

Illustrative Case Studies of the
Fracture Points in Social Policy
Formation for Poverty Reduction

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1. Introduction

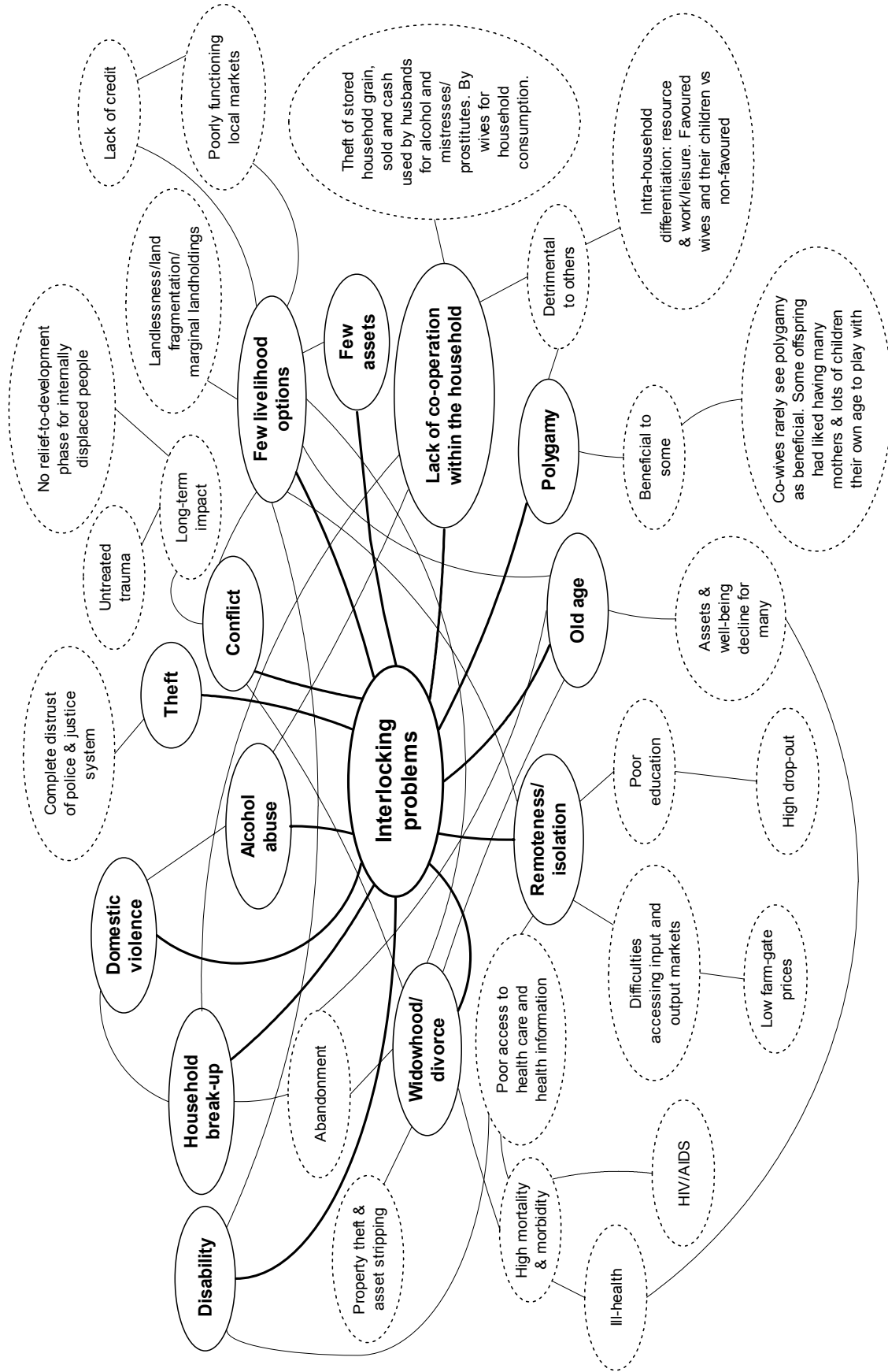
This paper presents case studies that examine the barriers to effective policy responses to the problems of marginalised and vulnerable groups. The multiple deprivations experienced by some of these groups increases their likelihood of being not only poor, but chronically poor. Although theoretical understanding of the drivers, maintainers and interrupters of marginality, vulnerability and chronic poverty is now considerable and many donors and country governments have a coherent and multi-sectoral approach to poverty reduction, there are some problems that are still only weakly addressed. The case studies in this paper help us to understand why this might be the case, and illustrate the political economy and administrative barriers to policy innovation and implementation in Uganda and India. The analytical working paper which was produced following the development of these case studies can be found on the websites of both the Overseas Development Institute and the Chronic Poverty Research Centre (Bird, K. and Pratt, N. with O'Neil, T. and Bolt, V. J. (2004) *Fracture Points in Social Policies for Chronic Poverty Reduction*. ODI Working Paper 242, CPRC Working Paper 47. London: ODI and CPRC, October).

India and Uganda were selected as focal countries because it was felt that they illustrated the range of policy response from effectiveness and innovation to inertia and failure. These are also countries where in-depth research into chronic poverty has occurred, and therefore where there is some knowledge about the problems faced by the chronic poor.

The themes were selected as case studies following research that identified numerous complex and interlocking drivers and maintainers of chronic poverty (see Figure 1) (Bird, 2002; Bird & Shinyekwa, 2003). It became apparent during the research that, although many of these problems have also been identified in participatory poverty assessments and other poverty studies (de Haan and Dubey, 2003; Denninger & Okidi, 2003; Harriss-White, 2002; Lawson et al, 2003; Lwanga-Ntale, 2003; MFPED, 2000; Najjumba-Mulindwa, 2003; Sah et al., 2003), they have received little attention from policy makers or development practitioners. These case studies focus on a small number of these 'low priority' problems in order to attempt to understand better why they have not, or have only partially, made it onto mainstream development agendas.

The selected issues are disability, mental illness, alcohol dependency, male-biased inheritance systems, and the lack of social protection for older people. These have not been selected because they necessarily affect a larger number of people than other issues identified in Figure 1 or the Chronic Poverty Research Centre literature, or because they necessarily have the strongest causal link with chronic poverty, but rather because they represent a wide range of different groups of people and the policy responses to them are illustrative of the different fracture points in the policy formation and implementation process. Nevertheless, these issues *are* of considerable importance to many poor people in developing countries, and may prevent more orthodox approaches to poverty reduction – growth, health, education – from having their intended effects.

Figure 1: The interlocking drivers of chronic poverty in rural Uganda



These issues might be divided into three clusters to reflect their degree of neglect in development and poverty discourses. These are: (1) alcohol and mental illness, (2) disability, and (3) women's land rights and social protection for older people. People with alcohol dependence and mental illness tend to be profoundly excluded. They are commonly castigated as being the source of their own problems and therefore sensibly the best source of the solution. The problems associated with alcohol dependence and mental illness have been excluded from the development and poverty reduction map and policy responses in developing countries have therefore been weak. Responses to disability have been less poor, but it is still not routinely included in operational plans for development and poverty reduction. The need for social protection for older people and land rights for women has widespread recognition, but policy makers are stalled in the process of policy design.

Although they affect different (but sometimes overlapping) groups of people, these problems do have some common elements. They affect groups of people commonly – but often wrongly – identified as being the dependent or economically inactive poor. They are multi-faceted and deeply embedded socially and culturally. Responses are contested, and successful policy would require linked interventions by a number of organisations, making implementation both complex and difficult. In addition, ameliorating the impact of any of these problems requires long-term social change.

The remainder of the paper is structured as follows. Sections 2-6 present each of the case studies. Section 7 summaries the key issues in the policy process for each of the selected themes and Section 8 concludes by highlighting the main findings from the case studies.

2. Alcohol dependence

2.1 Introduction

We are interested in examining policy responses to alcohol dependence largely because of its socio-economic consequences (for further discussion of the scope and scale of the problem of alcohol dependence and its relationship to chronic poverty, see Bird et al. (2004: Section 2.1). Research by the Chronic Poverty Research Centre has found a strong two way relationship between alcohol dependence and chronic poverty (Bird and Shinyekwa, 2003; Lwanga-Ntale & McClean, 2003). In section 2.5, however, we also outline some of the health implications of heavy drinking.

Men drink more than women and problems of male drinking are more acute, but it is inaccurate to depict women simply as victims of male alcohol abuse and as opponents of male consumption. Both men and women can drink excessively, causing individual and social problems. Women's drinking can be a demonstration of their relative economic power, but tends to be subject to greater social sanction than men's. Excessive drinking is strongly associated with health risks, high-risk and anti-social behaviour, including violence and crime, and domestic disturbance and abuse. This can increase household poverty and damage the inter-generational transfer of human and social capital by creating unhealthy living conditions, reducing the provision of health care and education and increasing neglect. It also results in social stigma that isolates children from their friends.

Public policy responses to alcohol dependency in poor communities is often negatively influenced by the perceptions of the elite who regard the poor as undeserving and affected by a culture of poverty (Lewis, 1959). Value judgements about the morality and ethics of drinking result in the poor being regarded as imprudent and wasteful to spend money on alcohol. Despite the writing of anthropologists who have emphasised the positive aspects of 'constructive drinking' in local contexts, the use of alcohol tends to be seen as inherently problematic.

If policy makers are to challenge the negative consequences of excessive alcohol consumption they will need to understand why and how people drink and base any interventions on a detailed understanding of the subtle relationship between alcohol and poverty. Cultural rules and norms are established by all social groupings, governing who drinks what alcohol, where and how, and whether or not one gets drunk. These locally established norms are affected by the complex interaction of socio-economic status, age, gender, ethnicity, expectations and location. They vary between and within communities and over time, and can be central to the construction of individual and collective identities. Some drinking patterns, particularly those associated with traditional forms of alcohol, are subject to specific social and religious sanctions. The gendered nature of alcohol production and consumption affects the household level relationship between alcohol and poverty, and the likely effectiveness of policy responses.

In the late 1950s, Oscar Lewis presented his 'culture of poverty' theory, which essentially argued that people become, are and remain poor because of their beliefs, attitudes and behaviours, which are transmitted intergenerationally, perpetuating a (sub)culture that dooms people to economic and social marginalisation (Moore, 2001;

Rigdon, 1998; Lewis, 1959).¹ Seemingly perpetuating and worsening poverty and hindering its eradication, the use and abuse of alcohol by the poor appears to support this theory. This argument underlines much of what has been written about alcohol. For example, writing about poverty and alcohol use in India, Shankar Patnaik (2001) states that, even if income levels were increased through welfare schemes, drinkers would simply move onto more costly forms of alcohol, preventing any exit from poverty. But does alcohol consumption result in poverty or do poor people drink in order to escape from the day to day realities of their lives? Clearly both are true. Does alcohol abuse contribute to perpetuating a sub-culture of poverty?

Social stability, self-esteem and satisfaction with one's life are associated with lower drinking levels (De Silva et al., 1992). Alcohol consumption can be seen as a means of coping with highly stressful situations. Research has found that the unemployed drink slightly more than the employed and those in debt and under great financial strain also consume more alcohol. However, stress does not automatically lead to increased drinking and poverty does not necessarily result in destructive coping strategies.

Alcohol can be an important social lubricant, cementing personal ties and helping individuals to build and support social networks, but sometimes those who can least afford to spend the most on alcohol in a desperate attempt to expand their social alliances.

Box 1: The impact of alcohol dependence

Sajjabi is destitute and made ill by his heavy alcohol consumption. He is a chronic alcoholic and has been for the whole of his adult life. This has contributed to his position as the poorest of the poor in a very poor village – a lake-side internally displaced people's camp in Kamuli District housing people driven from their homes by ethnic killings in the mid-1980s.

Sajjabi is a pitiful figure. He can barely sit up straight and looks very weak. He has no assets, no savings and no regular livelihood. He occasionally does odd jobs for people, when his neighbours are driven by pity for his state to pay him a few shillings to do something simple. On those days he will eat, otherwise he only eats when kind people give him something. He manages to get alcohol by getting little bits here and there from other drinkers. He sleeps at night in a fish drying hut. He has no security and has had his few possessions stolen by children in the camp who tease, taunt and beat him.

His family in Teso were poor and his parents died when he was young leaving him very vulnerable. He got drawn into drinking heavily and became addicted. This has prevented him building a livelihood or lasting relationships. He had a son from an affair, but the woman was married, so he they have never lived together as a family and his links with his son are weak.

He exclaims that he would love to persuade the young men and women he meets not to drink alcohol because of the way that it gets hold of you, but he fears that they would not listen. He feels that it has ruined his life. He despairs, saying he is only waiting to die.

Source: Key Informant Interview. Kate Bird and Isaac Shinyekwa. September 2002.

2.2 Causes of high alcohol consumption

There appear to be few studies which examine the causes of high alcohol consumption in developing countries. In Uganda there is evidence that internally displaced people living in camps in the conflict affected North have higher than traditional levels of alcohol consumption. This has been associated with the general

1. Lewis also believed that most families fall into poverty because of macro-economic conditions and not through their own fault (Rigdon, 1998).

breakdown in societal norms and alcoholism and drug abuse have occurred amongst teenage school drop-outs (Global IDP Database, n.d.).

People in other parts of rural Uganda have complained that alcohol consumption has increased amongst young men. They see an association between land fragmentation and the resulting underemployment on the land and a lack of non-agricultural livelihood alternatives with increased alcohol consumption.

2.3 Economic impact of alcohol

Alcohol production as a livelihood

To cope with poverty and vulnerability, households have increasingly diversified their livelihood strategies. This often includes the occasional or regular brewing of alcohol, particularly by women.

Alcohol production is important for household survival in sub-Saharan Africa, particularly for women-headed households, who may not have access to land or other productive assets. In Botswana a survey identified brewing as the second highest household income source, and in Tanzania 73% of women brewed at some time. Brewing generates vital cash income that can be spent on caring for and educating children. However, brewing is very labour intensive and risky, with losses of up to 90%. Increased competition forces profits down and harassment from officials undermines production and sales.

Women brewers are not, however, a homogeneous group, and only a minority (who tend to be poorer) brew routinely as their primary, or sole, livelihood strategy; the majority only brew occasionally to meet specific cash needs (Green, 1999). To minimise the risks of production and to reduce competition, many women (poor and less/non-poor) utilise social networks to develop brewing rotas; this restricts the extent to which the less/non-poor can brew, protecting poorer women's access to a brewing income (ibid.). Participation in, and maintenance of, these vital social networks is likely to require some form of investment, without which individuals may be excluded, which would consequently undermine their capacity to earn an income from brewing.

An estimated 50% of global total alcohol consumption is from 'local alcohol' (Haworth and Simpson, 2004). A multi-country study² found that local alcohol is almost always cheaper than alcohol produced and sold in the formal sector, so its consumers are usually in the poorer socio-economic groups (ibid.). However, consumption behaviour differed from country to country. In Zambia only 29% of survey respondents reported consuming illicit alcohol, and these were mostly older drinkers (37-60 years). This compares with Tanzania where 90% of all alcohol produced is non-commercial, mostly opaque beers, many of which are legal.

Fiscal dependence on alcohol taxation

Nepal gains 6% of total government revenue from alcohol (FORUT, 2003). In India, tax on alcohol generates an estimated US\$5 billion per year (Saxena, 1999), with states gaining 10% of their revenue from alcohol, on average, but with much higher figures for some states (e.g. Punjab at around 33%) (Arora, 2001). In India alcohol is thought to generate roughly US\$5 billion in 'black money' in the form of bribes, protection payments and profits from illicit alcohol, allowing the industry to have significant leverage over government policy (Saxena, 1999: 53).

2. Covering Brazil, India, Mexico, Russia, Tanzania and Zambia.

But excessive alcohol use has a negative impact on society, so this tax take must be set against the damaging consequences of excessive consumption. These include:

- the cost of under-age drinking in the USA was estimated at nearly \$53bn in 1996 (Brundtland, 2001);
- alcohol-related hospitalisation cost \$51m in the state of New Mexico (USA) alone. This exceeded the state's alcohol-related tax take of \$35m (ibid.);
- alcohol-related car accidents were estimated to cost the Namibian economy at least 1% of GDP per year (ibid.);
- absenteeism from work, for example, in Malaysia alcoholics have been found to be 16 times more likely to be absent from their jobs (Assunta, 2001).

Unfortunately, the people benefiting from the revenue and the people suffering the ill effects of over-consumption are unlikely to be the same groups, providing a disincentive to change.

Consumption trends

Global figures for per capita consumption of alcohol indicate a rapid increase, with the fastest growth in developing countries in the Asian sub-continent where per capita pure alcohol consumption increased by over 50% between 1980 and 2000 (Rahman, 2003). But there are large variations within countries of both the percentage of the population drinking alcohol and in alcohol consumption levels. In India 60% or more of the adult population is abstinent and fewer than 5% of women drink, but of those that do drink, alcohol consumption levels are similar to those of northern European populations³ and addiction levels are now 1-2% of the adult population (Saxena, 1999). The consumption of both beer and spirits has been rising (Assunta, 2001), with the consumption of Indian Made Foreign Liquor (IMFL) (e.g. whiskey and gin) increasing by 15% per year (Arora, 2001), possibly due to liberalisation leading to greater availability and more aggressive marketing strategies. Household expenditure on alcohol (of those households drinking) varies between 3% and 45% in India (Assunta, 2001), and in Indonesia only 2.7% of adults drink alcohol but this rises to over 40% in Bali (ibid.). In Sri Lanka 20-32% of adults drink, but 71% of rural respondents reported drinking daily and 93% of poor rural adults reported consuming locally produced alcohol (ibid.). In Sri Lanka, India and Malaysia alcohol consumption is higher amongst the poor, and a study found that more than 30% of household consumption in poor urban households in Sri Lanka was on alcohol. Increasing consumption has been linked to a rise in levels of addiction and in India. There is evidence of a significant increase in addiction over the last decade (Rahman, 2003).

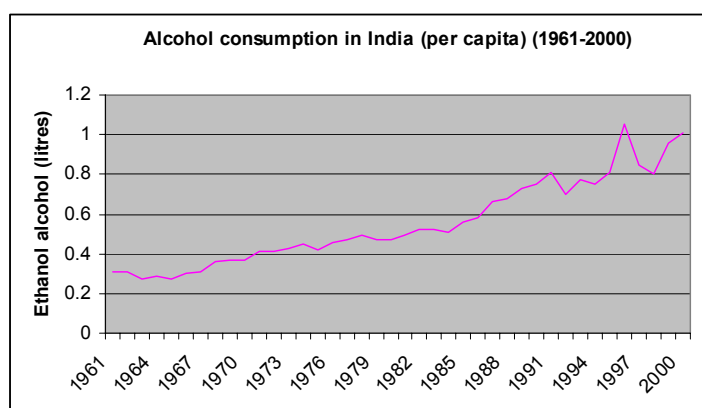
Figures 2 and 3 are produced from WHO data⁴ which use official statistics from national level imports, exports and formal sector sales of alcohol. The figures for ethanol are derived from estimating the ethanol content of common alcoholic beverages. As the figures only include alcohol produced and sold in official markets they exclude all artisanal production and therefore are likely to vastly underestimate both production and consumption figures. However it is interesting to note that over the 1961 to 2000 period officially measured consumption levels in India have increased sharply, albeit from a very low base (note axes), presumably due to cultural changes and increased prosperity amongst some social groups. Increased consumption is at least partly related to a decrease in the real price of alcohol over the last 20 years. Government has resisted increasing alcohol taxes in order to

3. Calculated to be approximately 9 litres of absolute alcohol per annum amongst adult male drinkers (Saxena, 1999: 44).

4. Data downloaded from WHO Global Alcohol Database (<http://www3.who.int/whosis/menu.cfm?path=whosis,alcohol&language=english>, accessed 8.04.04).

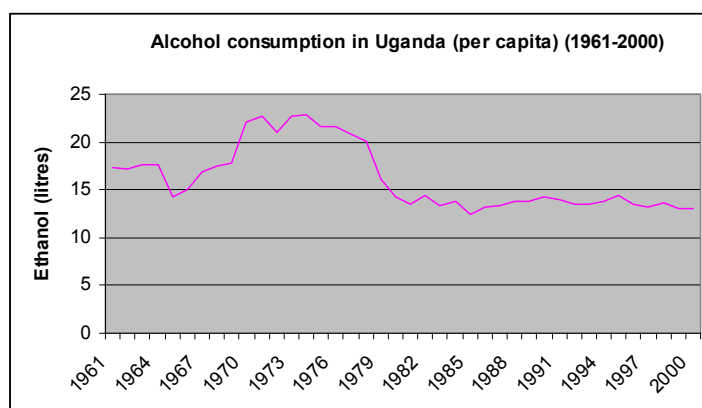
maximise their revenues from higher sales (Saxena, 1999: 53). There is considerable price elasticity for the cheapest alcoholic beverages, so tax increases, which would increase retail prices, could have a significant impact on consumption levels (Saxena, 1999: 53). Officially measured consumption in Uganda increased during the 1970s then slumped and has remained stable at a lower rate than during the pre-independence period, possibly reflecting the persistence of poverty and the small size of the urban middle class (whose consumption is key to affecting formal sector production and consumption figures).

Figure 2: Alcohol consumption trends: India



Source: Figure derived from WHO data

Figure 3: Alcohol consumption trends: Uganda



Source: Ibid.

2.5 Physical impact of excessive alcohol use

Patterns of alcohol consumption have changed in India from ritualistic and occasional consumption around festivals and religious events to being part of routine social interaction and entertainment. However, drinkers commonly binge drink, drinking to get drunk as quickly as possible and stay drunk as long as possible, rather than drinking convivially (Mohan et al., 2001). However, detection and treatment of alcohol-related problems in India is extremely poor (Saxena, 1999: 54).

Time series analyses in western Europe find that overall mortality rises by 1.3% for every extra litre of pure alcohol consumed per annum per capita, so this trend towards increasing consumption has worrying health implications (The Globe, 2003). Health risks posed by alcohol consumption is likely to be higher for drinkers in developing countries because of poorer nutritional levels, the presence of other

illnesses, and harmful impurities in the alcohol, and alcohol-related mortality is often highest among the poorest people in a society (ibid.).

Table 1: Health impacts of alcohol consumption

Country	Health impact
Malaysia	Alcohol is connected with 38% of traffic accident deaths and 30% of hospital admissions for head injuries
Thailand	Alcohol is connected with 62% of traffic accident injuries
Sri Lanka	68% of oral cancer patients were alcohol users
Myanmar (Burma)	11% of psychiatric inpatients received a primary diagnosis of alcohol dependence
India	15-20% of Indian adults consume alcohol. Of these, 5% are alcohol dependent (around 5 million people). Suicide rates are higher in the families of heavy drinkers and the wives of alcoholics have higher rates of depression (Saxena, 1999:51-52)

Source: Assunta (2001); Arora (2001).

Alcohol abuse is responsible for 4% of deaths and disability (1.8 million deaths per year and 58.3 million DALYs), placing it ahead of either malnutrition or poor sanitation, and among men in developing countries it ranks fourth as a cause of disability (FORUT, 2003). Alcohol abuse contributes to a wide range of social and health problems, including depression, injuries, cancer, cirrhosis, dependence, heart disease, brain damage, high blood pressure, strokes, various maternal and child health problems including low birth weight, miscarriage and foetal alcohol syndrome, family disruption and loss of work productivity (Bolt, 2004; The Globe, 2003).

Ill health (alcohol induced or not) commonly leads to reduced productivity, higher unemployment and lower income levels and a simultaneous increase in medical costs and the burden of care. This situation often leads to reduced household spending on food and education, undermining children's development and increasing their susceptibility to illness. The children of alcoholics face learning disabilities, higher levels of generalised stress and more impulsive personality traits as an indirect consequence of their parent's drinking. They are also at higher risk of developing severe alcohol-related problems in later life.

2.6 Other impacts of alcohol use

A survey in Nepal found that more than one third of the children interviewed reported the negative impacts of parental drinking, including domestic violence, loss of wealth, indebtedness, loss of social prestige and the development of bad relationships with neighbours. Parental drinking was also identified as a push factor driving children to run away from home (FORUT, 2003).

Alcohol and domestic violence

A study conducted in Rakai District, South West Uganda (with a sample of 5109 women) found that 30% of women had experienced threats of physical abuse from their current partner, 20% of these during the previous year. They found that there was a strong association between alcohol consumption and domestic violence (Koenig et al., 2003) and 57% of women reporting recent domestic violence said that their partner had consumed alcohol.

Alcohol and HIV

Unsafe sexual practices, such as poor condom use and sex with prostitutes, tend to increase with alcohol consumption, increasing the probability of contracting sexually

transmitted diseases (including HIV) and unintended pregnancy. A study in Masaka, Uganda,⁵ found that there is a strong association between alcohol consumption and the risk of HIV infection. Those who drink had twice the infection rate of those who never drink (Mbulaiteye and Whitworth, 2001). Another study in Uganda found that domestic violence was associated with a woman's belief that her partner was HIV+, indicating that they were beaten on refusing sex. So, alcohol consumption not only increases the risk of the drinker's exposure to sexually transmitted diseases but also their partners'.

Alcohol use and poverty

Alcohol is both a cause and a consequence of poverty, as people drink to forget. As the Table A2 shows, excessive alcohol consumption was regarded by 56% of Ugandan participatory poverty assessment (UPPAP) respondents as being a cause of household poverty and by 24% of respondents as a response to poverty (USAID, 2003). The alcohol consumption of one household member can compromise the material status, food security and well-being of other household members as limited income is spent on alcohol rather than on food, education and healthcare (Lawson et al., 2003). It can also negatively affect intra-household relations, opportunities, and the personal security of household members (including protection from STDs) (World Bank, n.d.) (see Box 2).

Where the head of household spends most of the family's resources on alcohol it can be particularly difficult for the household to escape poverty, trapping them in long term or chronic poverty (Lwanga-Ntale & McClean, 2003).

Table 2: Causes and effects of household poverty most frequently mentioned by Ugandans (percentage of villagers agreeing)

Causes	%	Effects	%
Poor health and disease	67	Poor health and disease	50
Excessive alcohol consumption	56	Theft	44
Lack of education and skills	50	Death	38
Lack of access to financial assistance & credit	50	Inability to meet basic needs	35
Lack of access to markets	44	Low productivity	32
Ignorance and lack of information	44	Food shortage and hunger	27
Idleness and laziness	42	Limited income, funds and capital	27
Lack of cooperation	42	Divorce or separation	24
Large families	42	Excessive alcohol consumption	24
Insurgency	40	Failure to educate children	24

Source: Uganda Participatory Poverty Assessment Report, presented in USAID (2003).

2.7 Policy responses to reduce alcohol consumption

Policy makers in developing countries tend to give low priority to alcohol supply and pricing issues or to the treatment of alcohol dependency (see Bird et al. (2004: Section 2.2) for a discussion of the implications of failing to put in place effective policies to reduce chronic poverty in terms of achieving both sustained growth and the MDGs). Individual alcohol consumption is seen as being down to individual choice, with over-consumption resulting from personal weakness. Rather than being regarded as a health issue, policy makers tend to link alcohol-related problems with poverty and the erosion of traditional values (Bryceson, 2002).

5. Survey of 2374 sexually active adults were questioned about their alcohol consumption. They were then tested for HIV infection.

It seems to us that alcohol dependence needs to be considered both in terms of its impact on health and its links with impoverishment. In order for policies to control over-consumption and dependence to have any hope of success, public opinion would have to regard alcohol dependence as both widespread and a source of problems (policy legitimation). Even with widespread support, successful policies are difficult to develop and implement in developing countries where much of the production and consumption is in the informal economy.

Reviewing policies introduced around the world, those that seem to work include those that focus on reducing demand and those attempting to control supply:

Reduce demand:

- simple counselling of people who drink heavily (but are not alcohol dependent) can have a significant positive effect on both average alcohol consumption and intensity of drinking (Brundtland, 2001);
- control commercial advertising;
- public education campaigns to raise awareness of the consequences of alcohol;
- increase prices: alcohol consumption is normally price sensitive and production quotas and licence fees can all be used to restrict supply and drive up prices.⁶

Control supply:

- restrictions in the number of hours per day (or days per week) when alcohol can be bought (Brundtland, 2001);
- prohibition (Rahman, 2003);
- restrictions on what kinds of outlet can be licensed to sell alcohol (Brundtland, 2001);
- a minimum legal drinking age (Brundtland, 2001).

Price increases and reduced availability tend to reduce alcohol consumption and associated problems, but different socio-economic groups respond distinctly. Wealthier groups tend to be more responsive to health education campaigns while poorer groups are more sensitive to price changes.

For alcohol policies to be effective they should be complemented with programmes to treat people with alcohol dependence. Effective programmes are likely to incorporate early recognition; psychological treatment (which has higher success rates when coupled with 'community reinforcement' e.g. Alcoholics Anonymous); treatment of the medical problems associated with dependence (e.g. withdrawal); identifying alternatives to drinking in 'high risk situations' and providing families with support (WHO, 2001b). These programmes require adequate funding and trained personnel, however, they are unlikely to be given priority until the scale of the damage done by alcohol dependence is more widely recognised in developing country contexts.

6. The exact relationship between changes in price and consumption is locationally specific but a rough generalisation suggests that an increase in price of 10% leads to a 5% reduction in beer consumption, a 7.5% decrease in wine consumption and a 10% decrease in spirits consumption. There is evidence that heavier drinkers reduce their consumption more. A 10% decrease in per capita consumption will result in roughly a 20% decrease in male alcohol-related mortality and a 5% decrease in fatal accidents, suicides and murders in the population as a whole (Edwards, 2001). Price increases also result in a reduction in the severity and regularity of domestic violence against women (Markowitz, 2000).

Box 2: The impact of alcoholism on the next generation

Laurant is 22. The story of his life illustrates the potentially long-term impact of conflict within the household, and shows that the impact of alcoholism is often difficult to disentangle from other social and economic factors.

Laurant's father (Moses) is an alcoholic and regularly beats his mother. Laurant has tried to intervene, but feels unable to protect Agatha from Moses' drunken rages. Their poor relationship affected him as a child, and has strongly influenced the way his life has turned out, influencing his diet as a child, his access to education, the amount of land he now has to farm and his choice of wife. Moses is relatively wealthy by village standards. He had five acres of land, a range of productive and household assets and a better quality house than many. He was respected in the community and was the elected village head until 18 months ago. Nevertheless Laurant is poor.

Moses had two wives. Laurant's mother, Agatha, was the first wife, but it was the second wife who was favoured. When Laurant was a child, his father gave his step-mother meat to cook for herself and her children, but only vegetables to his mother. When Laurant was only a few months old Moses lost his Kampala-based job in a hotel. He chased Agatha away and sold off household assets in an attempt to maintain consumption levels for his second wife. Agatha left her children behind, but Laurant's 'stepmother' refused to feed them. Moses claimed that Laurant was illegitimate and singled him out for harsh treatment. When Agatha found out what was happening, she collected her children and took them to live with her at their grandfather's house. But she had difficulty supporting them as a single mother, resulting in the children being shuttled between their father's and their grandfather's house. Agatha kept Laurant with her, to protect him and eventually, when Laurant was 2, decided to go back to her husband. This seemed to be the only way to ensure that everyone had enough to eat. She and her husband had several more children, but by the time he was six the marriage had broken down again. She left, but returned *again* when he was 14 to ensure that her sons were given some of their father's land when they got married.

Laurant knew that with his family's history of problems it would be difficult to find a woman prepared to marry him, but 2 years ago he was introduced to a secondary school drop-out who was eight weeks pregnant. He is delighted with his wife, has adopted her daughter, and they have had a son together. There is little now left of the family's former wealth for Laurant and his five brothers to inherit, and Laurant received only $\frac{1}{8}$ acre from his father when he got married. They depend on brick building and casual work to in order to have enough food to eat.

What is clear is that Laurant's poverty is not simply job loss or the erosion of family assets. It is also the long-term outcome of strife between his parents, the systematically unequal distribution of resources within the household, and the damage to his family's reputation made by his father's alcoholism and his parent's erratic relationship.

Source: Key informant interview. Kate Bird and Isaac Shinyekwa. Buwopuwa, Mbale District. August 2002.

Prohibiting alcohol production, sale and consumption is an extreme response to the social and health consequences of alcohol over-consumption. Some doubt prohibition's effectiveness (Brundtland, 2001), but others use evidence from India to show that it can reduce the proportion of the population drinking⁷ and the volume of both spirits and beer consumed (Rahman, 2003). The price effect of prohibition can dampen demand, as can the difficulty in obtaining supplies, but price depends on the level of enforcement, the previous level of taxation and the availability of supply and thus depends, in part, on the scale of the artisanal brewing sector. In India, prohibition has had little impact on the consumption of home brew, and less impact in rural than in urban areas. The total amount of alcohol consumed only went down slightly but the proportion of incomes spent on income was reduced, indicating that the price of alcohol probably declined, almost certainly due to ineffective enforcement (Rahman, 2003).

7. Complete prohibition has been found to have a significant effect on the proportion of the population drinking alcohol, reducing the number by around 22% (37% fewer drank arrak), but Toddy production increased. It is home-brewed and therefore very difficult to police (Rahman, 2003).

Box 3: Prohibition in India

There are strong anti-alcohol social movements which have grown out of the Indian women's movement. Some of these are supported by international NGOs (e.g. the People's Rural Education Movement in Orissa, which is supported by Community Aid Abroad), others have developed locally. One of the best known is one run by rural women in Andhra Pradesh. In the early 1990s the women of one village organised themselves and picketed the local liquor vendor. They also ostracised the drinkers and finally were able to force the district administration to close the liquor shops (Saxena, 1999: 55). Women in neighbouring villages joined the movement and eventually the state government declared prohibition throughout the state. This was later partially reversed due to the pressure of lost revenue (ibid.). There are three main types of prohibition policy in India: (1) complete prohibition of production and consumption; (2) partial prohibition where on or more type of liquor (usually arrack) is prohibited; and (3) dry days where consumption is prohibited for certain days of the week or month (Rahman, 2003).

Prohibition was introduced then withdrawn in Haryana (repealed in 1998) and Andhra Pradesh in the mid 1990s. Gujarat has had complete prohibition since 1947 (Saxena, 1999: 52) and there are partial restrictions in other states – Delhi, for example, has dry days. Prohibition was attempted and repealed earlier in Tamil Nadu (Arora, 2001). Difficulties with maintaining prohibition policies are illustrated by Andhra Pradesh which reversed its prohibition policy due to smuggling (encouraged by the failure of the state agencies to monitor the state's long border); illicit brewing and distilling (which was reported to have increased 20-30 times as a result of prohibition) and loss of revenue.

The Ministry of Welfare is responsible for preventing alcohol consumption, but substance abuse has low priority and most attention is targeted to illegal drugs rather than alcohol (ibid.: 53). Alcohol does not compete well with other pressing health and disease priorities for health funding (ibid.: 54).

The table below shows prohibition across selected Indian states between 1983 and 2001.

Table 3: Prohibition policy across Indian States, 1983-2001

State	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Andhra Pradesh																			
Arunachal Pradesh																			
Assam																			
Bihar																			
Gujarat																			
Haryana																			
Himachal Pradesh																			
Jammu & Kashmir																			
Karnataka																			
Kerala																			
Madhya Pradesh																			
Maharashtra																			
Manipur																			
Meghalaya																			
Mizoram																			
Orissa																			
Punjab																			
Rajasthan																			
Tamil Nadu																			
Tripura																			
Uttar Pradesh																			
West Bengal																			

Note: Lighter shade (yellow in colour version) refer to partial prohibition policies.

Source: Compiled from State Local Acts (Rahman, 2003).

A summary of the key issues in the policy process in relation to alcohol dependence can be found in Section 7.

3. Mental illness in developing countries

Mental illness is a pervasive problem in both developed and developing countries. Of the top ten causes of disability worldwide in 1990, measured as years lived with a disability, five were psychiatric conditions (unipolar depression, alcohol use, manic depression, schizophrenia and obsessive-compulsive disorder) (WHO, n.d.), amounting to 12% of the total global burden of disease (15% by 2020) (WHO, 2001b). Unipolar depression alone was responsible for more than one in every ten years of life lived with a disability worldwide. Around 10% of adults (or 450 million people) are affected by neuro-psychiatric conditions at any one time, and 25% of people are affected by mental or behavioural disorders during their lifetime (ibid.).⁸ By 2020, 'depression will disable more people than AIDS, heart disease, traffic accidents and wars combined' (Underhill, 2003). See Bird et al. (2004: Section 2.1) for further discussion of the scale and scope of the problem of mental illness and relationship to chronic poverty.

3.1 Policy response

Despite the scale of the problem, stigma and the personalised nature of mental illness means that mental health policy is given inadequate attention by policy makers and 52% of African countries and 44% of South East Asian countries do not have any mental health policies in place (WHO, 2001b). The importance of mental health is similarly downplayed during budgetary processes, leaving the sector underfunded. This tends to be a more acute problem in lower income countries, where a smaller proportion of national budgets is spent on mental health care than in richer countries. This is particularly true in South Asia and sub-Saharan Africa (Underhill, 2003). 33 countries (with a combined population of 2 billion) spend less than 1% of their total health budget on mental health (ibid.), which compares poorly with the 11% allocated in Canada and the 6% in the USA (WHO, 2001a) and results in desperately inadequate levels of service provision. (See Bird et al. (2004: Section 2.2) for a discussion of the implications of failing to put in place effective policies to reduce chronic poverty in terms of achieving both sustained growth and the MDGs.)

More than 25% of countries do not have access to basic psychiatric medication at the primary care level and 75% of the world's population has access to less than one psychiatrist per 100,000 people (WHO, 2001b). More than 680 million people (mostly in SSA and S. Asia) have access to less than one psychiatrist per million of population. South East Asia has only 0.3 psychiatric beds per 10,000 population, compared with 0.4 in Africa, 3.6 in the Americas and 9.3 in Europe (ibid.).

This inadequate funding in developing countries' mental health services results in them being non-existent or serving only a small portion of those affected by mental and behavioural disorders (WHO, 2001c). Those served are rarely the poorest (WHO, 2001b) and mental illness often goes undiagnosed and untreated (Araya, 2003). A study in Goa, India, found that only a third of patients attending primary healthcare clinics had their mental disorders identified, and that treatment relied purely on drugs (Patel, 2001). Other studies have found that over 30% of adults visiting general medical outpatients clinics in developing countries have a common mental disorder, such as depression or anxiety (Patel et al., 2003). Mostly their mental illnesses go undiagnosed and they are given painkillers, vitamins or other drugs or treat their physical symptoms (ibid.). In Tanzania, researchers found that 40-

8. These figures include Alzheimer's and other dementias, epilepsy, and alcohol and selected drug use disorders and therefore cannot be classified simply as mental illnesses.

50% of all patients visiting traditional healers were suffering from common mental disorders compared with around a quarter of patients visiting primary health clinics (WHO, 2001b; Ngoma et al., 2003).

The absence of adequately funded policy responses is partly due to ignorance about mental illness which is seen as a sub-category of disability in both India and Uganda (Lwanga-Ntale, 2003; Mohapatra, 2004), indicating that it is not seen as either curable or treatable. It may also be that mental illness is associated predominantly with individual responses to the stresses of living in dislocated and individualised developed country contexts. However, cross national data shows that common mental disorders are about twice as frequent among the poor as among the rich (WHO, 2001b). Budgetary allocations also reflect the dominant development narratives found in a society, and if the mentally ill are seen as less deserving of help than other categories of ill people (e.g. people with communicable diseases), and if mental illness is, inaccurately, regarded as untreatable and incurable, then budgets are likely to reflect this.

Depression has been found to be particularly common amongst people living in poverty (Araya, 2003). Research in Brazil, Chile, India and Zimbabwe found that women, those with little education, the poor and older people are most likely to suffer from mental disorders (Patel et al., 2001). Relative and absolute poverty contribute to stress, depression and anxiety, indicating the impact of income inequality in a country on the incidence of mental illness.

Women are particularly vulnerable to high levels of stress due to their multiple roles, violence and unequal power relations with men. Changes in rural societies mean that older people suffer from loneliness and economic hardship, which can lead to increased vulnerability to mental illness (ibid.). Disabled people, indigenous people, those exposed to disasters and war, displaced people, those coping with chronic diseases such as HIV/AIDS and individuals who have experienced the death of a relative are also vulnerable to becoming mentally ill (Patel, 2001; Todd and Patel, 2001, WHO, 2001b).

So, this under-funding of mental health in poor developing countries is leaving a vast untreated problem. This leads to individuals and households being trapped in long-term poverty and ill-being. Depression can be as (or more) disabling than several other chronic medical conditions in terms of social, physical and role functioning and days spent in bed (Gender and Health, 2002). Mental illness places an enormous burden on relatives who care for the patient, emotionally and in terms of the financial cost and lost wages as well as diminished quality of life (ibid.).

Effective treatment reduces the level of impairment or disability experienced by individuals and enables them to not only lead happier lives but to contribute economically (and in terms of reproductive tasks) to their households.

3.2 Mental health services in Uganda

Until recently mental health policies were given low priority in Uganda (WHO, 2001c). Major reforms started in Uganda in 1996 when the national health programme was being designed (WHO, 2001a). This involved reviewing the 1964 Mental Treatment Act and, in 2000, a new mental health policy was completed, which contains components on advocacy, promotion, prevention, treatment and rehabilitation (ibid.).

Standards and guidelines have been developed for the care of adults and children, health workers have been trained in how to recognise and manage common mental disorders, a new referral system and support network has been established and linkages have been improved between mental health services and other programmes e.g. HIV/AIDS. Drugs for the treatment of mental illnesses have been included on the essential drugs list and the Mental Health Act has been revised and integrated into a Health Services Bill. Mental health has been included as a component on the national minimum health care package and mental health is now part of the budget for the Ministry of Health (WHO, 2001d). This all sounds very positive but, as we show in Bird et al 2004, there is a mismatch between policy on paper and policy as implemented.

Mental health comes under the primary health care system but treatment of acute mental health disorders is not available at the primary level. There are 10 regional referral units and the National Mental Referral Hospital. Community-based care is still in its infancy (WHO, 2001a). Therapeutic drugs are only available in Kampala, the capital city (ibid.; Lwanga-Ntale, 2003), and it is not clear whether the implementation of reform has resulted in improved diagnosis and treatment at the local level.

Just over 4% of Uganda's budget is spent on health care (WHO, 2001a) but under 1% of the health budget (0.07%) is spent on mental health (ibid.). This compares with 0.01% in Kenya, 2% in Malawi, 2.7% in South Africa and 0.5% in Ghana (WHO, 2001a).

3.3 Mental health services in India

Despite there being around 30 million mentally ill Indians (in a population of over a billion), with over 7 million suffering from schizophrenia, there are only 3500 trained psychiatrists. It is estimated that in India no more than 10% of those who require urgent mental health care receive it (Leonard Cheshire, n.d.). People in rural areas with mental illnesses are often treated as fools and exploited and are unlikely to be able to access any support at all (ibid.). The medication they need is rarely available locally, and, when it is, it is unaffordable. Qualified psychiatrists tend to be located in urban areas and are unwilling to work in rural areas. Accessing government support schemes and getting a certificate from a doctor, which is necessary for treatment and benefits, is also very difficult for rural people (ibid.).

Box 4: The rights of the mentally ill

This story illustrates how families and communities of mentally ill people can fail to cope with the changed behaviour of the mentally ill, and can respond by infringing the rights of mentally ill people.

Venkata Ramana was employed in a factory in Bangalore. Something drove him to leave his job and return to his village. He was very depressed and his behaviour changeable. The community observed his 'strange' behaviour and he was branded as mad. His family decided to lock him in a room. He remained there for seven years, being fed through a small window, without any sort of treatment. A mental health NGO active in the area learned about this and persuaded his family and community leaders to let him go. The NGO took responsibility for his medical treatment and the family and community agreed to provide him with support. Six months later he was much better and working as a farmer. His community see him as being the same as everyone else, although he does still need some support.

Source: Leonard Cheshire (n.d.).

3.4 Improving mental health services

As we have shown, there are serious barriers to improving mental health services in developing countries. Mental health is given low priority in budget allocations and service provision at the primary health care level tends to be poor. Table 4 suggests that stigma and discrimination contributes in an important way to this neglect, and shows that there are problems at both the policy level and within health systems. Inadequate resources and poor training combine with stigma to result in a lack of trained medical staff, drugs and appropriate services.

Table 4: Barriers to effective mental health services

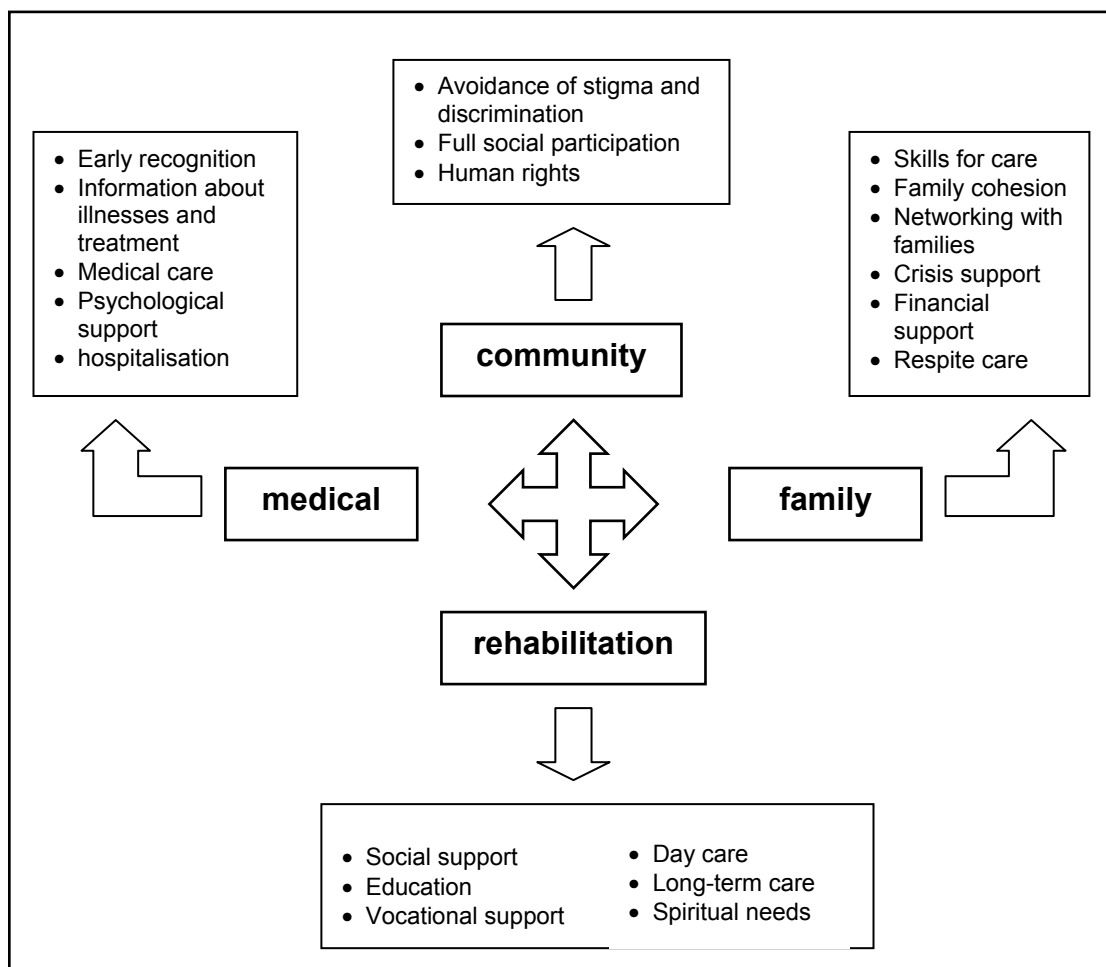
Policy Level	Stigma and Discrimination	Health System Level
<ul style="list-style-type: none"> • Extent of the problem disproportionate to the limited mental health budget • Mental health policy inadequate or absent • Mental health legislation inadequate or absent • Health insurance which discriminates against persons with mental and behavioural disorders (e.g. co-payment) 	<p>Large tertiary institutions</p> <ul style="list-style-type: none"> • Stigmatisation, poor hospital conditions, human rights violations and high costs • Inadequate treatment and care <p>Primary Health Care</p> <ul style="list-style-type: none"> • Lack of awareness, skills, training and supervision for mental health • Poorly developed infrastructure <p>Community mental health services</p> <ul style="list-style-type: none"> • Lack of services, insufficient resources <p>Human Resources</p> <ul style="list-style-type: none"> • Lack of specialists and general health workers with the knowledge and skills to manage disorders across all levels of care <p>Psychotropic drugs</p> <ul style="list-style-type: none"> • Inadequate supply and distribution of psychotropic drugs across all levels of care <p>Coordination of services</p> <ul style="list-style-type: none"> • Poor coordination of services including non-health care 	<p>war and conflict</p> <p>disasters</p> <p>Urbanisation</p> <p>poverty</p>

Source: WHO (2001b: 85).

Reversing the inadequate attention to mental illness will be difficult. The mentally ill tend to be marginalised and ignored with few lobbying on their behalf. Where policy reform is being attempted, the WHO suggests that it is more likely to be effective if it includes community-based care and is integrated into primary health care. Also the supply of appropriately trained staff must be adequate. The policy must also recognise the special needs of women, children and adolescents, as they may be different to the needs of adult men (WHO, 2001b). Even where good mental health policy has been developed, there can be important barriers to effective implementation. Common obstacles include a lack of interest in mental health by health authorities and other stakeholders, a lack of agreement on policy and treatment amongst health professionals, inadequate ring-marking of funds for mental health and competing health problems, which are seen as more important (WHO, 2001c). A summary of the key issues in the policy process in relation to mental illness can found in Section 7.

Improvements in service delivery will require the legitimization of policy reform and increases in budgetary allocations. Relatively low cost improvements can be achieved by improving primary care. The contribution made to the care of the mentally ill by traditional healers, families, self-help groups and volunteer workers can be increased by providing them with a better understanding of mental health problems, their causes and available treatments (ibid.). If traditional healers are provided with accurate information about mental and behavioural disorders, they can be integrated into primary care systems by encouraging them to refer mental health cases that they identify (WHO, 2001b). Primary health care staff also need to be trained in basic mental health care, and the shortage of essential psychotropic medicines needs to be reversed. They should be made available at all levels of health care and included in the country's essential list of medicines. These improvements in primary care would enable larger numbers of people to get easier and faster access to services (WHO, 2001d).

Figure 4: Needs of people with mental disorders



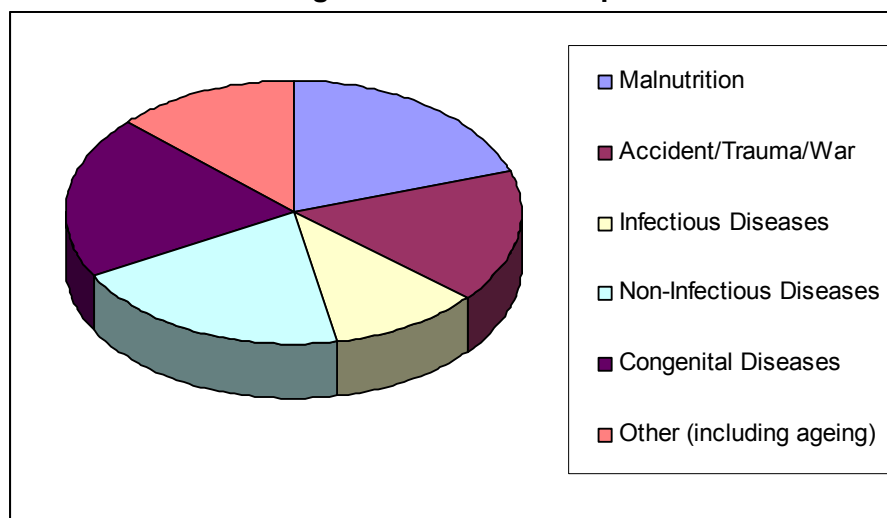
Adapted from WHO (2001b).

4. Disability

4.1 The scale of the problem

There are 600 million people with disabilities globally, 80% in developing countries (WHO, 2003). Long term disabilities were responsible for 31% of DALYs (disability adjusted life years)⁹ lost worldwide (2000 estimate, in Gender and Health, 2002). Conservative estimates suggest that India alone had 18.5 million people living with disabilities¹⁰ (Mohapatra, 2004). Incidence is high in developing countries partly because of poor pre-natal and obstetric care, poor diagnostic and curative care and high risks of work-related injury. This is illustrated by research in India which found that around half the disabled people attending government treatment centres had become disabled since birth (ibid.).

Figure 5: Causes of impairment



Source: DFID (2000:3) from UN Figures in Overcoming Obstacles to the Integration of Disabled People, UNESCO, March 1995

In developing countries, living with an impairment of any kind can have serious and often negative impacts on the lives of individuals and their households because of the widespread stigma and discrimination associated with it. In Uganda, disabled people are feared because disability is still strongly associated with witchcraft. Many people continue to believe they can 'catch' disability (Lwanga-Ntale, 2003) and in Uganda congenital disability is blamed on the child's mother, who is thought to have brought a curse on the family (ibid.). She may find herself and the child driven out from the family and the community. Fathers and other family members may also be taunted and targeted for abuse.

Socio-cultural attitudes towards disabled people have led to continuing exclusion from most social processes and leaves disabled people isolated and often unaware of their rights. Disabled children are often hidden out of view because their parents fear the shame they bring. Few disabled children enjoy the educational opportunities given to their peers (Lwanga-Ntale, 2003), and neglect leads to raised mortality

9. The DALY is a health gap measure (potential years of life lost due to premature death or years of 'healthy' life lost in states of less than full health) which combines information on the impact of premature death and disability and other non-fatal health outcomes (WHO, 2001d).

10. These figures are from the National Sample Survey of India, 2000, which estimated that 1.8% of the population or 18.5m of the population was disabled. DFID suggested a higher figure of 32 million people, which was also seen as a conservative estimate (DFID, 2000).

levels, which can be as high as 80% in countries where under-five mortality as a whole has fallen to below 20% (DFID, 2000). Children and adults with impairments constantly find themselves socially excluded because of institutional, environmental or attitudinal barriers. Many disabled people do not attend community meetings or celebrations; often for the simple reason that they are never invited. Disabled adults may be deliberately excluded from savings and loans groups because it is assumed they will be unable to repay. Or they may be unable to qualify for membership because they have no ownership rights. Few disabled people will find themselves allowed to take up leadership positions, even if they have overcome barriers to get that far and they may lack the respect accorded to others in those positions. In many situations, disabled people find it almost impossible to marry. Of those attending treatment centres in India 58% of men and 74% of women were unmarried (Mohapatra, 2004). This can have serious implications in societies where parenting children is necessary for adult status and long term security.

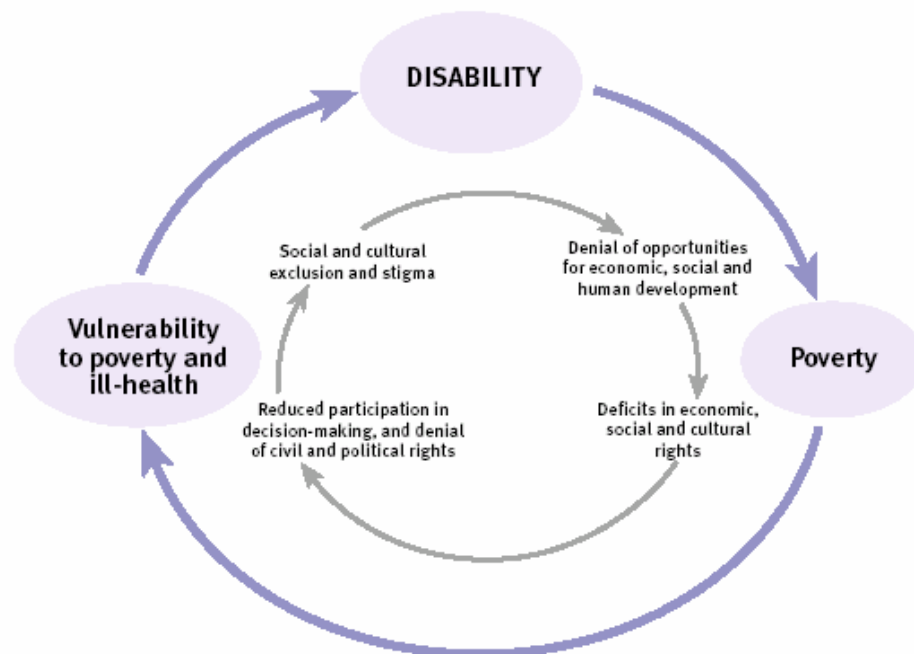
Poor road conditions, inaccessible transport and buildings and paths which are unpaved or potholed increase the difficulties those with reduced mobility face in accessing services. But exclusion often goes beyond rectifiable environmental barriers to encompass attitudes and ignorance even from within the disability movement itself. Disabled people complain of there being a hierarchy of disability with people with severe mental impairments at the bottom (Lwanga-Ntale, 2003). This exclusion extends to service provision and NGO interventions. In Uganda researchers were unable to identify a single organisation working with people with severe mental disabilities (*ibid.*). Women with disabilities also tend to experience worse social and economic exclusion than men with similar disabilities, and in India only 29% of the people attending a government treatment centre were women, indicating that women are less able to access care (Mohapatra, 2004). The availability of physiotherapy and other services tends to be limited, and even where such services are available, access is often poor. The WHO reports that less than 5% of disabled people have access to any kind of rehabilitation services (WHO, 2003).

Where social protection and other supportive policies are in place they are not always universally applied. In India only 61% of the disabled people attending government treatment centres had been issued with a disability certificate, and yet without these certificates disabled people are unable to access various benefits and concessions (e.g. travel concessions, subsidised loans, education, scholarships and positive discrimination through 'reserved places' in public sector employment). However, even those who had been issued with disability certificates experienced difficulties and less than half had secured these rights (Mohapatra, 2004).

As poor people in developing countries commonly depend heavily on their labour as the basis of their livelihoods, disability can cause severe hardship. Policies and customs can also impoverish disabled people. For example, in Uganda customary law means that disabled people are unable to inherit land (Lwanga-Ntale, 2003). Exclusion from the ownership of key productive assets combines with low human capital to drive and maintain the disabled person and their household in poverty. In Tanzania households with a disabled member were found to be 20% more likely to be poor and to have mean consumption levels of less than 60% of the average (DFID, 2000). Once disabled people are poor the limited opportunities that are available to them mean that they are more likely to be trapped in chronic poverty (Mohapatra, 2004). Households with disabled and chronically sick members tend to be smaller, have smaller operational landholdings, lower grain consumption from own production and greater market dependence for food (Harriss-White and Subramanian, 1999 in Mohapatra, 2004). For further discussion of the scale and

scope of the problem of disability and relationship to chronic poverty, see Bird et al. (2004: Section 2.1)

Figure 6: Poverty and disability – a vicious cycle



Source: DFID (2000: 4).

4.2 Policy responses

International standards for the rights of people with disabilities are laid out in the UN standard *Rules on the Equalisation of Opportunities for persons with Disabilities*, which were adopted by the UN General Assembly in December 1993. These are not compulsory but, by agreeing to them, member states have made a strong moral and political commitment to creating the conditions in which disabled people can be equal and fully participating members of society (DFID, 2000). In order to achieve these commitments, countries need to remove discrimination. Three major types of discrimination are identified by the social model of disability:¹¹

- institutional (e.g. where there is no provision to ensure that children with a disability can attend school, also important to consider legal and customary practise, such as the lack of rights to own land or inherit assets)
- environmental (e.g. where a person with a disability is unable to participate due to a physical barrier, such as inappropriately designed buildings or to access information because of poor communication environment);
- attitudinal.

11. This emphasises that disability is not simply due to medical conditions but a complex system of social restrictions caused by discrimination (DFID, 2000).

Box 5: Basic principles for rights-based development for disabled people

1. **Social Protection:** People with disabilities should have access to basic social protection, defined as housing, health care, rehabilitation services and access devices.
2. **Accessibility:** People with disabilities should have access to education, credit, information, and income earning opportunities. Technical training (e.g. for small enterprise) should take the needs of disabled people into account. Building should be adapted where necessary. Disabled children should be integrated into mainstream schools.
3. **Consciousness:** People with disabilities are conscious of their own needs and rights. They are aware of the consequences of neglecting and discriminating attitudes in the society.
4. **Influence:** People with disabilities are entitled to have equal opportunities to influence decision and policy-making through processes of participation. Opportunities should be created for political representation. Disabled people should be consulted on policy formulation and implementation.
5. **Control:** People with disabilities are entitled to take initiatives to assert their influence, and promote awareness of their rights. This enables increased control over the distribution of resources and benefits. In order to achieve this the development of a democratic and representative disability movement should be supported.

Adapted from DFID (2000: 8).

These five principles might be seen as a hierarchy, with 'social protection' being the most basic and least politically challenging, fitting with a charity response to disabled people and 'control' being the most likely to require changes in society. As we discuss later, India and Uganda are still to provide effective social protection for all disabled people. (See Bird et al. (2004: Section 2.2) for a discussion of the implications of failing to put in place effective policies to reduce chronic poverty in terms of achieving both sustained growth and the MDGs.)

However, as we have seen, the incidence of disability is much higher in developing countries than in richer countries. As shown by Figure 5, malnutrition, accident/trauma/war and infectious diseases cause just under half of all disability. If we add non-infectious diseases, we see that two thirds of disability are from often preventable causes. Some are clearly very closely related to poverty (e.g. malnutrition), but others are directly due to poor service provision. Interventions to reduce the incidence of avoidable disability might include:

- general improvement in pre- and post-natal care
- improved diagnostic and curative care
- reduced traffic and work-related accidents
- improved living conditions
- improved immunisation and prevention measures for
 - malaria
 - poliomyelitis¹²
 - river blindness
 - leprosy
 - tuberculosis
 - meningitis
 - encephalitis
- iodising salt to reduce goitre and cretinism.

India and Uganda are both in advance of many other developing countries when it comes to policies for physically, mentally and sensory impaired people. However, as we will see below, policy is not necessarily resulting in effective implementation on the ground.

12. New cases of polio were reduced from 350,000 in 1988 to 5,000 in 1999, through a concerted effort to eradicate the disease (DFID, 2000).

4.3 Uganda

In Uganda people with disabilities have a greater levels of formal political representation than anywhere else in the world. The constitution provides for disabled people to be represented at all levels of political administration. This includes the reservation of five parliamentary seats for people with disabilities, representing the four regions of Uganda and the interests of women with disabilities (DFID, 2000). Some believe that the disability movement has begun to have a real impact on Uganda's political culture (ibid.). However, this apparent political inclusion has not resulted in significant changes in policy formation or implementation, and Uganda still does not have any explicit disability policies (Lwanga-Ntale, 2003). Disabled people complain of a lack of laws to protect them, and there have been limited attempts to identify and eliminate discriminatory legislation in Uganda. As a result large sections of the legislative framework in Uganda still fails to meet international human rights standards regarding the rights of people with disabilities (ibid.). Disabled local government councillors are unclear about their role and disability issues are not integrated into the work of local government. Disabled councillors seem to be expected by their fellow councillors to respond to the needs of disabled people alone and with limited budgets (ibid.). Disability budgets tend to be too low to cover both awareness raising (e.g. workshops and celebrating disability day) and targeted interventions (ibid.; Lorraine Wapling, ADD, pers. comm.).

Education policy in Uganda appears to respond to the needs of disabled children. Under UPE (Universal Primary Education) four children from each family are provided with free primary schooling. Policy specifies that two of these children should be girls, if the family has any girls, and any children with disabilities take priority (DFID, 2000). In addition, Ugandan education strategy specifies that specialist teachers should be trained and that a nationwide network of district centres should be established, to assess children's disabilities to ensure that they are provided with appropriate education and adequate support systems. In reality, a lack of funding means that this policy has not been effectively implemented. Disabled children are rarely given an opportunity to go to school. Some parents feel ashamed of their disabled offspring and most schools lack appropriately trained teachers. This particularly affects mentally and visually impaired children who need either special teaching methods or materials. Poor school design (e.g. narrow doorways, steps) and a lack of mobility aids (wheelchairs, crutches etc.) prevent attendance. Fees for special schools are high, barring children from poorer families. Where these problems are overcome, disabled pupils experience bullying and taunting from other children and are not given enough attention to keep them in school. Examinations are not adapted (e.g. allowing extra time) so disabled children are unable to progress through the school (Lwanga-Ntale, 2003).

Livelihood activities in rural Uganda are predominantly centred around agriculture and agricultural processing and have a heavy dependence on labour intensive methods. Public transport is limited and tends to be very crowded. Both aspects of rural life are difficult for people with physical impairments. This makes their needs for particular services, training and social protection more intense than other members of their community, but access, even in even well connected villages, can be extremely limited. This access could be improved through the distribution of free or subsidised mobility aids. Alternative livelihood opportunities could be supported through technical training or enterprise support and promotional activities could be used to change societal perceptions and reduce stigma, improving inclusion in mainstream society. There has not even been effective social protection to prevent vulnerable

disabled individuals and their households from experiencing food insecurity or poverty.

The absence of effective local action reflects a combination of ineffective national policy leadership, poor budgetary provision and weak implementation by local government. There is an assumption that traditional safety nets and the extended family will protect the well-being of disabled individuals and their households, and within the broader population and amongst policy makers disabled people are not seen as a priority for policy action. Few policies are available to intervene creatively in the lives of people who cannot be described as the active poor.

Box 6: Old, disabled and alone

This story illustrates the overlap between chronic ill-health, disability and old age.

Samuel is only 54, but looks much older. He has had a string of bad luck which has left him prematurely aged, ill and alone.

In 1987, when he was 39, Samuel developed the first of a number of persistent health problems. He cut his leg with his hoe, and the cut became infected. It has never healed properly and his leg is now painful, swollen and heavily scarred. This reduces his mobility, and makes it difficult for him to work. He has also developed what sounds like heart disease. His chest hurts if he does any physical work, meaning that he cannot cultivate the land he owns or do any other livelihood activities.

This situation would be bad enough if taken on its own, but in 1990 his only child, a twelve year old daughter, died suddenly of a fever. His wife died in 1994, also of an undiagnosed and untreated fever. He sold 2 of his 2½ acres to cover funeral costs for his daughter, wife and parents, who all died within a few years of each other. In a short space of time he went from being a fit healthy man with a family and a small surplus-producing farm, and to being unwell, alone and with only a marginal patch of land.

He has no close relatives in the village, but two of his nearest neighbours support him by bringing him cooked food. He does not borrow money, even for necessities, as he would be unable to pay it back, but one of his distant relatives runs a petty grocery shop in the village and he will sometimes get salt or soap from him, if he is desperate.

Source: Key informant interview by Kate Bird and Isaac Shinyekwa in Buwapuwa, Mbale District., Uganda, September 2002.

Box 7: Hearing impaired and isolated

Moses enjoyed primary school as a child but he was forced to leave in his second year when he caught severe measles. It affected his hearing and he has been left almost totally deaf. He still suffers painful symptoms if he works long hours, is out in the sun or doing hard physical work. Then his ears swell, produce fluid and hurt. This affects his day to day life as well as his choice of livelihood activity. As a young man he got into artisanal alcohol production and he was noticed as a hard working young man. This led him to being introduced to his wife, and he is now the middle aged head of a large family. He combines alcohol production and sale with farming and in these respects his life is a success. However, he and he and his family are in the poorest income category in their village and interviewers noticed that his deafness meant that he was cut off from important information. He did not know about the government services that might be of use to him, such as agricultural extension or local health workers, which meant that he did not have access to information which could help to improve family well-being. Had he been able to complete his education his level of isolation may well have been reduced.

Source: Key Informant Interview. Isaac Shinyekwa, Kalaangalo, Mubende District, Uganda, October 2002.

4.4 India

India also appears to have good provision for disabled people. The Persons with Disabilities Act of 1995 makes discrimination on the grounds of disability illegal. Legislation requires that 3% of all rural development programme expenditure benefits the disabled (Mohapatra, 2004). Impact assessment data is not available to confirm whether this target is met. Expenditure on the 'disability sector' has increased, with nearly half being spent through NGOs (ibid.). But both coverage and the effectiveness of programmes are patchy.

The government provides treatment centres for people with physical impairments. However, their urban location makes access difficult for people from rural areas, particularly for groups who are likely to find access to treatment more difficult in any case because of gender, ethnicity or caste.

A pilot project in Andhra Pradesh (covering 30-40 schools), supported by the state government, is enabling disabled children to attend mainstream schools. The children are assessed medically and socially in order to prepare an individually-tailored education programme. Teachers are trained in how to meet the educational needs of disabled children and free aids (mobility, hearing etc.) are provided where required. It is hoped that in addition to providing these children with education their inclusion in mainstream schools will also break down stigma and stereotypes (DFID, 2000). Evidence evaluating the pilot is not available, but it will be interesting to learn whether the pilot will be rolled out across the state and to other states.

A summary of the key issues in the policy process in relation to disability can found in Section 7.

5. Women and land rights in Uganda

5.1 Background

In many parts of the world women access productive assets through their fathers, husbands or adult sons. Women who are orphaned, unmarried, separated, divorced or infertile are therefore at a significant disadvantage. Even women who are able to access land and other resources through other people are disadvantaged by not having their own independent rights. In Uganda women's access to land depends on the particular kinship and marriage traditions of their ethnic group. Inheritance is usually patrilineal and, where women do inherit land, this is normally less than their male siblings. 'Bride price' continues to be widespread and, whilst women are 'gifted' land by their husbands or are given usufruct (usage) rights to it, they lack rights to ownership or control e.g. of the income generated from it or of its sale or transfer (Human Rights Watch, 2003a: fn 264). Limited land is available for purchase and rental markets tend to be fragmented and localised.

Widows are among the most land insecure due to traditional systems that deny them rights to the land that they have lived on or used while their husbands were alive. Land is held by the clan, allocated to clan members and can only be inherited within the clan. Since marriage is patrilocal (women move to their husband's village) and women do not become members of their husband's clan, if they separate¹³ the land is kept by him and if he dies the land is returned to his heirs within the clan. This may be a son, if he is old enough, but will also commonly be a brother, nephew or uncle. The heir is responsible for supporting the husband's former dependents, but this part of traditional custom is sometimes disregarded and women find themselves forced from their homes and land and stripped of all their assets (including livestock, tools, furniture and cooking utensils)¹⁴ despite legislation which preserves a widow's right to remain in the matrimonial home until remarriage or death.¹⁵ These now impoverished widows may return to their father's village and re-settle there if allowed to, but some will find themselves destitute and depending on drudgery-intense livelihoods, for example producing home brewed beer (see the section of this paper on alcohol) or sex work.

Property grabbing impacts negatively on the welfare of the widow and her household. Due to the prevalence of HIV/AIDS many younger women with dependent children are being widowed and both younger and older women may be responsible for AIDS orphans, increasing the probability of inter-generationally transmitted chronic poverty. The absence of land rights also leads to economic dependence and the inability of women to resist customary practices such as 'wife inheritance' and 'cleansing rituals', which, apart from their negative impact on women's dignity and well-being, have also increased exposure to HIV/AIDS (Human Rights Watch, 2003b).

13. If the couple have been formally married the former wife has some rights, but many marriages are informal or customary and the former wife has no rights to property or support. Wives in customary marriages have no rights under Section 40 of the Land Act (whereby a wife must give permission before land she is dependent on is sold).

14. Property grabbing was consistently the primary concern expressed by women with regard to land ownership in the 2002 Gender and Land Rights Study (HRW, 2004: 46).

15. The legislation is the 1972 Succession (Amendment Decree).

Box 8: Death and poverty: the asset stripping of widows in Zimbabwe

The death of the male head of household has a significant impact on the household. It can reduce crucial labour inputs making diversification impossible and shifting dependency ratios, it can also result in widows losing access to land and other assets.

In Chivi District a young pregnant widow with two young children was stripped of her assets by her husband's family. They 'sent her back to her parents' with the excuse that only part of the labolo (bride price) had been paid and her parents might cause trouble for her in-laws. However, paying only part of the labolo is customary, and is used to symbolise the long-term link and trust between the two families. The young woman lost her house, land and all her livestock, pots, pans, tools and other assets. She returned to her parent's house, where she had her third child. Her father allocated a small portion of his land to her, so she now scratches a living and faces a very uncertain future.

Asset stripping occurs in just the same way in Uganda, and in much of sub-Saharan Africa.

Source: Key Informant Interview, Kate Bird. Chivi District, August 2000.

The intra-household allocation of resources and assets, including land, also has a substantial impact on the well-being of both women and the wider family (Deininger, 2003: 38). Therefore, apart from the intrinsic value of gender equality, research has also demonstrated that equal access, control and ownership of land has instrumental value in terms of its positive impact on consumption (increasing spending on food, children's welfare and education) and productivity (particularly in areas, such as sub-Saharan Africa, where women are responsible for the majority of land cultivation)¹⁶ (ibid.: 57-9). Land ownership also enables women to access other assets and resources, such as credit, enabling investment and diversification (Dolan, 2002), and increases their economic independence and power, which has a positive influence on other areas of gender equality.

In this section, we discuss attempts to change women's land tenure rights in Uganda. Future work will apply similar analysis to land issues in India. For further discussion of the scale and scope of the problem of the absence of land rights for women in Africa and its relationship to chronic poverty, see Bird et al. (2004: Section 2.1). A discussion of the implications of failing to put in place effective policies to reduce chronic poverty in terms of achieving both sustained growth and the MDGs, can also be found in Bird et al. (2004: Section 2.2).

5.2 Policy formation and legislation

Women's influence on the policy formation process

Since coming to power in 1986, Museveni's National Resistance Movement (NRM) (or the 'Movement' as it is now known) has provided an enabling environment in which to forward women's equality. Government initiatives have included:

- the establishment of a Ministry of Gender, Labour and Social Development (1988);
- the establishment of a Directorate of Gender and Community Development;
- the formation of Women's Councils under the National Women's Council Act (1993); and
- the adoption of a National Gender Policy and Action Plan on Women (1997).

16. Women have a dominant role in food production in Uganda, as in much of sub-Saharan Africa. They produce over 80% of the food and provide 70% of agricultural labour but own only 7% of land (HRW, 2004).

However, perhaps the most significant development is the provision for gender equality in the 1995 Constitution. There was extensive consultation around the new constitution, including that organised by the Women's Ministry and by the Women's Caucus¹⁷, which fed into a memorandum to the Constitutional Commission establishing areas of concern for women. Two of the Commission's members were female lawyers who also introduced clauses on women's issues. Furthermore, the women that took part in the Constituent Assembly debates acted as a distinct negotiating and voting bloc which enabled them to ensure that certain provisions were included in the constitution (Goetz, 2003: 117-8). As a result of such activities, the new constitution includes important provisions advancing gender equality, such as granting women legal equality and protection through the promotion of non-discrimination on the basis of sex and the prohibition of laws, cultures, customs or traditions that violate the dignity, welfare or interest of women (Khadiagala, 2001: 62).

The Ugandan constitution also makes provisions for affirmative action for women and other marginalised groups. Women now constitute 19% of MPs at the national level and 30% at the local government level. However, this does not appear to have boosted their ability to get women's issues on the political agenda and influence policy-making. Deep-seated sexism and patriarchy in Uganda influences voter's responses when offered female Parliamentary candidates. Their voting behaviour is affected by the candidate's family relations and marital status. Male dominated selection panels can result in women being selected who are perceived to be socially conservative. Posts reserved for women representatives are in addition to the existing seats that are subject to open competition, and the nature of positive discrimination undermines the legitimacy of the elected female representatives (Goetz, 2003).¹⁸ In addition, rather than being discussed in plenary, issues relating to women are referred to the Councils for Women, the Youth and People with Disabilities. These councils are not well linked to the local council (LC) system or the national women's movement, entrenching marginalisation and ensuring that LCs remain dominated by men and their concerns. Gender relations are still affected by unequal power relations and processes of subordination. Women councillors (whether elected or awarded reserved seats) tend to be inactive with few attending meetings. Their husbands restrict involvement fearing that the 'public gatherings' will expose their wives to 'illicit liaisons'. Even when women are actively involved they feel unable to support women's interests if these conflict with either Movement policy and/or local (male) elite interests.

Women also hold key ministerial and judicial positions, including the deputy speaker and chief justice (Tripp, 2001: 104; HRW, 2003: 18-19). However, some argue that patriarchal social norms and the restrictions on party activities hamper women's effectiveness in parliament and other institutions: 'Participation does not necessarily result in effective political influence', and what we see is a 'politics of presence' rather than a 'politics of influence' (Goetz, 2003: 21). In effect, affirmative action draws women into patronage politics and shifts the focus away from feminist policies, and while the Museveni administration is keen to secure women's support, it blocks feminist-inspired change (Hickey, 2003; Tamale, 1999). In short, commentators express doubt about high-level commitment to gender equality. The Movement has regarded women's support as integral to its legitimation and to its promotion of non-sectarian political participation under the no-party system (Goetz, 2003: 121) but its

17. The Caucus system includes five 'special interest' groups, including women (56 members, one per District).

18. The national PPA exercise indicated that women thought that the village-level local council officials (LC1) were biased against them, disregarded their opinions and ignored the female representatives (Moncrieffe, 2004: 31).

record in terms of legislating to promote women's rights and its marginalisation of female Ministers in decision-making bring its commitment into doubt (Tripp, 2001: 114-5).

However, as Tripp argues, the willingness of the Museveni government to create a space for women's representation and participation has accorded the women's movement a degree of autonomy not usually seen in sub-Saharan Africa. Urban-based women's organisations are often self-supporting and are therefore able to work outside the state patronage networks. Furthermore, they are able to select their own leaders and agenda and campaign for improvements in the status of women, even if this is in opposition to the government's position (Tripp, 2001: 109-12). A two-way process therefore exists between the NRM and the women's movement. The NRM needs to promote gender issues in order to maintain women's support and women's organisations have utilised the autonomy they have been given to influence the issues that are promoted and temper the NRM's attempt to co-opt them (ibid.: 113-16).

Box 9: The Women's Movement in Uganda

There is disagreement amongst researchers as to whether Africa has a robust and effective women's movement or not. Some suggest that women's movements have been more successful in Latin America than in Africa. They state that ethnic conflicts have impeded the emergence of broad-based women's movements in Africa and that these types of divisions do not have a similar impact in Latin America. (Okeke-Ihejirika and Francschet, 2002). Others disagree with this argument and feel that women's groups in many African countries have worked successfully across ethnic divisions and have been deliberately inclusive (Tripp, 2000).

Focusing on Uganda, some see the women's movement there as being one of the most effective in Africa (Tripp, 2001). Although the women's political leadership promoted by the NRM has been self serving the Ugandan women's movement has avoided being co-opted. By retaining its autonomy it has been able to promote a radical agenda. This does not always result in the desired policy change, but they are exposing policy makers to a different way of seeing issues.

Sources: Okeke-Ihejirika and Francschet (2002), Tripp (2000).

Legislation relating to women's land rights

Moncrieffe (2004: 31) describes gender equality as being 'one of the areas in which there is a strong and enduring conflict between culture and official policy, with serious consequences for citizenship and political development. Culture pervades government structures'. Despite the constitutional recognition of gender equality, including the right to own land, and its protection through provisions relating to non-discrimination, customary and statutory laws continue to discriminate against women in areas of marriage, divorce and inheritance, for example, polygyny continues to be legal under both customary and Islamic law (HRW, 2003: 19). Additional legislation and action is therefore needed to make the legal recognition of gender equity meaningful (Deininger, 2003: 59).

Land reform first emerged in political discussions in Uganda when the Constituent Assembly was established to discuss the draft constitution. The interests of women and marginalised groups were sidelined by the conflicting interests of powerful ethnic groups and, owing to the sensitivity of the issue, the Assembly did not include land reform in the constitution, instead making a commitment to pass legislation on the issue by July 1998. Women's interests were again sidelined during the drafting of the bill, Ugandan women's movement, CSOs and women in parliament lobbied for women's land rights to be strengthened in the bill but they found it difficult to get the

male-dominated decision-making bodies to take their concerns seriously and this was reflected in the final draft of the Land Bill.

The 1998 Land Act has two objectives: (i) to provide a basis for formalising traditional land rights and accelerated transition to freehold tenure; and (ii) to enhance the land security of marginalised groups, including women (Hunt, 2004: 177). However, there is tension between these two objectives. The Act supports decision making under customary land tenure systems, which reflect custom, traditions and practices, but states that these should not be implemented when they will deny women, children or people with disabilities from ownership, occupation or use of land. The Act also emphasises that land cannot be sold without the permission of a resident spouse or from dependent children or orphans with a claim on the land.¹⁹ The Act therefore contains internal contradictions; customary systems commonly reflect entrenched paternalism and therefore registering customary land is likely to come into conflict with gender equity.

Furthermore, although the land reform legislation appears to protect women, the absence of provisions for co-ownership weakens this objective. The introduction of a co-ownership amendment initially faced strong opposition from vested interests within government, including the majority of women MPs, but was eventually accepted unanimously by parliament following a widespread media campaign by the Ugandan women's movement countered. However, the key clause was removed by President Museveni in the final Land Act.

An analysis of the land sector undertaken for the government (GoU, 2001) recommended that widows should be able to inherit land that they used during their husband's life and have full rights over it. However, the Domestic Relations Bill, intended to reform marriage, divorce and inheritance laws, has been held up in Parliament. In fact, widows rights to continue to use their husband's land has been weakened by the Land Act. It removed women's automatic right to 'letters of administration' and lawyers now commonly favour families in disputes when a widow is thought to have HIV. This presumably makes the last years of these women's lives even harder and condemns their children and adopted orphans to a difficult start in life.

This discussion shows that women's land rights in Uganda are still not secure. Although the constitution allows for land ownership by women, the laws which currently restrict this will have to be changed before women are able to exercise this right.

5.3 Legality and locality²⁰ (legitimation, constitution building, access, enforcement)

Deininger describes property rights as social conventions that are backed up by the power of the state or the community. As social constructs, they require social legitimacy to be effective: 'Property is not merely the assets themselves, but consensus between people about how these assets should be held, used, and exchanged' (Deininger, 2003: 22). Such consensus will be susceptible to change and government plays a key role in defining property rights and enforcing them (ibid.). However, as Goetz and Hassim argue, government often make commitments without having either the will or means to implement them in the face of social resistance

19. In the case of minors, permission should be obtained from the local Parish Land Committee.

20. Khadiagala (2001: 71) borrows this phrase from the title of Martin Loughlin's book on central-local government relations.

(Goetz and Hassim, 2003: 4). In the Ugandan case, this is the primary reason for the gulf between government rhetoric, legislation and policy and the reality as it is experienced by, particularly rural, women; commitments have been made in relation to gender equality and land rights without being accompanied by measures to ensure their social legitimation, implementation and enforcement.

Social legitimation

At the heart of this problem is the need to acknowledge that the promotion of women's rights and gender equality cannot be tackled in a vacuum outside of the wider socio-economic structures and power hierarchies that determine women's role in society. Government-led reform of legislation and policy is a necessary first step, but it is unlikely to be reflected in actual practice, in the short-term at least, if it is not accompanied by measures to achieve social legitimation, particularly at local levels. Ideally, this should begin during the policy formation process, but work will also need to continue once legal reforms are in place. All this requires an abundance of political will.²¹ In the absence of such measures, discriminatory practices that impede both policy implementation and women's ability to access their rights will continue. Moncrieffe (2004: 31-2) highlights the effect that popular democracy and decentralisation can have in this respect in terms of being used as instrument to reinforce social control by local elites: 'Gender discrimination persists despite structural reforms and claims of right to custom perpetuate inequalities and abuse'.

As discussed, the persistence of traditional norms also means that women's achievement of numerical representation may not produce the intended benefits or be converted into political capital and influence, despite being constitutionally protected and promoted through an affirmative action programme. For legal reforms to be successful, women need to know about their rights²² and have the capacity to claim them. Women may be unable to access their rights through fear of social stigmatisation (women may be branded greedy or traitors) or because local institutions are dominated by male elites who may not necessarily protect or enforce women's rights (Deininger, 2003: 61).

Attitudes towards women in Uganda are in a state of flux, with practice yet to catch up with legislation, particularly the further one moves from the cities. As part of its formulation of a Land Sector Strategic Plan, the government undertook a Land Sector Analysis, which included a study of gender/family issues and land rights. This recommended that 'interventions must take into account which changes are most likely to be accepted, and start with those interventions ... legislative change should parallel education and information, and the first effort at education must be with the men who are the keepers of custom and traditional values' (GoU, 2001). Additional measures that are needed include:

- education/ awareness raising (targeting both women and men);
- capacity building;
- incentives;

21. Importantly, there may be the need for more, rather than less, commitment from the government. A government review of gender and poverty predicts that discrimination against women is likely to increase as land become scarcer and more commercialised (Ministry of Gender, Labour and Social Development & MFPED, 2003).

22. Although, HRW report that research to date indicates that knowledge of land reforms is good (HRW, 2004: 46). Khadiagala (2003: 118) also argues that there is general awareness of the constitution because LCs were used to organise community debates in rural areas, including around the issue of women's rights. Although, given the domination of the councils by men and other concerns about using LCs to for dissemination, the nature of such debates and the quality of participation could be questioned.

- positive discrimination/ preferential treatment.

These are discussed further below.

- a) **Education/awareness raising.** Women and men need to know about women's rights. The government needs to be wary of relying on LCs to disseminate education and public awareness campaigns, given their traditional biases (Khadiagala, 2001: 69). However, it is vital that men, particularly those in implementing institutions, are persuaded of the worth and benefits of women's land rights (see Box A10).
- b) **Capacity building.** Women not only need to know about their rights but they also need to be able to access and contest them supported by, for example, legal aid, training and women's groups. Increased demand for legal aid has led to the growth of these services in Uganda over the past five years. Ugandan Women's Lawyers' Association and Ugandan Law Society run clinics to supply legal information, mediate disputes and provide lawyers. However, women face difficulty in accessing these services because they must be referred to them by their local council (see below) (Khadiagala, 2001: 63).

Women's conception of their property rights, and willingness to defend and contest them, is centred in their particular customs rather than solely in civil law (Khadiagala, 2003: 111-12). Women in Kabale have defended their rights in land disputes in magistrates courts since the late 1930s, whereas women in Mbale have rarely taken legal action. Both districts share similar characteristics but, in Kabale, land acquisition is associated with marriage and the production of children, whereas in Mbale it is triggered by male circumcision. An *a priori* conception of the right to land will have an impact on future willingness and ability to access rights, even if one is based on social status and the other on individual rights (see Box A10).

Box 10: Building public support for women's land rights

To generate public support for women's land rights the Land Sector Analysis (GoU, 2001) recommended:

- Using male gender workers from outside the community to work with men and male leaders on women's legal rights and the benefits of them, such as increased productivity, and the value of including women in the decision making process and control over family income. They could also discuss current treatment of women and the effect of this on their well-being. Women in remote areas suggested this would be more useful than a media campaign.
- Encourage male leaders at all levels to champion women's ownership of land, including land away from the home. Consider including these leaders in a campaign, beginning with an issue where there is most agreement between men and women.
- Consider a weekly question and answer on gender, the family and land on a weekly radio show, which could include participation of government officials and use a toll-free number.
- Consider TV soap opera format, which has worked well in other countries, particularly among people with limited education.

Source: GoU (2001).

- c) **Incentives.** The Land Sector Analysis (GoU, 2001) recommend that voluntary co-ownership be encouraged through programmes that benefit families through incentives such as regulations that require co-ownership for micro-credit or give reduced interest rates on loans.

- d) **Positive discrimination/preferential treatment.** Government interventions can be designed to give positive discrimination to women e.g. land titling programmes in Latin America (Deininger, 2003: 61-2). This can begin to redress the imbalance in the proportion of women with land title.

Box A11: Training and support to enable improved access to justice for women

Measures to empower women recommended by the Land Sector Analysis (GoU, 2001) included:

- Training to help women understand their rights under the law as well as other information and skills in relation to agriculture and livelihoods to increase women's independence, which interviewees believed was the only way for them to gain permanent access to land.
- Providing villages with gender workers to give training on legal issues and discuss option for exercising legal rights.
- Listening to women about the effects of empowerment within their families and give assistance where negative affects occur.
- Establishing a government programme to establish women's self-help groups in rural areas.
- Providing women on LCs with training and information so that they are able to acquire advocacy skills.
- Establishing free legal aid programmes that use local lawyers who live in a rural centre and go out to villages to train villagers and answer legal questions, provide legal advice, and take cases to court or to clan leaders.
- Distributing laws in local languages to clan leaders, LC1 counsellors and other involved in dispute resolution.

Implementation and enforcement

Capacity-building measures and promotional measures need to be accompanied by measures to ensure that rights are enforced in a legally-binding manner by institutions which are seen as legitimate (Deininger, 2003: 33). Deininger suggests that where formal institutions are not available or do not enjoy legitimacy, it may be better to build on existing systems and structures (ibid.).

Other measures that the state needs to take to ensure that land rights are implemented include:

a) Training of implementers. Implementers, who may resist new policy or have other political/economic motivations to distort it, have the ability to shape the content of the policy at local levels and therefore it is vital that street-level bureaucrats and central civil servants receive training regarding the law and women's rights. It is also important that action are taken when there are transgressions of these rights or discriminatory practices.

b) Enforcement and access to justice. There are two main issues concerning access to justice for women in Uganda:

- (i) *Problems associated with justice obtained through LC courts.* In an attempt to make justice systems quicker, cheaper and more culturally appropriate, justice has been decentralised right down to the village level since 1987. However, evidence suggests that optimism regarding this new system was based on naïve expectations about the functioning of community. Popular justice delivered by informal magistrates at the local level has not protected women's customary rights to land (Khadiagala, 2001). Localised justice is vulnerable to arbitrariness and abuse, and local elites have used the system to further their social control. Male networks linking court officials with those involved in cases make it difficult for women to trust the justice they will obtain. To be seen by the chief magistrate, disputes must first go through legal processes at three layers

of local government, meaning that this local, low cost justice can be more expensive than conventional forms of justice. Furthermore, a letter of introduction from the LC is necessary to access the magistrate and gatekeeping by local officials may make this difficult for women to obtain (Khadiagala, 2001).

(ii) *Ability to access state judiciary.* Accessing magistrates courts may be difficult for poor women because of cost and literacy problems. Nevertheless many women prefer going to a magistrate rather than LC courts. Corruption and social biases have undermined the legitimacy of the LC courts and many women feel that magistrates 'arbitrate matters according to law rather than custom' (Khadiagala, 2001:63, 65-6).

c) Institutional framework. The Land Act provides for decentralised land administration and dispute resolution. While it removed the ability of lower-level courts to hear land disputes, it failed to put provisions in place for the new tribunals, primarily due a lack of resources for training and salaries, resulting in a backlog of disputes (Hunt, 2004: 186). Civil servants, working under a tight schedule, failed to develop a detailed budget, resulting in annual costs 500% greater than the preliminary budget ratified by Parliament (ibid: 187).²³

5.4 Conclusion

One of main factors constraining successful policy in the area of women's land rights in Uganda is the lack of social legitimation because of the challenge such rights present to prevailing social norms and power relations. However, there are also political factors at work (decentralisation, a lack of will, institutional failure in the judiciary and corruption, particularly at local level). It appears that economic factors/affordability issues are secondary, although there was certainly failure in budgetary planning around the Land Reform. A summary of the key issues in the policy process in relation to women's land rights can found in Section 7. Closing the gap between women's legal rights and practice will require further political commitment and will and a range of further interventions.

23. Hunt (2004: 187) argues that these costs will actually be greater because the Act is unlikely to generated the expected opportunity costs and will have unintended negative impacts on urban credit supply.

6. Social protection for older people

The level of well-being experienced by older people in developing countries is highly variable. Some have been able to accumulate assets during their life times and are wealthier than many of their neighbours. Some are fit, healthy and vigorously active. Some are well respected by their communities and have taken on leadership roles. Others are deeply embedded in supportive family structures and gain both identity and material support as a result of these linkages. However, evidence from work by Chronic Poverty Research Centre partners shows that older people – particularly women – are disproportionately represented amongst both the severely and the chronically poor (Beales, 2002; Heslop & Gorman, 2002; Bird & Shinyekwa, 2004). Many older people see their health status decline. Where they lack assets, their inability to do hard physical labour can severely limit their livelihood options, earnings and therefore food security, access to services and general well-being. These individuals tend to be vulnerable to shocks and are often deeply fearful of the future. Once they have experienced a decline into severe poverty, older people are often not able to accumulate and therefore experience prolonged periods of poverty. This section of the paper explores policy responses to the need of older people for social protection.

The most striking characteristic about social protection for older people in developing countries is its absence. (See Bird et al. (2004: Section 2.2) for a discussion of the implications of failing to put in place effective policies to reduce chronic poverty in terms of achieving both sustained growth and the MDGs.). The protection that does exist is often in the form of contributory insurance schemes or targeted assistance programmes that are unsuitable for older people. Evidence emerging from studies of the few universal or means-tested non-contributory schemes that do exist suggests that these can have a positive impact on reducing poverty for both older people and their families. However, real challenges exist in successfully implementing these schemes in countries with poor institutional capacity and a small tax base. This means that policy makers face important decisions regarding the design of social protection programmes and how these can be made accessible to the intended beneficiaries. Nevertheless, the key message is that the affordability and sustainability of social protection for older people, and the poor in general, is as much a political as technocratic or economic decision.

6.1 Older people and their need for social protection

The UN estimates that by 2050 three quarters of the world's older people will live in developing countries and that people over 60 will account for 10% of the population in Africa and 23% in Asia and Latin America. Older people in developing countries consistently refer to income security and health as priorities for improving their livelihoods and well being, however, fewer than 20% of people aged over 60 in developing countries receive any formal social protection (HAI, 2003c).

This lack of provision of social protection must be viewed alongside the decline in the traditional bases of security for older poor people. Governments and donors commonly assume that older people will be protected by the extended family and traditional safety nets. However, evidence suggests that the extended family is breaking down in many developing countries. In Ghana, the bonds that sustain reciprocal support between parents and their children have been weakened because of changes to filial support and the increased financial incapacity of younger people owing to modernisation and the impact of structural adjustment (Aboderin, 2002). In other countries, extended families find themselves overwhelmed by the scale of the

problem created by caring for those affected by HIV/AIDS and their orphans. Carers are often older people who find themselves responsible for extended families, increasing the burden they face at a time when their resources and capabilities are declining. Traditional safety nets can no longer be relied on, leaving particularly the frail elderly vulnerable to deep declines in well-being (Bird et al., 2002). Furthermore, social policy often exacerbates rather than mitigates the vulnerability of older people as a result of discrimination and other barriers they face in accessing services (HAI, 2002: 4). See Bird et al. (2004: Section 2.1) for further discussion of the scale and scope of the problem of the absence of social protection for older people and its relationship to chronic poverty.

Box 12: A vulnerable older woman in need of support?

Grace is a frail and elderly widow bringing up her young granddaughter alone. They are terribly poor, with no regular income and no assets, apart from the tiny one roomed thatched hut they live in, in an internally displaced people's (IDPs) camp near Lake Kyoga in Kamuli District, Uganda. Grace was widowed shortly after she and her husband escaped brutal inter-tribal violence which took place in Uganda in the mid to late 1980s. They escaped with a little money which her husband spent on buying some land. But he was murdered by the land's original owners and Grace was driven away. She settled in the IDPs camp and has been there now for over 10 years, but she has been able to re-accumulate very little.

Grace has limited support from others. Although she had 13 children, only 5 lived beyond early childhood. Of the surviving children, the youngest daughter died some time ago of AIDS leaving 3 children. Two of these children died and Grace is now bringing up the third, a girl. She feels that she has no-one else to go to for help in the village, as there are no clan leaders or members of her tribe in the camp, and although her three surviving daughters and her son are all in the camp they rarely give her any food or other support. When she is ill it is difficult for her to go to the clinic, as 'you have to go with your brother', in other words you have to take a bribe for the doctor. She does not have anyone who will give her the money. Nevertheless she is not entirely without a support network. A young man lent her a small patch of land during the last agricultural season, on which her children helped her to cultivate sweet potatoes. An old man built her a granary next to her house, where she planned to store the potatoes. Unfortunately pests destroyed the crop, leaving her no better off than she had been before. She does not expect to be offered land again 'you are given only once, and if you are unfortunate, that is it.'

A small cash pension would clearly improve this woman's level of well-being and would give her granddaughter a more secure start in life.

Source: Key informant interview by Kate Bird and Isaac Shinyekwa in Kiribairya, Kamuli District, Uganda. September 2002.

6.2 Policy formation: International discourses and evidence-based policy-making

The international discourse on social protection has developed during the past two decades from a focus on safety nets for poor people to a more holistic concept that includes the promotion of sustainable livelihoods through measures that act as a springboard. Social protection in developing countries usually falls into three categories:

- social assistance: based on merit/need, can include subsidies and exemption from paying for state services and other targeted programmes such as guaranteed employment schemes, food for work programmes, etc.;
- social insurance: management of risk, usually contributory pension or health schemes; and
- other promotional measures: microfinance, price support, labour exchanges.

The World Bank has been central to the shift in thinking as reflected in the headline messages of the World Development Reports in 1990 (economic growth and safety nets) and 2000/01 (security, empowerment and opportunity). Whilst this has elevated the position of social protection in development policy, there are important concerns in relation older people: (i) Is the new focus on promotional activities to the detriment of more traditional assistance measures? Whilst older people do continue to contribute to productive activities and support for their livelihoods is important (Beales, 2002), what they primarily need is predictable and adequate social assistance; (ii) Do targeted social assistance schemes meet older people's needs? Older people are often physically unable to participate in work-based social assistance programmes and there are trade-offs associated with targeted programmes (see below); and (iii) How appropriate is the focus on contributory (either state- or privately-managed) insurance schemes for older, poor people. The focus again seems to be on how pension schemes can contribute to economic growth but this excludes the majority of the poor in developing countries who work in the informal sector and are therefore not covered by contributory (state or private) insurance schemes and, in any case, the nature of their work (for example, if it is seasonal or piece rate/home-based) and level of income mean that they are unable to make regular contributions (Rao, n.d.). Furthermore, there is a proportion of the population who have already passed 'retirement'²⁴ age without any insurance and who require protection.

What older people require to reduce their vulnerability and poverty is a predictable form of income such as a regular, non-contributory state pension. When asked, older people express a preference for cash transfers (Devereux, 2001a). However, there remains considerable resistance to establishing non-contributory pension programmes in developing countries, with arguments against including that they are not economically viable, that traditional support mechanisms are adequate for older people and that there are more pressing development priorities (Barrientos, 2004). Part of this resistance to non-contributory pension programmes in developing countries has been due to the dominance of the World Bank in this area. The Bank established its thinking on the role of pensions in development policy in its 1994 Report, *Averting the Old Age Crisis: Policies to Protect the Old and Promote Growth*, which highlighted the growing elderly population in developing countries (HAI, 2002: 4-5). In response to this concern, the Bank identified pension reform as a relevant component of development policy and advocated a model with a three tier system, including a sizable private sector pillar (Beales and Gorman, 2002: 8).²⁵ This model was implemented in parts of Latin American and Eastern Europe during the 1990s, resulting in the rolling back of public sector schemes.

Therefore, in the area of social protection, and in particular pensions, the World Bank has set the tone of the development narrative, or, as Charlton (2002) terms it, 'a global pensions reform monologue'. In aid dependent countries in particular, its monopoly on policy advice for social protection policy has marginalised alternative viewpoints, 'even though available evidence give little support to either the developmental or welfare efficacy of key elements in the World Bank's market-based pensions reform strategy' (ibid.).

24. Obviously the notion of retirement is something of a misnomer for most poor people in developing countries.

25. Although a speaker from the World Bank at a seminar on social pension did say that the Bank was looking at the viability of non-contributory pension schemes and that 'in low-coverage countries this [social pensions] may be the only way of reducing old-age poverty and offering security to all of the elderly' (Beales and Gorman, 2002).

6.3 New thinking about social protection and poverty reduction

Researchers have been assessing the impact of social assistance schemes involving cash transfers in developing countries and examining whether it is feasible to deliver such schemes in other developing countries. This is important because many of the existing schemes are to be found in middle-income countries, such as Brazil or South Africa, or higher lower-income countries such as India (although there are also examples in poorer countries in Africa and Latin America, for instance, Bolivia, Tanzania or Namibia) (see Table 5). This research demonstrates the positive impacts of non-contributory pension schemes on both welfare and poverty reduction and challenges the orthodoxy regarding their unsuitability for developing countries due to affordability or administration issues (see Charlton, 2002; Barrientos, 2004, Devereux, 2001c; Heslop, 2002b). This work also challenges the propagation of a unitary pensions model for developing countries. As Joseph Stiglitz²⁶ comments, although developing countries have low income in common, and this characteristic often delimits their policy choices, they also vary in terms of other characteristics and policy therefore needs to be tailor-made according to country context. For some countries this may mean that there is a persuasive case for a broader public role in pension provision for the elderly (Beales and Gorman, 2002).²⁷

The positive impacts of non-contributory pensions on poverty and welfare can be summarised as:

- **Intra-household distribution:** Research suggests that, owing to intra-household distribution, the benefit of pensions extend beyond the welfare of the older person who receives it. In surveys in Brazil and South Africa, 83% and 64% of the respective respondents said that their pension benefits were shared within the family (Barrientos and Lloyd-Sherlock, 2003). Evidence from Tanzania, Mozambique and South Africa demonstrates that pensions have secondary benefits such as contributing to school fees and food and, therefore, influences whether poverty is inter-generationally transmitted (Heslop, 2002b). Cash transfers are particularly important in households where older people have taken on the role of primary carer for their extended family due to HIV/AIDS or migration (Disney, 2002).
- **Multiplier effects:** Even small cash transfers can have an impact on productivity and investment (Devereux, 2001a) and can stimulate trade and marketing infrastructure (Devereux, 2001b).
- **Lifting households above the poverty line:** Studies in Brazil have shown that rural old-age pensions are lifting households above the poverty line (HAI, 2003c). In South Africa and Brazil social pensions have been found to reduce household vulnerability and both the number of poor people and the severity of their poverty (Barrientos and Lloyd-Sherlock, 2003). In fact, the incomes of smallholder farmers and informal sectors workers have often been found to increase on becoming eligible for a pension (Devereux, 2001c: 51).

In light of such evidence, Barrientos (2004) argues that there is an emerging consensus on the need to consider non-contributory pensions as part of a social protection programme. However, as shown in Table 5, only three countries in sub-Saharan Africa currently provide non-contributory social pensions for older people (South Africa, Namibia and Botswana).

26. Comments at a seminar on social protection (Beales and Gorman, 2002).

27. Devereux (2002b) also advocates basing policy decisions on the specific conditions of a country. For instance, he argues that whether or not cash transfers are appropriate will depend on whether a country's commodity markets function effectively (rather than being dictated by the belief that cash transfers will generally be used for non-essentials, which the evidence challenges).

Table 5: Examples of non-contributory pensions in developing countries

Country	Type	Age of eligibility	No. of beneficiaries ('000s)	Expenditure (% of GDP)
Argentina	Means tested	70	113	0.23
Bangladesh	Means tested	57	403.1	NA
Bolivia	Universal but cohort restricted	65	NA	0.9
Botswana	Universal	65	71	0.4
Brazil				
Urban social assistance	Means tested	67	1,216	0.3
Rural pension	Means tested, basic contributory record	60 (Men) 55 (Women)	6,024.3	1
Chile	Means tested	70	163.3	0.38
Costa Rica	Means tested	65	41.6	0.3
India	Means tested	65	2,200	0.01
Mauritius	Universal	60	112	2.0
Namibia	Universal	60	82	0.7
Nepal	Universal	75	192	NA
South Africa	Means tested	65 (men) 60 (women)	1,900	1.4
Sri Lanka	Means tested	No data	425.5	NA
Uruguay	Means tested	70	64.6	0.6

Notes: Beneficiaries figures for 1999 except Argentina (2000) and Nepal (2001/2).

Source: Barrientos and Lloyd-Sherlock (2003).

Box 13: Old age pensions in selected countries

- **Bolivia:** Small, annual pension was introduced in 1997.
- **Brazil:** Guaranteed basic benefit is a citizenship right in the 1988 Constitution.
- **India:** Operates a means-tested National Old Age Pension Scheme (NOAPS), however, there is a financial ceiling that is set nationally for each state, limiting the number of pensions available (Soneja and Heslop, 2003). Other social protection schemes do exist for the unorganised sector but these are minimal and vary across the different States, for instance:
 - **Uttar Pradesh** has three means-tested schemes:
 - state pension of Rs50 (\$1) a month for people aged 65 and over who have no family support or income from employment;
 - national pension of Rs75 (\$1.60) a month for people aged 65 and over who are living below the poverty line (combined with the state pension to give a total of Rs 125 a month);
 - the 'Annapurna', a monthly allowance of 10 kilos of grain or rice for older people who are eligible for either a state or national pension, but who do not receive one (Heslop, 2003).
- **South Africa:** Extended to Africans in 1944, with parity of benefit levels being reached by 1993. In 1998/99, 35% of older persons were in receipt of the old age pension but this increased to 86% for the over-84 age group, with majority of recipients being African (May, 2003: 35).

6.4 National level issues: politics, policy formation, design and implementation

Policy formation process

The emergence of a growing evidence-base which supports the introduction of non-contributory pensions will only result in policy formation and implementation where policy makers are persuaded by the idea. The effectiveness of pensions depends on programme design but older people are not necessarily able to influence the design process. Policy makers rarely differentiate poor people by age or any other characteristic, making for blunt policy responses (HAI, 2003a). The invisibility of old people in the policy-making process stems from their marginalisation which makes it difficult for them to organise to mobilise around their interests. Additional problems result from the perception of their low productive capability (Beale, 2002) and value as a 'vote bank' (Gorman, 2004: 3). This means that they not only have difficulty in influencing the policy-making process directly but that it is also less likely that other political actors will act as a 'champion' for their interests, even if a political environment exists that is supportive of policy formation or reform. Instead, the process will be dominated by other actors who have their own agenda, which may or may not reflect or support the priorities of older poor people. As discussed, this will often include external actors, such as the World Bank or other donors, in addition to domestic forces, who, as Gorman (2004: 4) argues, 'tend to be an elite group, developing policy on the basis of their own experience, rather than on that of people living in poverty'. Furthermore, the lack of established policy to build on in this area can act as a brake on more radical policy reform (Orenstein, 2000).

Affordability

Experience in Latin America and Eastern Europe suggests that politics is central to the formation and reform of social protection policy (Müller, 2002; Orenstein, 2000). However, as with much social policy, decisions are often presented as being technical/economic and about affordability rather than being political or normative decisions. Universal non-contributory pensions in developing countries would cost the same proportion of GDP as in developed nations (Heslop, 2002b). Universal pension schemes could probably be afforded through taxation in high- and middle-income developing countries, if social security provision was given priority over other expenditure, but external support may be required in low-income developing countries, although both India and Nepal provide its citizens with a small universal pension without external assistance. Where governments are concerned about the fiscal pressure pensions would create, Stiglitz believes that it is wrong to assume that private schemes are the only option (Beales and Gorman, 2002). Beattie and McGillivray argue that the World Bank and other actors discuss "affordability" and "sustainability" as if these were objective scientific concepts ... [but] there is no economic law that prevents societies from deciding to allocate more resources to old-age security and less to some other expenditure' (Devereux, 2001c: 22). Although the priority given to social pensions must obviously be weighed along side that of other social policy programmes, it should not be assumed *a priori* that it is social assistance that should be given less value.²⁸ As Devereux states: 'decisions about how to allocate public spending are political choices, not technical imperatives ... a more pertinent question is whether political commitment to the social pension is diminishing' (Devereux, 2001b). There are concerns in this respect. In Namibia,

28. Although there are issues around visibility. For instance, Gorman (2004: 4) points out that the NOAPS in India lacks the political profile that other kind of transfers, such as food, enjoy and that this has repercussions for whether or not street-level implementers prioritise it.

social pensions are coming under attack as shown by the comments of the Minister for Health and Social Security in a parliamentary debate that they are 'nothing but a subsidy to liquor stores', and the World Bank and others are questioning the sustainability of the South African programme (ibid.), although others report that they are both financially sustainable and receive political support (Barrientos and Lloyd, Sherlock, 2003). The impact of the presence or absence of political will can be seen by comparing the record of different Indian States; some manage little social assistance for poor people, whereas Kerala has achieved social insurance for around 50% of its informal workers (Devereux, 2002a: 18).

Programme design

Decisions about policy design have a significant impact on who does and does not gain from social assistance programmes. One of the main issues is whether programmes are universal or targeted. Another is the form in which the benefit is given, for instance whether it is a cash transfer or in the form of a commodity such as food. Devereux argues that intended beneficiaries should be able to participate in these design decisions and, as far as possible, their preferences accommodated (Devereux, 2001a).

Orthodox thinking about social assistance in developing countries suggests that targeted programmes are the most appropriate as they maximise the benefits for the poor. However, such schemes have high administration costs and need well-functioning and efficient bureaucracies and institutions. In the absence of such institutional capacity, there is poor delivery and large targeting errors resulting in the inclusion of the non-poor and the exclusion of the poor. In addition, the dynamic nature of poverty means that regular reassessments are needed if targeting is to be effective, creating additional burden on administrative systems. Targeted schemes can also create stigmatisation if badly designed (Devereux, 2002a: 3-4). There are challenges attached to all targeted schemes but some of these can be alleviated (or heightened) depending on the form of targeting that is chosen. Devereux (2002b: 7-10) describes the characteristics of the main approaches:

- *Individual assessment of need:* Means-testing is the most objective and accurate approach also the most difficult and expensive to implement.
- *Group characteristics used as proxy indicators of need:* This approach is less complex and cheaper than individual assessment, and less susceptible to incentive distortions, and is therefore commonly used where financial and personnel resources are limited. However its accuracy is dependent on the selected proxy and evidence suggests that demographic categories are often inaccurate proxies.
- *Self-targeting:* In schemes such as these the poor are encouraged to select themselves. Such an approach is often popular with designers because it is theoretically cheaper and more accurate than other alternatives. Disincentives for the non-poor are achieved by either lowering the value of the transfer or increasing the cost of accessing the scheme, however, these same mechanisms also have social implications in terms of stigmatisation.
- *Community-based targeting:* In these schemes the communities themselves identify beneficiaries. Whilst this has many advantages, it also solves technical problems at the cost of the political ones, for instance, vulnerability to elite capture, exclusion of the really poor and vulnerable and politicisation of the process. Such schemes have yielded mixed results in practice.

There are trade-offs with both universal and targeted schemes but commentators suggest that the benefits of universal schemes in terms of ensuring that poor people are not excluded outweighs the additional expenditure needed, particularly when the cost of targeting is considered (Heslop, 2002a). Soneja and Heslop (2003) suggest that further work on the cost of implementing the current system in India might provide justification for simplifying administration and expanding the scheme rather than means testing. Devereux (2002a: 4) suggests that 'the minimisation of targeting errors is a political rather than technical question and most policy makers are preoccupied with minimising inclusion errors rather than ensuring maximum coverage of poor or vulnerable groups'.

Sustainability

It is arguable that if the elderly were a more powerful group a higher priority would be assigned to their welfare by political elites. Their lack of power makes it more important that politically sustainable ways are found to support their welfare. Targeted programmes risk alienating the very groups whose political and financial support is required for a sustainable social assistance policy. Therefore, although universal programmes reduce the amount of benefits available by including the non-poor, there are other gains that need to be considered in terms of mobilising the support of middle classes who constitute the tax base (Devereux, 2002a: 3). This is important even where tax funds are supplemented by aid funds. Devereux makes the point that, whilst this means that universal social pensions are regressive, they have progressive attributes in that they can result in wealth redistribution (Devereux, 2001c: 25). Gorman (2004: 3) also highlights that programmes that are given as a right are more political sustainable and less susceptible to erosion, than targeted schemes, which can be seen as charity, e.g. the Indian NOAPS scheme.

Administration and access

Even well-designed policies will be ineffective if they are not implemented efficiently. Beneficiaries must know about their entitlements and be able to access them. This can be supported by measures which combat discrimination, which hinders older peoples' access to their entitlements, and identify other obstacles to access, such as whether requiring proof of eligibility limits access for older people. A lack of capacity to administer and deliver programmes efficiently, due to an insufficient allocation of human or financial resources or poor training and institutional design, can mean that the benefits that people are entitled to are not delivered.

Box 14: Examples of poor pension delivery in developing countries

- In Bolivia, the Human Rights Ombudsman has estimated that only 37% of people over 65 who are entitled to free healthcare are receiving their benefits. One of the main causes is the lack of documentation needed to prove eligibility. However, there are also administration problems; a third of Bolivia's municipalities have no systems or registers to check eligibility and also lack means of disbursement (HAI, 2002: 5).
- In India, a means-tested pension of US\$2 per month is taken up by fewer than 20% of those eligible (HAI, 2003c). Some of the reasons for poor uptake are considered in Box A15, below.
- In Mexico, 60% of working people are covered by the national social security scheme but only 35-40% are receiving due benefits because of poor levels of payment, bad record-keeping and poor administration (Beales and Gorman, 2002: 9).
- Abuse of power by village officials was highlighted in a study by Help Age India (see Box A15). One respondent reported that the head of his village committee controlled access to pension applications and that he had been told that, as only a limited number of applications would be accepted, he should not apply, despite being eligible (Seneja and Heslop, 2003). In a tribal village in Madhya Pradesh, an elderly woman was told by the village head that she didn't need her pension. He kept it, giving her discretionary 'presents' on festival days, maintaining traditional power asymmetries and patron-client relationships (Bird, 2002)
- Gorman (2004: 3-4) compares pension schemes in Nepal and India. Although the Nepalese scheme is for only a small amount, it is well understood, enjoys widespread support and achieves high-coverage (80%), whereas leakage in the Indian scheme is thought to be high due to poor design and understanding.
- A study in Ghana showed that few people were aware that there was free-healthcare for the over 70s and those that did complained of illicit fees (Heslop, 2002: 8).
- May (2003: 35) reports that a large proportion of the funds allocated to annual social service expenditure in South Africa has not been spent due to mismanagement, corruption and lack of capacity. For instance, between 1996 and 2000, the Department of Welfare was estimated to have been unable to spend R616 m. allocated for poverty relief, social development and social welfare.
- The importance attached to the state pension by older people was demonstrated during an administration crisis in the Eastern Cape (South Africa) in 1998. A rationalisation process was instigated to identify claimants that should not be receiving the pension but the net was cast too wide and, in the process, many eligible people were excluded.

Whilst the problems facing developing countries in terms of effective implementation of social protection programmes should not be understated, these issues are often presented as technical problems when, again, political will and commitment have a large role to play.

Box 15: Pension administration in Uttar Pradesh

Help Age India undertook research into pension administration, including consultation with 1,105 older people and government officials responsible for service delivery. They found that:

- whilst awareness of the old age pension scheme was high, understanding of eligibility criteria and application procedures was poor, including among implementing officials;
- people in positions of power within the local community could act as a gateway to access to pensions;
- the requirement for written applications forms and supporting documents were an obstacle due to low levels of literacy among older people;
- there was evidence of corruption at various stages of the application process;
- there was a need for more transparency regarding eligibility, including information about failed applications, particularly as the financial ceiling limits the number of available pensions;
- despite problems associated with the scheme, support for it among poor people was high and they felt that it should be expanded.

Source: Seneja and Heslop (2003).

The possibility of government implementing measures to improve access to entitlements is demonstrated by the example from Namibia in Box 16. Local action can also improve access; examples include:

- Mediation with the government by the Social-Legal Centre in Bolivia led to a change to procedures so that witnesses could be used to prove the age of the applicant (Buentas and Beales, 2003).
- Around 60 Pensioners' Associations have been established in Ethiopia to assist members in receiving their pension on time and to lobby for improved pensions (HAI, 2003b: 2).

Box 16: Technological solutions to pension delivery in Namibia

Only 50% of eligible Namibians were receiving their pensions at Independence in 1990. The government committed themselves to increasing this number and by 2000 it had risen to 88%. One of the primary reasons for this success was the innovative solution that was found to delivering small cash-pensions across vast and often inaccessible areas. The contract for pension delivery was put to tender and won by the company responsible for delivery in South Africa. Its vehicles are fitted with cash-dispensing machines that visit designated points every month and require pensioners to verify their identity using biometric identification methods, linked to a national database. This system has increased access for elderly, usually illiterate, rural Namibians, whilst reducing the opportunity for corruption.

Source: Devereux (2001c).

6.5 Conclusion

This section has shown that poor older people are in need of social protection. We have shown that whether to implement or preserve social protection for older people is, in fact, a political decision and that arguments of affordability and sustainability should be seen in this light. Targeted approaches which focus on frail and unsupported poor older people might allow beneficiaries to receive higher per capita payments but universal schemes will suffer less from administrative failures, will avoid targeting errors, including the exclusion of eligible people, and are less likely to be captured or undermined by disgruntled tax payers. A summary of the key issues in the policy process in relation to social protection for older people can found in Section 7.

7. Summary of the key policy process issues

The boxes below provide a summary of the key issues in the policy process for each of the case studies.

Box 16: Alcohol dependence

Policy formation

Policy responses to alcohol dependence appears to be influenced negatively by the perceptions of the elite who castigate the poor as undeserving, and identify alcohol dependence as a self-created problem related to the cultures of the poor, which is best dealt with through self-help.

It has been difficult to persuade policy makers in Uganda to take alcohol dependence seriously because the problem falls outside mainstream development, livelihood and poverty debates. Domestically, alcohol dependence is identified as a problem largely experienced by poor people and there is reluctance amongst policy makers to do anything that will remove a rare source of solace. The impact of problem levels of alcohol consumption on the families and communities of drinkers seems to be poorly understood – if known, it might provide a counter-point to the solace argument.

India has an ambiguous relationship with alcohol. Unlike Uganda, there is a proactive anti-alcohol social movement, largely rooted in the activities of locally-generated radical women's movements and NGOs. These tend to take a highly moralistic stance against alcohol, perhaps generated by the limited history of widespread constructive or social drinking and the widespread problem of binge drinking, commonly associated with domestic violence and household impoverishment. The Constitution demands that states do all they can to control and reduce alcohol consumption and alcohol use is increasing both in terms of the proportion of the population drinking and their consumption per head. But States are so dependent on revenue from formal sector producers and vendors that introducing and preserving policies which limit or prohibit alcohol production and sale is difficult. Liberalisation of alcohol markets has been associated with the globalisation of middle class norms and behaviours, and, in some circles, alcohol consumption has connotations of modernity and sophistication – this may have something to do with the reluctance to tackle the problems of increased alcohol dependence and binge drinking head on.

Resource accumulation

Prohibition in India has been initiated in some States and then reversed because of the negative impact that it has on State revenues. States have been unable to offset longer-term reductions in health-related costs and increases in revenue associated with productivity gains (from reduced levels of alcohol dependence) against the short term revenue declines from reduced tax take.

Implementation

Implementing prohibition in any developing country is likely to be difficult, as alcohol produced and sold informally has substantial market share, particularly amongst the poor and those living in rural areas. Where enforcement is weak, prohibition *can* result in increased production by the artisanal sector and a resultant reduction in cost of informally produced beers, wines and spirits. Enforcement problems associated with rent-seeking and poor administrative capacity can lead to increased cross-border smuggling and sales and the increased involvement of black market and underground networks in the production, wholesaling, transportation and sale of alcohol.

Effective implementation requires not only successful and widespread policy legitimisation but adequate resourcing of enforcement and measures to compensate for the reduced tax base. However, there may be a simple solution; divert a percentage of taxes to earmarked spending to prevent alcoholism and to deal with its consequences – i.e. fund social services, NGOs etc.

Box 17: Mental Illness

Policy formation

- Widespread ignorance about mental illness leads to poor policy formation and resourcing (e.g. mental illness is commonly categorised as a form of disability and is seen as untreatable and incurable).
- Mental health policy is given inadequate attention by policy makers. 52% of African countries and 44% of South East Asian countries do not have any mental health policies in place – possibly due to stigma and the personalised nature of mental illness.
- The 2000 mental health policy replaced the 1964 Mental Treatment Act in Uganda and included the following provisions:
 - standards and guidelines have been developed for the care of adults and children;
 - health workers have been trained in how to recognise and manage common mental disorders;
 - a new referral system and support network has been established;
 - linkages have been improved between mental health services and other programmes e.g. HIV/AIDS;
 - drugs for the treatment of mental illnesses have been included on the essential drugs list;
 - the Mental Health Act has been revised and integrated into a Health Services Bill;
 - mental health has been included as a component on the national minimum health care package; and
 - the Ministry of Health now has a budget line for mental health.

Resource accumulation

- Many developing countries spend less than 1% of their total health budget on mental health (Uganda - 0.07%, Kenya - 0.01%, Ghana 0.5%), compared with 11% in Canada and 6% in USA.

Implementation

- A lack of resources means that mental illness commonly goes undiagnosed and untreated.
- More than 25% of countries do not have access to basic psychiatric medication at the primary care level.
- 75% of the world's population have access to less than 1 psychiatrist per 100,000 people. SE Asia has only 0.3 psychiatric beds per 10,000 population, compared with 0.4 in Africa, 3.6 in the Americas and 9.3 in Europe.
- In Uganda there is a mismatch between policy and implementation.

Box 18: Disability*Uganda***Policy formation**

Provisions in the Ugandan constitution mean that disabled people are represented at all levels of political administration through reserved places (including five reserved parliamentary seats – one for each of the four regions of Uganda and one to represent the interests of women with disabilities).

Resource accumulation

Budgets allocated to disability at the local level are too low to cover both awareness raising and targeted interventions.

Implementation

- Disabled representatives at local government levels tend to be ineffective. They are unclear about their role, disability issues are marginalised rather than integrated into the work of local government, and able-bodied councillors are not interested in the issues
- There is a lack of laws to protect disabled people.
- There have been limited attempts to identify and eliminate discriminatory legislation.
- The Universal Primary Education policy specifies that of the four children from each family receiving free primary education, two should be girls (if the family has any) and disabled children should be given priority, however, a lack of resources means that plans to train specialist teachers and establish a network of district level assessment centres are not being implemented. Poor school design prevents attendance and high fees for special schools bars children from poorer families.
- The response to severe mental disabilities is severely under-resourced. Researchers were unable to identify a single organisation working on this area in Uganda.

*India***Policy formation**

- Legal protection is good. The Persons with Disabilities Act of 1995 makes discrimination on the grounds of disability illegal.

Resource accumulation

- Legislation requires that 3% of all rural development programme expenditure benefits the disabled. Expenditure on the 'disability sector' has increased, with nearly half being spent through NGOs, but data to confirm whether this target is being met is not available.

Implementation

- Coverage and the effectiveness of programmes are patchy.
- Government treatment centres for people with physical impairments are located in urban areas, making access difficult for people from rural areas, particularly for people likely to be excluded because of gender, ethnicity or caste.
- Targeting of services and benefits is poor. Only 61% of the disabled people attending government treatment centres had been issued with disability certificates, which confirm their entitlement to various benefits and concessions. Of those with disability certificates, only half had secured their rights.

Box 19: Women and land rights in Uganda

Policy formation

Having women's representatives at all levels of government in Uganda appears to have had a limited impact in terms of getting women's issues on the political agenda or influencing policy making. There is a 'politics of presence' rather than a 'politics of influence' because:

- the nature of positive discrimination undermines the legitimacy of women's representatives filling reserved seats;
- issues affecting women are hived off for discussion in separate fora;
- women councillors rarely attend public meetings – their husbands veto attendance;
- women tend to be reluctant to defend unpopular or controversial positions – they tend to defend Movement policy and local (male) elite interests;
- women Ministers have been marginalised from decision-making.

There has been increased attention given to women's land tenure rights. However, during the consultation processes around the new Ugandan Constitution, women and marginalised groups saw their interests in land tenure reform sidelined by the conflicting interests of powerful ethnic groups. This also occurred during the drafting of the Land Bill. Policy making in Uganda is not always straightforward, and unpopular bills may be held up in Parliament (e.g. Uganda's Domestic Relations Bill) or have controversial clauses removed (e.g. the key co-ownership clause, removed from Land Bill by President Museveni).

Policy legitimisation

Customary tenure practices in Uganda reflect entrenched patriarchy and paternalism a strong advocate is required in order to overcome such powerful forces. However, the Ugandan Government lacks the will to ensure the social legitimisation of improved land tenure rights for women. The Ugandan Government is ahead of many other governments in sub-Saharan Africa in terms of promoting poverty reduction and rights, however, where women's land rights are concerned, it appears to have been deflected by a wish to protect traditional culture.

Implementation

The dominance of patriarchal culture in government institutions (from Ministries to Local Government) influences policy implementation. Furthermore women do not necessarily know what their rights are. They may not access or contest their rights because they fear social stigma (may be branded greedy or a traitor) or their local council, acting as gate keeper, may bar access to local magistrates, legal representatives and mediators. However, if they do attempt to contest their rights, the new decentralised tribunals established by the Land Act are not always a good environment in which to do this. They lack resources for training and salaries, which has resulted in a backlog of cases, and they have been used in some instances as an instrument to reinforce social control by local elites. The informal magistrates are prone to be arbitrary and abuse their power. When arbitrating land disputes, lawyers commonly favour the dead husband's family rather than the widow – particularly where she is thought to have HIV.

Box 20: Social protection for older people

Policy formation

- The absence of social protection can be the result of a lack of political will (for instance, as demonstrated by the wide range of experience in different Indian states).
- Poorly designed policies result from a failure to differentiate the poor by age or other characteristics.
- Existing social protection measures are often inappropriate for older people because they are poorly targeted or require contributions that older people cannot make.
- The marginalisation of older people means that they are rarely consulted during policy formation and they find it difficult to mobilise around their interests.
- International development narratives regarding social protection have constrained the 'framework of possible thought'. The World Bank approach to social protection has historically promoted an increased role for the private sector in pension provision despite the lack of evidence that such reforms deliver better outcomes in terms of either development or welfare. However, there is an increasing body of research illustrating the benefits of universal non-contributory pension schemes on both welfare and reduction.
- Politics is central to the formation and reform of social protection policy, but budget constraints and technical/economic are often used as an excuse for taking a particular policy direction.

Policy legitimisation

- There is considerable resistance to establishing non-contributory pensions programmes in developing countries. Arguments against include that:
 - they are not economically viable;
 - traditional support mechanisms are adequate for older people;
 - recipients are not seen as deserving or as spending the money well e.g. in Namibia, where there is a pension, the Minister for Health and Social Security has commented on them being 'nothing but a subsidy to liquor stores'; and
 - there are more pressing development priorities.

Resource accumulation

- Limited tax take in low income developing countries constrains the kinds of social protection they can offer unless they gain external support.
- External support may be needed to deliver universal non-contributory pensions in low income countries. A long-term commitment to deliver this scale of support has not yet been forthcoming from donors. However, both India and Nepal – low income countries – have non-contributory pensions, which they fund without external support, illustrating perhaps that they can be afforded where support is broad based, and where tax systems are effective.

Implementation

- Targeted schemes are subject to targeting errors, need highly effective administration and can reduce the political acceptability of the policy.
- A lack of administrative capacity may stop programmes being delivered.
- Programme design determines who benefits, who is excluded and potential problems (targeted or universal, in cash or kind, disbursed by local government officers or direct into a bank or post office account).
- Poor institutional capacity and a small tax base makes implementing non-contributory pension schemes difficult.
- Poorly advertised schemes may mean beneficiaries do not know about their entitlements or how to access them.
- There may be administrative hurdles that prevent people obtaining the paperwork which shows their eligibility to a pension.
- Pension application and disbursement processes may present opportunities for corruption.
- Low literacy may make accessing a pension difficult.

8. Concluding points

8.1 Alcohol dependence

Understanding how and why ‘constructive drinking’ cultures change and why the incidence of alcohol dependence increases is a first step to identifying useful policy interventions. Recognising the importance of artisanal alcohol production and sale for the livelihoods of the poor and the benefits that states and local government gain from taxing formal sector alcohol production and sale must be balanced against the highly detrimental impact that alcohol dependency can have on individuals, their households and wider communities and economies.

As with mental illness, policy responses to alcohol dependence tend to be inadequate and there is poor recognition of the two-way relationship between dependence and poverty or the impact that dependence can have on individual and household poverty and on economic growth. Policy interventions in poor developing countries have tended to focus on limiting and controlling formal sector production through registration, controlling price through taxation²⁹ and occasionally (particularly in India and the Islamic world) controlling availability through prohibition. The scope for a new constructive drinking culture has not been investigated.

8.2 Mental illness

Mental illness barely registers as an issue in either poverty or development discourses. Few developing country governments have policies which recognise the linkages between mental illness, poverty and economic growth, and what policy there is tends to be so inadequately funded that its implementation does little to either identify and treat mental illnesses or to reduce the exclusion and intensified poverty experienced by the mentally ill and their families. Stigma and fear surrounding mental illness means that much has to change in development and poverty discourses before mental illness is likely to be seen as relevant to development practitioners and policy makers.

8.3 Disability

Both India and Uganda have made impressive attempts to reduce the exclusion experienced by people with impairments. Indian legislation makes discrimination on the grounds of disability illegal and the reservations programme expands job and training opportunities for those with registered disabilities. Its network of treatment centres provides physiotherapy and other mitigating support to people with registered physical disabilities. However, many people with physical and mental impairments have been unable to gain registration documents, particularly rural women, and even those with correct documentation have experienced difficulty in claiming their rights (e.g. to reserved places, treatment and social protection). Small pilot schemes to support the integration of children with impairments into mainstream schooling are yet to be evaluated or expanded to give national coverage. In Uganda attempts to reduce exclusion and generate inclusive policy making and practice has included a constitutional requirement that places are reserved for people with impairments at all tiers of government. Unfortunately there is evidence that, as with the representation of women in government through reserved places, this has resulted in the politics of

29. Although governments with heavy dependence on alcohol-related revenues tend to balance raising taxes to dampen demand with their needs to maintain (and even increase) tax take through increased market size.

presence rather than the politics of influence (Goetz, 2003). ‘Disability issues’ (and ‘women’s issues’) are hived off rather than being dealt with in mainstream decision making fora and as part of mainstream policies. The effectiveness of attempts to integrate children with impairments into the education system has been marred by inadequate funding and capacity building and the stubbornly pervasive stigmatising and discriminatory attitudes towards disability. This is a rocky road, despite the promising constitutional, political and legal environment.

8.4 Women’s land rights

Despite widespread recognition of the importance of women’s land rights in international development debates, and vigorous national-level lobbies, attempts to change national asset inheritance and ownership policies, including those to do with land, have met with resistance from vested interests. In Uganda, although substantial policy change has been achieved, the highly contested nature of these policies and the disjuncture between urban educated opinion and that of street level bureaucrats and the general public has contributed to poor legitimation and has meant that *policy as practiced* lags behind *policy as written*. This indicates that, even where social movements are well developed and effective, rapid change in *policy as practiced* is by no means assured. It will be difficult to achieve effective policy in this area if the Ugandan government lacks the political will to challenge the entrenched gender hierarchy.

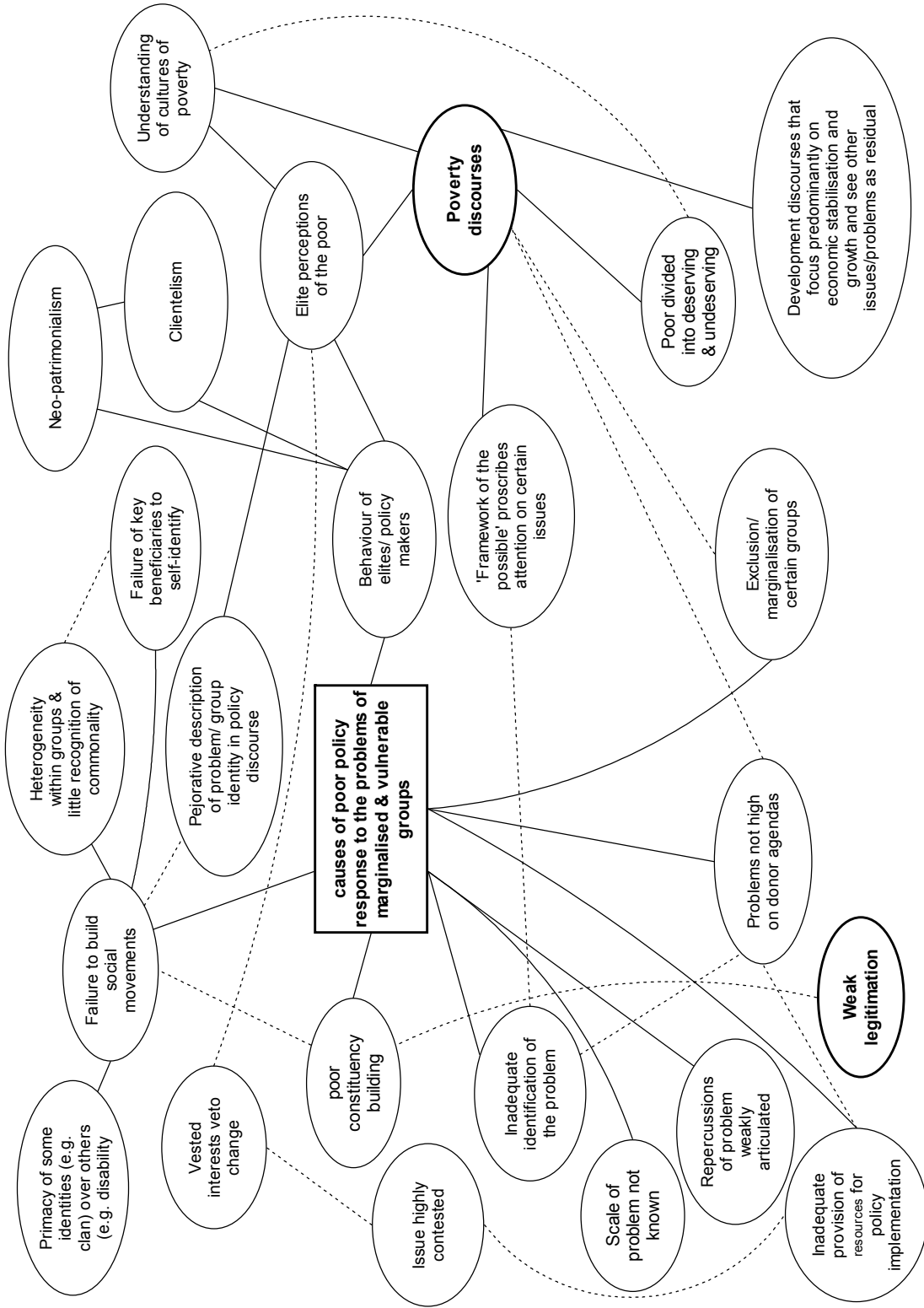
8.5 Older people

State provision of social protection for older people is largely absent in developing countries, despite evidence that kinship networks and traditional safety nets fail to support some of the most vulnerable. There is, however, growing international recognition that old age pensions represent a valid approach to poverty reduction. Successfully implementing universal or means-tested social protection in poor developing countries is made difficult by poor institutional capacity and a low tax base – in addition to the various fracture points in the policy formation and legitimation processes already discussed. However, what is clear is that the affordability and sustainability of social protection for older people is as much a political as it is a technocratic or economic decision. India has a number of interventions which provide income transfers to older people. These are not universal and do not provide national coverage, and there are problems with leakage and mis-targeting, however, they are widely acknowledged to generate welfare benefits for recipients and their families. Uganda does not have social protection for older people.

Figure 7 below represents the key issues that we have found to affect policy formation and legitimation. Further analysis of the policy process and the key fracture points preventing effective policy for chronic poverty reduction, drawing on these case studies and the policy process literature, can be found in Bird, K. and Pratt, N. with O’Neil, T. and Bolt, V. J. (2004) *Fracture Points in Social Policies for Chronic Poverty Reduction* (ODI Working Paper 242, CPRC Working Paper 47. London: ODI).³⁰

30. www.odi.org.uk; www.chronicpoverty.org.

Figure 7: Key factors influencing poor policy response to the problems of marginalised and vulnerable groups



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