BASIC SERVICES AND SOCIAL PROTECTION

Contents

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Summary

This paper discusses the connections between basic services and social protection, focusing on health (including nutrition), education, water and sanitation, and safety, security and access to justice (SSAJ). It argues that good quality services in all four sectors can play an important role in reducing vulnerability whereas, conversely, poor quality and inaccessible services in these areas can be a cause of vulnerability (Section 2). Much can be done through 'sectoral routes' to improve the accessibility and effectiveness of services for poor people (Section 3). However, these measures are unlikely to be enough on their own and need to be complemented with specific 'social protection measures' that enable the poorest to access and benefit from key services (Section 4). Most of these can be implemented through mainstream services; indeed, considering them as separate 'social protection' measures unhelpfully sets up a dichotomy between basic service provision and social protection. The need for special measures to ensure poor and marginalised people benefit fully from mainstream services is justified from a normative human rights perspective, which has human dignity and equality as fundamental values; it is based on the results of pilot or large-scale programmes that have sought to do so. However, for this review, no studies could be located which specifically compared the poverty and vulnerability-reducing effects of current sectoral investment programmes with particular 'social protection' measures aiming to enhance human development outcomes or service use. This paper concludes with suggestions for increasing the contribution of basic services to the social protection of poor and vulnerable people.

1 Introduction

In this paper, social protection strategies are understood as a range of measures that governments can pursue in order to provide protection both to the 'active poor', enabling them to participate more productively in economic activity, and to the less active poor with considerable benefits for society as a whole (Shepherd, 2004).[4] These strategies have the aim of preventing shocks and stresses (including long-term severe poverty) from having a harmful effect on wellbeing. This paper considers three main kinds of vulnerability to shocks and stresses: life-cycle vulnerability, including early childhood, youth, pregnancy and old age; structural vulnerability and exclusion (e.g. of disabled people or ethnic minorities); and more general vulnerability related to the economic, environmental and political context. While accessible and good quality basic services have an important role to play in addressing all these forms of poverty and vulnerability, they arguably have a particular importance at vulnerable life-cycle stages, and this paper reflects this, particularly in the discussion of education and health. Indeed investing in human development in childhood (and in pregnant women) can play an important role in breaking intergenerational poverty cycles.[5]

Six of the eight Millennium Development Goals (MDGs) are explicitly concerned with health, nutrition, education, or water and sanitation. This paper discusses the ways in which social protection can enhance human development outcomes in these areas, and basic health (including nutrition)and education services, water supply and sanitation, and safety, security and justice services can reduce vulnerability, largely by increasing their accessibility to and effectiveness for very poor and marginalised people. It focuses on health and education, drawing where relevant on examples from the water supply and sanitation and safety security and access to justice (SSAJ) sectors.[6] We define basic services as follows:

- Primary healthcare (following the Alma Ata definition)[7] plus adequate access to secondary and tertiary care in health emergencies;
- Ten years of education (i.e. not just primary education), since it is increasingly widely accepted that this is the minimum necessary to foster effective numeracy, literacy and other life skills;
- Access to sufficient water of acceptable quality to lead a clean, healthy and productive life;[8]
- SSAJ (using DFID's definition) giving priority to the problems of poor and disadvantaged people and the institutions that they use to resolve them, such as community policing, the lowest levels of the courts, or traditional conflict-resolution systems.[9]

2 Basic services and social protection: the connections

Until recently, improving human development outcomes or access to services was not seen as a major objective of social protection policy. In part, this rests on an equation of poverty involving incomes and livelihoods, at odds with contemporary multi-dimensional understandings of poverty which emphasise human development and other aspects of wellbeing as well as income. The old, but increasingly untenable, distinction between social protection as measures to protect livelihoods and wellbeing and anti-poverty strategies as 'promotional' mechanisms[10] has also led to investments in health, education, and water and sanitation being seen as 'promotion' or 'anti-poverty strategies' and thus not legitimately part of social protection.

Access to basic services can also be considered from a rights-based approach: there are a number of basic rights that states and others are under obligation to respect and promote. These are required to ensure that all individuals attain a minimum standard of living and can live a life of dignity. Of particular relevance for this paper are the right to compulsory, universal and free primary education,[11] the right to the highest attainable standard of physical and mental health,[12] the right to water,[13] as well as a number of civil rights that relate to SSAJ.[14] These rights are to be realised equally by all – a special focus is thus required to ensure that the very poorest, the marginalised, or those that suffer from various forms of discrimination also benefit from them, and can equally access the appropriate service.[15]

2.1 Services and vulnerability

The contribution that good services can make to addressing vulnerability and, conversely, the vulnerabilities that can be caused or exacerbated by inaccessible or low-quality services suggest that this should be a more prominent focus of sectoral policy. See Box 1 for illustrations from the water supply and sanitation sector (WSS). In addition, some institutions can actually cause harm to poor people and be in themselves a source of risks and vulnerability. See Box 2 for examples from SSAJ. The relationships between services and vulnerability are also discussed in more detail in Section 3.

Box 1: Water supply and sanitation and social protection

A recent review of water sector status under PRSPs in sub-Saharan Africa found that water supply and sanitation (WSS) was generally categorised under infrastructure and economic growth pillars; its contribution to wider social development objectives is poorly understood or articulated.[16]

WSS is rarely discussed in the context of social protection, although the importance of water resource management in reducing flood/drought-related vulnerability is well established. Nevertheless, a growing body of work on water and livelihoods suggests important linkages. The principle benefits of improved access to water and sanitation services can be divided into three categories:

- Health (reduction in water-related disease and improved nutrition);
- Convenience (time and energy saved); and
- Economic uses of water (food and non-food income).

While reduction of diarrhoeal disease, especially among infants under five, who are most vulnerable, is clearly important, access to safe water is just one of many variables. Various studies have sought to measure the cost of water-related sickness e.g. in terms of lost labour days.[17] However, this is difficult where underemployment is the norm and surplus labour, including that of children, can be substituted to maintain meagre income levels. In purely economic terms, the benefits of clean water are generally greater for the non-poor, where labour productivity becomes an issue. Regardless of impact on income, sick individuals are always a burden on other household members who must care for them.

Water and livelihoods analysis suggests that impacts extend far beyond health[18] and that water needs to be viewed as a productive asset which can be combined with other assets, not only to sustain life directly but to bring in food and non-food income required to sustain livelihoods. Interveners therefore need to understand impact in terms of *costs associated with accessing wate*r (time, energy, cash) and *net gains in livelihood security* (reduced vulnerability, increased productivity etc.). Household coping and accumulation strategies depend heavily on the labour availability; time and energy saved collecting water can be reallocated both to *productive* (labour resulting in food or cash income) and *reproductive* uses (childcare, healthcare, domestic activities etc.). The latter is particularly important in the context of social protection but is frequently overlooked/underestimated in the water sector.

Livelihoods analysis also provides important insights into the *distribution of costs and benefits associated with access to water*. While the potential health benefits (e.g. reduction in water-related disease) of improved access are essentially uniform, the overall impact on livelihood security often varies significantly. Household Economy Analysis shows that different wealth groups employ different strategies to achieve food security according to the assets available to them. The poorest and most vulnerable households are typically more heavily dependent on sale of their own labour to secure food and non-food income. This suggests that in terms of food and livelihood security the impact of time spent collecting water (and the benefits of improved access) may be greatest for the poorest and most vulnerable groups, especially female-headed households. Within households, the burden of water collection typically falls to women and (girl) children. As such, lack of access arguably undermines the realisation of other human rights such as health, education etc.

Box 2: Safety, security and access to justice and social protection

SSAJ matters for the very poorest

Various state and non-state institutions together provide services relating to physical safety, security of property, and justice. They include the police, courts, prisons, ministries of justice/interior, lawyers, customary justice mechanisms such as chiefs, self-help neighbourhood groups, and many more. Together, they constitute what DFID calls the 'safety, security and access to justice' (SSAJ) sector. The key objectives of SSAJ strategies are:

- to make all people safe from violence and intimidation in their communities, homes, work and schools;
- to make people's property secure from theft and damage; and
- to ensure that everybody has access to systems which dispense justice fairly, speedily and without discrimination.

Though there are no MDGs related to SSAJ, the Millennium Declaration does refer to the importance of the rule of law. Voices of the Poor studies and Participatory Poverty Assessments have shown that the sector matters a great deal to the poor. In Malawi, for example, the three main sources of crime directly affect livelihoods, and include theft of crop and livestock and corruption.[19]

SSAJ institutions can prevent and respond to risk and vulnerabilities[20]

The SSAJ sector provides a number of solutions in relation to risk and vulnerability; appropriate policing and legal strategies need to be considered as one avenue to guarantee social protection. For example, services provided by SSAJ institution can deal with inheritance and guardianship matters in the event of the death of a head of household and prevent the dispossession of widows or orphans and ensure a fair distribution of assets They have a central role to play in 'physical protection' (protecting individuals from preventable criminal death or bodily harm), and in the protection of assets needed to sustain livelihoods. 'Family protection' is an important dimension of (a perhaps expanded version of) social protection; it requires that the police, courts, social services and medical profession work together to prevent and respond to physical and other forms of abuse that may take place in the home, such as sexual violence against women and children. SSAJ institutions, however, rarely provide services in a way that is 'pro-poor'. Courts, for example, are formal and expensive, their processes technically complex and lengthy. Informal systems may be more accessible for resolving, for example, land disputes, but they may discriminate against women.

SSAJ institutions can also cause risk and vulnerabilities

In addition, these institutions can in themselves become a source of risk and vulnerability. The police are often seen as 'anti-poor', more at the service of the political masters of the day than ensuring that poor and marginalised people are physically safe and their property secure. The police and courts are often considered amongst the most corrupt state institutions. In developing countries, conditions of detention are often extremely bad, possibly verging on the 'inhuman': overcrowded cells, with little time outdoors, infectious diseases or physical violence, such as rape, and no focus on rehabilitation. Often, the majority are held are in pre-trial detention, which means that they have not yet been found guilty by a court but are deprived of their liberty. Poor people are more likely to be unable to pay for a lawyer to help their case or may be unable to pay the bribe required to get out. Their families are also affected as they need to provide food to prisoners, pay legal and other costs, or in some cases have lost an income earner. Ensuring that minimum standards are met in prisons and developing alternatives to prison, such as community service, which may be less costly and more socially rehabilitative, are important measures in reducing vulnerability engendered by the justice system.[21]

2.2 Complementarity between basic services and social protection

Access to certain basic services can itself affect the potential impact of social protection instruments, such as food or cash for work. For example, nutrition support programmes are unlikely to be effective unless the target population has access to adequate supplies of safe water both to drink and for safe food preparation. However, integrating (short-term) nutritional support programmes with (long-term) water and sanitation development is often problematic. Water and sanitation facilities established in connection with feeding centres often fail to

establish the requisite management structures to ensure improvements in access are sustainable in the long term.

Similarly, the benefits of food/cash for work schemes depend largely on availability of labour at household level. Access to water is often a key determinant of labour availability (especially women's labour). In areas with low levels of access, households face difficult trade-offs between water collection and earning food/cash income. While larger or richer households may be able to substitute labour or pay others to collect water, the poorest and most vulnerable are often forced either to use more convenient but contaminated sources or to collect water at night, thereby risking personal security.

'Livelihood-focused' social protection policies (i.e. those with a principal focus on protecting or promoting livelihoods, rather than access to services or human development) could achieve double dividends by considering human development goals. Public works programmes could enhance children's school attendance through, for example, the construction or rehabilitation of school toilets or roads which enable children (especially secondary age girls) to attend school more easily and safely. Clearly, how to make the most of these synergies must be a local decision.

Social protection measures also need to avoid increasing human development vulnerabilities. As Devereux observes,

> *the logic of forcing poor and food insecure men and women - who may already be undernourished - to expend physical energy on hard labour before receiving a payment or ration which may be inadequate even to meet their own nutritional needs is questionable, even perverse. At the very least it reduces the nutritional benefit of the cash wage or food ration*.[22]

Most analysis of the relationship between social protection and basic services has focused principally on social protection measures that can enhance poor people's access to these services; these are examined in Section 4. Before this, in Section 3, we discuss the contribution that pro-poor basic services can make to reducing vulnerability.

3 Pro-Poor basic services as a form of social protection

Basic health, education, water, and safety, security and justice services can contribute to protecting against three main kinds of vulnerability:

a) forms of life-cycle vulnerability. For example, in early childhood, people are both physically and nutritionally vulnerable. Health and nutrition services can protect against such vulnerability, both ensuring through the accessibility and affordability of these services, and specific services tailored towards young children and pregnant women. These might include immunisations, or micronutrient supplements, as well as accessible curative care. Similarly in old age, effective health services have an important protective role, guarding both health status of older people and their contributions to household livelihoods or care of children.

b) forms of structural vulnerability linked to social exclusion or discrimination based on identity, such as race, gender or ethnicity. Exclusion or self-exclusion from basic services can exacerbate such vulnerability. For example, in Rajasthan, India, girls' primary school enrolment is between 10 and 30 percentage points lower than that of boys. Furthermore, even where marginalised people do access basic services, discriminatory treatment can reduce their protective impact. So, for example, even where scheduled caste children do attend school, they are often forced to sit at the back, cannot use the same water facilities as other children, and are discriminated against in the classroom by teachers and other children.[23] Addressing barriers of gender, ethnicity or ability is essential to realising the protective value of education (i.e. its potential for social mobility and higher earnings, and its synergies with improved health).[24]

b) Vulnerability to economic, environmental, health or political shocks. For example, there is evidence that better educated people and societies are better able to weather economic shocks.[25] Similarly, there is substantial evidence that health shocks (serious illnesses or injuries that are costly to treat and affect a person's capacity to engage in livelihood activities) are a major cause of impoverishment;[26] accessible and effective services could thus prevent such impoverishment occurring. Inadequate access to water and sanitation facilities can be implicated in both vulnerability to health shocks and livelihood shocks and strains. Shocks deriving from abuses of political or economic power can sometimes be counteracted by using the courts, such as public interest litigation against the eviction of slum dwellers in Bangladesh or South Africa, or on an individual basis to assert legal ownership rights over natural resources, or employment rights. [27]

How far basic services can reduce vulnerability depends on their *accessibility* to poor and vulnerable people and their *effectiveness* in serving them**.** An in-depth discussion of either of these issues is beyond the scope of this paper. Nonetheless, some key issues are outlined, with implications for sector investment and reform programmes.

3.1 Accessibility

This section looks briefly at several dimensions of accessibility of basic services i.e. *physical*, *economic, cultural* and *non-discrimination*. Since non-discrimination is closely connected with to aspects of accessibility, it is discussed along with them. Access is clearly also related to information; this is discussed below in the section on accountability and empowerment.

3.2 Economic

Services that are accessible to poor and marginalised people and can thus fulfil their protective effect are adequately financed so poor people are not prevented from accessing them on financial grounds.[28] How this can best be achieved is the subject of much debate, particularly in the health and water sectors, where a wider range of actors are typically involved than in education, for example, and where demands on the service or resource are less finite than they are on education, for example. (Education services are generally used only at certain periods of an individual's life, generally in childhood and youth, whereas health, water and sanitation or justice may be needed at any point in the life cycle.)[29]

There is, however, a growing consensus that basic education of ten years and at least essential preventative and curative health services should be free at the point of use.[30] This implies a renewed emphasis on increased public finance to ensure accessible and quality services, at least for these components. While this would not ensure universal access and would need to be complemented by some of the measures discussed in Section 4, it would make a large contribution to fulfilling the potential of these services to protect against vulnerability.

In the water sector, there is an ongoing debate around the right to free water versus the right to affordable water,[31] linked as in the health sector to debates about the most appropriate roles for the public, NGOs and the private sector in providing services. The finite nature of water resources suggests that some degree of user financing above a certain level of use may be necessary to ensure efficient and sustainable resource use. However, cost recovery through user financing in water, health or education is potentially inconsistent with social protection objectives. This implies the need for fee waivers, lifeline tariffs, or poverty-focused insurance mechanisms, discussed further in Section 4.

As regards SSAJ, a number of mechanisms can reduce the costs of accessing justice and policing services, by speeding up court processes, removing a range of fees, addressing corruption that more severely affects the poor (such as small bribes), promoting alternatives to prisons, or using a range of legal assistance strategies (see Section 4). In particular, making greater use of informal dispute-settlement mechanisms can reduce costs and enhance confidence in systems more culturally attuned to social realities than formal systems, particularly in post-colonial contexts. However, informal systems may further inequalities based on gender, kinship or class, where chiefs may prefer their own kin or can be bribed for small amounts. In some countries, there have been attempts to work to modify these systems to make them less discriminatory and more pro-poor (e.g. Bangladesh).[32] Strengthening and increasing the pro-poor and anti-discriminatory focus of these informal systems may be a way in which they could provide greater social protection, and remove some of the risks and vulnerabilities created by malfunctioning formal systems.

3.3 Physical

Accessible services are also organised and located in such a way as to maximise physical availability to poor people. One example is the provision of mobile schools and clinics for pastoralist communities; scheduling opening hours to suit main livelihood strategies in an area is also important – for example, in communities where poor people are mostly casual labourers, ensuring that health facilities are open during customary rest periods can enhance their accessibility. Socially protective water provision will generally minimise the distance that

water has to be transported by poor people (usually women and children, frequently girls), and will be sited so as to enhance their physical safety. Courts can operate in 'circuit' or be mobile, and go to more remote places. Policing can be made community-based, by establishing community liaison officers. Paralegals (lay persons with basic legal knowledge) can also be trained in communities; they provide basic advice, which is either free or very cheap, and physically close.

3.4 Cultural

Accessibility also has social and cultural dimensions, which are especially important from an equality and non-discrimination perspective. Formal SSAJ institutions, for example, are often inaccessible not only because they are costly and distant, but also because they are culturally not appropriate, with ritualised and obsolete court procedures which can be both intimidating and confusing; they are also inaccessible as a result of the technical legal language, using the national rather than local tongue. Substantively, laws often date from colonial times, and are outdated and inappropriate.[33] In education, enhancing accessibility to poor children in multi-ethnic contexts will often mean mother-tongue instruction or programmes which help them make the transition to learning in the national language.

3.5 Effectiveness

The effectiveness of a service is the other major factor affecting how far it can help address vulnerability, and will depend largely on its quality and its relevance to users' needs. Thus, for example, an effective basic health service will provide both preventative and curative services, and an efficient transition to a higher level health service where necessary. Debates continue as to the goals of education, and thus what would constitute an effective service, but at a minimum level, it would include fostering numeracy, literacy and other basic life skills, such as an ability to negotiate the formal institutional environment. Water services are only likely to be effective if they respond to the specific needs of different user groups. Research suggests that for poor water users, having a *reliable* supply is often just as important as having more or better quality water. Demand for water varies significantly both between and within user communities. Effective service provision involves striking an appropriate balance between efficient management of competing demands and the protection of basic needs. With regards to SSAJ, cost-effective use of resources and speed in dealing with cases are major concerns, but these have to be weighed against the need to respect the human rights standards of 'fairness and due process' as well as non-discrimination, which are often guaranteed in constitutions.[34] As a result, services may be more costly – for example the use of torture may be cheaper than a proper investigation, but may not lead to fair results, and is not likely to generate more reliable evidence. Achieving effectiveness at or beyond these minimum levels depends on levels and methods of financing, the institutional environment for service delivery, and an environment supportive of service provider accountability.

3.6 Levels and methods of financing

Clearly, service quality is profoundly dependent on adequate levels of financing and equitable methods of raising finances. Though financing debates are outside the scope of this paper, a few key issues which impact on the potential protective role of basic services are addressed.

First, as is widely recognised, levels of public expenditure on basic health and education services in many poor countries are inadequate to provide quality services which can fulfil their social protection potential. For example, in 1998, health expenditure per capita in Ethiopia was US$1.35, as compared with the WHO's recommended minimum health expenditure per capita of US$30-40.[35] Among other issues, this impacts on staff training, pay and motivation, the availability of resources (e.g. teaching aids) and equipment (drugs, medical equipment). As a result, health services frequently fail to cure or prevent illness, often pushing people into poverty cycles; education services often fail to provide basic skills, let alone enable people to escape poverty. By contrast, addressing staff motivation and availability of drugs, as well as reducing financial barriers to health service access, has substantially increased poor people's use of health services in Uganda.[36]

Secondly, health and education expenditure in many poor countries benefits better-off people disproportionately. For example, in Ghana in 1994, the poorest 20% of the population received only 12% of public expenditure on health.[37] This widespread biasing reflects both the financial, time and other barriers, e.g. perceptions of poor quality that reduce poor people's use of services. It also reflects the skewing of expenditure in many countries, for example, with higher education absorbing greater proportions of education budgets than primary or secondary education. (In relation to health services, the situation is more complex, since primary healthcare activities are cheaper than secondary or tertiary care.[38] However, poor people's access to such services is often limited by cost or transport barriers, reducing the potential protective effect of higher levels of expenditure on curative care.)

Thirdly, efforts to address financing gaps which demand greater user contribution, such as user fees for health and education, are widely recognised as having reduced poor people's access to services, while the revenues raised have been too small to have any appreciable effect on service quality, even where they have been retained for use by front-line service providers (see Section 4).

In a similar vein, fiscal decentralisation has often had similar effects, where poor regions have been left with responsibility to supplement central budgets, but where the revenue base upon which they can draw is limited indeed. For example, as Tang and Bloom observe in China, decentralisation has reduced the supply of doctors and other health sector staff in poorer townships, county administrations have lost their power to address inequalities between different parts of their jurisdiction, resulting in growing polarity between poorer and better off areas, and patients have increasingly turned to self-medication or private practitioners.[39] Though decentralisation may have increased service access and quality in some cases, the pattern observed in China seems more common.

3.7 Institutional environment for service delivery

Enhancing the institutional environment for service delivery is a major focus of sector reform programmes; intuitively, addressing problems related to coordination between actors and the roles of different actors should enhance service effectiveness. While addressing coordination problems clearly has potential, as the example from the SSAJ sector below illustrates, other favoured initiatives in recent years may be more problematic. Beyond the issues outlined here, it is clear that staff training, capacity to deliver services, motivation and incentives to provide quality services etc., need to be addressed for services to effectively play a social protection role.

Coordination between actors. In the SSAJ sector, improvements in effectiveness that benefit the poorest can be attained by better sector-wide coordination. Uganda provides a good model, both at the local level and on a national scale. The Masaka chain-linked project established a local coordinating body which helped provide cheap, local solutions to deal with caseload backlog, for example through better provision of information, and enhancing trust between institutions that often consider one another as rivals rather than partners. At the national level, a Justice, Law and Order Sector (JLOS) has been established as a sector working group; it prioritises activities that enhance the efficiency of the sector as a whole, rather than that of individual institutions.[40]

Public private partnerships have been seen as one solution to problems of both financing and delivery capacity of basic service, particularly in the health and water and sanitation sectors. Such partnerships consist of a wide range of arrangements, from contracting in or contracting out of non-state providers, to private financing for construction of facilities, and partial privatisation of services (typically the provision of high-quality private services for those who can afford them). The impact on access and equity depends largely on whether charges related to the involvement of profit-making bodies are passed on to users. For example, contracting private providers into a system where costs at the point of use are minimal may enhance quality and access,[41] whereas moving parts of the health system onto full commercial cost-recovery basis invariably excludes the poorest people, while also having incentives to over-prescription/mal-prescription of essential medicines.[42] Policy frameworks which effectively harness the private sector to meet public objectives and address the needs of the poor remain rare in the water sector, although South Africa provides an interesting example (see Section 4).

Vertical initiatives. Programmes that are financed from particular 'global funds' have become increasingly common in the health sector, as specific funds have been set up to tackle particular diseases (e.g. TB, malaria and HIV/AIDS), although these have a longer history, e.g. specific programmes on leprosy. Where this has led to the creation of parallel structures, and bypassed or undermined mainstream delivery systems, cost effectiveness and sustainability are clearly problematic. At the same time, there can be challenges in maintaining programme effectiveness and accessibility when disease-specific programmes are absorbed into standard healthcare systems.[43] In the long-term system, improvements resulting from coordinated sector planning and development should redress these problems, as Brown concludes from the example of the health sector-wide approach (SWAp) in Tanzania.

3.8 Accountability and empowerment

As the World Bank[44] suggests, enhancing accountability to service users is another vital aspect of providing effective services. There are a number of innovative approaches which aim to bring not just customer focus but also citizen's voice, and to contribute to the application of a rights-based approach.[45] The right to participate in decision-making processes and access information is key. There are a number of 'horizontal' accountability mechanisms that are relevant for basic services:

- *Users participation* In Uganda there have been efforts to publish information on the allocation of resources at the local level, including to basic services such as schools or health centres. The Uganda Debt Network helps to promote participation and monitoring of use of resources by supporting district level citizens' committees.

- *Administrative standard setting* The Ministry of Health in Uganda is also working with the Consumer Health Association in preparing a citizens' charter, highlighting patients' entitlements.
- *Legal accountability* SSAJ institutions are in themselves accountability mechanisms, and complaints against service providers can be brought to the courts, ombudspersons or human rights commissions, all of which have a range of measures at their disposal to ensure that the services are rendered and compensation provided.
- *Political accountability* mechanisms include direct elections of representatives at the national and local level. Successful political decentralisation can potentially enhance accountability of elected officials (rather than bureaucrats) to service users.

Accountability is however a two-way channel: it requires not just formal accountability mechanisms but also an empowered citizenry, aware of its rights and entitlements, and willing to claim them.[46] Committees of users, such as parent-teachers associations, are well placed to monitor how services are delivered and to demand improvements. The Ghana Northern Development Network has adopted a scorecard methodology which includes communities and schools in measuring school performance across communities. Empowerment requires not just mobilisation, but also a basic knowledge of rights and entitlements, which can be provided by various legal literacy and other public education strategies (see Section 4). However, the most marginalised may not be able to participate in such mechanisms, or cultural barriers may remain too strong for them to assert their equal entitlements to services, including to social protection ones.

3.9 Summary / conclusions

This section has aimed to demonstrate some of the ways in which addressing some of the barriers to good quality, accessible, mainstream basic services can reduce vulnerability and help disadvantaged people escape poverty – in other words, how they can have socially protective effects. The ways in which particular services or aspects of services may achieve this are summarised in tabular form in the Annex.

However, good quality, adequately financed, accessible mainstream basic services cannot on their own fully replace the need for additional support to particularly disadvantaged groups. Thus, for example, Cook argues that in China, investment in (pro-poor) education and health services would constitute *ex ante* social protection, distinct from the social safety net which is needed to support people once they have fallen into difficulties.[47] In Uganda, Devereux warns that for orphans and other vulnerable children, universal vocational education may be as or more important than universalising secondary education, and argue that funding for smaller-scale programmes aimed at specifically vulnerable people must be maintained alongside sectoral investment.[48]

The next section outlines a range of 'social protection' measures that could enhance the contribution of basic services to protecting and promoting the livelihoods and wellbeing of vulnerable people. Most of the measures outlined in the next section could be (and would be most effectively) implemented as part of mainstream services. Many are already part of sector investment and reform programmes – for example, user fee waivers or exemptions, and social or community health insurance.[49] Rather than setting up a dichotomy between sector investment programmes and social protection mechanisms that enhance access to

basic services, the measures outlined in Section 4 should be seen as options that could be integrated with wider sector programmes, where the latter are failing poor, marginalised and vulnerable people.

It should be noted that no analyses could be located for this review to, for example, compare the impact of US$1 spent as sector budget support to basic education, with US$1 spent on a conditional cash transfer to tackle the specific financial barriers faced by poor or working children. Such comparisons would be inherently methodologically difficult, and are further complicated by the short periods of existence of many of the 'social protection' measures described below, compared with sector investment programmes. This means that it is not possible to draw generalised conclusions concerning the relative cost effectiveness of these two approaches. Rather, decisions should be made in context, reflecting the main barriers to accessible and quality services in particular locations.

4 Social protection measures that boost access to services and/ or human development outcomes

Since some social protection measures aim to boost human development on a variety of fronts simultaneously, rather than discuss social protection instruments sector by sector, we discuss their contribution to accessing services and protecting against vulnerability thematically. This section discusses social protection instruments with a particular impact on health, education, nutrition, access to water, and sanitation and justice, focusing on:

- social investment funds
- conditional cash transfers (e.g. where support is conditional on a child attending school), school subsidies and scholarships
- waiver and exemptions for key services
- lifeline tariffs for water
- health insurance
- nutrition support programmes
- legal assistance

As noted above, with the partial exception of cash transfer programmes, most of these measures can and should be implemented as part of sector programmes, rather than being seen as parallel to sector reform and investment efforts.

4.1 Social investment funds

Social (investment) funds are discussed briefly here, since the World Bank considers them a social protection tool. Their main contribution to access to services is via infrastructure development – in areas such as school construction, installation of water supply systems, building community health posts and roads, and creating irrigation infrastructure. Some social funds, such as Projet d'Appui aux Initiatives de Base in Mali, also emphasise community institution strengthening, both as an end in itself, and to ensure maintenance of infrastructure.[50] Though social fund activities are targeted to poor communities, their principal contribution to social protection is as a financing mechanism for mainstream services, which may help reduce vulnerability as outlined above; they do not, on the whole, target specific vulnerabilities within a community. Three ongoing concerns are: how far social funds substitute for, rather than supplement, social sector budgets; whether they are adequately integrated with sector plans so that newly built health clinics are staffed, for example; and the risk that they undermine sectoral delivery systems through setting up parallel structures.

4.2 Conditional cash transfers, school subsidies and scholarships

Conditional cash transfers have become increasingly popular as a social protection instrument over the last ten years, since they directly contribute to targeted investment in poor people's human development and, as such, may also help break poverty cycles.[51] They are thus seen by many governments and donors as more effective than non-conditional financial assistance. In these programmes, which are particularly common in Latin America, but have also been implemented in Bangladesh, financial assistance is conditional, usually on children's school attendance and, in some cases, on other family members' use of health

and nutritional services (e.g. in Mexico and Nicaragua). Some, e.g. Brazil's Programa do Eradicação do Trabalho Infantil (PETI) and Bangladesh's Food for Education programme, specifically aim to reduce child labour. With their focus on protecting and promoting poor children's human development, they make a particular contribution to addressing vulnerability early in the life cycle.[52]

Conditional cash transfer programmes have also proved effective at securing human development during a crisis, as the examples from Indonesia and Nicaragua below illustrate. Progresa has been most rigorously evaluated and more information is available on this programme than others; hence it is discussed in more detail (see Box 3). Other examples are given to illustrate the range of conditional cash transfer programmes. For a comprehensive listing of conditional cash transfer programmes, their costs and effectiveness see Barrientos and DeJong (forthcoming).

Most programmes use a range of geographical targeting and mean tests to target the poorest families. The efficacy of this varies – Coady and Morley[53] estimate that overall 72% of conditional cash transfer benefits go to people in the bottom two quintiles, as compared with 65% for safety net programmes in general. Of the main conditional cash transfer programmes worldwide, leakage to non-poor people was greatest in Bangladesh (40% leakage to non-poor people) and lowest in Chile (10% leakage to non-poor people), where participants put themselves forward.[54] Some examples of programme impact are discussed below.

Box 3: Progresa in Mexico

One of the longest standing, most successful and most discussed conditional cash transfer programmes is Mexico's Progresa (now renamed Oportunidades). Progresa targets poor families with children in small rural areas. It pays a household consumption subsidy of US$12.50 per household per month and a school subsidy of between $8 and $30.50 per school-going child per month, depending on the grade each child is attending. There is also an annual payment of between $15 and $20 per year to cover school materials. The combined incentives are capped at $75 per month to avoid creating benefit dependency, and are conditional on children attending school on at least 85% of school days, and on mother and infants attending regular primary healthcare examinations and parenting sessions. In 2002, it reached 40% of rural Mexican households. Owing to a combination of geographical and proxy means test targeting, 80% of its beneficiaries were in the bottom two income quintiles and 58% in the bottom quintile.[55] Since 2002, it has been scaled up to include urban areas.

Progresa's subsidies constituted on average 20% of household income, and it is estimated to have reduced the poverty gap (extent to which income fell below the poverty line) by 36 %.[56] It has also achieved a 12% lower incidence of illness among 0–5 year olds compared to non-participating children, and a lowered probability of stunting for 1–3 year olds – partly attributable to increased household consumption of fruit and vegetables.[57] Indeed, the incidence of illness among newborn babies declined by 25% and by 19% and 22% for two and three year olds respectively.[58] It has reduced the probability of children working, particularly that of boys, by 10–14% for 8–17 year olds and by 15–20% for 12–13 year olds.[59] It has also reduced school drop out and improved attendance, with girls gaining an extra 0.72 years of schooling and boys an extra 0.66 years by the final grade. In 2000, spending on Progresa constituted 0.32% of GDP.[60]

4.2.1 Other programmes

In Nicaragua, the Red de Protección Social, which provides US$17 every two months to participating families on the condition that children have fewer than six unexcused absences from school and progress satisfactorily between the grades, also includes healthcare visits for younger children's growth monitoring, provides up-to-date vaccinations, and involves

parental attendance at health and nutrition talks. It managed to stop consumption levels declining during a time of sharp decline in coffee prices and a drought, and protected both nutritional levels and children's school attendance. It has also increased school enrolment by 22% and attendance by 30%.[61]

In Chile, the *Chile Solidario* programme provides a more comprehensive set of services tailored towards the 250,000 families living in extreme poverty (unable to purchase a minimum subsistence basket). The programme includes cash transfers and support arranged by a social worker in the areas of health, education, work, income, housing and 'household dynamics' over a two-year period. Participants are also eligible for support in the areas of skills training, disability rehabilitation, child protection, control of household violence, and drug prevention and rehabilitation, depending on a household's particular needs; they sign a contract concerning their participation in agreed programmes. In its attempt to address a wide range of aspects of poverty and disadvantage, Chile Solidario is the most wide-ranging of existing conditional cash transfer programmes.[62]

Non-conditional education-oriented cash transfer programmes aiming to protect the poorest children's school access include:

In Indonesia, a comprehensive school scholarship programme introduced during the worst of the Asian financial crisis, which managed to reduce lower secondary drop-out by around 24% by providing scholarships that covered the costs of school fees. However, it had no discernable impact at the primary and upper secondary level. Evaluations conclude that it was reasonably well targeted in that expenditure was biased towards poor families, but there was both some leakage to better-off families and some exclusion of poor children.[63]

In Mozambique, the Acçao Social Escolar programme, also known as *Caixa Escolar*, administered by the Ministry of Education and financed by a local levy on all students. Beneficiary children are identified at school level, and are exempted from annual enrolment (matriculation) fees and eligible for financial support for the costs of text books and materials. All Mozambican school students are constitutionally eligible for free tuition, and text books for the first two years of schooling are provided free (by donor finance). Together with other social protection mechanisms, such as the Poverty Certificate, which once granted exemption for families from the costs of birth registration and healthcare, these programmes are largely nationally or locally financed. No further information could be located for this review; however, these measures do provide examples of attempts to enhance the poorest families' access to basic services in a very poor country.[64]

4.2.2 Conclusions

Intuitively, it might be expected that a more comprehensive programme, such as Chile Solidario, would have a stronger protective and promotive impact than its less wide-ranging cousins. However, the programme is too new for data concerning its effectiveness to be available. Indeed, as Barrientos and DeJong point out, until more longitudinal data is available, rigorous assessment of the impact of conditional cash transfer programmes will be difficult. It is clear that to help break poverty cycles, they can only be part of a package which also involves increased investment in the quality and accessibility of key health and education services, and an extension of economic opportunities. That countries such as Mozambique, Nicaragua and Bangladesh have implemented them indicates that they can be financially sustainable in low-income countries; Bangladesh's programme is fully government-

funded, whereas Mozambique's and Nicaragua's are based on a combination of government resources and aid.

One concern with conditional cash transfer schemes (which arguably makes them popular with policy-makers and the non-poor) is that the rights to assistance they involve are dependent on compliance with certain programme criteria deemed to be socially constructive – children attending school or other family members attending health centres. As with Western welfare states, this can represent an increased policing of poor people, which may be resented and could undermine programme success. None of the evaluations of conditional cash transfers have examined this.

Overall, conditional support programmes are most likely to be effective where the opportunity costs of using a service are particularly high for poor people (e.g. where there are child labour market opportunities or strong demands for children's labour at home), as well as financial barriers to service access. Where the main barriers are financial, a simple subsidy (or scholarship) with lower administrative demands may be all that is required.

4.3 Waivers and exemptions for key services

A technical distinction is generally drawn between waivers and exemptions for service charges or user fees,[65] although the term 'user fee exemptions' is often used to refer to both. Exemptions mean that an entire service is free to the user (a common example is child immunisation programmes, even where other health services must be paid for), while waivers allow specific groups to use services without charges. Waivers are usually based on a means test (or a proxy means test), or membership of groups deemed to be particularly vulnerable in specific contexts (e.g. children under five, pregnant women, older people).

Though the debate on user fees continues,[66] there is now substantial evidence concerning the harmful effects on poor people of user fees and the positive effects of removing them.[67] For example, following the abolition of user fees in primary healthcare in Uganda, WHO and Ministry of Health data show that the utilisation of small government health centres and of referral units increased by 77% and 55% respectively, while NGO unit reported much smaller rises of 5–8%.[68] This indicates that demand for health services had indeed been suppressed by user charges. Furthermore, the abolition of fees has reduced the proportion of poor people's expenditure that goes on healthcare – by 13% for the poorest quartile and 19% for the second poorest quartile over the period 1999/2000 to 2002/3, freeing it up for other purposes.[69] In education, user fees have had similar results as in the health sector. For example, when Tanzania removed primary school fees, enrolment increased by around 1.5 million children, while in Uganda, when primary school fees were removed for the first four children in each family, enrolment doubled, bringing three million additional children into primary school.[70] In both countries, this has substantially increased pressure on teachers and classrooms, implying that, as in the health sector, reducing costs to users must be accompanied by increased budgets to enhance the quality of provision.

For both political and pragmatic reasons, removing user fees on certain services or parts of services (i.e. exempting services) may be preferable to waiver systems. Waiver systems are often administratively complex, and in practice may be open to corruption, meaning that poor people are forced to pay bribes/fees to avail themselves of their entitlements. Service providers will have a disincentive to publicise the availability of waivers and exemptions if to do so would impact directly on their revenue.[71] The costs of implementing waiver systems

may even exceed the funds generated. Increasingly, it is also argued that there are political benefits in terms of community solidarity and middle-class support for quality services, if services are free to all users. Nonetheless, waivers are certainly preferable to charging poor people the full costs of service.

It is frequently assumed that the most protective effect for poor people is to ensure that *primary* health and education services are freely available. This is certainly important. However, there is also a strong case for secondary education services and curative healthcare services (including hospital care) that are free to the user. As Grant and Hulme citing Appleton[72] point out, it is at the secondary level that the strongest economic returns to education accrue – thus there should be a strong policy emphasis on enabling the poorest children (as well as their better-off counterparts) to access a good quality secondary, as well as primary education. Inequalities between different socio-economic groups' use of education services is often profound – in middle-income Peru and Egypt, for example, only 60% of adolescents from the poorest quintile had completed primary school, whereas all those from the richest quintile had.[73] This may well mean free services, or cash transfers, such as those of Progresa in Mexico, Bolsa Escola in Brazil, or the Food for Education[74] programme in Bangladesh, discussed above, which support poor children's primary and secondary school attendance.

The catastrophic economic effects of severe illness are now increasingly recognised, with curative care, often in hospital, being a major cause of impoverishment.[75] This implies that simply exempting primary care services will not be sufficient for the poorest people – waivers or exemption systems need to be designed to ensure that health crises do not impoverish and undermine livelihoods – which can also have drastic consequences for the human development and wellbeing of other families. Interviews with child workers around the world very frequently show up a parental health crisis as the trigger for children needing to start work or leave school.

One other issue is the importance of fees as a proportion of overall health or education costs.[76] Where other costs (e.g. transportation, school books, hospital food etc.) make up a higher proportion of the costs of accessing services than direct fees for services, social protection systems must also address these – either through specific targeted support programmes, or through more general assistance. Examples of the former would be local textbook funds for children whose families cannot afford to purchase books, and of the latter, social assistance programmes of the kind discussed above.

As Yates and Cooper[77] make clear in relation to the abolition of health user fees in Uganda, and others have stressed in other contexts, while being strongly pro-poor financially, abolishing user fees can only make effective contributions to enhancing poor people's health and education where there are simultaneous investments in the 'supply' side of the health and education systems. In the case of the Ugandan health sector, this involved increased budget allocations for pharmaceuticals, particularly for primary healthcare units in rural areas and improvements in drug supply systems, increased doctors' pay by two-thirds and speeded-up payroll reforms, all of which contributed to improvements in capacity. In the education sector, similar improvements might include increasing teachers' pay and teacher numbers (to cope with increased enrolment), enhancing the supply of text books and other learning materials, and increasing budgets for school infrastructure, including toilets, desks and chairs.

Yates and Cooper also point out that the increase in resource allocations to Uganda's health sector was made possible by a switch from donor project funding of the health sector to general budget support in 2001/2. Taking funds out of earmarked projects into more general sectoral support can therefore have positive pro-poor implications. This may have lessons for donor strategies elsewhere.

4.4 Lifeline tariffs for water

The development of lifeline tariffs reflects a recognition that potential human development benefits resulting from infrastructure and service provision will not necessarily be realised unless certain minimum levels of consumption are guaranteed. Where a certain minimum level of consumption of a particular service (e.g. water, electricity) is deemed to represent a 'lifeline' for some users, society may judge that they should not be excluded if they cannot afford to pay.[78] Once the principle has been established, the level of service envisaged as minimum standard must be negotiated and defined. In South Africa, for example, the free basic water policy (2000) stipulates that 6000 litres per month should be provided free to every household, with additional consumption billed according to an inclining block tariff. Under an increasing block tariff, consumption of services is priced at a low initial rate up to a specified volume or use (block) and at a higher rate thereafter. The actual tariff (cost per m^3) and the number of blocks can be varied according to context. Whereas general subsidies to infrastructure almost always benefit the non-poor disproportionately, block tariffs are considered more efficient in reaching the poor because they limit subsidised consumption. The free basic water policy has been the subject of much debate internationally and remains very much a 'test case'.

In theory, tariff structures can be adjusted according to both short and long-term policy objectives (e.g. equity, efficiency, financing etc.) and offer the possibility of cross-subsidy as a means of social protection. By generating a surplus through slightly higher marginal costs for bulk users, free or subsidised lifeline tariffs can easily be designed for the first block of consumption. In order to be sustainable, however, systems require a certain critical mass of users. Applications to date have been mainly limited to urban areas where user groups are large and piped systems and meters are more common. Individual connections are costly and remain rare in rural areas, although some examples exist, e.g. Sri Lanka. The experience in both rural and urban areas is that poor people are generally willing to pay for a more reliable service, assuming they can get access, but there remain significant obstacles to establishing a connection in the first place. Studies show that the poorest households often struggle to cover initial lump sum connection fees and while many schemes allow payment in cash or kind (labour and materials), the poorest and most vulnerable may still be excluded. Microfinance can be a key factor in improving access to new schemes.

It should be noted, however, that the vast majority of poor people live in areas which are not served by major service providers, e.g. in informal settlements. Lifeline tariffs are most effective when access is universal. Where the poor lack access, they typically end up paying much higher prices, often for inferior services. Finding ways of supporting small-scale private operators by providing quality services at a reasonable cost may well be a more effective in terms of social protection objectives.

4.5 Health insurance

Recognising the harmful effects of user fees, particularly on the poorest people's use of health services, health insurance is increasingly being considered as an alternative since, in principle, it may reduce the overall financial demands on poor people. The fact that treatment is pre-paid and that payments may be spread out over a period can, in principle, avoid poor people having to mobilise impoverishingly large sums of money in case of catastrophic illness. Health insurance – whether private (for profit), community-based or a national health insurance system (both not for profit) – is explicitly intended both as a mechanism for financing health services, and as a means of promoting access to these services, including among poor people. However, these dual objectives are not always compatible, as this section will show.

National (social) health insurance schemes have typically been available only to formal sector employees who, along with their employers, contribute to a health fund through payroll deductions. Historically, these have mostly excluded informal sector workers and thus poorer people. As Bennett and Gilson[79] point out, governments may be tempted to subsidise these schemes to make them attractive to contributors, and where resources are constrained this may reduce the funds available to invest in services or subsidies mainly used by poorer people. However, there have been some attempts to expand these to genuinely national and inclusive systems. The Thai Health Card programme specifically targets uninsured citizens who are generally on low incomes, and allows treatment at government facilities for a card-holder and their family members for 30 baht per year.[80] It has effectively managed to cover most poor people. (The exceptions appear to be those in the most remote localities.) Some poor Central Asian countries, such as Mongolia and Kyrgyzstan (whose GDP per capita is under US$500), are implementing such schemes, with certain groups (e.g. children, older people) automatically covered without their having to make financial contributions. Similarly, Ghana has introduced a national health insurance system to replace user fees – all adults are to pay a minimum of US$0.66 per month in contributions.[81] It is too soon to tell whether these national health insurance programmes will reduce the burden on poor people as compared with a user fee-based system, though they certainly have the potential to do so. The potential costs and benefits need to be examined in comparison with direct (tax and aid-financed) service provision, or some forms of community health insurance, particularly in the poorest countries.

Community health insurance schemes have often developed or been promoted in contexts where users are already making substantial financial contributions to healthcare, usually through user fees.[82] They are explicitly intended to cover people outside the formal sector, and to be accessible to poor people. In some cases, there may be a sliding scale of contributions. Bennett and Gilson conclude that community insurance mechanisms often 'offer considerable benefits to the majority poor. However, the poorest require special arrangements to enable them to access benefits under the scheme (such as subsidies from government or from higher income scheme members), and few schemes have effectively implemented these arrangements.'[83]

Reviewing a variety of community health insurance programmes in sub-Saharan Africa, Arhin-Tenkorang[84] finds few examples of schemes that are both affordable to poor people and provide adequate cover to protect effectively against health emergencies. The most effective of the schemes she reviewed, Carte d'Assurance Maladie in Burundi, was affordable for around 77% of the population, and in 1992 had enrolled 54% of the 'target population',[85]

while others covered as little as 5% of the target population and several of these were not affordable to the poorest. Yates and Cooper[86] and Jutting[87] raise similar concerns for Uganda and Senegal, respectively. However, Jutting[88] also points out that membership had increased the capacity to utilise hospital services of the 60% of the district population belonging to the Senegalese scheme he reviewed, and that members requiring hospitalisation recovered on average three weeks faster than non-members, in part because they did not delay treatment on cost grounds.

In other words, a well organised community health insurance programme can provide considerable social protection to poor people. Ensuring that such programmes reach the poorest and vulnerable population groups requires subsidies. While in some contexts this may be administratively and politically feasible, where the majority of the population are very poor and unlikely to be able to afford sustainable premia, it may be more equitable to 'use public resources to reduce the cost of access for all community members'.[89]

Private health insurance arguably constitutes a form of social protection for the rich. Its relevance to pro-poor health policy is the argument that, by moving better-off people into the private sector, more public resources can be concentrated on poorer people. However, as Bennett and Gilson[90] point out, private health insurance often attracts hidden subsidies (in Chile a larger per capita public subsidy than on public healthcare), meaning that resources continue to be skewed towards the better-off. Furthermore, allowing better-off people to opt out of national systems can reduce political pressure to maintain high standards of care for the majority in the public sector. Taken together, these points suggest that the contribution of private health insurance to social protection for the poor is likely to be minimal.

4.6 Nutrition support programmes

This section will focus on general or targeted food price subsidies, feeding programmes targeted at particularly vulnerable groups, and micronutrient supplementation and fortification programmes. These represent the spectrum of social protection measures aiming to support nutritional wellbeing, ranging from the most expensive (food subsidies and feeding programmes, averaging US$103 and $85 per capita respectively) to the least (micronutrient supplementation and fortification, averaging $0.05 to $1.70 per year.[91] General critiques of nutrition support programmes, particularly those which provide donated food directly to vulnerable people, include the distortionary effect they may have on food production, and the fact that they may be addressing Northern food surpluses or corporate food suppliers' agendas more effectively than the specific nutritional difficulties of particular groups.[92] Issues of paternalism related to making transfers in kind rather than cash also arise, and are discussed in Section 4. Nonetheless, well designed programmes can address nutritional deficiencies effectively, and thus contribute to the realisation of poverty reduction goals in the areas of education, health, gender equity and hunger.[93] Nutritional support programmes should be evaluated in terms of the cost effectiveness of their contribution to malnourished people's nutrition, rather than their cost effectiveness as an overall cash transfer – the goals are not the same.

4.6.1 Food subsidies and ration programmes

General food subsidies (e.g. a government subsidy on the price of maize, rice or wheat) have attracted much criticism for their regressive nature and high cost (cf the World Bank's safety nets website in 2000). However, it is arguably mass subsidies on staple products that have

enabled some countries, such as Bangladesh, to eliminate famine. Torlesse *et al*. cite evidence from Bangladesh, Indonesia and Peru which indicates that where staple food prices have been held down (through public or market action), child malnutrition tends to be reduced, since families are able to include a wider range of items with greater micronutrient value in their diets.[94] Despite the political economy benefits of ensuring cheap food supplies for all, current thinking emphasises the economic costs of such approaches and recommends targeting nutritional support to particularly poor or vulnerable groups. Though targeted or rationed food subsidies (i.e. those which make a certain amount of staple foods available only to certain population groups) are also relatively expensive, they may be an effective way of securing nutritional wellbeing where large proportions of the population live below nutritional poverty lines, or to protect people temporarily during a crisis, as in Indonesia following the financial crisis of the late 1980s. Their effectiveness will depend on the specifics of programme design, and in particular, who is eligible, the nutritional value of the ration, the administrative costs and efficiency of the programme and whether programme design and implementation stigmatises participants such that they do not wish to participate, thus undermining coverage.

4.6.2 School feeding programmes

School feeding programmes have generated substantial controversy, on both cost and efficacy grounds. In general, school feeding programmes are felt to be relatively ineffective in improving children's nutrition, since they do not target the most nutritionally vulnerable children (generally under threes or under fives), and may not actually increase resources flowing to nutritionally vulnerable children, since children who receive meals at school may receive less food at home.[95] One much cited positive example is the Tamil Nadu Integrated Nutrition Programme, which combines school feeding with health and education support, and which has resulted in rates of malnutrition 40% lower in participating than non-participating villages – however, it is the synergy between these three kinds of intervention which seems to have made the difference.[96] Targeting such programmes to adolescent girls is rare but could have substantial long-term benefits for their reproductive health and that of their future children.[97] However, the overall evidence is mixed and much depends on the quantity and quality of the school feeding programme (which may vary from a hot meal to a snack, and may essentially provide calories, or may also be rich in micronutrients), as well as the quality of diet otherwise enjoyed by school-age children, and whether the food received substitutes for or is additional to food received at home; the latter two factors clearly can only be assessed in context. More recently, discussion has started to focus on the educational benefits, since good quality school meals, particularly if provided before class, can increase children’s concentration at school and educational performance.

For example, a school breakfast programme in Peru, which provided a nutritionally fortified drink and an iron-fortified grain product, increased participants' memory and comprehension of geometric shapes; in Jamaica, a school breakfast programme led to increased school attendance and improvements in mathematics. In both programmes, the improvements were more striking among the most malnourished children.[98] Such assessments of the impact on children's school performance are relatively rare; analysis of school attendance rates suggests that school feeding programmes can lead to substantial improvements, often particularly for girls in contexts where girls' education is not prioritised, including among pastoralist communities in Burkina Faso and Niger.[99] As such, good-quality school feeding programmes can constitute an important form of social protection. Nonetheless, they do not

address systemic problems with education systems; their contribution is likely to be strongest where poverty and hunger undermine children's ability to concentrate at school.

Unit costs can be reduced by providing meals prepared off-site, or fortified snacks instead of meals[100] – the appropriateness of either strategy will depend on the specific nutritional problems the programme aims to address and the kinds of multiplier effects the programme hopes to achieve (e.g. in creating additional local employment, often particularly for women). Problems of wastage or ineffective targeting can be addressed via focusing these programmes in areas with high concentrations of poor or nutritionally vulnerable children; as with all geographical targeting, there is, of course, a risk that nutritionally vulnerable children in heterogeneous areas may be missed.

4.6.3 Other feeding programmes

In the context of emergencies, whether natural or human-made, emergency feeding programmes are intended to save lives and/or to prevent irreversible nutritional damage, particularly among young children. Though usually considered as 'emergency response interventions' rather than as part of a holistic social protection package, these can nevertheless play an important role in protecting human development in extremely stressful situations where other mechanisms have broken down. As the World Development Report (2000/01) points out, effective social protection can be scaled up when the need arises and, as such, interventions of this kind should form part of the social protection continuum.

Micronutrient supplementation and fortification programmes generally aim to tackle micronutrient deficiencies, sometimes across the population as a whole, sometimes among specific groups, such as children of a particular age group, pregnant women or, more rarely, older people. Programmes aimed at boosting the nutrition of pregnant women and young children are generally intended to help break intergenerational nutritional poverty cycles, and often focus on preventing iron and folic acid deficiencies, while those aimed at the population in general often also aim to prevent iodine deficiency. Provision of food or nutrition supplements generally takes place through health services and doing so is far more cost-effective than parallel vertical nutrition programmes; supplements provided in this way are generally free to designated nutritionally vulnerable groups. For example, provision of vitamin A supplements can reduce child mortality by 23% in areas of high vitamin A deficiency.[101] Micronutrient supplement programmes are sometimes criticised for applying medical solutions to nutritional problems, without addressing their root causes. Certainly, for maximum effect they may need to be coupled with nutritional advice, which addresses eating patterns, but it is increasingly recognised that poverty often means it is impossible to follow such advice. This points to the need for nutritional support programmes to be linked with wider health sector support and anti-poverty action.

Fortification of frequently consumed foods is generally the cheapest strategy; its efficacy will depend on nutritionally vulnerable people purchasing rather than self-providing key foodstuffs. As far as staples are concerned, the impact may thus be greater in urban areas, and among rural wage labourers; reaching nutritionally vulnerable farming households may require supplementation programmes. Realising the potential of fortifying foods that are generally purchased, such as salt, may also require subsidies or special targeting. For example, in Bishkek, the capital of Kyrgyzstan, where goitre is a major public health problem, iodised salt costs around six times non-iodised salt, and is thus simply too expensive for most poor people.

4.7 Legal assistance

Legal aid is the clearest example of an SSAJ instrument that contributes to social protection. Legal aid refers to financial transfers (of the state or other sources to legal aid councils, legal aid NGOs or lawyers providing legal aid) so that poor people can benefit from (free or subsidised) legal advice and legal representation in courts, in particular in criminal cases. Poor people accused of serious crimes, for example those that can be punished by the death penalty or life imprisonment, are often constitutionally guaranteed such protection. Such schemes are, however, often poorly designed and implemented: there are insufficient financial resources; the financial ceilings are usually too low (thus excluding many poor people); legal aid agencies have a low status; there may be competition rather than coordination between legal aid providers, especially NGOs dependent on donor funds; and legal aid lawyers, because they are not well paid, may not be the best qualified, as for example, when law students are used with limited supervision.[102]

Legal aid can both respond to immediate risks (e.g. arrest by police, unfair dismissal – see Box 2 for a description of the risks faced in inhumane prison conditions) and prevent further decline in poverty (effectively enforcing legal entitlements, such as over land or other assets). Legal aid should thus be seen as a targeted social protection instrument; donor financing can be justified on humanitarian and human rights grounds. In many countries, these schemes are poorly designed and implemented, and technical, as well as financial, assistance is required (which donors can also provide).

Legal aid is important, but not necessarily always the best option from a social protection point of view; there is wider range of cheaper and culturally appropriate 'legal assistance' strategies that can also play a social protection role. These include:[103]

- advice provided by paralegals, who are not trained lawyers but can provide advice in accessible manner, such as community-based paralegals;
- strategies of legal empowerment/legal literacy, providing training on human and legal rights and on how to ensure rights are claimed from the correct authorities and respected in practice; and
- public interest litigation, which refers to lawsuits on behalf of groups of individuals or the general public, such as against slum evictions or practices of forcibly detaining patients that cannot afford to pay fees.

In addition, these other instruments should not only be seen through a direct social protection lens; in particular, they have a key role to play in improving the accessibility, fairness and efficiency of the SSAJ sector, by creating a 'demand' for better services and pro-poor laws. More generally, they are central to a rights-based approach, as they contribute to an informed and empowered citizenry able to claim its rights and entitlements to basic and other services.

5 Conclusions and implications for DFID

Enhancing the accessibility of basic services to poor, marginalised and vulnerable people and improving their quality can play an important role in reducing vulnerability. Achieving this means incorporating some measures, traditionally seen as 'social protection' rather than core service measures, into sector investment and reform programmes.

5.1 ***Where the state is the dominant service provider, the priority to achieve this will be investing in state services –*** probably through sectoral or general budget support in the context of PRS or sector strategies that prioritise improving quality and poor people's access. This is particularly likely to be the case in education and health services. It must be noted that the fact that a sector is prioritised or is receiving increasing allocations in a PRS is no guarantee that expenditure will actually be pro-poor – pro-poor intra-sectoral distribution is essential to achieving this. Beyond financing, this includes sector reforms to improve the quality of delivery – which may involve enhanced coordination, in some cases through a SWAp.

5.2 Where the poorest people make use of a greater range of service providers, securing poor people's access to quality services is likely to require a wider range of actions and be less amenable to financial support via sectoral or general budget support. Supporting coordination and synergy within the sector is important, whether via a SWAp or a sector strategy. For example, in Uganda legal assistance NGOs have an agreement with the formal JLOS sector strategy. Support for improved regulation of private sector service providers is also important, for example requiring the private sector to provide pro-poor service options, e.g. through cross-subsidies and lifeline tariffs. Finally, subsidies that allow the poorest people to make use of effective non-state service mechanisms, e.g. community health insurance, are an important part of enhancing both access to basic services and their socially protective role.

5.3 Addressing non-financial barriers to service use (e.g. social exclusion and discrimination). A range of measures beyond promoting poor people's financial access to services, related to enhancing service quality and physical and cultural accessibility as well as non-discrimination, is also vital if basic services are to make their full contribution to the social protection and wellbeing of the poorest people. These include: addressing service provider motivation (often pay-related); enhancing drug and learning material supply and use; providing mother tongue instruction at least in the early stages of education; addressing cultural congruence of justice institutions in post-colonial societies and reforming outdated or anti-poor laws and regulations; and ensuring physical access to services – for example, ensuring women's and girls' needs are taken into account in water supply and sanitation decisions. The role of donors is likely to include financial support for reforms and technical assistance in certain areas.

5.4 Role of social protection mechanisms in access to basic services. Investing in mainstream services alone is unlikely to secure poor people's access and to promote human development outcomes. For poor and vulnerable people, the opportunity costs of using even good-quality, accessible services may be prohibitive. Child labour among poor households which need the child's labour or income is a good example; another is not accessing health services or police and courts because of transport costs. Social protection mechanisms that

address these continued barriers to uptake are, themselves, important components of investment in good quality accessible services. The most relevant social protection mechanisms will depend on the key constraints to service access, but are likely to include cash transfers – whether conditional on the use of a specific service (as in the case of legal aid, or cash for education transfers) or unconditional payments to poor households.

5.5 Mainstreaming social protection mechanisms into basic services. The social protection measures discussed in this paper are often implemented by the providers of basic services; in some cases, such as conditional cash transfers or and health fee waiver exemptions, they may be administered by social welfare departments or specific agencies. While there are advantages and disadvantages to any institutional arrangement, as far as possible social protection measures should be integrated into relevant basic service systems (e.g. micronutrient supplement provision into healthcare systems).This is likely both to reduce costs and to enforce the principle of promoting vulnerable people's access to and use of basic services. Only those without an obvious institutional 'basic service' home, e.g. cash transfers or food fortification, should be implemented by other structures, e.g. local authorities, or other designated agencies. Mainstreaming social protection measures will make additional demands on financial, management and delivery capacity, and these need to be addressed as part of the mainstreaming process. It should be noted that in many contexts, the ministries responsible for social protection programmes (often ministries of welfare) are politically and administratively weak; moves to shift functions to basic service line ministries need to take this context into account.

It is also critical that organisations making decisions about particular people's eligibility for social protection support are not directly affected financially – otherwise there may be incentives to exclude some poor people from their entitlements in order to maintain budgets.[104] Patronage networks more generally can also be a source of exclusion – or adverse incorporation – of the very poorest and most vulnerable in social protection schemes.[105]

5.6 Importance of providing information to users on their entitlements and the roles and responsibilities of government and others in service provision. Many social protection entitlements are unclaimed simply because poor people are unaware of them. Strengthening transparency about services and poor people's entitlements is another critical dimension in enhancing the contribution that services can make to social protection. Without stronger emphasis on provision of information, enhanced accountability will be impossible.

5.7 Mechanisms for enhancing service provider accountability are also vital, to enhance both accessibility and service quality. To be most effective, these require some legal underpinning of the right to information, and to hold service providers to account. Particular promising mechanisms include: district, municipality or village-level monitoring of government budget allocations and actual disbursements; and user-provider councils and citizen report cards. These need to be linked to enhanced participation in decision-making, and empowerment of the poorest people so that they can actually hold service providers to account.

5.8 Ensuring complementarity between policies and provisions, within and between sectors. This requires:

- *That mechanisms to promote access to services strengthen and are strengthened by interventions in other areas.* Examples include ensuring that livelihood support measures do not undermine nutrition because they require poor people to expend excessive energy; or that health and nutrition address the accessibility of clean water. This requires strong coordination between and within sectors, whether through a PRS or a more conscious linking of sector strategies.
- *Balancing short-term interventions which address immediate needs* (e.g. serious nutritional deficiencies) *with those that address longer-term problems* (e.g. food insecurity). There may be contradictions and trade-offs between the two objectives; decisions should be based on an evaluation of the costs and benefits of particular approaches. In doing so, it is important to bear in mind that while tackling immediate human development needs may appear 'welfarist' or 'relief-oriented', this may have long-term (even intergenerational) benefits in breaking poverty cycles, and thus enhance productive capacity and productivity in the long run.
- *Enhancing coherence between specific social protection measures and wider sectoral programmes.* For example, a cash transfer programme to enhance children's school attendance should be implemented in parallel with investments in the education sector which enable already over-stretched schools and teachers to cater for the additional children attending.
- *Sustainability* – greater attention to both financial and environmental aspects of sustainability is important if basic services are to play a genuinely socially protective role.

6 References

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7 Annex: Elements of basic services and their implications for reducing vulnerability

Elements of service/issue	Particularly relevant to address vulnerability among	Issues
Primary healthcare[106]		
General issues		Physical and financial accessibility to user; overall affordability of system; quality (staff know-how and attitudes, availability of equipment and drugs)
Particular services		
Immunisation	Young children, pregnant women; whole population during epidemics	Ensuring adequate financing and supply systems – often largely donor financed. Adult vaccination often given lower priority by public health services and users despite potential to protect livelihoods
Maternal and child health including: ante-natal and post-natal care, and child growth monitoring	Young children, pregnant and lactating women	General issues of financing, availability of service and quality of care outlined above
Micronutrient supplements	Usually aimed at young children, pregnant and lactating women; substantial intergenerational benefits in also targeting adolescents girls	Where whole populations are deficient in key micronutrients, fortification of key foods rather than supplements may be more cost effective; however, there are clear logistical challenges and fortified food may need subsidies. Needs to be supplemented with wider agricultural/ food security and dietary advice efforts which help increase consumption of key nutrients
Prevention and control of locally endemic diseases, including hygiene and nutrition education, water and sanitation	Whole population, though young children particularly vulnerable to diarrhoeal disease, and to many endemic diseases e.g. malaria. However, costs of endemic disease to livelihoods may be huge	General issues of financing, availability of service and quality of care outlined above. Often low priority given to preventative care by primary health facilities and users, particularly where this involves changed sanitation or dietary practices
Treatment of minor injuries	Whole population; specific importance in protecting livelihoods; also wellbeing of children and older people	General issues of financing, availability of service and quality of care outlined above. Also affected by essential drugs supply
Provision of essential drugs	Whole population – vital for effective preventative and curative care	Financing and supply, particularly to primary healthcare units. Maintenance of cold chains for particular drugs; patenting and restrictions on production of generic drugs for some key diseases (e.g. HIV/AIDS)
Relationship to secondary and tertiary healthcare	Whole population	Speed and adequacy of referral procedures, or access to secondary and tertiary care in emergency – strongly affected by financing arrangements esp. costs to users, and physical accessibility
Basic education[107] defined as 10 years of schooling	10 years seen as minimum for acquiring effective numeracy, literacy and other life-skills. Also clearly relationship between secondary education and improved future earnings, and for girls, reduced fertility	Financing; physical access; quality (related to finances, teacher training and motivation, and perceived relevance of curriculum); language of instruction (bridge to national languages); particular efforts (and sometimes incentives) needed to tackle structural disadvantages e.g. those facing girls, the poorest children, child workers, and disabled children
Improved access to water and sanitation facilities	Whole population; although the costs of lack of access and the benefits of improved access are greatest for the poorest (especially female-headed households). Women and children particularly vulnerable	Health and nutrition benefits (especially infants). Physical accessibility, convenience, time/energy spent collecting water and impact on household labour availability. Physical injury, personal safety and dignity (especially women and children) Financial costs associated with access, including contribution to capital and O&M costs and water tariffs Sustainability: managing changing patterns of competing demands and prioritising basic needs

8 Endnotes

[1] Childhood Poverty Research and Policy Centre, Save the Children UK

[2] Overseas Development Institute

[3] Overseas Development Institute

[4] Shepherd, 2004.

[5] Harper *et al.*, 2003.

[6] These sectors were chosen by DFID through an internal consultation process. The diversity among them inevitably presents difficulties in coherent analysis across these four sectors.

[7] The Alma Ata Declaration of 1978 defines the following as key elements of primary healthcare: education concerning health promotion, promotion of proper food supply and nutrition, an adequate supply of safe water and sanitation, maternal and child healthcare, including family planning, immunization against major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries and provision of essential drugs (WHO, 1978).

[8] Basic water needs are context specific and setting quantities as standards should be avoided. Basic sanitation is typically defined as access to a sanitary facility for human excreta disposal in the dwelling or immediate vicinity. Sanitation services are typically seriously underprovided largely because they require coordinated effort across different sectors (notably health, education and water).

[9] DFID, 2000.

[10] Devereux, 2002.

[11] ICESCR Article 13.

[12] ICESCR Article 12.

[13] ICESCR Articles 11 and 12 and CESCR General Comment 12.

[14] ICCPR.

[15] Piron, 2004.

[16] ODI, 2002.

[17] Rosen and Vincent, 2001.

[18] ODI, 2003.

[19] NSO, 2004.

[20] Anderson, 2003.

[21] PRI, 1999.

[22] Devereux, 2003:18.

[23] Mathur, Rajagopal and Bhargava, 2004.

[24] On synergies with health, see Mehrotra (forthcoming).

[25] Vandemoortele, 2001.

[26] CPRC, 2004.

[27] Piron, 2004.

[28] Pearson, 2002.

[29] World Bank, 2004.

[30] Ibid.

[31] See ODI (2004) for detailed discussion.

[32] DFID, 2004.

[33] Anderson, 2003.

[34] ICCPR.

[35] Save the Children, 2002.

[36] Yates and Cooper, 2004.

[37] World Bank, 2004.

[38] Mehrotra (forthcoming).

[39] Tang and Bloom, 2001.

[40] SSerumaga, 2003.

[41] The 2004 World Development Report gives numerous examples, including that of the health sector in Cambodia.
[42] Hilary, 2002.
[43] Brown, 2001.
[44] World Bank, 2004.
[45] Goetz and Gaventa, 2001.
[46] Piron, 2004.
[47] Cook, 2002.
[48] Devereux, 2002.
[49] Cash transfers may be the exception as they may pose excessive administrative burdens on front-line sectoral service providers and may be more effectively provided by a separate agency (e.g. a ministry of social welfare) or through local administrative structures. Similarly fortification of staple foods is likely to take place through a partnership between the ministries of agriculture and health and the private sector, rather than through investment in a particular sector.
[50] Marcus, 2002.
[51] Rawlings and Rubio, 2003; Coady and Morley, 2003.
[52] Coady and Morley, 2003.
[53] Coady and Morley, 2003.
[54] Self-targeting may more feasible in a highly literate context with strong flows of information, such as Chile, than elsewhere.
[55] Coady and Morley, 2003, cited in Barrientos and de Jong, (forthcoming).
[56] Barrientos and deJong (forthcoming).
[57] Rawlings and Rubio, 2003.
[58] Barrientos and de Jong (forthcoming).
[59] Rawlings and Rubio, 2003.
[60] Barrientos and deJong, (forthcoming).
[61] Rawlings and Rubio, 2003.
[62] Barrientos and de Jong, (forthcoming).
[63] Cameron, 2000.
[64] This paragraph is based on a personal communication from Karen Johnson, Save the Children UK, Mozambique.
[65] Bitran and Giedion, 2003.
[66] The World Development Report 2004, for example, provides a flow-chart to help readers assess when user fees may be justified. It concludes that user fees should be used where poor people can be compensated or their fees waived, where service financing is impossible by any other route and where the service may be overused if fees are not charged (e.g. water, electricity and some forms of curative care).
[67] Arhin-Tenkorang, 2001; Nyonator and Kutzin, 1999; Reddy and Vandermoortele, 1996.
[68] cited in Yates and Cooper, 2004.
[69] Yates and Cooper, 2004.
[70] CHER, 2002.
[71] Bitran and Giedion, 2003; CHER, 2002.
[72] Grant and Hulme, 2004, citing Appleton, 2003.
[73] World Bank, 2004: 3.
[74] Later renamed Cash for Education.
[75] World Bank, 2004: 3.
[76] Bitran and Giedion, 2003.
[77] Yates and Cooper, 2004.
[78] World Bank, 2004.
[79] Bennett and Gilson, 2001.
[80] Gilson, cited in Bitran and Giedion, 2003.
[81] UN OCHA, 2004.

[82] Bennett and Gilson, 2001.

[83] Bennett and Gilson, 2001:12–13.

[84] Arhin-Tenkorang, 2001.

[85] The CAM was preferred by women over user fees since pre-payment meant they no longer had to negotiate with their husbands over cash for particular medical expenses, and could take sick children for treatment more frequently.

[86] Yates and Cooper, 2004, citing Arube Wani *et al.* 2002.

[87] Jutting, 2001.

[88] Jutting, 2001.

[89] Yates and Cooper, 2004: 3.

[90] Bennett and Gilson, 2001.

[91] Horton, 1999 cited in Gillespie and Haddad, 2003.

[92] Rogers and Coates, 2002.

[93] Gillespie and Haddad, 2003

[94] Torlesse *et al.*, 2003.

[95] Rogers and Coates, 2002; Del Rosso, 1999.

[96] Rogers and Coates, 2002; Anna Taylor, Nutrition Advisor, Save the Children, UK, personal communication.

[97] Rogers and Coates, 2002.

[98] Del Rosso, 1999.

[99] Del Rosso, 1999.

[100] Del Rosso, 1999; Rogers and Coates, 2002.

[101] SCN, 2004, citing Beaton, 1994.

[102] For a recent review of legal aid schemes and successful reform, initiatives see Open Society Institute (2004).

[103] For good country illustrations, see McClymont and Golub (2000).

[104] Bitran and Giedion, 2003.

[105] Wood, 2003.

[106] This table is based on the Alma Ata definition of primary healthcare, which is taken as a proxy for basic healthcare here. The definition of basic education is 10 years (which usually incorporates both primary and some secondary schooling), since it is widely recognised that solely attending primary education often leaves young people without functional skills.

[107] Because education cannot be broken down into discrete service elements in the same way that health services can, different elements are discussed together.