/3

MAKING SOCIAL POLICY WORK FOR WOMEN

SHAPING A REVOLUTION

Transforming social protection for women in Egypt

Women's empowerment is at the heart of the Egyptian Conditional Cash Transfer (CCT) programme. Born in a turbulent political climate, the programme has survived the upheaval of the Arab Spring revolution and subsequent political turmoil, and delivered results for some of Egypt's most marginalized women.

In the programme, low-income families get financial support from the Egyptian government as long as they meet certain conditions on school attendance, regular visits to health clinics and nutrition.

Launched in 2008, it was the first of its kind in the Arab world, but it was not a new idea: across Latin America, CCT programmes have long been hailed for reducing poverty. These CCTs are aimed at women but not designed with women's rights in mind, and feminists have argued the duty of fulfilling the necessary conditions to qualify for payment can become a burden for women, increasing their workloads and reinforcing the stereotypical notion that unpaid care work is their responsibility.

A family in Cairo's Ain El-Sira neighbourhood

Photo: Pathways of Women's Empowerment/Heba Gowayed

The team behind the Egyptian programme, led by Dr. Hania Sholkamy, a feminist researcher from the Social Research Centre at the American University in Cairo, took the existing CCT policy framework and rebuilt it with women's rights as its core.

The Egyptian team decided that women should be compensated for any time spent fulfilling the conditions, recognizing and rewarding their unpaid care work, and that payment should be made through bank transfers so women could keep control of their own finances. They launched a pilot scheme in 2009 with 400 families in Cairo's Ain El-Sira slum.

"We were aware of the criticisms of conditionalities, but we soon realized that, designed well, they could actually strengthen women's decision-making power in the household," says Hania. The Ain El-Sira women told the team they wanted their children to be educated, well-fed and healthy, and if the state was endorsing their wishes, this gave them license to spend money in the ways they thought most important.

"We talked to the women in the area, we talked to social workers, and developed our programme in consultation with women and with field workers who also happened to be women themselves," says Hania.

Perhaps the most significant change came when the women were issued with their bankcards. When they went to collect them, the bank manager closed the branch and called the police because he had never seen poor women in his bank. After some diplomacy, Hania got the cards to the women, and then trained them how to select a pin and use a cash machine.

The team decided that women should be compensated for any time spent fulfilling the conditions, recognizing and rewarding their unpaid care work

Walking in Cairo's Ain-El-Sira neighbourhood

Photo: Pathways of Women's Empowerment/Heba Gowayed

"These women were so focused on protecting their money, on how never to lose this card, never to give this card to anyone, never to forget the pin," says Hania. The thin piece of plastic gave the women a new sense of dignity. They possessed something powerful that belonged to no one else in the family.

The role of the social workers was also key. Mostly low-income women themselves, these workers provide support and information. They also organize monthly meetings, bringing together programme participants, to cover topics including housing, voting and health.

After a year, children's school results were improving. The women were working fewer hours but in better jobs: the reliability of the payments meant they knew their minimum needs would be met, so they didn't have to take on badly paid, exploitative work for survival. More than a quarter of women who had reported domestic violence said it had stopped now that financial pressure on the family had eased and they no longer had to ask their husbands for money. The pilot was a success.

Just as the team prepared to roll out the programme to 25,000 families in 65 villages in Upper Egypt, the Arab Spring came. The project was put on hold. In 2012, the Government said they planned to scrap the entire programme, outraging the women of Ain El-Sira. "I got a phone call from the head of security at the Ministry of Social Affairs telling me that these women were protesting and were barricading the building," Hania smiles. "They'd got on public transport and taken themselves to the Ministry to demand the programme not be scrapped." In the end their protests proved fruitless. The programme was deemed against the interest of Egypt. There was no longer political will for it.

Yet the idea for the programme remained in people's minds. When the regime changed once more in June 2013, a new minister was appointed, Ghada Wali, who in her former role at UNDP had helped Sholkamy raise funds to cover research costs. She invited Sholkamy back to relaunch the programme and it's now finally going national, with a budget allocation to cover half a million families in six months.

For Hania, it's been a steep learning curve. "Initially I was hoping no one would realize that this money is going to women, that it would just be under the radar, but the revolution meant we were put under tremendous scrutiny," she says. "Now at every juncture you're never sure if this will continue or not." But if the team can continue their work, she says, its momentum will become unstoppable.

Hania Sholkamy, lead researcher of Egypt's CCT programme

Photo: UN Women/Ryan Brown

"These things have to build like sedimentation. You need to have layer upon layer of people who have a vested interest in empowering women."

"These things have to build like sedimentation. You need to have layer upon layer of people who have a vested interest in empowering women, particularly poor women, all working in union, building up one thing after the other. That's when you have an achievement on which there can be no U-turn."

Story: Jenny Kleeman. For more information on the Egypt's Conditional Cash Transfer Programme see Sholkamy 2014 and the Pathways of Women's Empowerment website: www.pathwaysofempowerment.org

IN BRIEF

/1 Demographic, family and household structures are experiencing major shifts in both developed and developing countries with implications for income security and care provision. Social policies need to adapt to the reality of population ageing, single parenthood and migration.

/2 Currently, 73 per cent of the world's population have only partial or no social protection. Women are over-represented in this group.

/3 The best way to realize economic and social rights for all, without discrimination, is through a comprehensive approach to social policy that combines universal access to social services with adequate social transfer systems in a 'social protection floor' (SPF).

/4 Policy makers designing national SPFs should conduct a thorough assessment of care needs to make sure that SPFs contribute to the recognition, reduction and redistribution of unpaid care and domestic work.

/5 Social transfers can reduce poverty and inequality and increase women's access to personal income. To achieve this, benefit levels should be high enough and regularly adjusted to guarantee the right to an adequate standard of living.

/6 Accessible and affordable social services are also essential for substantive equality for women. Their effect on poverty and inequality can be even greater than that of social transfer systems.

/7 Social services are particularly important to alleviate demands on women and girls to provide unpaid care and domestic work. Public investments in health, water, sanitation and care services, in particular, need to be increased.

/8 Together, social transfers and services can be a powerful tool to redress women's socio-economic disadvantage resulting from unpaid care responsibilities and unequal employment opportunities. In order to do so, however, they need to be transformed to better respond to women's rights.

INTRODUCTION

Social policy is fundamental to the quest for social justice, women's rights and gender equality. Defined broadly as a set of public interventions that affect the welfare and well-being of citizens,[1] social policy is typically understood to cover issues such as income security, health, housing and education. It is therefore crucial to the reduction of poverty and inequality, the strengthening of human capabilities and the realization of human rights, the enjoyment of which has long been enshrined in international human rights treaties (see Box 3.1).

BOX 3.1

Economic and social rights: Interlinked and indivisible

The International Covenant on Economic, Social and Cultural Rights (ICESCR) clearly stipulates a series of economic and social rights, including:

- The right to social security (article 9)
- The right to an adequate standard of living, including adequate food, clothing and housing (article 11)
- The right to the highest attainable standard of physical and mental health (article 12)
- The right to education (article 13)

In 2010, the United Nations General Assembly also recognized that safe and clean drinking water and sanitation was a human right 'essential for the full enjoyment of life and all human rights',[2] reinforcing an earlier clarification by the Committee on Economic, Social and Cultural Rights (CESCR) that the right to water was part of the right to an adequate standard of living and the right to health.[3]

Although the above rights are separately codified, in practice their realization is highly interdependent. For example, realizing the right to health requires not only accessible and affordable health services but also the availability of food, water and sanitation, clothing and housing; access to quality education; and protection from risk and contingencies such as maternity, illness or work-related accidents through adequate social security.

States are obliged to ensure that women and men can equally enjoy these rights without discrimination (article 3). The CESCR has also clarified that the realization of these rights depends on the accessibility, affordability, acceptability and quality of related social services as well as on the adequacy of transfer payments such as pensions, family allowances or unemployment benefits.

As Chapter 2 has shown, paid employment does not always provide a route out of poverty. Nor does it automatically lead to women's empowerment or protect them from economic dependence. To guarantee women's right to an adequate standard of living, employment policies aimed at the generation and regulation of decent work have to be accompanied by social protection and social services that provide income security and enable people to live their lives in dignity.

Towards a universal social protection floor

Recently, the United Nations Social Protection Floor (SPF) Initiative has given substance to the rights outlined here, as well as a concrete strategy for their progressive realization. The SPF proposes a nationally defined set of minimum guarantees, including basic income security for children, working-age adults, older people and people with disabilities, as well as basic social services for all.[4] This initiative holds significant promise for women, who are over-represented among those excluded from existing social protection schemes.

Gender inequality in access to social services and social protection is particularly marked where public provision is weak, since women's lower access to income and assets means that they are less able than men to join private insurance schemes and more likely to be deterred by user fees for social services.[5] There are fears that the lingering economic crisis and ensuing fiscal austerity measures will have similar effects to those of structural adjustment programmes in the 1980s and 1990s, which had devastating social consequences, particularly for women and children.[6]

In the absence of adequate public support, women and men, especially in low-income households, are forced to rely on informal social networks.[7] Dependence on kinship, family and community can be deeply problematic for women. On the one hand, informal networks rely heavily on women's unpaid care and domestic work. On the other hand, women's own needs for support are rarely adequately acknowledged and addressed due to prevailing social norms and gender power relations. In addition, family and household structures are rapidly changing in ways that affect the potential for informal support within and between households (see Box 3.2).

Greater state involvement does not, in and of itself, ensure equitable outcomes from social policy. Examples abound of gender gaps in access to state-run social protection schemes and gender-biased delivery of social services. Social protection and social services are sometimes delivered in ways that stereotype or stigmatize women—especially those who are poor, disabled, indigenous or from an ethnic minority—or burden them with additional unpaid labour. Yet, the state 'remains the only actor able to extract the vast resources from society that make possible significant distributive and redistributive policies and (...) the most readily available route for poor social groups to influence the conditions of their own lives'.[8]

National SPFs can be a powerful tool for **redressing women's socio-economic disadvantage**. But in order to advance substantive equality, their design needs to account for the gender, as well as other, sources of discrimination, that prevent women from enjoying their socio-economic rights on the same basis as men. For example, women's disproportionate responsibility for unpaid care and domestic work impedes their enjoyment of rights to work, rest and leisure, social security, education and health.[9] This needs to be acknowledged in the design and implementation of SPFs by **addressing stereotyping, stigma and violence** through measures that reduce gender-specific risks and responsibilities. Equally, women's rights to income security and to access basic social services cannot hinge on a presumed relationship to a male breadwinner, which risks either exposing them to abuse, humiliation or violence or excluding them from these rights. In order to prevent unwanted economic dependence, social policies must treat women as individual right-bearers. Greater efforts are also needed to make the delivery of social services—such as education, health, housing and water and sanitation—responsive to the specific needs of women and girls. As this chapter shows, **strengthening women's agency, voice and participation** in

social policy design and delivery can improve state responsiveness to women's needs and accountability for gender equality.

Investing in social protection and social services seems daunting in the prevailing economic climate, but it is by no means impossible. In fact, some countries, such as Argentina and China, have scaled up their investments in social protection in response to the recent economic crises.[10] Even for the poorest countries, providing a basic benefit package along the lines of the United Nations SPF is within reach.[11] It has been estimated, for example, that the introduction of universal social pensions would cost around 1 per cent of gross domestic product (GDP) per year in most countries of sub-Saharan Africa. In Viet Nam, a package for children under 16 years consisting of a family allowance per child equivalent to 50 per cent of the minimum wage plus additional educational services and one meal per day would cost 0.8 per cent of GDP.

In many low-income countries, the introduction of these benefits will have to proceed gradually and alongside increased efforts to expand fiscal space (see Chapter 4). Governments and donors need to weigh the immediate costs of such social investments against their long-term benefits: adequate social protection can prevent the depletion of skills during times of widespread unemployment and ensure continued investment in child nutrition, health and schooling.[12]

Chapter overview

In line with the building blocks of the SPF, the chapter is divided in two parts. Figure 3.1 provides a visual overview:

The first part of this chapter focuses on social transfers. These are the typical measures through which governments provide income security to their citizens throughout their life course. The second part looks in depth at the provision of social services and essential public goods. It focuses on health care, water and sanitation and care services, where significant challenges remain to the realization of the rights of women and girls.[13] These areas are of paramount importance for the achievement of substantive equality, but they have received limited attention from feminists compared to issues such as reproductive rights or violence against women. In both parts, the chapter scrutinizes existing policies and programmes from a gender perspective and highlights ways to improve their performance for the advancement of substantive equality for women. Specific attention is paid to the constraints faced by indigenous women, rural women, women with disabilities and ethnic minority and migrant women, who face multiple challenges to realizing their rights.

This chapter supports the argument—also made by other United Nations agencies—that the best way to realize economic and social rights for all without discrimination is through a comprehensive approach to social policy that combines universal access to social services with social protection through contributory and non-contributory transfer systems.[14] While the narrow targeting of social protection to the poorest households may seem to be more affordable in the short term, building universal systems that benefit everyone can actually expand financing options by increasing the willingness of middle and higher income groups to pay taxes for well-functioning education, health or pension systems that they would also use.[15]

In order to achieve substantive equality for women, the challenge is not only to redress their disadvantage in access to transfers and services already in place. Existing provision must also be transformed to take better account of gender differences in status and needs and to effectively address stereotypes, stigma and violence. This chapter highlights promising innovations across a range of policy areas that can contribute to such transformations. It underlines the vital role played by women's movements and organizations in raising new or neglected issues—including violence against women and unpaid care and domestic work—to be addressed through public policies. It also highlights the importance of women's organizations working with others, including governments, bureaucracies and parliaments, to translate their claims into concrete policy changes.

Figure 3.1

CHAPTER STRUCTURE AND TERMINOLOGY

Well-designed social protection and social services can bolster the realization of women's rights

SOCIAL POLICY

Well-designed social protection and social services can narrow gender gaps in poverty rates; enhance women's income security and access to personal income; provide a lifeline for poor women, especially single mothers; and contribute to the reduction and redistribution of unpaid care and domestic work

SOCIAL TRANSFERS

- *Child benefits*
- *Unemployment benefits / public works**
- *Old-age pensions*

SOCIAL SERVICES

- *Health services*
- *Care Services*
- *Water and sanitation*

MODES OF ACCESS

Non-contributory

Eligibility for transfers or access to services requires no prior contribution from beneficiaries

⟷

Contributory

Eligibility for transfers or access to services is contingent on prior contributions to social insurance, usually covering workers in formal wage employment

Universal

Eligibility for transfers or access to services is based on the single condition of residence

⟷

Means-tested

Eligibility for transfers or access to services is contingent upon proof of need, usually targeting households whose income falls below a certain threshold

Unconditional

No further requirements

⟷

Conditional

Eligibility for transfers is contingent on the fulfilment of further conditions, such as work requirements, medical visits or school attendance

* Public works or Employment Guarantee Schemes are not strictly speaking social transfers, since the cash benefit is usually conceived of as a wage in exchange for work participation. However, because they aim to fulfil a similar role as traditional unemployment benefits—namely enhancing income security among the unemployed—they are treated under the category of social transfers in this chapter.

TOWARDS GENDER EQUALITY IN SOCIAL TRANSFER SYSTEMS

SOCIAL TRANSFERS AND WOMEN'S INCOME SECURITY

Social transfers—such as child and family allowances, unemployment benefits, paid maternity and parental leave, old-age pensions and disability benefits—play a major part in reducing poverty and inequality.[16] From a human rights perspective, thoughtfully designed social transfer systems not only bolster the right to an adequate standard of living but also contribute to the realization of other rights, including those to education, food, health and work.[17] They encourage investments in skills and human capabilities, facilitate the acquisition of productive assets, stabilize demand in times of economic downturn, stimulate productive activity and assist people in looking for employment.[18]

Social transfers can be powerful tools for redressing women's socio-economic disadvantage. Women are particularly vulnerable to economic insecurity and financial dependence due to their unequal employment opportunities. Changes in family and household structure also have major implications for women's income security (see Box 3.2). In many parts of the world, large numbers of women raise children on their own, and the migration of both women and men raises additional challenges for the care of children or elderly parents. Informal safety nets are increasingly fragile: many households simply cannot afford to extend support to others for long periods, while community-based support is frequently minimal and precarious.[19] Social transfers can mitigate these risks and lessen the effect of market-induced inequalities.

BOX 3.2

Changing demographic, family and household structures: New challenges for social protection

Both developing and developed countries have experienced major shifts in patterns of family formation and living arrangements, including population ageing, the postponement of marriage, declining fertility, increasing rates of cohabitation outside marriage, a rise in same-sex unions, rising rates of divorce and a growth in single-person, female- or child-headed and multi-generational and transnational households. These shifts have led to a huge diversity in family and household structures, challenging stereotypical assumptions about the 'family' that have long underpinned social policy in different countries and regions.[20]

Today, about 15 per cent of children in Organisation for Economic Co-operation and Development (OECD) countries live in single-parent households—and this number is expected to grow.[21] Women, who head 85 per cent of these households in the OECD,[22] often cannot—or choose not to—rely on income transfers from a male breadwinner. Across a range of developed countries, single-mother

households are three times as likely to be poor as households where mothers live with a partner or spouse, reflecting the difficulty of combining family responsibilities with earning an adequate income.[23] Social policies—including income support, parental leave and childcare services—can make a big difference here.

In Latin America, the prevalence of both two-parent nuclear families and extended families declined between 1990 and 2004 and the share of single-parent households increased.[24] In Central America and sub-Saharan Africa, a particularly high share of children lives with only one or neither of their parents. In South Africa, for example, where childbearing often takes place outside of marriage, only 35 per cent of children were living with both parents in 2012, while 39 per cent were living with their mothers but not their fathers, 23 per cent with neither parent and 3 per cent with their fathers only.[25]

Demographic ageing represents a major challenge for social policy in both developing and developed countries.[26] Between 2013 and 2050, the global population aged 60 years or over is projected to more than double.[27] By 2050, nearly 8 in 10 of the world's older people will live in the less developed regions.[28] Migration within and across national borders also raises challenges including the organization of care, given the increasing numbers of women on the move. In China, for example, rural-urban migration of working age adults has resulted in a large left-behind population: a full 28 per cent of rural children live with only one parent, grandparents or other relatives.[29]

Social transfers reduce poverty and inequality

Public social transfers have a major poverty-reducing effect. A recent review of pre- and post-transfer poverty rates in 27 high-income and 10 middle-income countries shows that in developed countries, social transfers reduce by around 60 per cent the proportion of women and men living in poor households and in Latin America, they decrease female and male poverty by 30 per cent.[30] In South Africa transfers bring poverty rates down by 37 per cent. The poverty-reducing impact of social transfers is lower in China, India and the Republic of Korea, but still significant at 18 per cent, 11 per cent and 32 per cent, respectively.[31]

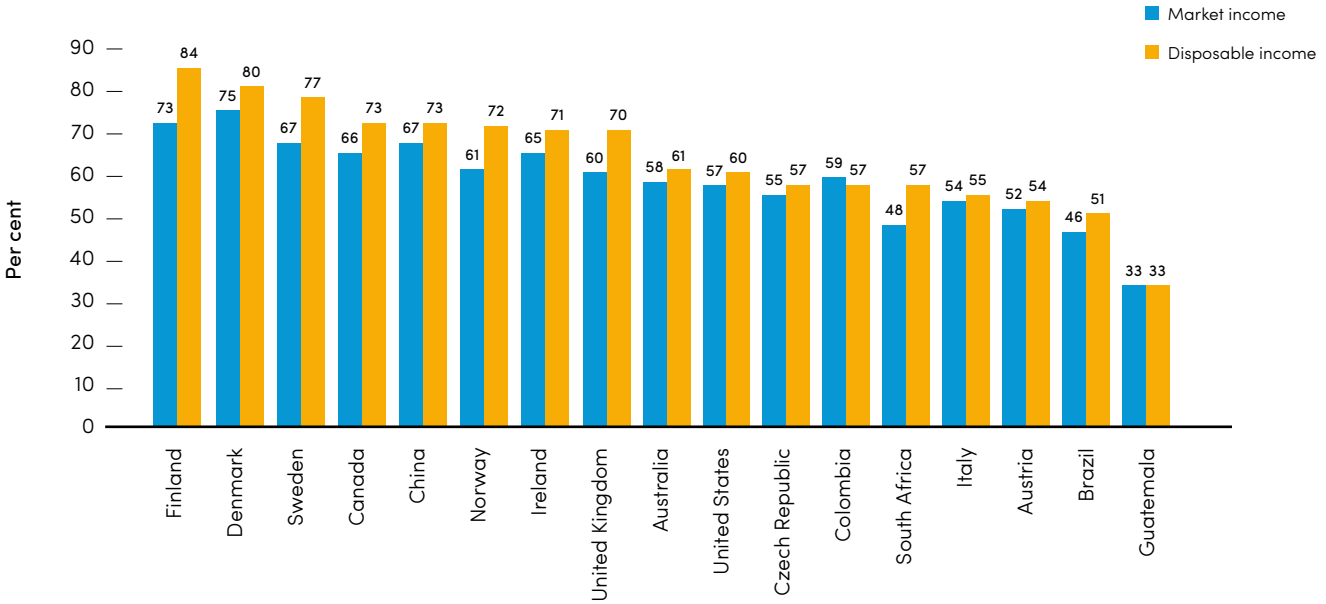
Social transfers also narrow the gender gap in poverty rates and increase women's access to personal income. In 28 countries where women are more likely than men to live in poor households before transfers, the gender gap in poverty narrows substantially after transfers. In Guatemala, for example, women's poverty rates are 4.2 percentage points higher than men's before transfers but almost 1 percentage point lower after transfers.

Across the 17 countries for which individual-level data on women's access to income from paid employment and social transfers are available, women's income from paid employment, before transfers lags behind men's—with the female/male ratio ranging from 33 per cent in Guatemala to 75 per cent in Denmark, as shown in Figure 3.2.[32] With the exception of Colombia and Guatemala, this ratio improves after social transfers are taken into account. But women's personal income continues to be substantially lower than men's everywhere, indicating that existing social transfers are insufficient to fully redress the disadvantage arising from gender inequality in labour markets.

Figure 3.2

Women's personal income as a percentage of men's before transfers (market income) and after transfers (disposable income), 2000-2010

⟶ Across countries, social transfers narrow but do not eliminate the gender gap in income from paid employment



Source: Gornick and Jäntti 2014, based on data from the Luxembourg Income Study (LIS) Database.

Note: Market income includes, for example, income from earnings (both employee and self-employed earnings) and occupational pensions (public and private). Disposable income adds, for example, state old-age and survivors benefits, unemployment benefits, short-term sickness and injury benefits, child-related benefits and family leave benefits. Both market and disposable income are net of taxes. Data refer to the most recent available during the period specified.

From a gender equality perspective, the growing emphasis on social protection in low- and middle-income countries is encouraging. Greater access to non-contributory pensions can enhance women's income security in old age, while increasing cash transfers to families with children can promote investment in girls' education as well as women's economic activity (both discussed further in this Chapter). Nevertheless, social transfer systems face serious challenges in many countries, including insufficient coverage, low benefit levels and institutional fragmentation. Meanwhile, many high-income countries are reducing social protection in response to austerity measures (see Chapter 4).[33]

The following sections focus on the three main types of social transfers that support income security at different stages of the life course: child and family allowances, including conditional cash transfer schemes; unemployment protection, including employment guarantee schemes; and old-age pensions, including both contributory and non-contributory schemes. For each type of transfer, different modes of benefit provision—universal and means-tested, conditional and non-conditional—are analysed through the lens of substantive equality. Finally, the sections highlight pathways for transforming social transfer systems towards greater gender equality, through women's active participation in their design, management and monitoring.

SOCIAL TRANSFERS FOR FAMILIES WITH CHILDREN

There is growing interest among governments and donors in the potential of social policy to mitigate poverty among families, which is perceived to be especially harmful for children's long-term development.[34] Families with children are at higher risk of poverty due to the costs of childrearing and the difficulty of combining caregiving and paid work. Single-parent households, most of which are headed by women, face the greatest challenges (see Box 3.2). Indeed, as shown in Figure 3.3, without social transfers, more than half of single mothers and their children would be living in poverty across a range of countries.

Social transfers are essential for reducing poverty among single mothers in all countries, although their impact varies. At one end of the spectrum, transfers in Denmark, Poland and Sweden reduce poverty among single mothers by 70–90 per cent. At the other end, transfers in India, Italy, Japan and South Africa reduce poverty among single mothers by 18–30 per cent. Although poverty rates among single mothers remain above average in almost all countries, transfers clearly do make an important difference.

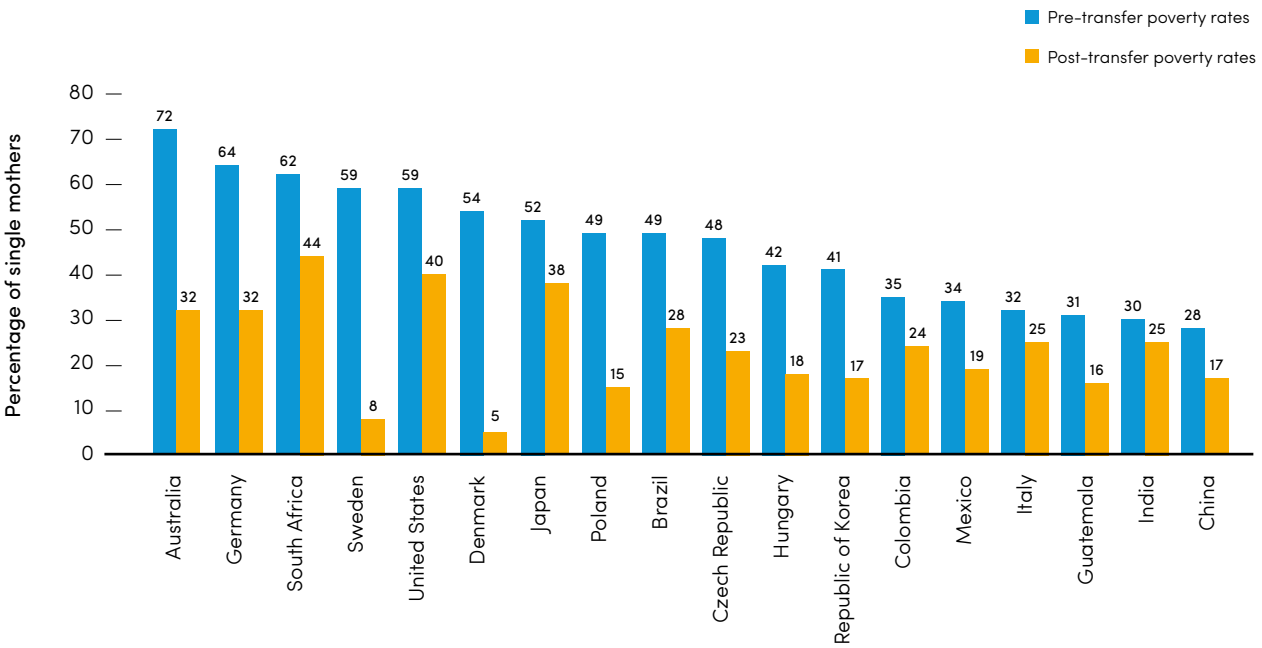
The growth of child-related transfer programmes

Gender equality and women's income security have never been the primary objectives of child or family allowances, which are usually intended to help families shoulder some of the costs associated with raising children. Nevertheless, since they often provide a source of autonomous income for mothers and a recognition of their role in society, they have

Figure 3.3

Poverty rates among single mothers before and after transfers, percentage of single mothers, selected countries, 2000-2010

⟶ Social transfers are essential for reducing poverty among single mothers



Source: Gornick and Jäntti 2014, based on data from the LIS database.

Note: Data refer to the most recent available during the period specified.

the potential to contribute to the achievement of substantive equality for women.

Child-related transfers come in different shapes and sizes, including direct transfers or indirect tax benefits, universal or targeted, conditional or unconditional schemes.[35] Such transfers have a long history in the developed world, where they have evolved from targeted transfers for vulnerable orphans and widows to more universal benefits.[36] In 2012, more than half of the Organisation for Economic Co-operation and Development (OECD) countries for which data were available provided universal family benefits. Yet, faced with economic crisis and austerity, the temptation is growing for governments to turn away from universalism towards targeted benefits. For example, since 2011, the United Kingdom has frozen child benefits and transformed them from previously universal entitlements into means-tested ones.[37]

In developing countries, a new generation of child-related cash transfer programmes channels payments to mothers in the knowledge that women are more likely than men to prioritize children's well-being.[38] Initiated in two countries—Brazil and Mexico—in the 1990s, conditional cash transfer programmes now operate in more than two dozen countries in Africa and Asia and virtually everywhere in Latin America (see Table 3.1 for selected examples).[39] There is growing evidence that cash transfers contribute to the reduction of poverty and inequality.[40] In most cases, receipt of benefits is conditional on ensuring school attendance, taking children to regular health checks or participating in parenting workshops. Access is also, for the most part, means tested, specifically targeting poor and vulnerable households. But exceptions exist: in Argentina, for example, a Universal Child Allowance was introduced in 2009 to make family benefits available to those who were not already covered though family allowances in the contributory system.

Social transfers and girl's education

Conditional and unconditional transfers can also support the realization of children's rights to education, food and health by improving school attendance, nutrition levels and immunization rates.[41] In some cases, through affirmation action, cash transfers have been used to redress the disadvantage faced by girls with regard to secondary school attendance. Bangladesh's Female Secondary School Stipend Programme, for example, has decreased gender disparities in enrolment and boosted girls' completion rates by providing tuition fees as well as a monthly stipend for girls.[42] In Mexico's *Oportunidades*, recently rebranded as *Prospera*, transfers were 10 per cent higher for girls than for boys at the onset of secondary school, which is when the risk of female drop out is highest.[43]

Such measures send a strong message to households and communities that girls are 'worth investing in' and can be a catalyst for the long-term realization of gender equality.[44] Better educational opportunities for girls enhance their self-esteem and life chances through increasing their lifetime earnings, delaying marriage and reducing fertility and maternal mortality rates.[45] In Malawi, for example, a cash transfer programme for girls resulted not only in higher school attendance but also in declines in early marriage and teenage pregnancy.[46]

Child-related cash transfer programmes can also provide a regular and reliable source of income to women caring for children, particularly those who receive limited or no support from male partners. In a number of cases, they have been found to promote women's economic activity. In Mexico, for example, women's participation in the *Oportunidades/ Prospera* programme has been associated with increased investment in productive assets that they control, while the guarantee of a regular monthly stipend in Brazil eased women's access to credit and allowed many to return to education.[47] South Africa's Child Support Grant has been found to facilitate women's access to paid employment.[48] Finally, cash transfers can enhance women's self-esteem and financial security as well as giving them opportunities to access new public spaces and communicate with other women.[49]

Table 3.1

Cash transfer schemes for families with children in selected developing countries

Country	Cash transfer scheme	Year established	Reach	Benefit level	Conditions
Argentina	*Asignación Universal por Hijo and Asignaciones Familiares*	2009	Combined 10.5 million children = 85% of children	$46 per month	Yes
Bolivia, Plurinational State of	*Bono Juancito Pinto*	2006	400,000 households = 19% of population	$29 per year	Yes
Brazil	*Bolsa Familia*	2003	14 million households = 29% of population	$35–284 per month depending on household size and characteristics	Yes
Ecuador	*Bono de Desarrollo Humano*	2003	1.2 million households = 41% of population	$50 per month	Yes
Ghana	Livelihood Empowerment Against Poverty	2008	70,000 households = 1% of population	$4–7 per month depending on household size and characteristics	Yes
Malawi	Social Cash Transfer Programme	2006	28,000 households = 1% of population	$4–13 per month depending on household size and characteristics	No
Mexico	*Oportunidades/ Prospera*	1997	6.6 million households = 27% of population	$25–219 per month depending on household size and characteristics	Yes
Namibia	Child Maintenance Grant	1960	86,100 children = 9% of children	$26 per month for first child, $13 for every additional child	Yes
South Africa	Child Support Grant	1998	11.3 million children = 55% of children	$35 per month	Yes (since 2011)

Source: ECLAC 2014b; DFID UK 2011; Barrientos and Niño-Zarazúa 2010b; Fultz and Francis 2013; Levine et al. 2009; The Government of Ghana 2013; Patel 2011; Roca 2011.

Note: All benefit amounts are in US dollars.

No guarantee of empowerment

However, cash transfer programmes do not always confer benefits on women and their impact is not automatically 'empowering'. Benefit levels are often too low to provide women with financial independence or a greater say in household decision-making. Evaluations of Ghana's Livelihood Empowerment Against Poverty (LEAP) programme, for example, found that, in spite of transfers being directed to women, decision-making remained with husbands, brothers and sons.[50] In this case, the low level of benefits was compounded by irregular and inconsistent payments.

There is also a tension between the economic support that such programmes provide, on the one hand, and the risk of reinforcing exclusion, stigma or gender stereotypes, on the other, through the use of means testing and conditionalities. Means testing raises the danger of excluding potentially eligible and vulnerable people.[51] The methods used are often complex and opaque, making it difficult for poor women to 'scrutinize the targeting process, claim their entitlements, and hold administrators of the programmes accountable for mistakes or errors'.[52] Research on the Mexican *Oportunidades/ Prospera*, programme, for example, found widespread resentment and lack of understanding among non-beneficiaries over the beneficiary selection process and their exclusion from the programme, leading to social tensions and divisions within communities.[53]

Means-tested interventions are also more likely than universal schemes to contribute to stigmatization because they single out specific disadvantaged social groups. In the Plurinational State of Bolivia, Ecuador and South Africa, for example, cash transfers have generated stereotypes about beneficiaries being lazy or having more children in order to receive benefits.[54] Fear of facing discriminatory attitudes, harassment and abuse may discourage women from accessing transfers even when they are entitled to them. The risk of stigmatization is greatest where gender inequalities intersect with other axes of disadvantage such as class, ethnicity, disability, location or race. In Ecuador's conditional cash transfer programme, *Bono de Desarrollo Humano*, for example, some indigenous women did not collect their benefits because the private guards of the financial institution mistreated them while they were queuing.[55]

Finally, means testing can enhance the discretionary power of programme administrators to withhold benefits or subject potential recipients to humiliating additional 'tests'.[56] Administrators may feel entitled to engage in the surveillance of beneficiaries' behaviour or inspect their homes.[57] Centralized data systems and electronic payment technologies, introduced by some countries, can reduce the risk of administrative malpractice as well as increasing the efficiency and transparency of targeting methods.[58]

Conditionalities: Neither effective nor empowering?

The conditions that mothers are expected to fulfil in cash transfer programmes—such as attending parenting workshops or taking children to health checks—reproduce gender stereotypes. Tying the receipt of transfers to mothers' childrearing performance reinforces the idea that children's well-being is a female responsibility and does nothing to encourage men's involvement in parenting. Moreover, the requirements may add to women's already heavy workloads and take away time from income-earning activities.[59]

Conditionalities can also exacerbate the risk of stigmatization and abuse by authorities. Requirements to take children to regular health checks or ensure school attendance are based on paternalistic, and often racially biased, assumptions about the ability of poor people to

make rational choices. Rather than reflecting negligence on the part of beneficiaries, failure to comply with programme requirements may be due to the lack of accessible services, their inadequate quality or—in the case of indigenous populations— language barriers.[60] Evidence from the Plurinational State of Bolivia and Peru, for example, suggests that distant health facilities, long waiting times and mistreatment by staff led women to forgo maternal health services even where conditionalities encouraged their use.[61]

Whether conditionalities are necessary to achieve improvements in child nutrition, health and education has become a subject of intense debate among experts and practitioners.[62] Support remains strong among donors and international financial institutions, but emerging research suggests that the injection of additional cash into the household might well be enough to generate positive results.[63] The South African Child Support Grant, for example— one of the few child-related transfer schemes that, until recently, was unconditional—achieved poverty reduction outcomes and improvements in children's school enrolment and attendance without the use of conditionalities.[64] A randomized cash transfer intervention in Malawi also found that conditional and unconditional transfers resulted in the same gains with regards to higher school enrolment and lower drop-out rates.[65]

Monitoring and enforcement of conditions as well as proof of compliance have significant costs for both governments and beneficiaries. If, in practice, conditionalities have no or little bearing on child development, government budgets might be better used to invest in more and better schools and primary health care centres. The desired impact of conditionalities on child well-being could also be achieved by other means including, for example, subsidized or free school meals, school-based health checks and local family health programmes that actively reach out to the poor, as is the case in Brazil.[66]

Recommendations

Universal child allowances are an important part of social protection floors and can help families shoulder some of the costs associated with childrearing. In order to contribute to the achievement of substantive equality, child-related cash transfer programmes need to:

- Make women's empowerment an explicit goal rather than an accidental side effect by enhancing their income security and access to decent work opportunities
- Provide adequate benefit levels and more and better services—including health care, education and training, credit and childcare—to address women's needs head-on and bolster their income security in the long term
- Work towards universal rather than means-tested programmes to avoid stigma and exclusion errors and reduce administrative costs
- Reconsider the use of conditionalities; where their contribution to social development outcomes, such as child health and survival, is questionable, these should be eliminated
- Sensitize beneficiary households, programme managers and service providers about harmful social norms and equal sharing of responsibilities.

To achieve these changes, women beneficiaries and gender equality advocates must be involved in the design, implementation and monitoring of cash transfer schemes. Recent experiences in Brazil and Egypt, for example, show that the active involvement of women's rights advocates can be a catalyst for transformation. In both cases, cash transfers were explicitly designed with women's rights in mind, tackling the limitations of existing schemes (see also Box 3.3).

BOX 3.3

Transforming conditional cash transfer schemes to empower women in Brazil and Egypt

In the State of Pernambuco in north-eastern Brazil, the *Chapéu de Palha Mulher* programme, launched in 2007, channels cash to poor rural households to combat hunger between sugar cane harvests (see story: *Making rights real*). Unlike *Bolsa Familia* (see Table 3.1), however, it supports women's economic empowerment head-on by training them to take up non-traditional jobs in the growing construction industry in the region. Specific measures include:

- The stipend is tied to classes in citizenship rights and vocational training for women
- Feminist popular educators encourage women to explore how gender stereotypes limit their ambitions, thus opening up a wider field of training options in non-traditional jobs such as welding, soldering, plumbing and electrical work
- Training sessions include information on domestic violence legislation and related services
- Childcare services, transport and meals are provided to enable women to participate in the training courses.[67]

In Egypt, feminist activists, academics and state officials came together to pilot a conditional cash transfer scheme in the Ain El-Sira slum in Cairo (see story: *Shaping a Revolution*). Drawing on an understanding of some of shortcomings of conventional conditional cash transfer programmes, the Ain-El-Sira pilot aimed to contest traditional gender dynamics that emphasize women's roles as mothers and ignore their productive roles and agency. Four key programme design features stand out:

- Women's participation in paid employment was encouraged, departing from previous practice that made transfers contingent on proof of unemployment
- Payments were transferred directly into women's bank accounts in order to protect the cash from possible family demands or community thefts and to give women a sense of security
- Self-monitoring tools were employed that enable women to monitor their own compliance with conditions and thereby avoid social workers gaining too much control over information
- Collective sessions were organized for groups of 15 to 20 beneficiaries to support their involvement in programme governance and facilitate ongoing collective action among women.[68]

SOCIAL TRANSFERS FOR WORKING-AGE ADULTS

In most of the world's high-income countries, governments provide social transfers to women and men whose ability to participate in the labour market is constrained by sickness, disability, maternity/paternity or unemployment. For working-age women, services such as childcare and water and sanitation (discussed in section Investment in social services) are critical to redressing their socio-economic disadvantage by enabling their participation in the workforce. In addition, child-related transfers can help them shoulder some of the costs associated with raising children (see section Social transfers for families with children), while paid maternity and parental leave ensures that income is available when parents stay at home during the first months of a child's life (see Chapter 2). This section focuses on income security for the unemployed.

In developed countries, income security for the unemployed is typically provided through temporary transfers from unemployment insurance or long-term social assistance schemes. In much of the developing world, however, such schemes either do not exist or reach only a minority, particularly where most workers are in informal self-employment, as in many sub-Saharan African and South Asian countries (see Chapter 2). Worldwide, only 12 per cent of the unemployed receive public income support. Effective coverage reaches more than 90 per cent of the unemployed in some European countries but only 7 per cent in Asia and the Pacific, 5 per cent in Latin America and the Caribbean, less than 3 per cent in the Middle East and under 1 per cent in sub-Saharan Africa.[69] At the time of writing, more than half of the countries for which data are available do not provide any statutory social protection against unemployment, although some of these countries have legally mandated severance pay.[70]

In some developing countries, large-scale social assistance programmes combining employment and social protection have emerged that offer a degree of income security, albeit limited, to those who are unemployed, underemployed or earning low incomes. Public works programmes or employment guarantee schemes such as those established in Argentina, Ethiopia, India and South Africa (see Table 3.2) are a form of conditional or self-targeted 'workfare' rather than rights-based welfare. Yet, these programmes can provide poor or unemployed women, as well as men, with an important source of income in the face of persistently high levels of unemployment, widespread rural poverty and economic crisis. And some programmes, such as the National Rural Employment Guarantee Scheme (NREGS) in India, may offer better conditions for women than available employment alternatives.

Public works programmes have often been introduced as temporary measures in response to natural disasters or economic crises and subsequently phased out when conditions improve. This was the case for the Unemployed Heads of Household Programme (*Plan Jefes y Jefas de Hogar Desempleados*) in Argentina, introduced during the economic crisis in 2001 and closed in 2010. Moreover, budgetary constraints often limit the scope of programmes and prevent them from reaching all of those who may require employment. The case has been made for using such schemes on a permanent basis to promote the right to work as a guaranteed entitlement, as in India's NREGS.[71] In practice, few existing programmes are national in scope or provide a guaranteed entitlement, though some have become long-term interventions in response to high structural un- and underemployment or chronic food insecurity. This is the case for South Africa's Extended Public Works Programme (EPWP) and, prospectively, Ethiopia's Productive Safety Net Programme (PSNP) (see Box 3.4).

Table 3.2

Selected employment guarantee schemes in Africa, Asia and Latin America

Country	Programme	Benefits offered	Year established	Current status	% participation of women (country average)
Argentina	*Plan Jefes y Jefas Desempleados*	Stipends of 150 pesos in exchange of 20 hours of paid work.	2001	Ended 2010	71
Ethiopia	Productive Safety Net Programme (PSNP)	Households with able-bodied adults receive a transfer equivalent to 15kg of cereal (in cash/food) in return for five days of work per month and household member. Households whose members are unable to work (due to pregnancy, lactation, disability, illness or old age) receive the same transfer without work requirements.	2005 (pilot)	Entered third phase in 2015	40
India	National Rural Employment Guarantee Scheme (NREGS)	100 days employment in a financial year to registered rural households on demand, with minimum wages, gender parity of wages and provision of basic worksite facilities.	2005	Ongoing, enacted in legislation	48
South Africa	Expanded Public Works Programme (EPWP)	Work opportunities for poor and unemployed people, along with basic training in some sectors.	2004	Entered third phase in 2014	62

Source: The Government of South Africa 2012; Holmes et al. 2011; Kelkar 2009; The Government of India 2014; Tabbush 2010.

Designing gender-responsive public works schemes

Women's participation rates in public works schemes have been high (see Table 3.2), reflecting the extent of women's poverty and unemployment and, in the case of India's NREGS and South Africa's EPWP, aided by gender quotas. In 2004, South Africa's EPWP set a quota for women at 60 per cent—later reduced to 40 per cent—as well as for youth (20 per cent) and people with disabilities (2 per cent).[72] By 2012, women

represented more than 60 per cent of participants.[73] In India, women comprised almost 50 per cent of participants in NREGS nationally in 2010, even though the actual proportion varied widely across states.[74] During the design phase, women's rights advocates achieved several important victories, including a reservation of one third of all jobs for women and the mandatory provision of childcare at all worksites,[75] although lack of monitoring and enforcement has meant that these services are rarely implemented.[76] In some states, including Uttar Pradesh, women's organizations have been successful in making NREGS more gender-responsive and increasing women's participation rates, wages and representation in supervisory roles.[77]

The benefits offered by such schemes, however, have not always been sufficient to provide participants with an adequate standard of living. In the Argentinian scheme, for example, payments represented approximately 75 per cent of the monthly minimum wage up to 2002 but this gradually decreased to 10 per cent by 2010 as minimum wage levels were raised in subsequent years.[78] Benefit adequacy was also a major issue in the first phase of South Africa's EPWP. There was no specified minimum wage and stipends varied widely across regions and sectors, with payments in the social programmes being especially low. In 2008/2009, the average rate for social sector work, where women dominate, was R43 (US$5.8) per day compared to R78 ($9.6) in the more traditional infrastructure components where men dominate.[79] In the second phase of the programme, a minimum wage of R60 per day was introduced to address the low and varying benefit levels. This was also inflation-adjusted on an annual basis, reaching R66.34 ($6.9) in mid-2013. This is similar to the minimum wage stipulated for domestic workers and higher than the average stipend paid during the first phase of the EPWP.[80]

Many public works programmes still exhibit gender biases that dilute benefits or discriminate against certain categories of women. In the Indian NREGS, for example, the guarantee of 100 days of work per rural household risks putting women at the back of the queue, given rural power inequalities.[81] While the reservation rule for women helps counter gender bias, expanding the overall availability of work opportunities and defining these as an individual entitlement would benefit both women and men. Public works programmes that only offer physically demanding work are also likely to exclude some women or put them at a disadvantage where wages are linked to workload.

Benefits of public works participation

More positively, some design features of public works schemes have enhanced their direct and indirect benefits, including specifically for women. In the NREGS, for example, wages are set in accordance with the state minimum wage, which in some states is higher than the wages women typically receive as unskilled agricultural workers.[82] The availability of work through NREGS may also have had a positive knock-on effect by 'pulling up' the wages paid to women agricultural workers in the vicinity.[83] Evaluations of the *Plan Jefes y Jefas* programme in Argentina suggest that, while its impact on poverty is unclear, it has reduced unemployment and helped people to move into new jobs.[84] Female participants particularly valued the acquisition of new skills and the greater probability of finding formal employment.[85]

The introduction of a social service component in South Africa's EPWP is also an important innovation that supports gender equality. Social service work opportunities offered by the programme include care of young children and home-based care for people living with HIV. This has benefited women directly since many of the social sector work opportunities have been allocated to them. It may also have benefited women and girls indirectly by alleviating the burden on unpaid family caregivers.[86]

Ethiopia's Productive Safety Net Programme (PSNP) vividly illustrates the potential of employment guarantee schemes to include gender-responsive elements (see Box 3.4). It also demonstrates how difficult it is to make these elements work on the ground. This underlines not only the need for gender-responsive programme design but also the importance of monitoring implementation and of effective mechanisms for improving programme performance with regards to women's rights.

BOX 3.4

Ethiopia's PSNP: Gender-responsive design meets implementation challenges

Launched in 2005 as a key component of the country's food security strategy, the Productive Safety Net Programme (PSNP) in Ethiopia has become one of the largest social protection programmes in sub-Saharan Africa. It provides food and cash transfers to over 7 million chronically food-insecure people, particularly in rural areas, in order to smooth household consumption and prevent the depletion of household assets. For households with available labour, benefits are provided in return for work in community agriculture and infrastructure projects. For households with no available labour—due to sickness, disability, old age, pregnancy or lactation—cash and food are provided without further conditions. The public works component also aims to create infrastructure and community assets, including roads, water and fuel sources, all of which potentially benefit women. One evaluation found that road construction and improvement has facilitated access to health care, including for pregnant women seeking maternity care.[87]

Women represent approximately 40 per cent of public works participants. The design of the PSNP takes account of their practical needs on a number of levels.[88] It foresees the provision of community-based childcare services and reduced working time for women with children and provides for women to receive direct support without work requirements before and after childbirth. Responding to social norms that constrain women's ability to plough their land, it also allows for public works labour to be used to cultivate the private land-holdings of female-headed households.[89] In addition, public works are supposed to prioritize projects that will reduce women's work burdens.[90]

However, the implementation of 'women-friendly' measures was inadequate during the first and second phases of the programme, with on-site day care, reduced working time and less physically demanding tasks for women being scarcely offered.[91] Nor does the programme address unequal gender relations at the household and community level.[92] Participation in PSNP public works is on a household basis, as is payment, irrespective of who does the work, ignoring that women may not have equal say in decisions over how the money is spent. Similarly, at the community level, women's unequal access to agricultural extension services and credit is not addressed, and extension services continue to be designed around the needs of male farmers.[93]

Recommendations

In order to create universal social protection floors, significant efforts are necessary to scale up unemployment protection, especially in developing countries. While unconditional support for the unemployed is preferable to maintain an adequate standard of living from a human rights perspective, the creation of public works programmes, if adequately designed, can contribute to redressing women's socio-economic disadvantage. In order for these programmes to work for women, they need to:

- Provide a minimum level of accessible employment and adequate income support to all those who may require it, ideally backed by a legally binding and enforced entitlement

- Provide access to benefits as an individual entitlement rather than a household-based one, and use quotas or reserve spots for women to ensure equal participation

- Offer non-manual work that can be reasonably performed by women and ensure equal wages for such work

- Provide mandatory on-site childcare and other basic services while making sure that these are monitored and enforced.

SOCIAL TRANSFERS FOR OLDER PEOPLE

Demographic change poses a significant challenge for both income security and the provision of care for rapidly ageing populations (see section Care services). Some governments are responding more effectively to this challenge than others, as this section will show. In developed countries, these issues are hotly debated. However, about two thirds of the world's older people[94] live in the developing world, and by 2050 this share will have risen to nearly 80 per cent.[95] Globally, about half of people above the statutory retirement age are in receipt of an old-age pension while only 31 per cent of the working-age population contribute to a pension scheme.[96]

Women's socio-economic disadvantage in old age

Ageing has specific implications for women and thus for gender equality outcomes. First, women tend to live longer than men. Second, they have less access than men to land and other assets that could help them maintain an adequate standard of living in old age. In India, for example, 60 per cent of women compared to 30 per cent of men have no valuable assets in their name, and few widows can count on family or community support.[97] Even in countries with good pension coverage, women are significantly more likely to suffer poverty in old age than men. In the EU, for example, the poverty rate of elderly women is 37 per cent higher than that of elderly men.[98] Third, prevailing gender norms and the fact that women tend to marry or co-habit with older men mean that it is women who provide the bulk of unpaid care and domestic work for elderly spouses, as well as for parents, parents-in-law, friends and neighbours.[99]

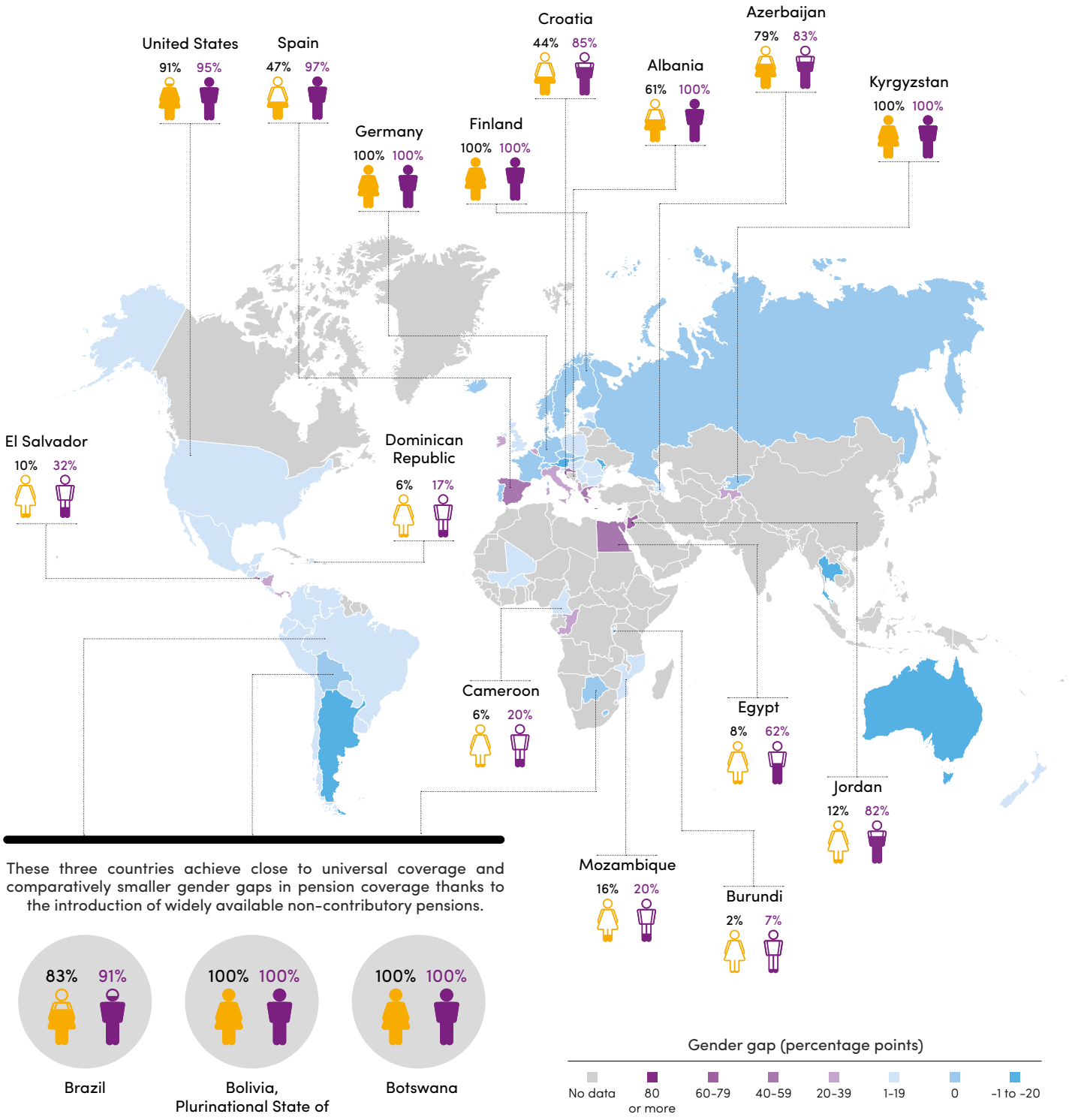
In most countries for which data are available, women are less likely than men to receive a pension in old age (see Figure 3.4), and where they do their benefit levels are usually lower. Central and Eastern Europe and Central Asia have relatively high coverage rates with some countries, such as Kyrgyzstan, having achieved universal coverage among both women and men, often thanks to the effective combination of contributory and non-contributory pensions.[100] Yet, important gender gaps remain in other countries in this region. In a number of countries in Latin America and the Caribbean, including the Dominican Republic and El Salvador, women's old-age coverage is less than half of the already low coverage of men. The Plurinational State of Bolivia is a notable exception, with universal coverage for both women and men owing to the introduction of a universal non-contributory pension scheme.

This is also the case of Botswana, Lesotho and Mauritius, the exceptions in sub-Saharan Africa, where coverage in most countries is low for men and almost insignificant for women. In Burundi, for example, 2 per cent or less of women above statutory pension age are in receipt of a pension compared to 7 per cent of men. The largest gender gaps in coverage, however, are found in Egypt and Jordan, where 62 per cent and 82 per cent of men, respectively, receive a pension compared to only 8 per cent and 12 per cent of women. While some European countries have achieved high coverage rates among women, their benefits levels are often only a fraction of those of men. In France, Germany, Greece and Italy, for example, women's average pension is more than 30 per cent lower than men's.[101]

Figure 3.4

Proportion of people above statutory pensionable age receiving an old-age pension by sex, selected countries, 2006-2012

⟶ *In most countries, women are less likely to receive an old-age pension than men*



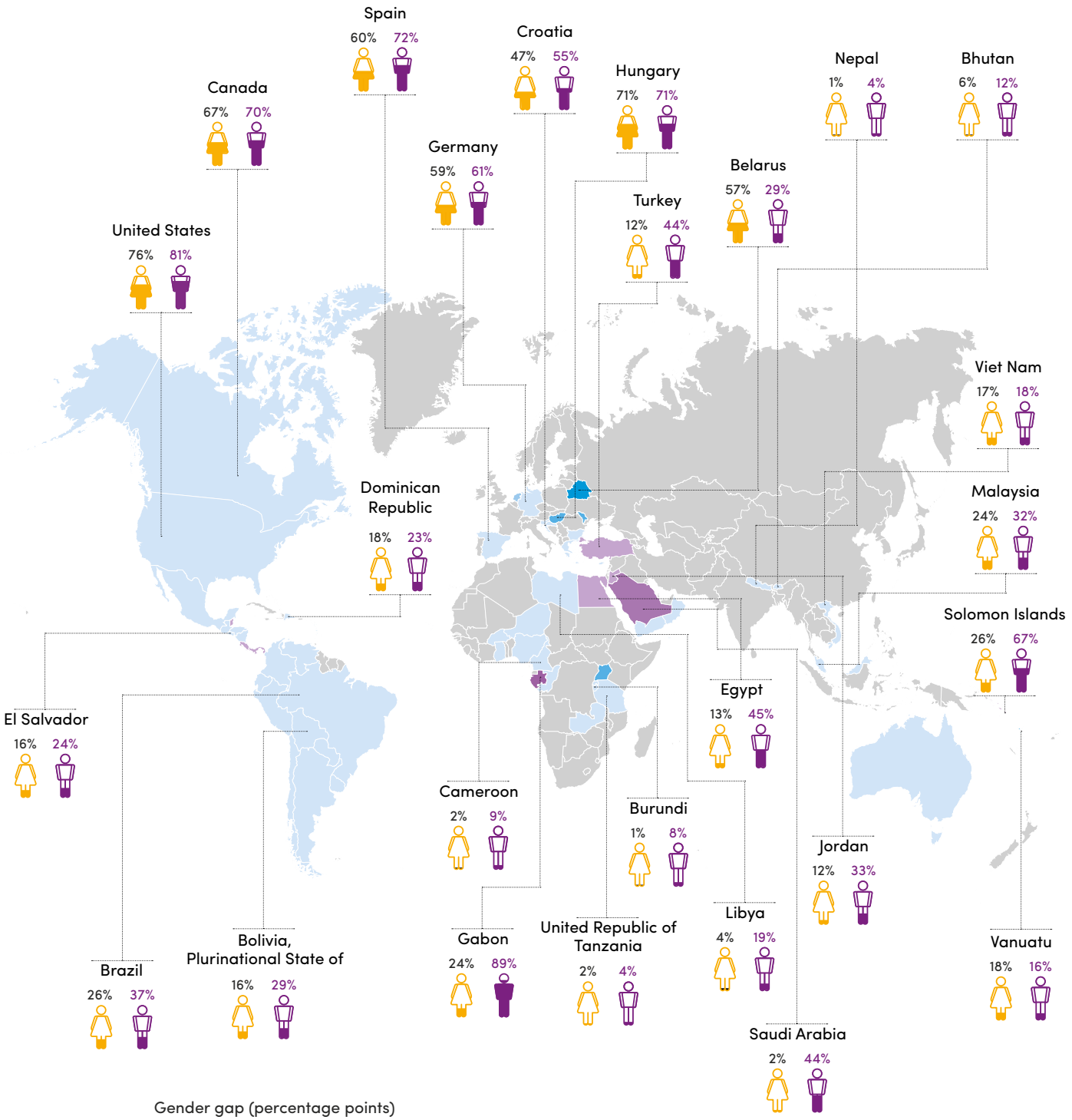
Source: ILO 2014h.

Note: Data refer to the most recent available during the period specified. See Annex 5 for a complete list of countries with data. The amount of pension benefits women and men receive differ widely across and within countries. Even if a relatively large share of women and men receive an old-age pension, there may be large gender gaps in benefit levels; or non-contributory pensions, on which women rely more strongly than men, may not be enough to lift them out of poverty (see data on benefit levels in Annex 5).

Figure 3.5

Proportion of working-age population contributing to a pension scheme by sex, selected countries, 2007-2012

⟶ In most countries, women are much less likely than men to contribute to a pension scheme



Source: ILO 2014h.

Note: Data refer to the most recent available during the period specified. See Annex 5 for a complete list of countries with data.

Gender gaps in pension outcomes reflect women's and men's different life courses and employment histories. In addition, key pension design features systematically penalize women, further reinforcing their socio-economic disadvantage in old age. These unequal outcomes are not inevitable, however, and can be remedied by action on several fronts. Chapter 2 has already outlined actions to facilitate women's access to decent work and to eliminate gender wage gaps. In addition, pension systems can be designed or reformed to redress women's socio-economic disadvantage in old age. First, in contributory pension schemes, access has to be equalized and gender gaps in benefit levels have to be reduced. Second, the coverage and benefit levels of statutory non-contributory social pensions needs to be increased, particularly in countries where the majority of older people currently lack any form of social protection in old age. The following sections discuss these two strategies in greater detail.

Gender biases in contributory pensions

Currently, women face important disadvantages in earnings-related contributory pension schemes, which are the dominant form of coverage in countries with pension provision.[102] Women participate less in the labour market and are more likely to be unemployed or to work informally or on a part-time basis. They also tend to earn lower wages and interrupt their market-based work more often than men to take care of dependants. As Figure 3.5 shows, women are therefore under-represented among active contributors to contributory schemes in most countries.

Outside the developed world, contributory schemes exclude the majority of working-age women and men. Gender gaps vary widely, but they also tend to be greater in Developing Regions. In some countries in the Middle East and North Africa, men are 10 to 20 times more likely to contribute to a pension scheme than women. While coverage rates are low for both sexes in South Asia and sub-Saharan Africa, women still face significant disadvantages vis-à-vis men. Even in countries with relatively high coverage rates, such as Gabon, a much smaller share of women (24 per cent) than men (89 per cent) contributes to social security. In Latin America and the Caribbean as well as in East Asia and the Pacific, gender gaps are smaller but remain significant. In the Dominican Republic, for example, 23 per cent of men are active contributors to pensions compared to 18 per cent of women.[103]

Large gender gaps are also evident in pension benefits derived from earnings-related schemes, and they are wider for women with children. In France, for example, the gender gap in pensions (relative to average pensions for all men) is 19 per cent for women who have no children, 31 per cent for women who have one or two children and 50 per cent for women who have three or more children.[104] These gaps not only undermine gender equality in old age but also women's right to an adequate standard of living. In relative terms, mean pension income for single women is just above or equal to the poverty line in several European countries, including the Czech Republic, Estonia, Germany, Iceland, Latvia, Slovenia and the United Kingdom.[105]

The shift to individual capital accounts

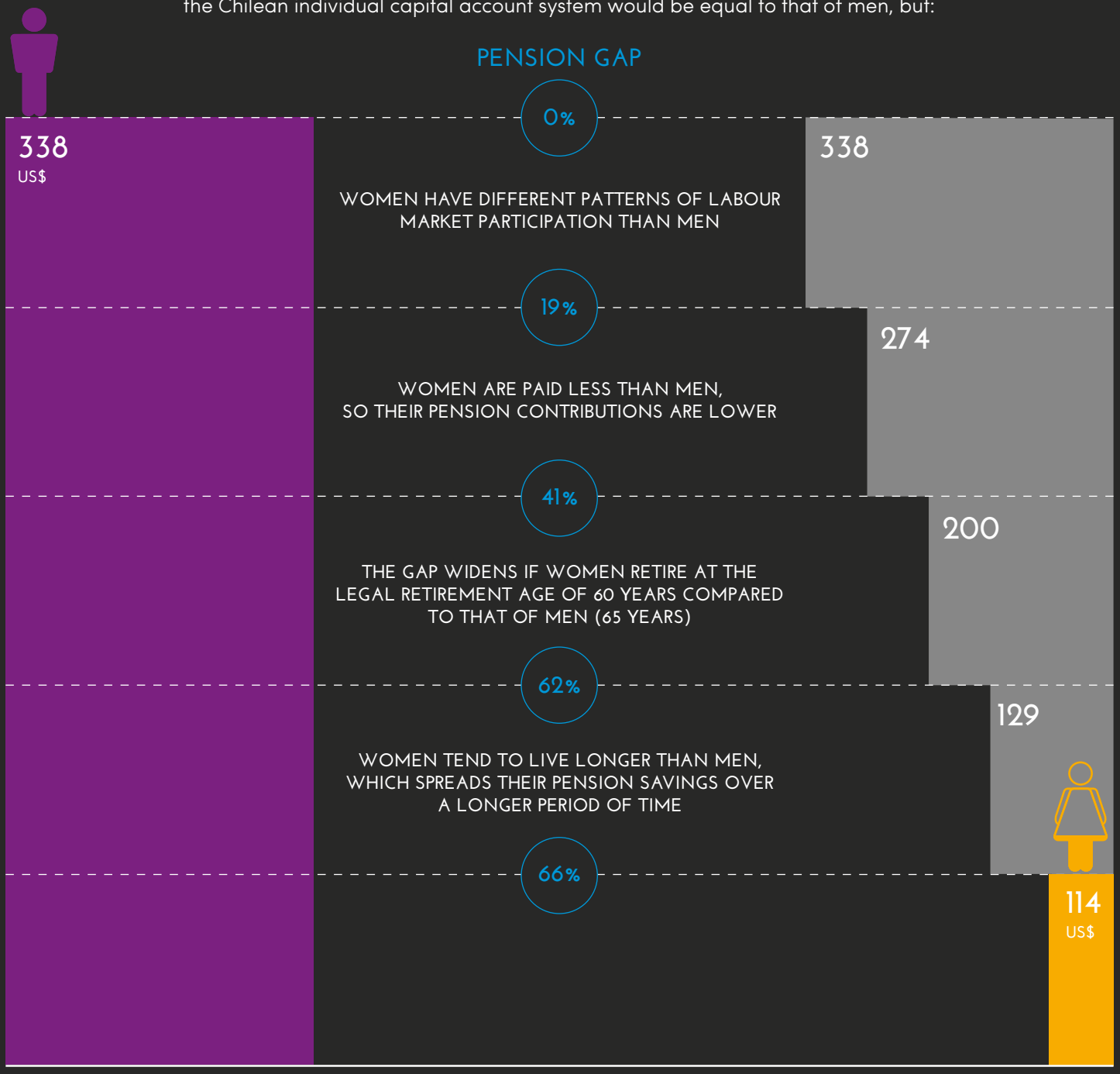
In at least 26 countries, mainly in Latin America and Central and Eastern Europe and Central Asia, there has been an increase over the last two decades in individual capital account schemes, many of them privately managed, following the earlier experience of Chile in 1981 and the advice of international financial institutions such as the World Bank.[106] The shift from social insurance to individual capital accounts has had detrimental effects, specifically on women's income security in old age.[107] This is both because benefit levels are directly based on past contributions and because the benefit formula usually considers the number of years during which the person is expected to collect benefits, penalizing women for earlier retirement and, in some cases, their greater average longevity through the use of gender-specific actuarial tables. In Chile, for example, the combination of these factors creates a gender gap of 66 per cent in pensions derived from the individual capital account system (see Figure 3.6).

Figure 3.6

WOMEN'S PENSION ATTRITION AND THE GENDER PENSION GAP

Individual savings accounts system, Chile

If women were like men—in terms of their individual characteristics, employment patterns, wages and treatment in the pension system—their average monthly pension in the Chilean individual capital account system would be equal to that of men, but:



Multiple factors contribute to create a gender pension gap, so that in reality, women's pensions equal only about one third of men's pensions

Source: Based on Fajnzylber 2014.

Note: The results presented in this figure are based on econometric projections using data for one cohort of Chilean women from the 2002 Social Protection Survey. Factors like age, education and the presence of children were kept constant. The impact of other factors depends on the order in which each factor was included in the calculation, giving more importance to the elements introduced earlier in the analysis

But even where individual capital account systems have already been introduced, much can be done to redress women's socio-economic disadvantage. Chile's 2008 pension reform, led by President Michelle Bachelet, introduced a number of gender-sensitive measures and reversed some of the negative impacts of earlier policies (see Box 3.5). Bachelet's leadership and commitment to advancing gender equality were crucial to the success of the reform process.[108]

BOX 3.5

Redressing women's socio-economic disadvantage in Chile's 2008 pension reform

In the early 1980s, Chile carried out a major pension reform that introduced privately administered individual capital accounts and gradually phased out publicly managed social security schemes. This shift had a particularly adverse impact on women's pension entitlements.[109] Minimum pensions for those with limited individual savings required long contributory records (20 years), reducing women's access to these benefits, while non-contributory pensions were low and tightly targeted. By the mid-2000s, only 55 per cent of women over 65 years of age were in receipt of an old-age pension compared to 71 per cent of men. Gender gaps in the level of benefits derived from the individual capital account system were also large (see Figure 3.6).

When Michelle Bachelet stood as a Presidential candidate in 2006, she promised to undertake a profound review of the pension system. Once elected, she used her presidential powers to ensure that women's access to pension benefits was central to the reform project, mandating the pension reform commission to eliminate gender discrimination from the pension system. Although this ambitious objective was not fully achieved, the 2008 reform did significantly enhance women's income security in old age by:

- Extending the reach of non-contributory pensions to 60 per cent of the lowest-income households. In 2013, more than 70 per cent of all non-contributory benefits went to women.[110]
- Recognizing employment interruptions due to childrearing through care credits for mothers, which have been estimated to increase women's average pensions by as much as 20 per cent.[111]
- Creating provision for pension splitting on divorce, whereby the main (usually male) spouse's pension funds accumulated during marriage are split upon separation if the divorce judge considers that one of the two parties faces economic disadvantage.

These advances notwithstanding, the scope of gender-sensitive pension reforms has been limited by the country's privatized pension system. Indeed, the administration was reluctant to overhaul the individual capital account system, fearing turmoil in the financial markets and facing opposition from powerful business interests including private pension fund administrators.[112] While the expansion of non-contributory benefits provided a less-contested reform path, this choice left unaddressed one of the most discriminatory features of the Chilean pension system: gender-specific actuarial tables. It remains to be seen whether the commission recently established to look at further reforms of the pension system will address this issue during Bachelet's second term (2014–2018).

Meanwhile, pension reforms in many countries in Europe are eroding entitlements. France, Greece, Ireland, Italy and Spain have tightened eligibility rules, strengthened the link between contributions and earnings or shifted their benefit formulas from final salary to average lifetime earnings. In other countries, benefit indexation has been reduced or frozen. These measures are likely to have a disproportionate impact on women. To mitigate this risk, some countries have introduced measures to strengthen women's pension entitlements alongside broader cost-containment reforms. In Spain, for example, recent reforms raised the retirement age as well as the number of years of contributions required for a full pension, but they also increased survivor benefits and care credits.[113]

Reforming contributory pension systems

Key features of pension design, including eligibility requirements and a pension formulas, affect how much gender inequalities in the labour market spill over into old age. As a general rule, the closer the link between pension entitlements and past employment and contribution records, the greater women's socio-economic disadvantage vis-à-vis men.

In contributory schemes, individuals are typically entitled to benefit at retirement age if they comply with a minimum number of years of work and/or contributions, sometimes referred to as the 'vesting period'. Long vesting periods can limit women's access to retirement benefits if there are no adequate mechanisms in place to compensate for time dedicated to unpaid care and domestic work. In Argentina, for example, when the vesting period was increased to 30 years in the early 1990s, women's coverage dropped from 73 per cent to 65 per cent.[114] The trend was reversed a decade later when contributory requirements were waived, increasing overall access and reducing the gender gap in pension coverage. In addition, many countries have traditionally set the retirement age for women up to five years before that of men (Annex 5).[115] This can have negative outcomes for women's income security in systems where entitlements are strongly linked to contributions, as in the Chilean individual capital account system (see Figure 3.6).

Benefit formulas specify how benefit levels are calculated for each pensioner, typically based on past contributions or earnings. Formulas that closely reflect earnings and contributory histories tend to generate lower benefits for women than men, while the inclusion of flat or redistributive components tend to favour women. The period of earnings taken into account is also relevant for gender equality as is the existence of minimum benefits and mechanisms for indexation, meaning that pensions are regularly adjusted to inflation or wage increases. When benefits are calculated based on average lifetime earnings rather than final salary, for example, the penalties for time spent out of the labour market will be greater. When benefits are not indexed, pensioners may struggle to maintain living standards when the cost of living rises. Since women live longer than men, they face higher risks of depreciation of the value of their pensions.[116]

Care credits

Care-related contribution credits are another important policy tool to improve the adequacy of old-age pensions for women. They are widely used in developed countries and have recently been introduced in some developing countries too. Care credits acknowledge and compensate for contributions that were lost due to time spent out of the labour force—usually by women—caring for dependants. They can be provided irrespective of whether the care is provided to children, the elderly, the sick or people with disabilities, although in practice credits are primarily awarded for caring for children.[117] In Uruguay, for example, women are credited with one year of contributions per child, up to a maximum of five children. Since 2010, mothers in the Plurinational State of Bolivia benefit from a care credit equivalent to one year of contributions per child, up to a maximum of three children. The credit can be used to get better benefits or to retire earlier.[118]

Care credits are a valuable tool to improve women's pensions in contributory systems, as part of a wider package of equality-enhancing measures, and contribute to redressing women's socio-economic disadvantage in old age. They are less relevant in countries with low contributory

coverage. In these cases, women will benefit most from the introduction of universal and adequate non-contributory pensions discussed in the next section.

To be effective in redressing disadvantage, care credits need to be sufficiently generous to compensate for time spent on childrearing or other care-related employment breaks. At current levels, child credits show positive but limited impacts on women's pension outcomes. In a number of OECD and EU countries, for example, mothers' pensions would decrease by 3 to 7 percentage points on average if these credits did not exist.[119] Where care credits are based on the minimum wage, as in Chile and Poland, this effectively penalizes women who earn above the minimum for periods spent out of the labour market.[120]

In many pension schemes, care credits are paid to the main caregivers independent of their sex. In practice, however, credits accrue to women to a much greater extent than men, given that women take on the larger share of caring work. In Finland and Sweden, care credits are linked with 'use-or-lose' leave and cash benefits for fathers, thus encouraging men to take on a greater sharing of caregiving and enabling transformative change in gender relations.[121] By contrast, most of the newly created care credits in Latin America are targeted to mothers, excluding fathers or other caregivers. This is a missed opportunity to challenge gender stereotypes.

The rising importance of social pensions

The relevance of non-contributory pensions—also referred to as basic or social pensions—is increasingly recognized. Social pensions are particularly significant in countries where the coverage of contributory social insurance schemes is limited and the majority of the labour force is in informal employment. Because individuals with limited contributory records tend to be concentrated among low-income groups, non-contributory social pensions are essential for old-age poverty prevention. Collective action by older women and men has been a key influence on both the introduction and the improvement of social pensions (see Box 3.6).[122]

BOX 3.6

Advocating for social pensions: Civil society strategies in the Philippines

In the Philippines, older people's associations—with the support of HelpAge International—successfully lobbied the Government to introduce social pensions in 2010. Older women have been at the forefront of these mobilizations.

The Coalition of Services for the Elderly (COSE)—a local non-governmental organization—started its advocacy efforts for the introduction of social pensions in 2007. COSE drafted a social pensions bill, identified and approached potential sponsors in the legislature and mobilized its supporters to attend parliamentary committee hearings. These efforts were preceded by several years spent gathering evidence and building grassroots support through participatory research.

Although convinced that a universal social pension is the best approach, COSE opted for a means-tested scheme in the bill as a more realistic goal. COSE lobbied individual legislators, generated media coverage and used special occasions such as the International Day of Older Persons, to rally older

people in support of the campaign. In early 2010, demonstrators gathered in large numbers outside the presidential palace to make sure that the President signed the bill in the face of objections from the Ministry of Finance. Older people's collective action was key to the eventual passing of the Expanded Senior Citizens Act in 2010.

Since then, COSE has monitored the implementation of the law and developed concrete proposals for improving its delivery. Key challenges in this regard include the low value of the pension ($12/month) as well as its very narrow targeting. Currently the pension is only available to senior citizens aged over 77 years who are frail or disabled and without either regular support from their family or other pension benefits. In 2014, the Government doubled the budget for social pensions, meaning that it can be extended to a greater number of people.[123]

Women benefit from universal pensions

By 2014, HelpAge International had registered more than 100 social pension schemes around the world, with varying design, scope and impact.[124] Women benefit disproportionately from the introduction of such schemes, given their greater longevity and large-scale exclusion from contributory pension schemes.

In some countries—including the Plurinational State of Bolivia, Botswana, Mauritius, Namibia, Thailand and rural Brazil—access is granted as a universal right to all older persons. In the Plurinational State of Bolivia, for example, *Renta Dignidad* has helped to make pension coverage almost universal—a significant achievement in a country that previously had very limited social protection for old age. Women are the majority of recipients of *Renta Dignidad* as well as of Mauritius' Basic Retirement Pension and Chile's *Pensión Básica Solidaria*.[125]

In other countries, access is conditional on a pensions test and granted only if the applicant is not entitled to any other type of pension—be it contributory or based on widowhood or disability (e.g., Kyrgyzstan, Lesotho, Mexico and Nepal). Still others make access conditional on a means test with varying income thresholds, usually defined at the household level (e.g., Bangladesh, Chile, South Africa and Ukraine).

Women are most effectively reached as individuals by universal schemes that are either offered to all citizens or residents or that consider only whether the individual beneficiary is in receipt of any other pension. Universal or pension-tested benefits bolster women's economic autonomy, strengthening their voice and agency within households and raising their social status.[126] In contrast, means-tested pensions often require that households—rather than individuals—have no other income source. This means that they exclude women who live in households above the income threshold even if they have no access to personal income. This assumes that income from cohabiting spouses or other family members will be shared fairly, which is not always the case.

The benefit levels of social pensions are almost always lower than those derived from contributory schemes, where men are over-represented. Annex 5 illustrates the enormous variation across countries in the level of benefits offered by basic pension schemes. In Mauritius, for example, which has had a universal social pension scheme since 1958, the Basic Retirement Pension amounts to around $118 per month, equivalent to about five times the poverty line. By contrast, the Indira Gandhi National Old Age Pension in India and the Old-Age Allowance in Bangladesh offer benefits of around $3 per month—corresponding to only

22 per cent of the poverty line. To the extent that women rely more heavily on non-contributory benefits than men, the adequacy of these benefits is of major concern from a gender equality perspective.[127]

Recommendations

The specific types of reforms required to redress women's socio-economic disadvantage in old age depend on the economic and social context as well as on the extent and form of existing coverage. Combining contributory and non-contributory old-age pensions can be an effective way to advance towards national social protection floors. Universal social pensions are the best way to ensure an adequate standard of living for all older people, women and men, but they are particularly important for women, who have less access to contributory benefits, savings and assets in old age than men. For pension reforms to effectively support gender equality it is crucial to:

- Mobilize older women and engage them, as well as women's rights activists, in debates on pension reform
- Extend the reach of social pensions, particularly in low-income countries where the majority of older people currently lack any form of social protection in old age
- Pending the introduction of universal systems, choose pension testing over means testing based on household income to ensure that all women who do not have a pension of their own benefit from social pensions
- If means testing is chosen, adjust income thresholds to reflect the number of older people in the household and ensure that all eligible elderly people receive a social pension in their own name
- Equalize access to contributory pension schemes where these enjoy broad coverage and reduce gender gaps in benefit levels by adapting eligibility criteria and benefit formulas to women's life course and employment patterns
- Make care credits available to all caregivers, regardless of their sex, to compensate for contributions 'lost' during periods out of the labour force to look after dependants (whether children or elderly, sick or disabled family members).

INVESTMENT IN SOCIAL SERVICES: A LINCHPIN OF GENDER EQUALITY

SOCIAL SERVICES AND THE REALIZATION OF WOMEN'S RIGHTS

Public investment in accessible and affordable good quality social services—including health, education, water and sanitation, as well as care provision—is key to the realization of economic and social rights, including the right to an adequate standard of living.[128] Evidence shows that the effect of social services on poverty and inequality can exceed that of social transfers. Across OECD countries, in-kind social services increase disposable income by

around 30 per cent, compared to 23 per cent for social transfers in cash, almost halving poverty and reducing inequality by an average of 20 per cent.[129] In Brazil and Mexico, education and health services contribute twice as much to reducing income inequality as taxes and social transfers combined.[130]

Social services are particularly important for women. Because of their reproductive and other gender-specific health needs, women rely on public health services to a far greater extent than men. They also tend to perform the bulk of unpaid health care, accompanying children and other relatives on medical visits and caring for sick family members at home. Where basic social services are lacking and care needs are great, women and girls' unpaid workloads increase. Conversely, investment in basic services can reduce the demands of unpaid care and domestic work on women, freeing up time for other activities. A study from rural Senegal found, for example, that the time savings associated with small piped water systems and increased water availability allowed women to enhance productive activities and initiate new enterprises.[131] A study of urban Morocco, in turn, showed that connection to the water grid increased women's time for leisure, including social activities with neighbours and watching television.[132]

Glaring disparities in service provision

Millions of women and men are daily denied their rights to decent social services because of a lack of adequate public investment. Governments face enormous challenges to ensuring the availability, accessibility and quality of social services for all, without discrimination. On average, public per capita health expenditure increased between 2000 and 2010 in most regions, but there are huge disparities in levels of expenditure and the share of GDP devoted to health care between developed and developing regions. In 2012, governments in the developed regions spent over 5,500 per capita on the health of their citizens (8.1 per cent of GDP), while the average numbers for South Asia and sub-Saharan Africa were as low as $202 and $159 (PPP) per capita (1.5 per cent and 3 per cent of GDP, respectively).[133]

Low levels of spending on health translate into serious shortcomings in service delivery, including staff shortages and poor motivation, which are particular problems in rural areas. In sub-Saharan Africa, there are fewer than one physician per 1,000 people and on average, one nurse and/or midwife per 1,000 people, while developed regions have 16 and 9 times as many, respectively.[134] According to the International Labour Organization (ILO),[135] 10 million additional health workers are required globally to ensure the delivery of health services for all, most of them in Asia (7 million) and Africa (3 million). Health facilities also often lack essential equipment and medicines, or even energy or water supplies.[136] The devastating consequences of underinvestment in health and other social services have become tragically clear with the ongoing Ebola epidemic in sub-Saharan Africa (see Box 3.7).

BOX 3.7

Underinvestment in social services and the gender dimensions of Ebola

By February 2015, the Ebola outbreak had claimed the lives of more than 9,000 people, mainly in Guinea, Liberia and Sierra Leone.[137] Lack of access to safe water, sanitation and other infrastructure as well as poor housing and overcrowding in urban slums have contributed to the rapid spread of the epidemic.[138] And weakened by fiscal constraint, reductions in public sector employment and premature decentralization, health systems have struggled to respond.[139] Ebola has taken a particularly harsh toll

on women and girls. Because they are over-represented among caregivers, nurses and cross-border traders, women have an increased risk of exposure, and more women than men have contracted the virus in Guinea and Sierra Leone.[140] Some reports also claim that women are dying from Ebola in much greater numbers than are men.[141] In addition, observations from the field point to a series of indirect consequences for women. Because medical staff are focused on Ebola and because many people are afraid of getting infected if they visit health facilities, women are not receiving treatment for other conditions; and childbirth has become more risky because maternal health clinics have had to close or pregnant women choose to stay home to give birth.[142]

Affordability and accessibility are major issues, particularly for women who are less able to pay user fees or travel costs to reach facilities. Poor service quality as well as discriminatory social norms, stigmatization and fear of violence may also deter women and girls from using education, health, water or sanitation facilities. Addressing these barriers is essential to ensure their equal enjoyment of rights.

Women have organized to improve their access to and delivery of social services through their involvement in water or school management committees, local health councils and patient forums.[143] Ensuring the transformation of social services in the long term requires government action to hold service providers to account on gender equality outcomes. Such action must be bolstered by making information freely available to citizens, regularly monitoring the performance of providers as well as rewarding responsiveness and sanctioning neglect of women's needs. Vigilant users and civil society organizations are also crucial to counter strategies by conservative lobbies or vested interests to subvert gender equality mandates during implementation. This is particularly important where service provision is contested, as is the case for sexual and reproductive health.[144]

The remainder of the chapter focuses on three types of social services: health, care and water and sanitation. It reviews the extent to which current policy and provision in each of these areas supports gender equality and the realization of women's economic and social rights.

HEALTH SERVICES

Biological differences between women and men—as well as socially determined differences in their rights, roles and responsibilities—have an impact on their health risks and status.[145] For example, although women across the globe tend to live longer than men, for both biological and behavioural reasons, their lives are not necessarily healthier. Lack of control over resources, the burden of unpaid care and domestic work and gender-based violence all undermine well-being among women. In some countries, gender-based discrimination dampens the general pattern of greater female longevity, such that female life expectancy at birth is similar to that of males.[146]

The right to health is enshrined in a number of human rights treaties and instruments (see Box 3.8). It goes beyond access to health services to encompass a range of factors influencing whether people can lead healthy lives. It is intimately connected to other economic and social rights, including rights to food, social protection, housing, water and sanitation as well as rights at work. For example, women's greater morbidity in old age may be magnified by their lesser access to pensions, while women's health risks during pregnancy are affected by the availability of paid maternity provision and health and safety conditions at work (see Chapter 2), as well as by their access to antenatal care.

BOX 3.8
The right to health

The right to health has been enshrined in a number of international treaties and conventions, including the Universal Declaration of Human Rights (article 25(1)) and the International Covenant on Social, Economic and Cultural Rights (article 12 (2d)).

The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) explicitly states that 'States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning' (article 12). The International Conference on Population and Development in Cairo (1994) and the Fourth World Conference on Women in Beijing (1995) further clarified that women's right to health includes reproductive health and rights.

The right to health contains both freedoms and entitlements. Freedoms include the right to be free from non-consensual medical treatment, such as medical experiments and forced sterilization. Entitlements include the right of access to health facilities, goods and services on a non-discriminatory basis, the right to prevention, treatment and control of diseases and the right to participate in health-related decision-making at the national and community levels. Health facilities, goods and services must be provided so that they are available, accessible, acceptable and of good quality for all without discrimination.

Improving women's access to health care

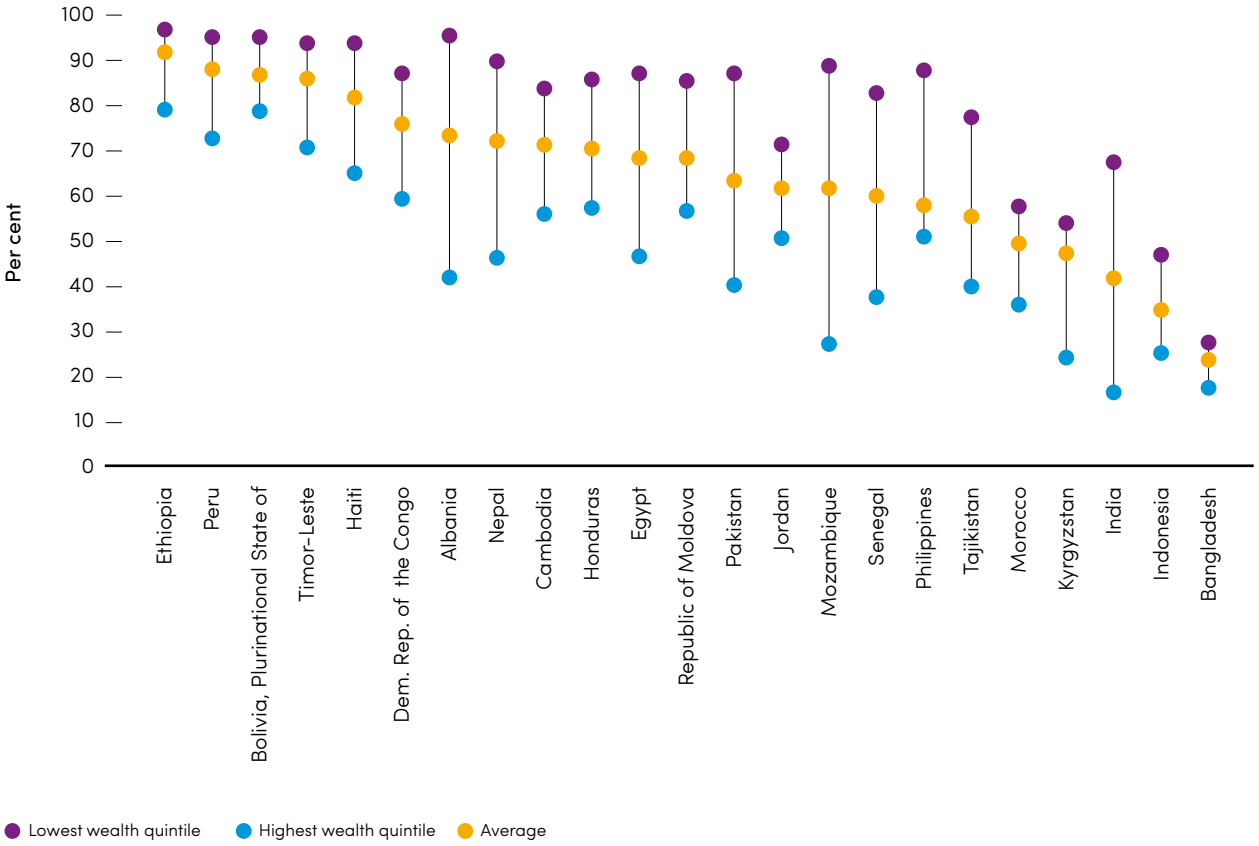
Overcoming financial barriers to access to health care is an important first step towards the enjoyment of the right to health by all. Every year, about 100 million people are pushed below the poverty line as a result of catastrophic health costs, and even relatively small payments can result in financial catastrophe.[147] Affordable health care is particularly important for women because they have less access to personal income, face costly health conditions, such as pregnancy and childbirth, and are often responsible for the health care of family members. As Figure 3.7 shows, across regions low-income women face major barriers to accessing health care to a far greater extent than high-income women.

But even for better-off women, barriers to accessing health can be significant: in the Plurinational State of Bolivia, Democratic Republic of the Congo, Ethiopia, Haiti, Peru and Timor-Leste, for example, the majority of both higher- and lower-income women report major barriers. In addition to income, restrictions on mobility or the need to obtain consent from family members may limit women's and girl's access to health care, especially when health facilities are not nearby.[148] Discrimination on the basis of race and ethnicity—among other factors—can also compromise women's enjoyment of health care. In Nepal and Viet Nam, for example, ethnic and indigenous minority women are less likely than non-indigenous women to have access to contraception, antenatal care and skilled birth attendance.[149] Patronizing and coercive practices

Figure 3.7

Percentage of women who reported difficulties in accessing health care, by wealth quintile, 2010-2013

⟶ Women, particularly those from lower-income households, face major barriers to accessing health care



Source: ICF International 2015.

Note: Data refer to the most recent available during the period specified. The Demographic and Health Surveys ask survey respondents the following question: Many different factors can prevent women from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not? Getting permission to go to the doctor? Getting money needed for advice or treatment? The distance to the health facility? Not wanting to go alone? The data included in the figure capture the percentage of women who reported at least one of these problems.

of health providers may also keep women from consulting health services.[150]

Efforts to extend coverage and ensure affordability of health care are critical to address financial barriers to women's enjoyment of the right to health. Recently, many governments have begun to look at options to make health care more affordable, and the implications of different funding modalities for health services for gender equality are reviewed below. But achieving substantive equality in health also requires improvements in the quality of services as well as broader attitudinal and institutional change to address stereotyping, stigma and violence head-on. The section therefore goes on to examines how the delivery of health care can be transformed to enable all women and girls' to have access to services, to address their specific health needs and to give them greater voice in the health system.

Out-of-pocket payments reinforce inequality

Most countries finance health care from a combination of sources, including government revenue, social insurance, community-based insurance, private insurance and out-of-pocket payments (OPPs). Each of these mechanisms has different implications for access to health services, for equity and for protection from the financial consequences of illness.

OPPs at the point of service delivery are a highly inefficient and inequitable way of financing health care.[151] In Africa, OPPs by households exceed public expenditure on health, while in richer regions such as Western Europe and North America they amount to only a small fraction of total health spending. In many countries, those living in poverty incur higher OPPs than other groups of the population because they are more often affected by sickness. Targeted measures to address the needs of poor and vulnerable groups in commercialized health systems—such as fee waivers or subsidies—have been put in place but have often proven ineffective in reducing out-of-pocket expenditures.[152] Current cutbacks in public health expenditure threaten to increase the financial burden on households. For example, between 2007 and 2011, OPPs for health care increased by 35 per cent in the United Republic of Tanzania, 8 per cent in the Ukraine and 6 per cent in Sri Lanka.[153]

OPPs have also been found to reinforce women's disadvantage in access to health care. Women's OPPs have been found to be systematically higher than men's in a number of countries, including Brazil, the Dominican Republic, Ecuador, Paraguay and Peru, not only because of gender-specific health needs but also due to the greater prevalence of chronic illness and some mental health conditions among women.[154] This also increases the likelihood of women not seeking care because of their lower capacity to pay.[155] Although women from poor households are most likely to forego treatment, a study from Latvia also found significant gender gaps in unmet need for health services among higher-income groups.[156] A recent ethnographic study in Mali further showed that, where medical treatment requires co-payments, access to health care for women and children hinged on the readiness of male partners and fathers to provide the necessary cash.[157]

Making health care affordable: The quest for universal coverage

Over the past two decades, several countries have started to roll out universal health coverage reforms, using a variety of approaches and funding sources to enhance affordability.[158] Universal health coverage is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.[159] These experiences highlight both the potential and pitfalls of different approaches in terms of achieving substantive equality for women and girls.[160] Gender equality outcomes can be assessed in terms of the numbers of women and men covered, as well as the types of services and degree of financial protection offered.[161]

Whether or not the specific health needs of women and girls are adequately addressed is particularly important when universal coverage reforms define 'essential service packages' (ESPs). Decisions on what health conditions are included can be heavily gender-biased. In the late 1990s, for example, an assessment of publicly financed ESPs in 152 countries found that delivery care and emergency obstetric care were often missing.[162] Although unsafe abortions claim the lives of thousands of women each year, safe abortion is rarely included in ESPs, even where it is legal.[163] Where reproductive health needs are included, this is often done selectively, focusing on maternal health and safe delivery while ignoring the reproductive rights of adolescent girls and older women.

Affordable health care in the United States

The approval in 2010 of the Patient Protection and Affordable Care Act (ACA) in the United States

was a watershed, bringing the country closer to universal health coverage after decades of failed attempts.[164] Prior to the ACA, almost 16 per cent of US citizens had no health insurance, and since private insurers had significant authority to exclude applicants, set different rates or exclude certain medical treatments, even those with insurance could find themselves without cover for needed medical services. Once the ACA is fully implemented, health insurance will be mandatory for all citizens and insurance plans will be required to include basic health services.

The Act is expected to vastly improve access to health services, including for women. It is expected, for example, that 47 million women will gain access to free preventative health care.[165] The ACA outlaws discriminatory pricing policies of private insurers that charge higher premiums to women and people with pre-existing conditions. It establishes mandatory, full-cost coverage of reproductive and family planning services as well as preventative medical services for women such as mammograms and cervical cancer screenings. And it foresees more comprehensive services for pregnant women and mothers on Medicaid and all women on Medicare.[166]

Yet, while the ACA expands access to basic health-care services, especially for women, it falls short of universal coverage for all without discrimination. Two main avenues for extending coverage—the expansion of employer-based insurance and of Medicaid—have in the past disadvantaged women, especially unmarried, poor and ethnic minority women, and are likely to do so in the future.

First, employer-based insurance coverage allows companies to make decisions about the type of health plans they provide to workers, leading to variability in what is covered and how much employers contribute. This discretionary power was further bolstered by a 2014 Supreme Court ruling that allows certain employers to opt out of the newly introduced birth control benefits based on their religious beliefs.[167] Higher-paid workers are more likely to have insurance through their employers and also to have better coverage than those in lower paid jobs. This has important gender implications given that women—especially women of colour and immigrant women—are over-represented in low-wage occupations.

Second, the eligibility rules and benefit levels of Medicaid vary and tend to be more restrictive in states that have a high proportion of women of colour in their population.[168] Undocumented immigrants are excluded altogether from purchasing insurance coverage. Finally, the reform fails to address a major strategic health need of women by precluding any federal funding for abortion. As a result, the 'right to choose' will remain unaffordable for many, particularly those on low incomes.

Expanding health coverage in Thailand

In Thailand, the Government introduced the Universal Coverage Scheme (UCS) starting in 2001. Under this scheme, general revenue is used to pay the contributions of 80 per cent of the population, i.e., all those who are not already covered by public social insurance for private sector employees and civil servants.[169] The introduction of the UCS followed a number of unsuccessful attempts to extend social insurance coverage to informal workers, who represent about 62 per cent of the workforce.[170] The UCS enrols entire households and offers a relatively comprehensive benefit package, including a wide range of sexual and reproductive health services such as safe abortion in the case of rape and health risks.[171] Because the state assumes almost the total cost of coverage for the majority of the population,[172] the Thai system is comparable to the tax-financed health systems of Malaysia, Sri Lanka or the United Kingdom, which provide high levels of financial protection.[173]

The UCS has achieved impressive results. By 2010, total health coverage had reached 98 per cent of the population and the share of OPPs

in total health expenditure had fallen from 27 per cent in 2002 to 14 per cent. Service utilization has increased among the previously uninsured, especially poor women of childbearing age and their infants.[174] This dramatic progress is not only the result of the UCS as investment in the expansion of primary health-care centres, particularly in rural areas, has also ensured that universal coverage translates into access to services on the ground.[175] Despite being formally covered under the UCS, however, some groups continue to experience access barriers. These include older women, women living in remote areas, as well as women and men from ethnic minority and migrant communities.[176]

Scaling up community-based health insurance in Rwanda

In contrast to tax- or social insurance-financed schemes at the national level, community-based health insurance (CBHI) targets lower-income populations with weak contributory capacity, often at the local level. CBHI schemes vary considerably but are usually based on solidarity among individuals with common geographic, occupational, ethnic, religious or gender characteristics, with risk being shared within that specific community. Membership is voluntary and, in most cases, CBHI schemes are run on a non-profit and participatory basis.[177]

CBHI schemes typically offer limited service packages and often exclude key health needs such as routine sexual and reproductive health services.[178] Progress in extending coverage can also be painfully slow. In the United Republic of Tanzania, for example, it took social and community-based insurance schemes a decade to enrol only 17 per cent of the population.[179] In Ghana, where community-based plans were absorbed into the National Health Insurance Scheme (NHIS) from 2003 onwards, almost two thirds of the population remained without coverage in 2011.[180] Even when premiums are set at low levels, CBHI schemes often fail to reach the poorest groups: 39 per cent of women and 32 per cent of men in Ghana reported that they had not registered with the NHIS because the premium was too expensive.[181]

The experience of CBHI in Rwanda has been more positive. CBHI schemes have been part of an overall strategy of the Government to rebuild the country's health system after the 1994 genocide. *Mutuelles de Santé* were piloted in three districts in 1999 and later extended to other districts. The *Mutuelles* enrol entire households and provide a minimum service package at the primary care level as well as a complementary services package at district level. Users contribute through co-payments,[182] but the poorest quarter of the population is exempt thanks to international donor funding. The service package includes family planning, antenatal and postnatal care, childbirth, HIV testing and treatment as well as prescribed drugs. By 2011/2012, the coverage of the *Mutuelles* had reached 91 per cent of the population.[183] Together with pre-existing private and social insurance schemes, this has brought Rwanda close to universal coverage within a decade.

The reforms in Rwanda have significantly reduced financial barriers to health-care access for women and expanded their uptake of services. The share of women who reported lack of money as the main barrier to accessing health care declined from 71 per cent in 2005 to 53 per cent in 2010. In the same period, skilled birth attendance increased from 39 per cent to 69 per cent and women's use of modern contraceptive methods from 10 per cent to 25 per cent. Gaps in access between women from rural and urban areas and between women from higher- and lower-income groups have narrowed substantially and access has expanded for all groups.[184] Box 3.9 highlights the dramatic impact of these changes on maternal mortality rates. These achievements have been bolstered by significant investments in health infrastructure and service delivery, heavily supported by international donors.[185] A performance-based financing system rewards service providers for better patient follow-up. Improved indicators and monitoring systems track progress in health outcomes, including, for example, the proportion of women delivering at health facilities.[186]

BOX 3.9

Rwanda's rapid decline in maternal mortality

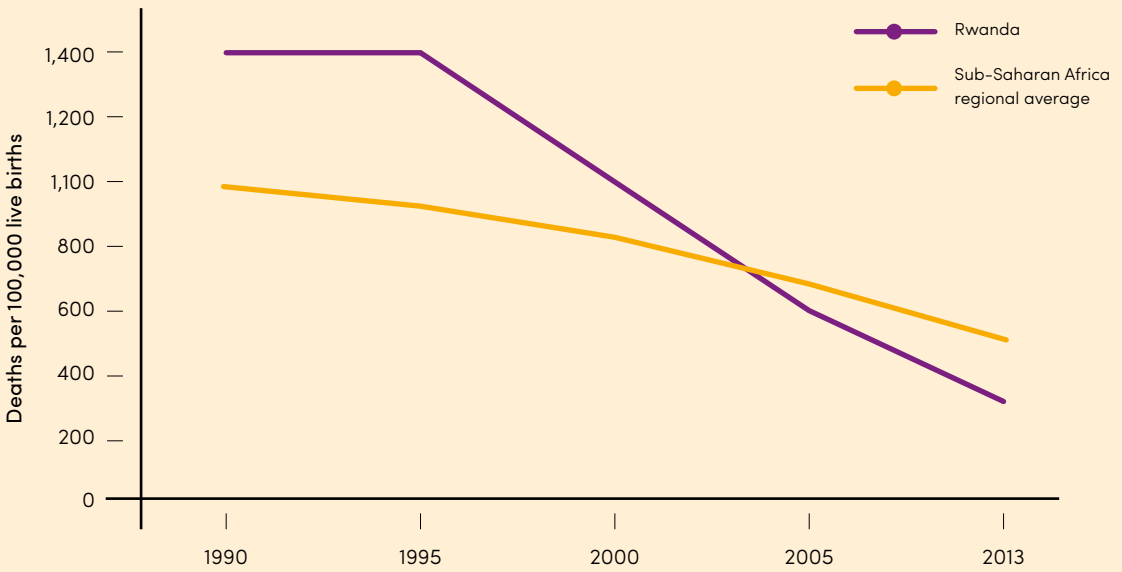
In 2013, sub-Saharan African countries accounted for an estimated 62 per cent of maternal deaths worldwide.[187] Most of the complications responsible for women's deaths during pregnancy and childbirth can be prevented by enhancing access to family planning, effective antenatal care and skilled birth attendance, including emergency obstetric care. However, take-up of these services is hampered by lack of information, inaccessible facilities and prohibitive costs. And shortcomings in the quality of care result in failures to diagnose and treat pregnancy-related complications.

Rwanda's experience shows that these barriers can be overcome. Following the 1994 genocide, it was among the poorest countries in the world, its health system lay in ruins and maternal mortality rates were well above the regional average. Yet, as shown in Figure 3.8, Rwanda has reduced the number of maternal deaths faster than most other countries in sub-Saharan Africa, from 1,400 deaths per 100,000 live births in 1990 to 310 in 2013. Along with Cabo Verde, Eritrea and Equatorial Guinea, Rwanda is one of only four countries in the region that are on track towards meeting the Millennium Development Goal (MDG) target of reducing maternal mortality by three quarters between 1990 and 2015.[188]

Figure 3.8

Trends in the maternal mortality ratio: Rwanda and sub-Saharan Africa regional average, 1990-2013

⟶ Maternal mortality in Rwanda has declined faster than the regional average



Source: WHO et al. 2014

A combination of measures lies behind this impressive progress:[189]

- The rapid roll out of health insurance removed financial barriers to accessing services, in particular for ambulance transfers to higher-level facilities for emergency interventions
- The nationwide expansion of adequately equipped public health centres with decentralized management allows for performance-based financing
- Well-trained community health workers (CHWs) provide antenatal care and delivery services in health centres as well as promoting hygiene, health insurance and family planning
- New mobile technologies help CHWs track pregnancies and enable a quick response to pregnancy-related complications and referral for emergency obstetric care if needed
- CHWs and other health-care professionals are given incentives to meet maternal and child health targets and provide quality care, with regular visits to monitor compliance
- Participatory processes at the local level, which provide a mechanism to feedback problems and lessons into policy, are essential to enhancing accountability in the health system as a whole.

Overall, universal health coverage is an important step in the right direction and one from which women can benefit. But the experiences of Rwanda and Thailand demonstrate that in order to be effective, significant subsidies from general taxation or international aid are required to make up for the limited contributory capacity among low-income women and men. In both cases, the impressive improvements in health outcomes, particularly for women, are also the result of longer-term investments in decentralized health services and the development of administrative capacity to manage these effectively. This suggests that contributory social or community insurance schemes may not be the most effective way to achieve affordable access to health care, particularly in low-income countries where the amount of contributions that can be extracted from informal workers and other low-income groups is usually low.[190] Instead, resources could be invested directly in the extension and operation of public health facilities with the aim of building national health systems that are free at the point of service delivery.

Towards gender-responsive service delivery

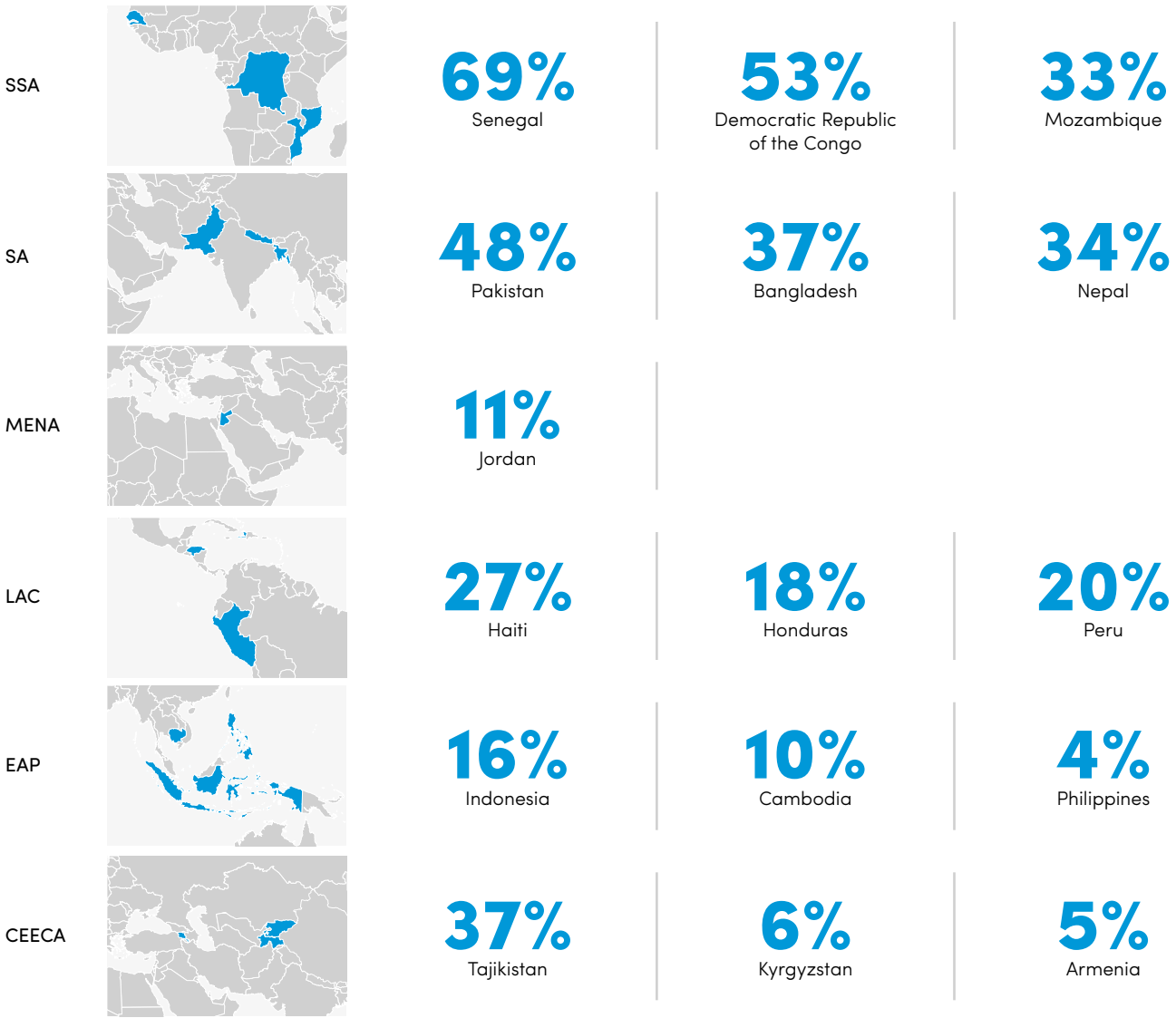
Affordability is not the only barrier to equitable access to health care for women and girls. Gender-based differences and structural inequalities—including those resulting from stigma, stereotypes and violence—also need to be addressed at the service delivery level.[191] Gender norms and biases shape how women perceive their own health and influence whether and how they can act on their own health needs. At the household level, women's health problems may be neglected because of the relatively low value attached to their lives, and resources for health care may be allocated preferentially to male household members.[192]

Women also often need to obtain consent from family members to seek medical care. Figure 3.9 shows that, across a range of countries, a significant proportion of women do not decide independently on their health care—more than two thirds of women in Senegal, for example.

Figure 3.9

Proportion of women who say they do not make the final decision on their own health care, 2010-2013

In many countries, women's autonomy in relation to seeking health care is constrained



Source: ICF International 2015.

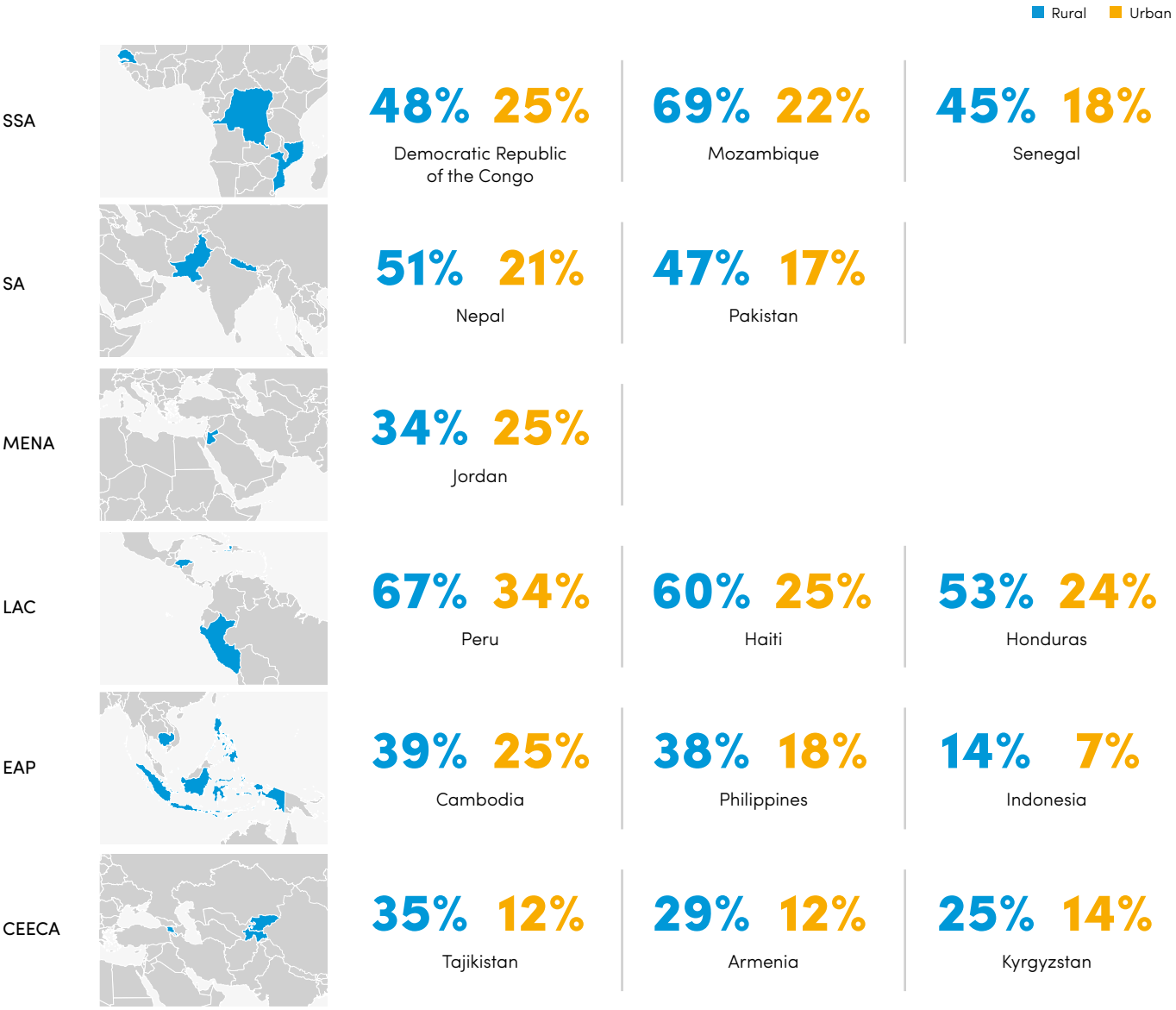
Note: Data refer to the most recent available during the period specified. The data included in this figure captures the percentage of women who reported not having a final say alone or jointly (with husband/partner or other person) in their own health care. Regions are as follows: CEECA (Central and Eastern Europe and Central Asia); Developed (Developed Regions); EAP (East Asia and the Pacific); LAC (Latin America and the Caribbean); MENA (Middle East and North Africa); SA (South Asia); SSA (sub-Saharan Africa). See UN Women's regional groupings for the list of countries and territories included in each region in Annex 7.

Women's access to health services may also be affected by the location, opening hours and staffing of health services. As Figure 3.10 shows, where services are far away, women may face transportation costs or safety risks that prevent them from seeking care, particularly if they live in rural areas. In some communities, women's ability to move freely in public spaces is restricted, making it difficult for them to attend medical facilities outside their homes or to receive confidential medical advice.

Figure 3.10

Percentage of women who reported difficulties in accessing health care because of the distance to health facility, by location, 2010-2014

⟶ Distant health care services are a major barrier to access for many women, particularly those in rural areas



Source: ICF International 2015.

Note: Data refer to the most recent available during the period specified. The data included in the figure captures the percentage of women who reported distance to the health facility as a problem in answering a question in the DHS on factors limiting access to health care (see note to Figure 3.7).

Finally, women may be reluctant to consult doctors of the opposite sex or be culturally discouraged from doing so. In such cases, lack of female health staff constitutes a significant access barrier. In the Plurinational State of Bolivia, Ethiopia, Maldives, Peru, São Tomé and Príncipe and Timor-Leste, for example, half or more of the women reporting difficulties in accessing health care cite concerns over the availability of a female health provider.[193]

Breaking down institutional barriers

Different measures can be taken to overcome these barriers. Multi-purpose clinics that integrate services—for example, sexual and reproductive health services alongside paediatric care—can save time for women who are in charge of children or other dependents. This increases the likelihood that women will seek advice or treatment for their own health problems.[194] Upgrading village-level health centres, training community-based health workers for home visits and setting up systems for reliable emergency transport can make an important difference for women in rural areas, as the experience of Rwanda shows (see Box 3.9).

Outreach services can improve access, privacy and confidentiality for women who experience limits on their mobility or on their interaction with male care providers. In Pakistan, for example, the Lady Health Workers (LHW) programme provides door-to-door health services mainly for rural women who are unable to visit health facilities. Established in 1993, the programme has trained more than 100,000 women as community health workers (CHWs) who provide information, basic services and access to further care. The programme has been effective in improving maternal and child health care, including antenatal services and skilled assistance at birth. Positive outcomes include increased child immunization rates and greater uptake of contraceptives.[195] The LHW programme has also strengthened the skills and capacities as well as income-earning opportunities of the women who are trained as CHWs. In a context where employment options for women are very limited, this has enhanced women's status within their communities and households.[196]

Addressing stereotypes, stigma and violence

Professional, respectful and non-abusive patient-provider relations are an important aspect of quality health care broadly and of gender-responsive service delivery specifically. For example, aggressive treatment of women during labour by overworked and underpaid health staff has been documented in maternity wards in Latin America and the Caribbean and sub-Saharan Africa.[197] Action is needed to combat stigma, discrimination and abuse against women and girls who are seeking care.

The redesign of medical curricula and the provision of on-the-job training can address such problems and also enhance understanding among health providers of how gender norms and roles affect women's health. Domestic violence is a case in point. Health-care providers have a critical role to play in detecting abuse and in caring for women who experience violence. Yet, without proper training and clear screening protocols or referral mechanisms, health personnel are often unable to identify and adequately support victims.[198] They may also fail to respond in the face of obvious signs or even blame women victims, particularly in societies where violence against women is condoned.

In the Dominican Republic, *Profamilia*, an affiliate of the International Planned Parenthood Federation, developed a comprehensive model for addressing this issue within its network of clinics.[199] The organization began training all clinic staff, developed a standard process for screening clients and created on-site spaces for psychological and legal counselling. Internal evaluations show that the programme changed the perception of service providers towards domestic violence, leading to a dramatic drop in the tendency to blame the victim. The experiences of women seeking care in their clinics also improved. Progress has also been made in the Pacific, where recent prevalence studies have detected high levels of violence against women (see Box 3.10).

Women's organizations have often been at the forefront of uncovering and denouncing service delivery failures in health care, spurring important reforms. The mobilization of poor and marginalized women against low-quality maternal health services in Uttar Pradesh (India), for example, ushered in tangible improvements, including a reduction in demands for informal payments.[200] In Peru, feminist lawyers and women's rights organizations worked together to uncover mass sterilization campaigns that systematically targeted indigenous women in poor, rural communities, as part of a broader family planning programme. Their advocacy spurred an investigation by the national human rights

BOX 3.10

Addressing violence against women through the health system: The case of Kiribati

Recent research on the prevalence of violence against women in the Pacific has been critical to spurring policy change, including in the health system. Prevalence studies from the Pacific Islands, supported by the United Nations Population Fund (UNFPA), the Secretariat of the Pacific Community and the Governments of Australia and New Zealand, show that in 5 out of 10 countries for which data are available, intimate partner violence affects more than one out of two women. At 68 per cent, Kiribati has the highest rates of intimate partner violence in the region. In addition, 11 per cent of Kiribati women aged 15–49 reported physical violence by men other than their partners, most commonly by male family members including fathers or stepfathers, and 10 per cent reported having experienced non-partner sexual violence. The detrimental impacts of violence on women's physical, sexual and mental health are well documented, including unwanted pregnancies, unsafe abortions, miscarriages, sexually transmitted diseases, emotional distress and thoughts of suicide.

In response, the Government of Kiribati has started to integrate the issue of violence against women into sexual and reproductive health programming by, for example, setting up a Women's and Children's Health facility in South Tarawa—close to a referral hospital and a shelter—that will support referral between psycho-social support, legal aid and health care. Gender-based violence coordinators have been put in place in the Ministry of Health and the Ministry of Women, Youth and Social Affairs to support health promotion to outer islands, capacity building and improved availability of emergency contraceptives. Health providers have been trained, with support from UNFPA and the Auckland University of Technology, to follow a women-centred approach, allowing survivors to speak, finding solutions that they feel are safe for them and connecting them with other services. Special measures have been put in place to reach adolescents through community outreach, peer education and comprehensive sexuality education programmes. Improvements in health information systems, including standardized procedures for monthly reporting and for the assessment and management of violence against women, will help track progress.[201]

commission that eventually led to the programme's reform.[202] These and similar efforts pave the way for the wider transformation of health services to enable women's enjoyment of their right to health.

It is important to note, however, that the barriers to women and girls' equal enjoyment of the right to health cannot be dismantled by the health system alone. For adolescent girls to realize their sexual and reproductive rights, for example, sex education in schools can be just as essential as access to confidential counselling and affordable contraception in health centres.[203] Substantive equality in health requires broader changes in social norms and gender power relations as well as enabling policies that enhance women's and girls' rights and status.

Recommendations

The transformation of health systems towards the achievement of substantive equality for women requires financial, geographical and social access barriers for women and girls to be removed and their health needs to be addressed head-on. In line with the social protection floor, national health systems that provide universal, affordable health

care for all are the best way to ensure affordability and can be built gradually. To eliminate all barriers for women and girls, health systems need to:

- Remove out-of-pocket payments and replace them with different financing mechanisms
- Gradually move towards universal coverage that is affordable for all through national health systems or the effective combination of insurance contributions and public funding
- Provide a basic level of care free of charge to all, independent of labour market and family status; at a minimum, sexual and reproductive health services should be available and affordable for all women and girls
- Invest in health service delivery, including in basic infrastructure, staff and essential medicines, to make universal coverage effective on the ground
- Upgrade village-level health centres, train community-based health workers for home visits and set up systems for reliable emergency transport to better reach women in rural areas
- Train health staff in women's rights and in the delivery of women-centred services
- Institutionalize mechanisms to enhance the accountability of service providers to women and girls, including effective monitoring and incentive systems, to make health services more gender-responsive.

CARE SERVICES

Care for dependent people—children, people with disabilities, the frail elderly, the chronically ill and others who need assistance in daily living—is intimately connected with health and other social services. This connection is particularly visible in the case of care for people with HIV and AIDS. Family and community caregivers in Kenya, Uganda, Zimbabwe and other countries in sub-Saharan Africa, for example, have been vocal in their demands for better health services, including access to anti-retroviral therapy, as well as for greater recognition and support of their unpaid caregiving (see story: *A seat at the table*).

The right to care and to be cared for

The international human rights framework has little to say on the right to care. Children's right to care is explicitly recognized in the Convention on the Rights of the Child,[204] for example, but there is little clarity on how this right is to be realized in ways that are equitable and do not infringe on women's rights to an adequate standard of living, work, rest and so forth. The tendency has been to assume that mothers or other female family members are available to meet the care needs of children and other dependants on an unpaid basis.

Feminists have long proposed that the rights to give and receive care should be recognized as human rights.[205] More recently, interest in unpaid care and domestic work and its implications for women's human rights has also been growing within the United Nations system. In her landmark report on unpaid care and domestic work, poverty and human rights, then United Nations Special Rapporteur on extreme poverty and human rights, Magdalena Sepúlveda, argued that 'heavy and unequal care responsibilities are a major barrier to gender equality and to women's equal enjoyment of human rights, and, in many cases, condemn women to poverty. Therefore, the failure of States to adequately provide, fund, support and regulate care contradicts their human rights obligations, by creating and exacerbating inequalities and threatening women's rights enjoyment.'[206]

Against this backdrop, available, accessible and affordable care services have a double role to play. On the one hand, these services can promote the autonomy, rights and capabilities of those who need care and support. This has been a long-standing demand of disability rights movements, for example. These movements have also denounced the fact that social services are often provided in ways that curtail rights by restricting the autonomy and preventing the full participation

of people with disabilities in their communities. People with disabilities are subjected to degrading procedures and confinement in institutions, often with high rates of abuse. Activists have also directly challenged the notion of care itself as disempowering and objectifying of people with disabilities, especially if it is conceived of as a one-way flow of giving and receiving (see Box 3.11).

BOX 3.11
Care and the rights of people with disabilities

Research and advocacy on care have focused primarily on the rights and needs of caregivers, both paid and unpaid. They have highlighted the emotional and financial costs of caring and constructed a comprehensive policy agenda around greater recognition and material support for carers in terms of time, money and services.[207] The rights and needs of care receivers, in contrast, have received relatively little attention in debates around care.[208] The disability movement has forcefully exposed this bias.

People with disabilities have broadened the policy agenda on care by identifying themselves as subjects of rights, not objects of care.[209] Furthermore, they have drawn attention to the fact that people with disabilities are often caregivers themselves.[210] In the fight for their human rights, people with disabilities have emphasized the importance of empowerment, autonomy and self-determination both in their lives and in how their support needs are met.[211]

These challenges may seem to pit the rights of caregivers against those of care receivers. In fact, however, both constituencies share common histories, goals and interests. Both have struggled against oppression, inequality and discrimination. Both suffer from a lack of entitlements and social support systems that would protect them against impoverishment and exploitation.[212] While each side has its specific concerns, there is a common agenda to be built around recognition and resources.

For example, transformations in the physical and social infrastructure, by providing better and more accessible transport options, enhance the autonomy of people with disabilities while at the same time reducing the demands on those who support them. Alliances must be forged between the disability rights movement and organized caregivers around common demands for affordable, accessible and adequate services and infrastructure to work towards 'a fulfilling life both for the carer and the cared-for'.[213]

On the other hand, care services can reduce the time constraints faced by those—especially women—who perform the bulk of unpaid care and domestic work on a day-to-day basis. As such, they play a pivotal role in promoting substantive equality for women. The availability of care services can help redress women's socio-economic disadvantage by enhancing their ability to engage in paid work. Care services also contribute to the transformation of gender stereotypes by allowing women to move out of the home and into the public domain. In doing so, they can enable women's enjoyment of a range of rights, including the rights to work, education, health and participation.

In order to play these roles, care services must be affordable, accessible, of appropriate quality and respectful of the rights and dignity of both caregivers and care receivers.[214] These conditions are far from being met at present.

Early childhood education and care

In most countries care services are still scarce, and where they exist their coverage and quality is often

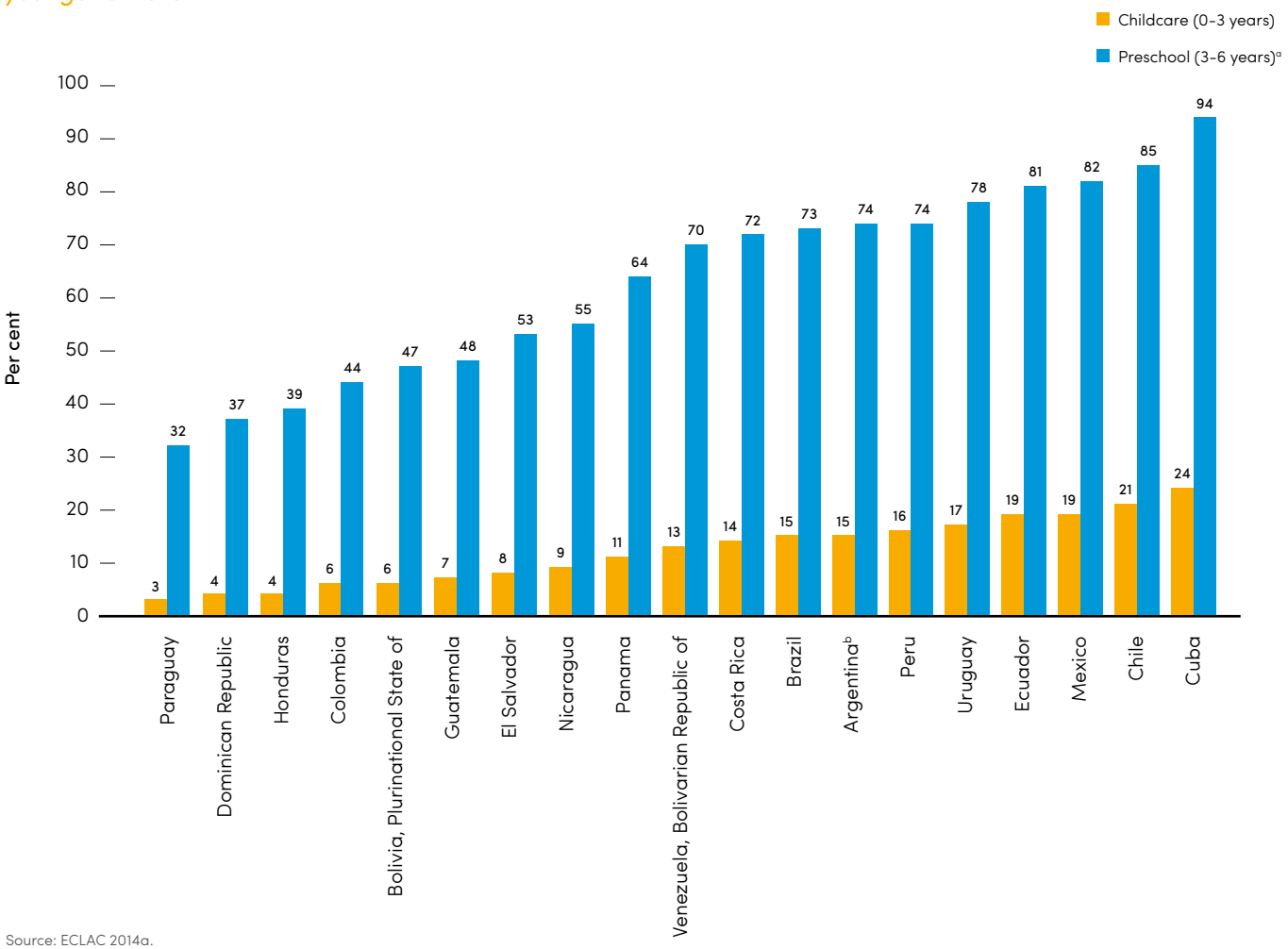
uneven. Data on early childhood education and care (ECEC) services illustrate this point.[215] Across OECD countries, for example, coverage of ECEC services for children aged 0–2 years, when the care burden on women is largest, lags far behind coverage for children aged 3–5 years. Coverage for 3–5-year-olds is above 70 per cent in most OECD countries and close to universal in some, whilst average coverage for 0–2-year-olds is only about 33 per cent, with important variations across countries.[216] Coverage is particularly low among Eastern European countries, where public support for family-friendly policies declined significantly with the transition from state socialism to a market economy. Meanwhile, the Nordic countries, the Netherlands and France, Malta and the Republic of Korea achieve high levels of coverage among the under-3s.

In addition, care services for under-3s are rarely provided free of charge and costs vary as widely as coverage rates. In OECD countries, the average cost of full-time care for 2-year-old children is just over 16 per cent of average earnings, but this ranges from less than 5 per cent in Greece to over 30 per cent in Switzerland. The high cost of childcare may restrict women's ability to work outside the home or force parents to opt for informal care arrangements, which offer varying levels of quality and are often dependent on relatively low-paid female workers.[217]

Figure 3.11

Net enrolment rates in pre-school and childcare, in Latin America and the Caribbean, 2012

⟶ In Latin America, childcare services have been extended, but coverage rates remain low, particularly for younger children



Source: ECLAC 2014a.

Note: Data refer to the most recent available. a. For pre-school education net enrolment was estimated based on linear models using household surveys in countries with available information. The age groups vary depending on the official school starting age of each country. b. Urban areas only

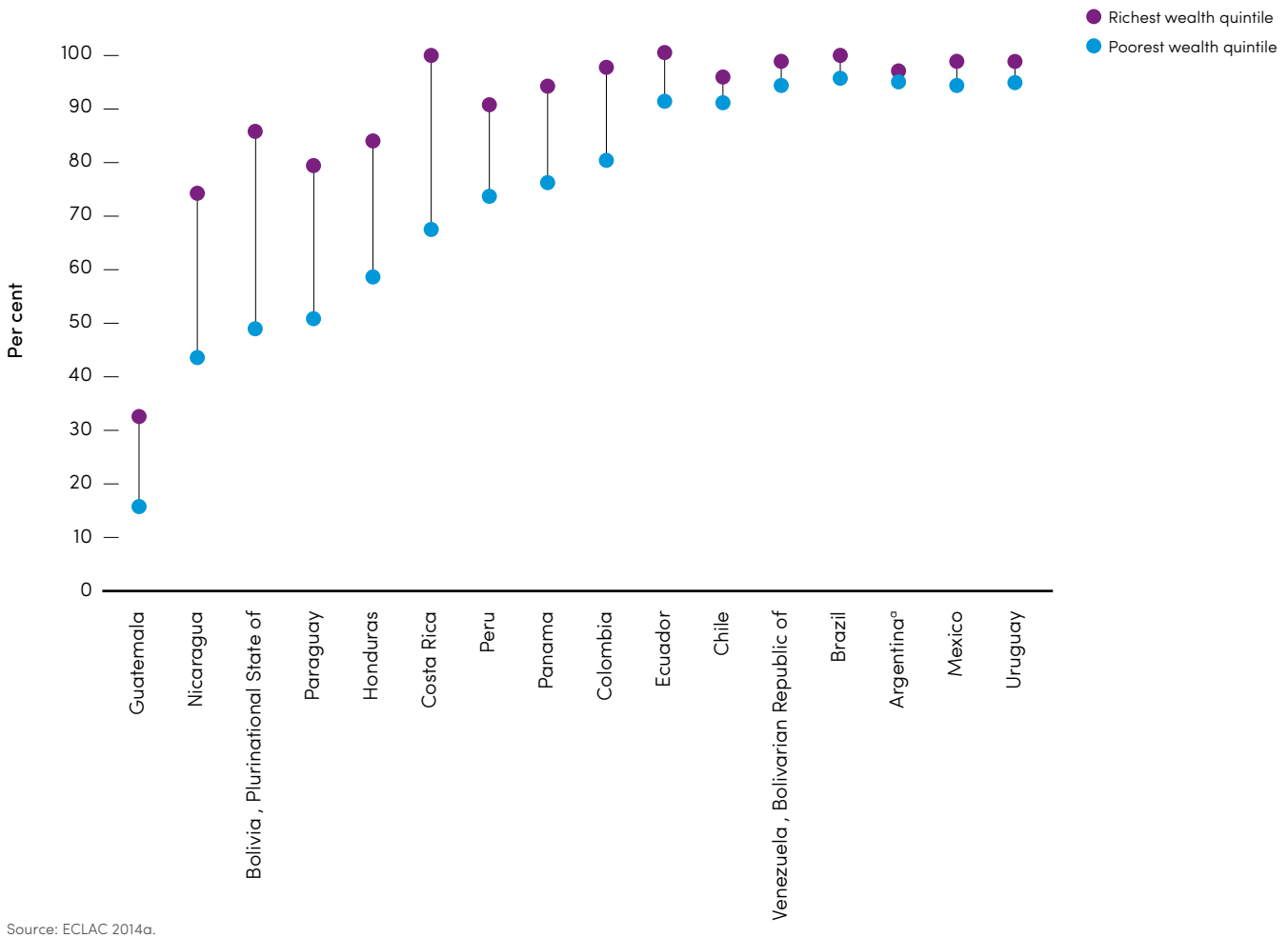
Public investment in ECEC services has been gaining ground on the policy agenda of both developed and developing countries. In Europe, there has been a gradual shift in spending over the last 15 years away from child-related financial transfers in favour of ECEC services, along with greater efforts to direct expenditure towards younger children.[218] Even countries such as Germany and the Netherlands—often considered strongholds of traditional family policies—have made significant investments in the expansion of childcare services for under-3s.[219]

East Asia and the Pacific as well as Latin America and the Caribbean have also seen significant progress in the expansion of ECEC services. Pre-primary enrolment for children in these two regions jumped by 30 and 21 percentage points, respectively, between 1999 and 2012.[220] Figures 3.11 and 3.12 show, however, that in Latin America and the Caribbean, where more detailed data are available, average coverage for under-3s remains at very low levels and inequalities across income groups are significant. Some countries in the region have made important strides to scale up ECEC services and also succeeded in reducing income-based inequalities in access to these services, as discussed further below. Argentina, Brazil, Chile, Mexico and Uruguay have invested in provision both at the preschool (3–6 years) and day-care (0–3 years) levels.[221]

Figure 3.12

Pre-school attendance rates by income quintile in Latin American countries, 2006-2012

⟶ In Latin America, children from higher income households are more likely to be in pre-school than children from lower income households



Source: ECLAC 2014a.

Note: Data refer to the most recent available during the period specified. a. Urban areas only

Balancing educational and childcare needs

In many developed countries as well as in Latin America, preschool and day-care services have developed in parallel.[222] The educational model of preschool services holds that children need access to schooling before reaching the age of compulsory education. This model tends to be quite universalist, that is, concerned about the early education of all children. However, it is not necessarily in tune with the needs of working parents. Indeed, preschool services often run only part-time programmes. Day-care provision, by contrast, is based on a work-family conciliation model aimed at enabling parents to work outside the home and protect their offspring while they do so. However, unlike preschool services, which are offered to all children, this type of provision has tended to be more targeted, focusing on children from low-income or vulnerable households.

Recent efforts to expand ECEC services in Chile and Mexico illustrate this split. In Mexico, preschool services for 3–5-year-old children are integrated into the broader educational system, with preschool enrolment mandatory for this age group since 2002. This strategy, which has also been pursued in Argentina, has helped raise attendance and reduce coverage gaps between high- and low-income groups. However, reflecting their educational mission, most preschools run only half-day programmes, limiting the extent to which they can free working parents from their childcare responsibilities. Access to formal, full-time day care, especially for younger children, has been largely restricted to women in formal employment.[223]

To remedy this shortcoming, in 2007 the Mexican Government launched the Federal Day-Care Programme for Working Mothers (*Programa de Guarderías y Estancias Infantiles para Apoyar a Madres Trabajadoras*). This programme promotes the creation of home- or community-based day-care centres for children from low-income households, where parents have no access to other day-care services. The *Hogares Comunitarios* in Colombia and Guatemala follow a similar approach.[224] In Mexico, parents are supported through a voucher system that reduces user fees on a sliding scale based on household income. The achievements in terms of expanded coverage have been remarkable. The programme now constitutes the single most important source of day care for children under the age of 4, running 84 per cent of day-care centres in the country and absorbing 56 per cent of total enrolment for that age group.

The programme is an important step towards universal access to childcare services. However, there are concerns over the quality of services. The programme has a significantly lower budget than services available to formal workers who contribute to social security, and there are lower requirements in terms of staff educational credentials and basic infrastructure. The quality of jobs that have been created is also questionable. Paid caregivers and their assistants are self-employed and thus lack access to social protection. Caregivers have complained about the low level of subsidies, suggesting that it is difficult to both comply with programme delivery requirements and earn a decent wage.[225]

Chile has also made progress in terms of equalizing access to childcare services, especially since 2006. In contrast to Mexico, day-care services were expanded by increasing the availability of tax-financed public services for 0–3-year-old children from lower-income households. As a result, coverage increased from 17 per cent in 2006 to 26 per cent in 2011 and the gap in access to these services between socio-economic groups has also decreased.[226] In addition, efforts have been made to provide services in ways that meet the needs of working mothers by ensuring that the majority of newly created childcare centres offer full-day and extended schedules. Yet, in common with Mexico, day-care services for under-3s are followed by a preschool system for 4- and 5-year-old children that offers largely part-time programmes and operates on a school year calendar, with extensive holidays.

Care of dependent adults

As shown above, ageing represents a growing challenge for the provision of income security through adequate pension schemes. It also creates new requirements for care. Some developed countries, including Denmark, Norway and Sweden, provide tax-financed long-term care services for the elderly, while both Japan (since 2000) and the Republic of Korea (2008) have introduced long-term care insurance following the example of Germany (1995). Through these systems, older people have access to a range of services depending on the intensity of their care needs, including ambulant and home-based care as well as institutionally based day care and residential and nursing homes.[227]

In general, however, policy responses to the care needs of dependent adults—including frail elderly people and people with disabilities—have been gaining ground more slowly than those responding to the needs for childcare, even in developed countries. Public expenditure on elderly care remains low.[228] Families, friends, neighbours and community networks provide the bulk of long-term care, with women assuming most of the related unpaid work.[229]

Meanwhile, in middle- and lower-income countries, services for the frail elderly and other care-dependent adults remain very limited. In Myanmar, Thailand and Viet Nam, for example, governments have supported non-governmental organizations in the recruitment and training of volunteer caregivers and the creation of self-help groups as a way to manage the rising share of older people who require assistance.[230] In other countries, such as China and Singapore, legislation has been put in place to stipulate the obligation of adult children to provide care for their elderly parents by threat of jail or fines.[231] In both cases, state commitment in terms of funding and service delivery is minimal. As a result, there are few alternatives to unpaid family care, which can have enormous economic and psychological costs for women.

A recent survey of long-term care arrangements in China, Mexico, Nigeria and Peru found that the principal caregivers of care-dependent older people with dementia were mostly women—daughters or daughters-in-law as well as spouses—and that many of them had cut back on paid work in order to provide unpaid care and domestic (see Table 3.3).[232] As in high-income countries, unpaid caregiving was associated with significant psychological strain.[233] With the exception of households in Beijing and Lima, few could afford to hire paid caregivers to ease the burden.

Table 3.3

Care arrangements for older people in China, Mexico, Nigeria and Peru

	Peru		Mexico		China		Nigeria
	Urban	Rural	Urban	Rural	Urban	Rural	
Principal caregiver is female	86%	89%	83%	82%	67%	50%	n/d
Principal caregiver has cut back on paid work to care	16%	23%	25%	37%	4%	48%	39%
Paid caregiver	33%	8%	4%	1%	45%	2%	2%

Source: Based on Mayston et al. 2012, Table 1.

Towards an integrated response: Care and the definition of national social protection floors

Care services are crucial for the achievement of substantive equality for women and girls. In order to address the rights of caregivers and care receivers comprehensively, however, a combination of investments are required: in basic social infrastructure, from water and sanitation to public transport systems; in social services, from primary health care to school feeding programmes; and in social transfers, from disability benefits to paid parental leave. This should also be kept in mind in the design of national social protection floors. Setting priorities for investment in social protection should include a thorough assessment of the needs of caregivers and care receivers to make sure that policies contribute to the recognition, reduction and redistribution of unpaid care and domestic work.

The combination of transfers and services that will best respond to this goal depends on the national context. Low-income countries with serious deficits in basic social services might choose initially to focus on expanding access to safe drinking water, particularly in rural areas, to reduce the demands on women and girls' time and energy. Middle- and high-income countries, on the other hand, might place greater emphasis on work-family conciliation policies, including parental leave and child and elderly care services. In both cases, priorities for social protection should be determined through open dialogue, involving all stakeholders, and with the active participation of women.

Uruguay has pioneered such a process with the creation of a National Care System (*Sistema Nacional de Cuidados*) in 2011. Starting in 2007, the Government engaged in extensive civil society consultations in order to redesign its social protection framework. Women's rights advocates have actively participated in this process, placing care squarely onto the government agenda (see Box 3.12). The ensuing National Care System is explicitly framed around gender equality and the human rights of caregivers, both paid and unpaid, as well as care receivers, including children, older people and people with disabilities.

BOX 3.12

Towards a national care system in Uruguay: The role of women's agency

The combined actions of women's organizations, female legislators and feminist academics have been central in placing care on the public and political agenda in Uruguay.[234] A network of women's organizations—the *Red de Género y Familia*—and feminist academics began collaborating in the mid-2000s. Together, they forged a common understanding of care from the point of view of gender equality and human rights, collected data, analysed existing policy frameworks and identified coverage gaps. The results of two time-use surveys, conducted by the National Statistical Institute, the National Women's Agency and UN Women, provided powerful evidence on the unequal distribution of unpaid care and domestic work between women and men. They also highlighted other inequalities in access to care based on income and life course stage.[235]

In 2008, the *Red de Género y Familia* organized roundtable discussions in order to bring government officials, civil society organizations and care service providers together to discuss these issues. The sessions brought the insufficient and fragmented nature of existing care services to the fore, giving rise to the idea of an integrated national care system. Female members of the ruling left-wing party *Frente Amplio* successfully placed this idea on the political agenda, such that the *Frente Amplio*'s re-election platform for 2010–2014 included the promise to create a national care system. After the *Frente* regained power, the Government organized 22 debates across the country to ensure broad participation in defining the new system, including by women's organizations, pensioners, caregivers and their families, programme administrators, service providers and regional and local authorities. The Cabinet approved the ensuing proposal for the National Care System in 2011.

The proposal is ambitious and explicitly rights-based, with reference to international and regional conventions and agreements. It is universal in thrust, starting with the most disadvantaged and foreseeing the progressive expansion of benefits and services. Caregivers, both paid and unpaid, were identified as a key target group for government support alongside three groups of care receivers: preschool children, the elderly and people with disabilities. Measures have been proposed to improve the working conditions and wages of paid care workers and increasing support for unpaid family caregivers. There is also a commitment to promote a more equal sharing of care responsibilities between women and men, including through awareness-raising campaigns as well as special incentives for hiring male care service staff.[236]

These achievements notwithstanding, the actual implementation of the system's components has been slow. One of the key challenges is to place the system on a secure financial footing. In parallel, strategic planning processes need to be scaled up in order to ensure implementation, including concrete goals, timelines and budgets as well as a clear definition of institutional leadership for different components of the system. To achieve these outcomes, civil society coalitions need to keep up the pressure and ensure that care remains high on the political agenda.

Recommendations

Care services are an essential component of social service provision and a powerful tool for promoting substantive equality for women. They support women to access better employment opportunities and reduce social and intergenerational inequalities by making extra-familial care available and affordable for lower-income and disadvantaged households. In order to reap the 'double dividend' in terms of women's economic empowerment and child health and education, the ways in which services are delivered is fundamental. Priorities include:

- Improve the reach and quality of care services for both children and care-dependent adults
- Develop comprehensive national care strategies through participatory processes, with implementation aiming at the progressive expansion of services and entitlements
- Consider making preschool education compulsory and invest in the provision of public childcare services to reduce access gaps in the context of high income inequalities
- Make early childhood education and care services compatible with the needs of working parents and improve quality standards through curricular development and the professionalization of caregivers
- Include assessment of and response to care needs, including those of older people and people with disabilities, in the development of national social protection floors, selecting the best combination of transfers and services for the national context
- In low-income countries, introduce or expand school feeding programmes as well as investments in water and sanitation to alleviate the burden on unpaid caregivers.

WATER AND SANITATION

In 2010 the United Nations General Assembly finally recognized the right to safe drinking water and sanitation as a fundamental human right (see Box 3.1).[237] However, despite significant progress since the early 1990s, close to a billion people in 2012 were still without access to an 'improved' water source, defined by the World Health Organization (WHO) as water from a protected well, protected spring, collected rainwater or tap.[238] Oceania and sub-Saharan Africa have the highest proportion of people who rely on unsafe water sources, including surface water from rivers, streams or ponds as well as unprotected open wells.[239] Across the developing world, urban access to improved water is higher than rural access and high-income groups have significantly better access than low-income groups. In Sierra Leone, for example, 87 per cent of urban households have access to drinking water compared to 35 per cent of rural households.[240] Even in urban areas, however, the reliability, quality and affordability of access for the poorest households are often insecure.[241]

Similarly, over 2.5 billion people still have no access to improved sanitation facilities such as flush toilets, composting toilets or ventilated improved pits.[242] Of these, 700 million use shared facilities, which pose particular problems for women and girls due to their lack of privacy and safety. As with water, poorer and rural households are much less likely than wealthier and urban households to have access to improved sanitation. In sub-Saharan Africa, for example, 73 per cent of households from the richest fifth of the population have access to improved sanitation compared to 15 per cent of households from the poorest fifth.[243] Globally, open defecation remains the norm for over 1 billion mainly rural people.[244]

Even when improved water and sanitation are available in or near the dwelling, inequalities within households can affect women's ability to use them. For instance, the Special Rapporteur

on the human right to safe drinking water and sanitation, Catarina de Albuquerque, reported that in her mission to Senegal in 2012 she visited families 'where the water connection tap was closed with a padlock in order to control consumption. Women and children complained about the lack of water for personal hygiene and housekeeping; in some cases, the key to the lock was held by the male head of the household'.[245]

Realizing women's rights to water and sanitation requires attention to decisions about who gets water for which purposes, who gets access to sanitation and how wastewater from sanitation is treated and disposed of, all of which reflect power dynamics and political prioritization. Existing data are insufficient to give a full picture of these issues. Most information about water and sanitation is gathered through household surveys, which do not disaggregate based on sex for most issues. This can mask intra-household inequalities.[246] The Special Rapporteur has suggested that household surveys should be amended to capture these inequalities 'by focusing on the actual use of water, sanitation and hygiene by all individuals within a household'. She has also urged for specific efforts to measure 'the ability of all women and adolescent girls to manage menstruation hygienically and with dignity'.[247] Collecting data on the actual use of water and sanitation facilities at public places, such as schools and hospitals, is also crucial for building a better understanding of whether women and girls are able to enjoy this right.

Inadequate access to water and sanitation jeopardizes women's health

Apart from constituting a human rights violation in itself, the lack of adequate water and sanitation indirectly limits women's enjoyment of range of other rights, such as those to education and health and to live free from violence. One of the major obstacles to girls' education in developing countries, for example, is the lack of sanitation facilities that allow adolescent girls to deal with menstruation.

Ill health caused by the lack of adequate water and sanitation increases the need to care for sick family members, a responsibility that falls primarily on women and girls. Women are also susceptible to greater health risks from certain water and sanitation-related diseases because of their caring role. For instance, trachoma, an infectious eye disease that can lead to blindness, spreads easily in overcrowded conditions and where there is a lack of safe water and sanitation.[248] The disease affects 2.2 million people worldwide. Women have been shown to be 1.8 times more likely than men to be infected because, as primary carers for the sick, they are more likely to be in close contact with infected individuals.[249]

Menstruation, pregnancy and pregnancy-related conditions, as well as taboos and stigmas surrounding these, mean that safe water and adequate sanitation facilities are particularly important for women. During labour and childbirth, a hygienic environment, including safe water and sanitation, is paramount for the survival and health of both mother and child.[250] Obstetric fistula—a pregnancy-related complication affecting 2 million women in Africa and Asia—leads to incontinence and in turn to social stigmatization as well as severe health problems. Lack of access to water and sanitation reinforces the stigma against women, who need to wash and bathe frequently.[251]

Meanwhile, latrines continue to be constructed without facilities or spaces for women to wash themselves and use their sanitary method of choice, and they frequently provide no means for disposal of sanitary products. In addition, sanitary napkins are often unavailable or unaffordable because they are not considered essential commodities within health systems and may have to be imported. In their absence, women and girls are often forced to use unhygienic sanitary methods, such as rags, dirt, ash or newspaper.

Women generally place higher priority than men on having a toilet in the home and require more privacy in order to attend to their needs. However,

they rarely have the control over household resources that would enable them to make the decision to invest in a toilet. Where there are no sanitation facilities, women and girls will often only relieve themselves under the cover of darkness, seeking private spaces and potentially risking violence or attack by animals on the way.[252] Women and girls who use shared sanitation facilities in informal settlements may be exposed to a very real threat of violence.[253]

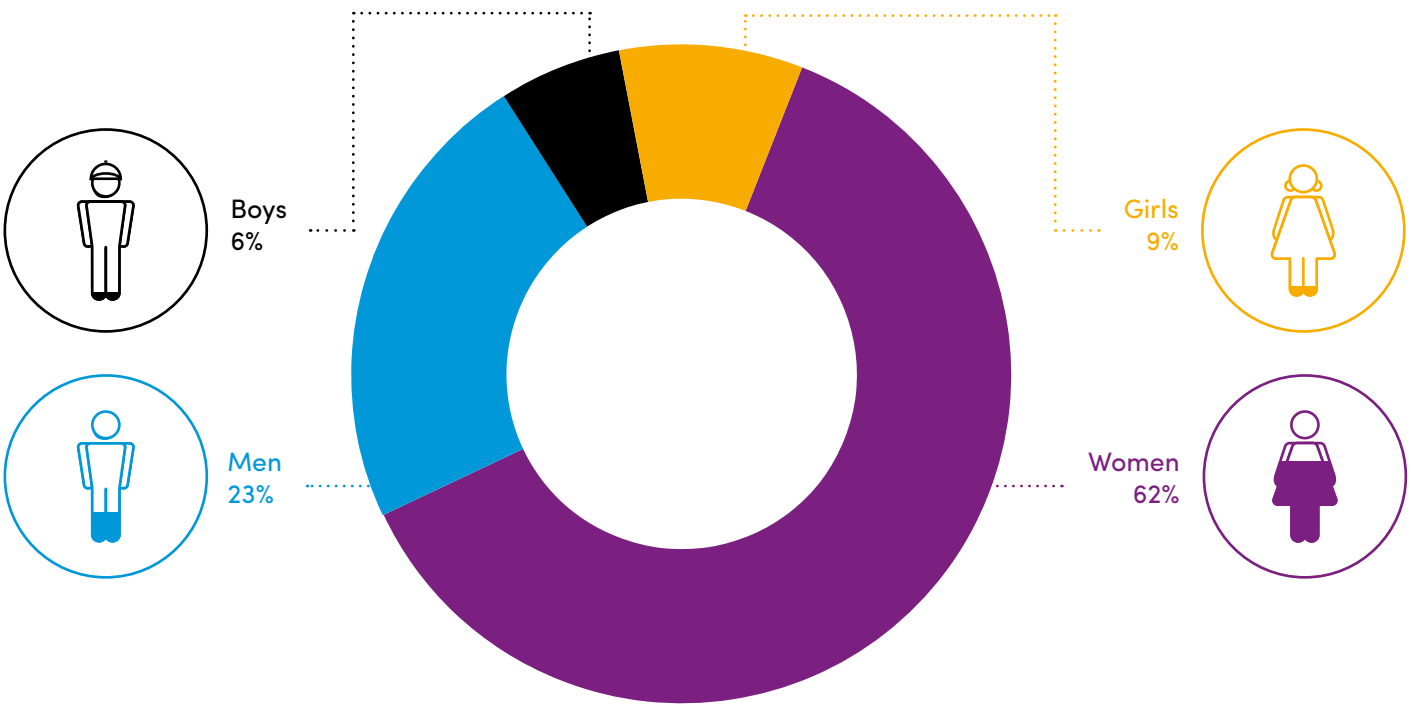
Stigmatization can result in social exclusion from water and sanitation services

Even where water and sanitation services are available, stigma can result in entire groups being disadvantaged and excluded from access based on caste, race, ethnicity or gender.[254] In India, for example, Dalits are often not allowed to use taps and wells located in non-Dalit areas, and Dalit women are made to stand in separate queues near the bore well to fetch water after the non-Dalits have finished.[255] In Slovenia, the requirement of proof of ownership or authorized occupation for receiving municipal services has been a major barrier to Roma communities' access to water. Experience with waiving such requirements has been positive: all but three of the 38 Roma settlements in Prekmurje region, for example, have gained access to water and sanitation after removal of these conditions. By contrast, targeting vulnerable groups can further entrench stigmatization. Shower programmes for Roma children in some Eastern European

Figure 3.13

Percentage distribution of the water collection burden, in sub-Saharan African households without piped water on the premises, 2006-2009

⟶ Women and girls are the primary water carriers for their families in sub-Saharan Africa



Source: UN 2012.

Note: Based on population-weighted averages from 25 countries in sub-Saharan Africa.

municipalities, for example, had 'the unintended effect of identifying them as being too "dirty" to receive education'.[256]

Stigma is often linked to perceptions of uncleanliness. This affects the rights of menstruating women and girls, women with obstetric fistula and women living with HIV, who may face seclusion, reduced mobility and restricted access to shared water and sanitation facilities. Societal silence and individual shame combine to keep women's and girls' water and sanitation needs, including for menstrual hygiene, invisible.

Water collection puts a major strain on women and girls

In sub-Saharan Africa, only 55 per cent of households are within 15 minutes of a water source. Women and girls are the primary water carriers for their families, doing the fetching in over 70 per cent of households where water has to be fetched, as shown in Figure 3.13.[257] Where rural water sources are distant, women walk up to two hours to collect water. Where urban water is obtained from shared standpipes, they may wait in line for over an hour.[258] Survey data for 25 countries in the region indicate that women spend a combined total of 16 million hours per day collecting water.[259] Case studies from around the world show that water-related 'time poverty' translates into lost income for women and lost schooling for girls.[260] Fetching and carrying water also causes wear-and-tear to women's bodies, and high levels of mental stress may result when water rights are insecure.[261]

Increasing the availability, affordability and accessibility of water and sanitation provision is a priority for enhancing substantive equality because women are disproportionately burdened with poor health and unpaid care and domestic work in their absence.[262] Conversely, enhanced access to water has been associated with increases in women's productive activities as well as children's school attendance.[263]

A regular supply of water piped into the household is the ideal but is not the reality for most women and girls in low-income countries, especially in rural or marginalized urban areas. A large proportion of the world's poor rely on a 'patchwork quilt of provision',[264] including water standpipes, water kiosks and delivery agents. These sources count as 'improved' but may still require women and girls to walk long distances or queue up for hours. It has therefore been suggested that, after 2015, one of the indicators for access to basic water should be the percentage of the population using an improved source with a total collection time of 30 minutes or less for a round trip including queuing.[265]

Standpipes have also been found to charge prices several times higher than those associated with a network connection for low-income households in Benin, Kenya, Mali, Senegal and Uganda.[266] Water resellers often charge a much higher per unit price than public utilities. The further away from the household, the higher the price—even without considering opportunity costs that arise from travelling and waiting time, particularly for women and girls.

Regulating private sector participation in water and sanitation

Investing in water and sanitation for women and girls is not only a necessary step towards the fulfilment of international human rights commitments but also makes good economic sense. Overall, the benefits in terms of health and productivity gains exceed the costs of providing and maintaining water and sanitation services.[267] As is the case with other public goods, however, water and sanitation are unlikely to be delivered affordably, equitably and at scale by markets alone. They are hence clear candidates for public investment.

In low-income slums or other informal settlements, where initial capital investment and set-up costs are high and short-term returns on investment are low, the state may be the only actor willing and able to finance the expansion of services.[268] Community-based approaches—such as rainwater harvesting, treadle pumps or community-based total sanitation campaigns—are also unlikely to go to scale without state support.[269] Public involvement and regulation are necessary to ensure that water and sanitation services remain affordable and reflect the needs of marginalized groups. Even where network connections are available, hardware costs and connection and supply charges can present

formidable access barriers, particularly for low-income households, and may require subsidies.

Private sector participation in water and sanitation provision has had mixed results for availability and affordability. There are cases of success in increasing access to water and sanitation through privatization. In Senegal, for example, the private company SdE (*Sénégalaise des Eaux*) expanded the number of connected households from 58 per cent to 87 per cent, with many of these being subsidized 'social' connections where the connection fee is waived and 20 cubic meters of water is provided every two months at a subsidized rate.[270] Meanwhile, the Government continues to support the installation and maintenance of infrastructure, particularly in rural areas.[271] However, there have also been spectacular failures in water privatization. In the early 2000s, for example, Argentina, the Plurinational State of Bolivia, Indonesia and the Philippines all terminated their concession agreements with private providers in response to public protest—often with women at the forefront—or court disputes over tariff hikes.[272]

In any case, an effective regulatory framework is key to ensuring that services continue to be extended to underserved areas, are provided to all groups without discrimination and remain affordable for the whole population.

Ensuring access and affordability

A variety of approaches can be used to enhance affordability in networked water supply. These include waiving or subsidization of connection and supply charges, regulating tariffs and providing targeted subsidies to ease the financial burden on poor households.

In Cambodia, for example, the publicly owned Phnom Penh Water Supply Authority (PPWSA), set up in the 1990s, was particularly successful in providing water access to the urban poor. The company's pro-poor approach includes connection subsidies (up to 100 per cent), possibilities to pay in instalments for poorer households and a ban on disconnection. The cost of water is reportedly 25 times cheaper than before, while the service level has been maintained.[273] The company has also been proactive in seeking out households in need of financial assistance and raising awareness about the availability of subsidies.

In South Africa, the right to water is enshrined in the Constitution. To fulfil this right, public authorities use various strategies for the provision of free basic water and sanitation services. Each household is entitled to a supply of 6,000 litres of free, safe water per month, and ventilated improved pit latrines and flush toilets are being installed to replace bucket latrines in townships. However, the implementation of this policy has highlighted concerns about how minimum entitlements are defined (see Box 3.13).

BOX 3.13

Women claiming the right to water at South Africa's Constitutional Court

In 2009, the Constitutional Court of South Africa ruled on a case concerning access to water in Soweto, Johannesburg: Mazibuko and Others v. City of Johannesburg. The five complainants from an informal settlement, of whom four were women, were from households with between 3 and 20 people living in them. In line with South Africa's constitutional guarantee of the right to water, Johannesburg implemented the Free Basic Water policy to provide all households with at least 25 litres of water per day by installing prepaid meters that provide water up to a defined maximum (6 kilolitres per month). Beyond this, users were required to purchase credit to obtain water from the meters.

The complainants challenged the city's policy on various grounds. They argued that the amount of water provided free of charge was set too low and that it failed to consider household size. They also asserted that the policy did not consider the special needs of people who might require more water.

In the initial ruling, the lower court explicitly recognized the gender dimensions of access to water, finding that, since women and girls were disproportionately burdened with water-related chores, the policy indirectly discriminated based on sex.[274] Ultimately, however, the Constitutional Court found the city's policy to be reasonable and in line with its obligation to progressively realize the right to water—a position that was widely criticized by human rights activists.[275] Despite this setback, the case has spurred policy change. The Johannesburg municipality subsequently agreed to provide larger amounts of free water to extremely poor households and to address some of the shortcomings attributed to the use of prepaid water meters.[276]

Subsidising water use

Subsidies are a suitable affordability mechanism where a large share of the population is connected to a network. Chile, for example, has been operating a tax-financed water subsidy for low-income households since 1989. The subsidy covers between 25 per cent and 85 per cent of the cost of the first 20 cubic meters of water per month. In Colombia, a solidarity-based tariff scheme has been put in place whereby low-income households receive a graduated subsidy financed out of the higher tariffs paid by wealthier households.[277]

But where network access is limited, subsidies can exclude those who struggle the most in accessing affordable water. Subsidizing and regulating the water sources that are actually used by the poor—including standpipes and water kiosks—may be a better strategy in these contexts.[278] Kenya's overhaul of the water and sanitation sectors in the early 2000s, for example, was driven by a pro-poor approach and explicitly sought to enhance the right to safe drinking water.[279] Water kiosks are required to sell safe water at controlled affordable prices and offer alternative payment options for those who cannot afford a monthly bill. The new tariff guidelines also establish a maximum of 5 per cent of household expenditure on water and sanitation.

Towards gender-responsive water and sanitation policies

Efforts to improve the availability and affordability of water and sanitation services must also take women's specific water and sanitation needs into account and actively work towards strengthening the ability of women and girls to voice their concerns. This goes beyond providing a tap and a toilet in every home.

Women's participation at different levels is crucial for the development of gender-responsive and effective water and sanitation initiatives. Experiences from Ethiopia, India, Kenya, Nepal, Pakistan, South Africa and the United Republic of Tanzania suggest that placing women at the centre of water decisions leads to improved access, more cost-effective delivery and less corruption in water financing.[280] Women have also been essential to the success of community-led total sanitation (CLTS), a subsidy-free approach that encourages people to build their own toilets/latrines with local resources to stop open defecation. CLTS encourages women to take leadership roles, but it can also add to women's existing labour as it builds on traditional notions of women as the keepers of cleanliness and order in the family.[281]

If they are to advance substantive equality, water and sanitation programmes must consciously address stigma, stereotypes and violence related to the sanitary needs of women and girls. Awareness-raising and advocacy campaigns are one way to break taboos and to make such needs visible. Menstrual hygiene, for example, was a major theme in India's *Nirmal Bharat Yatra*—a nationwide sanitation campaign spearheaded by

the Geneva-based Water Supply and Sanitation Collaborative Council (WSSCC). The campaign travelled 2,000 kilometres across rural parts of the country in 2012, reaching over 12,000 women and girls with the message that menstruation is just as natural as hunger or sweating and that there is no need to be ashamed or afraid.[282]

Similarly, Plan International set out to address stereotypes in CLTS projects in West Africa. In Sierra Leone, for example, projects started with an assessment of attitudes related to gender stereotypes around sanitation. Based on the information gathered, awareness-raising sessions were organized to tackle attitudes concerning the work considered to be that of women and girls, such as cleaning latrines, washing clothes and dishes, sweeping, fetching water and cleaning and dressing children. According to the project documentation, these efforts have been successful in changing attitudes: for example, since the awareness-raising campaign, girls and boys do the sweeping and cleaning of latrines and facilities on a rotational basis.[283]

Recommendations

Investing in water and sanitation services is not only essential for the realization of the right to water. It also has the potential to unburden women and girls, enhance their physical safety and promote their enjoyment of a range of other rights, including the rights to education, health, work, rest and leisure. Concrete steps to advance towards substantive equality in water and sanitation include:

- Extend water and sanitation services to underserved areas, particularly poor rural areas and low-income settlements in urban areas, as a matter of priority
- Ensure water is accessible on household premises or requires no more than 30 minutes collection time for a round trip including queuing
- Keep access to water and sanitation services affordable through effective government regulation, connection charge waivers, pro-poor tariffs and subsidies
- Design and deliver water and sanitation services with women and girls' needs in mind
- Raise awareness of taboo issues such as obstetric fistulae and menstrual hygiene, which can limit women and girl's access to services
- Increase opportunities for women users and women's organizations to participate in decision-making on and management of water and sanitation services.

CONCLUSIONS

Social policy is essential to advance towards substantive equality for women: it can reduce poverty and inequality, bolster women's income security and economic independence and contribute to the realization of a broad set of economic and social rights. But, as this chapter has shown, reforms and innovations are needed in the provision of social transfers and social services to ensure that they reach women and girls and respond to their needs.

First, redressing women's socio-economic disadvantage requires an integrated response. A combination of enabling social services and adequate social transfers is necessary to ensure that

women enjoy their rights to social security and to an adequate standard of living. Provision of adequate and affordable social services—in particular health, water and sanitation and care—is essential to reduce the demands on women of unpaid caregiving and domestic work and thus increase their likelihood of gaining access to an education or an income of their own.

Social transfers are critical means to address poverty and inequality, particularly for women who are raising children alone, those who struggle to find paid work in the face of widespread unemployment and labour market discrimination, and those who face old-age poverty as a result of a lifetime of socio-economic disadvantage. The growth and institutionalization of large-scale cash transfer programmes and of non-contributory pensions, especially in some middle-income countries, are an encouraging development for women. But much more needs to be done to remove gender biases and move towards universal coverage.

Advancing substantive equality requires not only greater access to existing social transfers and services but also radical transformations in how they are organized and delivered.

Second, social policies and programmes can be effective means to address stigma, stereotypes and violence. There are many ways to do this. Minimally, policy and programme features that perpetuate gender stereotypes or social stigma need to be removed. Social transfer schemes, for example, should not impose conditionalities that increase women's unpaid care and domestic work and should gradually work towards universal coverage in order to avoid stigma. More positively, policies and programmes can provide incentives for men to take on childcare responsibilities and build the capacity of health services to respond to violence against women. In addition, governments and civil society can roll out awareness-raising campaigns to break down gendered taboos around, for example, menstruation in order to enable women and girls to effectively enjoy their right to sanitation.

Third, strengthening women's agency, voice and participation by promoting feminist research, advocacy, legal action and mobilization as well as women's political leadership is fundamental to achieving such transformations in social policy and programmes. From the design of empowering cash transfers in Brazil and Egypt, to the recognition of care in national policy-making in Uruguay and the delivery of affordable and adequate urban water and sanitation in South Africa, women have organized and networked to define, claim and defend their rights.

The social protection floor (SPF) initiative is an important step in the right direction, but care needs to be taken in the definition of priorities for social investments. In their quest to define national SPFs, countries should conduct thorough assessments of the needs of caregivers and care receivers in order to ensure that the expansion of transfers and services contributes to the recognition, reduction and redistribution of unpaid care and domestic work. Realizing minimum levels of social protection for all should be a priority for countries with wide coverage gaps. The idea is not to stop there, however, but to expand the range and level of benefits as well as the quality of the services that are provided. Strategies for financing a progressive upgrading of transfers and services should therefore be mapped out from the start. The next chapter, on macroeconomic policy, discusses this issue in greater depth.

A SEAT AT THE TABLE

Caregivers in Kenya come together to demand a voice

Violet Shivutse knows from experience that to advocate effectively women need to organize, define goals, and then insist on a place at the decision-making table.

A 47-year old farmer, Violet is the founder of Kenya's branch of the Home-Based Care Alliance, which brings together around 30,000 caregivers across 11 African countries. The vast majority women, these carers collectively treat and care for around 200,000 friends, relatives and neighbours, many affected by HIV and AIDS.

"Our main goal ... is to make sure we have a collective voice to lobby for recognition of caregivers as key players in healthcare provision and HIV and AIDS in our communities. Most of our caregivers have gone to a level where they are really recognized by senior government people" says Violet.

It hasn't always been this way. Violet says it has been a long, hard struggle to get to this point. For years, caregivers received little or no recognition for the critical role they played in filling the gaps where formal healthcare facilities were lacking.

Violet Sivutse speaks to the community in Kakamega, western Kenya

Photo: UN Women/Alex Kamweru

Violet with her colleagues at work

Photo: UN Women/Alex Kamweru

The story of Kenyan caregivers' empowerment goes to the heart of some of the issues of exclusion that affect many facets of women's lives around the world.

"Caregivers strengthen the social fabric because for us health begins in the community"

Working with small-scale farmers in western Kenya in the late 1990s, Violet saw that male farmers had the power to take out loans or benefit from agricultural extension schemes, while women were more likely to be found in the fields, working hard, with little support and no role in decision-making.

She also noticed that many women in her community were dying in childbirth, and that the response of the nearby hospital was to blame traditional birth attendants.

Shaken by the death of a local woman, Violet made contact with the local hospital and asked them to include traditional birth attendants in their outreach programmes instead of ostracizing them.

The hospital agreed to work with traditional birth attendants to facilitate mobile clinics for women in the villages. Since many of the attendants were illiterate, they were unable to fill out the hospital's paperwork so Violet agreed to be their secretary.

It was the first step on a journey that would lead Violet to form the Shibuye Community Health Workers. Since the group's inception, it has expanded its work to include other health issues such as measles outbreaks, diarrhoea, and providing advice on sanitation, good nutrition and family planning.

Then, as Kenya's AIDS pandemic took grip in the mid-1990s, caregivers found themselves under increasing

strain. In 1996, the country's HIV prevalence rate hit 10.5 per cent and three years later HIV and AIDS was declared a national disaster and a public health emergency. Since the beginning of the crisis, Kenya's caregivers have been on the frontline of the response - treating long-term patients at home, ensuring their fields were tended, tackling stigma and defending the land rights of women with HIV/AIDS.

Yet initially their efforts were barely acknowledged.

"Every time resources for HIV and AIDS came or meetings (were held) to discuss policy around HIV, caregivers were excluded or represented by big organizations," Violet says.

Her epiphany came during a meeting in Nairobi in 2003 to discuss the effect of HIV and AIDS on Africa.

"The donors, the policy-makers in the room said: 'we know caregivers are there but they are fragmented, they work in small groups so it becomes difficult to bring them to a decision-making platform because they can't represent each other well,'" she said.

Violet relayed this to her community and set about creating a local chapter of the Home-based Care Alliance, which was already working on HIV and AIDS in other countries across Africa. The women organized and started talking to the authorities about how to refine policy around HIV and AIDS. One of the first meetings was with the Constituency AIDS Control Committee, part of the National AIDS Control Council.

As the Home-based Care Alliance grew, Violet realized there was a need to address some ingrained misconceptions about the nature of healthcare.

"The view was that health begins at the health facility. So we came in to say, health begins in the community."

She says the work the caregivers were doing on HIV and AIDS was an economic necessity, as they helped prop up a national health system under incredible strain, but it was also a moral and social imperative.

"Caregivers strengthen the social fabric because for us, in an African context, any sick person belongs to their community ... It's not just about health facilities that are collapsing. No. It's actually what ... people should do when people fall sick and have a long-term illness. We are not just responding to healthcare," she said.

Today, the Kenyan branch of the Home-based Care Alliance has around 3,200 members. In recent years her advocacy work has focused on creating enabling relationships between communities and health facilities, helping caregivers organize and access resources and key policy-making forums.

For Violet, who often represents caregivers in global meetings, the fact that she remains rooted in her community is key to her effectiveness.

"I think this is a comprehensive, holistic way of doing development where you are not just handpicked to sit on a committee, but you come from a community," she says.

The fact that Violet remains rooted in her community is key to her effectiveness

Photo: UN Women/Alex Kamweru

Story: Clar Nichonghaile. For more information on Violet and her work, see www.homebasedcarealliance.org