

# Strengthening Community Based Social Protection Practices for Child Protection

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## **Abstract:**

Much attention is paid to social protection at macro-level, using a variety of centralized instruments to deliver a range of benefits to poor and vulnerable people. However, less attention has been paid to the role of communities in social protection, and in particular the role of traditional systems<sup>1</sup>. Such mechanisms are known to exist in Myanmar<sup>2</sup>, but to date few studies have documented their range, impact and potential utility for social protection. Data was collected by community volunteers from 39 villages representing eight of the 14 States and Regions of Myanmar. All communities studied had evidence of community led social protection systems, and the average fund distributed per year amounted to \$2,650 per village. Community based programmes to enable poor children to access to primary education were practiced in all eight respective States/ Regions funded by primarily by the contributions of the community. These typically delivered a cash grant to children of school age in poor households. In terms of health, several villages had schemes to enable access to vaccination and health care for poor children, providing either a cash grant or volunteer help. Community based systems are estimated to meet around 30% of reported social protection needs for children. Community systems were limited in approach, and by relatively small capital funds. Limited data exists to demonstrate the evidence of efficacy of scaling up of community led systems.



**Keywords:** Child protection, Community based social protection

**Research objective:** to analyse existing traditionally rooted social protection mechanisms which can be strengthened to facilitate social protection for children using a sustainable and inclusive approach

**Literature review:** Social protection is often defined as 'a sub-set of public actions that help address risk, vulnerability and chronic poverty'<sup>3</sup>. Much attention is paid to social protection at macro-level, using a variety of centralized instruments to deliver a range of benefits to poor and vulnerable people. However, less attention has been paid to the role of communities in social protection, and in particular the role of traditional systems<sup>4</sup>. Despite this, much evidence exists validating the efficacy and efficiency of community based, community led social protection mechanisms<sup>5</sup>. Such mechanisms reside in a contextual framework, and rely on local resources, and are shaped to deliver locally appropriate solutions in the community setting. Analysis of child-sensitive social protection programmes highlight the need for greater synergy, and for a more robust evidence base for social protection programmes. Despite noting the difficulties in implementing comprehensive social protection systems, a recent UNICEF analysis of social protection failed to sufficiently consider the potential role of communities in social protection<sup>6</sup>. Sector-specific community based mechanisms, such as Community Based Health Organizations, have been shown to be effective in reducing out-of-pocket payments and improving access to health<sup>7</sup>, although evidence on outcomes is still limited<sup>8</sup>. Such schemes are recommended to be 'a complement to, not as a substitute for, strong government involvement in health care financing and risk management related to the cost of illness.'<sup>9</sup> Analysis from the World Bank identified a number of reasons for considering community based approaches, including Good development outcomes, cost-effectiveness (where 'decentralizing responsibility to communities can be an effective way of delivering social services because the community resources that supplement the external resources help make the services more affordable..and... Community participation can also help reduce "leakages" and ensure more efficient use of resources", flexibility and contextual appropriateness ( where "A community-based approach helps to ensure that services are appropriate for the local context and suit local preferences.") increased effectiveness of targeting vulnerable groups, and increased ability to respond to growing demand for services.<sup>10</sup> Based on existing research, there appear to be three main modes of community-based social protection. Firstly, there are schemes where the community is essentially the implementing mechanisms for a regional or national social protection programme, either a multi-faceted programme, or more typically, a single component programme such as community based health insurance schemes<sup>11</sup>. Secondly, there are schemes whereby communities are given funds for activities such as economic development, infrastructure and village development. Examples of this include the 'One million baht' scheme in Thailand, which mainly focussed on providing a village-administered capital fund for micro-credit<sup>12</sup>, and a post-conflict project in Sri Lanka which provided funds for infrastructure and livelihoods for vulnerable persons<sup>13</sup>. Less common are the third category, where communities have access to funds which allow the community to effectively take on a range of social protection duties using approaches and schemes which are designed by, operated by and administered by the community. One concern for this third category is the recognition that the technical demands of a community based social protection



project are more demanding than for an infrastructure or micro-lending project, and hence considerable input is required to ensure and sustain adequate technical capacity and support<sup>14</sup>. Although open discussion of social protection is only a recent development in Myanmar, the existence of traditional, community based approaches to addressing vulnerability is well known<sup>15</sup>, although typically ignored in most policy analyses<sup>16</sup>. Initial preliminary research identified a number of different approaches in different communities<sup>17</sup>; however, there is little detailed evidence of the types and mechanisms of social protection at community level, how they are administered, how they are funded and how beneficiaries are selected. Such evidence can usefully inform efforts to strengthen community based systems. With the readily acknowledged challenges of building a comprehensive, nationally administered social protection system in a context of chronic underinvestment in public services, an inefficient and as yet non-transparent taxation system and significant regional variations in vulnerability, the suitability of community based approaches needs to be considered. Research institutions have conducted detailed analysis of vulnerabilities in Myanmar, including dimensions and causes of child poverty<sup>18</sup>. Additionally, new tools to assist communities in mapping community vulnerability have been developed, providing more robust measures to determine eligibility and measure outcomes<sup>19</sup>. Hence, research is needed to analyse the current form and effectiveness of existing traditional social protection mechanisms, and to explore the potential impact of strengthening these systems on overall social protection programmes.

## Methodology

The overall research question is *‘what are the prevalence, modus operandi, efficiency and effectiveness of community based social protection mechanisms?’* The application of this research question is *‘In what way could strengthening/up scaling of community based social protection systems contribute to wider social protection programmes?’* Following this question, the research methodology was designed to elicit the following:

- Prevalence and types of different community based social protection mechanisms
- Beneficiary types, eligibility/selection criteria for beneficiaries
- Type of assistance (financial or other), degree of assistance, coverage
- Size and sources of funding, fund management approach
- Evidence of benefits of up-scaling of fund size on efficiency and effectiveness
- Examples of ‘good practice’ which could serve as model for future programmes

The overall methodology was based eliciting quantitative data on typology and characteristics of community based social protection programmes, together with demographic information from the community. However, the research design framed a series of open questions, which allowed for respondents to give context-specific details rather than selecting a response from pre-set answers. A participatory focus group discussions were conducted by 49 community volunteers representing 8 respective States/ Regions as a pilot test for upcoming widespread data collection for community based social protection mechanisms. Analysis was made to identify the existence, coverage and spread of community based traditional social protection mechanisms. Focus Group discussions methods with



guided Questionnaires were mainly used for the research and descriptive analysis were applied. The initial findings were collated to present an initial impression, which will be further analysed with detailed, village based questionnaires in 50 villages.

## Method

Research was planned and undertaken by the Social Policy and Poverty Research Group, which is a consortium of three non-government organizations and one government department<sup>20</sup>. The group has a specific focus on research to assist the development of evidence based social policy, particularly in the area of social protection for vulnerable groups. The research was conducted together with ActionAid Myanmar, who have an extensive network of village volunteers (called village fellows) who are trained as community animators for a variety of social and poverty reduction related activities. Villages were selected from five of the 14 States and Regions of Myanmar, designed to adequately represent the different regions (central, Delta, coastal, hilly tract). Villages were selected which had an active village volunteer, but which had not had significant input from outside organizations in the area of social protection. Training of fifty enumerators was conducted in February 2013, both in questionnaire use and in research methods. A number of the enumerators had previously undertaken research tasks with SPPRG. The questionnaire format required responses by a representative group from each selected village, including village authorities, older persons, women and persons with disabilities. The questionnaire was developed, printed and administered in Burmese language, with translation by the enumerators in cases where the villagers did not speak Burmese language, and is available as appendix A. The questionnaire recorded all the participants in the interview process. The questionnaire then allowed participants to describe the various social protection schemes at community level, together with the characteristic, aspects of funding, distribution and criteria. Through these discussions, different categories of traditional social protection were identified, along with their associated rules, regulations, funding mechanisms and efficacy. The findings were then categorized by type of beneficiary (e.g. General welfare, children, women, older persons, person with disabilities, youth, disaster response, maternal health etc.) to further to demonstrate a heterogeneous result

## Findings and analysis:

### *Profile of sample*

Completed questionnaires from 50 villagers were analyzed, and of these, data was completed for 39 villages. The remaining questionnaires did not include sufficiently complete data for analysis, and so were excluded from the study. In all cases, the main reason for exclusion was omission of data on household numbers in the village and types of social protection schemes. All incomplete villages reported some social protection schemes, but did not provide sufficient detail for analysis. Hence, incomplete questionnaires were not regarded as negative responses (no social protection schemes) but as null responses, meaning that the data was excluded in entirety. The typical household number for the sample villages 111, slightly lower than the national average of 126 households per village/ward. This reflects the more rural composition of the sample, which included only two peri-urban villages. The strengths and weaknesses of the sample and method will be discussed in the next section.

### *Overall social protection programme profile*



In total, 159 social protection schemes were administered, delivering benefits to 2792 beneficiaries, disbursing a total of K88,809,600 (US\$103,000), an average of K 2,277,169 per village (US\$2,650). There were no villages which had no schemes, and a village typically would have 4 social protection schemes-general social welfare, a health scheme, an education scheme and a scheme based around religious ceremonies, including funerals. The mean benefit amount was K31,800 (US\$37). Around half of the benefits were delivered in cash, with the remainder being delivered by a mixture of cash and labour (20%), cash, labour and food (11%), labour or service (9%) or food/materials (6%) or cash plus food (4%). The main categories of social protection schemes were for general social welfare (31%), health (25%), education (11%), religious affairs (7.5%) and emergency support (7.5%). Most programmes had no specific targeting criteria, but of the group-specific programmes, those for women (12.6%) and children (13.8%) were the most frequent. Interestingly, over half the programmes were available to ‘any reported case in the village’ even if the person was not a native of that village, refuting the notion that village based social protection programmes tend to be exclusive to long-term village residents. In fact, several villages had well-organized programmes to provide emergency assistance to neighbouring villages in times of difficulty. In terms of funding, the majority of schemes (82%) relied on systematic contributions from villagers in some form, with only 18% of schemes drawing mainly from private donors. Only three schemes had contributions from government sources, and 29 (18%) reported some involvement or funding from an NGO. There is some evidence that NGO funding resulted in increased ability to deliver adequate benefits to beneficiaries. Community based programmes to enable poor children to access to primary Education were practiced in all eight respective States/ Regions driven by the major contributions of the community and NGOs (100%). These typically delivered a cash grant to children of school age in poor households. In terms of health, several villages had schemes to enable access to vaccination and health care for poor children, providing either a cash grant or volunteer help. Many villages practiced schemes to help poor children attain novitiation into the Buddhist monastery, as an essential rite of passage. One State also reported support to mothers of newborn children, providing volunteer help and a cash grant, adjusted according to poverty and needs.

Administration of the programmes was almost exclusively by village committees. The only exceptions were programmes operated by private donors, but even in these cases committee management was more common than individual disbursement. Typically, a committee would established the type of benefit, the eligibility criteria and the fundraising mechanism. The procedure for formation of committees was not recorded, so it was not possible to establish the extent to which committees were representative, democratic or transparent. There were no legal frameworks for the functioning of the committees, as laws for forming associations are rarely implicated at individual community level. This is not to describe the practice as illegal; more as ‘non-formal’ in that practices are nor governed by any particular statute.

#### *Child orientated social protection programmes*

In terms of social protection programmes specific to children, 22 such schemes were operated in 16 villages, and were primarily oriented towards education, health and religious participation. There were 43 villages without any programme specifically orientated to social protection for children. However, there were 49 programmes which were described as ‘general social welfare’ and these included children as potential beneficiaries for a range of benefits such as nutrition, emergency assistance and healthcare. Hence, child social protection at community level comprises a mix of child specific programmes and programmes which include children as beneficiaries, but which are nor exclusively targeting children.



Table 1: Distribution and description of child-orientated social protection schemes

Target	Social Protection Program	Sub-Categories	States/Regions	Benefits (Type) per Beneficiaries	Eligibility Criteria	Types of Donor
CHILDREN	Education (18)	Access to Education (Primary& Secondary)	Kachin, Kayah, Kayin, Mon, Rakhine, Magway, Ayeyarwaddy, Mandalay	Cash (MMK)	Reported poor school aged children of the community	Village/ NGOs/ Individuals
	Health (4)	Access to free Vaccination/ health care	Magway, Ayeyarwaddy, Kayin	Labor Support+ Cash (MMK)	Reported poor children who needs health care/ vaccination	Government/ NGOs/ Village
WOMEN	Maternal Health (1)	Financial Support on Childbirth	Kayah	Labor Support+ Cash (MMK)	All reported poor pregnant women of the community	Village

When comparing child-orientated schemes to other beneficiary schemes, the typical number of beneficiaries, average fund size and average value of benefits were all higher for child-orientated schemes than for other beneficiaries, and were more likely to be funded by village donations. When considering the likely coverage of community based schemes, we can estimate that 3.5% of all children would receive benefits from a community based scheme, or around 6% of all households with children. Survey data from Myanmar indicates that 30% of households with children report unmet needs for health, education or social welfare for children in the household suggesting that community based schemes address around 20% of the need at community level. However, as indicated before, many non-specific schemes also include children as potential beneficiaries, and so the likely coverage may be higher.



Table 2: Comparison of child-orientated and other social protection schemes

Beneficiary	Villages with programmes	Average beneficiary number per scheme	Average beneficiary number per scheme per 100 households)	Average fund size	Average value of benefit	Typical donor profile
Children	16	17	14.5	K631,614 (US\$ 732.5)	K56,486 (US\$65.5)	Village donation
Other	35	10	8.5	K543,899 (US\$ 631	K49,347 (US\$57.2)	Village donation, private donors, village youth funds

Table 3: Summary of types of support for child-orientated social protection schemes

Scheme	Type of support
Education	Stationary support (6), School building renovation (4) Student awards (3) Support for teachers costs (2) Out-of-school study (2) Early child education (1)
Health	Nutrition (1) vaccination & child health (3)

When considering the role of community schemes in the wider provision of essential education, health and social services for children, expenditure through community based schemes may in fact exceed central government spending, particularly in social welfare and social protection.



## **Policy Implications:**

*Community based social protection schemes are already playing a major role in overall social welfare & social protection services*

The presence of community based social protection schemes in all the villages sampled confirms earlier reports of the near ubiquitous nature of community led mechanisms in Myanmar. Furthermore, the scale of delivery of benefits through community led systems confirms the significant role played by community systems in overall social protection. If these findings are representative of provision of community based social protection related services in Myanmar, the projected value of annual expenditure by community based schemes is US\$211 million, approximately 0.31% of annual GDP. When compared with combined government spending on health, education and social welfare combined (2.24%), community based schemes spend approximately one dollar for every eight dollars spent by government. When this is narrowed to social welfare related benefits only, community based schemes spend three dollars on social welfare for every dollar spent by central government, where social welfare spending represents 0.02% of GDP. Where the social protection system in Myanmar is still in the early stages of development, the role of community based systems, many pre-dating the more formal, government led systems, needs to be formally acknowledged, and consideration needs to be given as to how to better integrated community based systems in wider social protection. Child related issues represent a significant financial challenge to households. Out-of-pocket spending for education is conservatively estimated at 30% of overall expenditure, with school fees amounting to up to 6% of annual household income<sup>21</sup>. A study of causes of dropouts in rural communities revealed that 53% of families of children who had discontinued school cited poverty as the main reason. This relates not only to inability to pay school fees, but also the pressure on children to work to supplement the household income. This will be explored below.

A recent review of healthcare financing in Myanmar found that out-of-pocket expenditure on health accounts for 87% of overall expenditure<sup>22</sup>, with 28.6% of households experiencing catastrophic health payments (often resulting in unsustainable debt). Healthcare costs amounted to 40% of non-food expenditure. A survey of 6,000 rural households in the Dry Zone found that healthcare accounted for 14% of ALL household expenditure<sup>23</sup>, and that high proportions of healthcare expenditure were associated with high levels of 'high-risk' debt<sup>24</sup>. The 2010 Integrated Household Living Conditions Analysis estimated average healthcare spending per household at around \$32 per year, with expenditure in urban areas nearly twice that of rural areas<sup>25</sup>.

*Community based social protection systems demonstrate a high level of contextual appropriateness*

Community based systems demonstrate a wide range of approaches to child social protection issues, covering nutrition, education, social development and healthcare needs. Most appear to have developed based either on community need, or in some cases, the availability of a donor willing to support a certain activity. However, careful study of reported needs of families with children indicate that the main priorities for children are education, health and nutrition<sup>26</sup>. A public opinion survey conducted in 2012 to determine public priorities for government spending on social welfare issues identified children's education as the number one priority overall, and education and health were the two main priorities for child-orientated social welfare spending<sup>27</sup>. Hence, it is encouraging to observe that community based systems are working to address needs which are given high priority by the public, suggesting that most schemes do in fact emerge as a response to felt and articulated needs by communities. This further



reinforces findings from other studies that community based systems offer a significant advantage to centrally administered schemes by their ability to adapt to local needs and preferences.

*The majority of community based programmes had inclusive criteria*

Despite concerns that community based schemes would operate on an exclusive basis, with restrictive eligibility criteria, the majority of schemes studied demonstrated broadly inclusive criteria, including anyone resident in the village who had a reported need which was covered by the scheme. Only a small percentage (11%) limited provision to those who were 'native' to that village, and only 1% of schemes required membership of a village association to be eligible. However, this data was based on reported eligibility criteria, and there was no data on whether these criteria were applied in an equitable and non-discriminatory way.

*Community based schemes have limited effectiveness due to small operating capital*

When compared with reported need, and the usual amounts of reported needs, community based systems appear at best to be able to address the needs of between 20 and 30% of those who have need, and the size of benefit in many cases is insufficient for need. For example, the typical cost of education per year is 65,000 kyat (depending on grade) and yet the typical benefit for education from the schemes studied was 56,000 kyat. Healthcare costs vary more significantly, and so are more difficult to estimate. However, when estimating the size of capital and operating expenditures, coverage and effective coverage appear to be significantly limited by the lack of funding. Programmes were typically funded by one main source. Government funding was identified in only one of the 139 schemes.

*Limited evidence exists for the benefits of up scaling programmes*

One community scheme reported having assistance from an NGO, which included training, a seed fund and additional support to develop eligibility criteria, and this village reported an increase in both the number of beneficiaries and the value of the benefits provided. However, data on outcomes was not available. The village reported that the additional support had enabled their programme to be more effective.

*What are the weaknesses and limitations of community based systems in overall social protection for children?*

When considering the overall scope of social protection for children, elements of human rights (child rights) child development and specific child welfare and benefits all form a matrix of social protection components. When evaluating the community led programmes, few if any make explicit reference to child rights, or indeed any statutory right. Likewise, most schemes are designed to address very specific needs (such as nutrition, need for school fees etc.) rather than as a mechanisms for wider child development. Thus, schemes can best be described as non-formal social welfare or social assistance, some directed towards child development, but without any clear framework. Likewise, few schemes made any reference to other schemes (such as government health or education assistance schemes) , but rather tended to operate independently. There was no evidence of formal evaluation or monitoring of schemes for appropriateness or effectiveness, although informal discussions took place from time to time. Thus, the role of community based systems is limited in its current form by a lack of orientation towards child rights, a lack of correlation with a more comprehensive framework for child development and a lack of



co-ordination or integration with other child-orientated social services. Thus, although community based systems can effectively and efficiently provide a number of services, more complex, demanding and sensitive issues such as child abuse, child trafficking and child labour may not be addressed through these systems. A lack of accountability could also lead to inequalities, lack of efficiency and inappropriate services, although the current data does not indicate that this is widespread. Another major weakness identified was a lack of understanding of issues relating to disability, and specifically children with disabilities. Whilst most communities would be expected to have at least one school aged child with a disability, none of the villages mentioned specific interventions for child-related disability, and only one programme mentioned any activities relating to disability, and that was a welfare, rather than rehabilitation or development orientated scheme.

*What is the potential role of community based systems in overall social protection for children?*

Based on the above analysis, we can see on one hand that the strengths of community based systems lie in their contextual relevance, self-sustainability and efficiency. The role of community based systems, therefore, is determined by three things:

*The existence and role of other (non-community) systems*

*Political will to invest in up-scaling of community systems*

*Ability of community systems to adapt and broaden their scope and approach*

Where there is a well-developed central or regional social protection system, the community role may be determined in a complementary way, either providing services on behalf of a central programme, providing services jointly or receiving assistance to implement services locally. However, in each case, the existence and relative efficiency of other systems will have an impact on the role of community based systems. Furthermore, accepting the above limitations on community systems, a second factor determining the role of community systems is the degree to which a central authority (typically a central or regional government) is willing to delegate authority, provide training and upscale capacity, and then the extent to which the community itself is willing and able to work within a different operational paradigm. Where a community does take on an expanded role, issues of equity, efficiency, data management, reporting and accountability would all need to be addressed, as well as the community's ability to work within a more rights-based, statutory framework.

*How can community based systems be strengthened to play a stronger role?*

In order to enable communities to play a stronger role in social protection for children, the limitations of community based systems would need to be addressed. As indicated above, this would include embarking on awareness raising and capacity build to orientate communities to a more rights-based approach, as well as building stronger links with existing social welfare and social protection services outside the community (e.g. local child rights committee, local disability resource centres). Additionally, capacity building would be needed to address issues of equity, efficiency and accountability. Depending on the level of assistance and delegated authority by central or regional government, community schemes would also need to be assisted with reporting and providing accounts of activity and expenditure. Community schemes would also need some form of output and outcome monitoring to provide information on effectiveness and efficiency. Finally, depending on the degree of proposed responsibility, community



schemes would need to have access to increased funding, either as initial capital or additional operating funds. A proposed mechanism for scaling up of community based systems is described below, under ‘Policy Recommendations’, detailing the principles of the ‘Community Led Action for Social Protection (CLASP)’ approach.

#### *Limitations of this study*

Although providing representation of eight of the 14 States and Regions in Myanmar, and capturing different areas (coastal, central, hilly and delta) the sample size was still relatively small, and predominantly rural, thus not fully reflecting the Myanmar situation, which is 30% urban or peri-urban. The existence of community based social protection mechanisms in urban areas is known, but has not been extensively studied, and this study draws on predominantly rural data. Hence, the findings cannot be considered to be truly representative of Myanmar, and indeed, question remain as to the existence, nature and effectiveness of community based systems in urban areas. The incomplete data from 11 of 50 samples further weakened the study, and although the remaining data was robust, sampling errors due to incomplete data cannot be fully excluded. This study also did not include any indicators of relative coverage, effectiveness or impact of community systems, and so only the form, activities and operating budget of schemes can be reported. Likewise this study did not include any confidential reporting on actual delivery, so we rely on the community respondent to accurately report what was delivered to beneficiaries, without any corroborating evidence from beneficiaries that this is what they actually received.



## Policy recommendations:

*Further study into the outputs and impact of community based systems can determine effectiveness and efficiency*

Following the limitations of this study, it is clear that further study, in particular evaluating the outputs and impacts of community based systems, would provide more robust evidence as to the efficacy of community systems. Such a study could either be done as a longitudinal 'Action Research' type study, or a comparative study of social protection indicators in villages where community based systems were and were not in place. However, given the near ubiquitous presence of community based systems, a genuine case-control study would be difficult.

*Pilot programmes to assess the requirements and potential benefits of up scaling of community based programmes should be undertaken*

Pilot programmes can be established to assess the needs, approaches and likely impacts of scaled-up community systems. One such scale-up approach is the Community Led Action for Social Protection (CLASP) approach, which aims to increase awareness of the community of wider, rights based and statutory social protection, to increase the responsiveness of local government and CSO to provide support for social protection of communities and to increase the ability of the community itself to address social protection issues in a more comprehensive, effective, efficient and transparent way.

*Figure 4: schematic representation of CLASP approach*



The model starts with a visit to each village/ward to explain the project activities, and form a responsible village committee (or delegate responsibility to an existing village development committee if appropriate). The project will then collaborate with the village to establish a 'community learning centre' which will act as a hub for information, co-ordination, meetings, self-help groups and training for social protection issues. This will build, where possible, on existing structures and systems where these are amenable to such an approach. Through an iterative process, research will be conducted into existing social protection systems, and initial capacity building will be done at community level to facilitate the first stage of development of community social protection plans. Community plans may draw on a decision matrix (see table 5) which describes different approaches to social protection. Community plans would not be limited to the matrix choices, but available budgetary support would be limited for each community. Hence, for example, a community may choose to invest the majority of funds into a health insurance scheme, or, conversely, spend those funds on educational assistance, establishment of a rice bank, mass immunization of children, etc. The plans would be developed in collaboration with the consortium, and each plan would be approved for a 2 year trial, with close review at the community learning centre. In parallel to the capacity building at community level, capacity building of CBOs, NGOs, INGOs and local government staff who are in a position (in terms of proximity, capacity and mandate) to provide support to the community social protection plans. For example, if a community decided to focus on formation of non-formal education as part of their plan, an NGO or INGO would then be called upon to provide the training. Likewise, if referral for assistance for children with disabilities was required by the community plan, local providers would need to be given capacity building to respond to this. Selected organizations would be given a general training on social protection as well as targeted training relevant to their area of input. In the same manner, local government staff whose role and mandate would also be relevant to social protection would also be given capacity building. This would include educational, administrative, health, social welfare and judiciary staff. In terms of the community-led social protection planning, the process will initially identify (through research) existing systems and strengths, and then, in discussion with the project staff, the committee will draw up a social protection plan to pilot. Funding for the pilot will be allocated from the project, with a maximum value of US\$2,500 per village, adjustable according to population. Although not restricted to these categories, villages may develop plans according to a 'basket' of policy options, as listed below:



Table 5: 'basket' of options for community led child orientated social protection

<b>Children</b>	<b>Conditional Cash Transfer</b>	<b>Systems strengthening</b>	<b>Capacity &amp; awareness</b>
Health	Free basic healthcare	Specific disease screen & treat	Early childhood development training
Education	Abolition of all user fees	After-school programmes	Teacher education enhancement
Social protection	Nutrition support	Reporting of child abuse & child labour	Family based training to prevent child abuse
Economic/livelihoods	CCT for children attending school (reduce child labour)	Family support to reduce child labour	
Legal	-	Community mechanism	Training on child labour & anti-trafficking
<b>Children with disabilities</b>	CCT	Systems	Capacity & awareness
Health	Cash transfer for general health	Access to rehab	Health professional & PHC training
Education	Additional grants for education access	School modification	Teacher & community training
Social protection	Income protection	SHG	SHG & CBR group training

These options could be included in a way which builds on existing systems and incorporates new elements, as well as linking to assistance provided by NGOs and CBOs. Likewise, some aspects would require greater collaboration with local government. The village plan would be funded from the grant, in co-operation with the project staff, and staff would then support the village to enact the plan through monthly meetings at the community learning centre. Lessons learned would need to be collated, centralized and analysed to effectively inform broader policy development.

*Community based systems need to be designed to have stronger links with existing programmes, and to work in a complementary way*

Following the above proposal, stronger emphasis needs to be placed on determining the role of community based systems, and how those will complement existing services. This requires a planning process where communities are fully included, and a willingness of central and regional authorities to delegate powers, provide funding and technical support to communities to ensure that communities have sufficient resources to undertake delegated roles. This could entail the establishment of regional and local social protection committees, where communities are represented. The process of integration of community based systems can further be strengthened by regional (sometimes referred to as territorial planning) planning for social protection, which allows regional governments (as opposed to central



governments) to identify locally relevant priorities and to draw more on local resources, approaches and innovations to address issues in a more contextually appropriate and relevant manner. Regional planning can more effectively define and clarify the role of community based systems.

*An evidence based approach is need to assist planning process*

Frequently, planning is based on political priorities rather than actual needs. Where community group have the access to, and frequently the mechanisms to collect localized data, the potential for using and evidence based approach to planning of community based social protection is significant. Key to this process is a way to collect data in a uniform way to allow for analysis, and the ability to use evidence to set policy priorities in a way which is transparent and which allows for participation by communities in decision making



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