. The Commonwealth Secretariat advocates for social protection, mindful that for our small states affordability and sustaining outreach to vulnerable populations are important factors in instituting sustainable social protection measures.

This volume attests to the Secretariat's commitment to contribute to global thinking on policy solutions to addressing poverty and inequality. We hope the anticipatory social protection framework proposed enables meaningful policy solutions.

**Esther Eghobamien**
Interim Director
Social Transformation Programmes Division
July 2013

# Acknowledgments

We acknowledge the policy-makers, researchers and activists who were part of the October 2011 Commonwealth Roundtable on 'Sustaining gender-responsive social protection and economic resilience' (London, Commonwealth Secretariat), where the collective thinking towards a framework for anticipatory social protection took root. The Roundtable saw the launch of the publication, *Who Cares? The Economics of Dignity*, a research journey on unpaid work in HIV care in 11 countries. We owe an immense debt of gratitude to the unpaid carers who shared the realities of living with acute time poverty and without dignity. Their stories left us grappling with more questions about the human rights of those without social protection. Hopefully this volume provides some answers.

Other milestones during the research journey include the February 2012 annual consultation of Commonwealth national women's machineries (NWMs) in New York where the country reports on social protection that were presented enabled us to situate our analysis in the context of country experiences. We are grateful to Commonwealth members who provided information on policies and programmes. The International Roundtable on Social Protection convened by the Auckland University of Technology, New Zealand, helped us advance our thinking on the anticipatory framework for social protection. We are grateful to all participants who shared their insights and experiences.

We are also grateful to our families, colleagues and research partners without whom this work would not have been completed. We especially want to thank Esther Mwara Muiru, Sithandiwe Shongwe, Corina Rodriguez Enriquez, Thembi Gama, Jerker Edström, Naren Prasad and Ralph Regenvanu, whose work on social protection has enriched our thinking. Our gratitude to David Wilson, Robin Hannah, Margunn Bjørnholt, Ailsa McKay, Margaret Wilson, Peggy Fairbairn-Dunlop, Roselyn Tor, Choopug Suttisa and Chantana Wech-o-sotsakda for asking questions that helped enhance our framework. We owe much to Karanina Sumeo and Josephine Stewart-Tewhiu for valuable research assistance.

# Contents

**Foreword** iii
**Acknowledgments** iv
**List of tables, figures and boxes** vii
**Abbreviations and acronyms** viii
**About the authors** ix

**1. Towards an Anticipatory and Transformative Social Protection Agenda** 1
1.1 Background 1
1.2 Setting the social protection agenda 2
1.3 The Social Protection Floor initiative 4
1.4 Human rights framework with women at the centre 7
1.5 Transformative social protection 9
1.6 Anticipatory social protection 11
1.7 Programme design and implementation 13

**2. Rights and Unpaid Work: A Critical Review of International Experience** 16
2.1 Context 16
2.2 Institutional measures: experiences and lessons learned 17
2.3 Social transfer designs: Mexico, Bangladesh, South Africa 19
2.4 Implementation: financing, targeting, delivery 22
2.5 Incorporating gender, human rights, women's unpaid work, children's agency 25

**3. Regional Developments** 30
3.1 Africa 30
3.1.1 Targeting 31
3.1.2 Gendered anticipatory social protection 33
3.2 South Asia 35
3.2.1 Livelihood and income security 35
3.2.2 Education and health 37
3.2.3 Social protection in old age 38
3.2.4 Gender-based discrimination and violence 39
3.3 East and Southeast Asia 41
3.4 The Pacific 43
3.5 The Caribbean 47

**4. Politics of Care and Isolation: Case Studies** 51
4.1 Caring for children with disabilities in an advanced welfare state: Denmark 51
4.2 Caring for the aged in a developed economy: South Korea 53
4.3 Community action in support of marginalised sex workers: India 56

4.4 Community action for dignity and rights: India 58
4.5 HIV care and access to land, the GROOTS Model: Kenya 59
4.6 A revived land tradition protects HIV-affected children: Swaziland 60
4.7 Building peace through anticipatory and transformative social protection: Rwanda 62
4.8 An endowment fund protects education of HIV-affected children: Papua New Guinea 64
4.8.1 Background and structure 65
4.8.2 Bringing hope to HIV-affected children, families 67
4.8.3 Limitations 67
4.8.4 The HIV-protective effect 68
4.8.5 Anticipatory, transformative and energising 68
4.9 Social protection models: New Zealand and India 69
4.9.1 Crown Corporation accident compensation, New Zealand 69
4.9.2 Private sector distributes free milk to New Zealand's primary schools 70
4.9.3 Programme design for financial inclusion in India 71

**5. The Carer's Journey 73**
5.1 Elizabeth's voice, 1993 73
5.1.1 How did we make that transition from diagnosis to living? 74
5.1.2 Living with dying was not always easy 75
5.1.3 During the dying, the role of the carer changes 75
5.2 Elizabeth's voice, 2013 76
5.2.1 Lost livelihoods, lack of benefits 76
5.2.2 Carer's voices begin to be heard 76
5.2.3 Assessing economic value 77
5.2.4 Psychological, emotional, social costs 77
5.2.5 Gender income gaps 78
5.2.6 Social and economic justice for carers 79
5.2.7 Feminisation of care, masculinisation of labour 79

**6. Endnote 81**

**Notes 84**
**References and bibliography 85**

# List of tables, figures and boxes


| | | |
|---|---|---|
| Table 3.1 | Safety net programmes in selected Caribbean countries | 48 |
| Figure 1.1 | The Social Protection Floor | 5 |
| Figure 1.2 | Human rights linkages in social protection: Ensuring a life of dignity | 9 |
| Figure 1.3 | Anticipatory social protection framework using the life cycle approach | 12 |
| Figure 1.4 | Operational framework for a rights-based social protection approach | 14 |
| Figure 2.1 | Social protection expenditure as a percentage of GDP | 18 |
| Figure 2.2 | Social protection spending in Africa as a percentage of GDP | 19 |
| Figure 2.3 | Social protection expenditure in small island countries as a percentage of GDP | 20 |
| Figure 2.4 | Women's unpaid work in different regions | 26 |
| Figure 2.5 | Women's productivity in agriculture and access to resources: African experience | 28 |
| Figure 4.1 | Estimate of the percentage of citizens over 65, 2000–2050 | 54 |
| Box 2.1 | Comparative assessments of three social protection programmes | 21 |
| Box 2.2 | Identity and social protection for the poor and vulnerable: India's unique ID number | 24 |
| Box 4.1 | Facing the reality of the genocide | 64 |

# Abbreviations and acronyms

| | |
|---|---|
| **ACC** | Accident Compensation Corporation |
| **ADB** | Asian Development Bank |
| **AIDS** | acquired immune deficiency syndrome |
| **APBCA** | Asia and Pacific Business Coalition on AIDS |
| **BAHA** | Business Against HIV and AIDS |
| **CCT** | conditional cash transfer |
| **CEDAW** | Convention on the Elimination of All Forms of Discrimination against Women |
| **CTP** | cash transfer programme |
| **ESCAP** | Economic and Social Commission for Asia and the Pacific |
| **HIV** | human immunodeficiency virus |
| **ICCPR** | International Covenant on Civil and Political Rights |
| **ICESCR** | International Covenant on Economic, Social and Cultural Rights |
| **ILO** | International Labour Organization |
| **ISEE** | Implementation Stabilisation Enablement and Empowerment |
| **LEAP** | Livelihood Empowerment Against Poverty |
| **LTCI** | Long-Term Care Insurance |
| **OAS** | Organization of American States |
| **OECD** | Organisation for Economic Co-operation and Development |
| **ODA** | official development assistance |
| **OVC** | orphans and vulnerable children |
| **MDG** | Millennium Development Goal |
| **NCD** | non-communicable disease |
| **NERCHA** | National Emergency Response Council on HIV and AIDS |
| **NGO** | non-governmental organisation |
| **NREGS** | National Rural Employment Guarantee Scheme |
| **NWM** | National Women's Machinery |
| **RISE-UP** | Rights of Individuals to Social and Economic Security-Universal Prosperity |
| **SEEF** | Serendipity Education Endowment Fund |
| **UDHR** | Universal Declaration of Human Rights |
| **UID** | Unique Identification Number |
| **UN** | United Nations |
| **UNCRC** | United Nations Convention on the Rights of the Child |
| **UNDP** | United Nations Development Programme |
| **UNGA** | United Nations General Assembly |
| **UNHRC** | United Nations Human Rights Council |
| **UNICEF** | United Nations Children's Fund |
| **UNRISD** | United Nations Research Institute for Social Development |
| **VAMP** | Veshya AIDS Muqabla Parishad / Women in Prostitution Confront AIDS |
| **VAW** | violence against women |
| **WHO** | World Health Organization |

# About the authors

Professor Marilyn Waring is a feminist economist and public policy expert specialising in the economics of unpaid work.

Dr Anit N Mukherjee is an economist specialising in public finance and social sector policy in education, health and social protection.

Dr Elizabeth Reid AO, FASSA (Academy of the Social Sciences in Australia) is a feminist, philosopher and ethicist engaged in development work focused on policy advocacy and building community voice.

Dr Meena Shivdas is a gender and development expert at the Commonwealth Secretariat, focusing on women's rights, HIV, culture and the law.

This page has been intentionally left blank

# Chapter 1

# Towards an Anticipatory and Transformative Social Protection Agenda

## 1.1 Background

Social protection is now established as a central aspect of the international development discourse. It gained traction in the aftermath of the financial and fiscal crisis that has gripped much of the world since late 2007. With the 2015 endpoint of the Millennium Development Goals (MDGs) agenda fast approaching, the discussion on social protection is juxtaposed with that of a long-term development paradigm drawing upon the lessons learned over the last decade and a half. Social protection could form the core of a future global strategy to eliminate all forms of inequity in the post-2015 world.

It is therefore imperative that a concerted effort is made to clarify and refine the tenets, objectives, shortcomings and challenges of the policy and implementation of social protection as it stands in 2013. In this 'think piece' we argue that social protection, as it is envisaged in policy documents and implementation guidelines, is premised upon a reactive and static system. In practice there is confusion in this approach between what social protection is supposed to address and the means by which it should be put into practice.

The social protection agenda of the future should instead be anticipatory and transformative, based on a continuum of protection and redressing of inequities. It should be anticipatory in terms of identifying potential threats to the enjoyment of life and livelihood for all, and have the ability to make a substantive difference to people's lives, especially the most vulnerable sections of the population. We propose a social protection system wherein the underlying inequities of gender, marginalisation and discrimination are addressed through the application of human rights principles.

Policy-making in relation to social protection programmes suffers from inefficient design in which the political, economic and social objectives compete and are often in conflict with each other. This lack of coherence is translated into implementation challenges whereby programmes suffer from lack of accountability, inadequate coverage and flawed targeting. As opposed to the current discourse of 'designing for results', we put forward a proposal in which different types of social protection programmes would seek to ensure the participation and accountability of the state, the community and the individual.

It is through the allocation of rights and duties of social protection to these main stakeholders that the success or failure of the system is determined. We argue that putting gender and inequity at the core of the social protection agenda has the potential to shift the development paradigm to maximise impact and transformative outcomes.

## 1.2 Setting the social protection agenda

At the international level, donor countries and agencies have been driving the social protection agenda. Each donor agency or multilateral organisation has its own definition of social protection (Gross 2007). Conceptually there is little difference between them; most focus on 'labour markets', 'income risk' and 'benefits'.

The World Bank for example, views social protection as 'a collection of measures to improve or protect human capital, ranging from labour market interventions, publicly mandated unemployment or old-age insurance to targeted income support' and as a coping mechanism to 'assist individuals, households, and communities to better manage the income risks that leave people vulnerable' during crisis periods (World Bank 2009).

Similarly, the Asian Development Bank (ADB) links social protection with 'policies and programmes designed to reduce poverty and vulnerability by promoting efficient labor markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and interruption/loss of income'. Here the focus is on better managing income risks that leave people vulnerable (ABD 2013).

The International Labour Organization (ILO) focuses on income security, so the emphasis is on workforce and working conditions, the same argument it uses to promote its Decent Work Agenda programme. It defines social protection as 'the provision of benefits to households and individuals [...] to protect against low or declining living standards' (van Ginneken 1999).

These three definitions refer to the formal employment sector. However, given the complex and nuanced contexts of social protection, this is clearly inadequate. Social protection is much more than protecting incomes and enhancing labour market outcomes (Devereux and Sabates-Wheeler 2004). Social protection must address the vulnerabilities associated with 'being poor', including the risks of 'becoming poor', particularly during periods of economic crisis. It should also address the social injustices arising from prevailing inequalities in the society and the law.

The term 'social protection' has become a catchall phrase for multiple programmes targeted at multiple stakeholders addressing multiple objectives. The United Nations Research Institute for Social Development (UNRISD) broadens the scope of social protection to include situations that adversely affect people's well-being. UNICEF, the UN Children's Fund, has recently articulated its vision of social protection, which

recognises children's capacity to be individuals in their own right. There is a pressing need for rethinking the social protection paradigm.

Devereux and Sabates-Wheeler (2004) have distinguished between a conceptual and an operational definition of social protection that has been widely used in the literature.

- *Conceptual* social protection describes all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalised with the objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups.
- *Operational* social protection covers all formal and informal initiatives that provide social assistance to extremely poor individuals and households, social services to groups that need special care or would otherwise be denied access to basic services, social insurance to protect people against the risks and consequences of livelihood shocks, and social equity to protect people against social risks such as discrimination or abuse.

Under this characterisation, social protection includes a range of policy interventions that protect the vulnerable against livelihood risks, such as poverty, lack of access to basic services and discriminatory treatments. Consequently, social protection promotes the human rights of marginalised groups and individuals, particularly women, children, the elderly and persons with disabilities.

Social protection policy has four distinct but interconnected roles – protection, prevention, promotion and transformation (Davies and McGregor 2009). While each of these roles entails a certain set of actions (such as disability benefit, pension schemes, cash or in-kind transfers, amendment of legal provisions), they are mutually reinforcing. Each has a multiplier effect on the impact of social protection policies.

- *Protection* measures provide relief from deprivation and include traditional safety net instruments, social assistance and social services for poor individuals or groups in need of special care, for example old age or widow pensions.
- *Preventive* measures seek to avert deprivation through poverty alleviation. They include social insurance for people who have fallen, or might fall, into poverty as well as formal systems and informal mechanisms such as women's self-help groups and co-operative microcredit societies.
- *Promotive* measures address the longer-term dimensions of social policy by enhancing livelihood strategies through asset protection and access to common property resources. Examples include employment guarantee schemes such as the National Rural Employment Guarantee Scheme (NREGS) in India and South Africa's Extended Public Works Programme.

- *Transformative* forms of social protection are designed to address the underlying social structures that are at the root of social vulnerabilities. More than a programmatic approach, transformative social protection entails changing the regulatory framework to protect socially vulnerable groups, such as women and children affected by HIV, against discrimination and abuse. The Grassroots Organizations Operating Together in Sisterhood (GROOTS) initiative in Kenya, which protects women's land rights, is an example. Policies targeted at protection and prevention will have limited economic outcomes without addressing access to assets and property and other transformative policy measures for the dispossessed and disenfranchised.

This delineation of objectives leaves open the question as to whether such a complex system is actually feasible to implement, and more importantly, to sustain. The logic of a social protection framework is intuitively easy to comprehend; a just society is one where nobody is denied the right to live a life of dignity and which calls for the state to allocate and distribute resources to those that need it most. In aiming to reduce poverty, establish basic social services and meet individual adversity, countries of the Organisation for Economic Co-operation and Development (OECD) now spend an average of one eighth (12.6%) of their gross domestic product (GDP) on public social security cash benefits, and altogether more than one fifth (20.9%) on public social services and social security, excluding education (Townsend 2007). For the three principal social groups that benefit – children, the disabled and the elderly – these can therefore be regarded as the 'bedrock' measures in social security systems everywhere (Townsend 2007).

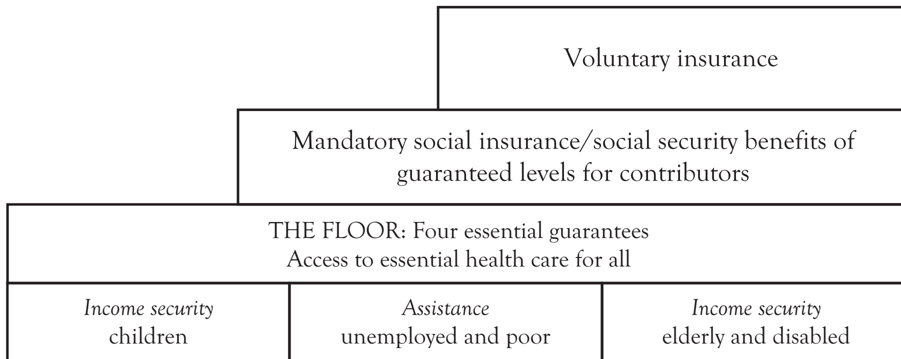
Recent OECD data suggests that this spending has increased to nearly 22 per cent of GDP in 2012. However, in 11 out of 32 countries, social spending actually declined by at least 5 per cent (OECD 2012). It is not surprising that this set of countries are most affected by the ongoing crisis in the Eurozone, including Greece, Iceland, Ireland, Portugal, Slovenia, Spain and the United Kingdom. It seems obvious that the current paradigm of austerity in countries hit by economic crisis is leading to significantly fewer resources for social protection, precisely when demand is increasing for the same reasons (OECD 2012).

## 1.3 The Social Protection Floor initiative

The Social Protection Floor is conceptualised as an integrated set of social policies designed to guarantee income security and access to social services for all, paying special attention to vulnerable groups and protecting and empowering people across the life cycle.

The World Health Organization (WHO) and ILO formulated the concept as co-leaders of this United Nations initiative. The Social Protection Floor outlines an adaptable policy approach to social protection and is anchored in the principal of social justice. It is promoted not as an alternative, but rather as a complement to social insurance

**Figure 1.1 The Social Protection Floor**




**Source:** Prasad 2011

institutions where these exist, and hence as a component of a comprehensive and pluralistic social protection system.

In the recent thinking on international development paradigms, it is widely perceived that the two rights – to social security and to an adequate standard of living – are the guiding principles on which any social protection system would have to be based. WHO and ILO convened the Social Protection Floor Initiative Advisory Group in 2010 to formalise this concept, under the guidance of Michelle Bachelet, who was then UN Women's Executive Director. The Advisory Group presented its report (hereinafter the Bachelet Report) in October 2011. The report states that 'The notion of the social protection floor is anchored in the fundamental principle of social justice, and in the specific universal right of everyone to social security and to a standard of living adequate for the health and well-being of themselves and their families. ... The core idea is that no one should live below a certain income level and everyone should at least have access to basic social services' (ILO and WHO 2011: xxiv).

The Bachelet Report conceptualises the social protection floor as an integrated set of social policies that guarantees:

- basic income security in the form of various social transfers (in cash or in-kind), such as pensions for the elderly and persons with disabilities, child benefits, income support benefits and/or employment guarantees and services for the unemployed and working poor;
- universal access to essential affordable social services in the areas of health, water and sanitation, education, food security, housing, and others defined according to national priorities (ILO and WHO 2011: xxii).

While this is an exposition of an indicative structure of social protection, countries are free to design their policies in a sequential manner, keeping in view their

existing social protection framework, needs and capabilities. This, however, dilutes the force of the recommendations especially when it comes to implementation of socially and fiscally difficult measures, such as reforming asset ownership laws to address gender inequities or moving from a targeted to a universal system of health care benefits.

There is also an over-emphasis on cash (or benefit) transfer programmes without much discussion on addressing underlying inequities of gender, social group and geography in these interventions. As suggested in the recent literature on gender and conditional cash transfer (CCT) programmes, women are the 'operative beneficiaries' who are also responsible for fulfilling the conditionalities associated with them. In general, CCT programmes fail to challenge and transform the gender division of labour or the unequal distribution of opportunities for productive work, while reinforcing the role of women as caregivers (Rodriguez Enriquez 2011).

The multi-sectoral and multidimensional approach of the Social Protection Floor focuses on complementarities between income security, investment in human capital, employment and access to social services. However, it does not explicitly embrace a rights approach, although the Bachelet Report claims that the 'provisions made within the framework of the floor relate to a range of rights listed in the Universal Declaration of Human Rights' (ILO and WHO 2011: xxiv). Nor does it address the issues of unpaid work in the care and subsistence economies and the impediments, such as stigma and discrimination, which prevent marginalised populations from accessing services.

Since the approach is supply driven, the onus is on countries to design and implement appropriate systems that would be consistent with the Social Protection Floor.

Thus the rights-based approach that the Floor imputes to itself is limited. Universal access to those essential services would certainly be transformative, but there is much that is missing, particularly civil and political rights, including rights to dignity, equality and to be free from discriminatory outcomes on the grounds of sex. Advocates of the Social Protection Floor are silent on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the rights of women to land, natural resources, inheritance, safety and property.

The framework is also silent on gender-responsive social protection in respect of third gender persons. In Asia and the Pacific, there is a rich diversity of cultural and social expression of other gender identities, such as *hijra* and *kothi* in India and *fa'afafine, akava'ine, fakaleiti*, and *mahu vahine* in the Pacific region. The term 'third gender' is currently used to describe individuals who are neither male nor female, those who have or who are sexually transitioning, those who are both or neither, those who are transgender, and those who cross or swap genders. The 'third gender' is officially recognised in India, Nepal and Pakistan. The third gender is about gender identity – a person's deeply felt sense of being male or female or as one or other of the categories

falling under 'transgender'. A person's gender identity may or may not correspond with their sex (including their indeterminate sex). In our case studies of the Women in Prostitution Confront AIDS (VAMP) network in India and the Serendipity Education Endowment Fund (SEEF) in Papua New Guinea, we see civil society working with third gender persons in social protection programmes.

In addition, the framework does not acknowledge the prevalence of indigenous or traditional forms of social protection in some Pacific islands and countries in Africa, where traditional authority, the community – in particular women – and the Church draw on the strength of kinship structures and social relationships for the provision of social protection. It has been observed that traditional forms of social protection often complement the more formal forms of social protection provided by the state, particularly in Vanuatu and Botswana, and that lessons can be drawn from these experiences to enhance state provision of social protection (Ratuva 2010; Mupedziswa and Ntseane 2013). It has also been noted that traditional forms of social protection have buttressed Pacific island communities in the aftermath of the 2007 global financial crisis (Regenvanu 2011).

If nation states support the current conception of the Social Protection Floor then they commit themselves to maintaining the invisibility of these issues – all of which were first raised decades ago at the first International Conference on Women in Mexico City in 1975, and are yet to be recognised.

## 1.4 Human rights framework with women at the centre

The clearest enunciations of a human rights approach to social protection are to be found in reports prepared by the United Nations Special Rapporteur on extreme poverty and human rights for the Human Rights Council and General Assembly.[1] These reports are on human rights and cash transfer programmes (A/HRC/11/9); the role of social protection in the face of the 2008–2009 global financial crisis (A/64/279); a human rights framework for non-contributory pensions (A/HRC/13/31); the importance of social protection measures in achieving the MDGs, with a particular focus on gender-related concerns (A/65/259); and the human rights approach to recovery from the global economic and financial crises (A/HRC/17/34), which includes an analysis of the important role played by social protection programmes during times of crisis and recovery (Sepulveda and Nyst 2012).

The approach of the Special Rapporteur involves the application of the central principles of the human rights framework – equality and non-discrimination (including accessibility, adaptability, acceptability, adequacy and incorporation of the gender perspective), participation, transparency and accountability – to the design, implementation, monitoring and evaluation of social protection systems. One of the key messages of the Special Rapporteur's analysis is that human rights obligations

relate not only to the final outcome of social protection programmes, but also to the process through which such programmes are designed and implemented.

There is strong evidence that social protection systems can assist governments in fulfilling their obligations under national, regional and international human rights law to ensure the enjoyment of at least minimum essential levels of economic, social and cultural rights. In particular, social protection systems have the potential to assist in the realisation of the right to an adequate standard of living (including the right to adequate food and housing), the right to social security, the right to education and the right to the highest attainable standard of health (including the right to sanitation and safe drinking water).

This conceptual advance creates the space for putting dignity, social justice and unpaid work more firmly in the policy-making domain. Research on women's care work in the context of HIV conducted across 11 countries – both developing and developed – shows that very often, policy outcomes do not achieve the intended benefit due to the fact that 'designing for results' did not address underlying violations of human rights. For example, a programme to distribute food baskets to children who cared for HIV parents in Botswana ended up stigmatising them when the baskets quickly became known as 'AIDS food' (Waring et al. 2011), and the extent of requirements to access education and health services in some CCT schemes often increases the time and burden of care for women (Rodriguez Enriquez 2011). Devolution of social protection programme administration and delivery to local self-governments often reinforces traditional patriarchal power structures, exacerbating the inequities against women to the detriment of their capability and freedom to lead a life of their choice. There have been several instances in the recent past in India where 'Khap Panchayats' (traditional village councils of elder men) have misused the power devolved under the law to prohibit inter-caste marriages and to restrict women's employment and mobility (Kaur 2010).

The examples cited above point to the missing link in the human rights discourse on social protection: the right to live a life of dignity. While the right to dignity is universal, it is the right most often denied to the poor and most marginalised sections of the population – as clearly seen in the stigmatisation of 'AIDS food', women's burden of compliance for CCTs, and reinforced patriarchy through gendered distribution of devolved administrative power. In many societies, the most intrinsic form of violation of dignity comes from the fact of being born a girl (Sen 1990).

Moreover, as the Special Rapporteur for extreme poverty and human rights notes in her report on access to justice, 'the inability of the poor to pursue justice remedies through the existing systems increases their vulnerability to poverty and violation of their rights. In turn, their increased vulnerability and exclusion further hamper their ability to use justice systems. This vicious cycle impairs the enjoyment of several human rights' (UNHRC 2012: 3–4). Any framework for rights-based social protection that takes into account these vulnerabilities, especially for poor and marginalised women, will therefore have to incorporate protection from social, economic and cultural biases and discrimination.

## 1.5 Transformative social protection

In light of the above, we propose a social protection framework with three interlinked sets of rights that enable individuals – especially women, children, and persons with disabilities and HIV – to enjoy a life of dignity (Figure 1.2). These rights are not conceived to be hierarchical. Rather, we propose that social protection frameworks should put rights at the centre of the discourse to have a transformative impact. This impact would be the greatest for poor and disadvantaged women, children, the elderly and the physically and socially marginalised communities.

This formulation brings out clearly the fact that protecting the right of individuals and marginalised communities (for example, sex workers, third gender persons, *dalit* and aboriginal groups) to enjoyment of life with dignity is a multi-dimensional objective that encompasses the three broad sets of rights.

The first set comprises the right to adequate food, housing and decent work, linking up to the right to social security as enshrined in the Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). This set is relatively heavy with individual rights and corresponds to a social protection system that incorporates policies designed to transfer and redistribute resources by the state, either in cash or in kind. However, in our gendered framework, the notion of social security is broader: it encompasses both economic and personal security. Without the latter, the former could not be fulfilled, as noted in a

**Figure 1.2 Human rights linkages in social protection: Ensuring a life of dignity**

recent report by a judicial commission on incidences of sexual violence against women (VAW) in India (Verma 2013). The report also notes public spaces should be safe for women so that they can live a life without threat and intimidation, overt or covert, which may prevent them from pursuing their profession or occupation (Verma 2013).

The second set of rights is more collective in nature, comprising rights to education, highest attainable standards of health, as well as other civic amenities such as safe drinking water, adequate sanitation and care services for children, the elderly and the disabled. Fulfilment of this set of rights calls for significant state investment in systemic measures such as public health and education services, as well as co-ordination with the social security system mentioned above. Most CCTs aim to address either one or a combination of these rights – for example, health and education as in the case of Oportunidades in Mexico or South Africa's old age pension scheme (see Box 2.1), which is complemented by childcare, disability and care dependency grants. As the report of the Special Rapporteur points out, however, 'CTPs are not necessarily the most appropriate and effective means of tackling extreme poverty and protecting human rights in all contexts. CTPs should be seen as only one component of social assistance policies. As such, they must be integrated within social protection systems and grounded by solid legal and institutional frameworks framed by human rights standards and principles' (UNHRC 2009: 2).

International research accumulated over the years shows a significant correlation between lack of civic facilities such as drinking water and the incidence of time poverty among women and girl children. This is particularly true when women are responsible for home-based care of persons infected by HIV, persons with disabilities and those with terminal medical conditions. Our previous research has thrown light on how the burden of care for women pushes them into 'capability servitude',[2] which is often characterised by indignity and hopelessness (Waring et al. 2011). Our proposed framework focuses on the right to access adequate standards of health, civic amenities and social assistance as the core elements for reducing women's care burden and alleviating time and capability poverty.

Finally, the third set of rights corresponds to redressing the underlying structural inequities vis-à-vis the most marginalised, especially poor women. As noted by the Special Rapporteur, legal redress, while enshrined in the international human rights instruments, remains out of reach of the poor (UNHRC 2012). Moreover, public mobilisation and action are needed to modify and/or enact legislation related to marriage, inheritance, asset ownership, use of common property and communal resources. This is often the most difficult step, requiring strong political will, public pressure through political participation and a strong civil society.

The human rights approach to social protection that puts women at the centre is a transformative system wherein individual and collective rights are advanced by addressing the causes of inequity and disempowerment, ensuring an adequate standard of living, and increasing accountability and transparency.

## 1.6 Anticipatory social protection

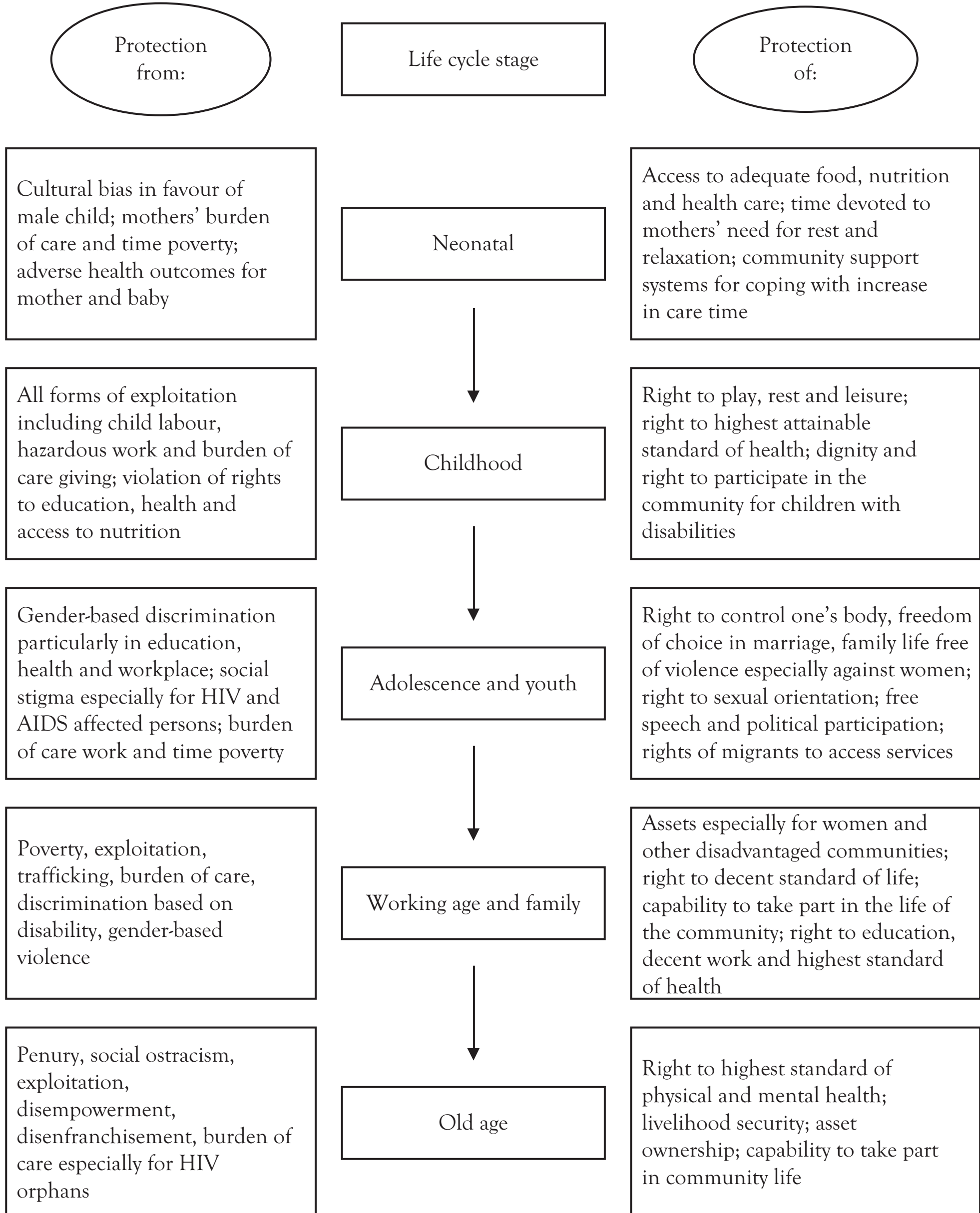
Most of the existing social protection systems are static – there is a set of rights that are guaranteed by the state, with a set of programmes designed to further those commitments. Often, neither the set of rights nor the set of programmes correspond to the state's obligations under international human rights instruments, especially in developing countries. Even when rights are not violated, the political will and/or budgetary resources needed to enhance the existing social protection framework may be absent, as in many European countries after the global financial crisis.

From a feminist perspective, social protection has often been equated with exclusion from occupations deemed unsuitable for women (mining, for example) or from working on more remunerative night shifts in commercial establishments. This reflected the view of policy-makers on what is 'appropriate for women' rather than being an outcome of any consultative process. The predominant question for policy discourse seems to be, 'What do women and children need to protect them from adversity?'. In contrast, our anticipatory framework asks the question, 'What would make women's lives easier, safer and freer, and what would make women more valued, productive, have more life opportunities, have more power?' (Reid et al. 2012). The life cycle approach elaborated in Figure 1.3 provides a pointer to what a gender centric social protection framework would entail if adversity were replaced by opportunity in designing such a scheme.

The life cycle approach is an integrated system of analysis that provides a list of rights and freedoms every individual (including persons of third gender) must enjoy. These rights and freedoms are enshrined in various international agreements, declarations, covenants and conventions, including the aforementioned UDHR, ICESCR and CEDAW as well as the International Covenant on Civil and Political Rights (ICCPR), UN Convention on the Rights of the Child (UNCRC) and the Beijing Declaration and Platform for Action, which was adopted by governments at the UN's Fourth World Conference on Women in 1995. We have listed them against matching stages in the broad life cycle: neonatal, childhood, adolescence and youth, working age and family, and old age (Figure 1.3). The list can be modified to incorporate specific country contexts and future advances in the international discourse on human rights.

Our framework also disaggregates the operative aspect of this life cycle approach into two distinct but interconnected processes. Policy-making often takes place with an imperfect understanding of the difference between the terms 'protection from' violations and 'protection of' rights. The former refers to the set of rights that address underlying inequities and discrimination, especially against women and vulnerable sections of the population. The latter is the set of rights guaranteed under the international human rights conventions and other instruments. Listing these core rights against each stage of life will provide an integrated picture to enable policy-makers to identify key areas of social protection and to anticipate which components of a comprehensive social protection policy to put in place from a human rights perspective.

## Figure 1.3 Anticipatory social protection framework using the life cycle approach



One significant inference from our anticipatory scheme is that gender-based discrimination is the one common area of protection at each stage of the life cycle. This may take several forms, from male child preference to education and health inequities, workplace discrimination, trafficking and old age penury. Similarly, at each stage of the life cycle, the common thread that binds the rights together combines alleviation of women's unpaid work and care burden with enhancement of their capabilities and freedoms. This calls for an integrated approach under social protection that anticipates the needs of women at each life stage, with the purpose of ensuring they can have a life of dignity with the ability to take part in the life of the community, and to live a life without 'capability servitude' arising from the burden of unpaid care work (Waring et al. 2011).

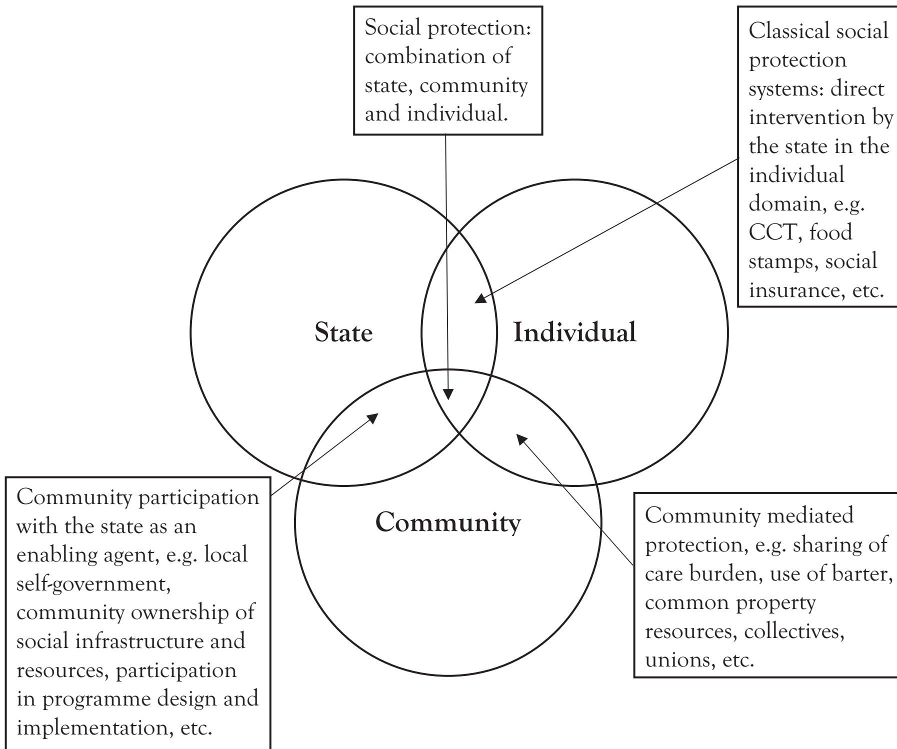
## 1.7 Programme design and implementation

What approach could be adopted to bring about an effective implementation scheme for a rights-based, gender sensitive, transformative and anticipatory social protection agenda? We propose that a truly social system of protection would have to involve all three key rights holders and duty bearers – the state, the community and the individual. That is, the set of interventions under social protection has to fall in the space where these domains intersect. Moreover, as we can see from Figure 1.4, the area of the intersection implies that the set of programmes currently falling under social protection is not very large. This is seen more clearly when we categorise the existing schemes under the three domains of interaction: state–individual, state–community and community–individual.

The dominant relationship in existing social protection systems is between the state and the individual. Social protection is viewed as an umbrella encompassing different schemes. Most social protection frameworks would include programmes designed to meet targets such as the MDGs, or to reach certain target population such as children and elders, the chronically sick and the disabled. Few, if any, social protection systems provide compensation for the care work undertaken by these categories of persons. Women are particularly disadvantaged since it is they who perform most unpaid care work (childcare, looking after the sick and infirm, etc.).

This stems from a lack of understanding of the human rights foundations that an effective social protection system must have. As noted by the Special Rapporteur on extreme poverty and human rights, grounding the programme design and delivery on human rights principles would provide the necessary anchor for effective implementation. Moreover, as rights-based programmes get off the ground, complementarities with other similarly designed programmes would ensue, for example using the right to information in the monitoring of NREGS in India. The human rights framework therefore provides an operational guideline for an effective social protection system and changes the dynamic between the state and the individual. It transforms beneficiaries from passive receivers to active participants in the system.

**Figure 1.4 Operational framework for a rights-based social protection approach**




There is, however, significant confusion regarding what the 'social' in social protection stands for in different contexts. In societies where the norm is still communal sharing of production and use of natural resources, such as land and water, the state plays a minimal role in determining the social protection framework. Traditional and community practices shape daily life; customary laws handed down through generations or mediated through solidarity societies, non-government organisations (NGOs) and private philanthropic initiatives determine the interaction between individuals and the social protection system. In times of crisis, the community ensures that the rights of each vulnerable individual are protected. While different mechanisms have been tried in many countries, the main outcome is to strengthen community ties and make these an effective instrument for social protection.

The third arm of this system is the interaction between the community and the state. In our proposed framework this is interesting for several reasons. First, the recent paradigm of decentralisation in some programmes has, in spite of all its flaws, devolved some power to lower tiers of governments, be it provincial or local. This has provided space for communities to mobilise and demand more locally relevant rights that were hitherto ignored. The overarching framework of a rights-based approach to development has transformed the benefits of public programmes into entitlements

that are legally enforceable and justifiable. In most cases the special status of women is built into the design and thus the existing gender imbalances in access to services and decent employment are taken into account. The state, on the other hand, has used communities as agents for implementation and monitoring – for example, the 'social audit' system in the NREGS in India is used to ensure malpractices are made public.

CCT schemes, like the Livelihood Empowerment Against Poverty (LEAP) programme in Ghana, have sought to engage communities in identifying beneficiaries in order to minimise exclusion errors. While the benefits of this framework have been well documented, less is known about its impact in addressing underlying inequities, especially those of gender, disability and HIV. But, as demonstrated above in the case of the food basket for children in Botswana that quickly became a stigmatising 'AIDS basket', existing discrimination and inequality may be persistent even with a concerted effort to implement a human rights framework for social protection.

Our proposal for a rights approach to social protection, which takes into account the structural inequities of gender and marginalisation, will help to expand the ambit of the state–community–individual interaction. The power of the transformative and anticipatory agenda can be harnessed to identify the continuum of rights that have to be protected, discrimination on the basis of gender and marginalisation that need redressing, and the roles of the state, community and individual in the establishment of a social protection mechanism that is truly social.

# Chapter 2

# Rights and Unpaid Work: A Critical Review of International Experience

## 2.1 Context

The role of the Commonwealth in shaping the emerging global dialogue on social protection is significant against the backdrop of the global financial crisis and its aftermath. It is widely acknowledged that what started off as a financial sector crisis in 2007 escalated into a 'compound crisis', which is still putting a fiscal strain on the major economies of the world in 2013. At the same time, economically weaker nations are grappling with severe volatility in food and fuel prices, which is stoking inflation in countries previously unaffected by downturns in the global economy.

The crisis has exposed the vulnerabilities of smaller countries in Africa, Asia, the Caribbean and the Pacific to the existing structure of the global economy, where their dependence on primary exports, remittances and external aid is leading to domestic economic and social crises. It is in this context that social protection becomes significant. In situations where there is a high demand for the work of unpaid carers, for example in countries with a high incidence of HIV or with other 24/7 care circumstances, the resources of the unpaid care sector are particularly stretched.

It is increasingly recognised that countries with well-developed systems of social assistance are better able to cope with the impact of the crisis. In these countries, the most vulnerable sections of the population – poor women and men, children, the elderly and persons with disabilities – are protected by social transfers. Where legal systems protect the rights of citizens, the vulnerable, particularly women and children, are protected against discrimination and exclusion. In the late 1990s and early 2000s, countries in Latin America, particularly Brazil, had put in place social protection mechanisms following their own crises. The Commonwealth could therefore learn from the experiences in Latin America.

Social protection encompasses a range of policy sectors including infrastructure, health, food and income security, social assistance, legal rights and governance. Social protection delivery systems also vary, ranging from contributory pensions, conditional and unconditional cash transfers and tax-financed social insurance to public service delivery in health, education and nutrition. Since both state and non-state actors implement these systems, applying a variety of arrangements, it is extremely difficult to agree on one particular definition of social protection.

What social protection might encompass is currently a contested space for framing the debate and practice. Who controls what 'social protection' means? Who is making the decisions about its nature and the responses? In raising these questions, this research situates the current debates, analyses international practices and outcomes, and elaborates on the Commonwealth Secretariat's approach to social protection, which promotes models of both transformative and anticipatory social protection.

There is a need to expand the notion of social protection as social assistance to include the protection and promotion of the right to social security in order to design appropriate policies and ensure adequate resources for vulnerable groups: poor women, children, the elderly and persons with disabilities. When we consider the list of challenges faced by carers who work unpaid and full-time in their homes caring for family members with HIV and disabilities, and we consider their fundamental human rights, it is clear that a great deal more thinking about social protection is required.

The next section examines global experiences, especially from the Commonwealth regions, to understand which of the approaches can be scalable and under what conditions.

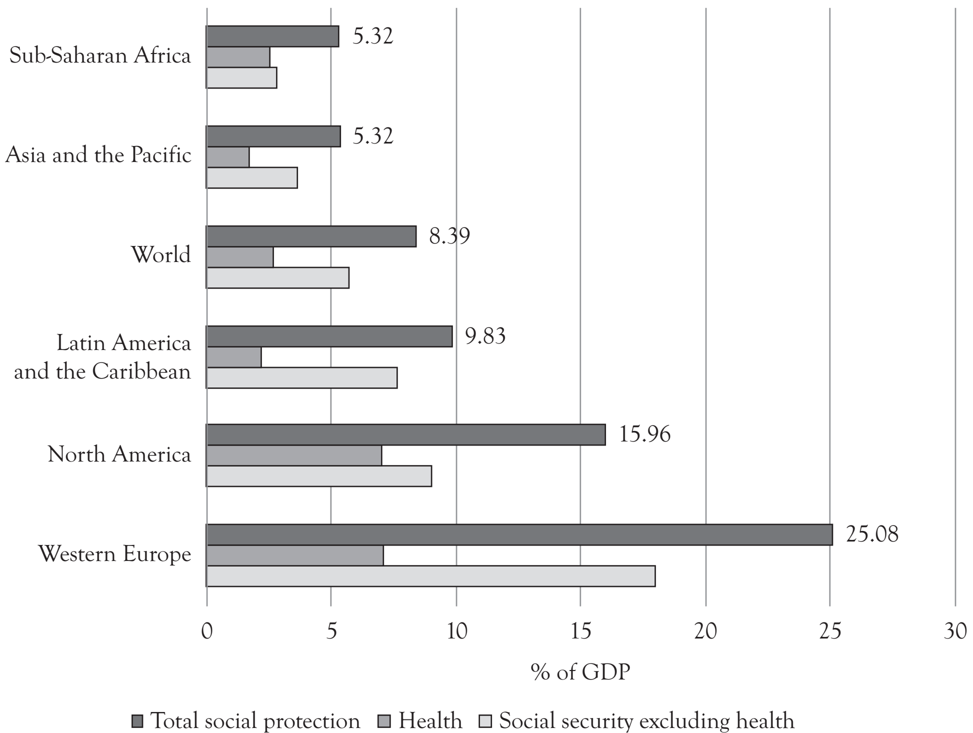
## 2.2 Institutional measures: experiences and lessons learned

There are several types of social protection in operation across the world and in different sectors. CCT initiatives, supported by the World Bank and other multilateral organisations, is the predominant type of intervention directed at the poor. Most of these initiatives require the beneficiaries to meet basic selection criteria and the delivery of benefits is contingent on them fulfilling conditionalities related to health and education outcomes. This type of intervention dominates in Central and South America. In Africa, the establishment of social action investment funds has been a common response, particularly in relation to public works programmes. There is a widespread view that social protection is donor driven with many short-term pilots.

Apart from cash transfers, some form of social protection exists in almost all countries, but the content, scale and delivery of the programmes varies significantly. Inadequate administrative capacity is a common problem many developing countries face in efforts to implement good social protection strategies. For example, some countries in sub-Saharan Africa or the Pacific have social pension schemes, but they may be extremely small in scope catering to retired government servants. In terms of their functions, most of the government social protection programmes fall under protection and preventive components of the life cycle approach.

There is considerable variation in social protection expenditure from public resources across regions of the world and across countries in similar levels of development or facing similar constraints, such as small island nations. Figures 2.1, 2.2 and 2.3, using data compiled by the IMF (2009), show the extent of these differences.

**Figure 2.1 Social protection expenditure as a percentage of GDP**



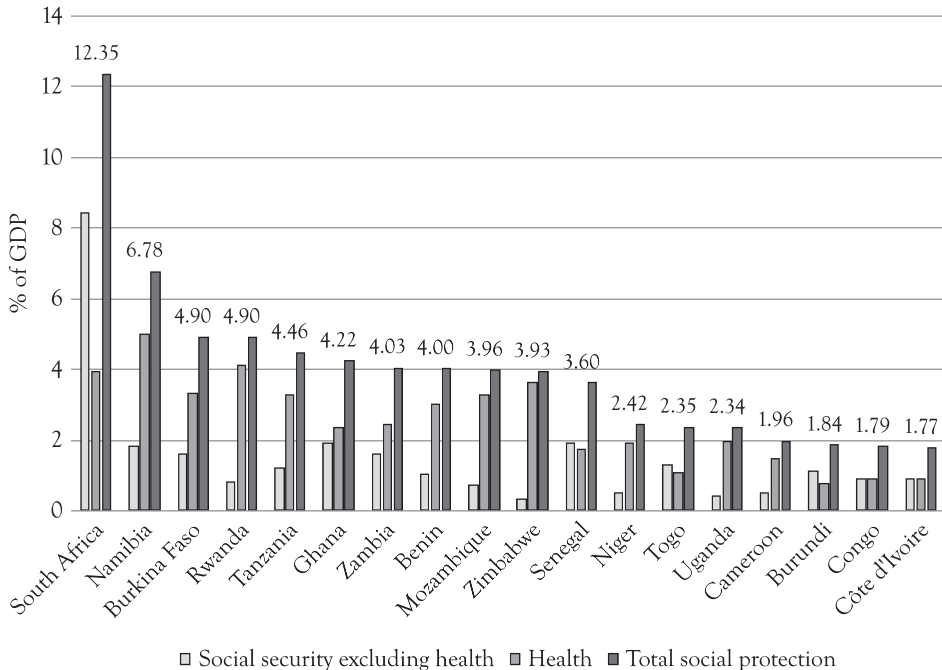

**Source:** IMF 2009

Advanced OECD countries, which have the most extensive social protection systems, spend five times as much as developing countries of sub-Saharan Africa and Asia as a share of GDP. Interestingly, social security expenditure is higher as a share of total social protection expenditure in countries of Western Europe and Latin America compared with the United States, which spends proportionately more on health.

Within Africa, the share of social protection expenditure ranges from a high of 12.3 per cent in South Africa with the most extensive social transfer system to 1.6 per cent in Côte d'Ivoire. Most countries of sub-Saharan Africa spend around 4 per cent of GDP on social protection (Figure 2.2). The variation is similar among small island nations, ranging from 16.7 per cent in Seychelles to 3.4 per cent in Vanuatu. Seychelles has one of the most advanced and comprehensive social protection systems, including home-based care for the elderly that incorporates social transfers for unpaid care workers in the family. This scheme is funded from the domestic budget and implemented through the Agency for Social Protection.

Small island countries of the Caribbean generally spend more on social protection than do those of the Pacific (Figure 2.3). This reflects the relative state of economic

**Figure 2.2 Social protection spending in Africa as a percentage of GDP**




**Source:** IMF 2009

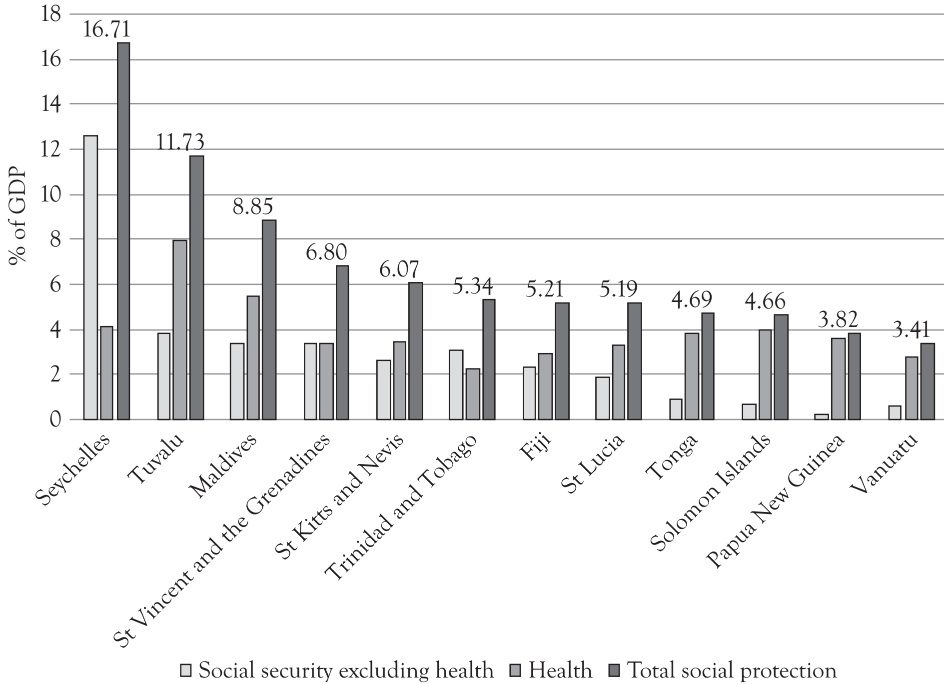
development between the two regions and the affordability of social protection, as well as the existence of traditional forms of social protection in the Pacific countries, which makes them less dependent on public provision.

The big drawback of this data is the limited scope of the definition of social protection and the non-inclusion of unpaid care work in the calculations. New evidence and methodological advances have challenged the prevailing argument that it is difficult to estimate the size of the unpaid care economy. Estimates published in 2011 of detailed time use surveys for 25 OECD member countries and 3 emerging economies suggest that between a third and a half of all economic activity in the countries under consideration was unpaid work, and as such was not accounted for in GDP (Veerie 2011). Moreover, in all countries women did more unpaid work than men, and the difference was especially marked in the field of unpaid care (Veerie 2011).

## 2.3 Social transfer designs: Mexico, Bangladesh, South Africa

Given the wide variation in social protection expenditure across regions, it is not surprising that the design of social transfers reflect the socio-economic context,

**Figure 2.3 Social protection expenditure in small island countries as a percentage of GDP**




**Source:** IMF 2009

although in our definition they fall under the broad categories of preventive, promotive, protective and transformative social protection.

Three different types of social protection programmes are highlighted in Box 2.1; the Oportunidades programme in Mexico, the Ultra-Poor Programme in Bangladesh and the old age pension scheme in South Africa. These programmes, which have different histories, implementation modalities and targeting approaches and experiences, offer valuable lessons.

These examples point to one important issue: focusing on vulnerable women and children is critical to achieving effective social protection. Furthermore, there is evidence to show that social protection programmes have greater outcomes if there is a gender focus and community involvement.

Both the Mexican Oportunidades programme and South African pension scheme form the core of a social assistance framework that is supplemented by other government schemes such as skill development in Mexico or child support grant in South Africa. The South Africa example shows that a rights-based approach can strengthen the foundations of social development policy in general. The Bangladesh

**Box 2.1 Comparative assessments of three social protection programmes**

**Mexico – Oportunidades**

The Oportunidades programme in Mexico, which was formerly the Progresa programme, is now the centrepiece of the country's targeted poverty reduction strategy. It provides cash and in-kind transfers that are conditional on school attendance and regular visits to health centres. In rural areas, Oportunidades has reportedly increased education achievement by 14 per cent. In relation to nutrition, children in the scheme have experienced higher growth than average and lower levels of anaemia than children outside the scheme. In terms of health, Oportunidades is credited as having boosted demand for antenatal care by 8 per cent, and for contributing to a 25 per cent drop in the incidence of illness in newborns and 12 per cent lower incidence of ill-health among under five-year-olds compared with children who are not in the programme. (www.oportunidades.gob.mx)

**Bangladesh – BRAC's Ultra-Poor Programme**

In Bangladesh, the BRAC[3] Ultra-Poor Programme has focused on the poorest and most vulnerable groups for whom crisis is a common occurrence. As part of BRAC's wider programme, 'Challenging the Frontiers of Poverty Reduction', the Ultra-Poor initiative seeks to build up the productive asset base of the poorest households and individuals that have often been seen as beyond the reach of traditional poverty focused initiatives. The core strategy is to provide households that qualify as 'ultra-poor' with enterprise development training, an asset transfer averaging US$100, and a weekly stipend for income support. Additional activities include social awareness and community mobilisation for education, and facilitating access to health care, incorporating financial assistance if needed. It is estimated that around 85,000 women have graduated out of this 'ultra-poor' status to date. Earnings from skill-based productive activities increased in 90 per cent of targeted households, with income growth varying from 40–56 per cent between 2002 and 2005. The programme also reported an increase of more than 400 per cent in primary school enrolment rates among children of targeted ultra-poor households between 2002 and 2005. (www.brac.net/content/challenging-frontiers-poverty-reduction-targeting-ultra-poor-cfpr-tup#.UffniW34uqE)

**South Africa – Old age pension scheme**

The government of South Africa extended its 1928 means-tested, non-contributory old age pension scheme to all racial groups in 1993. It is the largest social security transfer programme in the country, covering women over 60 years and men over 65 years. The monthly pension is roughly R780 (US$109). The landmark Social Assistance Act, No. 13, of 2004 formed the core of a new strategy in the development of social protection in the country. The Act charges the national government

*(continued)*

*(continued)*

with responsibility for social security grants. In keeping with this mandate, the South African Social Security Agency has since taken over the management, administration and payment of social assistance grants. The old age pension grant is complemented by other types of cash transfer programmes that have been put in place in response to the burden of care of HIV. These programmes disperse grants for child support, disability, care dependency and foster care. Taken together, these forms of institutional social assistance have mitigated the impact of HIV on the most vulnerable section of the population – unpaid carers, who are mostly elderly women and children in affected households. (www.services.gov.za/services/content/Home/ServicesForPeople/Socialbenefits/oldagegrant/)

example, on the other hand, indicates that social protection can be inclusive; it complements other public social assistance programmes and fills an important gap in programme design and implementation, which often miss out the most vulnerable sections of the population – ultra poor women. Targeting of specific vulnerable groups, such as children affected by HIV, and including them in social protection is not only efficient from an economic point of view, but also protects, promotes and enhances their human right to social security as enshrined in the Universal Declaration of Human Rights.

## 2.4 Implementation: financing, targeting, delivery

A large part of the international discourse on social protection implementation is confined to design and outcome issues. There is less focus on the operational issues of who finances, how the targets are set and who delivers the programmes. It is often presumed that comprehensive social protection is beyond the fiscal capacity of most developing countries and certainly unaffordable for low-income countries with weak tax systems and revenue capacity. However, even for large programmes like Mexico's Oportunidades, Bolsa Familia in Brazil and NREGS in India, the fiscal costs range between 0.5 and 1 per cent of GDP, reaching around a quarter of the population. (All of this cash is immediately spent and in country; it does not disappear offshore). This is much lower than pension payouts for public sector workers, who are the most protected against income shocks due to inflation-indexed wages.

For low and middle-income countries of the Commonwealth, it is feasible to start with a social protection scheme targeted at the most vulnerable section of the population, institutionalise it through fiscal and budgetary instruments, mainstream the programme in national development plans and provide the legal framework for long-term viability. In Ghana's CCT programme, LEAP, community implementation committees undertake beneficiary identification and outreach. Monthly transfers

range from GHS8 (US$6.90) for one dependent to a maximum of GHS15 (US$12.90) for four dependents. The programme is also time-bound in the sense that beneficiaries are expected to 'graduate' from it within three years.

In comparison, Zambia's Household Grant is a purely social transfer programme that provides general subsidies to poor households with different criteria depending on the regional vulnerabilities. The programme involves the community in the identification of beneficiaries using a set of household level criteria including the presence of older people, disabled persons and/or children. In the Kalomo, Kazungula and Monze district pilot schemes, each approved household receives about US$10 per month in cash and those with children (any number) get a bonus of approximately US$2.50. Higher transfers, with bonuses for children enrolled in primary and secondary school, are also tested in one pilot district. In Katete, pensioners receive US$15 per month, which is transferred bi-monthly.

For resource rich countries like Ghana and Zambia, it is possible to fund a medium-scale programme, such as LEAP or the Household Grant, through a dedicated fund pooled from taxes on mining and petroleum. This pool of domestic resources can be augmented by donor contributions, which will enable future expansion of the social protection architecture as resources become available.

Targeting remains an area of debate in all social protection regimes in poor countries, given the resource constraints they face and consequent need to prioritise investment. As can be seen in the cases of Mexico, Brazil and India, large-scale transfer-based social protection schemes are not a very big proportion of GDP. The main question, however, is whom to target and how to go about doing it.

There are three main strategies that countries have followed in this regard. Latin American cash transfer programmes set strict qualifying benchmarks and try to reduce inclusion and exclusion errors. This 'means-testing' requires regular collection and analysis of quality datasets and continuous evaluation of fulfilment of conditionalities on the part of the beneficiaries. Administrative capacity is a precondition for monitoring compliance and payment if, for example, the social transfer is contingent on school and health clinic attendance. The attendance contingencies are frequently dependent on mothers being available to accompany their children, a condition that interrupts their paid and unpaid work. Such systems may not exist in many low-income countries due to weak governance and human resource capacity constraints.

To overcome such issues, many countries implementing social transfers rely on the community to identify beneficiaries. This has two important benefits. First, it does not depend on a pre-determined means test, which may not be applicable in diverse geographic and socio-economic and cultural contexts. The definition of household, for example, may be different among different communities. Second, communities are more accountable to the individuals and vice-versa, which can be expected to

improve both targeting and compliance. Social protection schemes in Ghana, Kenya, Sierra Leone, Uganda and Zambia have adopted the principle of community targeting and accountability in their programme implementation architecture.

Finally, many formal government social protection schemes rely on self-targeting. These include old age pensions, child support for HIV-positive families and employment programmes targeted at the most vulnerable sections, such as NREGS in India and the Expanded Public Works Programme in South Africa. Self-targeting also encompasses school feeding and public food security programmes. This strategy,

**Box 2.2 Identity and social protection for the poor and vulnerable, India's unique ID number**

Taking the concept of a single registry one step further, the Government of India launched an ambitious project to provide unique biometric ID numbers. Also known as UID or *Aadhar* (foundation), this architecture is designed to be inclusive, providing an online verifiable identity for the poor to enable them to access social protection services. By eliminating the need to prove identity at multiple service access points and moving to a verifiable identification method, UID is streamlining and enhancing existing channels of service delivery.

Migration imposes huge challenges on the system of social protection in India. Entitlements such as food rations, cooking fuel subsidies and maternity benefits are designed for a population that resides in the same geographical area. The reality is that over 300 million poor, illiterate and vulnerable people migrate regularly in search of livelihood opportunities, most of them to the urban areas that are experiencing rapid economic growth. By linking biometric identity to the beneficiary database, verifiable anywhere at anytime, the *Aadhar* number protects the right of the poor to access social security and makes targeting more efficient.

The Reserve Bank of India, the country's central bank and sector regulator, has accepted the *Aadhar* number as one of the methods of fulfilling the KYC (know your customer) norms, which has huge implications for financial inclusion. In fact, the *Aadhar* enrolment process offers the option of opening a 'no-frills bank account' with a limit of Rs50,000 (nearly US$100) on annual transactions. These accounts enable direct transfers to beneficiaries, with plans to link through mobile phones to disseminate information, register grievances and enable payments through future mobile payment platforms.

From the initiation of the enrolment process in September 2010, over 300 million *Aadhar* numbers have already been registered. The target is 600 million by 2014.

More information is available at the Unique ID Authority of India website: www.uidai.gov.in See also 'The Magic Number', a huge identity scheme that promises to help India's poor and to serve as a model for other countries (*The Economist* 2012a).

however, presupposes information about entitlements on the part of the beneficiary and an efficient registration system to process the social protection entitlement.

Several lessons have been learned from the accumulated evidence on implementation of social protection schemes. Community targeting is effective in most low-income countries with limited administrative capacity and it has been observed that Zambia's Household Grant scheme has been particularly effective. Political involvement is higher in entitlement schemes, which reach large sections of the population in strong electoral constituencies. Programme financing and performance is better if there is one co-ordinating ministry with strong bargaining power over other ministries, especially if the co-ordinating ministry is Finance or, for example, the Ministry of Social Development in Brazil with its Bolsa Familia programme, or the President's Office in South Africa. Finally, easy access to the social transfer is crucial. In the case of cash transfers in old age pension schemes, for example, difficulty in withdrawing the entitlement from banks or post offices can impose high costs on the beneficiary, and women beneficiaries may find their safety and their freedom from violence and harassment is compromised in circumstances of cash payments.

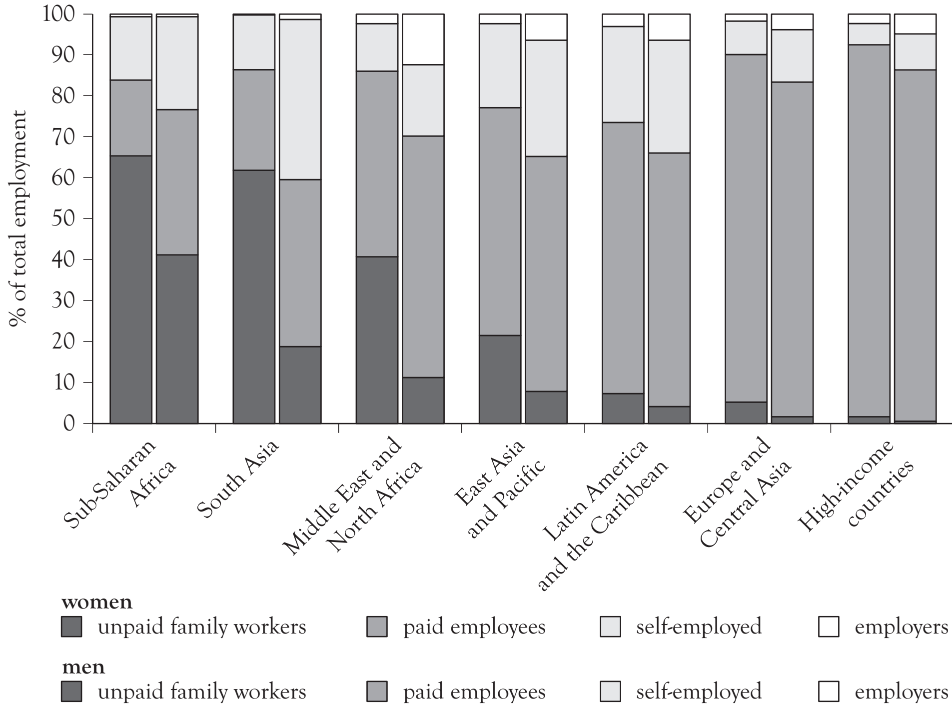
There is a case for leveraging the delivery of social protection for greater financial inclusion and financial literacy especially for women, as has become evident in NREGS payments in India. Direct payment of wages into bank accounts opened in the name of women beneficiaries has had a spill over effect into women's empowerment, along with demands for functional literacy and numeracy skills in order to undertake banking transactions, especially to access wages. Moreover, financial literacy has had a positive impact on gender relations within the household, with women making decisions on how much to spend, save and invest in the future well-being of their families.

## 2.5 Incorporating gender, human rights, women's unpaid work, children's agency

Due to the focus on cash transfer-based social assistance schemes, the current discourse on social protection pays inadequate attention to a rights-based approach that takes into account women's unpaid work in the care economy and rural subsistence. Research for *Who Cares? The Economics of Dignity* (Waring et al. 2011) demonstrated that this is a major issue. This is a particularly significant omission in the countries of the Commonwealth in sub-Saharan Africa and Asia, where women carry the disproportionate burden of disease, particularly HIV and non-communicable diseases (Figure 2.4).

The HIV pandemic often makes women's position even more precarious, for example, when widows are stigmatised as the carriers of the infection, shunned by their husband's family and thrown off their land. The HIV pandemic has substantially increased the number of widow-headed households in Africa. There is little quantitative

**Figure 2.4 Women's unpaid work in different regions**




**Source:** World Bank 2012: 207

evidence on the proportion of widows who lose their land after the death of their husbands, whether they lose all or part of that land and whether certain characteristics of the widow, her deceased husband and/or her household influenced the likelihood of her losing land rights.

While data is often lacking on women's rights to land, a longitudinal study of considerable validity and reliability found that mean land-holding declined for widows in Zambia by 39.8 per cent among households experiencing the death of a male head of household (Chapoto et al. 2011). Almost half of the widowed households experiencing a decline in land access, had incurred a greater than 50 per cent decline. Widows and households that were initially wealthier were more likely to lose land and other productive assets after the death of the husband.

The '*Who Cares?*' research showed that women and children, particularly girls, bear the greatest burden in families affected by HIV. Women are caregivers by default and have no choice in this matter, even when they themselves are infected and need care. In addition, women and girls almost always face the greatest degree of stigma and social discrimination. Women's unpaid care work is relentless and unceasing, which leaves them unprepared for paid work; they are unavailable and they do not have the time or

resources to train. These issues are not recognised in current social protection discourse, even though women's unpaid work, in effect, subsidises the cost of care.

Violations of the rights of carers are manifested in various ways. They are denied the right to dignity, the right to rest and leisure, the right to a decent standard of living and the right to take part in the life of the community due to social discrimination. More importantly, unpaid carers are denied the basic capability of every individual to live a normal life and therefore are in a condition of 'capability servitude' and time poverty. The current social protection architecture does not take into account these violations of the rights of carers, which are universal.

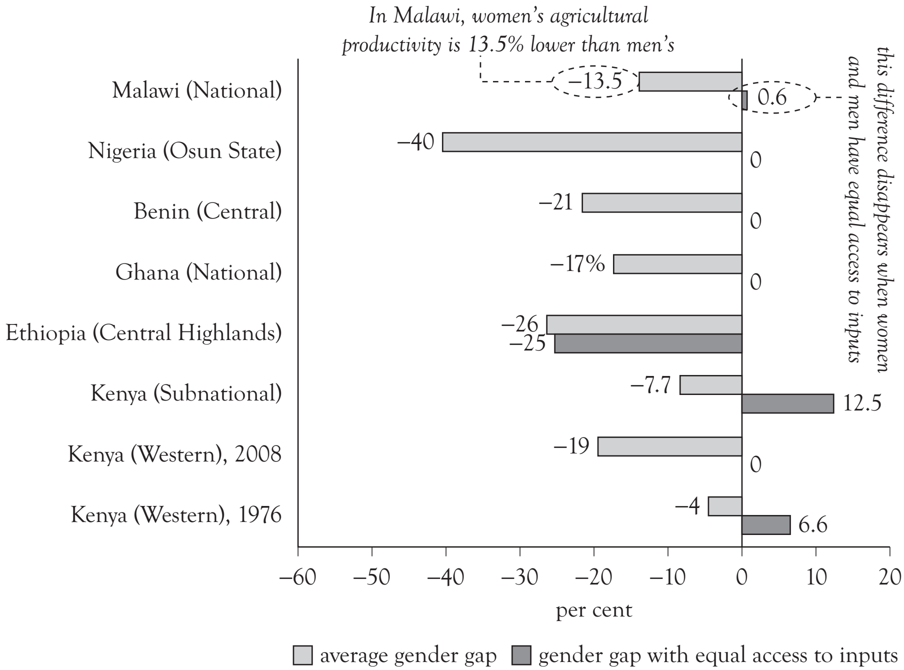
Central to a rights-based approach to social protection is the issue of livelihood security and ownership of assets for women and children. Gender discrimination in the ownership of land and other assets imply that women are in a position of disadvantage in a rural subsistence economy where land is the most important form of social protection. Moreover, unequal access to inputs is economically inefficient; the productivity of women in agriculture is equal to, if not more than, that of men if they have the same right to resources, even discounting their care and reproductive roles (Figure 2.5).

In all the countries surveyed, women's agricultural productivity is on average around 20 per cent lower than that of men. However, the situation is reversed once women's access to agricultural inputs – land, credit, extension services as well as seeds, fertilisers and harvesting equipment – are factored into the analysis. Except in the central highlands of Ethiopia, women's productivity in agriculture is at least equal to that of men, if not more. In western Kenya for example, the difference in gender productivity increased substantially between 1976 and 2008. However, in both the time periods, providing equal access to inputs eliminated this difference. Women's productivity in agriculture is 12.5 per cent higher if we consider all regions of the country. However, the analysis only mitigates inputs and not other unpaid work that traditionally women perform both within and outside the household, which may underestimate the positive impact to a large extent (World Bank 2012).

The Social Protection Floor treats all children as if they are dependents. It does not mention the millions of children who are now heads of households, not just in circumstances related to HIV but also in the aftermath of war and refugee flight, famine, and traumatic weather and geological events. The Floor offers no agency at all to children who head families, something UNICEF has recognised as necessary for decades. Cash transfers discriminate because payments are not usually made to an older child looking after children. In South Africa, for example, the law prevents children under 16 who head households from receiving the child support grant on behalf of younger siblings.

Children who are caregivers face different vulnerabilities to those of adults since children will live with the consequences of their caring for most of their lives (Edström 2007). In this context, social protection measures are not one-off approaches that can

**Figure 2.5 Women's productivity in agriculture and access to resources: African experience**




**Source:** World Bank 2012: 20

be withdrawn when the sick family member dies. The risks associated with the loss of family in countries with high HIV prevalence, and in weather and seismic catastrophes or during- and post-war periods, means social protection needs to address multiple issues in the best interests of the child. These needs can be anticipated.

The revision of laws for orphans and vulnerable children (OVC), in particular those related to issues of land-grabbing and lost inheritance, have been a key concern of the GROOTS initiatives in Kenya. Here grassroots women's initiatives have been used to build a community social protection network based on the 'transformative social protection' approach.

In Papua New Guinea, Solomon Islands and Vanuatu, about 80 per cent of the population live within the informal economy. Indigenous knowledge systems and traditional social mechanisms, such as reciprocity, access to communal lands, forests and communal fisheries custom farming and kinship social support, operate as social protection mechanisms. In 2009, the Vanuatu Ministry of Health declared there was enough food from subsistence agriculture, gardening, fishing and rearing poultry and livestock to feed the entire population. Inbuilt norms of social obligation should make it almost impossible for an individual or family literally to starve. Yet the *Who Cares?*

research found that norms of social obligation and related support systems broke down when stigma and discrimination associated with HIV were encountered.

The situation of HIV orphans in Papua New Guinea is a case in point. While most orphans tend to be supported by the Wantok system, a deeply held tradition of community support, extended families are much more likely to reject HIV orphans. Widows are regarded as the most disadvantaged group in the Pacific and with both urban and international migration there is a pattern of older people being left to care for children. Across the Pacific, discrimination against those living with disabilities is widespread, with people often ashamed of disabled family members. Many disabled children are hidden away and kept out of school, the girls losing out more than boys. The situation is worse for those with intellectual or learning disabilities. So what happens to traditional, informal social protection when patriarchy, stigma and discrimination are part of the picture?

Any discussion of stigma and discrimination must confront the particular dangers for the gay partners/carers of those living with HIV. Forty-one of the 54 countries in the Commonwealth criminalise homosexuality. Even where homosexuality is not criminalised, there seems to be little appreciation that carers may be male partners and in equal need of social protection interventions. Third gender communities are also entitled to full dignity and equality in access to, and outcomes of, social protection programmes.

Apart from the intrinsic value of women's empowerment and gender equality, women provide a vital link between food, nutrition and income security, which has instrumental consequences for the whole society. Recognising women's agency is the core of a social protection system founded on the principles of equity and social justice.

# Chapter 3

# Regional Developments

## 3.1 Africa

In Africa there is little history of central government social protection beyond pension schemes for civil servants. As in the Pacific, communities and villages have relied on traditional forms of support to provide basic food, water and shelter, often in the context of clans or extended families. Low-income, aid-dependent countries could not afford even the smallest cash transfer programmes, and their capacity for efficient delivery and corruption-free administration has been highly questionable.

The political will in the region is changing, with the Livingstone Accord of 2006 and the African Union Social Policy Framework in 2008. Under the Livingstone Accord governments committed to developing national social protection strategies and integrating them into their national development plans and budgets. The Social Policy Framework, meanwhile, signalled the African Union's increased political commitment to social protection. The declarations represented an emerging consensus that a minimum package of essential social protection should cover essential health care and benefits for children, informal workers, the unemployed, the elderly and persons with disabilities, to be expanded as more fiscal space becomes available.

Successive governments in South Africa have developed and expanded nationwide social protection schemes, and other governments and donors have initiated forms of cash transfer payments across the region. The South African government has had the budgetary resources underpinned by a constitution based on human rights, distinguishing it from other state responses in the region. The Bill of Rights includes the right of all 'to have access to social security, including if they are unable to support themselves and their dependents, appropriate social assistance'. Civil society in South Africa has successfully resorted to legal challenges on social and economic rights such as housing and access to water.

South Africa's Child Support Grants scheme, which began in 1998, is the largest in the region. Studies have shown that poverty has been reduced in households receiving the grant and by 2008 it had also been shown to improve nutritional intake and school attendance amongst child beneficiaries. A 2009 amendment to the scheme requires child beneficiaries to attend school. Research has shown the grant is being used overwhelmingly to pay for food: 51 per cent of households always use it for food and a further 23 per cent often or sometimes do. It is also used to pay for school fees and uniforms: 38 per cent always use it for school costs and a further 27 per cent often or sometimes do (Patel and Hochfeld 2011).

The children who are beneficiaries are more likely to live with their biological mothers than with both parents or with their biological fathers. The grant was designed to be a gender-neutral, child-centred cash transfer, but 96 per cent of the recipients are women. This reflects the social dynamics of need/poverty. Women's ability to control and allocate resources has a positive impact on household food security and eases their domestic responsibilities, but they remain largely responsible for caring and looking after families. The child support grant is certainly an example of anticipatory social protection, but it is more palliative than transformative with respect to social power relations. Patel and Hochfeld's research (2011) on the child support grant concluded that social protection policies may contribute to transforming gender relations, but on their own they are limited, and need to work in concert with other public policies. Research on HIV home-based care volunteers in Kwa Zulu-Natal also found a 'feminisation of responsibility', effectively coercing the women into agency that was manifested as home-based care work (Naidu et al. 2012). Principles of gender justice should be core objectives of social protection programmes and must be incorporated into the programme design and implementation plan to be transformative of social power relations (Kabeer et al. 2010).

When gender equality is enshrined in a national constitution, outcomes are different (Rask 2012). In Botswana, South Africa and Zimbabwe women are over half the people living with HIV. These states have pluralistic legal systems with civil, common and customary law. They each ratified CEDAW without reservation. They have all implemented parent-to-child HIV transmission programmes. But in Botswana and Zimbabwe traditional practices discriminating against women are not prohibited; customary law is exempted from anti-discrimination legal provisions.

While the obligations for social protection lie with the state, many African communities have developed a number of initiatives themselves, in particular in the context of HIV; for example, GROOTS in Kenya and the Indlunkhulu programme in Swaziland, which are both aimed at protecting access to land.

### 3.1.1 Targeting

The question of targeting social protection is a major issue in Africa. Douglas Webb has reported that in 2010 in sub-Saharan Africa, the number of orphans from all causes was over 50 million with one fifth of those orphaned by HIV (Handa, Devereux and Webb 2011). The major issue of orphans has led to a number of well-intentioned schemes that target HIV orphans. But these schemes have excluded many children in extremely poor households who are not orphans and children orphaned for reasons other than the pandemic. According to Stewart and Handa (2011), in research on which approach to targeting reaches the greatest number of poor and vulnerable children, '[t]he key finding from micro simulations is that targeting either households with children or the poorest households reaches a higher proportion of poor children than does targeting orphans [...] Delivering cash transfers to poor households with

children is found to have the biggest positive impacts on child well-being [...] [it is] more efficient and achieves better outcomes for children' (Handa, Devereux and Webb 2011: 9), than targeting orphans or labour constrained households, for example.

Support for this approach in adult social protection is highlighted in research that examines the policy preferences of rural African beneficiaries with respect to development and health interventions (Kim 2012). Villagers and headmen in rural Malawi decided to prioritise interventions that would serve the whole village over HIV interventions; 'Why not provide something that will benefit everyone?' was a typical response. Access to clean water, food security and agricultural development were consistently named as most important issues, although people who were HIV-positive or knew someone who had died of AIDS had preferences for HIV programmes. The research suggested 'bundling' HIV interventions with those issues of great importance to communities.

The Malawi social cash transfer scheme pilot programme, which began in 2007, may assist this 'bundling' approach. It targets poverty, malnutrition and school enrolment. Here, the District Assembly manages a community-based system to identify the poorest households, in a complex logistical and technical environment, requiring payments to thousands of households scattered over hundreds of miles, without sophisticated information technology back-up. Researchers found early indications of a reduction in child morbidity and in the number of underweight children, greater gains in school enrolment and reduced incidence of child labour outside the home. In addition, total food expenditures increased by 87 per cent in these households, with an increase in food diversity. In measuring impact changes over one year the researchers reported that 'providing regular and reliable cash grants to ultra-poor and labour constrained households in Malawi (created) profound changes in the lives of children, sick and disabled adults, caregivers with many dependents, and the elderly' (Miller et al. 2011).

Kenya's OVC cash transfer programme targets the very poor. To qualify, OVC must be under 17 years old and come from a household with one deceased or chronically ill parent, or where the main caregiver is chronically ill. The regions targeted are selected on the basis of poverty levels and HIV prevalence. Community committees visit households where there are children living in poverty, gather data about the household and then decide which households meet the criteria for the cash transfer. Local knowledge is valued in this process. A list of the households selected is sent to Nairobi. Another visit takes place to collect data related to living conditions including the dwelling construction, drinking water source, cooking fuel, livestock and the toilet (if there is one). This data are used to further rank the families so the most vulnerable have immediate access. Child headed households are prioritised (Handa, Alvier et al. 2011).

Where social protection programmes target adults without a 'bundling' approach, opportunities to participate in public works programmes may be offered without a

parallel social protection programme to keep children in school. Children can be removed to replace the unpaid subsistence and domestic work previously performed by adults in the household. However, there is a gendered outcome of such an approach. In Ethiopia, where the Productive Safety Net Programme adopts this approach, school attendance among boys in recipient households increased and the hours worked at home or on the farm went down. For girls in the 6–10 year age group, however, school attendance dropped and work hours increased (Gilligan et al. 2011).

Access to an education is a basic right for children and one that is totally 'anticipatory' in the context of this research. School attendance is at risk whenever household income is reduced, whether by famine, war, flood, accident, illness or the death of an adult in paid work. The household often resorts to paid, subsistence, or home-based child labour to survive. Household income is one of the main determinants of school attendance. The likely outcome of further poverty is a reduction in children's school attendance, especially among girls. In order to isolate school participation from negative shocks, international agencies put more and more emphasis on CCTs. However, while the CCT has the potential to be 'transformative' in the life of the girl child at school, it can reinforce old stereotypes when a social protection programme's conditionalities fall on women in the household to ensure compliance.

Social protection may be effective in raising school attendance and therefore increasing educational investment, as long as poor households are given financial assistance. Males consistently have a higher probability of attending school, particularly when the average enrolment rates are lower. In Ghana there is a strong correlation between child enrolment and parental education, especially in relation to the literacy of the mothers. In Mauritania, a scarcity of resources means fewer school enrolments. In Uganda, both family financial resources and parental education are considered in the decisions about schooling of children (Checchi and Salvi 2010).

### 3.1.2 Gendered anticipatory social protection

In Africa, a wide range of gendered social protection needs can be anticipated. A malnourished and extremely poor young girl who becomes pregnant will deliver a sickly weak child who will immediately have health needs and whose early development will be compromised. Ensuring nutrition to the expectant mother is a far more efficient approach than trying to sustain the mother and infant later.

Children of unmarried mothers may face major challenges with the loss of this parent. Where there is no identified father there may be no birth certificate or other form of registration (which is a precursor to education), primary health care and forms of assistance such as food or cash transfers. In the research for *Who Cares?*, this was a key breach of human rights that confronted grandparent carers. Even where there is community identification of the most needy, orphaned children of 'unmarried' mothers can be subject to discriminatory treatment.

The world of HIV is a gendered environment. Swaziland has the highest prevalence rate of HIV in the world. Women account for two thirds of new infections; VAW and multiple concurrent partners are key factors in the transmission of the disease. In 2007, the Swaziland national survey on violence against children (Reza et al. 2007) showed that one third of girls had experienced sexual violence prior to age 18. Swaziland responded with numerous programmes, including a national education campaign to raise awareness and promote prevention, and the adoption of safe school initiatives. A safe court system for survivors was set up and the establishment of units to investigate sexual violence against minors has increased the capacity of police officials to enforce the law.

More than 100,000 children in Swaziland are now orphaned or vulnerable and many of them are heads of households. The major issue is that children are not necessarily granted agency when they choose to head a household of friends or siblings because they perceive this as safer than an alternative of having an older male in a household. These children should receive all forms of social protection available to adults in their position, including access to sex education, ongoing support to cope with the pressure on them to have sex or to use transactional sex as payment, and to keep them safe from abuse and from feelings of vulnerability that arise from being placed in the care of males who are expected to keep them safe.

This question of when a child becomes an adult for the purposes of social protection needs a resolution in favour of the child. The interests of the child need to be paramount. Article 12 of the UNCRC guarantees the child's right to express his or her views freely in 'all matters affecting the child', with 'those views being given due weight'. What does this mean if not agency? Child headed households are especially vulnerable and too many of those who are supposed to protect them – in the household, the community and government – cannot be trusted to do so. OVC are a significant cohort of the population in many countries in Africa. Children are the largest group of poor individuals within many countries in Africa, especially in Kenya, Malawi, Mozambique and Zambia. Children's right to agency in what they consider their paramount interests would result in social protection that would be both anticipatory and transformative.

Elderly caretakers often lack resources to purchase necessities for children and the energy to engage in subsistence or informal paid work. With nearly 1.3 million orphans, Zambia has the highest proportion of orphans in the world. Evidence demonstrates that grandmothers care for approximately 43 per cent of the 845,546 HIV orphans.

Divorced, widowed or separated status can significantly affect inheritance rights and responsibilities of women. Access to land and assets on death or divorce are significantly gendered social protection issues and the likely outcome determines behaviour well before the event. In Ethiopia, where divorce is frequent and serial marriages are common, research examined how women's perception of the division of household

assets upon divorce affected women's well-being and child schooling outcomes in rural areas. Women who perceived that their husbands would get all the assets in a divorce also felt they had less control over their lives. Girls, in households where the women perceive the custody of an asset (land, livestock, or the house) would be given to the husband on a divorce, were more likely to fall behind their cohort in terms of the highest grades obtained (Kumar and Quisumbing 2012).

The ongoing land registration in Ethiopia has much improved the status of women. The process requires that the land be registered in the names of both spouses. It also involves the setting up of land administration committees at the village level. Kumar and Quisumbing (2012) found that the presence of women members in these committees has a positive impact on shifting perceptions toward equal division of assets upon divorce. As a result, resources controlled by women often result in increased investments in the next generation's health, nutrition and schooling, and they have increased bargaining power. The land registration measures appear to lead toward transformative social protection outcomes.

## 3.2 South Asia

As a region, South Asia has one third of the world's population in seven countries – Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka – which together have less landmass than that of Canada. Some of the development indicators are comparable to those of sub-Saharan Africa. Persistent levels of inequity in incomes, assets, education and health pose seemingly insurmountable challenges to reducing poverty and hunger in the region. The most critical issue for social protection in the region is to ensure livelihood and a decent standard of living for the population.

From the turn of the twenty-first century, however, South Asia has made a significant contribution to the global development discourse. Countries in the region have used new political spaces, like the election of new governments in Bangladesh, India and Pakistan and the end of civil conflict in Nepal and Sri Lanka, to fashion a new social protection agenda. Initiatives ranging from the micro-credit movement in Bangladesh to rights-based employment guarantee in India have been continued and strengthened, even in the aftermath of the global economic crisis.

### 3.2.1 Livelihood and income security

Although over 70 per cent of the population in South Asia resides in the rural areas and the vast majority of them are employed in agriculture, the region is yet to see the sort of transformation from farm to non-farm activities occurring in Southeast Asia, or the rapid urbanisation of the scale witnessed in Japan, South Korea and, more recently, China. Inevitably, conflicts over land and natural resources (especially water) have increased significantly in the recent past. This has been exacerbated by climate

change and catastrophic natural disasters – periodic floods in Bangladesh and Pakistan, persistent droughts in India, environmental degradation and melting of Himalayan glaciers in Nepal, and the devastation caused by the tsunami in Sri Lanka, Maldives and south India in 2004. Distress migration from rural to urban areas in times of natural disasters or crop failures limits the capability of individuals, families and communities to lead a life of dignity with livelihood security. It also means that the region has the highest number of people living in chronic poverty (Barrientos and Hulme 2009). All this poses considerable policy challenges and makes it imperative for a broad-based social protection system to be put in place (IDS 2010).

This was the motivation that prompted the enactment of the National Rural Employment Guarantee Act in India in 2005. The Act guaranteed the right to one hundred days of employment for every family registered under the Mahatma Gandhi NREGS. It also heralded the end of several smaller employment generation schemes that had been stalled by a lack of political will, bureaucratic apathy and rampant corruption. The transformative agenda included a rights-based approach to livelihood security, accountability of state institutions for demand-based provisions, payment of unemployment benefit and penalty for implementation agencies in the event of non-compliance. The agenda also mandated 'social audits' involving beneficiaries and gave non-government organisations and other watchdogs the authority to summon officials and obtain records under the Right to Information Act enacted around the same time.

The model of the Mahatma Gandhi employment scheme has been replicated in at least three other South Asian countries. It was introduced in 2008–2009 in Bangladesh as the Employment Generation Programme for Hard-Core Poor (initially called the Employment Generation Programme). It applies to rural areas of the country, with priority given to 81 highly poverty-prone *upazillas* (sub-districts). The scheme was introduced because of seasonal poverty, which, as in India, prevails for about three months per year. It is meant to benefit 2 million 'hard-core poor families' and one person per family, male or female, who do not receive benefits from other ongoing social safety nets. In contrast, the Mahatma Gandhi employment scheme stipulates that half of the person-days generated and works sanctioned must go to women.

In Pakistan, a similar employment generation scheme for rural unskilled workers seeks to guarantee employment, again for one hundred days a year. The scheme is devoted to small, local level works with a guaranteed daily wage equal to the minimum wage. A pilot scheme was planned in 120 sub-divisions in 12 of the least developed districts and districts that have suffered from the security situation. To date this has not been scaled up to a national level. In Nepal, the Karnali Employment Programme, adopted as a policy in 2010, is designed to arrange for 100 days of employment for persons out of employment in the poorest region of the country, comprising the five north western districts of Dolpa, Humla, Jumla, Kalikot and Mugu with a combined population of

around 350,000 people. Unlike the other three South Asian countries, however, the Government of Nepal has not cast the programme as an employment guarantee (Koehler 2011).

There has been no study of the anticipatory nature of social protection for this class of livelihood schemes until now. In our framework, a rights-based, gender-equity focused employment scheme based on constitutional and legal foundations incorporating other rights – such as the right to food, decent working conditions, and a fair and equitable wage – will fall in the intersection of the state, community and individual domains, the 'sweet spot' for social protection. Moreover, it has several other consequences, including:

- preventing displacement of families through distress migration and mitigating the degrading conditions and exploitations accompanying that situation;
- diversifying occupational choice since the selection of the nature of work to be performed rests with the individual and the group seeking work;
- protecting the rights of the child by stipulating that worksites put in place crèches and childcare workers, and supporting collective action for universal pre-school education;
- promoting and protecting the right to education and reducing children's economic vulnerability; and
- enhancing both economic and political empowerment with equal wages and participation in social audits.

It must be noted that field studies show a mixed bag of impacts in the implementation of employment guarantee schemes across India and other countries. However, one unequivocal finding is that the rights-based approach transforms citizens, especially women, into agents of change by giving them a greater voice in decision-making and empowering them to challenge power structures beyond the confines of the scheme. This is a huge step forward in a region where gender inequities and violation of rights is a systemic problem (Nayak and Khera 2009; Sudarshan 2011).

### 3.2.2 Education and health

Basic education and primary health care are two fundamental components of any social protection system. As noted above, the development indicators in parts of South Asia are the lowest in the world. This is particularly striking for education and malnutrition, especially for the girl child, and shows the weakness of existing social protection mechanisms in failing to ensure basic needs for the most vulnerable.

Countries such as Bangladesh, India, Nepal and Pakistan spend nearly 3.5 per cent as a percentage of GDP out of the national budget on education, which is nearly the average for all developing countries. In health, however, these countries spend less

than 1 per cent of GDP, falling behind among their peers in the regions, such as Sri Lanka. Poor quality of education and health care, combined with absenteeism and lack of accountability on the part of the providers, has forced a shift towards private paid health care. This has led to catastrophic health expenditure for the poor. Health care cost is one of the most important determinants of indebtedness and asset liquidation, especially in rural areas.

The conceptualisation of education and health as human rights to which citizens have a claim and the state has an obligation to provide, is relatively new in the South Asian context. Historically, education in general and higher education in particular has been the preserve of the elite. As a consequence South Asia lags significantly behind countries in East and South East Asia as far as universalisation of education is concerned.

There has, however, been significant improvement in gross enrolment rates as countries focused on expansion of the public education system following the adoption of the MDGs. However, the bigger challenge is to ensure children attend school and learn. The dropout rates are unacceptably high, especially for girl children who are pulled out of school to undertake household and sibling care, thereby violating their right to education and constraining their capabilities and freedoms.

The Right to Education Act, passed by the Indian Parliament in 2009, seeks to provide a constitutional and legal basis for protecting the rights of children to free and compulsory elementary education from the age of 6 to 14. Coupled with other measures and incentives such as abolition of school fees, incentives such as scholarships, uniforms and hot cooked meals as well as a child friendly environment, the Education Act is designed to involve parents and communities in implementation and oversight. It can, therefore, be classified in the state–community–individual domain in our anticipatory social protection framework. Guaranteeing the right to education should become one of the pillars of a social protection system, not only in India but in other countries in South Asia as well.

The debate on the dismal state of health care provision in the region and the consequent violations of human rights has not been very effective in crystallising public action. Traditional and modern systems of health care co-exist in South Asia even today, but the absence of a universal, publicly funded, quality health care system backed by a progressive insurance mechanism is one of the greatest challenges for building an anticipatory and transformative social protection system.

### 3.2.3 Social protection in old age

South Asian countries are witnessing what is called a 'demographic dividend'. In almost all countries of the region, persons under 25 years of age constitute between 40 and 60 per cent of the population. This implies a low dependency ratio – i.e. the number of elderly non-workers sustained by each of those currently employed – which

in turn has the economic implication of a higher pool of productive workers who can save and invest if provided with gainful employment. However, this dividend is not being realised fully due to the inadequacy of quality education, comprehensive health care, gainful employment, widespread gender-based discrimination and the lack of meaningful social protection.

The social protection mechanisms for senior citizens are generally restricted to a narrow segment of the labour force, estimated to be around 10 per cent, who are covered by the pension system upon retirement. The vast majority of agricultural workers, landless labourers, the urban informal workforce and household workers, paid or unpaid, are not covered adequately. Social transfers for the elderly exist in the list of government schemes. In most countries of South Asia old age pension schemes transfer very small amounts and lack scale in coverage. The exception is Nepal where it has received popular and political support. In India, old age and widow's pensions reach only 7 per cent of the target population, with large variations among states, according to the India Human Development Survey carried out by the National Council for Applied Economic Research in 2005 (NCAER 2005). The amounts range from US$4–10 per person per month. Although the amounts are very small, field surveys report that beneficiaries place considerable value on these transfers since this is their only regular source of income.

This points to the need for an anticipatory framework for social protection for the elderly. Identifying those most in need is not difficult – the essential problem lies mostly in the criteria for beneficiary selection. In our framework, the state can enact legislation to protect the needs of the elderly following a rights-based approach and let the communities decide on those most in need, with the right to a redressing of grievances on the part of the citizen or beneficiary. This would fall in the 'sweet spot' where the state, community and individual domains intersect (see Figure 1.4). Most importantly, the rights approach to social protection of the elderly would value them as citizens and ensure they have a dignified life as members of society.

### 3.2.4 Gender-based discrimination and violence

South Asian societies are highly fragmented by class, caste, ethnicity, religion and gender. Each produces its own dynamic of violation of rights of individuals and communities, but the most pervasive is that based on gender. Gender-based discrimination and violence prevails in all stages of the life cycle, elaborated in Figure 1.3. Its effects ripple across the social fabric and impact on everyday lives of women and girl children. The 2013 case of the gang rape of a young woman on public transport in Delhi and the widespread protests following the incident focused worldwide attention on the problem of gender discrimination and gender-based violence.[4] This came after the attempt on the life of a young girl who campaigned for access to education[5] and the fatal attacks on women polio immunisation volunteers in Pakistan.[6]

Social protection systems across the region have been slow to address this issue. While all countries in South Asia have ratified the United Nations conventions on the rights of women and of children, they have lacked the level of political will and administrative effort that is needed to implement the provisions. Social transfers have been used in various ways to tackle gender-based discrimination:

- providing scholarships to girls for enrolment and attendance in schools in Bangladesh, India, Nepal and Pakistan;
- distribution of bicycles for girls to ensure continuation in education in several states in India;
- establishment of an endowment fund for girl children, which can be cashed in on attaining adulthood, provided the beneficiary has completed 10 years of schooling; and
- a cash transfer known as Janani Suraksha Yojana (Mothers' Safety Fund), which is conditional on institutional delivery.

While all these programmes seek to provide incentives and support women and girls in education and reproductive health, removing entrenched cultural biases and discrimination against women and girls needs a long-term strategy. For example, laws to prevent sex-selective abortions and VAW have been in place for several years with varying degrees of success across countries of South Asia. Public pressure and collective action facilitated by an active media can put pressure on the political, administrative and legal systems to act to enforce the law. However, women face discrimination in various forms when they go to seek redress, especially when those institutions such as the police, judiciary, religious and tribal councils are male dominated, reinforcing the underlying power structures in a society. This situation is highly disempowering and only a fraction of women come forward to report sexual abuse and domestic violence, especially if it happens within the family.

Our anticipatory life cycle approach offers a mechanism for design of a social protection strategy taking into account the country and societal context. The framework identifies the most critical entry points for eliminating gender-based discrimination at various stages of life, provides instruments for policy-makers to address the underlying structural inequities and helps identify laws that need to be enacted or strengthened.

As a practical example, our anticipatory approach can be applied to the situation of young women who work in the garment industry across the region. In Dhaka, Bangladesh, two incidents in 2013 – in May the collapse of a factory building and a fire in another one month later, which left more than 1,100 people dead and over 2,500 injured – showed that the right to decent working conditions is violated with impunity. Protection of the right to health (including sexual and reproductive health care) is almost non-existent. The majority of garment sector workers are displaced

from rural areas and arrive in the city seeking jobs without requisite skills and knowledge of their rights, making them vulnerable to exploitation in terms of working conditions, salaries and benefits. They also bear the burden of childcare in the absence of institutional support, which adversely impacts on the physical and emotional development of their children.

The anticipatory social protection framework would incorporate:

- the rights of children to attend school up to 16 years of age with provision of child support grants for their families;
- strict enforcement of laws prohibiting child labour in any form and amending the provisions of existing laws to take into account the period of compulsory education;
- provision of quality education including technical training;
- enactment and enforcement of laws guaranteeing decent working conditions with equal pay and benefits;
- sensitisation and promotion of adolescent sexual and reproductive health in the workplace;
- women's representation in workers' collectives; and
- protection of the right to employment for expectant mothers and those with small children to prevent gender-based discrimination and exploitation.

The above would form the core principles of the anticipatory framework when transposed onto our life cycle approach to social protection. This framework, when coupled with state provision of elderly and childcare support, would create the necessary conditions for meaningful empowerment of women and make them equal participants in the development process. Depending on the country context, however, they may have to be supplemented by policy, legal and community action to improve the economic and social opportunities for women and girls, especially in terms of freedom of movement and personal security.

## 3.3 East and Southeast Asia

The East and Southeast Asia region provides a mix of social protection systems at different stages of development. Hong Kong, Japan, Singapore, South Korea and Taiwan all have advanced social protection systems. Social protection in these countries was at the heart of their development strategy during the period of post-war reconstruction and the high growth phase from the early 1960s to the late 1980s. Universal employment with retirement benefits, especially contributory pensions, universal education and universal health coverage were the three pillars of social protection in East Asia over the last three quarters of a century.

On the other hand, most countries of Southeast Asia did not begin to put in place social protection systems until after the turmoil witnessed during the Asian financial crisis of 1997–98. The fragility of economic growth and the ensuing social crisis in the region pointed to the need for a two-pronged strategy of inclusiveness and comprehensiveness as far as social protection systems were concerned.

In Thailand, the crisis led to political change in 2001. The new government made an election promise to start a '30 Baht' universal health-care scheme, which it implemented on gaining power. In spite of concerns that public expenditure on health would become unsustainable, the scheme has proved to be a success both politically and fiscally. In Indonesia, after the elections in 1999 that ended another phase in the transition from military rule, the new government extended unemployment benefits to both formal and informal sector workers. This was in response to the very high levels of unemployment triggered by the Asian financial crisis, which affected mostly informal sector workers. In 2012, the Philippines Parliament passed a law allowing contraception and promoting family planning to help manage the problem of very large families, especially among the poor. The government had to overcome strong opposition from the powerful Catholic Church but had unequivocal support from women's groups. Over the last decade, therefore, health care reform, employment generation and women's empowerment have become the focus for public policy in the more advanced Southeast Asian countries such as Indonesia, Malaysia, the Philippines and Thailand.

The other countries in the region fall under two categories: low income, low human development countries such as Cambodia, Laos and Myanmar, and the two 'transition economies' of China and Vietnam, which are the fastest growing economies in the region. Social protection systems in the first group of countries are virtually non-existent; the main mechanism is the family unit. However, these countries have suffered from significant political and social upheaval for the last 50 years, which has thwarted any effort at building a consensus on what a social protection system would look like. The state remains at best weak and at worst autocratic.

In contrast, China and Vietnam have both passed through a phase of reform since the late 1970s when the statist structures were dismantled and a market economy was embraced. This process also led to the demise of the state-led social protection system, which at one point guaranteed food, education, health care and social services for everyone. Privatisation of these basic needs has meant a steep rise in out-of-pocket expenditure, generating significant inequities within the society and across regions of the country.

The process of rapid urbanisation has compounded the issues faced by the two countries, especially China. There are nearly 145 million rural-to-urban migrants, the majority of whom were born after 1980. Migrants are getting increasingly younger, dropping out of school earlier and are motivated by considerations other than remittances to family left behind in the rural areas (Hu 2012). The traditional social

protection system of sons (and daughters) caring for their elderly parents is coming under pressure. The rising cost of private health care also means that migrants have to send back larger and larger sums of money to sustain their families in the villages, leaving them economically vulnerable. This is especially true of young women migrants who have the double burden of employment and care work.

In summary, the biggest challenge to East and Southeast Asia is to adapt their social protection systems for a rapidly aging population at a time when traditional systems of familial care are breaking down and rapid urbanisation is leading to an increase in rural-to-urban migration. The case study on South Korea's old age care reform in this volume (Section 4.2) shows that a rights-based, community driven and individual focused intervention is possible, which may hold lessons for other countries in the region. While the region has done well in universalising education and health care, it needs to do more in terms of the depth of its social protection framework in the future.

## 3.4 The Pacific

Access to customary land and marine resources, determined by social relationships and unwritten custom, is a key to social protection in the island nations of the Pacific. A significant portion of the island populations live in rural areas and rely heavily on natural resources for their livelihood, particularly in Melanesia where rural dwellers make up 80 per cent of the population (Government of New Zealand 2012). Melanesia holds 95 per cent of land in the Pacific excluding New Zealand and Australia. These resources provide food security, medicines, materials for shelter, a place for settlement, goods for building economic wealth and collateral (ESCAP 2012). Goods from the land and animals are also used as currency instead of money in parts of the Pacific. Access to land is the key for social protection. If large portions of these customary lands are leased to private holders, it affects food security and all subsistence activities for those who have previously relied on these natural resources. The dispossessed then squat in urban areas close to the capital.

Sixty-two per cent of all participants in the 2009 RAMSI People's Survey in Solomon Islands said they practiced subsistence cultivation or fishing and 26 per cent reported subsistence plus another activity that earned cash or wages. Twenty-one per cent of the participants did unpaid voluntary work in a church or NGO. Only 30 per cent had regular wage employment, and the majority of these were men. Twenty-five per cent said they had a bank account, and 25 per cent said there was a bank near their home. These last considerations are very important logistically when deciding whether or not social protection interventions should be cash transfers. Solomon Islands people perceived retired or aged people, the unemployed, young married couples, the disabled and school leavers as the most vulnerable groups. Some said traditional family and community safety nets were beginning to fail and there was growing resistance and loss of capacity to support those who cannot support themselves.

Social protection would embrace policies that create access to limited land supply for citizens marginalised by legislation, such as women in Tonga[7], non-indigenous people like Indo-Fijians who make up 36 per cent of Fiji's population (United States Department of State 2012), and settlers who may have been granted land rights under customary arrangements but later had their status challenged, resulting in conflict and displacement (Asian Development Bank 2012).

*Education:* Early childhood education is often run and funded by churches and communities. But although it is an important foundation for learning and socialisation, there is little knowledge of the status of this across the region. Primary education is not universal or free across the Pacific. In Papua New Guinea, where 70 per cent of the Pacific population live, it is estimated that only 63 per cent of eligible children are enrolled in primary school (Human Rights Watch 2012). At secondary school level there is concern that the traditional economy is underserved by mainstream education provision, yet there are few jobs in the non-traditional economy to accommodate job seekers. Supporting careers and industries in the traditional economy for youth and women could better support sustainable employment and development of Pacific economies (Anderson and Lee 2010).

*Income:* A huge proportion of the working age population in the region is unemployed or underemployed. Estimates of the population in Papua New Guinea found there were 220,000 registered employed and 1,000,000 unemployed or underemployed, with the potential for an annual addition of 150,700 to the labour force (Hughes and Sodhi 2007). In Fiji, there were 111,100 employed and 155,000 under/unemployed, with an annual addition of 20,000 seeking employment. Samoa was the only island nation that had a significant number of the population in paid employment: 50,300 as opposed to under/unemployed at 22,500 with an annual addition of 3,400 (Hughes and Sodhi 2007). Throughout the region, there is significant urban drift. The majority of these people will be engaged in informal activities rather than regular waged employment (Department of Labour 2012). Social protection mechanisms necessitate access to foreign employment markets and better alignment of tertiary education training to aid the transferability of qualifications.

*Health:* The geographical make-up of the Pacific island nations means that infrastructure remains a major hurdle to getting health services to recipients, with cost hurdles affecting location of provision, access, affordability, response times and quality of response. This affects everyone, from newborn babies to the elderly.

Senior citizens or elders have traditionally held positions of cultural and social status, with roles and ongoing responsibilities in Pacific families and communities. Thus, they remain active contributors in families and communities. Life expectancy varies widely in the region from 63.7 years to 78.7 years for females and 59.5 years to 73.3 years for males (ESCAP 2012). 'Old' does not correlate with retirement age, which varies between 50 and 65, meaning that some have less time than others to support themselves and their families through paid employment and to prepare for

retirement. Aside from financial/income insecurity, social protection mechanisms need to support quality of life and integrity through services. There are emerging concerns for the vulnerability of senior citizens in rural areas with non-communicable diseases, in particular diabetes.

A significant amount of social protection in the Pacific is paid for by remittances from overseas, primarily from Australia, New Zealand and the United States (ESCAP 2012). In 2008 it was measured at US$470 million, equal to around one third of overseas development assistance (ODA) allocated by those countries in that year. The remittance figure is also understated: money is frequently carried in person when traveling 'home'. In Tonga and Samoa, remittances far exceed ODA receipts: in Samoa in 2008 remittance flows were US$135 million and ODA was US$39.5 million; in Tonga the figures were US$99.5 million and US$27.5 million, respectively. This informal social protection is particularly noticeable when a significant population of a Pacific country has migrated. For Samoa, an estimated 67 per cent of the population lives abroad and for Tonga the figure is 45 per cent. The countries with a smaller percentage of their populations living abroad have very different remittance figures with a large gap between the value of remittances and that of their ODA. For instance Solomon Islands remittances in 2008 amounted to US$3.2 million against US$224 million ODA and respective figures for Vanuatu were US$7 million to US$91.7 million.

There is a need to strengthen civil society, particularly programmes resourced and managed by churches and community collectives. These are important, especially in rural and remote areas where state reach is limited, as these institutions are responsible for maintaining social order and protection as well as for supporting health and education provision and economic development. But churches and communities have had little effect on extremely high levels of violence against women and children.

*Gender-based violence:* Violence against women and children is a common human rights violation in the Pacific (UNIFEM 2010). VAW is at epidemic proportions in Papua New Guinea where rape, robbery and beating of women in markets are daily occurrences. Around 80 per cent of vendors at Papua New Guinea's markets are women (UNWomen 2012) so VAW impacts individuals and the economy. Bride price remains a factor in the perpetuation and tolerance of VAW in Melanesia. Children are harmed as witnesses and victims including children in utero, with significant numbers of pregnant women victimised. Violence to girls includes sexual exploitation under custom (to make amends between families, forced marriage and marriage before legal age) and abuse by family members. Exploitation and trafficking of children is also emerging around mining, forestry projects and ports.

The extent of community and police tolerance of violence against women and children is breath-taking. In 2013 programmes to increase women's literacy, knowledge of rights and legal literacy are being implemented in parts of the region as one avenue to lower women's victimisation, but political commitment to anything more than rhetoric has yet to be demonstrated.

*Loss of assets:* Traditions and a history of colonialism have perpetuated male dominance in the control of customary land, even in matrilineal communities. Over time women have been excluded from the management and control of their biggest collateral (Jalal 2010), particularly in negotiations with foreign companies. Some mining and forestry development deals have created social insecurity due to the loss of access to natural resources and contamination of water and land (Human Rights Watch 2012). Since women's access and rights to customary land is directly linked to their social relations with men, the economic security, health and overall safety of sexual minorities who do not have such relations may be at risk.

In Vanuatu traditional chiefs mediate on land issues, and food can be used as currency in accessing social services such as health (Regenvanu 2011). The dominant relationship here is that between the community and the individual, without any substantive involvement of the state. Collectives, mutual societies, trade unions, bartering, local exchange trading systems are examples. Some of these systems have shown resilience in times of economic crisis in advanced economies like Greece (Donadio 2011) and remain relevant in a market economy, offering a responsive mechanism to the global economic crisis.

However, it is not entirely clear if community-enforced norms would address underlying inequities of gender and marginalised groups. For example, in 2011 the WHO-based report on 'Women's Lives and Family Relationships'[8] reported that 60 per cent of women had been subjected to physical and/or sexual violence by husbands/partners in their lifetime, and for 90 per cent of these women the violence was severe. More than 1 in 4 women over the age of 15 years experienced physical violence by non-partners, 1 in 3 women experienced sexual abuse when they were under the age of 15 years and 2 in 5 women were forced into first sex. The study showed that acts of sexual violence caused injuries for many women (including loss of consciousness for 50%). One in 5 of those injured suffered permanent disability. Women coped by not telling anyone (2 in 5 women) and/or temporarily leaving home (almost half). The study reported less than 1 per cent of women left home permanently because of violence. Given the relationships between men, women and custom land, many have nowhere to go beyond squatting on the verge of the capital with their children, in a precarious existence and stigmatised by the locals.

In Melanesia up to 50 per cent of the urban population live in squatter or informal settlements. Here, women and girls become more vulnerable to increased sexual and domestic violence,[9] as well as entry to the sex industry to survive. The shortage of land for settlement in urban areas exacerbates existing inequities between men and women, ethnic clashes and efforts by governments to have customary land titled and leased.

The effects of climate change will lead to further loss of assets because so many people inhabit coastlines and live off the natural resources of the sea. There are also populations for whom complete resettlement in a new or foreign land is a reality due to rising sea levels.

## 3.5 The Caribbean

Most Caribbean countries only emerged as independent nations in the last half of the twentieth century. They carried with them a colonial legacy of deeply embedded social problems including high levels of inequality in incomes and of opportunity, including gender inequality, and high rates of unemployment and of rural and urban poverty (UNDP 2012).

The demands for social justice and equity of the post-independence social movements became part of the political mainstream and influenced the development priorities of governments in the region. A political consensus emerged on the need to focus on reducing the levels of poverty. Life expectancy increased in most of countries and infant mortality declined. Access to education, including secondary education, is nearly universal and there is much greater access to tertiary education (UNDP 2012).

However these impressive social indicators exist alongside high levels of poverty and continuing inequalities. Several countries in the region are experiencing high rates of crime, including gendered violence. This reflects the persistence of inequities of opportunity, income and access. Caribbean populations are young and in several countries most people now live in urban areas.

On the whole, tourism has replaced light industries, services and primary production as the source of income generation and job creation. Tourism accounts for 25 per cent of the foreign exchange earnings, 20 per cent of all jobs and between 25 and 35 per cent of the total economy of the Caribbean (UNDP 2012).

The regional consensus on social justice and poverty alleviation have given rise to strongly people-centred approaches to social policy. Social protection mechanisms, in particular social safety nets, are the main way by which governments have attempted to ensure that the poor did not fall deeper into poverty and that they could survive and recover from the natural disasters that afflict the region.

The main source of social protection in the region is governments. Historically, diverse measures have been used, including cash transfers, labour market programmes and in-kind transfers (see Table 3.1).

Table 3.1 shows how diverse and dense the social support systems are in the Caribbean. It also shows the extent of the commitment of governments to social protection. Governments in the Eastern Caribbean have funded up to 75 per cent of social protection initiatives. The examples in Table 3.1 also provide proof of their commitment to investing in children and youth with initiatives as diverse as scholarships, school feeding programmes, transportation allowances, book loan schemes and skills training programmes.

However, the diversity and number of initiatives has led to duplication, overlap and fractionalisation. Budget constraints have also led to limited coverage with schemes failing to reach the majority of the poor. Schemes are not well targeted and significant

**Table 3.1 Safety net programmes in selected Caribbean countries**

| *Transfer category* | *Country* | *Examples of transfer* |
|---|---|---|
| Cash transfer programmes | St Lucia | Public assistance programme |
| | St Kitts and Nevis | Compassionate grants, poor relief, disability grants, food vouchers, foster care allowance |
| | St Vincent and the Grenadines | Public assistance, elderly assistance and non-contributory age assistance pension |
| In-kind programmes | St Lucia | Student welfare assistance, school feeding programme, school transportation programme, roving caregivers, disaster assistance, burial assistance |
| | St Kitts and Nevis | Student Education and Learning Fund (SELF), school feeding programme, home repair, rental allowance, burial assistance, medical expenses |
| | St Vincent and the Grenadines | Book loan scheme, school feeding programme, roving caregivers, fee waivers for medical care, burial assistance |
| Labour market programmes | St Lucia | Holistic Opportunities for Personal Empowerment (HOPE), Belfund, job search assistance |
| | St Kitts and Nevis | Job search assistance, national skills programme |
| | St Vincent and the Grenadines | Youth empowerment service, road cleaning and road maintenance programmes, job search assistance |

**Source:** Ashwell and Norton 2011

social groups, such as the working poor, out-of-school youth and single parents, are often excluded, particularly for income support programmes (Ashwell and Norton 2011). There was a clear need to improve the design and implementation of social protection strategies and programmes.

In response to this need a pilot initiative, Puente (Bridge) in the Caribbean Programme, was introduced in June 2007 in three countries. The Puente is a South–South, technical co-operation capacity-building initiative. Its aim is to improve social protection strategies in the English-speaking Caribbean using the Chilean Puente Programme as a model. Since then Barbados, Jamaica, St Kitts and Nevis, St Lucia, St Vincent and the Grenadines, Suriname, and Trinidad and Tobago have received technical assistance from Chile, with support from the Organization of American States (OAS), in the development and implementation of local versions of the Puente programme.

The Puente in the Caribbean Programme is designed to improve the quality and coverage of social protection strategies. So, for example, in Jamaica the Bridge Jamaica initiative assists families to access basic services or benefits to which they would not normally have access. These services or benefits all relate to the seven supporting pillars of the bridge, namely, personal identification, health, education and training, family dynamics, housing conditions and disaster management, employment, and income.

The commitment of the families to the project and their resolve to improve their living conditions is critical to the success of the project as is the support they get to assist them to live up to their commitments. The creation of a Social Protection Network (SPN) is included in the design as a means of providing guarantees to the families to enable them to live with dignity.

The member organisations of the SPN are chosen based on their potential and ability to offer services that would fulfil the needs of beneficiary families in accordance with the pillars of the bridge. To this end, the members of the SPN facilitate preferential access to services for beneficiary families and seek to reduce costs where feasible.

Other initiatives in the region that incorporate relevant lessons of the Puente Programme are Koudemain Ste Lucie in St Lucia, Rights of Individuals to Social and Economic Security-Universal Prosperity (RISE-UP) programme in Trinidad and Tobago, Implementation Stabilisation Enablement and Empowerment (ISEE) Bridge Programme in Barbados and Livelihood Empowerment Against Poverty (LEAP) in St Vincent and the Grenadines.

The Puente in the Caribbean has been very effective in strengthening institutional and human capacity for more effective social protection strategies, particularly in terms of:

- targeting;
- inter-institutional collaboration in social protection and establishment of local social networks;
- family-oriented interventions; and
- increased knowledge of best practices in social protection among the ministries of social development, other public entities and civil society organisations in the seven countries.

The programme has created active learning communities that have shared implementation experiences, gained political endorsement of local programmes and developed a replicable model of a community of practice. This, in turn, has inspired the work of the Inter-American Social Protection Network, which was launched by the OAS in 2009 to exchange information on policies, experiences, programmes and best practices, with the goal of supporting national efforts in reducing social disparities, inequality and extreme poverty.

Informal forms of social protection, such as community and family care work (Waring et al. 2011), unpaid/voluntary communal labour practices, bonds of reciprocity and mutual support, gifting relationships and local exchange economies also contribute to people's survival strategies and well-being. Market transactions occur among households and the local fishing and farming sectors provide livelihood opportunities, employment and income. The growing phenomenon of insecure work, particularly short-term employment, places greater demand on these informal social safety nets, and the social relations and networks that underpin them, and forces greater mobility between various market and non-market opportunities.

As poverty and social and economic inequalities continue to rise in the region, the understanding of social protection will have to change, from merely social support schemes and safety nets to become an instrument to facilitate development and foster participation and citizen engagement. This was foreshadowed in the 2004 Regional Report on social protection and poverty reduction in the Caribbean (Barrientos 2004). This report argued that social protection programmes must be designed and implemented in ways that maximise its contribution to economic and social development. This, it argued, would require a fundamental shift from social assistance understood as remedial and residual help to the needy, towards integrated human development programmes.

More recently, the rising levels of crime and perceived insecurity have drawn attention to the social conditions that are linked to crime and violence, including gender violence. Social crime prevention will require ending marginalisation and inequality and more effectively integrating excluded sections of the population. A sense of belonging and of social efficacy will need to be strengthened (UNDP 2012).

Social protection then becomes an instrument to rethink redistribution, to address the root causes of poverty, to foster the expansion of opportunities and to create greater awareness of rights, entitlements and voice amongst citizens. Such a rethinking is transformative. It promotes human rights, strengthens human and ethical capital, and draws on the Caribbean tradition of people-centred development.

# Chapter 4

# Politics of Care and Isolation: Case Studies

## 4.1 Caring for children with disabilities in an advanced welfare state: Denmark

Denmark, an advanced welfare state, has a system of compensation for the disabled that is mainly administered by the commune or local government body. The Danish welfare model is anticipatory in recognising the unpaid carer's time poverty and having in place a system of assistance. However, the 2009 financial crisis and its aftermath have had a serious impact on time poverty.

Majbritt Nunnegaard Thomasen is a single mother and the primary carer of her 14-year-old son, who has cerebral palsy and multiple disabilities, and his twin sister who is doing well at school and in sports. Majbritt works as an accountant part-time. The children's father lives in the United Kingdom, pays child support and sees the children once a month.

This case study illustrates the differences in perceived needs and interpretation of social protection. These differences are evident when the state and the individual interact in the process of assessment of needs and the consequent dispensation of resources/benefits. The following interview with Majbritt Thomasen also illustrates how the right of an individual or carer to social protection is influenced by that person's ability to question and challenge policy, especially when cutbacks in social spending have had an impact on care budgets.

*How did the commune compensate you for your time and provide information on benefits?*

I work 18 hours a week and get compensated for the other 19 hours as the commune tops up my salary. When I was first granted salary from the commune because of my son's handicap, it was based at the level of my then salary when he was one-and-a-half years old. Since then that salary has been adjusted for inflation during the years, but not according to what I actually earn today. So I actually get less salary from the commune for the 19 hours than from the 18 hours I work as an accountant.

Since he was two-and-a-half years old, my son has been going to a relief home. A relief home frees up my time. He used to be with a family in private care for seven years; one weekend a month and one day per week. He is now at the school relief home; one day in the first week, two days for the second week, and for three days in the third week.

The commune provides salaries for the helpers who provide assistance with his special exercises. They pay for diapers and for the bibs used for his drooling; wear and tear of clothes is covered by a fixed amount every month as he uses up more clothes because of soiling them. Given that my son is wheelchair bound, a car is provided with insurance and the repairs are covered. I do not have to pay road tax and I am exempt from other special taxes on the car. Half the loan for the car is paid over six years without interest and the car can be changed once in six years. The house has also been fitted out for him. The commune pays the difference between my previous rent and the new mortgage since we could not stay in the rented house due to my son's handicap.

*How have cutbacks in benefits affected you and how have you coped?*

In 2011, the commune took away some of my work compensation and provided only for 14 hours instead of the 19 hours for my personal time and time for caring for my daughter. The commune also only provided payment for five hours a week as relief for my son's general care at home as opposed to the 17 hours they had covered earlier.

They used to pay for a cleaner but now they have removed that benefit because they maintain that the cleaning is not related to my son's handicap; that is, he does not have problems breathing and does not require special equipment such as oxygen. When they provided the benefit, it was seen as a compensation for my time.

They also took away costs such as for his bibs, car expenses (services and part of insurance) – they decided that their calculation was to be based on log use of the car for my son only, both direct and indirect. This cut into the needs of my daughter and myself.

I first opposed the commune in July 2011; I filed a complaint, which was to be reviewed in three weeks. They took longer and when they came back, it was still in dispute. We were required to go before the social court where hearings take up to a year because of backlogs. I complained in July 2011 and the decision finally arrived in February 2012 after intense pressure through local media and appeals. I won on all counts except for coverage of car tyre changes from summer to winter, to be paid retrospectively.

The judgment held that the assessment was done without considering the context and individual circumstances of the single mother, the family as a whole and my son's particular needs. This was the point on which the case was won. The court held that the 'legal certainty' for a citizen was in breach, as an individual assessment was not conducted.

The court asked the commune to make a new decision in four weeks. As the local newspaper coverage in the run up to court proceedings had kept the issue in the limelight, the commune reverted to previous arrangements and did not make any new assessment or raise new questions. Communes try to save budget through cutbacks and when the issue is under dispute awaiting hearing, they save money.

I have been made to feel that I am asking too much from the commune, but the law says that you will be compensated so you can lead a 'normal' life or near normal life. The commune said that as my daughter is old enough to look after herself, compensation for time caring for her is not required. But they are the same age and have very different needs. My daughter loves sports, she plays table tennis and football, and would have had to give it up and I would have had to work more hours.

The experience has taken a toll; I was on medication for stress but now have completely stopped. During the time of the dispute, when I was strapped for time and money because I had to pay the helpers and expenses from my savings, the stress was acute and the children were deeply affected. My son's school has said that now his well-being is better and my daughter is also happier.

*What is most helpful? Which of the forms of help eats into your time?*

Compensating for time is most helpful, especially having helpers for my son's special exercise sessions. Placing him at school over weekends and certain weekdays gives me time for my daughter and she is able to benefit from quality time.

However, I have to spend a lot of time on administrative requirements; salary slips have to be worked out for the helpers and I have to arrange time slots for the special exercises as I have to synchronise these timings with grocery runs, school meetings for my daughter and taking her for sports training and camps.

In terms of family vacations, although the commune pays for a helper's air ticket and food expenses and salary, the commune does not cover the helper's work over a weekend. I have to then juggle between looking after my son and spending time with my daughter. I also had to fight the commune to get expenses covered for the helper.

I do not have a normal life; more time and effort is required to do every day things like go shopping, so having more helpers to exercise or mind my son would free up my time. I've had to be creative about exercise arrangements to split the helpers' time-slots, so I can keep appointments at the hospital or attend meetings at my daughter's school. My employer's understanding has been critical; I have been lucky.

My life is all about care; I have lost my network of friends and hardly see my family. Much of my chosen social contact has been virtual.

## 4.2 Caring for the aged in a developed economy: South Korea

The Government of South Korea introduced the Long-Term Care Insurance (LTCI) scheme in August 2008 to deliver appropriate health care services to the rapidly aging population. South Korea was facing major increases in health care expenditure for the elderly. The purpose of LTCI is to preserve and improve the quality of life for senior citizens and their caregivers, and to promote better health and stable livelihoods while reducing the burden of care on family members.

The rapid aging of the South Korean population is a result of increased life expectancy and the sharp decline in fertility. According to the Report on the Population and Housing Census, in 2005 the fertility rate was below 1.1 and the proportion of elderly people is forecast to increase at an unprecedented rate (Statistics Korea 2007). Changes in the traditional family structure, increases in the labour participation of women, a limited ability to pay for the elderly and the financial burden of elderly care in health insurance systems all contributed to the introduction of LTCI in South Korea.

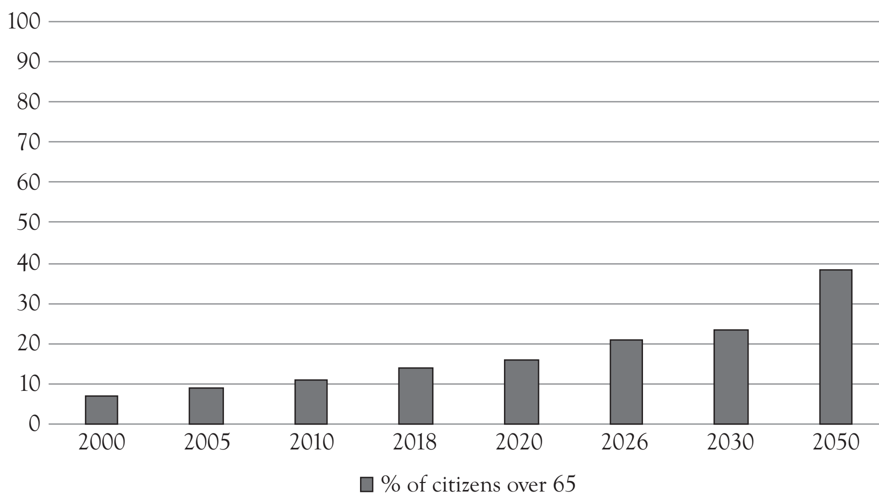
Figure 4.1 shows an estimate of the percentage of citizens over 65 to the year 2050, according to official predictions based on the population dynamics of fertility and mortality in 2010.

In response to this growing demand, the state moved to provide sufficient care facilities and support efforts to train more staff. This would ease the burden on families (including the elderly relatives) working in unpaid care work, so they were better able to participate in economic activity.

The choice was between the provision of services and the payment of a benefit to those in need to purchase the services. A countrywide response from women was that elderly men would spend the money on gambling, smoking, drinking and their social life, and women would still be expected to do the unpaid caring. The loud message women sent to the government was, 'We won't do it!'. The result was the introduction of the LTCI scheme.

Eligibility is dependent on certification. Local agents of National Health Care Insurance visit applicants (or their carers) and assess them according to two criteria defined by the LTCI law:

**Figure 4.1 Estimate of the percentage of citizens over 65, 2000–2050**




**Source:** Compiled by authors with information drawn from South Korean government sources

- Physical condition, which covers physical and mental functions and the nursing and rehabilitation care required.
- The degree of independence for the essential tasks of everyday living, which takes into account living conditions and environment.

The results of the assessment are used to calculate a standardised score to estimate the level of care needed. The maximum score is 100 and individuals must score 55 or over to be eligible for insured care. An assessment committee of 15 (including a chairman) consisting of doctors, nurses and experts in health and social care review the scores (taking into account the statement of the primary care physician and specific comments from the first assessment) then decide on the eligibility of the applicant. Based on individual needs, care is then (mainly) delivered in kind according to the client's wishes. The client has the freedom to choose a service provider.

Long-term care benefits consist of community-based home care, institutional care and cash benefits.

Home care, designed to help with activities of daily life, includes:

- bathing, toileting, dressing, cooking, cleaning, shopping;
- bathing services (a vehicle fitted out with a portable bath is used to provide this service at home);
- nurses to give care and treatments prescribed by physicians, oriental doctors or dentists;
- day and night care, including functional therapy and medical treatments;
- short-term respite care in a long-term care facility on occasions where the family member who looks after the elderly person is not available; and
- medical and orthopaedic equipment such as wheelchairs and orthopaedic mattresses.

Institutional care includes:

- care in long-term care facilities, licensed nursing homes, retirement homes and licensed residential establishments.

Cash benefits are used to:

- help with elderly people and their families who live in a remote region or island;
- assist those who need care but whose physical, mental or psychological condition makes them unsuitable for admission into long-term care facilities; and
- assist with costs where a non-registered service provider offers long-term care.

Before the introduction of LTCI health care spending, welfare expenditure and pension spending were rising rapidly. Since LTCI has been meeting the needs of the

elderly there has been a rise in LTCI spending. However, 'healthy aging' of the aging population has resulted in a decrease in health care spending and a decrease in hospitalisation for the elderly from 15.7 days to 11 days.

The increase in healthy elderly care means more elderly are remaining in the working population for longer and 95.8 per cent of families of the elderly have reported that LTCI insurance has helped them participate in economic activity, all of which benefits tax revenue.

In comparison with other sectors where employment levels decreased or remained stable because of the economic recession, in health and social work, under which LTCI industry falls, the workforce has increased by more than 190,000. In the field of technological innovation and manufacturing in elder care support, the workforce has increased by more than 40,000.

LTCI is an example of a social protection 'sweet spot', a partnership between the state, the private sector and the individual (Figure 1.4).

## 4.3 Community action in support of marginalised sex workers: India

In India, women sex workers are mainly portrayed and treated in public discourse and policy as vessels of moral hazard, vectors of disease and objects of pity. They rely on their communities to provide social protection, in a situation where economic and socio-cultural realities determine access to health information and services.

Sex workers have become the focus of research and health programmes since the beginning of the HIV pandemic. Despite this, the stigma associated with sex work and other barriers such as gender identity, including identity as the third gender, often prevent sex workers from organising themselves. However, the experience of women sex workers who formed a collective in 1996 and called it VAMP (Veshya AIDS Muqabla Parishad or Women in Prostitution Confront AIDS) demonstrates that efforts to mobilise and support members of the sex worker community can be successful.

VAMP offers a form of social protection that is mediated by the community in the absence of any state-provided social protection.

This form of social protection helps to combat harassment by authorities, offers support during bereavement and assists with childcare, education and health needs. Of significant importance is that it provides a support system during old age. VAMP's social protection model is anticipatory and transformative as members are able to provide support and care as needs arise through a community-based support system and the peer education in place helps towards women's empowerment.

Before the VAMP collective was formed, women sex workers could not do much about routine police harassment. Now, they are treated with more respect when they

approach police officers for help. In some cases, VAMP has successfully negotiated an end to police hostility and brothel raids. However, this does not mean that all VAMP members are able to confront and challenge police harassment. What has happened is that more women have become aware of their rights and recognise that they have the capacity to negotiate with others, including those in authority, to diffuse threatening situations. They are no longer in a position where they are willing to accept the dictates of others about how to act. They have the confidence to know what they want to do about problems and to decide on processes for conflict resolution.

In addition to peer educator programme and advocacy initiatives that are the basis of its identity formation, leadership development and mobilisation efforts, VAMP has expanded its work focus with an initiative directed towards helping the children of its members to cope with the stigma of their mothers' sex work. Having a mother who is also a sex worker brings with it more than its share of stigma and marginalisation. VAMP members felt that the children needed a safe space to explore and strengthen their ability to deal with the mainstream attitude towards them. The Supplementary Education for Kids intervention has established classes for the children as an entry point to teach them core life-skills. The children examine their identity and explore ways to reclaim spaces for respect given the type of work and lives that their mothers lead.

VAMP asserts that violence – social, emotional, psychological, legal and economic – is more acute for women and third gender members in sex work. They are often denied health care treatment. Being labelled vectors of HIV, blamed for the violence inflicted upon them and living under the constant threat of violence damages self-esteem and results in poor health-seeking behaviours and exposure to health risks. VAMP works by helping sex workers tackle violence in order to reduce vulnerability to HIV. VAMP's peer activists have become the de facto families and caregivers of women who fall ill. They assist women to go to the hospital, organise food for them, look after children and even ill lovers in their absence, and support them through painful moments.

The care of sex workers living with HIV is part of the peer activist portfolio. VAMP has a system where two women from the community are assigned day and night duties, rotating as care workers for women admitted into the civil hospital. They carry food for the patient, wash clothes and boil and cool drinking water. The community also cares for the children of sex workers living with HIV when they are hospitalised. This includes sending the children to school and caring for them both physically and emotionally.

Making funeral arrangements for those sex workers who have died from HIV-related symptoms involves liaising with relatives who sometimes perform the last rites. Where women are left with no one to do their last rites, VAMP arranges for a community funeral through individual contributions from women in sex work.

## 4.4 Community action for dignity and rights: India

Clothing is one of the basic needs to which every human being is entitled. In a conservative country such as India lack of appropriate clothing leads to shame, humiliation and discrimination, especially for poor women. The ability to lead a life of dignity is one of the basic freedoms that every individual should enjoy, failing which their capability to take part in the life of the community is jeopardised.

Goonj is a non-government organisation established in 1999 in India to bridge the clothing divide between rich neighbourhoods and adjoining poor slums, and between thriving urban centres and rural areas where the majority of the poor people live. Goonj organises the collection of old items of clothing as well as cotton cloth, like bedspreads and towels. With the help of paid staff and volunteers, these items are sorted, labelled and sent to remote villages most in need of extra supplies of clothing, as per the expressed needs of the recipients. This is different from the usual approach to charitable distribution, which does not take into account the needs of the people being served, considering them to be passive receivers rather than individuals and communities with a right to request clothing according to their needs.

Goonj performs a particularly important service for the millions of poor women in India who do not have access to sanitary napkins. This crucial need must be viewed in the context of existing cultural taboos whereby women are required to stay indoors and are not allowed to touch food items or enter temples during menses. There are health implications for women who cannot access sanitary towels; they generally use rags and even ash as absorbents, leading to severe vaginal tract infections. Adolescent girls are not allowed to go to school during their menstrual period, which has educational as well as psychological impacts. Before Goonj, however, there were no social protection measures in place to fill this basic need and address the multiple violations of human rights.

Goonj converts donated old cotton cloth into sanitary napkins using a strict quality controlled but replicable process. It runs campaigns among urban residents who are likely to have spare items of cloth or clothing, sensitises them on the issues facing poor women, produces and distributes the sanitary napkins in villages and urban slums accompanied by information campaigns on health and hygiene aspects of menstruation, and encourages partnerships between NGOs and community groups to undertake similar activities in their own area of operation. This activity builds trust between the community and poor women, which ultimately helps them to lead a dignified life. In our anticipatory framework, Goonj would occupy the space where social protection is mediated through a collective action – communities providing social protection through promotion of women’s reproductive health rights, as well as ensuring that inadequate clothing and hygiene products do not lead to indignity and social ostracism.

## 4.5 HIV care and access to land, the GROOTS Model: Kenya[10]

GROOTS Kenya is a national network of 2,500 grassroots women's self-help groups, which began organising a home-based care alliance for HIV-affected families in 2003. Working from the bottom up, GROOTS Kenya creates greater co-ordination and peer learning to enable carers to advocate for recognition of their work, greater integration into formal health responses to HIV and strengthened livelihoods. Self-help, savings and credit, revolving loan and income generating initiatives have been established to help caregivers make a living. Caregivers have also spearheaded the creation of community land watchdog groups – partnerships between community members and government officials – to prevent and redress land grabbing from widows and orphans.

GROOTS Kenya views access to land as a critical form of social protection, in addition to routine policy mechanisms such as school grants to reintegrate orphaned children back to school, food rations and cash to buy basic commodities for survival, and provision of shelters. Land and inheritance matter for widows and orphans as land is not only a productive asset, but also a source of identity that promotes their dignity. GROOTS found that the HIV pandemic often results in disinheritance and asset stripping among widows and orphans as the extended family seeks control of land and property by invoking customary practices. These practices emphasise inheritance through males and tend to exclude women and children from decision-making and land ownership.

In Kenya, only 5 per cent of registered land is in the hands of women, yet women contribute up to 80 per cent of agricultural labour. The majority of poor women are only able to access or control significantly small portions of land, in both rural and urban areas, which tend to be less fertile and are often seen as insecure. Through an elaborate community organising model, access and control over land has proved to be an important 'buffer' in protecting the livelihoods and dignity of many widows and the inheritance rights of orphans.

The following testimonies from GROOTS attest to the transformational nature of community organised social protection:

> 'When R's husband was bedridden, his relatives shunned her house. She was weak too with only an unpaid home-based carer to provide assistance. When R's husband died, the family appointed his brother to 'administer' her husband's three acre sugarcane farm while R was given access and control to a half acre piece to cultivate vegetables and subsistence food crops. The community land watchdog group assisted R to process the death certificate and gain legal administration of her late husband's properties, including the entire three acres and a rental house that the husband co-owned with his sister, of which R was not previously aware. She now has enough money to feed her family and educate her five children through university.

> P's mother, a former clinical officer, and his father, a civil servant, died of AIDS-related symptoms in 2000 and 2002, respectively. The family took control of all the properties and P and his siblings were assigned to different relatives. At the age of 15, P and his younger sister moved to the slums after being thrown out by the uncle's family. A home-based carer collected food rations from the community clinic, negotiated a school bursary and helped to reintegrate them into a slum school. P later got married and had two children. He now relies on casual labour and the home-based carer for guidance and basic survival. Members of the community land watchdog group traced down P's uncles and, through negotiations, he and his siblings have regained two commercial vehicles and eight acres of cash crops. They have appointed a manager for the properties and no longer require support with basic livelihood needs, shelter and education.'

The community land watchdog groups engage with all stakeholders and advocate for responsible actions to protect the most vulnerable. Members of the community land watchdog groups were actively involved in the writing of the 2010 constitution and the national land policy. They have sought to transform governance in land boards and provincial administrations through lobbying for membership. In 2007, there was only one woman among 24 provincial administrators; by 2011, there were nine women provincial administrators, five of whom are former members of the community land watchdog group with in-depth knowledge of legal issues and community problems. Some of the women provincial administrators are also champions for transformative leadership.

At the community level, the land watchdog groups have created surveillance groups that identify, report and address potential dispossession cases.

GROOTS's efforts on information sharing and support for care giving have enabled carers to increase their effectiveness, link the government to NGOs, eliminate duplication and fund the people most in need in their communities. One important evaluation finding has been that because of GROOTS's organising and community mobilisation efforts, when new programmes and resources come into communities, they can be of immediate benefit to the community because they can build on and invest in what has already been prioritised.

## 4.6 A revived land tradition protects HIV-affected children: Swaziland

Swaziland reported the first case of HIV in 1986. The pandemic spread rapidly leaving in its wake social inequities, poverty and unemployment, increased morbidity and mortality rates and a rise in the number of OVC. Realising the impact of the pandemic on government resources, the Swaziland National Emergency Response Council on HIV (NERCHA) Secretariat had to think outside the box, be innovative and draw on traditions and culture that could be revived to protect the rights of children.

Community Leaders (Chiefs) were invited to get involved in the care of orphans and needy children, in keeping with the tradition that destitute people could find protection at the Chief's kraal. It was also traditional for the Chiefs to secure the land of deceased members of a community until the children of the deceased were old enough to use it. Some of the positive traditional structures had been eroded over time because of social dynamics.

The *Indlunkhulu* or 'traditional chiefs' fields for OVC initiative, began in 2004 as a programme of NERCHA and is an example of community-based social protection. The initiative sought to revive a tradition where chiefs set aside fields in order to provide for destitute members of their communities or those unable to cultivate fields for themselves because of illness, accident or old age. The tradition was found to offer a long-term solution to food security for OVC. By 2007, 360 of the 369 Swazi Chiefdoms were participating in the *Indlunkhulu* programme.

Following the willingness of the chiefs to take action in their communities, chiefdom committees responsible for HIV and OVC, were set up. They were mandated to:

- Establish food security programmes for OVC in their communities – through cultivation of *Indlunkhulu* fields (community fields), which are fields under the authority of the chief. The fields provide food to any member of the community in need. This is one of the oldest traditions that earned respect for the chiefs because of the paternal roles they played among the people they led.
- Appoint responsible women in each community to serve as caretakers – *Lihlombe lokukhalela* (shoulder to cry on) – of child-headed households and keep the chiefdom committees updated on the state of these households. This system of support is also a traditional practice, wherein neighbours cared for each other; if there were a sick person in the community, it would be every neighbour's duty to visit the family and assist where necessary without payment.

Between 2003 and 2004, the Chiefs made land available for the construction of Kagogo Centres in almost all chiefdom kraals in the country. A total of 325 were built, 37 of which are in peri-urban areas and managed by city councils. The centres are used to serve meals, as play schools for young children and as offices where records of OVC are kept (each centre has a clerk). In addition to the Kagogo Centres, communities, municipalities, and private sector and religious groups assisted in the construction of neighbourhood care points (NCP) in most communities, where children staying too far from the Chief's kraal are able to have at least one meal a day. Mapping of these NCPs has been done and the number now stands at 1,550, evenly distributed throughout the country, which accommodate 40 to 100 children.

The committees also compile lists of beneficiaries in each community and are responsible for the allocation of inputs like tractor services or seeds between beneficiaries. The criteria for beneficiaries are fairly broad in scope to allow for local interpretation, and causes of OVC vulnerability such as disability may be overlooked.

Complementing the *Indlunkhulu* initiative is a programme funded by the Japanese International Co-operation Agency which allocates 0.5 hectare plots in 320 chiefdoms to be farmed individually by child-headed households. The programme recognises the erosion of social cohesion caused by the loss of customary land entitlement of children who have become orphans and the farms have been set up to redress this.

The women carers, or *Lihlombe lokukhalela*, have been hailed as the backbone of the programme, but the additional responsibility of supporting the young and the aged with feeding and home-based care, leaves them time poor. Moreover they are resource poor, as they often have to overstretch their family budgets to look after OVC. In many cases, the *Lihlombe lokukhalela* lack adequate information on sexual and reproductive health issues to counsel adolescents. OVC and girls in particular, are very vulnerable to older predatory males, with rape and harassment a common problem.

The Centre for Social Protection, UK, asserts that HIV has shifted the realities of care for children in Africa, boosting social protection, and other shifts are taking place including:

- the strain on traditional support structures and the ageing and deaths of grandparents, which place new challenges on protection and care for children;
- rapid urbanisation, which is changing the location as well as options for care and the 'face' of marginalisation and risk for children; and
- changes in information and communication technology may lead to fundamental changes in children's risks and opportunities as well as for new modes of programme design and delivery.

Anticipatory social protection systems need to engage with these changing realities in determining options for transformative policies and strategies.

## 4.7 Building peace through anticipatory and transformative social protection: Rwanda

> *The genocide took place when I was too young. Until today, I didn't know its extent. I had a lot of questions. This gave me some answers. It's not easy to say, 'This happened in our country,' but it's important we learn from it.* – Jean-Claude Rikorimana, 21, student, after participating in the 'Learning from the Past, Building for the Future' course.

In 1994, over the course of 100 days an estimated one million men, women and children (20% of the population) were killed in the Rwandan genocide.

The genocide was the result of longstanding tension and ethnic rivalry between the minority Tutsi, who had controlled Rwanda for centuries, and Hutu who came into power during the rebellions of 1959–1962.

In 1990, a rebel group consisting mostly of Tutsi refugees attempted to defeat the Hutu-led government of Juvenal Habyarimana. Civil war broke out and ethnic tensions heightened. Many Hutu (meaning 'servant' or 'subject') believed that the Tutsi (meaning 'rich in cattle') intended to enslave them.

International pressure on the government resulted in a ceasefire in 1993. However, the assassination of Habyarimana in April 1994 set off a violent reaction. Hutu groups conducted mass killings of Tutsi and pro-peace Hutu, who were labelled as traitors and collaborators. The murderers used machetes, clubs, guns and any blunt tool they could find to inflict as much pain on their victims as possible. Women were beaten, raped, humiliated, abused and murdered, often in the sight of their own families. Children were forced to watch as their parents were tortured, beaten and killed, before their own lives were brutally taken. The elderly, the pride of Rwandan society, were despised and killed without mercy. Neighbours turned on neighbours, friends on friends, and even family on their own family members. Eighty-five per cent of the Tutsi population in Rwanda were murdered.

The Rwandan Peace Building programme, 'Learning from the Past, Building the Future' is designed for those born after the genocide or who were young at the time. It is an example of transformative, rights-based and anticipatory social protection in action.

The programme was launched in 2004 at the unveiling of the Kigali Peace Memorial. Both the peace-building programme and the memorial have resulted from a partnership between the Aegis Trust and Rwanda's Ministry of Education. Aegis (meaning 'shield' or 'protection') is a registered public charity in the UK and US and a registered NGO in Rwanda, which campaigns against crimes against humanity and genocide.

The peace building programme acknowledges that youth all have different stories in their past and they are not responsible for that past, but they do have a common future and they are responsible for their decisions in that future. Educators teach that hatred and violence can lead to mass violence, and why peace and reconciliation is vital for the future, both personally and nationally. Survivors of the genocide are trained as guides at the centre and work hand in hand with the educators.

The programme also acknowledges and explores current conflicts in the lives of young people because of ethnicity. For example, in school children supported by the Genocide Survivors Support and Assistance Fund have had their notebooks thrown in the toilets; genocide orphans are considered inferior because they cannot afford school fees or decent clothes; the children of parents who are in prison are called *Interahamwe* (name of the Hutu militants that participated in the genocide).

It is evident that children not born during the genocide are subject to bullying from other children who adopt their parents' ethnic prejudice.

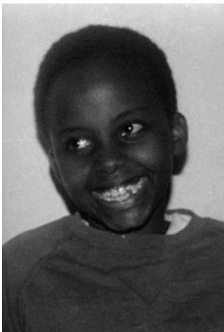
At the 'Learning from the Past' centre, students spend the mornings revising their country's history and learning to develop empathy, leadership skills and critical thinking using role-play, storytelling, problem solving and discussions. In the afternoons students visit the memorial exhibits, walking through rooms filled with victims' clothes, photographs, skulls and bones stacked behind glass. Pictures of smiling children are accompanied with notes that depicting their name, age, favourite things and how they died (Box 4.1).

Sixty per cent of the Rwandan population is under the age of 24 and so far 11,000 students have attended the course. Minerva Research and Media Services report a dramatic popular impact after a detailed analysis of the programme. After attending the course there was a greater empathy for other ethnic students and people in need, materials for the poor survivors and anti-genocide groups were established.

Today Rwandans are urged to leave their ethnic diversity behind. They are encouraged to think of themselves simply as 'Rwandan' and ID cards no longer list tribes.

**Box 4.1 Facing the reality of the genocide**

Students attending the 'Learning from the Past' memorial exhibition are confronted with pictures of smiling children with personal details of their lives and how they died.



Francine Murengezi Ingabire

Age: 12

Favourite sport: Swimming

Favourite food: Eggs and chips

Favourite drink: Milk and Fanta tropical

Best friend: Her elder sister Claudette

Cause of death: Hacked by machete

**Source:** www.kigalimemorialcentre.org/old/centre/childrens.html

## 4.8 An endowment fund protects education of HIV-affected children: Papua New Guinea

There are more women than men living with HIV in Papua New Guinea. Almost all people living with HIV, most of whom are parents, struggle to survive socially as well as economically. This is particularly true for HIV-infected women. Indifference is

endemic. It is a daily struggle to provide their children with the necessary care and protection to which they have a right.

Children with HIV-infected parents feel the impacts long before the parents die or disappear. These children are more likely to fall behind in grade level and on payment of their school fees. Under the strain of living with HIV, affected families become distressed, unstable and dysfunctional. Children whose parents have died may be in the care of other family members or in informal fostering arrangements. Sometimes these are caring arrangements; too often they are exploitative of children's labour and their bodies. Others are abandoned, living under houses, on the streets, on the edges of villages.

The Serendipity Education Endowment Fund (SEEF) seeks to mitigate the negative impacts of the HIV epidemic on children's education and well-being in the absence of attention to HIV-affected children in the national and local responses. The strategy is to help those from the poorest families to complete their education and to ensure that girl children are also educated so that they and their families might, over time, be able to move out of the cycles of poverty and social marginalisation (Checchi and Salvi 2010; Sabates-Wheeler and Roelen 2011).

### 4.8.1 Background and structure

SEEF was started with a gift to the Asia and Pacific Business Coalition on AIDS (APBCA) from the Italian tenor, Andrea Bocelli, after his 2008 tour of Australia. He asked that it be used to fund an HIV project in Papua New Guinea. APBCA joined forces with the Papua New Guinea Business Coalition Against HIV and Aids (BAHA PNG) and in 2009, after consultation, they set up SEEF.

SEEF is an autonomous fund governed by a small Board of Trustees, one of whom is responsible for the management of the programme. It works in partnership with organisations providing care, support and treatment to people living with HIV to enable these organisations to provide educational support alongside HIV treatment, counselling and care.

It was decided that SEEF would reach out to HIV-affected children through their parents and carers. Traditionally, programmes designed to meet the needs of children affected by HIV targeted individual children rather than working with children in their family settings (International HIV/AIDS Alliance with Save the Children UK 2012). However, there is evidence that children cared for in families develop better cognitively, physically, educationally and socially (International HIV/AIDS Alliance with Save the Children UK 2012; JLICA 2008a, 2008b).

It was anticipated that SEEF could also assist in strengthening the HIV care work of its organisational partners by helping them work with families affected by HIV. Traditionally HIV counselling, support and treatment organisations work with

HIV-infected individuals (International HIV/AIDS Alliance with Save the Children UK 2012). By giving partners the capacity to assist with children's educational needs, SEEF could help these organisations see their patients and clients as socially inter-connected, as parents and carers of children, as well as individuals living with HIV.

SEEF puts the rights of the children at the centre of the programme. It honours their right to education and an equal chance to grow up to be responsible and useful, but also to develop physically and spiritually in a healthy and normal way, free and with dignity (UNGA 1990). It pays particular attention to ensure that girl children can access these rights alongside their brothers.

By 2010, SEEF was working with five partner organisations across the country – three in the Highlands, one in Western Province and one in Port Moresby – to support 106 children – 57 boys and 49 girls – in 43 families. By 2011, it had eight partners, adding one in the Highlands, another in Port Moresby and one in Lae, and was working with 185 children in 84 families – 109 boys and 76 girls.[11] By working through HIV care and support programmes, SEEF has been able to reach marginalised children – those of abandoned women, of widows, of sex workers, of *sista girls* and men who have sex with men, of landless settlers, the homeless and more.

The selection of partners is critical to the success of the programme. Partners must have the trust and respect of the people living with HIV that they work with and must 'work from the heart'. Clear roles and responsibilities are delineated between SEEF and the partners and between the partners and the SEEF families.

Partners select SEEF families according to principles laid out in the SEEF guidelines. Participants have to be HIV-infected or caring for children whose parents have died of HIV, experiencing financial hardship, prepared to contribute towards their children's education and willing to educate their girl children. People living with HIV who work as HIV volunteers are particularly welcomed. In SEEF, the term 'family' is used to describe HIV-affected children and the person or persons who care for them. Where a child does not have parents or carers, the partner organisation has taken on the carer role.

Once a family enters the programme, all children in the family are eligible for SEEF support and the support lasts for as long as they want to and can continue their education, including after the death of their parents. SEEF supports primary, secondary, technical and tertiary education. Because so many of the children have lived and are living with trauma and pain, consistent attendance at school, rather than academic performance, is the determinant of continuing support.

SEEF supports education-related costs. Fees are paid direct to educational institutions; partners or retailers supply uniforms, books, stationary and such like where needed. SEEF supplements contributions made by the families, in cash, kind or labour, towards the costs of the children's education. SEEF also supports partners to hold

meetings or celebrations to bring together its SEEF families to create and strengthen networks of friendship and support amongst the children and amongst their parents and carers.

### 4.8.2 Bringing hope to HIV-affected children, families

The outcomes of the programme have been impressive. Partners report that SEEF has helped them move from providing services to individuals to providing care and support to families, and to integrate health, education and social support for children and their families.

SEEF brings hope to HIV-infected parents and to the carers of HIV-affected children. It lightens the burden of parenting, lessens feelings of inadequacy or failure and gives parents a sense that they can provide a future for their children. As they become more engaged in the children's schooling, their desire to stay alive and well so that they can see their children through their education is increased. Their health and well-being improves as does their health-seeking behaviour and treatment adherence.

SEEF helps parents and carers keep their families together, or re-assemble them, and to care for the children within their families. By working with the social structures within which HIV-affected children live, SEEF reduces stresses within families and lessens the likelihood of child abuse, exploitation and neglect.

SEEF helps the children feel valued and socially visible. The children find themselves in networks of concern and support and are being given the chance to continue their education. They feel better when their parents are healthy and are taking an interest in them and their schooling. They attend school diligently, appreciative of being there. Most of them are doing well academically. SEEF's policy of including the carers' children in situations of need, removes the likelihood of resentment and can result in better care and greater social justice.

The true value of SEEF is in giving children a sense of belonging, in their families and socially, and in lifting the bleakness of their previous lives. SEEF is anchoring them in the present and future, preventing them from disappearing into invisible spaces. It offers them hope, a scarce commodity in many of their lives, so that they can dream of a future.

### 4.8.3 Limitations

As a social protection and development measure, SEEF has some limitations:

- It is not government led, neither nationally nor locally. Instead it links with civil society and the private sector and, through these partners, has weak ties with government agencies and other service providers.

- It does not address questions relating to the quality of the education received or the competencies and motivation of the teachers.
- It reaches only families attending the centres and programmes of its partners, although it is also bringing people into these programmes.
- It is small scale.

In 2012, the Government of Papua New Guinea introduced a free education policy and despite innumerable obstacles implementation is proceeding. Although tuition in government-funded primary and secondary schools is now free, parents still have to contribute to school development funds, purchase school uniforms and materials and meet other education-related costs. SEEF families live in poverty and distress and, even with the free education policy, struggle or fail to meet these costs. This is documented elsewhere in similar circumstances (Kidman et al. 2012). The free education policy does not include technical or tertiary education fees, which are high.

### 4.8.4 The HIV-protective effect

The value of SEEF also lies in its HIV-protective effect, that is, in the lessening of the likelihood that the children it works with will become HIV-infected. Experience across the world has shown that the simple fact of going to school offers a strong measure of protection against HIV and that each additional year of schooling brings additional protective benefits, in particular for girls (Jukes et al. 2008; Kelly 2006; Global Campaign for Education 2004; World Bank 2002). In addition, where the education system includes HIV-related content, this protective effect is greater (IATT 2008; Kirby et al. 2006; Kirby et al. 2005). SEEF's partners actively seek to help the children remain uninfected.

### 4.8.5 Anticipatory, transformative and energising

SEEF is an anticipatory social protection initiative. It starts when parents come into HIV care, before children become HIV orphans. It anticipates and helps reduce the impact of HIV illness and dying on children. It helps extend the life of the parents so that they can care for their children. It anticipates and aims to pre-empt the withdrawal of children from education.

SEEF is also a transformative social protection initiative. It is gender sensitive and child sensitive (Sabates-Wheeler and Roelen 2011; DFID et al. 2009). It addresses the underlying social structures that give rise to social vulnerabilities (Commonwealth Secretariat 2012). It harnesses the transformative potential of education and the transformative power of hope (*The Economist* 2012b).

SEEF energises those involved. It creates a sense of agency. It is conceptualised and delivered in respectful and empowering ways. It strengthens social solidarity and

embodies the principles of gender equity and social justice (Reid et al. 2012). It is transformative, of its families, its partners and its Trustees.

## 4.9 Social protection models: New Zealand and India

### 4.9.1 Crown Corporation accident compensation, New Zealand

The Accident Compensation Corporation (ACC) is a New Zealand crown entity that is responsible for administering the Accident Compensation Act 2001. ACC is the sole and compulsory provider of accident insurance for all work and non-work related injuries in the country.

The Act provides financial compensation and support to New Zealand citizens, residents and temporary visitors who have suffered personal injuries in New Zealand. New Zealanders returning from overseas with an injury are also included, as long as they are permanent residents and have been away for six months or less.

The scheme is administered on a no-fault basis, so all who meet these criteria are eligible for coverage regardless of the manner in which they were injured. Coverage includes the cost of medical treatment (short-term and long-term), home and vehicle modifications for the seriously injured, and compensation for loss of earnings (paid at 80% of the person's pre-injury earnings).

ACC is funded by a combination of levies on people's earnings, business payrolls, petrol taxes, fees from motor vehicle licensing and government funding.

When calculating how much money to collect through levies, ACC balances the likely cost of claims against the need. This keeps the levies fair and stable. This money is then distributed into one of five accounts. Each account covers a specific group of injuries and is funded differently.

The five ACC accounts are as follows:

*Work Account*

Covers claims for all work related injuries. The work account is based on payroll or liable earnings. The level of risk and the cost of injuries associated with individual industries are also taken into account.

*Earners Account*

Covers claims for people in paid employment who are injured outside of work (for example, in sporting activities or in the home) but does not include motor vehicle injuries. Everyone in the paid workforce pays levies into this account. For employees, this is deducted from gross pay. The self-employed are invoiced.

*Non-Earners Account*

Covers claims for injuries to people outside the workforce, such as students, beneficiaries, retirees and children but does not include motor vehicle injury. The New Zealand Government funds this account using money from general taxation.

*Motor Vehicle Account*

Covers claims to all injuries involving motor vehicles on public roads in New Zealand. This is funded by a levy included in the price of petrol and motor licensing fees.

*Treatment Injury Account*

Covers claims for treatment injuries (injuries connected with the medical treatment received). Funds for this account are drawn from the Earner Account or the Non-Earner Account, depending on whether the patient is in paid employment or not. The scheme is certainly anticipatory and is focused on rehabilitation back to paid employment for those injured.

### 4.9.2 Private sector distributes free milk to New Zealand's primary schools

Up until 1967, the Government of New Zealand supplied milk, free of charge, to every student in New Zealand schools. In 2012, New Zealand's largest company, Fonterra, began a nationwide programme to re-introduce the scheme. Fonterra is a multinational dairy co-operative owned by 10,600 New Zealand farmers and responsible for 30 per cent of the world's dairy consumption

By February 2013, 58 per cent of all New Zealand primary schools had started receiving free milk or had registered interest in joining Fonterra's free-milk-in-schools scheme.

The scheme involves distribution of one free 180 ml carton of Anchor Lite milk to every school child in years 1–6 (ages 5–11). All schools, regardless of wealth, public or private, are invited to join. Early registrations covered 45 per cent of children in the 10 richest schools and 66 per cent in the 10 poorest. Dairy farming regions of New Zealand have signed up in the greatest numbers and in Auckland, New Zealand's largest city, the least.

It has been observed that since being introduced in schools, teachers and principals alike have reported improvements in children's overall physical health. As their diets have shifted, from more milk to less sugary drinks, there have been fewer trips to the dentist. In addition, attendance has risen, the children are more focused and there has been overall behavioural improvement. Kaitaia Primary School principal, Brendon Morrissey commented, 'You notice little things, like the colour of the kids' eyes, the state of their fingernails, the condition of their hair. They are little things but they make the world of difference to the kids' self-esteem. If the kids' self-esteem is in the right place they are far more receptive to learning.'

Patricia Andersen, a school teacher from Ngatoki Primary, a low decile school in the upper north island, noted that sometimes the children drink up to five cartons a day. Welfare rolls in New Zealand have jumped to 12 per cent of the population, with those beneficiaries caring for 22 per cent of New Zealand's children. Households that said they could 'afford to eat properly' only 'sometimes' or 'never', rose from 14 per cent in 1997 to 20 per cent in 2009. Milk in New Zealand supermarkets is priced at NZ$4.15 for 2 litres (March 2013), compared with NZ$3.67 for 2.25 litres of Coca-Cola. The community of Ngatoki Primary School acknowledges that the free milk provides essential nutrition to the children.

After a pilot project, Fonterra reduced the size of the carton from 250ml to 180ml, and the big fridges that the company originally supplied to schools were found to be using too much power and are being replaced with smaller ones. Each school also received a recycling bin, which is collected daily. Thus far the scheme has created 20 new jobs at the Fonterra processing plant, with the possibility of more as the scheme rolls out to the whole country by the end of 2014. The approximate cost to Fonterra is NZ$10–20 million per year.

### 4.9.3 Programme design for financial inclusion in India

The NREGS being implemented in India is the largest public employment scheme in the world. Over 126 million households have been enrolled into the scheme, which entitles them to 100 days of employment in a year. In the 2012/13 financial year, nearly 49 million households demanded their entitlement and 47 million were provided employment.

Learning from the implementation experiences of previous public employment schemes, NREGS has sought to institutionalise two elements:

- Tackling the issue of transparency and accountability through social audits. A social audit ensures that malpractices (such as inclusion of false names in the beneficiary list, non-existent worksites, unfair determination of work performed and calculation of wages to be paid) are brought before the general public for discussion.
- Encourages financial inclusion by opening bank or post office accounts for the beneficiaries. The final wages are paid directly to the bank account of the beneficiary – male and female separately – through the financial inclusion initiative.

#### *Challenges*

There are several challenges to the financial inclusion approach. The major constraints identified are the inadequate coverage of financial institutions, especially banks, and the difficulties for beneficiaries to negotiate the transactions in the banking system due to lack of literacy and numeracy skills. The latter is critical since moving from cash

payments to direct benefit transfer through bank accounts is dependent on empowering the beneficiaries to obtain their entitlements correctly and efficiently. Having them depend on others for accessing their entitlements makes them vulnerable to malpractices. This is especially true for poor women who make up over half of the NREGS beneficiaries.

### *Helping women to take charge of their lives*

Field studies, however, have shown that despite these challenges, nearly 80 per cent of beneficiaries prefer receiving their wages through bank or post office accounts than in the form of cash. The popularity of bank transfers was even higher for women. The main reason cited was that wage payment through individual bank accounts enabled them to have control over their own income for the first time. This income is spent primarily on paying off small debts and children's education, and part of it is saved for future exigencies, especially medical costs. The anticipatory nature of financial inclusion under NREGS lies in the fact that it affords women the choice to use their own earnings in ways that they deem appropriate, especially in their ability to invest in the future. It is therefore a tool for a sustainable empowerment of women and their ability to take charge of their own lives.

# Chapter 5

# The Carer's Journey

*Starting with memories of her own caring experience over 30 years ago, Elizabeth looks at the Australian Government's recent responses to the voices of carers and their organisations.*

## 5.1 Elizabeth's voice, 1993[12]

Bill was my companion, colleague, lover and husband. For most of our life together, we lived and worked in Africa. Our son John-William, was born when we lived in Kinshasa, Democratic Republic of the Congo. The respect and trust we shared for each other, the fineness of Bill's character and his gregarious personality drew others into our company. Life was rich, challenging and rewarding.

Somewhere, sometime during our relationship, almost certainly time and time again in both South Africa and the United States, Bill was transfused with HIV-contaminated Factor VIII. Life continued, rich, challenging and rewarding, but we were living first with the fear that he might be infected, later with the knowledge. Then the dying began.

His was a terrible, anguishing, drawn-out dying. His body shrank to a brittle gauntness more harrowing than any offensive plea for famine aid. The ravishing of his mind meant that he became more and more silent, more and more withdrawn, and more unable to distinguish the threshold between his dream worlds and reality.

I wrote some weeks before he died:

> 'My heart breaks for him. I think after he dies, the nightmare of his dying will live on with me for a long, long time. Images of him while he was at home wanting to, trying to play Scrabble. Now his attempts to communicate, reduced to a few glances, a kiss, incomprehensible sentences. His vivid dream worlds in which he lives as he enjoyed living: dealing with people, smiling, moving about, the two of us together. Now the images are of medicine being forced down him, of him lying in his faeces, of growing gauntness, of infantile reflexes, of helplessness. A terrible encroachment on his dignity.'

Yet, somehow throughout this, he remained. The person, wasted and HIV-demented, such a harsh word, was Bill, seeking my hand to hold, turning his staring eyes to greet me as I entered his room. 'We are one,' he said in a period of lucidity, 'one body, one person. Whenever you leave the room, I cease to exist. I cannot think, go to the toilet, do anything because I am not there.'

The journey from knowing that Bill was infected to knowing how to live with that knowledge was one of the hardest that I or he ever made. The sadness and hopelessness was overwhelming. He refused to buy a new pair of shoes. Bill was infected and there was no way to do anything about it. We were left with a sense of deep bewilderment, of absolute powerlessness. We were fearful, a fear not so much of the death but of the dying.

### 5.1.1 How did we make that transition from diagnosis to living?

Much of it had to do with the sort of person Bill was. Bill had a strong desire to continue living. He believed that life was worth living, that we had much more happiness to find and that we had worthwhile work to do. He realised that not taking his life into his own hands was leading to a death wish, a sense of hopelessness and helplessness.

The living that we found was simple enough: we did those things that we would have been doing anyway. We led full, happy lives. The reality of his infection had been acknowledged but placed in its proper perspective. And life continued. Pity had no place there. It is an emotion from outside looking in. We were involved, absorbed, challenged, laughing, learning, bickering – together.

But as a carer, I had failed my first task. Our journeys to living were journeys made alone, not together. I had not been able to help him through from diagnosis to living. Throughout the time I knew Bill, it was the only period that we shared so little, where we were so little together in spirit and intellect. However, we did reach the living together and then my role as carer changed back to that of lover, of Scrabble opponent, dinner companion and co-worker.

We had come back to living but our lives had essentially changed. I was never again to be without the knowledge that Bill was infected. It was not incapacitating, just constant. Just something heavy inside me as I went about living my daily life, a constant call for courage, a constant challenge to courage. This constant companion was further conjured up by the need to protect ourselves against the omnipresent nose and other bleeds and, later, incontinence.

Our love was strong, yet we had to struggle to be aware of the intangible, imperceptible things that threatened it. I was within the epidemic but he was of it. His perspective on time, on what was important, changed. His shadows were different from mine. His needs changed. We did not know his fatigue was HIV-related. Small frictions suddenly emerged seemingly from nowhere. Communication and solace became even more important.

Our period of living with the knowledge of HIV was short, just six months, before the dying began. But thank heavens we had made that transition to living, for we were to learn that the living could continue through the dying. We had learned the art of living whatever life was possible.

### 5.1.2 Living with dying was not always easy

The dying of this disease can be so painfully slow. There were times of deep depression, for each of us. Fatalism and despair lurked in the shadows, at least for me, fed by uncertainties about prognosis and treatment. I faltered from time to time. But Bill's desire to live whatever life was possible was strong, his body was still young, unprepared to die.

There was no one, nothing, to help us. No one spoke of these things. The territory most uncharted was how the HIV-related dementia might affect his mind and his emotional states. As he began imperceptibly to withdraw, doubt quickly crept into the vacated space: does he no longer love me? Have I said something wrong? Is this a rebuff? Later, silent and withdrawn, as he lay looking at me, I was overwhelmed by fears. Is that a look of resentment for something done or not done, of dislike, of sadness that I cannot talk to him, as he might want me to, about his feelings, his dying? These fears bore down on me and had to be constantly held at bay.

### 5.1.3 During the dying, the role of the carer changes

He or she not only remains a partner and loved one of the living, but must also become the midwife for the dying. This role is almost impossible to take on unless the carer also has learned to live with HIV. The carer becomes acutely aware that he or she is not the dying, but only the observer of the dying.

The carer therefore lives in two worlds: one of the dying, the other of the present and future living, the pain for the now and the pain for the future. The distress is immense but for most of the time cannot be expressed, since it gets in the way of the living.

Finally, Bill died. Immediately they double-bagged his warm infected body in thick yellow plastic and sealed it closed.

I do not know what grief is. The word makes me feel inadequate as I go about my life. It so fails to capture the complexity of what I have experienced.

What they say about grief bears little relation to what I experienced as I tried to establish a life without Bill, to help my children live without him, as I struggled, alone, as sole income earner, sole parent and sole putter-outer of the garbage bin. It bears little relation to what I still feel years later. What they say gets in the way of my understanding of how our lives can be lived, with and without him, with laughter and pain, fullness and emptiness.

Bill's grave was to be a haven, a place of remembering, of closeness. I cannot bear to go there. I cannot bear the thought that there will be no cycle of regeneration, that the matter of Bill's body, trapped in non-biodegradable plastic, will not become one with nature, metamorphosed, living on. The disease itself and its social stigma mark the survivors.

## 5.2 Elizabeth's voice, 2013

### 5.2.1 Lost livelihoods, lack of benefits

Bill died on the last day of winter 1986, giving us, our son and myself, the healing warmth of spring. There were few, if any, social support services available to us. When we came to Australia in 1986, HIV support organisations were just being established. The first care and support volunteers were being trained. We were isolated by the social reaction to the HIV epidemic and by the time demands of caring. There were no benefits for carers. Bill had been employed by the US government in Zaire and so, fortunately, we had some health insurance benefits. I had been self-employed and had had to resign from my contracts. We lost our livelihoods. We lived off our savings and the kindness and generosity of family, friends and strangers, throughout the dying and during its aftermath.

Our son had just turned four when Bill died. He too, even though so very young, had been a carer. His memories are of a gaunt, demented figure, incontinent of faeces, shuffling, unbalanced. He watched his father dying and held out his arms to help him. They journeyed together through the dying and Bill's death stripped him of a life companion and mentor. And care giver for him.

### 5.2.2 Carer's voices begin to be heard

In the years between Bill's death and now, the story-telling voices of the carers of people living with HIV, and of all carers, and their organisations, have begun to be heard. In 2008–2009, the Australian Parliament held an enquiry into the experience of carers, into how their contributions could be better recognised by the community, and into how the government could better respond to their needs.

The first principle of the resulting Carer Recognition Act 2010 is that all carers should have the same rights, choices and opportunities as other Australians. This is in line with the UDHR, which recognises the universal right to social security. The 10 core principles enumerated in the Act recognise that whether carers can achieve these rights, choices and opportunities is dependent on their neighbours, friends and communities, on the way others treat them and respond to them, as well as on their employers and governments. Their need for dignity, acceptance and respect is as critical as their own need to be supported and cared for.

In June 2012, Australia adopted its first National Carer Strategy, which envisions carers as valued and respected by society and with rights, choices, opportunities and capabilities to participate in economic, social and community life.

The Strategy recognises that care relationships vary according to the needs of the person(s) being cared for, the carer's own individual needs, and changing life circumstances:

> Caring is done by individuals who bring their life experiences, values, beliefs, attitudes, expectations, coping mechanisms, economic resources, culture and gender to caring. Caring is therefore shaped by the environment in which it occurs and by an individual's history. As a result, every caring situation will be unique and every carer will care differently (Submission 121 from nationwide consultations on developing the National Carer Strategy, 2010).

The Strategy recognises the need to support and sustain these care relationships and the health and well-being of each person involved in them. Its six priority areas are: i) recognition and respect; ii) information and access; iii) economic security; iv) services for carers; v) education and training; and vi) health and well-being (Australian Government 2012).

### 5.2.3 Assessing economic value

The economic value of the work that carers in Australia do has now been documented. The astonishing extent of unpaid care work was calculated at 21.4 billion hours in the financial year 2009–2010 (when the total population of Australia was around 22.3 million). The 11.1 million full time equivalent workers in the unpaid care economy were 1.2 times the total Australian full-time employed work force (Hoenig and Page 2012).

In the financial year 2009/2010, the combined paid and unpaid work done in the care economy was estimated to be worth a total of AU$762.5 billion. Of that amount, paid care was worth AU$112.4 billion, 8.8 per cent of GDP and nearly 20 per cent of all paid employment. Unpaid care, the care I provided to Bill, was estimated to be worth AU$650.1 billion, equivalent to 50.6 per cent of GDP. Women contributed 77 per cent of paid care work and 66 per cent of unpaid care work (Hoenig and Page 2012).

Carers not only provide direct care but they also do what has been called 'quilting work' (Balbo 1992), that is matching the needs of those they care for with the resources available. The resources available to carers include: kinship networks; community resources; local, state and national government provided resources; resources provided by firms and foundations; and goods and services provided in the market. There is rarely an easy fit between what is needed and what is available. As Balbo says, this 'quilting work' involves 'the endless sorting and putting together of available resources, the minute coping strategies, the overall aim of survival, and the imagination, ingenuity and amount of work that [it] requires' (1992: 45).

### 5.2.4 Psychological, emotional, social costs

As well as determining the economic value of the work that carers in Australia do, there is a need to understand and address the personal impact of caring work. Our

son and I are still scarred by the psychological, emotional and social impact of our caring. Our son has a recurring nightmare, continuing into adult life, of people he cares about dying without his being able to do anything about it. The social isolation of carers, the disruptions and physical demands of caring, the lost opportunities for work and social relationships and, in our case, the stigma of HIV and the nature of the HIV dying, leave their marks on the carer. Our son was unable to talk to other children at school about his father's dying. He was socially silenced. I am still reluctant to visit the plastic bags in Bill's grave. I dream of taking him out of the earth, cremating him and scattering his ashes where we were happy. Caring has psychological, emotional and social costs to the carer as well as a social and economic value to society.

Caring also has economic costs as well as economic worth. It is women who overwhelmingly take on unpaid care work and this has a significant detrimental effect on their economic well-being, particularly on their workforce participation, their savings and on their retirement income (Australian Human Rights Commission 2013).

The Australian Government has a system of payments to carers but the provision of care has an impact on the carer's labour force participation. In the Australian context, women are more likely to manage their caring responsibilities by working part-time, taking casual work, freelancing, becoming self-employed or leaving the workforce. Men in paid employment with caring responsibilities are more likely to remain in paid employment and take advantage of workplace flexibilities in a way that many women do not. They are more likely to use mechanisms such as paid leave, a roster of days off and flexi-time. Data from 2001 show that in one state in Australia an estimated 15 per cent of carers were self-employed. Of these 16 per cent had started their own business or become a contractor, which made it easier for them to do their care work. This was higher for self-employed women (29%) than men (9%).

The data show that many of the mechanisms introduced to provide social protection to carers and to recognise and value unpaid care work, such as leave arrangements, flexible work hours and other workplace initiatives, largely benefit carers who work in or remain in the formal workforce. Measures are required to help carers who are not in or who did not remain in the formal workplace, including re-entry and retraining schemes, workplace flexibility and assistance to re-enter social spaces.

### 5.2.5 Gender income gaps

The 2009 study of the Australian Human Rights Commission, *Accumulating Poverty: Women's experiences of inequality over the life cycle*, found a significant gender gap in retirement incomes. This is primarily the result of three factors:

i. women moving in and out of the paid workforce because of their caring responsibilities;

ii. women's lack of understanding of superannuation, especially those who are freelancing or self-employed; and

iii. gendered inequities in pay and conditions.

Estimates from financial year 2009/10 suggest that the average (mean) superannuation payouts for women are just over half (57%) of those of men; a significant proportion of women have little or no superannuation (Australian Human Rights Commission 2013).

### 5.2.6 Social and economic justice for carers

This raises the question of how a social protection framework can provide increased social and economic justice for carers. This is complicated by the fact that, as quoted above, 'every caring situation will be unique and every carer will care differently'. However, there are some principles. Most carers are women, both in the paid workforce, where wages are low, and in the unpaid workforce. Predominantly women work as unpaid carers for children and the elderly, and both women and men care for spouses and partners (Australian Human Rights Commission 2013). Most women provide care at some stage in their life cycles, hence caring requires a social protection framework that is women-centred and anticipatory. Such a framework would recognise and enhance women as citizens and enable women to live the lives they choose and fulfil the obligations that they value (Sholkamy 2011).

Relatively little work has been done on the types of employment conditions that can best support caregivers to combine caring with paid employment. Many women in caring work are not in full-time work. Forty-two per cent of women not in the labour force cite family reasons (Hoenig and Page 2012). Many women in caring work engage in informal, occasional or insecure work. Hence a women-centred and anticipatory social protection framework cannot rely just on labour market mechanisms and carer payments to provide social and economic justice for carers.

So the situation of carers, and those they care for – children, the ill, the dying, the disabled, the frail elderly and communities – poses the question of scope of social protection programmes. Are social protection frameworks meant to address the underlying social and economic structures that are at the root of insecurity and inequity for carers, and therefore in that sense, are they meant to be transformational?

### 5.2.7 Feminisation of care, masculinisation of labour

Two root causes stand out: the feminisation of the care economy and the masculinisation of labour markets.

For as long as men fail to take their rightful place in the care economy, the burden, as well as the joys, of caring will fall mainly on women. The continuing disproportionate

absence of men from unpaid and paid caring work will remain a cause of social inequity and caring work will remain the site of gendered discrimination and deprivation.

But a transformative approach to social protection will require more than men's presence, more than equal participation, in the care economy. If the architecture of labour markets, that is, their structuring values and regulatory principles and practices, remains as it is, men who take on the care of others will also be disadvantaged – in their careers, their earnings and their retirement incomes. The vulnerability of carers to such inequity is a structural problem created by a workforce that reflects and is structured by the way men have lived their lives; by their narratives, their values and their categories (Reid 1995).

Underlying both the feminisation of the care economy and the masculinisation of labour markets is the deeply socially embedded doctrine of the headship of men and its corollary doctrine that a woman's place is in the home. This doctrine gives rise to the concepts of the 'male breadwinner' and the 'male head of the household', to images of women as home-makers, and to gendered differences and inequities in wages and conditions of employment. A women-centred, anticipatory and transformative approach to social protection needs to challenge this doctrine if social protection is to be more than palliative care for carers.

# Chapter 6

# Endnote

What social protection might encompass is currently a contested space in the framing of the debate and the practice. There are many players and many claimants for priority social protection measures. The World Bank and other multilaterals have given strong support to CCTs as an intervention to support the poor in the adjustment process. This domination is most evident in Central and South America. In Africa the establishment of social action investment funds has been a common response especially with public works programmes. Social protection has been seen as donor driven with many short-term pilots. At the national level, administrative capacity to carry out good social protection strategies is a common problem.

The global discourse on social protection encompasses several sectors including food and income security, social assistance and governance. Social protection delivery systems and implementation arrangements vary, from contributory pensions, conditional and unconditional cash transfers, tax-financed social insurance and public service delivery in health, education and nutrition, in-kind payment for services, community cash and in-kind contributions, provision for social housing and related infrastructure to support communities, social barters and social obligations. Since both state and non-state actors implement these arrangements, it is difficult to agree on one particular definition of social protection.

Each donor agency or multilateral organisation has its own definition of social protection, reflecting its particular mandate. But these definitions do not encompass care work, domestic work, community work, subsistence work, social obligations and more. Social protection should also be about access to land and property, traditional modes of social support and safety nets that are particular to cultures, and about safe structures and places where the mobility of women and children is not threatened or hindered. The challenges faced by women, children and men, highlighted in Chapters 4 and 5, provide evidence that a great deal more thinking about social protection is required. We need to listen for the silences, for whose voices are not being heard, which stories are not being told, what issues are not present.

In research on the unpaid carers of those living with HIV, a critical feature was time poverty (Waring et al. 2011). A large number of social protection initiatives entail a constant presumption that a person is work-ready or available to access forms of market or social protection paid work. Our carers had no time to do anything else but care. When labour is not available for sale, what might 'social protection' mean? How can it assist unpaid caring work and support the lives of all in the household? Unpaid 24/7 carers are not mentioned or envisaged in the global discourse on social protection.

This group of carers is large and getting larger. As well as the carers of those living with HIV, there are the family members, partners, loved ones, caring for the frail elderly, for those with non-communicable conditions, in particular diabetes and cancer, and those who care for people who live with severe physical or mental disabilities requiring full-time care.

When we locate these invisible carers in a global migrant labour market we can see that the cohort of those the state depends on for this unpaid labour are often those migrating to urban areas or other countries as temporary labour to work in paid domestic work, often as paid caregivers. When we turn to the demographic phenomena of the millions of 'missing' caregivers – for example in China, India and South Korea as a result of amniocentesis and sex selection – the pool of unpaid caregivers shrinks.

In a national context, while the social protection agenda is often grounded in government policy and fiscal arenas, bilateral and multilateral institutions also drive some issues on the agenda. While the different institutions understand the concept of social protection or of the social protection floor differently, they agree that social protection is about protection from adversity.

Whatever the governance system, a core responsibility and a measure of the legitimacy of governments is to protect the people they govern against physical harm or economic hardship (Devereux et al. 2011). This underscores the central role for governments in protecting people from adversity. However, as observed by UNDP Associate Deputy Administrator, Rebeca Grynspan, in a plenary address to the 2012 Association for Women's Rights in Development Forum, with the global economic downturn 'there is a hollowing out of the welfare state [...] and this creates more unpaid work'.

How then can the debate about social protection capture the lives of women, children and other outsiders? How can policies targeted at protection and prevention go beyond limited economic outcomes and address access to assets and property and other transformative policy measures for the dispossessed and disenfranchised?

To do this, social protection must empower those drawn into its ambit and create agency and engagement. The literature on social protection is saturated with the language of vulnerability and risk. The concept of vulnerabilities disempowers, reducing women and children's agency and productivity to trembling inadequacy in the face of adversity. People and communities need to be supported from their strengths and capabilities rather than reduced to the vulnerable to be protected.

This volume attempts to show that such support is possible. It tells of how women in Korea insisted on a form of social protection that fitted the realities of the lives of elderly men as well as women and as a consequence the scheme has increased the health of the elderly and contributed to an expanding economy through employment creation. It has shown in its case study of VAMP that sex workers' organising in India is a form of social protection, and a source of individual and collective strength. The

production of locally available and affordable menstrual pads, also in India, shows how social protection can be an instrument of redistribution, while a school milk programme in New Zealand demonstrates that local collective forms of organising can strengthen the ethical capital of a society. The community land watchdog groups created by GROOTS in Kenya have socially protected widows, orphans and HIV-infected women by protecting their livelihoods and respecting their dignity. Compensation for the care of the disabled in Denmark shows the critical role that state actors can play.

The anticipatory and transformative social protection framework that we articulate in this volume gives rise to policies of social protection that capture the patchwork nature of women's lives, their texture and integrity,[13] and the cohesiveness of the disparate parts. It responds to the ways in which women's fractious and assorted responsibilities and coping strategies are woven into a cohesive whole. The paid work in women's lives cannot be taken out of this patchwork quilt and treated as a divisible entity, different in quality and kind from the work women do to stitch together family, community, church, schools, friendships and the other aspects of their lives.

The discourses and paradigms of the literature of social protection do not reflect the texture and integrity of human lives. We need a discourse of social protection in a language of agency, of dignity, of capability and contribution, and of meaningful social relationships, that captures the complexity of human lives, particularly the lives of women.

# Notes

1 Available online at www.ohchr.org/EN/Issues/Poverty/Pages/AnnualReports.aspx

2 'Capability servitude' describes a condition wherein a person's dignity and freedom are circumscribed by an inability to breakaway from a life of constant work and no leisure, especially in the case of unpaid women carers in HIV-affected households (see Waring et al. 2011).

3 BRAC, formerly Bangladesh Rural Advancement Committee, is the largest NGO in the world.

4 See: www.thedailybeast.com/newsweek/2013/04/01/nirbhaya-the-woman-who-ignited-a-fire-in-india.html

5 See: www.guardian.co.uk/world/2013/feb/03/schoolgirl-shot-taliban-surgery

6 See: www.guardian.co.uk/world/2012/dec/18/polio-vaccination-workers-shot-pakistan

7 *Tonga National Report of the United Nations Convention to Combat Desertification*, page 2, available at: www.sprep.org/att/IRC/eCOPIES/Countries/Tonga/20.pdf (accessed 3 October 2012).

8 www.ausaid.gov.au/Publications/Pages/3442_9413_2732_2996_2379.aspx

9 Melanesia Indigenous Land Defence Alliance, August 2012, page 17, available at: http://mildamelanesia.org/sites/default/files/Forum-News-Vol-25-No1-August-2012.pdf (accessed 3 October 2012).

10 Source: Asaki and Hayes 2011; Esther Mwara Muiru, presentations at Commonwealth Roundtable on Social Protection 2011, and AWID Conference 2012.

11 SEEF Trustees are concerned that the gender imbalance has grown since 2010, despite its constant focus on the importance of girl children. It has proved difficult to understand the social dynamics behind this. Remedial measures are continuing.

12 Excerpts from a speech delivered at The World Federation of Haemophilia Satellite Symposium on Living with AIDS in the Haemophilia Community, Ninth International AIDS Conference. Berlin, Germany, 10 June 1993.

13 Marilyn Waring in plenary speech delivered at AWID Forum 2012.

# References and bibliography

Anderson, T and G Lee (eds) (2010), *In Defence of Melanesian Customary Land*, AID/WATCH, Sydney, available at: www.aidwatch.org.au/publications/publication-in-defence-of-melanesian-customary-land (accessed 9 October 2012).

Asaki, B and S Hayes (2011), 'Leaders, not clients: grassroots women's groups transforming social protection', *Gender and Development* 19: 2.

Ashwell, M and A Norton (2011), *Building Citizenship through Social Policy in the Eastern Caribbean: The Role of Social Guarantees*, World Bank, Washington, DC.

Asian Development Bank (2012), *The State of Pacific Towns and Cities: Urbanization in ADB's Pacific Developing Member Countries*, ADB, Manila, Philippines.

Asian Development Bank (2013), *Social Protection Index: Assessing Results for Asia and the Pacific*, ADB, Manila, Philippines.

Australian Bureau of Statistics (2001), *NSW men and women: balancing work and care*, available at: www.abs.gov.au/ausstats/abs@.nsf/mediareleasesbytitle/44C4895794DAA4A8CA256A56007C0737?OpenDocument (accessed 20 April 2013).

Australian Bureau of Statistics (2006), *Managing Care and Work, New South Wales, Oct 2005*, available at: www.abs.gov.au/AUSSTATS/abs@.nsf/ProductsbyCatalogue/C42FC1C2B2D9B550CA25714600153821 (accessed 20 April 2013).

Australian Government (2010), *Carer Recognition Act 2010*, available at: www.comlaw.gov.au/Details/C2010A00123 (accessed 17 April 2013).

Australian Government (2012), *National Carer Strategy*, available at: www.fahcsia.gov.au/our-responsibilities/disability-and-carers/publications-articles/national-carer-strategy (accessed 17 April 2013).

Australian Human Rights Commission (2009), *Accumulating Poverty: Women's experiences of inequality over the life cycle*, Australian Human Rights Commission, Sydney.

Australian Human Rights Commission (2013), 'Investing in care: Recognising and valuing those who care, Volume 1', *Research Report*, Australian Human Rights Commission, Sydney.

Balbo, L (1992), 'Crazy quilts: Rethinking the welfare state debate from a woman's point of view', in Sassoon, A (ed.) *Women and the State*, Routledge, London.

Barrientos, A (2004), *Social Protection and Poverty Reduction in the Caribbean: Regional Report*, Study commissioned by the Caribbean Development Bank in collaboration with DfID and the European Commission.

Barrientos, A and D Hulme (2009), 'Social Protection for the Poor and Poorest in Developing Countries: Reflections on a Quiet Revolution', *Oxford Development Studies*, 37(4): 439–456.

Bonilla Garcia, A and JV Gruat (2003), *Social Protection: A Life Cycle Continuum Investment for Social Justice, Poverty Reduction and Sustainable Development*, International Labor Organization, Geneva.

Chapoto A, TS Jayne and NM Mason (2011), 'Widows' land security in the era of HIV/AIDS: Panel survey evidence from Zambia', *Economic Development and Cultural Change* 59(3): 511–549.

Checchi, D and L Salvi (2010), 'Does Education Represent a Social Protection for Lifetime in Sub-Saharan Africa?', Paper prepared for the Conference on Promoting Resilience through Social Protection in Sub-Saharan Africa, organised by the European Report of Development in Dakar, Senegal, 28–30 June.

Commonwealth Secretariat (2012), 'Social Protection: A Question of Delivering on Rights and Resources', *Discussion Paper No. 13*, Commonwealth Secretariat, London, available at: www.thecommonwealth.org/files/246777/FileName/SocialProtectionDP13EB.pdf (accessed 30 July 2013).

Davies, M and J Allister McGregor (2009), *Social Protection: Responding to a global crisis*, Institute of Development Studies, University of Sussex.

Department of Labour (2012), *Population movement in the Pacific: A perspective on future prospects*, Government of New Zealand, Wellington, February, available at: www.dol.govt.nz/publications/research/population-movement-pacific-perspective-future-prospects/01.asp (accessed 27 February 2013).

Devereux, S and R Sabates-Wheeler (2004), 'Transformative Social Protection', *IDS Working Paper No. 232*, University of Sussex.

Devereux, S, J Allister McGregor and R Sabates-Wheeler (2011), 'Introduction: Social Protection for Social Justice', *IDS Bulletin Vol. 42* No. 6, November. Institute of Development Studies, University of Sussex.

DFID, HelpAge International, Hope & Homes for Children, Institute of Development Studies, International Labour Organization, Overseas Development Institute, Save the Children UK, UNDP, UNICEF and the World Bank (2009), *Advancing Child-Sensitive Social Protection: Joint statement*, UNICEF, available at: www.unicef.org/socialpolicy/files/CSSP_joint_statement_8.20.09.pdf (accessed 28 April 2013).

Donadio, R (2011), 'Battered by Economic Crisis, Greeks Turn to Barter Networks', *The New York Times*, 1 October, available at: www.nytimes.com/2011/10/02/world/europe/in-greece-barter-networks-surge.html?pagewanted=all&_r=2& (accessed 30 January 2013).

*The Economist* (2012a), 'The magic number: A huge identity scheme promises to help India's poor—and to serve as a model for other countries', 14 January, available at: http://uidai.gov.in/images/FrontPageUpdates/hope_the_economist.pdf (accessed 30 June 2013).

*The Economist* (2012b), 'Hope Really Does Bring 'Change' When It Comes To Lifting People Out Of Poverty', May 15.

Edström, J (2007), 'Rethinking "Vulnerability" and Social Protection for Children Affected by AIDS', *IDS Bulletin*, Vol 38 Issue 3, 101–105.

ESCAP (2012), *Statistical Yearbook for Asia and the Pacific 2012*, ESCAP, Bangkok.

Evans, R and F Thomas (2009), 'Emotional interactions and an ethics of care: Caring relations in families affected by HIV and AIDS', *Emotion, Space and Society* 2(2): 111–119.

Gilligan, D, J Hoddinott and A Taffesse (2008), 'The impact of Ethiopia's Productive Safety Net Programme and its linkages', *IFPRI Discussion Paper 839*, International Food Policy Research Institute, Washington, DC.

Global Campaign for Education (2004), *Learning to survive: How education for all would save millions of young people from HIV/AIDS*, available at: www.campaignforeducation.org/en/resources (accessed 28 April 2013).

Government of Australia (2010), *Carer Recognition Act 2010*, available at: www.comlaw.gov.au/Details/C2010A00123 (accessed 17 April 2013).

Government of Australia (2012), *National Carer Strategy*, available at: www.fahcsia.gov.au/our-responsibilities/disability-and-carers/publications-articles/national-carer-strategy (accessed 17 April 2013).

Government of New Zealand (2012), *Population movement in the Pacific: A perspective on future prospects*, Department of Labour, Wellington.

Government of the United States of America (2011), *Country Reports on Human Rights Practices for 2011, Fiji*, Department of State, Bureau of Democracy, Human Rights and Labor, Washington, DC, available at: http://cop.mdgasiapacific.org/files/cop/7/Fiji.pdf (accessed 9 December 2012).

Gross, R (2007), 'Definition of key social protection terms from other donors', *USAID Knowledge Services Centre*, Washington, DC.

Handa, S, C Alviar, D Musembi and S Ochieng (2011), 'Targeting of Kenya's Cash Transfer Program for Orphans and Vulnerable Children', in Handa, Devereux and Webb (eds), *Social Protection for Africa's Children*, Routledge, New York.

Handa, S, S Devereux and D Webb (2011), *Social Protection for Africa's Children*, Routledge, New York.

Hoenig, S and A Page (2012), 'Counting on Care Work in Australia', Report prepared by AEC Group Limited for Economic Security4Women, Australia.

Hughes H and G Sodhi (2007), 'Pacific Island economies. The role of international trade and investment', Centre for International Economics, Canberra.

Human Rights Watch (2012), *Papua New Guinea Country Report*, available at: www.hrw.org/sites/default/files/related_material/papuang_2012.pdf (accessed 23 May 2013).

Institute of Development Studies (IDS) (2010), *Social Protection in Asia: Research Findings and Policy Lessons*, IDS, University of Sussex.

Inter-Agency Task Team on HIV and Young People (IATT) (2008), *HIV Interventions for Young People in the Education Sector, Guidance Brief*, United Nations Population Fund, HIV/AIDS Branch, New York.

International HIV/AIDS Alliance with Save the Children UK (2012), *Good practice guide: family-centred HIV programming for children*, available at: www.aidsalliance.org/publicationsdetails.aspx?id=90567 (accessed 26 April 2013).

International Labour Organization (ILO) and World Health Organization (WHO) (2011), *Social Protection Floor for a Fair and Inclusive Globalization*, ILO and WHO, Geneva.

International Monetary Fund (IMF) (2009), 'Public social protection expenditure (excluding health) as a percentage of GDP', IMF, Washington, DC, available at:

www.social-protection.org/gimi/gess/ShowTheme.do?tid=361 (accessed 23 May 2013).

Jalal, P Imrana (2010), 'Gender equity in justice systems of the Pacific Island Countries and Territories', *Asia-Pacific Human Development Report Background Papers Series* 2010/14, UNDP.

Jamaica Social Investment Fund (JSIF) (nd), 'The Bridge Jamaica Project', available at: www.jsif.org/Funder_Worldbank_BridgeJa.asp (accessed 30 May 2013).

Joint Learning Initiative on Children and HIV/AIDS (JLICA) (2008a), 'Strengthening Families', *Learning Group 1 Synthesis Report*, JLICA, Pretoria.

JLICA (2008b), 'Inside-Out? Strengthening Community Responses to Children Affected by HIV/AIDS', *Learning Group 2 Synthesis Report*, JLICA, Pretoria.

Jukes, M, S Simmons and D Bundy (2008), 'Education and vulnerability: the role of schools in protecting young women and girls from HIV in southern Africa', *AIDS* 22 (suppl 4): S41–S56.

Kaur, R (2010), 'Khap panchayats, sex ratio and female agency', *Economic and Political Weekly* XLV (23): 14–16.

Kelly, M (2006), 'The Potential Contribution of Schooling to Rolling Back HIV and AIDS', *Commonwealth Youth and Development*, University of South Africa.

Kidman, R, J Hanley, G Foster, S Subramanian and J Heymann (2012), 'Educational Disparities in AIDS-affected Communities: Does Orphanhood Confer Unique Vulnerability?', *Journal of Development Studies*, 48(4): 531–548.

Kim, Y (2012), 'Local Demand for a Global Intervention: Policy Priorities in the Time of AIDS', *World Development*, 40(12): 2468–2477.

Kirby, D, B Laris and L Rolleri (2005), *Impact of Sex and HIV Education Programs on Sexual Behaviors of Youth in Developed and Developing Countries*, Family Health International, Washington, DC.

Kirby, D, A Obasi and B Laris (2006), 'The Effectiveness of Sex Education and HIV Education Interventions in Schools in Developing Countries', in D Ross, B Dick and J Ferguson (eds) *Preventing HIV/AIDS Among Young People: A Systematic Review of the Evidence From Developing Countries*, World Health Organization, Geneva.

Koehler, G (2011), 'Transformative Social Protection: Reflections on South Asian policy experiences', Paper submitted at the Conference on Social Protection for Social Justice, Institute of Development Studies, University of Sussex.

Kumar, N and A Quisumbing (2012), 'Beyond "Death Do Us Part": The Long-Term Implications of Divorce Perceptions on Women's Well-Being and Child Schooling in Rural Ethiopia', *World Development*, 40(12): 2478–2489.

Miller, C, M Tsoka, and K Reichert (2011), 'Impacts on Children of Cash Transfers in Malawi', in Handa, Devereux and Webb (eds), *Social Protection for Africa's Children*, Routledge, New York.

Mupedziswa, R and D Ntseane (2013), 'The contribution of non-formal social protection to social development in Botswana', *Development Southern Africa*, 30: 1, 84–97, DOI 10.1080/0376835X.2013.756099

Naidu, T, Y Sliep and W Dageid (2012), 'The social construction of identity in HIV/AIDS home-based care volunteers in rural KwaZulu-Natal, South Africa', *Sahara Journal*, 9(2): 113–126.

Naidu, V (2009), *Draft Report Fiji Islands Country Profile on Excluded Groups*, UNESCAP.

Name withheld (2010), *Submission 121 from nationwide consultations for developing the National Carer Strategy*, (unpublished), Canberra, Australia.

National Council for Applied Economic Research (NCAER) (2005), India Human Development Survey, NCAER, available at: www.ncaer.org/downloads/Reports/HumanDevelopmentinIndia.pdf (accessed 13 July 2013).

Nayak, N and R Khera (2009), 'Women workers and perceptions of the National Rural Employment Guarantee Act', *Economic and Political Weekly*, XLIV(43), 24 October.

Organisation of American States (OAS) (nd), *Puente in the Caribbean Brochure*, OAS, Washington, DC, available at: http://socialprotectionet.org/resources/puente-caribbean-brochure (accessed 23 May 2013).

Organisation for Economic Co-operation and Development (OECD) (2012), 'Social spending during the crisis', OCED, Paris, available at: www.oecd.org/els/soc/OECD2012SocialSpendingDuringTheCrisis8pages.pdf (accessed 20 May 2013).

Patel, L (2012), 'Poverty, Gender and Social Protection: Child Support Grants in Soweto, South Africa', *Journal of Policy Practice*, 11(1–2): 106–120.

Patel, L and T Hochfeld (2011), 'It buys food but does it change gender relations? Child Support Grants in Soweto, South Africa', *Gender and Development*, 19(2): 229–240.

Phiri, J (2011), 'An exploration of the challenges of grand parenting in HIV/AIDS affected families in Zambia', University of Manitoba, Canada.

Prasad, N (2011), 'Report on the Social Protection Floor', presented at the Commonwealth Roundtable on 'Sustaining Gender Responsive Social Protection and Economic Resilience', October, Commonwealth Secretariat, London.

Rask, G (2012), 'Bringing Rights Home: A Comparative Analysis of Human Rights and Women's Vulnerability to HIV in Botswana, South Africa, and Zimbabwe', PhD Thesis, Webster University, St Louis.

Ratuva, S (2010), 'Back to Basics: Towards Integrated Social Protection for Vulnerable Groups in Vanuatu', *Pacific Economic Bulletin*, Vol. 25 No. 3, Australian National University, Canberra.

Regenvanu, R (2011), *Report of the Commonwealth Roundtable on Social Protection*, Commonwealth Secretariat, London.

Reid, E (1995), 'And What Is My Career?', in Waterfield, D (ed.), *A Decade of Mary Owen Dinners*, The Mary Owen Dinner Committee, Sandringham, Victoria.

Reid, E, M Waring, C Rodriguez Enriquez and M Shivdas (2012), 'Embracing Disruptions, Responding to Uncertainties and Valuing Agency: Situating a Feminist Approach to Social Protection', *Development*, 55(3): 291–298.

Reza, A, M Breiding, C Blanton, JA Mercy, LL Dahlberg, M Anderson and S Bamrah (2007), *Violence against Children in Swaziland: Findings from a National Survey on*

*Violence Against Children in Swaziland, May 15 – June 16, 2007*, Centers for Disease Control and Prevention and Swaziland United Nations Children's Fund, October, available at: www.unicef.org/swaziland/sz_publications_2007violenceagainstchildren.pdf (accessed 30 July 2013).

Rodriguez Enriquez, C (2011), 'Conditional Cash Transfer Programs and Gender Equity: Are they an advance or a setback for Latin American Women', Paper presented at the IAFFE Conference, Zhejiang Gongshang University, Guanzhou, China.

Sabates-Wheeler, R and K Roelen (2011), 'Transformative social protection programming for children and their carers: a gender perspective', *Gender and Development*, 19(2): 179–194.

Schaan, M, M Taylor, J Puvimanasinghe, L Busang, K Keapoletswe and R Marlink (2012), 'Sexual and reproductive health needs of HIV-positive women in Botswana – A study of health care worker's views', *AIDS Care – Psychological and Socio-Medical Aspects of AIDS/HIV*, 24(9): 1120–1125.

Sen, A (1990), 'More Than 100 Million Women Are Missing', *New York Review of Books*, New York, 20 December.

Sepulveda M and C Nyst (2012), *The Human Rights Approach to Social Protection*, Ministry for Foreign Affairs, Government of Finland, Helsinki.

Sholkamy, H (2011), 'How Can Social Protection Provide Social Justice for Women?', *Pathways Policy Paper*, Pathways of Women's Empowerment Research Programme Consortium, Brighton.

Stewart, S and S Handa (2011), 'Reaching Orphans and vulnerable children through cash transfers in sub-Saharan Africa: simulation results from alternative targeting schemes', in S Handa, S Devereux and D Webb (eds), *Social Protection for Africa's Children*, Routledge, New York.

Statistics Korea (2007), 'Report on the Population and Housing Census', Republic of Korea, Daejeon.

Sudarshan, R (2011), 'India's National Rural Employment Guarantee Act: Women's participation and impacts in Himachal Pradesh, Kerala and Rajasthan', *Centre for Social Protection Research Report 06*, Institute of Development Studies, University of Sussex.

Townsend, P (2007), 'Right to social security and national development: Lessons from OECD experience for low-income countries', *Issues in Social Protection Discussion Paper 18*, International Labour Organization, Geneva.

United Nations Development Programme (UNDP) (2012), *Human Development and the Shift to Better Citizen Security. Caribbean Human Development Report*, UNDP, available at: www.undp.org/content/undp/en/home/librarypage/hdr/caribbean-human-development-report-2012-1.html (accessed 30 May 2012).

United Nations General Assembly (UNGA) (1990), *United Nations General Assembly Convention on the Rights of the Child*, Office of the High Commissioner for Human Rights, Geneva.

United Nations Human Rights Council (UNHRC) (2009), *Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the*

*Right to Development: Report of the independent expert on the question of human rights and extreme poverty*, A/HRC/11/9, UNHRC, Geneva.
UNHRC (2012), *Report of the Special Rapporteur for Extreme Poverty and Human Rights*, A/67/278, Presented to the 67th Session of the General Assembly, UNHRC, Geneva.
UNIFEM (2010), 'Ending violence against women and girls: Evidence, data and knowledge in the Pacific Island Countries', *Literature review and annotated bibliography*, UNIFEM, available at: www.undp.org.fj/pdf/unp/evaw.pdf (accessed 19 February 2013).
UNWomen (2012), *Safe Cities: Port Moresby, Papua New Guinea*, video, 23 August, available at www.youtube.com/watch?v=NRrGDERE3CI (accessed 20 February 2013).
United States Department of State (2012), 'Fiji 2012 Human Rights Report', *Country Reports on Human Rights Practices for 2012*, Bureau of Democracy, Human Rights and Labor, available at: www.state.gov/documents/organization/204413.pdf (accessed 30 July 2013).
van Ginneken, W (ed.) (1999), *Social security for the excluded majority: Case studies of developing countries*, International Labour Organization, Geneva.
Veerie, M (2011), 'Cooking, Cleaning and Volunteering: Unpaid Work around the World: 2011', *OECD Social Employment and Migration Working Papers: No. 116*, OCED, Paris.
Verma, J (2013), *Report of the Committee on Amendments to Criminal Law*, Ministry of Home Affairs, Government of India.
Waring, M, R Carr, A Mukherjee and M Shivdas (2011), *Who Cares? The Economics of Dignity*, Commonwealth Secretariat, London.
World Bank (2002), *Education and HIV/AIDS: A Window of Hope*, World Bank, Washington, DC, available at: http://go.worldbank.org/75O93FFLF0 (accessed 28 April 2013).
World Bank (2009) 'Social Protection (article 28)', available at http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTDISABILITY/0,,contentMDK:20194090~menuPK:419409~pagePK:148956~piPK:216618~theSitePK:282699,00.html (accessed 29 July 2013).
World Bank (2012), *World Development Report 2012: Gender Equality and Development*, World Bank, Washington, DC.
Xiaochu, H (2012), 'China's "New Generation" Rural-Urban Migrants: Migration Motivation and Migration Patterns', *Manuscript*, George Mason University, Washington, DC, available at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1978546 & http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1978546 (accessed 23 May 2013).

This page has been intentionally left blank