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Edited by Helder Ferreira do Vale



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Meet the editor



Helder Ferreira do Vale is a Professor of International Relations at the Federal University of Bahia in Brazil. His research and teaching cover territorial politics, international relations, and comparative politics. He has published extensively in social and political science journals. Dr. do Vale was honored with the Stein Rokkan Award from the International Political Science Association. National authorities, including the Spanish Ministry of Education, the European Commission, and the German National Research Foundation, have funded his research. He has held academic positions at various institutions, including XianJiotong-Liverpool University in China, Hankuk University in South Korea, the University of Barcelona in Spain, the University of Lisbon in Portugal, the Center for Advanced Studies Hanse-Wissenschaftskolleg in Germany, the Center for Political and Constitutional Studies in Spain, the University of Cape Town in South Africa, and Aalborg University in Denmark. Dr. do Vale holds a Ph.D. from the European University Institute in Italy and an M. A. in International Relations from Johns Hopkins University (USA).

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Preface

Social welfare policies, services, and institutions have been established for various reasons. Most social welfare resources have been utilized to support marginalized members of society. In addition to addressing and preventing social problems such as poverty and exclusion, social welfare institutions can serve as a tool for distributing services and resources. This edited book aims to stimulate critical debates on the provisions and impacts of social welfare in different sectors and groups.

Nowadays, social welfare is associated with a wide variety of areas that extend beyond the social sphere, and it is a crucial component of a society's economic and political changes. Economically, the scope and quality of social welfare influence economic efficiency, worker productivity, and government spending. Politically, the extent and availability of social benefits have influenced election results, the agendas of political parties, and the sustainability of various political regime types. In concrete terms, the provision of social services has been necessary for the maintenance of political regimes (e.g., dictators' carrot and stick strategy), the consolidation of elite groups in positions of power (e.g., state capture), the adoption of transformative economic policies of once poor economies (e.g., Southeast Asian developmental states), and the restructuring and organization of capital (e.g., liberalism).

The book contains chapters that examine programmatic, structural, and systemic aspects of social welfare provision. The book focuses on innovative global and local social welfare policies, exploring the following themes: inputs, outputs, and outcomes of policies, social and economic exclusions, welfare reforms, and perceptions of welfare services. Most chapters concentrate their investigation on specific social welfare programs and their impact on a particular group of beneficiaries.

Assuming that social welfare policies, services, and institutions are configured differently according to specific sectors and national settings, the book presents a wide range of analyses focused on policy and program developments in and across countries as well as on single or multiple policy areas. Additionally, the book features chapters on the historical development of social welfare systems, policies, and programs. Not limited to qualitative assessments, quantitative analyses are also used in the book.

Aiming to examine the complex challenges confronting welfare systems worldwide, the book addresses the following question: How has social assistance evolved over the last several decades? What are the patterns in the evolution of social welfare services? What are the most current social welfare innovations, and how do they affect service delivery? Which social welfare policies and services have helped to reduce social problems? What factors influence the quality of social welfare services?

This book is divided into two sections. Section I, "New Policies and Trajectories of Welfare Development", introduces the readers to innovative welfare policies and

examines macro-level processes in countries that expanded their welfare systems. Section II, “New Methods and Approaches to Social Welfare”, includes chapters that present tools and perspectives for addressing social welfare issues and services.

In Section I, Chapter 1, “Age Management for Healthy and Active Aging: Analysis of the Impact on Employment Status and Household Composition in the Czech Republic and Selected Eurozone Countries”, identifies and explains the indicators of age management (e.g., limitation on long-term activity, personal perceptions of health, temporary employment) that affect the work status and household composition in selected eurozone countries, namely, the Czech Republic, Finland, Germany, and the Netherlands. In this chapter, the author explains how the workability of individuals changes over their lifetime and draws meaningful conclusions based on correlations established between labor status and household composition, as well as employment by type of business enterprise (e.g., collective agreement, number of employees).

The following two chapters discuss recent developments in welfare systems from a macro perspective in Brazil and South Africa. In Chapter 2, “Activating the State for Social Assistance Provision: Constitutional Catching-Up in Brazil’s Family Allowance Program”, Ferreira do Vale traces the expansion of Brazil’s welfare system via conditional cash transfer programs. These programs are described as the consequence of a “constitutional catching-up” process, in which lawmakers and high court justices broaden social rights and enhance the benefits of social assistance programs. This constitutional and rights-based perspective enriches our understanding of the expansion of welfare systems that occurs with the establishment of a democratic legal framework. Chapter 3, “Perspective Chapter: Ethics of Social Welfare in Modern Democracies – A South African Perspective”, authored by Khali Mofuoa, posits that South Africa represents a distinctive case for the ethical foundation of social welfare development. This chapter exemplifies through the South African case that social welfare in a just and democratic society is framed within the ethical context of rights and responsibilities.

Section II begins with Chapter 4, entitled “The Child Welfare Service’s Ignorance: The Use of Attachment Theory in Norwegian Child Welfare”. The authors of this chapter, Hilde Anette Aamodt and Nicole Hennum, demonstrate that Attachment Theory lacks specific guidelines for practical implementation, leading to biased decisions regarding the welfare of children. This is illustrated by the actions of the Norwegian Child Welfare Services concerning a mother who lost custody of her daughter when the child was eight months old. In the following chapter, Chapter 5, “Perspective Chapter: Bridging the Gap – Health Communication and Cervical Cancer Awareness in Low-Income Communities”, Maphuthi Elizabeth Choung examines communication tactics that are effective in preventing cervical cancer. She suggests that for an effective prevention of the illness in the context of poverty and illiteracy, it is necessary culturally appropriate communication and community-based interventions.

Chapter 6 of the book, “Refugee Welfare in Kenya: Challenges and Solutions”, written by Abulogn Ojulu Okello, identifies the persisting needs of refugees that the international donor community and recipient countries do not easily cover. Highlighting the main challenges of refugee settlements in Kenya, the chapter enhances our knowledge about the vulnerabilities and needs of the refugee populations. Based on interviews with refugees in camps in Kakuma, Kalobeyei, Nairobi, and Dadaab, the author shows

the welfare needs of refugees. In the last chapter, Chapter 7, “Perspective Chapter: Post Modern Case Management – Towards Compassionate, Person-Centred Community Aged Care in Australia”, Michelle Manning Hutson critically assesses changing patterns of service delivery, showcasing the improvement of Australian age care services. The chapter emphasizes the “case management perspective”, which is based on the integration of clinical and non-clinical care applied to individualized cases, as an efficient and cost-effective approach to service delivery that improves the quality and satisfaction of aged care services.

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Section 1

New Policies and Trajectories of Welfare Development

Age Management for Healthy and Active Aging: Analysis of the Impact on Employment Status and Household Composition in the Czech Republic and Selected Eurozone Countries

Emilie Jasova

Abstract

The book chapter applies the concept of age management to promote active and healthy ageing of the population in the Czech Republic and in selected Eurozone countries, especially with regard to the resilience of the pension system. Ageing should be understood as a lifelong process. In addition to activities to prevent age discrimination, the employment of older people should also be promoted, for example, by developing a corporate culture that is friendly to all age groups, raising awareness of the principles of age management among employers, and increasing interest in implementing it in practice. The principles of age management are represented by the concept of work ability. International and domestic research has located the impact of age management measures on published labour market indicators and family by labour market status and composition. Regression analysis was applied to confirm these conclusions using data from the Czech Republic and the Eurozone. In the area of labour status and household composition, for example, the analysis confirms an above-average, statistically significant, undesirable effect of the indicator % of enterprises with a collective agreement between social partners out of all enterprises with 250 or more employees.

Keywords: population ageing, age management, work ability, households by labour market position and composition, pension system, Eurozone

1. Introduction

According to the Action Plan for the Implementation of the Strategic Framework for Preparing for an Ageing Society 2023–2025 of the Ministry of Labour and Social Affairs [1], ageing is a society-wide phenomenon that requires a change in the understanding of who is a senior. Ideas about ageing and people of a certain age are

often outdated and do not respect the fact that today's senior men and senior women represent a very heterogeneous group of more than 2 million people in the Czech Republic, and this diversity will become even stronger in the future.

Old age is the result of a lifelong ageing process. At each stage of life, more attention needs to be paid to relationships, to supporting the ability to work, but also to accepting illness, finitude and mortality as a specific dimension of a meaningful life. Therefore, it is necessary to create conditions for personal activity in old age, civic engagement and volunteering towards the senior population, but also for the seniors themselves or for the development of quality interpersonal and family relationships in general.

The Action Plan reflects the priorities of the Government in the Programme Statement of the Government of the Czech Republic after the revision 03/2023 [2]. These include the promotion of flexible working hours, the implementation of pension reform, the promotion of quality affordable social care and social services, the adjustment of the legislative framework for lifelong learning and the promotion of housing for seniors. As the predominant income of seniors is the old age pension, comprehensive pension reform is a prerequisite for the fulfilment of financial security in old age. This will make it possible to diversify the risks of public and private systems in order to ensure the long-term financial sustainability of pension systems and the adequacy of benefits for current and future seniors.

The current Action Plan views ageing policy as a cross-cutting policy with a strong need for interdisciplinarity, interdisciplinary and inter-departmental cooperation. It is closely intertwined with labour market policy, public health policy, social policy and specifically family policy. The framework and conditions for ageing policy are provided by the state, in cooperation with other actors (regions and municipalities, employers, the non-profit sector and academia). In view of demographic developments, employers should ensure that age management principles are applied to company culture and to personal processes that support employees' ability to work and intergenerational cooperation.

The Action Plan is based on five value bases (pillars): Pillar 1 is participation (e.g., active citizenship; social inclusion; labour market); Pillar 2 covers health and care (e.g., prevention; work longevity/age management); Pillar 3 promotes safety (e.g., economic stability-decent pensions; housing); Pillar 4 represents resilience/resistance (e.g., ecological crisis; energy crisis; lifelong learning); Pillar 5 covers development (e.g., digitalisation; design of things and services in an age-friendly way (innovation); age management).

The main and strategic objectives of the Action Plan include, for example, promoting employment and adaptability in the labour market. Specifically, within the framework of the Application of Active Employment Policy (AEP) instruments and other measures for the sustainability of employment of older persons, for example, about supporting retraining of seniors and lifelong learning for persons 50+, supporting activities to prevent age discrimination in the labour market. In the framework of developing an age-friendly corporate culture, for example, about increasing awareness of the principle of age management among employers, about supporting the implementation of age management in practice, and taking into account the latest age management trends in work processes and the labour market.

One way of applying age management principles is through the concept of work ability [3].

In this research, we therefore look at age management through two approaches, namely:

1. Age management within companies in the Czech Republic (hereinafter age management at employers), is a pilot verification of the tool—the Finnish model, including recommendations for creating an age-friendly corporate environment;
2. Age management to promote healthy and active ageing, is the use of age management by employers to promote healthy and active ageing in society.

These two approaches are expressed by the main objectives, which take into account the different floors of the House of Work Ability of the above authors. These are mutually intertwined. Age management within companies (4th floor—leadership style, workplace and working conditions) influences through employees their active and healthy ageing (not only) in their working life, which is the content of the 1st–3rd floors (1st floor—health and functional capacity; 2nd floor—competences; 3rd floor—values, attitudes and motivations). Thus, all the floors are interconnected. Our proposed research approach starts on the 4th floor of the Work Capability House because the actions taken here have an impact on all floors below, that is, floors 1–3.

The aim of this research in the theoretical part is first to map the principle of age management through the concept of work ability abroad and in the Czech Republic (Section 2). Next, in this section, we will map the issue of age management and its measures arising from domestic and foreign strategic materials. We will then examine the theoretical and empirical results of international and domestic research on the impact of age management measures on published indicators of the family by labour market status and its composition (Section 3). We then specify the data and methods of analysis used (Section 4). We then apply regression analysis to data from the Czech Republic and selected Eurozone countries and present the results of the impact of age management measures on family data (Section 5). Finally, we will compare the findings with those of international and domestic research (Section 6).

2. Principles of age management and the importance of healthy and active ageing as a prerequisite for a stable pension system

2.1 Age management through the concept of work ability abroad and in the Czech Republic

According to Gould et al. [3], problems with labour availability and social security funding will increase the importance of work ability. Promoting the working ability of the working-age population allows people to maintain health and functional capacity longer into retirement. Work ability is related to the individual, the workplace, the immediate social environment or society. Multidimensional and integrated models include, in addition to traditional factors, the work community, management and the micro and macro environment outside of working life. The basis of the Balance Model [4] is the search for a balance between people and working life. Criteria for finding it are, for example, maintaining health, work ability and well-being at work and coping with work. Tension can be positive (maintaining and developing a person's resources) or negative (reducing ability and well-being). The essence of the Multidimensional Model of Work Ability (coping with work, control over one's work and participation in the work community) is the individual's prerequisites for coping with work life and for realising work ability [5]. The model depicts work capability holistically. The three dimensions of work ability interact continuously.

The multidimensional model of work ability (individual resources, work, family, close community and society) was developed by the Finnish Institute of Occupational Health in Helsinki based on studies and development projects conducted in the 1990s in industries and among different age groups. The work ability dimension is displayed by the house of work ability, its floors and the surrounding environment [6, 7]. An individual's resources make up the first three floors and consist of health and functional capacity, expertise and values, attitudes and motivation. The fourth floor is occupational and consists of the work environment, job content and demands, work community, work organisation and management. Close to home are areas that support work life (e.g., safety), family and close community (relatives, friends and acquaintances). The most distant area, but also very important, is society, infrastructure, social and health policy, employment policy and the resulting impact on working life extension.

The first floor of the house of work capacity is human resources (physical health, mental health and functional capacity). The second floor of the house is based on knowledge and skills that are continuously updated (e.g., through lifelong learning). The third floor represents the intrinsic values and attitudes of people, including motivation in work and personal life. The fourth floor of work sets the standards for the other floors. If an individual's resources are in balance with it, work ability remains at a good and/or excellent level. If the employee's resources are not in balance with the demands of the work, work ability will deteriorate. Managers play a key role in maintaining the balance by having the authority to organise the fourth floor according to the requirements of the employees.

Maintaining a balance between the demands of the job and the employee's individual resources, which change as he or she ages, is essential to maintaining work ability. The need for health and work ability support services increases as the population ages. In addition to supportive work organisations, the family and the individual's immediate environment can also support work ability. Reconciling family and work life is essential for work ability. Labour, health and education policies create the conditions for work ability and other challenges (e.g., the requirement for higher employment rates).

Cimbálníková et al. [8] state that examples of good practice in large companies, especially those with an international background, provide hope for the use of the age management concept, the work ability concept and the self-assessment questionnaire Work ability index (WAI) in the Czech Republic. It is necessary to extend the theory of age management and the concept of work ability to different work environments and departments (e.g., health care, social work, education) and to support research on their effective use. Cooperation between different departments and institutions in the care of older workers and the unemployed (not only) is essential. Legislation, employment policy and pension reform in Finland can serve as an example for the Czech Republic. Many companies are already applying some age management principles, albeit rather subconsciously and intuitively.

According to Charles University [9], the issue of age management is not systematically addressed in the Czech Republic, even though extending the working career of workers and motivating them to postpone retirement is one of the strategic objectives of the National Action Plan to Promote Positive Ageing for the period 2013 to 2017. This document highlights the concept of age management in the workplace and its use as part of human resource management and corporate social responsibility. Age management is still a relatively new concept in the Czech Republic. Partial age

management measures (education or health promotion) have been introduced in workplaces in the Czech Republic. Supporting employees' working ability should include measures to support all factors of working ability.

Husaříková et al. [10] state that during the ageing process, the employee's job performance changes and the demands of the job change. If each stage of life is not taken into account, it can lead to a deterioration in job performance, difficulty in finding a new job and/or loss of the current job. Good health, appropriate competencies, motivation and a suitable workplace and working environment are needed to maintain a suitable level of work ability. A tool for identifying and assessing work ability is the WAI. The basis of the method is a self-assessment questionnaire translated into more than 30 languages. The approach includes medical, sociological and demographic perspectives. This multidisciplinary method has already been tested and scientifically investigated many times, for example in the Netherlands, Finland, Austria and Germany. The results of the WAI measurements are the basis for the Slovak "National Programme of Active Ageing for 2021-2030." Ageing policies have also been formulated in Hungary using WAI measurements. In the Czech Republic, no large-scale surveys have been carried out yet, only partial measurements have been made in several sectors and organisations of the national economy.

Dobeš et al. [11] state that the COVID-19 pandemic has begun to change existing economic and social processes. Deglobalization processes can also have a serious impact on the labour market. Intense competition between groups in the labour market can lead to labour market disparities. The position of disadvantaged groups can be supported by effective employment policy instruments. The House Principles of Work Ability represent a comprehensive, dynamic concept that shows companies/organisations ways to promote longer and better-quality working lives. Better work capability and support in the workplace increase productivity. A current trend in European countries is also to improve employee well-being. The concept of work capability (appreciation, trust, fair treatment and support) also provides indicators for better workplace well-being. The main areas for promoting work capability are, for example, health for individuals (prevention and treatment), and occupational health and safety for organisations.

Dobeš et al. [12] state that age management will provide organisations with goal-oriented strategies and appropriate employee-focused measures. Work should not hurt, it should be doable, bearable and encourage learning. People contribute health, competence and motivation to cope with the demands of work. The employer creates the conditions for work performance. When the balance between job demands and individual abilities is not established, work ability is average or low. Risks for ageing workers include, for example, shift work, long working hours, low autonomy, risk of accidents. Ageing workers should have the opportunity for training, further education, working time arrangements.

According to Dobeš et al. [13], proactive approaches are more successful than individual solutions. Lifelong learning opens up opportunities for new career paths suitable for ageing. Long-term imbalances between human resources and work demands can cause an increase in absenteeism, sickness absence and a decline in work quality and productivity. Measures to regulate working conditions need to be taken in cooperation between workers and managers. Concrete examples of company support may include healthy meals, health benefits, smoking bans, updating training programmes, regular staff appraisals, company nurseries, ergonomics at work.

2.2 Issues and actions arising from domestic and international strategic materials for age management policy

2.2.1 Age management in employers (main objective 1)

2.2.1.1 Relationship to conceptual and strategic documents CR

The National Action Plan to Promote Positive Ageing for the period 2013 to 2017 [14] states, for example, that in order to increase economic competitiveness, the Czech Republic must be friendly to employees of different ages. The main challenges are changing attitudes towards ageing, linking age management measures with pension reform. An important document in the field of comprehensive age management (main objectives No. 1 and No. 2) is the Strategic Framework of Employment Policy until 2030 [15], which presents measures to support employers (especially small and medium-sized ones) in setting up internal personal processes to increase the integration of age management and to maximise the use of the workforce at all life stages. It proposes the measure Modernisation of Active policy of employment tools to increase the adaptation of employers and the workforce to technological change and demographic ageing (support for lifelong learning, an adaptation of older people, intergenerational exchanges). Another document of comprehensive age management is the Family Policy Strategy 2024–2030 [16], which, for example, talks about the promotion of age management and diversity of work teams at employers through subsidy support.

2.2.1.2 Links to other domestic and foreign documents

The research also takes into account international and EU documents that deal directly or indirectly with age management. (1) Recommendations for EU-wide ESF strategies: Career Management and Age Management [17]; (2) Europe Strategy 2020: A strategy for smart, sustainable and inclusive growth [18]; (3) Action Plan for a European Pillar of Social Rights [19]; (4) Past, present and future of work ability [20]; (5) Age-Related Changes of the Work Ability Construct and its Relation to Cognitive Function in the Older Worker: A 16-Year Follow-up Study [21]; (6) The effect of re-employment on perceived health [22]; (7) Retirement on Grounds of Ill Health [23]; (8) Ageing, work, life-style and work ability among Finnish municipal workers in 1981–1992 [24]; (9) Age management: how to understand and respond to ageing [25]; (10) Ageing is unavoidable [26].

2.2.2 Age management to promote healthy and active ageing (main objective 2)

2.2.2.1 Linking age management, healthy and active ageing to the documents of the Czech Republic

The National Action Plan on Promoting Positive Ageing for the period 2013–2017 in the context of healthy and active ageing points out that to effectively use the potential of the growing number of seniors, the focus should be on health and lifelong learning. There is a growing need to extend the working lives of older people. Volunteering is an alternative opportunity for active involvement in society after leaving the labour market. The Strategic Framework for Employment Policy 2030 proposes support for lifelong learning, adaptation of older people,

intergenerational exchange and the concept of age management. It also emphasises the need to reflect labour market requirements and to motivate employees to prolong their active working lives in retirement. The Family Policy Strategy 2024–2030 promotes the growth of flexible forms of work and working from home; and the expansion of homeworking and teleworking. It also promotes the creation of family-friendly and elderly-friendly public spaces; strengthening intergenerational cooperation and participation of seniors in society; and preventing social isolation of caring families and seniors.

The Strategic Framework for the Preparation for an Ageing Society 2021–2025—STRAPS [27] cover only the area of age management to promote healthy and active ageing (Key Objective 2). Under Lifelong learning, labour market and active ageing, supports the introduction and development of flexible forms of work. The impact of demographic change is addressed in the sections on More accessible and quality social and health services; More accessible and barrier-free housing for the elderly; Supporting families and interpersonal relationships. Healthy and active ageing is specifically covered by the STRAPS headline objectives Lifelong learning, labour market and active ageing; Barrier-free public space; Family support and interpersonal relationships. The Action Plan for the implementation of the Strategic Framework for Preparing for an Ageing Society 2023–2025, approved in 2023, proposes, for example, to raise awareness of age management principles; to take into account the latest trends in work processes; to promote active policies in practice (it is also not a comprehensive view of age management). To limit the negative effects of demographic change, it proposes, for example, promoting access to social and health services. To promote healthy and active ageing, it proposes, for example, promoting volunteering and providing an institutional framework.

2.2.2.2 Links to other foreign documents

The research takes into account international and European Union (EU) documents that deal directly or indirectly with preparing for ageing and its impact on working life. (1) The United Nations Plan of Action on Ageing and Health—the so-called “Ageing and Health Action Plan” [28]. (2) The Future of Social Protection and of the Welfare State in the EU [29]; (3) European Innovation Partnership on Active and Healthy Ageing—EIP for the AHA [30]; (4) European Commission Report on the Impact of Demographic Change [31]; (5) Council Conclusions on Ageing Mainstreaming—6976/21 [32]; (6) Green Paper on Ageing: Promoting Intergenerational Solidarity and Responsibility [33]; (7) Council Conclusions on Demographic Challenges—The Way Forward [34]; (8) The Future of Social Protection and the Welfare State [29].

2.2.2.3 Follow-up to other domestic documents

The research builds on these already approved national conceptual and strategic documents: (1) Strategic Framework Czech Republic 2030 [35]; (2) Strategic Framework Health 2030 [36]; (3) National Strategy for the Development of Social Services for the Period 2016–2025 [37]; (4) Housing Concept of the Czech Republic 2021+ [38]; (5) Concept of Social Housing of the Czech Republic 2015–2025 [39]; (6) Strategy of Gender Equality for 2021–2030 [40]; (7) Action Plan for the Prevention of Domestic and Gender-Based Violence for 2019–2022 [41]; (8) Action Plan for the Prevention of Domestic and Gender-Based Violence for 2023–2026 [42].

The Ministry of Labour and Social Affairs (hereinafter referred to as the “MLSA”) is the coordinator of the policy of preparation for ageing in the Czech Republic. The MoLSA coordinates and links the different departmental strategies in the field of approaches to ageing and transversal priorities in the senior policy. In the past, the following documents have focused on preparation for ageing: (1) National Programme of Preparation for Ageing for the period 2003 to 2007 [43]; (2) National Programme of Preparation for Ageing for the period 2008 to 2012 [44]; (3) National Action Plan to Promote Positive Ageing for the period 2013 to 2017 Updated version as of 31 December 2014 [14].

3. Findings of foreign research on age management and its impact on employment status and household composition including deriving hypotheses for empirical testing

In the case of the explanatory variable personal perception of health, Targoutzidis [45] argues that unemployment, the extent to which available human capital cannot be fully utilised, should be taken into account when estimating the cost of lost output due to illness. The percentage of job seekers is between 30% and 55%. This coefficient would cause a chain of vacancies equal to or greater than 5.6. Ricketts et al. [46] find that income and hours of work are not endogenous with respect to mental health. Workers suffering from stress or depression can continue to work long hours despite adverse health effects.

Burgard and Kalousova [47] research on the Great Recession confirms higher suicide rates in many affluent societies immediately after the downturn. For those employed in a recession, changes in time use can have negative consequences. Labour market shocks can improve health if they change time use or consumption in healthful ways. The quality of home care services improves in recessions because more qualified staff remain employed. Burgard et al. [48] report that mortality rates decline during recessions. In contrast, individual-level studies find that job loss, unemployment and material deprivation, have negative health consequences. Slower rates of production and growth in weaker economic periods can reduce work-related injuries. There are reductions in transport use and air pollution, accidental deaths and cardiovascular disease.

In the case of the explanatory variable of self-perceived long-term limitations in normal activities due to health problems, Fell and Schinasi [49] state that a wide range of data sources, indicators and models should be used to thoroughly assess financial stability. Progress can be made by combining information contained in individual indicators such as credit growth and asset prices. Other cross-checking approaches may involve looking beneath the surface of aggregate data by examining micro-data (whether the most indebted households also have sufficient financial reserves).

Bryan et al. [50] report that shocks such as COVID-19 affect not only GDP and employment but also the long-term health of workers who lose their jobs. Policymakers should be interested in industries with a consumer orientation and a large number of low-wage workers. A model of transmission dynamics based on social interactions in the workplace is needed to address the optimal policy response to COVID-19. Ólafsdóttir et al. [51] argue that changes in smoking behaviour are a reason for improved health during economic downturns. Reduced family income and adverse mental health appear to underlie the pro-cyclical nature of “healthy food” consumption. The positive effect of employment rates on exercise was strongest

among working-age men with part-time jobs. Birgisdóttir and Ásgeirsdóttir [52] find a statistically significant relationship for women aged 45–64 years, with economic decline associated with lower all-cause mortality. Health may be positively affected in poorer economic times due to lower opportunity costs of leisure or financial constraints leading to better health behaviours. Deteriorating economic conditions will negatively affect health due to increased stress or poorer access to health care. Kondo et al. [53] confirm increasing or worsening health in specific social groups during and after recessions. Rising inequality in mortality has been attributed to increased mortality among the poorest quintile. Weakened social protection for the financially vulnerable can lead to less access to benefits and services to maintain health, increased psychosocial stress, and a reduction in the ability of ill individuals to resume gainful employment.

Eriksson et al. [54] find that experiences of long- and medium-term unemployment increase the likelihood of first psychiatric hospitalisation. Factors such as work income, wealth, cohabitation status and previous non-mental incapacity are important predictors of this hospitalisation. Ricketts et al. [46] show that the negative effects of inversely long working hours manifest earlier in women than in men. Increased working hours are associated with higher incomes and better access to medical care. It also creates greater physical and psychological strain and health problems.

In the case of the explanatory variable of temporary workers, Gash [55] finds a higher rate of transition to permanent employment than to unemployment for most temporary workers. Most temporary workers eventually obtain permanent jobs. Germany with its strict employment law provides some of the best opportunities for permanent employment. Polavieja [56] argues that when high institutional rigidity is combined with high economic insecurity, employers may forgo the benefits associated with long-term investments in specific human capital in exchange for the incentive properties of temporary work. Katz and Krueger [57] point to an increase in the prevalence of alternative work arrangements in the American economy. The percentage of workers (temporary agency workers, on-call workers, contract workers, and independent contractors or freelancers) has increased from 10.7% (2005) to perhaps as high as 15.8% (2015).

Golsch [58] argues that temporary employment increases the risks of unemployment and is the main route into the labour market. The highly skilled are more protected. Perceived job security is an important predictor of male partnership formation. Among employed women, those who perceive their jobs as relatively secure are more likely to become mothers. Ruhm [59] reports that job retention is associated with reduced verbal ability for three and four children. Maternal employment in the second and third years is also associated with reduced performance if the mother held a job during the first year. The more favourable outcomes when the mother works part-time rather than during years two and three suggest the potential benefits of policies that promote reentry into the labour market.

Sissons et al. [60] express concerns about persistent low wages, labour fragmentation and the growth of underemployment. The presence of a second earner in the family significantly mitigates the risk of poverty. Policymakers need to develop coherent poverty-focused policies that promote the distribution of “good jobs” among households. Giesecke [61] suggests a substantial impact of atypical employment on the extent and structure of social inequality. There are risks and disadvantages for those employed in these circumstances with respect to their income and career opportunities. The risks are the structural effects of the jobs themselves.

In the case of the explanatory variable firms with an SVT contract by type of contract, type of training provided and size class, Odaka [62] reports that in times of slack demand, the firm tries to retain skilled workers and tightens control of new entrants. Labour is a special kind of factor of production because it naturally embodies technological progress. This encourages entrepreneurs to invest in human capital. Greenhalgh [63] reports that French policy includes a fee for employer training. The British policy emphasises individual initiatives by workers and employers. The provision of training increases income inequality because it is most often received by higher-income earners.

In the case of the explanatory variable participation rate in education and training, Brunello and Wruuck [64] state that training support must be linked to evaluation to ensure effectiveness. The analysis also helps to identify the best responses to common challenges such as population ageing and digitisation. McKernan [65] states that microcredit programmes have attracted much attention as an instrument to alleviate poverty. Households with the fewest assets benefit most from participation in the programme. Thomson [66] suggests that there were no significant differences between the findings for non-pregnant women with two children and the findings for women who had (or expected to have within 9 months) three or four children. There appears to be little difference between having two or more children and having three or more children in terms of their impact on the mother's employment or in their impact on the wages and costs associated with their employment.

Dieckhoff [67] suggests that a strong negative impact of education on unemployment duration was found in Germany and Denmark, while in the United Kingdom, the effects of education were weaker. The results supported a strong impact of training on the probability of moving to a higher-level occupation in Germany and Denmark and no significant effects in the United Kingdom. Krueger and Rouse [68] estimate a small positive impact of the programme on earnings in a manufacturing company, but an insignificant impact on a service company. Trainees left the company in the same way as the untrained. Training was positively related to the incidence of job offers, upgrades, performance awards and attendance. Puhani and Sonderhof [69] found that extending parental leave negatively affects young women's training, even when they do not have children. Estimates suggest that parental leave and maternal non-participation in the labour market can have a desirable effect on children's health. Hersch [70] suggests that household responsibilities affect women's wages not only by reducing investment in human capital but also by reducing efforts to obtain a job in the market. Women's wages are positively related to the number of children.

Smith et al. [71] suggest that regulatory policies on working conditions reinforce gender inequalities in the labour market by encouraging single mothers to undertake training in occupations such as childcare. The authors suggest that caregiving training should serve the needs of dual-income professional couples.

Based on the conclusions from the in-depth desk research selection (all results could not be published in full in this section), the following hypotheses can be formulated about the expected effect of age management measures on the employment status and composition of households with regard to the selected explanatory variables. Specifically, these five hypotheses are involved:

1. Personal perception of health: Improving personal perception of health with the use of age management can positively affect labour market participation of employees of all age groups. This will result in a decrease in the unemployment rate and increase the economic stability of the families of older workers as well as other at-risk groups due to health problems.

2. Self-perceived long-term limitation in normal activities caused by health problems: Flexible working conditions and adaptation to them can improve the working status of older workers with long-term health limitations as well as middle-aged employees in a similar situation. A reduction in the risk of unemployment will be felt not only by older workers and their families but also by other age groups.
3. Temporary employment: Supporting the transition from temporary employment to permanent employment contracts can increase the stability of all at-risk age groups, as they are much more likely to face underemployment and repeated experiences of precarious contracts. In this way, age management will increase the economic security of older employees, as they are often the only source of income for families.
4. Enterprises with contracts according to the type of contract, the type of training provided and the size class: The organisation of specific training programmes for employees of all ages can increase the chance of their professional application. This can reduce inequalities in the labour market and increase the socio-economic stability of employees and their households.
5. Participation rate in education and training: Promoting education and training across age groups can improve the career prospects of both young and older workers. For older employees, competitiveness in the labour market will increase and thus the stability of their households. Younger workers will get better jobs and improve their family background through faster career progression.

4. Description of the data sources and analysis methods used

The explained variable in examining the impact (nature and intensity) of age management tools (firms and individuals) on healthy, active ageing in the Czech Republic and in selected Eurozone countries (especially with regard to the resilience of the pension system to population ageing and the application of structural economic and financial reforms for a more stable and sustainable EU and Eurozone), the indicator selected was the number of persons by working status within households and household composition (1000 persons).

In addition to this explained variable, a time series of categorical variables (time, country, occupation and household composition) and a cycle dummy variable were constructed.

Statistically significant explanatory (numerical) variables in this chapter (statistical significance was tested for 20 indicators at the beginning of the research) include the following indicators published by Eurostat: personal perceived health by sex, age and labour status (%)—Self-perceived health by sex, age and labour status (%)—(hereafter personal perceived health); Self-perceived long-standing limitations in usual activities due to health problem by sex, age and labour status (%)—Self-perceived long-standing limitations in usual activities due to health problem by sex, age and labour status (%)—(hereinafter referred to as long-term limitations in activities); Temporary employees by sex, age and educational attainment level (1000 persons)—Temporary employees by sex, age and educational attainment level (1000 persons)—(hereafter temporary employment); Enterprises with CVT agreement by type of agreement, type of training provided and size class (%)—Enterprises

with CVT agreement by type of agreement, type of training provided and size class (%)—(hereinafter referred to as enterprises with CVT agreement); Participation rate in education and training (last 4 weeks) by sex and age (%)—Participation rate in education and training (last 4 weeks) by sex and age (%).

The time series used covers the period from 2010 to 2022. From the original time series of the explained variables and the explanatory (numerical) variables, annual % changes (household indicator by occupational status and composition, temporary employment) and annual p.p. changes (personal perceptions of health, long-term activity limitations, businesses with a CVT contract, education and training participation rates) were calculated prior to analysis.

All the time series used were tested with the augmented dickey fuller test (ADF) test [72], which confirmed their stationarity. We use linear regression to assess the magnitude and nature of the impact of selected age management measures on employment status and household composition. We then extract the impact of selected specific indicators representing age management instruments on work status and household composition by country, tenure and household composition by defining categorical variables interacted with these explanatory variables. This allows us to specifically identify the effect of age management measures on work status and household composition, for example, by country, but also by type of tenure and household composition. In addition, a dummy (artificial) was also applied to give us insight into the impact of age management measures during the Great Global Financial and Economic Recession—then only the Great Recession (Phase 1 from 2012 to 2014), the Long Conjuncture (Phase 2. Phase from 2015 to 2019), in the period of the COVID-19 Pandemic (Phase 3 from 2020 to 2021), and in the period of the COVID-19 Recession and the coincidence with the War Conflict in Ukraine and the associated Energy Price Increases—hereafter only the energy crisis (Phase 4-year 2022).

To select the most appropriate model (Model 1 to Model 5 in the next section of the detailed analysis) to approximate the analysed data, the adjusted R^2 is applied. Jarque Ber's test is used to test the normality of the residuals [72]. The Breusch-Godfrey test is applied to test the autocorrelation of the residuals [72]. The Wald test [72] is used to test for heteroskedasticity of the residuals. The Variable Inflation Factor is used in the analysis to measure the multicollinearity carrying capacity [72]. The failure of the tests of normality of residuals due to fluctuations in the evolution of some segments of the explained variable and year-on-year changes calculated from them in the case of a large number of observations allows us to assume the validity of the central limit theorem, which states that t -tests are asymptotically valid. The reason for the deteriorated statistics and parameters of some models is then also due to the short and sometimes incomplete time series of the published indicators that represent age management instruments.

The impact of selected age management indicators on healthy, active ageing is examined using the Least Squares Method. The observed value of the regression coefficient then indicates the intensity of the influence of the selected age management indicators on the working status and household composition, and the sign (+/–) indicates its nature. Specifically, the text refers to a positive sign in the case of a positive relation and a negative sign in the case of a negative relation.

A positive value of the regression coefficient means that as the selected age management indicator increases, the impact on work status and household composition increases. A negative value of the regression coefficient means that the indicator of job status and household composition decreases as the selected age management

indicator increases. In our analysis, regression coefficients ranging from 0.001 to 0.99 indicate very weak sensitivity of work status and household composition to age management measures, ranging from 1.00 to 2.99 indicate weak sensitivity, ranging from 3.00 to 3.99 indicate moderate sensitivity, ranging from 4.00 to 4.99 indicate strong sensitivity, and ranging from 5.00 to 6.99 indicate very strong sensitivity of work status and household composition to age management measures. For regression coefficients of 7.0 and above, we speak of extremely strong sensitivity of work status and household composition to the age management measure.

To understand the full meaning of regression coefficients, it is also necessary to distinguish the intensity of their positive and negative values. The intensity of the impact of the regression coefficients of age management measures on employment status and household composition can be divided according to different levels of sensitivity. Regression coefficients ranging from 0.001 to 0.99 in our analysis suggest a marginal effect. Changes in the investigated factors are negligible and the given measures do not bring significant results. In the interval from 1.00 to 2.99, this is a weak sensitivity, the results represent an improvement of the given condition to a lesser extent, and the effect is not so significant as to have a major impact on the socio-economic status of households. A range of 3.00 to 3.99 indicates moderate sensitivity. The impact of age management is more pronounced and the measures already play an important role in shaping employment status and household composition. In the interval from 4.00 to 4.99, it is a strong sensitivity. Measures have a strong impact on the employment status and socio-economic situation of households (e.g., improved working conditions through training or improved health would be desirable and essential). In the interval from 5.00 to 6.99, they indicate a very strong sensitivity, as the measures significantly change the working status and the situation of households. In the case of a regression coefficient of 7.0 or more, we are talking about extremely strong sensitivity in a situation where the measures have completely fundamental and transformational effects. The result of the measure has an almost unlimited effect on working and living conditions in the sense of extreme improvement or extreme deterioration of the situation of individuals and their households.

5. Overview of results from empirical testing of the impact of age management measures on the working status and household composition in the Czech Republic and selected Eurozone countries

In order to understand the full meaning of regression coefficients, it is necessary to explain not only what a positive or negative coefficient means and how to distinguish between their strong and weak results. To fully understand the meaning of these coefficients, it is necessary to further define these results in the context of desirable and undesirable effects. Both positive and negative coefficients can be both desirable and undesirable. This interpretation allows for a more precise understanding of how the measures affect different aspects of the work environment and social structure. Favourable results represent desirable effects on employment status or households. Unfavourable outcomes, on the other hand, include undesired effects.

We divide the values of the adjusted regression coefficient obtained by regression analysis into two groups. The first group will summarise all the evidence of positive regression coefficient values of the categorical variables of employment and household composition, cycle and country in interaction with the selected age management instruments.

The result will then be the overall desirable impact of the selected age management indicator on employment status (adults working full-time) and household composition (adults living as a couple or having children), which is then also assessed in terms of the categorical variable cycle and country. The result will then also be the overall undesirable impact of the selected age management indicator on work status (adults not working), and household composition (adults living alone or without children), which is also assessed in terms of the categorical variable cycle and country.

The second group will summarise all demonstrated negative regression coefficients of the categorical variables of employment and household composition, cycle and country in interaction with selected age management indicators.

The result will then be the overall undesirable impact of the selected age management indicator on the number of people by employment status (adults working full-time) and household composition (adults living as a couple or having children), which is further examined in terms of the categorical variable cycle and country. Finally, the desirable impact of the selected age management indicator on work status (adults not working) and household composition (living alone or having no children) is also assessed using the categorical variable cycle and country.

In the following section, we present an overview of the summary results from a detailed analysis of the impact of selected age management indicators on the number of people by work status and household composition for the Czech Republic, Germany, the Netherlands and Finland, which are represented in **Tables 1 and 2** in the text of the empirical analysis. The average positive values of the statistically significant regression coefficients of the models are analysed in Section 5.1 and the negative values in Section 5.2 incl. distinguishing desirable and undesirable influences in a large part of them.

5.1 Comparison of the average positive value of statistically significant regression coefficients in the Czech Republic and selected Eurozone countries

In this subsection, the measures of age management by employment status and household composition were personal perceptions of health (see Model 4 below); long-term activity limitations (see Model 5 below); temporary employment (see Model 2 below); and participation rates in education and training (see Model 1 below).

The highest statistically significant positive value of the regression coefficient was found for the participation rate in education and training for men aged 25–34 (Model 1). This was a weak positive undesirable intensity (+1.14) impact on household status and composition (see **Table 1**). In terms of type of employment, there was a weak undesirable sensitivity (+1.65) for not working and a very weak desirable sensitivity (+0.65) for full-time employment. In terms of household composition, this was mainly due to weak undesirable sensitivity for households without children (+1.52) and single adults (+1.42). The cycle dummy variable then confirmed a strong positive impact in the COVID-19 reverberation phase and coincidence with the conflict in Ukraine incl. the energy crisis (+4.18), while a very weak positive impact of +0.70 was mapped in the long boom period. In the case of the geographical perspective, a medium sensitivity (+3.32) was mapped for the Czech Republic and a weak sensitivity (+1.23) for Germany.

Another indicator is the number of temporarily employed men aged 50 to 64 with upper secondary education (Model 2). This was a very weak positive desirable effect (+0.20). In terms of type of employment, there was a very weak positive undesirable sensitivity mapped for those not in employment (+0.21) and a desirable

Statistically significant positive relationship ^{1,2,3}					
Explained variable:	Number of persons by working status within households and household composition (year-on-year change in %)				
Model number: Explanatory variable/categorical variable	Model 1	Model 2	Model 3	Model 4	Model 5
In total	1.139	<i>0.204</i>	x	x	x
Single adults	1.415	0.186	x	0.157	x
Couple household	<i>0.608</i>	<i>0.146</i>	x	x	x
Households with children	<i>1.047</i>	<i>0.394</i>	x	x	<i>0.102</i>
Household without children	1.519	0.102	x	x	x
Full-time employed	<i>0.647</i>	<i>0.183</i>	x	<i>0.341</i>	x
Unemployed	1.653	0.210	x	x	1.144
Great Recession	0.150	Is not	x	0.081	0.435
Long Conjuncture	0.696	0.100	x	x	x
COVID-19 pandemic	0.103	0.205	x	x	x
Energy crisis	4.175	0.668	x	x	1.739
The Czech Republic (CR)	3.319	0.011	x	x	x
Germany	1.226	<i>0.450</i>	x	x	0.378
The Netherlands	x	<i>0.268</i>	x	1.955	x
Finland	0.212	0.082	x	x	4.576

¹Black bold values undesirable effect.
²Black italic values desired effect.
³For black bold italic values, the effect was not distinguished.

Table 1.

The impact of age management indicators on work status and household composition in the Czech Republic and selected Eurozone countries [73].

impact for full-time employment (+0.18). In terms of household composition, this was mainly due to a very weak desirable sensitivity for households with children (+0.39) and an undesirable impact for single adults (+0.19). The cycle dummy variable then confirmed a positive very weak impact in the COVID-19 reverberation phase and the coincidence with the conflict in Ukraine incl. the energy crisis (+0.67), while it was +0.21 in the COVID pandemic phase. In the case of the geographical perspective of Germany and the Netherlands, a very weak desirable impact was mapped (+0.45, +0.27).

For the indicator of self-reported long-term limitations in some usual activities due to health problems of unemployed men aged 45 to 54 (Model 5), only a weak undesirable impact on non-workers (+1.14) was confirmed in terms of the type of job. In terms of household composition regardless of the health aspect, a desirable very weak impact was found only on adults with children (+0.10). The cycle dummy variable then confirmed a positive weak impact in the phase of the COVID-19 recession and the coincidence with the conflict in Ukraine including the energy crisis (+1.74), while for the Great Recession, the value of the impact was (+0.44). In the case of the geographical perspective for Finland, a strong positive impact was mapped (+4.58), and in Germany a very weak sensitivity of +0.38.

Statistically significant negative relationship ^{1,2,3}					
Explained variable:	Number of persons by working status within households and household composition (year-on-year change in %)				
Model number: Explanatory variable/ categorical variable	Model 1	Model 2	Model 3	Model 4	Model 5
In total	x	x	-1.763	-0.370	-1.090
Single adults	x	x	-1.410	x	-1.122
Couple household	x	x	-1.774	-0.322	-2.198
Households with children	x	x	-2.140	-0.854	x
Household without children	x	x	-1.668	-0.367	-2.987
Full-time employed	x	x	-2.621	x	-2.643
Unemployed	x	x	-0.711	-1.081	x
Great Recession	x	Is not	-2.355	x	x
Long Conjuncture	x	x	-0.578	-0.473	-0.330
COVID-19 pandemic	x	x	-4.552	-0.235	-4.335
Energy crisis	x	x	-0.766	-1.197	x
The Czech Republic (CR)	x	x	-0.409	-1.061	-0.817
Germany	x	x	-0.374	-1.662	x
The Netherlands	-0.049	x	-6.787	x	-4.150
Finland	x	x	-0.379	-1.012	x

¹Black bold values undesirable effect.
²Black italic values desired effect.
³For black bold italic values, the effect was not distinguished.

Table 2.

The impact of age management indicators on work status and household composition in the Czech Republic and selected Eurozone countries [73].

The last indicator is the personal perception of health as good by employed persons aged 45 to 54 (Model 4). In terms of the type of full-time employment, only a very weak desirable impact was confirmed (+0.34). In terms of household composition, only a very weak undesirable effect was found for single persons (+0.16). The cycle dummy variable then confirmed a positive very weak impact in the Great Recession phase (+0.08). In the case of the geographical perspective of the Netherlands, a weak positive impact was mapped (+1.96).

5.2 Comparison of average negative values of statistically significant regression coefficients in the Czech Republic and selected EU countries

In this subsection (see **Table 2**), for the work status and household composition indicator, the age management measures are: personal perceptions of health (Model 4); long-term activity limitations (see Model 5 above); businesses with an SVT contract (see Model 3 above); and education and training participation rates (see Model 1 above).

The highest statistically significant negative value of the regression coefficient was found for the indicator % of enterprises with a collective agreement between the

social partners out of all enterprises with 250 or more employees (Model 3). This was a weak negative undesirable intensity (-1.76) of the impact on the household status and composition (see **Table 2**). In terms of type of employment, there was a weak undesirable sensitivity mapped for full-time employment (-2.62) and a very weak desirable sensitivity for non-employment (-0.71). In terms of household composition, this was mainly the result of a weak undesirable sensitivity for households with children (-2.14) and a desirable effect for households without children (-1.67). The cycle dummy variable then confirmed, for example, in the case of the geographic perspective, a very strong negative impact for the Netherlands (-6.79), while for the Czech Republic, Finland and Germany a very weak negative impact was mapped (-0.41 , -0.38 and -0.37 , respectively).

For the indicator of self-reported long-term limitations in some usual activities due to health problems of unemployed men aged 45 to 54 (Model 5), there was a weak negative undesirable intensity (-1.09). In terms of the type of full-time employment, a weak negative undesirable sensitivity was mapped for full-time employment (-2.64). In terms of household composition regardless of the health aspect, this was mainly the result of a weak desirable sensitivity for a household without children (-2.99) and undesirable sensitivity for a couple of households (-2.20). The cycle dummy variable then confirmed a negative strong impact in the COVID pandemic phase (-4.34) and a very weak impact in the long boom period (-0.33). In the case of the geographical perspective of the Netherlands, a strong negative impact (-4.15) was mapped, while in the Czech Republic, it was a very weak impact (-0.82).

For the indicator of personal perception of health as good by employed persons aged 45 to 54 years (Model 4), there was a very weak negative desirable intensity (-0.37). In terms of the type of employment, a weak negative desirable sensitivity was only mapped for non-employed persons (-1.08). In terms of household composition, this was the result of a very weak undesirable sensitivity for households with children (-0.85), while for households without children, it was a desirable sensitivity (-0.37). The cycle dummy variable then confirmed a weak negative impact in the reverberation phase of COVID-19 and coinciding with the conflict in Ukraine the energy crisis (-1.20). In the case of the geographical perspective of Germany, the Czech Republic and Finland, a weak negative impact was mapped (-1.66 , -1.06 and -1.01 , respectively).

The final indicator was the participation rate in education and training for men aged 25–34 (Model 1). Specifically, for the geographical perspective, only a very weak negative effect was mapped in the Netherlands (-0.05).

6. Conclusions

A number of significant new practical implications revealed by the regression analysis and compared with the findings of theoretical-empirical research from abroad and the Czech Republic confirmed the appropriateness of applying the analysis of the nature/intensity of the correlation and the indication of the causal relationship to an extended set of the labour market and household indicators.

The main conclusions from the mapping of the intensity of statistically significant positive and negative effects of age management indicators on the working status and composition of households for the Czech Republic and selected Eurozone countries include:

The overall conclusion of the empirical analysis using the regression coefficients of the impact of selected age management indicators on households by occupational status and composition in the Czech Republic and in selected EU countries first highlights the above-average statistically significant positive value of the indicator participation rate in education and training for men aged 25–34 (weak positive undesirable intensity of +1.14). A weak undesirable sensitivity was mapped for not working (+1.65), while a very weak desirable sensitivity was found for full-time work (+0.65). A weak undesirable sensitivity was found for households without children (+1.52), while for households with children, the desirable sensitivity was (+1.05). For example, a positive strong impact was confirmed in the reverberation phase of COVID-19 and the coincidence with the conflict in Ukraine including the energy crisis (+4.18), and a very weak positive impact was mapped in the long boom period (+0.70). A medium sensitivity (+3.32) and a weak sensitivity (+1.23) are confirmed for the Czech Republic and Germany, respectively, and only a very weak positive sensitivity (+0.21) in Finland. Dieckhoff [67] suggests that the impact of training varies across countries. While there were significant effects of training in Germany and Denmark, training in the United Kingdom does not appear to have had any significant effect on labour market outcomes. Another indicator is the number of men aged 50 to 64 in temporary employment with upper secondary education, where a very weak positive desirable effect (+0.20) was found. A very weak positive undesirable sensitivity was mapped for not working (+0.21), and a desirable impact was found for full-time employment (+0.18). A very weak desirable sensitivity was mapped for households with children (+0.39), undesirable for single adults (+0.19), desirable for couples (+0.15) and undesirable for households without children (+0.10). For Germany and the Netherlands, a very weak positive impact was mapped (+0.45, +0.27), while in Finland and the Czech Republic, the desirable sensitivity was only +0.08 and +0.01. Gash [55] found that most temporary workers eventually obtain permanent jobs. Giesecke [61] reports that strategies to increase labour market flexibility through atypical employment have an impact on the extent and structure of social inequality.

The highest statistically significant negative regression coefficient was found for the indicator % of enterprises with a collective agreement between the social partners out of all enterprises with 250 or more employees (weak negative undesirable of –1.76 impact on household status and composition). A weak undesirable sensitivity was mapped for full-time employees (–2.62) and a very weak desirable sensitivity for non-employees (–0.71). A weak undesirable sensitivity was found for households with children (–2.14) and a desirable effect for households without children (–1.67). A very strong negative effect is mapped for the Netherlands (–6.79), while for the Czech Republic, Finland and Germany a very weak effect is mapped (–0.41, –0.38 and –0.37 respectively). Odaka [62] argues that in the case of slack demand, for example, a firm tries to retain skilled workers and adjust the workforce by tightening the control of new entrants and/or firing unskilled ones. There was a weak negative undesirable intensity (–1.09) for the indicator of self-perceived long-term limitations in some routine activities due to health problems for unemployed men aged 45 to 54. A weak negative undesirable sensitivity was mapped for full-time employment (–2.64). A weak desirable sensitivity was found for a household without children from the point of view of the position and composition of households (–2.99) and undesirable sensitivity for a couple household (–2.20). Birgisdóttir and Ásgeirsdóttir [52] found that mortality from respiratory diseases generally increases with better economic conditions. Worse economic conditions can be beneficial for the health of the population. For the indicator of personal perception of health as

good by employed persons aged 45 to 54 years, there was a very weak negative desirable intensity (-0.37). A weak negative desirable sensitivity was mapped only for non-working persons (-1.08) and a very weak undesirable sensitivity for households with children (-0.85). A weak negative impact was mapped for Germany, the Czech Republic and Finland (-1.66 , -1.06 and -1.01 , respectively). Burgard and Kalousova [47] argue that people without work or with reduced working hours gain time to exercise, cook healthy meals, sleep or engage in other behaviours aimed at physical and mental well-being. These changes in time use reduce stress and thus improve health.

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Conflict of interest

The author declares no conflict of interest.

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Activating the State for Social Assistance Provision: Constitutional Catching-Up in Brazil's Family Allowance Program

Helder Ferreira do Vale

Abstract

The chapter examines the expansion of social assistance in Brazil as part of the “constitutional catching-up” process. This process is defined as the use of the democratic constitutional framework, which expanded fundamental rights to citizens in the Brazilian democratization, as a springboard for law-making and judicial activism. In the case of Brazil, constitutional rights were used to mobilize the state for the development of social assistance programs. The chapter shows how, in a policy climate characterized by low incentives and commitments to social policies, the incorporation of basic rights into Brazil's 1988 Constitution generated incentives for state participation in welfare state growth initiatives. By explaining how law-making and judicial activism through “constitutional catching-up” led to the creation of the family allowance program, the *Bolsa Família*, this chapter broadens our understanding of the conditions under which welfare states in the Global South can be expanded.

Keywords: welfare state expansion, social assistance, cash-transfer programs, judicial activism, Brazil

1. Introduction

Brazil has been praised around the world for its important social achievements in the last few decades. The national family allowance program *Bolsa Família*, a conditional cash-transfer (CCT) initiative, has been notably recognized for its impact on poverty reduction.¹ The program has successfully achieved its outcomes: it has lifted millions of citizens out of poverty [2], and it transformed governance of social assistance systems in Brazil [3].

¹ In terms of coverage, when first created in 2003 the program reached 20% of the poorest households in the country, increasing its reach to 70% of the poorest households in 2017. Considering the percentage point of poverty reduction, as of 2017, it represented a reduction of between 1 and 1.5 in poverty, which meant 15% of reduction of number of poor individuals [1].

Bolsa Família represents Brazil's anti-poverty efforts, which are often interpreted from several perspectives. The phenomenon has frequently been ascribed to the expansion of clientelist networks [4, 5], to the alterations in national leadership [6], to processes of policy diffusion [7–9], and to a diverse range of institutional factors [10].

In contrast to these explanations, yet complementing them, this chapter contends that the CCT programs can also be viewed as a consequence of “state activism”, primarily driven by a process of constitutional catching-up wherein institutions, policies, and policy instruments are employed to achieve new social objectives, such as poverty alleviation.²

This chapter makes the case that the democratic constitutional framework conditioned the emergence of new state-society relations in Brazil, which led to the *Bolsa Família*. This CCT program is different from other efforts to reduce poverty, especially in terms of its conditionality and non-contributive nature [11].³ Furthermore, *Bolsa Família* is considered innovative because it is the result of a new method to meet the growing demand for social protection in the efforts of the state to halt the inter-generational maintenance of poverty [10].

The dynamics of innovation in Brazil are deeply rooted in the democratic constitution of the country, which became a critical condition for the creation of the Brazilian CCT programs.⁴ In the face of the hurdles created by a deficient welfare system, this chapter is interested in showing how Brazil responded to the social challenges of the country through law-making and judicial activism.

There are different drivers behind the development of welfare states, which include mobilization of workers, state-society relations, appeasement of political conflict, wars, and building of state capacity, among others. The “logic” of welfare state developments, which result in different “welfare worlds” ([14], p. 32), helps to understand the complexity of factors that lead countries in their trajectories of welfare state creation.⁵ The construction of these worlds involves a complex interplay of actors, forces, contexts, and causal mechanisms, which collectively establish a distinct rationale in the development of a welfare state. And once developed, welfare states are often susceptible to reforms [14].⁶

Pierson [16] defined the welfare state reforms driven by social needs as “recalibration”. Based on this typology, this chapter asserts that the social vulnerability of

² In addition to changes in the constitutional regime, Brazil in the 1980s and 1990s experienced a far-reaching process of decentralization, which placed the subnational governments at the center of the delivery of public services. Decentralization widened the number of actors and institutions that became part of the public policy processes.

³ In the long-run, the program not only reduced poverty but also positively influenced various socioeconomic indicators, including employment outcomes, mortality rates for children and adults, school dropout and attendance rates among children and adolescents, and violence-related outcomes such as homicide, suicide, crime, and hospitalization [12].

⁴ Alternatively, there are important insights that suggest that CCT programs in Brazil emerged under changes that led to a type of “experimentalist governance”, as defined by Sable and Zeitlin [13].

⁵ They identify four logics: logic of socioeconomic development and modernization, logic of political integration and state-building, logic of need satisfaction and risk reapportioning, and logic of class politics and redistribution.

⁶ In the Latin American case, there was an increase of social protection across the countries in the region in the 2000s, yet public expenditure has been mainly driven by social insurance [15].

marginalized populations in the Global South is crucial for welfare state reforms, which have been characterized by the expansion of social assistance benefits. Brazil's family allowance program fits as a type of recalibration reform because the large number of families living below the poverty line has driven the creation of a program that, by its nature, was designed to alleviate poverty through direct cash transfers. In addition to lifting millions out of poverty with these transfers, families had to fulfill two main conditionalities: that the children in the family regularly attend school and go to clinics for health check-ups.

CCT programs have been extensively discussed in the literature as being propagated through policy diffusion mechanisms [17]. Research on the initial experiences in Brazil and Mexico, the first countries in the Global South to nationally develop CCT programs, has been conducted from various methodologies and viewpoints, resulting in findings that indicate countries progressively enhancing their welfare systems *via* targeted policies and programs for certain population groups. Furthermore, these countries demonstrate that social assistance can evolve under intricate causes that extend beyond the conventional welfare regimes originating from industrialization.⁷

This chapter provides an approach to CCT based on a constitutionally triggered mechanism that motivates the state to act, seek, and maintain welfare innovations. This approach goes beyond the arguments that posit that welfare states in developing contexts are established to cater to specific class interests with the cooptation of the state [19], economic growth goals [20], and at times, there is pressure to expand them to provide additional services and public goods [21].⁸ While this chapter recognizes the value of these arguments, it contends that the maintenance and further development of the family allowance in the format of CCTs was motivated by the guarantee of social rights.

A critical assumption in this argument is that the activation of the state does not occur in a self-enforcing manner. Rather, it undergoes a process of state activation that depends on actor-based mobilization to enhance the welfare state. In short, the expansion of rights promoted under the constitutional framework may mobilize the state to safeguard disadvantaged populations under concrete policies.

Based on this rationale, this chapter develops its argument in the next five sections. Section 2 clarifies the methodological orientation of this chapter. Section 3 explains the context of the Brazilian welfare state. Section 4 defines and explains the concept of “activating the state”. Section 5 analyzes how the state was activated in Brazil through the country's *Bolsa Família*, one of the first CCTs established in the Global South. Section 6 focuses on the evolution of the different stages of *Bolsa Família* leading to the “constitutional catch-up” stage. Finally, Section 7 concludes, highlighting the implications of this “activating the state” approach to welfare state expansion and innovation.

⁷ The transition from industrialization *per se* does not naturally guarantee the development of a welfare state, as it is required a combination of factors which explain the emergence of different welfare state regimes [18]. While Scandinavian welfare research highlight universalism and labor mobilization Brazil's trajectory reflects constitutional mobilization—where judicial and legislative actors, not unions, drove redistribution. This distinction highlights the Global South's reliance on legal frameworks to compensate for weak welfare legacies.

⁸ Tillin and Duckett [22] call attention to the lack of theorizing about the pattern of welfare state development in developing countries. However, there are encompassing interpretation of welfare regime development contexts in which countries adopted joint measures towards strengthening state capacity, stimulus towards industrialization and political mobilization in favor of the poor [23].

2. Methodological orientation

This research is rooted in the methodological tradition of Historical Institutionalism (HI) that places weight on a staged development of a process, which helps us to interpret how social assistance in Brazil expanded in the 1990s and 2000s.

The primary focus of this analysis is to explain the gradual transformation of Brazil's welfare system, which has developed within a context of clientelism [24]. This chapter elucidates that the thrust of this transformation stems from judicial activism in ensuring social assistance is recognized as a protected right. The interplay between actors and institutions, and consequently the establishment of new norms, is essential for research utilizing HI [25].

The literature on the expansion and innovation of social assistance has been interpreted as a result of international policy diffusion [9, 26], with a great focus on international determinants behind policy innovation. In terms of domestic incentives, the literature has mainly seen the Brazilian context as not very inclined to creating a long-lived program to alleviate poverty [24].

One research that offers a domestic perspective on the transformative changes in social assistance is Ansell [27], which analyzes the profound impact of *Bolsa Família* in disrupting clientelism. According to him, the program provided an opportunity for reframing the meaning of social assistance by the beneficiaries: they contested the notion of a cash transfer as a “gift” and started seeing it as a right.

By employing HI, this chapter prioritizes the macro-level sequencing of events that were consequential to the social assistance in Brazil being granted based on rights. This orientation is different from Ansell [27], which focuses on ethnographic analysis. This entails that the analysis here is centered on interactions among institutions and actors in elucidating how rights are expanded in Brazil. This chapter's macro analysis explains the expansion of the *Bolsa Família* in parallel to the spread of a legal activism that framed and consolidated the program. As such, tracing the sequence of this expansion of rights is a critical component of this analysis. And in this direction, the chapter identified seven legal measures adopted in Brazil—Law 8.742/1993, Measure 123/2003, Law No. 10.836/2004, Measure 1061/2021, Law No. 14.284/2021, Amendment 114/21, Law 14.601/2023—that once sequentially organized, provide a clearer basis to explain how the constitutional catching-up stage was consequential to the consolidation of the *Bolsa Família* in Brazil.

The term constitutional catching-up is used as a mechanism for explaining the gradual transformation of the Brazilian welfare system. In this direction, one of the main goals of the adoption of HI methodological approach is to identify causal mechanisms. Constitutional catching-up serves to elucidate the observed outcome, namely, the establishment of cash transfers as a right-based form of social assistance. **Figure 1** depicts the centrality of “constitutional catching-up” as a causal mechanism in the change from a period of temporary CCTs embedded in a context of clientelism to a period of social assistance enshrined in a legal framework and established as social rights.

Being coherent with HI tradition, the evolution of the CCTs in Brazil will be broken down into three stages. The first stage (1995–2003) marks the creation of the first CCT programs at the subnational levels of government. In this period, the federal government, inspired by the subnational CCT programs, adopted additional programs in several areas (food, household energy). The second stage (2003–2012) encompasses the integration of the different programs under one flagship program *Bolsa Família*. In this period, the program introduced major innovations in various

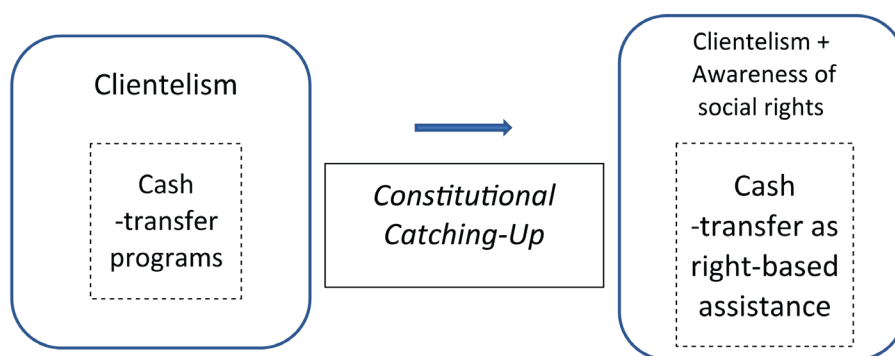


Figure 1.
Contexts, causal mechanism, and expansion of rights through CCTs in Brazil. Source: Own elaboration.

domains, namely conceptual, product, technological, process, and management [10].⁹ Also, during this period, there was an expansion of the CCT program to another area under more ambitious goals such as environmental preservation, which is the main objective of the *Bolsa Verde*.¹⁰ The third stage (2012 to present) concerns the intense mobilization of actors to expand and maintain the program. This active mobilization is seen in the more intense legislative production of lawmakers and decisions from the Supreme Court. This legislative and judicial activism has been critical for the consolidation of social rights through social assistance programs.

Lastly, in terms of method of analysis, this article combines historical institutionalism (HI) with legal-textual analysis to trace how constitutional provisions, legislative acts, and judicial rulings shaped Brazil's welfare expansion. Primary sources include constitutional amendments (1988–2018) cataloged by Gonçalves Brasil et al. [28], with emphasis on amendments advancing social rights (e.g., EC 64/10), rulings of the Brazilian Supreme Court (e.g., RE 587.970, MI 7.300) that reinterpreted social assistance as a right; and legislative records (e.g., Laws 8.742/1993, 10.836/2004) as well as survey data [29] tracking public support for Brazilian CCTs.

3. Welfare state context in Brazil

Social policy transformations in Brazil took place in a context of deepening democratization and decentralization of social policies. The socioeconomic achievements that Brazil started to experience under democracy came along with a change of political preferences of the Brazilian political elites, which have been increasingly dominated by

⁹ Conceptual innovation occurs with the introduction of a novel concept. It is frequently accompanied with governance innovation, which pertains to a new approach to tackling a particular social issue. Product innovation emerges when a service and/or product is launched for the first time. Technological innovation is the result of the introduction of a new technological instrument that will be utilized to deliver services. Process innovation is to enhance the delivery mechanism of a service and/or product. Management innovation emerges with the implementation of new management techniques and a new supervision framework to enhance the program's operation and efficacy [10].

¹⁰ In 2011 the *Bolsa Verde* was designed under the same framework as *Bolsa Família* but with a new objective, the engagement of the beneficiaries in environmental conservation activities.

social inclusion [30]. By embracing a policy that has been coined “inclusive growth”, it is possible to even identify the emergence of a new developmental state in Brazil [31]. Also, these changes can be understood considering transformations in the Brazilian public administration, which became more performance-oriented [32].

Contexts matter for social policy innovation because they can create vulnerabilities that determine a set of conditions that threaten the basic functioning of a polity [33]. In Brazil, socially related vulnerabilities such as poverty, inequality, and civil violence can push policymakers to create innovative solutions to reduce such vulnerabilities.

The creation of innovative institutions that alleviate social problems has been critical to the reduction of vulnerabilities [10]. As such, innovation arises in a fragmented policy environment tempered by collaboration institutions responding to vulnerabilities such as poverty. In addition to the institutional environment, agency matters for the reduction of vulnerabilities and the development of social innovation.

Brazil has a tradition of civil society mobilization targeting the state in their collective action for social changes [34]. Social movements have been successful in promoting and securing civil and social rights in Brazil. In the expansion of social security in Brazil, the mobilization of health professionals during the democratization of the country has allowed the creation of a universalized and decentralized health system [35]. However, judicial activism has been very important in guaranteeing access to the health system, particularly access to medicine [36].

Democratization and decentralization empowered different groups of public and private actors to influence the policymaking process, and consequently fragmented the process, making it less hierarchical. As a response to the emergence of new actors and to this fragmentation of policymaking, institutions for cooperation were engineered to mitigate the challenges of the new policy environment. An increase in the number of mitigating institutions precisely incentivized central state institutions to coordinate the proliferation of diverse interests of relevant actors in Brazil.¹¹

Democratization in the 1980s dispersed the center of decision-making in Brazil [38]. However, from 1994 onwards, the central government stepped up its coordination role with the aim of bringing coherence to policies and cohesion among them [39]. Together with these transformations, decentralization, which was a process of transferring fiscal and administrative authority from the federal government to subnational governments, fragmented the policy space in Brazil.¹² In this context, where the exercise of power is divided among different actors and dispersed over a multiplicity of institutions, political and administrative stalemates prevailed in the years immediately following the transition to democracy. This difficulty of effectively designing and implementing social policies due to federal institutional constraints served as an incentive for center-local collaboration in the case of the *Bolsa Família* [6].

Adding to this complexity, essential to comprehending the welfare state reforms in Brazil that resulted in the establishment of CCTs is the mismatch between the Brazilian “social constitution” of 1988 and the insufficient state capacity to execute

¹¹ The Brazilian federal system has become increasingly complex due to heightened intergovernmental cooperation in various social policy domains [37]. For the implementation of the CCT programs the engagement among various institutions at different levels of government was necessary, hence promoting federal coordination.

¹² The federal system in Brazil has often been pointed to as a hindrance to social policymaking given its high level of political fragmentation [35].

the social provisions (e.g., universal access to health and education) at that time. This chapter contends that such a mismatch was mitigated as social demand for state supply of public goods increased during the 1990s and 2000s. In the next pages, the examination of the legislative and judicial activism processes clarifies how the Brazilian state responded to societal demands through CCTs.

4. Constitutional catch-up in Brazil

The idea of “activating the state” stems from the observation that the state, under certain circumstances, acts beyond its routine operations. This suggests that not all state institutions are self-reinforcing, meaning that their objectives and guiding ideals do not dictate how they necessarily function. As contexts become complex with social and political changes, the state must adapt to these changes and adopt new institutionalized behavior. In other words, not always do states have institutions in place to respond to evolving contexts requiring an adaptation to new contexts to remain relevant, authoritative, and legitimized.

Recognizing that the state is not always able to adequately address complex issues, Shirk [40] elaborates the concept of “boundary-drawing”, which refers to the limits of state actions that are revised when provoked by non-state actors to act in a non-convention matter. In redrawing the boundaries of state actions, the state transforms itself and embraces new functions and activities. When evaluating state transformation, Shirk’s approach has proven especially helpful to consider non-state actors who seriously impair public institutions’ ability to be self-reinforcing. This perspective takes a bottom-up approach to state transformation.

In certain cases, however, the state is prompted to respond from above. This happens when constitutions are adopted, requiring new state actions to implement constitutional provisions. These constitutions are often referred as “social constitutions”, which are legal texts that promise social rights prompting citizens and legal actors to demand the enforcement of these rights ([41], p. 9). Talyor [41] uses this approach to identify the process of “constitutional embedding”, which is the involvement of actors in the legal and social spheres to compel the application of the social provisions found in the constitution.

The bottom-up and top-down processes of state transformation involve mechanisms referred to as “social welfare state activism”. State activism in this sense refers to the mobilization of people who wish to institutionalize new state actions or the adaptation of public institutions backed by legislative initiatives. In terms of public welfare development, this conception of “state activism” is applied to instances in which the state needs to supply goods and services to citizens with particular social vulnerabilities.

What is referred to here as “claim-making”—defined by Kruks-Wisner [42] as a direct and mediated citizens’ interaction with state institutions that lead them to “pursue access to social welfare goods and services”—is referred to as “social welfare state activism”. Claim-making practiced by poor citizens often occurs in non-programmatic settings in which the traditional political tools (e.g., voting) for influencing public institutions are not effective.¹³

¹³ Claim-making actions according to Kruks-Wisner [42] include “attending a meeting, filing an application, visiting an official, contacting a local broker, or engaging in other quotidian modes of interest articulation”.



Figure 2.

Process of social welfare state activism. Source: Own elaboration.

The other mechanism triggering state activism in social welfare reforms is what this chapter identified as “constitutional catching-up”. Such a mechanism refers to the actions associated with implementing constitutional rights and mandates through law-making and judicial activism. In this context, the legislative actions of lawmakers in the Brazilian National Congress have become essential for the institutionalization of social assistance laws that have solidified the extension of social assistance entitlements in Brazil. The legislative process concerning social assistance demonstrates an uncommon alignment in Brazil’s history between the motivations of political elites with societal needs.

In addition to claim-making, judicial activism contributed to social welfare state activism because it is a practice that employs judges’ power over the interpretation of the law to uphold social justice and extend rights [43]. According to Rodríguez-Garavito [44], this type of judicial discretion has an impact on court rulings, which have tangible and symbolic ramifications for social justice. As such, judicial activism is employed in the “constitutional catching-up”.

Figure 2 sums up the mechanisms identified in this chapter as triggers of social welfare state activism, which is critical to understand the most recent expansion of welfare states in developing contexts.

This chapter identifies three main characteristics of the “constitutional catching-up” trajectory of social assistance in Brazil. Regarding temporality, it may be posited that law-making and judicial activism were not pivotal in the initial phases of CCT growth; rather, they became relevant in the long-term progress and maintenance of social assistance. Second, there is evidence that “constitutional catching-up” generated support for CCT programs, which was essential for the development of a policy constituency in favor of social assistance policies in Brazil. Third, while the national executive established the national CCTs, their progress significantly depended on a combination of legal instruments, including constitutional amendments, statutes, and supreme court decisions, which rendered legislators and supreme court justices essential to the process.

5. Law-making and judicial activism

The legal context of guaranteeing fundamental rights dominated the transition to democracy in Brazil, which officially ended with the promulgation of the 1988 Constitution. The constitutional text significantly amplified the social and political rights of Brazilians. However, to enforce these rights the institutions of different levels of government were activated with the participation of public officials and civil society.

Based on the 1988 constitutional framework, the Brazilian welfare system in terms of a social security has been composed by three pillars: contributive social insurance, non-contributive social assistance, and universal health cover. These pillars are anchored on fundamental constitutional social rights that are regulated through specific norms and regulations.

However, the *Bolsa Família* was first established as a subnational policy experiment before becoming a national program in 2003 as a result of a federal law, the Provisional Measure 123/2003.¹⁴ Almost two decades later, the Brazilian Supreme Court decided through a court ruling in 2021 to guarantee social assistance as a constitutional right based on a reinterpretation of Constitutional Amendment 114/21.¹⁵ This trajectory of this social assistance is indicative of the social welfare activism that the “constitutional catching-up” mechanism sparked.

One important argument in the establishment of CCTs in Brazil has been the formation of a constituency group that creates public support for the advancement and maintenance of the *Bolsa Família*. This constituency puts weight on the “supply-side” of the policy process. This means that the policy instrument is designed based on a specific constituency. By considering the constituency in the policy process, a “constituency frame” is developed to ignite actor’s advocacy behavior [46]. This chapter contends that the sustained support for *Bolsa Família* over time depended on substantial citizen backing, an active constituency, which fostered a consensus among legislators and judges regarding the program’s significance in promoting social justice.

As a sign of the existence of a strong constituency group backing *Bolsa Família*, 72% of Brazilians expressed support for the program. Of those who claim familiarity with the program, 78.8% asserted that it enhanced the quality of life for Brazilian families, in contrast to 67.9% of individuals who, despite lacking knowledge of the program, believe that family livelihoods have not improved as a result of it [47]. More recent survey data suggest that approximately 71% of Brazilians believe that the *Bolsa Família* should be expanded, against 16% of those who think the program should be reduced, and 10% that want the program to be completely abolished [29].¹⁶

5.1 Law-making

National legislation has been a crucial component of Brazil’s efforts to address social welfare, public health, and economic challenges. They established the overarching basis for the subsequent formulation of specialized legislation on social assistance

¹⁴ The initial CCT programs in Brazil were implemented at the subnational level. In 1995, Brasília began a CCT program that established the principle of offering economic support contingent upon adherence to child school attendance. This experience prompted the federal government to establish a comparable national program, *Bolsa Escola*, in 1999.

¹⁵ This Amendment states that Brazilians who are in a socially vulnerable conditions are entitled to a basic family income, which is provided by the state through a permanent and unconditional income transfer scheme [45].

¹⁶ The theme of social support to CCTs warrant granter attention. Yet there is a scarcity of data concerning citizens’ survey necessary to understand the support of Brazilians to *Bolsa Família* from different angles. Despite the overwhelming support of the population to *Bolsa Família*, Brazilians do not seem to associate democracy with state taxation of the rich and assisting the poor. For example, based on the World Values Survey [48], 36% believe that taxing the rich and aiding the poor is not an essential attribute of a democracy.

policy. An example of the foundational framework established in the 1990s is Law No. 8.742/1993, which pertains to social aid and poverty alleviation and establishes that the Brazilian state is to provide social assistance. However, it was not until 2003 that the non-contributive nature of the social assistance gained a legal framework under Provisional Measure 123/2003, which created the *Bolsa Família* as a national program established by the federal government, representing the beginning of the CCTs period in Brazil. Subsequently, Law No. 10.835/2004 established a minimal vital household income, and Law No. 10.836/2004, which recognizes the necessity for a supplementary statute to govern the *Bolsa Família*.

It took 17 years for a new law to be passed to alter *Bolsa Família* following this series of legislative actions. Provisional measure 1061/2021, issued by the federal executive, renamed the CTT program to Brazil Aid Program (*Auxílio Brasil*). Pandemic-related health and economic assistance complementing *Auxílio Brasil* was covered by Law No. 14.284/2021. Due to the suspension of routine health and education services during the COVID-19 epidemic, this law eliminated the conditionality and raised the amount of money supplied per household. Following a change of government in 2023, the family allowance recaptured its original name *Bolsa Família* via Law 14.601/2023, and new standards for the beneficiaries were introduced, along with a minimum amount per beneficiary. **Table 1** explains the legal instruments by which the state delivered social assistance in Brazil. This table shows the three stages that compose the evolution of the *Bolsa Família*.

It is worth noting that one constitutional amendment, Amendment 114/21, which makes direct reference to the *Bolsa Família*, is part of the law-making process. This provision is relevant to guarantee a basic income (as opposed to minimal subsistence income) for individuals experiencing social vulnerability. This amendment comes after restrictions imposed on another benefit, the Continuous Cash Benefit (*Benefício de Prestação Continuada*—BPC), which is a cash social assistance for the elderly and disabled persons. Amendment 6/19 was particularly significant as it restricted the concession of a minimal subsistence income by increasing the eligibility age from 65 to 70 years old [49]. **Table 2** lists the main amendments in Brazil that contributed to the consolidation of social rights.

The process of law-making required important levels of legislative endorsement for social assistance in Brazil. Power and Zucco [51] report that over half of Brazilian national legislators, specifically 54.7%, supported an increase in public expenditure on social programs. Approximately 37% of the legislators wished to sustain present expenditure levels, while 7.9% advocated for a reduction in expenditures.

Although there is substantial support for public expenditure in social assistance, this policy area presents the lowest consensus regarding funding among the four other areas: health, basic education, higher education, and infrastructure. In health and basic education policies, 97.1% and 97.9% of legislators, respectively, advocated for increased or sustained funding, but support for infrastructure expenditure stands at 87.8% [51]. This indicates that expenditure on social assistance is among the most contentious policy area, implying that some degree of advocacy to maintain current policies may still be necessary compared to other areas.

Considering ideological divisions and legislators' spending preferences, Pereira and Bertholini [30] demonstrate that the social assistance area exhibits the greatest variation along the right-left ideological spectrum among legislators, whereas spending on the infrastructure policy area reveals the least ideological variation. This disparity is attributed to the Brazilian Workers' Party (PT)'s significant involvement in social assistance policy. With *Bolsa Família* emerging as the flagship initiative of the

Stage I	Stage II	Stage III				
		Constitution catching-up				
Law 8.742/1993	Provisional Measure 123/2003	Law 10.835/2004 10.836/2004	Provisional Measure 1061/2021	Law 14.284/2021	Amendment 114/2021	Law 14.601/2023
Source: Own elaboration.						

Table 1.
Process of activating the state for social assistance.

Amendments	Type of right	Summary
EC N. 26/00	Right to housing	It amplifies the range of fundamental constitutional rights by including housing as a social right.
EC No. 64/10	Right to food	It emphasizes the state's role in ensuring adequate housing as a basic human right, aiming to improve living conditions for the population, especially in urban areas.
EC No. 67/10	Right to guarantee minimal standards of living	Creates on a permanent basis a fund for eradication of poverty, the Poverty Combat and Eradication Fund.
EC No. 90/15	Right to transportation	It expands on the idea of social rights, by adding transportation as a right to the list of social rights.
EC No. 6/19	Continuous Cash Benefit (<i>Benefício de Prestação Continuada</i> —BPC)	It changes the contributions of taxpayers to the pension system, making this system more progressive. Also, the amendment introduces stricter requirements for public sector workers while creating the Continuous Cash Benefit.
EC No. 114/21	Defines the scope of families that are eligible to family allowance	Article 6 restricts the beneficiaries of the family allowance to those families facing social vulnerability.

Source: Own elaboration partly based on Maués [50].

Table 2.
List of constitutional amendments advancing fundamental rights in Brazil.

party in the early 2000s, the PT is recognized as the Brazilian party with the biggest commitment to social assistance expenditure ([30], p. 395).

5.2 Judicial activism

As a reflection of “constitutional catching-up”, the Brazilian constitutional amendment has been part of law-making.¹⁷ However, given the relevance of the amendment to the change in jurisdiction, the amendments concerning social assistance have a “positive feedback” impact on the judicial activism provided that it triggers new judicial interpretations on social assistance issues [52].

The areas of the constitution that have been most amended are those related to public administration functioning and design, social policy issues, judicial matters, energy, and natural management resources [28]. **Figure 3** illustrates this pattern, which makes evident that social and justice issues rank high among constitutional amendments in terms of percentage based on the number of approved amendments between 1988 and 2018.

Lassance [53] employs a different categorization of constitutional amendments and shows that dimensions related to individual and social rights represent a high percentage of total amendments. According to his assessment, approximately 13% of the total amendments between 2011 and 2016 were in the category of rights, while politically motivated amendments (“casuistic amendments”) and political reform amendments respectively represented 25.34 and 14.99% of the amendments approved during this period. The other categories represented a lower percentage than these three categories.

¹⁷ It is relevant to say that the Brazilian constitution has been amended 105 times from 1988 to 2018 [28].

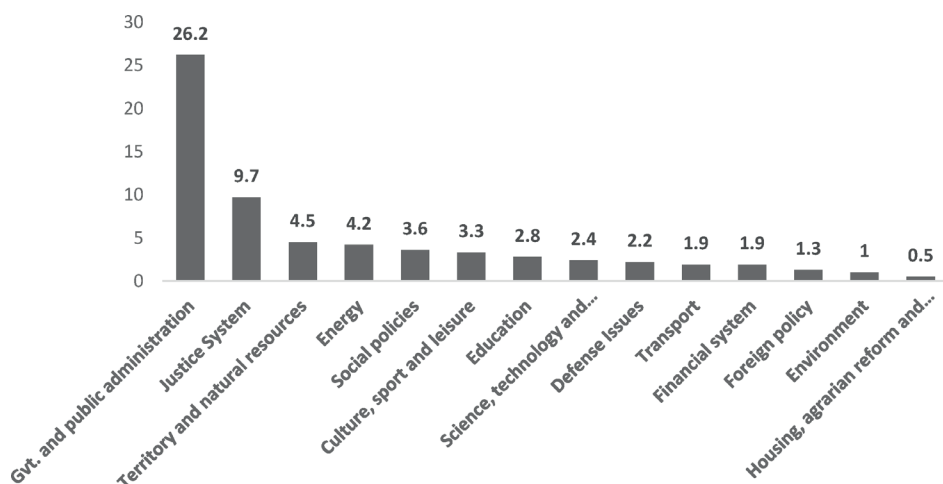


Figure 3.
Percentage of Brazilian constitutional amendment by category (1988–2018). Source: Own elaboration based on Gonçalves Brasil et al. [28].

It is important to acknowledge that the categorization of constitutional amendments presents some challenges because often a single amendment might deal with a wide range of issues that overlap with several categories [50]. This particularly happens in amendments associated with fiscality, which often interconnects financial and the provision of public goods and services. This leads to another problem: the state's financial capacity has been prioritized in fiscal constitutional modifications (e.g., EC 29/00) over social policy-related constitutional amendments.¹⁸

Five constitutional amendments related to fundamental rights, ratified between 1988 and 2021, need attention since they constitutionally embody social rights that mandate the state to ensure the supply of housing, food, transportation, and social assistance. The constitutional changes in Brazil through amendments have been persistent and reliant on a coalition of various political actors [50].

This incremental yet progressive extension of rights should be understood as altering the constitutional framework. Brazil is among the Latin American countries with one of the highest frequencies of constitutional alterations *via* amendments [55]. Nonetheless, rather than embodying a democratic practice, also it has been employed by legislators for electoral objectives [53]. While the method and intent of constitutional modification are contentious, it has favored a progressive enhancement of rights in Brazil. Below the chapter identifies three evidence of the expansion of rights.

In 2017 through an Extraordinary Appeal, RE 587.970, the Brazilian National Social Security Institute (INSS) filed an appeal before the supreme court against a lower court decision that interpreted that the Continuous Cash Benefit to the elderly were not restricted to Brazilian citizens. The supreme court ruled that the INSS also had to pay to elderly foreign citizens the benefit.

In 2020, in the face of the COVID-19 pandemic, the federal government declared the suspension of the CCTs and eight governors of the Northeast states, where most of

¹⁸ Campelli and Calvo [54] assert that the adherence of subnational governments and municipalities to the mandate of fulfilling a minimum expenditure on health and education is inconsistent over time.

the beneficiaries of CCTs live, initiated an Ordinary Civil Action, ACO 3359, attempting to guarantee the regularity of payment of *Bolsa Família*. The supreme court decided in favor of the governors' claim, indicating that the very first law creating the *Bolsa Família* did not anticipate any context under which the benefit would be discontinued.

The implementation of Provisional Measure 123/2003 required a complementary law that was never drafted, compelling the Supreme Court in 2021, *via* an Injunction Mandate, MI 7.300, to determine the National Executive to establish a vital minimum income and do everything possible, including altering the annual budget to meet the objectives of *Bolsa Família*.

6. The evolution of CCTs in Brazil

As explained in the methodological section above, the division of the evolution of CCTs into three stages is necessary to understand how the process of constitutional catching-up. The consolidation of the CCT programs in Brazil as a fundamental social right was only possible because it occurred gradually. This consolidation transformed state-society relations that fostered a dynamic wherein a coalition of actors advocated for the preservation and expansion of the CCT programs, mobilizing state actors in support of CCTs.

Based on Do Vale [10], each stage shows a type of innovation that can be summarized as follows. During the first stage (1995–2003), cash transfers became a widely accepted form of social aid to alleviate poverty, and as such, the federal government replicated state-level CCT programs. Then, in the second stage (2003–2012) with the expansion of the CCT programs at the federal level more households had access to this benefit across Brazil, and the program's scope expanded to include cash transfers for increasing access to services other than health and education (e.g., gas and electricity). In the last stage (2012 to present), the *Bolsa Família*'s fragile legal framework became noticeable as beneficiaries experienced changes in rules due to changes in federal governments and the COVID-19 pandemic. Below, the different stages will be analyzed in more detail.

It is worth highlighting here that the periodization of the program and its innovations are used from Do Vale [10], but this chapter emphasizes how constitutional mandates legally entrenched these innovations.

6.1 Stages of Bolsa Família

6.1.1 Stage I: Birth of the cash-transfer program

The Federal District was a pioneer in the introduction of CCTs in Brazil. During Critovam Buarque's governorship (1995–1998), the first CCT system was implemented. Buarque had previously served as rector of the Federal University of Brasília (UNB) in the 1980s and had envisioned the program.

Other municipalities quickly embraced the initiative, and by 1998, roughly 50 municipalities in seven Brazilian states (out of 5000 in total) had implemented CCTs [56]. The expansion of these CCT policies from the subnational to the national level through the development of new programs happened toward the end of the 1990s throughout President Fernando Henrique Cardoso's tenure (1996–2003), a period in which Brazil was undergoing economic austerity ([57], p. 215).

In this setting, the government was criticized for failing to address the population's deteriorating socioeconomic conditions. In response to criticisms, the Cardoso administration implemented three programs: School Aid (*Bolsa Escola*), Food Aid (*Auxílio Alimentação*), and Gas Aid (*Auxílio Gás*).

The *Bolsa Escola*, founded in 1999, became the first national CCT with the goal of offering scholarships to students from low-income families. For the first time in the country, a public initiative offered families cash compensation in exchange for their commitment to keeping their children in school. *Bolsa Escola*'s original critical feature was the provision of financial support to families who were unable to pay to the public welfare system, with the goal of increasing school attendance and decreasing dropout rates.

In 2001, the federal government expanded the program to include cash-transfer programs for nutrition (*Bolsa Alimentação*), the National Access to Food Program (PNAF), and social subsistence support (*Auxílio Gas*).

To summarize, the many CCT projects were integrated at the national level being a key first step in federalizing and expanding the CCTs.

6.1.2 Period II: Unifying cash transfer programs under *Bolsa Família*

In 2003, the government consolidated the existing net of CCTs under *Bolsa Família*, expanding the number of recipients and making it the government's flagship program. This new initiative relied on the integration of numerous previous projects, and its goals grew to include the promotion of social inclusion, as well as food and nutritional security.

The expansion of the programs required technological innovation, such as the construction of a centralized database with information on all beneficiaries. In effect, the nationalization of the program helped develop social assistance policy by creating a national registration of beneficiaries, the *Cadastro Único*, which became a federal government tool for identifying low-income households. The unified data gathering system helped enrolled households to receive benefits from several government programs.

To improve *Bolsa Família* monitoring, many managerial reforms were introduced. Municipal managers were appointed by their individual mayors and played an important role in implementing the program's decentralized aims. Several government bodies supervise tracking the program's accomplishments as the institutional constellation for its execution expands.

For example, the Ministry of Education's Secretariat of Continuing Education, Literacy, and Diversity (SECAD) collects data from municipal Secretariats of Education every 2 months and guarantees that recipients meet the children's attendance requirements. Furthermore, several departments within the Ministry of Health's administrative structure, such as the General Coordination of Food and Nutrition Policy (CGPAN), oversees verifying data on child vaccinations and pregnant women's prenatal care to ensure that beneficiaries meet their health obligations. The *Bolsa Família* created a public inspection network that included the Federal and State Prosecutors Offices, the Federal Comptroller's Office (CGU), and the Federal Audit Office (TCU).

With the program's unification, the federal government developed new instruments for recipients to access financial transfers, such as the creation of bank cards for beneficiaries to access the funds. Furthermore, federalization required

new coordination for program execution and monitoring, and, as a result, the federal government developed new coordination instruments for program execution and monitoring.

6.1.3 Stage III: Constitutional catch-up

This phase of “constitutional catch-up” is characterized by an escalation of legislative activity alongside the engagement of judges in the reexamination of the legal framework that facilitates the enhancement of social rights in Brazil and the maintenance of CCT programs. Nonetheless, two factors—the politicization of the CCTs and the COVID-19 pandemic—affected this process. These contextual factors shed light on the importance of the “constituency frame”, as previously mentioned, in the activation of the state in expanding social assistance programs.

The politicization of the CCTs can be understood through the election of the far-right president Jair Bolsonaro in 2018. Notwithstanding his government’s aim to reduce welfare expenditure, he upheld funding for the *Bolsa Família* with pressure coming from the National Congress. As previously stated, there was a sizable consensus among national legislators over the endorsement of the *Bolsa Família* expansion. Nonetheless, this program was renamed in 2021 as *Auxílio Brasil* as an effort of the Bolsonaro administration to dissociate the CCT from the prior administrations of the PT, which considerably expanded the CCTs in the second stage.

Due to the program’s popularity among a specific voter demographic, especially low-income women, this rebranding approach aligns with what Wonka [46] refers to as an advocacy strategy, aimed at voters who endorse a particular policy. This strategy gained significance for Bolsonaro as he sought presidential reelection in 2022, with the program’s association to his administration likely to secure votes in his favor.¹⁹

Also, the COVID-19 pandemic influenced the advocacy strategy of the Bolsonaro administration, as the parliamentary coalition supporting Bolsonaro in the National Congress established an emergency fund to increase the number of Brazilians receiving social assistance. The emergency fund aimed at families lacking a stable income throughout the epidemic, seeking to ensure a minimum standard of living.

This context had an impact on the CCTs, which began expanding social rights in 2010 and accelerated during the COVID-19 pandemic. Brazilian courts, especially the Supreme Court, established a jurisdiction that consolidated the principles of protection of human dignity, institutionalization, and the regularity of the social assistance support through CCTs. This in turn triggered a wave of judicialization of cases regarding social assistance matters [59].

In brief, the third phase addressed concerns among *Bolsa Família* beneficiaries about the program’s fragile legal basis. The program has survived changes of governments and a global pandemic, owing to the active advocacy of a key policy constituency.

7. Conclusion

This chapter interprets the Brazilian CCT programs as belonging to a process of “constitutional catching-up”. *Bolsa Família* has evolved from a temporary initiative

¹⁹ In presidential elections, there is a significant correlation between the votes for the Workers’ Party and the recipients of *Bolsa Família* [58].

to a rights-based policy. The initiative, which began as a temporary remedy, had a significant structural impact on the Brazilian welfare system.

The chapter sheds light on a dimension of social policy that fostered the emergence of social policy innovation, first, as a result of a constitutional framework conducive to the expansion of the Brazilian welfare state, and, second, as a product of the judicial activism that encourages the state to adopt innovative social policies.

Unlike Scandinavia's social democratic welfare states or Mexico's technocratic CCTs, the evolution of Brazilian CCTs reveals a legal pathway to welfare expansion—one where courts and legislatures, not just executives or interest groups, institutionalize rights. This redefines welfare state theorizing by centering legal activism as a catalyst in contexts of high inequality and fragmented institutions.

This chapter attempted to make contributions to the growing field of social protection policies by clarifying the relationship between these policies and the constitutional guarantee of fundamental rights. This happened first when Brazil transitioned to democracy while attempting to overcome social problems. After briefly mapping the process of “constitutional catch-up”, this chapter made evident that the Brazilian CCT programs are embedded within a robust network of democratic institutions and state-society relations.

Also, as demonstrated in the chapter, a constituency group was formed over time for the social rights in the Brazilian constitution to be embedded in society. For the *Bolsa Família*, the development of a strong constituency group has been crucial in fostering a dynamic where judges and lawmakers use a “constituency frame” to increase rights through actions that promote the program's sustainability. Put differently, the chapter connects the state's social welfare activism—which is supported by a sizable constituency group—with the growth of social assistance in Brazil.

The “constitutional catching-up” process is triggered over time and has the important function of maintaining and expanding the social assistance benefits. This means that this process has been important in the consolidation of *Bolsa Família*. This chapter precisely helps to emphasize the linkages between the legal and rights-based interpretations of the process of Brazilian social assistance formation and consolidation. Analyzing the evolution of *Bolsa Família* from a constitutional-judicial standpoint may shed light on novel viewpoints and frameworks to approach the subject.

Although there are relevant studies that consider the enlargement of social assistance in Brazil considering the pursuit of rights [60–62], this chapter has attempted to systematize an approach that identifies patterns of a process of matching public actions and intensions with the constitutional fundamental rights.

In terms of concrete policy recommendations, clear actionable measures emerge with the Brazilian CCT model that might be useful for other countries: to benchmark social rights compliance, to conduct civic education campaigns to frame welfare benefits as rights, and to create beneficiary councils (e.g., participatory budgeting forums) in order to institutionalize grassroots advocacy.

Brazil's *Bolsa Família* demonstrates that welfare states in the Global South can expand through “constitutional catching-up”—through which legal guarantees, judicial activism, and constituency-building reinforce one another. As the Brazilian case shows, welfare expansion in unequal societies requires legal mobilization, for policymakers, this underscores the need to embed social rights in national constitutions, empower courts to enforce them, and design programs with adaptive governance structures. Crucially, sustaining such reforms requires depoliticizing welfare delivery while fostering civic inputs and oversights. As other developing nations confront rising inequality, Brazil's experience continues to offer a roadmap for transforming temporary aid into enduring rights.

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Chapter

Perspective Chapter: Ethics of Social Welfare in Modern Democracies – A South African Perspective

Khali Mofuoa

Abstract

Social welfare services provision has become a common feature of modern democracies, with a huge burden on the public purse. Amid shrinking revenues to feed the over-stretched public purse, modern democracies continue to embark on a plethora of social welfare reforms for the benefit of those demonstrating economic need. Here, the provision of social welfare services and their associated reforms have raised ethical issues: Are modern democracies responsible for the wellbeing of their poor citizens? If so, at what cost and to what degree are they morally bound to act? Using South Africa as a case in point, the chapter explores ethics of social welfare in modern democracies. In so doing, it argues that South Africa provides a unique case for the ethical basis of social welfare. It also contends that South Africa offers an answer to the question of why social welfare is a vital aspect of modern democracies. It further states that South Africa presents a case as to why social welfare is couched in rights-based ethics. It is based on secondary data from available literature against the South African post-1994 efforts towards building itself as a welfarist state responsive to the economic needs of its poverty-stricken citizenry.

Keywords: South Africa, ethics of social welfare, social welfare, social protection system, modern democracies, Global South

1. Introduction

Social welfare services provision has become a common feature of modern democracies [1–6]. It is widely accepted as a product of the welfare state and understood as a way of governing in which the state provides social welfare service to its citizens deemed vulnerable and at risk of socio-economic hardships [7]. It is not surprising therefore that modern democracies “have programs that are reflective of a welfare state, such as unemployment insurance and welfare payments” [7]. This is the case despite questions about whether modern democracies are responsible for the wellbeing of their poor citizens. If so, at what cost and to what degree are they morally

bound to act? These questions are legitimately raised within the context of shrinking budgets in governments of modern democracies [8–10].

The shrinking budgets are a concern for the public purses for governments as the provision of social services does not come cheap [11]. In fact, it comes with a huge burden on the public purse as shown by “budgets allocated within social services in different countries in the Southern African region” ([9], p. 1). According to Bolton [9], the budget allocations within social services in modern democracies take a lion’s share in the ever-escalating high wage bills for general government expenditure. In fact, the number of budget spent on social protection services in modern democracies have raised concern in recent years: do they foot the bill? This is an interesting question as sizeable amounts of social budgets in modern democracies are destined to reduce government consumption spending in far distant future. Here, South Africa is by no means immune from this reality, prompting public commentary. Most recently, one commentary on the amounts of social budgets has suggested that they are not fit for purpose [10]. This is so amid worsening anticipated revenue collection to couch increasing social spending in recent years [12].

In South Africa, social protection is one of the factors that drive government spending post-1994 [13]. This is not surprising as Lachman and Bercuson [14] correctly predicted that “a major challenge to budgetary policy in the new South Africa will undoubtedly lie in the area of social spending”. Living true to this prediction, “social spending in South Africa—net of social security payments—has risen to levels that are relatively high by international standards” ([14], p. 18). This is the case because “The performance of any government is measured by improvement in its citizens’ well-being and the quality of life they live” ([15], p. 1). It is in this regard that, in South Africa, “[social] spending has remained an important instrument for the provision of public goods and services” ([15], p. 1). In fact, South African social spending in post-1994 has become “one of the vital ways for the provision of public goods and services with a view of improving the well-being of the populace” ([15], pp. 1–2).

Considering this, “South Africa [is] developing country [that] has the most comprehensive social protection system in terms of social grant coverage” ([16], p. 1). Its post-1994 progressive and transformative Constitution forms a developmental framework for building a truly South African inclusive social protection system [17, 18]. In building a nondiscriminatory social protection system, the South African Constitution provides an ethical frame for “Reimagining social protection in South Africa” [19]. It has become an ethical frame “Towards the reconceptualisation of social welfare in South Africa” ([20], pp. 433–455). In this regard, it has enabled South Africa to develop and implement successful social protection reforms [21]. These reforms are truly the defining thread behind the redistribution of socio-economic resources to the poor. They are the South African post-1994 efforts towards building itself as a capable, ethical, and developmental state responsive to the economic needs of its poverty-stricken citizenry.

Against this background, South Africa is thus a compelling case for the establishment and implementation of a comprehensive social protection system in modern democracies. This accolade is befitting for South Africa as its “developmental social welfare paradigm still remains the de facto approach in social welfare policy” ([20], p. 433). Thus, South Africa provides what Barrientos et al. [22] dub “a ‘rowing’ social protection” Ubuntu ethics-oriented path in modern democracies. In light of this, this chapter explores the ethics of social welfare in modern democracies predicated by the South African trajectory to re-establish itself as a just society post-apartheid era.

In so doing, the chapter argues that South Africa provides a unique case for the ethical basis of social welfare through its constitutional value of Ubuntu and its far-reaching Bill of Rights [23]. It also contends that South Africa offers an answer to the question of why social welfare is morally a vital aspect of modern democracies. It further states that South Africa presents a case as to why social welfare in a just society is couched in ethical terms of rights and responsibilities.

The purpose of this chapter is to argue the case for ethics in social welfare from a South African perspective. It argues that the South African social protection services beam the searchlight of ethically attuned mandate for rights-based social welfare in modern democracies. The chapter offers an examination of the ethical motivations behind South African social protection in the post-apartheid era. In a concise and clear manner, the chapter analyses the welfare system in South Africa, which is characterised by a constitutionally based protection of rights and a significant allocation of public funds to expand the system. This reflects the systematic commitment of democratic governments to fundamental welfare provision. Focusing on the ethical dimension of the social welfare development in South Africa, the chapter centres its analysis on the ethic of Ubuntu-Botho, an African moral theory that advocates for the social protection or welfare of the most vulnerable members of society.

The chapter is based on secondary data from available literature in terms of a qualitative desktop research methodology against the South African post-1994 efforts towards building itself as a capable, ethical, and developmental state responsive to the economic needs of its poverty-stricken citizenry from a social welfare perspective. In the main, the chapter is structurally divided into five sections of which Section 1 introduces the chapter by highlighting the place of social protection within the context of shrinking budgets in modern democracies. Section 2 generally discusses the ethical impetus for the establishment of social welfare protection in South Africa post-1994 anchored by the ethic of Ubuntu-Botho. Section 3 presents an overview of the South African social welfare system as a plausible instrument for reforming the countries' social protection by anchoring rights in law constitutionally. Section 4 makes a case for the South African rights-based ethics social welfare system as a shining example of reforming social protection in modern democracies. Section 5 concludes the chapter by underlining the developmental imperative of ethically-induced social protection in modern democracies in the Global South as underscored by the South African case.

2. Social welfare protection in South Africa: ethical impetus post-1994

The post-1994 South African social protection can be understood in the light of an African moral theory dubbed 'Ubuntu-Botho' [24, 25]. Culturally, Ubuntu-Botho is an African moral theory that calls for fostering of the social protection or welfare of the vulnerable others in society. In the words of Metz, it is "potentially foundational when thinking about social protection" ([26], p. 133). It is so in that it provides a social safety net a mechanism in welfare organisation for vulnerable individuals in society [26]. Thus, the ethic of Ubuntu-Botho is seen as one of the "newer normative philosophies of social protection" ([26], p. 133) whose influence is recognised for setting South Africa on the path of its internationally acclaimed social protection [17, 21, 27]. It is indeed the bedrock of South Africa's social protection. It is seen as a driver towards building an inclusive social protection system in South Africa [17]. Thus, there is a general feeling that Ubuntu-Botho "offers a philosophical foundation for

thinking about social [protection]” ([28], p. 1128). As such, Ubuntu-Botho is seen as “the bedrock upon which much of Africa’s social protection policy is anchored” ([28], p. 1128). In fact, Metz [26] views the implications of Ubuntu-Botho as more attractive for social protection. Hence, he suggests that “[it] should be taken no less seriously as potentially foundational when thinking about social protection” ([26], p. 132).

The ethical impetus of South African social protection as epitomised by the ethic of Ubuntu-Botho was first articulated by Tshoose [29]. Here, Tshoose [29] succinctly highlighted the significance of the African value of Ubuntu-Botho and its emerging role within the South African context of social protection. Tshoose [29] argued that the ethics of Ubuntu-Botho as a South African constitutional value plays a crucial role in supporting the current social protection system in South Africa [15, 16, 19]. Thus, Tshoose [29] concluded by highlighting the overarching potential that the African value of Ubuntu-Botho has for influencing the South African social protection context. It is in this regard that Mugumbate et al. [28] perceive Ubuntu-Botho as “a source of social knowledge” towards the social protection model of Ubuntu [26].

In his latest work after a decade ago, Tshoose [30] reignites his 2009 assertion that the principle of Ubuntu-Botho is foundational as a normative agency of South African social protection. Indeed, Tshoose [30] still sees the principle of Ubuntu-Botho as foundational for the existing South African social protection system. Like a golden thread, Tshoose [30] perceives the principle of Ubuntu-Botho as permeating the South African social protection system. For Tshoose, the constitutional role of principle of Ubuntu-Botho is evident “in the interpretation and protection of the right to have access to social security” ([30], pp. 163–194). He describes South African Ubuntu-Botho as “the value-based formulation to the protection and interpretation of the [constitutional] right to have access to social security” ([30], p. 185). In this regard, he sees as Ubuntu-Botho as providing “an important means of setting out the [South African] policy intent that drive[s] normative legislative [and constitutional] framework on access to social security” ([30], p. 185). As a value-based approach to social protection, Ubuntu-Botho has become a constitutional imperative towards creating a South African society that “ensure[s] that people are afforded their basic needs and that the necessities of life are accessible to all” ([30], p. 186).

It is in the above regard that the ethic of Ubuntu-Botho is seen as “a form of social protection [at least in the South African context]” ([31], p. 650). It is so in that in Ubuntu-Botho practice, “the emphasis is on one’s responsibility to ensuring the wellbeing of others” ([31]: 651). It is in this light that the ethic of Ubuntu-Botho is assumed as a guide for enriching people’s life [31]. It is therefore not surprising that, in the South African context, Ubuntu-Botho is recognised as “a system of social protection” ([31], pp. 2652–2654) that finds its expression in Batho-Pele (‘people first’) public service policy [32, 33]. Here, the South African Ubuntu-Botho-inspired social protection is understood as “a safety net to protect people from poverty, vulnerability and insecurity” [34–37]. Infused with the spirit of Ubuntu-Botho, “the South African social protection system makes provision for medical care, sickness, unemployment, old age, employment injury, family, maternity, invalidity, and survivors’ benefit” ([38], p. 33). These are the internationally acclaimed minimum standards of social protection and welfare “contained in the ILO Social Security Convention 102 of 1952” ([38], p. 33). Thus, South African social protection presents itself as giving expression to deeply-held African ideals of one’s personhood being rooted in one’s interconnectedness with others.

Thus, from the South African context, the lack of Ubuntu-Botho-inspired social protection insights and mindset is seen as an impediment to the post-1994

transformation agenda. It is in this light, therefore, that Ubuntu-Botho-infused social protection is perceived as important for repurposing post-1994 social protection in South Africa. Ubuntu-Botho repurposed post-1994 South African social protection anchored by Batho Pele ‘people first’ service is thus seen as a catalyst for provisioning of social welfare service to all South Africans. It is in this regard, at least in the South African context, that Batho Pele is seen as giving practical expression to the constitutional value of Ubuntu-Botho as the reformist bedrock of South Africa’s ethically attuned rights-based social protection regime.

3. South African social protection system: need for reforming to be inclusive

Inspired by the constitutional value of Ubuntu-Botho, the post-1994 South African social welfare system which is developmental in nature has been a pivotal instrument for reforming the country’s social protection. Early on, in the post-1994 democratic South Africa, it was clear that the social protection system needed reforming to be developmental and inclusive to cater to the majority of poor and vulnerable South Africans [39]. According to Brown and Neku ([40], p. 301), the South African history of social protection is mainly about “the plight of South Africa’s poorest Black majority and the government’s efforts to alleviate poverty”. The pre-1994 apartheid social protection system was racially designed and discriminative in nature. As such, the majority of poor and vulnerable South Africans were excluded from social protection under apartheid. They were excluded from receiving social protection services resulting in them being vulnerable to massive poverty and inequality which undermined their human rights and dignity [41].

Narrating the history of the South African social protection system prior to 1994, DPME ([42], p. 6) notes that the apartheid system “entrenched the socio-economic privileges of the white minority both in its design and in its implementation”. As a result, the apartheid system “was inefficient and ineffective, with fragmented and duplicated services that did not meet the human needs of vulnerable and poor citizens” ([42], p. 6). The apartheid social protection system’s downfall was engineered by its exclusionist welfare policy that “entrenched the socio-economic privileges of the white population, and differentiated races along political, economic and social lines” ([42], p. 3). According to DPME ([42], p. 3), “the operating procedures of the welfare policy were fragmented along racial and ethnic lines”. In this context of apartheid social protection, “the white population group accessed better and well-resourced welfare services, as opposed to the black, coloured and Indian population groups” ([42], p. 3). Thus, prior to 1994, the South African social protection system was delineated by racial exclusion and inequalities [39, 42].

As alluded to earlier, post-1994 democratic South Africa saw the transformation of the social protection regime with developmental measures to extend social welfare services to the entire all South Africans. With developmental drive and mentality, the transformation of the South African social protection regime was initiated “in line with the constitutional provisions that envision a more inclusive, equal and caring society” ([42], p. 10). According to DPME ([42], p. 10), “These injunctions find resonance in the vision for a developmental approach to welfare provisions outlined in the RDP, and subsequently given expression to in the White Paper for Social Welfare”. In fact, from the South African context, the 1997 White Paper for Social Welfare (WPSW) was the basis for reforming and restructuring of the post-1994 South

African social protection system with a developmental mindset. The WPSW was thus “a response to th[e] call [to] embrace a developmental social welfare system that is more just, equitable, participatory and appropriate in meeting the needs of all South Africans” ([39] cited in [43], p. 155). For Patel [44], WPSW “is significant because it broke with past inequitable, inappropriate, and undemocratic welfare policies of the apartheid era”.

As a path for social protection welfare in the post-1994 South African context, WPSW ushered what Grey and Lombard ([45], p. 430) dubbed “the advent of developmental social welfare”. The attractiveness of the South African developmental social welfare is that “being policy-driven, [it] stem[s] from expert social analyses that resulted in technically oriented solutions” ([45], p. 430). In addition, the South African developmental social welfare attractiveness also lies in the fact that it is couched in a rights-based approach to social welfare service provision [46]. In fact, the adoption of a rights-based approach to social welfare service provision in the South African context is no surprise given the country’s unique history of inequality and the violation of human rights from colonialism to apartheid [39]. It was given that post-1994 social protection service provision would be predicted on social justice and human rights advocacy [41]. Hence, South Africa’s post-1994 move to extend social protection to all South Africans by anchoring rights in law continues to receive enduring international acclaim [47]. It is thus seen as a bedrock for achieving the much-desirable universal social protection at the forefront of the development agenda [48–50].

4. South African rights-based social welfare: a shining reform experiment

South Africans take pride in the founding 1996 Constitution of the democratic South Africa which enshrines the rights of all people in the country. Through its comprehensive Bill of Rights, the South African Constitution is recognised as the ethical architecture of social protection in South Africa. The Constitution’s compelling ethical force is abundantly evident in establishing a human right baseline for social protection in post-1994 South Africa. As Piron [51] fondly notes, “The South African Constitution is relatively unique in granting enforceable economic and social rights”. In this regard, it is pleasing to South Africans that South Africa has managed to establish an enviable social protection system “which is built on a strong human rights and value-based constitutional foundation” ([38], p. 57). It is this foundation that has enabled South Africa to fine-tune its craft in establishing a value-based comprehensive social protection system. It is in this regard that Mpedi believes that “South Africa is on the right path towards the progressive realisation of universal social protection for her population” ([38], p. 57).

In agreement with Mpedi [38], one observes that South Africa’s post-1994 conscious act of extending social protection by anchoring rights in law has obtained international acclaim and footing as a shining example [47, 52, 53]. It is argued that modern democracies in Africa and elsewhere can take a leaf from the South African ethically attuned rights-based approach to social protection. Here, ILO points out that, despite its imperfections that still need addressing to remedy, “the South African social security scheme illustrates a good example of a comprehensive system to fulfil the principles of universality of protection and social inclusion set in international standards” ([47], p. 4). In fact, it is a considered view of ILO that “countries that seek to fill social protection coverage gaps and continue building [their] social protection

systems [should look at the South African] rights-based approach for glues]" ([47], p. 4). For ILO, "the South African system is a good example for emulation in the development of social security systems, be it for middle income countries, countries with diversity in patterns of employment and relatively high unemployment rates and unequal distribution of income and jobs" ([47], p. 4).

The ILO's sentiments are shared by Seekings [53] who sees South Africa as a worthy pioneer of "enthusiasm for rights-based social protection programmes that has spread across much of Africa". For Seekings, South Africa is a classical instigator of the movement "for rights to social protection enshrined in the constitutions of several African countries" ([53], p. 2). The author notes that "South Africa is the case where social and economic rights are most fully institutionalized, not only in the Constitution and legislation, but also in court cases, political rhetoric and even popular discourse" ([53], pp. 3–4). In addition, the author describes South African social protection system as "both unusually extensive and unusually generous [having] adopted a classically rights-based approach to an extensive system of social assistance" ([53], p. 4). Indeed, according to Seekings [53], South Africa is "a case of a country with a strong formal commitment to social and economic rights".

The above consideration has placed South Africa on the international map as a champion of the 'global' discourse of rights to social protection among its peers. It has indeed become a country in which "the new 'global' discourse of rights has been incorporated into national law, strategy, policy and practice" ([53], p. 25). Because of its post-1994 bold vision of socio-economic rights entrenched in the 1996 Constitution, "South Africa is often held up as an international lodestar, in terms of both its constitutional provision for social and economic rights and the actual reach (and effects on poverty) of its social assistance programmes" ([53], p. 25). In this regard, Seekings [53] is moved to write that, among its international peers, "South Africa clearly has both an unusually high degree of institutionalization of rights and unusually extensive social protection coverage".

Bamu and Alfors [52] further agree with ILO [47] and Seekings [53] that when it comes to a rights-based approach to social protection, South Africa is exemplary. From the rights-based approach to social protection, the South African government has born "a duty to realize the right and are accountable for the actions they take towards this" [52]. Here, Bamu and Alfors [52] consider South Africa as also a classical case where "the court cases point to the potential for litigation as a way of enforcing the right to social protection". For them, the South African social protection regime has shown that "there is a clear need for this comprehensive and enforceable protocol on social protection" [52]. It has further shown that "it is also important to make constitutional commitments to social protection that encompass all of its forms and apply to everyone, making special reference to all marginalized groups, including self-employed workers" [52].

Thus, the importance of constitutional commitment to ethically attuned right-based social protection as exemplified by South Africa cannot be overemphasised. This ethically-inspired constitutional commitment is globally recognised for raising the bar for what the former ILO Director-General, Guy Ryder dubbed "the value of social protection" [54]. For him, despite our hazy knowledge and comprehension of "the full implications of the COVID-19 pandemic, one thing is already clear – the value of social protection has been unequivocally confirmed" ([54], p. 3). According to the former ILO Director-General, "The pandemic response generated the largest mobilization of social protection measures ever seen, to protect not just people's health but the jobs and incomes on which human well-being equally

depends” ([54], p. 3). For him, the pandemic-ignited mobilisation of social protection measures signalled to the world what he calls “th[e] renewed appreciation of the importance of social protection” ([54], p. 3).

The former ILO Director General is convinced that “th[e] renewed appreciation of social protection was well reflected in the adoption of the conclusions on social protection by the governments, employers and workers of the ILO’s 187 Member States at the International Labour Conference in June 2021” ([54], p. 3). He is adamant that the adoption of the conclusions on social protection “served as a powerful reminder that rights-based social protection systems, anchored in the principle of solidarity, are at the core of decent work and social justice” ([54], p. 3). As such, he firmly believes that

Now is the moment to strengthen and invest in social protection systems everywhere, including social protection floors, so we are better prepared for whatever future crises may come. This means implementing a rights-based approach, with universal social protection systems that guarantee access to adequate, comprehensive support throughout people’s lives, regardless of the type of employment they have or the nature of their work. This is essential for the human-centred, equitable recovery we need ([54], p. 3).

Like South Africa in 1994, it is indeed imperative according to the former ILO Director General that countries “deploy their social protection systems as a core element of their post-covid rebuilding strategies, identif[y] the protection gaps that must be closed, and set out key policy recommendations for achieving the goal of universal social protection for all by 2030” ([54], p. 3). Like post-apartheid South Africa with the widow opened by democracy, the post-pandemic human-centred protection recovery require countries to “use the window opened by COVID-19 to pursue the high road to universal social protection” ([54], p. 3). This calls for a deliberate and concerted effort towards “enshrining universal social protection in law [to ensure that it is assured]” ([54], p. 220). This is because “when social protection is not enshrined in law and is not predictable, individuals are not able to reap its socio-economic dividends” ([54], p. 220). Thus, it is always ethically preferable that, like South Africa, countries should adopt an ethically inspired “human-rights based approach to social protection that is embedded in a system of rights and corresponding obligations” ([54], p. 220). According to ILO, such a social protection system “ensures that benefit entitlements are prescribed by law, guaranteeing their continuity and predictability” ([54], p. 220). Here, the former ILO Director-General reckons that the pursuit of the high road to universal social protection “is an ethical and rational choice, and one that paves the way to social justice for all anchored by right to social protection” ([54], p. 3).

5. Conclusion

This chapter has focused on the right-based ethics of social protection in South Africa and the ethically attuned Ubuntu-Botho principle that grounds its constitutionality. Using South Africa as a case in point, the chapter has highlighted that an ethically attuned rights-based social protection system can have a transformational impact on the lives of the poorest and most vulnerable. In this regard, the chapter has argued that the South African Ubuntu-Botho social protection system anchored by the right to access social protection is a living good example for emulation by modern

democracies. The chapter has pointed out that South Africa's experience has demonstrated that realising the human right to social protection can play a pivotal role in establishing a comprehensive social protection system.

The chapter has further presented the South African social protection services as beaming the searchlight of the ethically and constitutionally attuned mandate for right-based social welfare in modern democracies. In this regard, the chapter has discussed the ethical impetus for the establishment of social welfare protection in South Africa grounded on the constitutional value of Ubuntu-Botho as its foundational anchor. It has also described the South African social welfare system as a plausible instrument for transforming social protection regimes in modern democracies. It further made a case for the South African rights-based ethics social welfare system as exemplary in reforming and enshrining social protection in law for modern democracies as illustrated by the post-1994 South African transformative social protection system.

The chapter concluded by underscoring the importance of building a post-1994 South African social protection system through the lens of the ethic of Ubuntu-Botho as a galvanising instrument for social change. In essence, the ethic of Ubuntu-Botho has become a transformative centrepiece of the post-1994 South African social welfare policy in moral and socio-economic terms. As such, the ethos of Ubuntu-Botho has profoundly transformed the post-1994 South African social welfare policy as a key development instrument. It has made the South African social protection regime more comprehensive, expansive and inclusive in developmental terms.

In the above regard, the post-1994 South African Ubuntu-Botho-inspired social protection undoubtedly underscores the feasibility of applying the nationally-inspired ethical ethos that underpins social welfare development to other countries in the Global South. It represents the highest level of global social protection messaging that the nationally-inspired ethical ethos can underpin social welfare policy in development contexts to countries in the Global South. It also presents a practical opportunity to not only decolonise social protection practices but to indigenise them to other countries in the Global South. Indeed, the South African Ubuntu-Botho-inspired social protection signals a new approach towards social protection policy in the Global South. It also beams the light that, perhaps, the global future of social protection ethics, principles and practice would undoubtedly be shaped by the Global South.

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Conflict of interest

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Section 2

New Methods and Approaches to Social Welfare

Chapter 4

The Child Welfare Service's Ignorance: The Use of Attachment Theory in Norwegian Child Welfare

Hilde Anette Aamodt and Nicole Hennum

Abstract

As studies show, families in contact with child protection services are families with many poverty issues, such as unemployment, low income, health issues, bad housing. The adverse living conditions make it often difficult to parent children. In this chapter, we have chosen to analyze an excerpt from an interview with a mother who has been deprived of custody of her child. In the interview, the mother explains how the Child Welfare Service uses attachment theory to support its assessments. By looking at how attachment theory dominates in the practice of the Child Welfare Service, risks being applied beyond how it is intended, we show how ignorance can contribute to producing, maintaining, and developing social work practice. In this way, we have tried to exemplify and make visible how practice emerges as a result of knowledge we do not have.

Keywords: child welfare, ignorance, attachment theory, Niklas Luhmann, care order

1. Introduction

“We relate to these past cultures almost as tourists. Cultural forms that are self-evident today and the “world” of today’s society will meet similar fate. No one can seriously doubt this” ([1], s. 75).

In his essay on the ecology of ignorance, Luhmann [1] writes about how any knowledge we hold to be true will eventually disappear. We look back on the past as surprised tourists, realizing that what we once believed to be true and evident now appears strange and ignorant in the light of day. According to Luhmann, this has always been the case. In this chapter, we will explore how practice can emerge as a result of knowledge we do not possess. It is a practice that arises because we are unaware of our own ignorance. Consequently, a retrospective look often becomes a reflection with the benefit of hindsight, where we fail to understand what we previously believed to be true.

In this chapter, we explore how ignorance can contribute to producing, maintaining, and developing social work practice. We have chosen to analyze an excerpt from

an interview with a mother who was deprived of custody of her child. In the interview, the mother explains how the Child Welfare Service uses attachment theory to support its assessments. The excerpt is intended as an example of how practice is created as a selection of knowledge. When the Child Welfare Service chooses to support its decisions with a basis in attachment theory, this theory's view of knowledge will become predisposing to what emerges and thus form the basis for practice. However, a lack of understanding of the theory's limitations could also lead to faulty practice.

In the analysis, we show how the Child Welfare Service, by being ignorant of its own ignorance, practices ignorance. The research question examined in this article is; *How does ignorance produce, maintain and develop child welfare practices?*

Originally, Bowlby [2] introduced the attachment theory to explain the child's emotional ties to his caregivers. The theory has become one of the most influential theories in the social sciences and its use has been constantly expanded in a number of disciplines [3–5]. However, several advocates that the theory is used far beyond what it is intended for and suitable for [6–9] and internationally, the knowledge base of attachment theory is discussed [7, 10–13]. Granqvist et al. [8] describe, among other things, how the attachment theory is used in misunderstood ways and that it is not suitable for assessments of neglect, for example. Furthermore, the theory cannot indicate that the child has been abused or predict illness or the child's potential for change or development.

Forslund et al. [7] account for misunderstandings related to the understanding and practice of the theory, stating that this indicates the theory is being applied incorrectly. They argue that the theory is primarily suitable for supporting and assisting parents, rather than assessing a lack of care. According to their perspective, attachment theory is relevant in highlighting the harm caused by disrupting the continuity of care between parents and children. Their study emphasizes the importance of helping parents provide adequate care to prevent ruptures in the parent–child relationship. When considering the removal of children from their parents, attachment theory illuminates the risks involved in severing attachment bonds between parents and children.

There are also other studies that show the danger of having too much faith in attachment theory and that child welfare staff assess children's attachment quality without having sufficient competence. This can mislead the child welfare service's investigations. Among other things, it is pointed out that there is a danger of using attachment tools developed at the group level in assessments of the individual child [9, 13].

In Norway, the Child Welfare Service's use of attachment theory has also been problematized [3]. Among other things, it is claimed that the Child Welfare Service is governed by a narrow view of knowledge, with a particular emphasis on attachment theory [14–17]. However, the issue here is not primarily that attachment theory is used incorrectly or misunderstood, but rather that attachment theory has an individualized perspective rooted in psychology. This implies that the Child Welfare Service should also ground its practice in other social science theories, such as sociology, anthropology, and social work.

Below we explain ignorance as a concept and field of research before we present the chapter's empirical data and analysis strategy. We then present an excerpt from an interview with a mother who has been deprived of custody of her child. In the interview, the mother says that she has been deprived of the child because the Child Welfare Service assesses, based on attachment theory, that there is a lack of attachment between her and her daughter. In the analysis that follows, we show how the

use of attachment theory becomes crucial for how the mother's care competence is assessed. This is followed by a discussion in which we problematize how the Child Welfare Service's use of attachment theory can be seen as an ignorant practice without those involved seeing that it is ignorance that is at play.

2. The ecology of ignorance

Ignorance and knowledge are often seen as contradictory phenomena [18]. For example, politics during the COVID pandemic is used as an example of how to deal with ignorance when one is aware of one's own ignorance. Here there were questions about how to handle and act when one did not know how the disease would develop. Ignorance of the disease and its dynamics was an important element in decision-making [19].

In a special issue of the journal *Ephemera: theory & politics in organization*, the role of ignorance in modern organizations is explored [18]. Among other things, it is highlighted how ignorance is produced as a resource for organizations to continue their activities, even if this has harmful consequences. An example could be the tobacco industry or companies that produce environmentally harmful products [20]. Ignorance can be seen, for example, as a result of hidden or secret knowledge [21–30]. In this way, ignorance is used to disclaim responsibility and as a strategy to avoid taking existing knowledge into account [18]. Ignorance thus becomes a strategy for ignoring or suppressing knowledge that one is actually aware of [31]. Marginalizing unwanted knowledge, and thus dealing with ignorance strategically, makes ignorance something different from the opposite of knowledge.

There are also researchers who study the ignorance that arises and unfolds in organizations, without this being the intention. Because ignorance is not something an organization will acknowledge, it is also not easy to study ignorance as a field of research. In order to study this form of ignorance, it is necessary to explore the power and structural processes of the organization that allow people and organizations not to know. What one is not aware of may manifest as irrational or unreasonable practices and contradictions [18]. There is also research that shows how ignorance is produced and maintained with the help of communicative selection [32]. Here, ignorance and knowledge are seen as the selection of information made by an observer. The information chosen is determined by the difference with which the observer sees. Some things are chosen as information, as opposed to something else. What is not selected remains in the dark. Knowledge and ignorance are the result of complexity and necessary selection processes (McGoey, 1969 in [18]).

3. Methodology

Below we present an excerpt from an interview with a mother who has been deprived of custody of her child. The interview is taken from an ongoing research project that studies care orders from a parent's perspective. The example actualizes and highlights the issue we are concerned with. Namely, how practice is created by what we make applicable in our observations and thus forms the basis for practice.

In the project, 30 interviews have so far been conducted with parents who have experienced being deprived of care. The interviews were conducted in 2020/2021 and

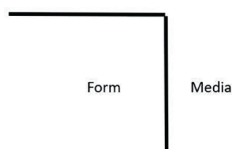


Figure 1.
Observation as a result of the difference between form and media.

2023/2024. We contacted the Organization for Child Welfare Parents (Organisasjonen for barnevernsforeldre, OBF) and asked them to invite relevant parents to join the project. The organization posted an invitation on its Facebook page with contact information for us researchers so that interested parents could get in touch. There were also situations where the leader of the organization gave us contact information for parents at their request. We then got in touch and made an appointment for an interview.

In the analysis, we have used a form/media analysis as Niels Åkerstrøm Andersen presents it [33]. A form/media analysis gives us an insight into how the child welfare service's observations are determined by which media are used in the observation. The observation thus emerges as a form as distinct from a medium and where the type of medium becomes predisposing to which form emerges [34]. Any established form can then establish itself as a medium for a new form. In this way, we get an insight into how current practice is created [35]. As early as 1920, Fritz Heider published an article in which he proposed the difference between form and medium as a prerequisite for all perception [36]. Talcott Parson and later Niklas Luhmann also use the concept of media when defining how observations emerge [37–39]. In line with this perspective, every observation will mark one side of the difference, where the other side remains unmarked, but nevertheless determines what emerges in the observation:

In **Figure 1**, we show how every observation emerges as a result of the difference between form and medium. In the analysis, we have thus looked at how the observations can be seen as a difference between medium and form, and thus how the observations construct what they see. By observing the communication in the case, we assume a second-order observer role where we observe what a first-order observer observes by setting a difference [34, 35].

3.1 Ethical guidelines

Current research ethics guidelines for the use of data have been followed and approval from NSD (now SIKT)¹ has been obtained. All formal requirements for the collection, use and storage of the data material have been met. All participation in the study is based on informed and voluntary consent. The participants' anonymity is safeguarded, and all results are presented at group level. No individual is identifiable. All the informants were informed that they could withdraw during the study if they still did not want to participate. No one has resigned.

¹ NSD is organized as a state-owned limited company under the Ministry of Education and Research (KD) and is a national center and archive for research data. About NSD—Norwegian Centre for Research Data | NSD.

4. A mother's description of a custody order with a reunification

Below are parts from an interview with a mother who was deprived of custody of her daughter when the girl was eight months old. She says that the Child Welfare Service justified the care order in a lack of emotional care and insecure attachment between her and her daughter. The daughter was returned when she was three years old. The mother then experienced that the girl missed her foster parents. Mother says:

(..) They thought it was a lack of emotional care on my part. That I didn't see the girl's needs. That I somehow couldn't answer her in the right way and give her what she needed emotionally (..) So they thought that she was in a way a bit evasive to me. (..) That there was poor eye contact and that was in a way what became the basis for the case in the board. A lack of attachment. They also thought it was very important to move her before she was two years old. And it was because of the attachment process she was undergoing, and then it was important that she got a good attachment to her foster parents, they said.

And then I thought, isn't that very contradictory? So, they sit and say that she is going to move during the period where she is in a process that is very important to her? And I remember asking them questions then, before they moved my daughter. What they thought about moving her, and what it would be like for her. And then they thought that living with me was worse than the reactions she would get because of being moved, and that it (the reactions) is part of the package. So, it's just something she has to go through in a way. When she is moved. (..)

And when it came to reunion, it came to light that she was too vulnerable to be moved. That she was too vulnerable in herself to handle a new move. They also added that I had problems with practical care, tunnel vision and yes and a lot of strange things that I haven't heard before. (..) But the tribunal went for reversal and decided that she should move back to me. When the girl was three years old. And now, in a way, she has the feeling that it is her foster parents who are her home. So of course, it's very painful when she's here and wants to go there.

So it has often been like that in the evenings, that she has had a little trouble sleeping. (..). Because then she thinks a lot, obviously. Because then comes the "I miss my mom Cathrine, I miss the red house and I want to go there again" and (...) so I think it's important that she gets to maintain a relationship with them. She talks a lot about them and then it's much easier to be able to say, "well now you're going to see them again soon". Instead of just having to say no. So, I think it's been very important to her. But that is completely contrary to what the Child Welfare Service believes. Because there everything has to be cut. (..), but I notice that she misses them. So, the day that the foster parents were here and delivered her, the foster mother was very sad of course. She started crying when she left, and the last thing my daughter saw of foster mother was in a way that she was crying and sad. So, I think my girl thought a lot about it, like that the foster mother was sad and ... So, I think there has been a lot of that too that has bothered her a bit. So, when they were here, four, five days later or something like that and she saw that foster mom was happy again, it was just like, something relieved for her. It was so much better for her when she saw it. (...) Yes, so I have made an agreement that they will be allowed to be, call it a visitor's home or weekend home or, so she will be allowed to be with them.

5. Case analysis

The mother describes that when her daughter is eight months old, the Child Welfare Service believes that she is unable to provide her daughter with adequate emotional care and that there is a lack of attachment between her and her daughter. This is what the mother perceives as the reason why her daughter must move. She goes on to say that the lack of emotional care is because the Child Welfare Service believes that she does not see the girl’s needs, that there is poor eye contact between her and the girl and that she is unable to respond to her daughter in a correct way emotionally. As the mother experiences it, this is because the child welfare perceives the girl as avoidant in relation to the mother. The reason why the girl must move is a lack of attachment between her and her daughter, as the mother perceives the Child Welfare Services.

5.1 Lack of attachment

If we set up the observation as a form/media observation in line with the analysis strategy, we can see how the justifications function as a *medium* in the child welfare service’s observation for *the form* lack of attachment to the mother:

In **Figure 2**, we show how the Child Welfare Service’s gaze can be seen as a difference between form and medium. The form or the Child Welfare Service’s observation is that the daughter has a lack of connection to the mother and the media that creates this form is that the daughter has poor eye contact, is avoidant, and that the mother does not see and respond to the daughter emotionally and correctly and thus does not see the girl’s needs.

5.2 Create an attachment

When the child is to move in with the foster parents, the mother describes how the Child Welfare Service uses attachment theory to argue that the girl must move quickly, before she is two years old, to create an attachment to the foster parents. The girl must endure the strain of moving away from her mother. It is part of the “package” has the mother been told. As shown below, creating attachment is used as a medium in the Child Welfare Service’s observation that the girl must move quickly to her foster parents. The Child Welfare Service is concerned with creating an attachment between the girl and the foster parents:

Figure 3 shows how the Child Welfare Service’s observation is that the girl must move quickly to her foster parents and that this is more important than the burden

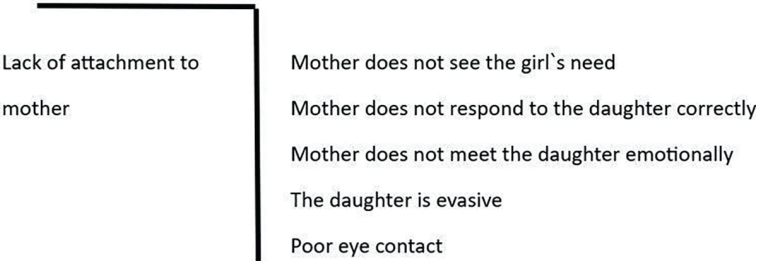


Figure 2.
Lack of attachment.

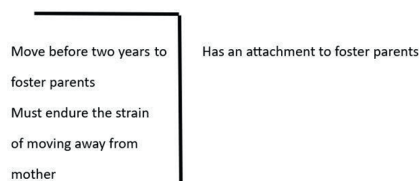


Figure 3.
Create attachment.

involved in moving away from the mother. The media that creates this form is the Child Welfare Service's perception that it is important to create an attachment between the girl and the foster parents.

5.3 Maintain attachment

After the girl has moved, the mother appeals the decision and asks for a return. The mother describes that the Child Welfare Service believes that the girl cannot be returned because the girl has now become attached to the foster parents. Below is shown how the attachment to the foster parents becomes a medium for the girl not to move back to her mother in the Child Welfare Service's observation:

Figure 4 shows that the Child Welfare Service believes that the girl cannot move back in with her mother because the girl now has an attachment to her foster parents. The attachment to the foster parents is now emerging as a medium where the Child Welfare Service becomes concerned with maintaining the attachment to the foster parents and thus that the girl cannot move back to the mother.

5.4 Avoid break-ups in attachment

When the girl is three years old, the girl is returned to her mother. As the mother perceives it, the Child Welfare Service is now not concerned about the attachment to the foster parents. The mother thinks that the girl has an attachment to the foster parents and cares about this. Avoiding a break in the attachment becomes a medium for the mother's commitment to maintaining the girls contact with the foster parents:

Figure 5 shows how avoiding break-ups in attachment emerges as a medium for the form of maintaining contact.

5.5 Summary of findings

In the analysis, we have tried to show that attachment theory does not provide concrete instructions for action. Rather, it depends on the observer. In this case, the

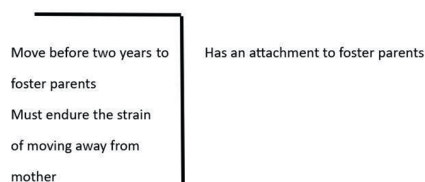


Figure 4.
Maintain attachment.

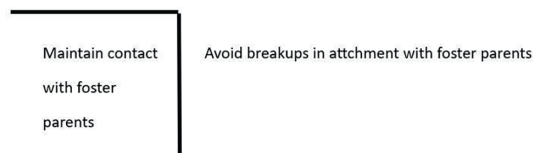


Figure 5.
Avoid attachment break.

attachment theory is used as a reason for the girl to move into a foster home and as a reason for her to move home to her mother. When it is decided that she should move into a foster home, there is more focus on creating an attachment to the foster parents than the girl's already attachment to the mother. When the girl is to be returned, there is more focus on creating or restoring attachment to the mother than on maintaining the attachment to the foster parents.

6. Discussion: when the child welfare service is unaware of its own ignorance

To create meaning is to see something as distinct from something else. Which media you watch will form the basis for what you discover [33]. When attachment theory operates as a medium, the theory will form the premises for what one sees. Eye contact between mother and child, interaction, and certain symptoms of secure or insecure attachment appear in response to what has been looked for.

Gaining an opinion about something will be presumed by the observation one has observed with. Something emerges at the expense of something else. When something emerges, reality is created [40]. What emerges as reality is assumed not only by the observer but also by the observation. If this recognition does not follow the reality-creating observation, ignorance may occur. Not as a strategic action, but because the individual does not see what they do not see. It does not see that recognition is presumed by a certain kind of observation.

The attachment theory conveys how harmful it can be to break the continuity between the child and its caregivers and how crucial it is that there is no break in this relationship [7]. In the case we have chosen as an example, it is conceivable that the Child Welfare Service considers that there is a lack of attachment between mother and child and thus it becomes crucial to offer the child new attachment opportunities. As the mother describes it, the child welfare service is concerned with creating bonds of attachment between the girl and new caregivers. It is as if the girl can only have a connection to one caregiver and that the girl cannot have a close relationship with the mother if the attachment to the foster parents is to be established. The question is whether the attachment theory here risks being used in ways it is not intended. Because attachment theory supports and shows the damage of breaking off the relationship, one might think that its special contribution is to emphasize how important it is to maintain the relationship and thus help parents to create good enough care. In the case above, one could thus have thought that the child welfare service would have been concerned with *preserving* the attachment to the mother when the child was to be moved into a foster home. One might also think that the Child Welfare Service would be concerned with *preserving* the attachment to the foster parents when it was decided that the child should be reunited with the mother.

As mentioned, several studies show how the Child Welfare Service in Norway is dominated by psychology rooted in attachment theory [3, 14–17]. The practice of the Child Welfare Service emerges as a discursive agreement on what is current knowledge. This is what Knudsen, et al., describe as organized ignorance. They write:

Organised ignorance can be understood as both selective structures ordering what people should know and not know and as the enactment of these selections in specific situations ([18], s. 1)

The ignorance of the Child Welfare Service emerges precisely as a selective choice of knowledge. It is attachment theory that dominates and thus risks creating unilateral decisions [14]. Ignorance emerges as a common endorsement of how the world should be understood. In Norway, we have seen how IT systems and decision-making procedures are established to ensure that good discretionary assessments are made [41]. If these are also anchored in the same knowledge base, there is a risk of cementing ignorance. Instead of computer-aided decision-making systems, we get computer-aided ignorance systems and ignorance-supported computer systems [42]. It becomes a reinforcing communication where ignorance emerges as more of the same. It is thus not a practice where the organization or field strategically uses ignorance to create a particular practice that we have explored in this chapter. Rather, we have tried to show how an ignorant practice is created through knowledge that is unaware of its own ignorance. When something is highlighted as knowledge, other information becomes non-knowledge, and ignorance arises. The Child Welfare Service's communication is thus not driven by evil intentions or strategic ignorance. It is a communication that is ignorant of its own ignorance. That way, the organization *remains* ignorant.

7. Concluding reflections

In his essay on the ecology of ignorance, Luhmann [1] challenges the concept of knowledge and problematizes how to know and hold something to be true. How can knowledge be extracted from time and space and which authority should be able to determine whether something represents knowledge, he asks. Luhmann [1] argues that ignorance becomes a premise for being able to act. Man is only able to act because he accepts and is able to be ignorant.

It is therefore crucial that the Child Welfare Service does not only focus on knowledge practices where ignorance is seen as a lack of knowledge [29, 43]. Ignorance also emerges as the choice of knowledge. As several researchers point out, if general attachment tools are directly transferred to the specific child, there is reason to warn [9, 13]. In Child Welfare, attachment theory emerges as a general theory that forms the basis for individual decisions. Ignorance causes the same knowledge to be chosen. It is the one we are all committed to through culture. Ignorance makes it possible for a particular practice to continue, despite the fact that other knowledge exists and could have been chosen [18]. In this way, ignorance also emerges as productive. It creates practice [42]. To do something about the practice of ignorance, one must have knowledge of how ignorance is also productive. And this is where we hope this chapter can be a contribution. Precisely because we have tried to show how the Child Welfare Service's practice is produced, maintained, and developed by an ignorance that the Child Welfare Service is unaware of.

Conflict of interest

The authors declare no conflict of interest.

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Perspective Chapter: Bridging the Gap – Health Communication and Cervical Cancer Awareness in Low-Income Communities

Maphuthi Elizabeth Choung

Abstract

This chapter explores the role of health communication in creating awareness with the goal of preventing and reducing cervical cancer rates in low-income communities. It will examine the various health communication strategies and highlight effective methods that can be employed to enhance disease management and prevention strategies predominantly in the areas that are characterised by shortage of healthcare providers, limited access to healthcare, poor infrastructure, health illiteracy, etc. This chapter will immerse itself in the challenges that affect the dissemination of health information, the significance of culturally sensitive communication and the impact of community-based interventions to emphasise the need for collaboration between healthcare providers, communities and policymakers. The success of this collaboration promises a sustainable provision of health education and awareness programmes that may help to bridge the knowledge gap as well as to empower members of communities, particularly women, to take control of their health.

Keywords: health communities, low-income communities, cervical cancer, prevention and awareness, healthcare provision

1. Introduction

Cervical cancer remains a significant public health challenge, particularly in low-income communities where healthcare access is inadequate. Despite advancements in treatments and diagnosis, cervical cancer remains at the forefront and the leading cause of cancer-related deaths among women worldwide [1]. Human papillomavirus (HPV), a risk factor for cervical cancer, is one of the major worldwide variables affecting cervical carcinoma. HPV is an infection that is transferred *via* sexual contact. That is comparatively typical among those who engage in sexual activities and have multiple sexual partners. Though various HPV strains exist, not all of them can cause cervical cancer; the leading causes of cervical cancer are HPV 16 and 18 [2].

Globally, it is estimated that 604,127 new cases of cervical cancer were diagnosed in 2020; of that number, a total of 341,831 women died due to the disease. It can also be observed that about 90% of incidents occur in low-income and middle-income countries [3]. Moreover, cervical cancer is six times more likely to develop in women who have been previously diagnosed and are living with human immunodeficiency virus (HIV) than women without HIV. This is an indication that an estimated 5% of cervical cancer incidences are attributable to HIV. Consequently, cervical cancer continues to be a global health concern, mostly in developing countries where vaccination campaigns and Papanicolaou (Pap) test screening programmes are not widely accessible [2].

This chapter explores the critical role of health communication in creating awareness about cervical cancer and its prevention. It begins with an introduction that sets the context for understanding cervical cancer awareness in low-income communities. It then explores the burden of cervical cancer in this setting, focusing on significant challenges such as limited access to healthcare, low levels of health literacy and cultural barriers that often hinder prevention and treatment efforts. Following this, the significance of culturally sensitive communication in promoting cervical cancer awareness is highlighted, emphasising its role in addressing these challenges. It is engaged on to discuss the significance of opting for culturally sensitive communication and community-based interventions that can help in fostering collaboration among healthcare givers, communities, and policymakers. The theoretical frameworks underpinning this discussion are rooted in behavioural change theories, specifically the Health Belief Model (HBM), the Theory of Planned Behaviour (TPB), the Culturally Competent Model (CCM) and Community-Based Participatory Research (CBPR). These frameworks guide the exploration of health communication strategies and their application to cervical cancer awareness. The chapter also addresses the challenges faced in disseminating health information effectively in resource-constrained contexts. By examining these health communication strategies, this research aims to recognise effective approaches that be adopted to enhance management and prevention of cervical cancer in areas that are characterised by shortages of healthcare provider, low infrastructure, and health illiteracy. Finally, the researcher discusses practical health communication strategies tailored to the needs of low-income communities and concludes by summarising key insights and implications for future interventions.

2. The burden of cervical cancer in low-income communities

Cervical cancer is a preventable disease, yet it continues to be a leading cause of cancer-related morbidity and mortality among women globally, especially in low- and middle-income countries (LMICs). According to the World Health Organization [4], cervical cancer is the fourth most common cancer among women worldwide, with approximately 604,000 new cases diagnosed in 2020. However, in 2022, there was a significant increase recorded as the rate increased to approximately 662,301 [5]. Considering the prevalence of the disease, it has been observed that the top five countries with the highest rates in the world are China, India, Indonesia, Brazil and the Russian Federation.

The high incidence rates in these regions and other parts of the world can be attributed to several factors that are discussed below and which may be the main drivers across different countries.

2.1 Limited access to healthcare

There is generally a lack of adequate healthcare facilities and providers in many low-income communities, making it problematic for women to access preventive services such as cervical cancer screening and vaccination [6]. Generally, access to quality healthcare services is a persistent problem in many countries, but the extent and severity of its manifestation depends on the location. The accessibility and availability of healthcare resources usually deteriorates when there is a decline in population density and as geographical isolation increases. The above suggests that peripheral areas, smaller populated and more remote areas, often do not have adequate hospitals, specialised care units and other significant healthcare resources [7]. On the other hand, Moeti et al. [8] have noted that demographic characteristics, such as gender, which are thought to have a significant effect on healthcare accessibility, might affect access to care. That is because women are regarded to have more communal traits than men, such as compassion and concern for others, and because female social responsibilities are more intimately related to the family than male chores, that is, taking a child or a sick family member to the clinic to obtain medical treatment.

2.2 Health illiteracy

A key component of using preventive and screening information is cancer health literacy, which is the capacity to find, understand, and use health information to make informed health decisions [9]. Thus, a lack of understanding about cervical cancer and its risk factors may contribute greatly to poor health-seeking behaviours among women [10]. Health literacy as well as knowledge and capacity improvement are important for cervical cancer and can help to better target public health interventions for cervical cancer prevention and screening practices for women. More than just being able to read and write, health literacy involves a variety of associated skills, including the capacity to apply these abilities to health-related circumstances. These skills include reading, listening, analysing, and making judgements. One of the main obstacles to effective health literacy has been shown to be health illiteracy [11]. Noteworthy, the prevention strategies and efforts for reducing cervical cancer rates also depend on the literacy levels of the populations that are particularly at risk, in order to have high efficacy and to be successful [12].

2.3 Cultural barriers

Cultural beliefs and stigma surrounding reproductive health can prevent open and honest communication about cervical cancer prevention among women [13]. These cultural beliefs significantly influence how individuals perceive and approach healthcare decisions that are directly linked to sensitive subjects such as screening for cervical cancer. In some cultures, it is still regarded as taboo to engage in topics like cervical cancer, and this has resulted in fear of familial judgement, thus limiting women's decision-making anatomy. This factor can result in reluctance to seek care, even when symptoms are present [14]. This influence of culture on health behaviours can be observed more in low- and middle-income countries, where cultural values are deeply ingrained in how communities perceive and understand disease and how they interact with healthcare systems. An example of such is Ugandan research, which has found that cultural concerns about the HPV vaccine's potential impact on fertility have delayed its acceptance, thus depicting how deeply held beliefs can surpass

scientific evidence [8]. For healthcare professionals offering cervical cancer services, it is important that they be cognizant of the cultural and religious perspectives of the communities in which they work since these beliefs have an impact on how people understand health information and may act as a barrier between the patient and the provider [15]. Adding to this, studies from a few African countries, including Nigeria, Kenya, and Botswana, indicate that women's involvement in cervical cancer screening programmes is poor. The research has further demonstrated that culture has a direct impact on how chronic illness treatment is provided. The poor participation rate in cervical screening programmes can be attributed to cultural differences in people's understanding and perceptions of cancer and cancer screening [15]. Consequently, this highlights the need for culturally tailored health communication strategies to increase engagement and participation in preventive care initiatives.

3. The significance of culturally sensitive communication for cervical cancer awareness

Culturally sensitive communication plays a significant role in cervical cancer awareness, particularly in low-income communities where cultural norms, language and beliefs have a great influence on their health behaviours and access to healthcare. On the other hand, care that is provided should also be culturally competent to be able to achieve the objectives of getting women screened to reduce costs related to cancer care and mortality. Culturally competent care, as Cohen [16] puts it, respects differences as well as cultural factors that can negatively impact healthcare provision, and some of those aspects include language, styles of communicating, attitude, behaviours and beliefs. Being cognizant of these cultural disparities can lead to the provision of services that are culturally sensitive while raising awareness and correcting the myths about cervical cancer screening.

Health information should always strive to provide culturally sensitive communication, but at times, it may be compromised due to the linguistic barriers that may exist for some patients who seek medical care at facilities that do not necessarily use a language which they understand. For example, women who move from their native country to another country that does not use her native language may encounter communication challenges which may in turn affect their comprehension of health messages. For them to be able to communicate with healthcare professionals, there needs to be interpreters to facilitate communication and aid understanding. This may make some women to feel uncomfortable to discuss sensitive topics like cervical cancer symptoms and other reproductive related topics during consultations. In such instances, it will be key to offer alternative educational materials that are culturally sensitive and to offer relevant care that will improve screening uptake and acceptability in such women [17]. Notwithstanding the above, there is still a need to involve culturally diverse community health workers when designing and delivering cervical screening promotion as they have the potential to improve engagement with remote areas. This may help to improve health literacy, the need for screening and by addressing cultural beliefs, values and religious perceptions that affect screening, cervical cancer interventions encourage more women to attend screening programmes than live healthier lives [18].

One of the aspects that are key when ensuring cultural sensitivity is the building of relationship of trust between the patient and healthcare provider to facilitate the cooperation that is required to implement and operate screening programmes. This is important to consider because communities often have a deep-rooted distrust

of health facilities, especially when they feel misunderstood and marginalised. The information shared with them should be carefully tailored for a specific and intended audience but at the same time should consider the linguistic diversity [19]. Even though information about cervical cancer is meant to empower women, it is still important to have information that will make men understand cervical cancer. In some cultures, the man is assumed to be the head of the house, and to some, it may be assumed that they should be the main decision-makers in the house and around their wife's health choices. In a South African study that explored the cultural beliefs that influence cervical cancer screening uptake, it was found that women were not allowed to proceed with health-related procedures without their husbands' consent. Some husbands did not approve of their wives' bodies being seen by other male doctors and their wives screening for cervical cancer due to the stigma around the disease [20].

This culturally sensitive communication for cervical cancer can also contribute to building trust for medical practices, more especially when designing health information for the most remote areas. These people often are not reached due to their geographical location and often are the ones who are reluctant to opt for scientific methods of healing and treatment. Modern science has demonstrated that early screening cervical cancer is essential for early detection of the disease even when symptoms are not visible. Nonetheless, some women still believe that traditional medicine and herbal remedies are the only ways to cure cervical cancer. In several African countries, including Ethiopia and Zimbabwe, traditional medicine has long been used as an adjunctive therapy for cancer. This is reflected in the participants who participated in a study [15], as they indicated that when they are faced with any type of cancer, they resort to traditional medicine. If women overly rely on traditional medicine and dismiss the scientific treatments, they may miss opportunities for screening, treating and overcoming cervical cancer.

To achieve cultural sensitivity, it will be key to ensure that cervical cancer messages' contents are adapted to the intellectual, emotional and motivational characteristics that are habitually determined by the cultural background of the target audience. Additionally, tailoring health messages to the target audience's cultural background enhances their comprehension and success in health communication [21]. Culturally sensitive materials contribute greatly to deeper understanding, decision making and awareness of suggested behaviours. Therefore, aligning information with cultural values encourages deeper thought, leading to more suitable and knowledgeable decisions, and narrowing health outcomes and discrepancies.

4. From a theoretical perspective

Addressing the gap in cervical cancer awareness and prevention, particularly for low-income communities, requires a multifaceted theoretical approach, and it is equally significant to draw from several frameworks in public health, community engagement and communication. This is done because communities frequently experience structural and social challenges such as inadequate access to healthcare, illiteracy, cultural stigmas and lack of capital. A combination of these challenges leads to ineffective health communication, which is critical for bridging the gaps.

At the core of enhancing cervical cancer awareness is the principle that health communication is a determinant of health outcomes. Important to note however, is that the effectiveness of health communication does not only depend on the content of the messages but also on the issues of access, clarity, and cultural relevance of the

medium/vehicle used to disseminate the message [19]. From a theoretical perspective, health communication can be seen through the lens of behavioural change theories such as the Health Belief Model and Theory of Planned Behaviour which take more care in explaining the significance of shaping attitudes, beliefs and behaviours that can be adopted to promote acceptance to preventive measures such as HPV vaccination and screening for cervical cancer. These models may be highly relevant as they highlight significant factors including perceived risk (susceptibility to cervical cancer), perceived benefits to preventive measures and self-efficacy (confidence and agency to take action) [22, 23]. However, in low-income countries, where barriers to accessing healthcare are more rooted, effective communication should go beyond engaging individual beliefs. It can be tailored to address issues of healthcare availability and finances to mediate how information is perceived and acted upon.

Other theoretical perspectives that can be referred to in bridging the gap are Cultural Competence Model (CCM) for message/content relevance and Community-Based Participatory Research (CBPR) for empowerment. The CCM ensures that messages for health communication resonate with what people believe in to overcome stigma and health illiteracy [16, 24] while the CPBR ensures that the communities are empowered through participatory approaches and that interventions are relevant and sustainable [25]. Even though health communication is important, it must be part of a broader strategy that can help to address the entrenched causes of health disparities.

4.1 The role of community-based programmes

Community-based programmes are essential in promoting cervical cancer awareness and prevention, particularly in low-income communities where access to healthcare and information is often inadequate. The programmes are usually designed to engage local communities by providing education on the risk factors of cervical cancer, the importance of early detection and the available prevention methods such as HPV vaccination. When members of the community work together on a community-based programme, it increases their success rate in addressing barriers such as cultural misconceptions, lack of knowledge and limited access to healthcare facilities [26]. Through direct engagement with community members, these programmes are able to better target their efforts to the unique needs and issues of the community, build relationships, and get support from those who will be most impacted. An in-depth understanding of the political, social, and economic aspects of the issue that community-based preventive initiatives seek to address is necessary for their success. They also call for a dedication to inclusion and equity, guaranteeing that every member of the community has equal access to opportunities and resources [26].

Working with communities may be beneficial when working towards the same goal, and some of the benefits are that they may be able to empower people in communities to be in control of their health due to their involvement, which may, in turn, make them feel a sense of ownership and investment of their success. Another benefit is that community-based prevention programmes tend to address the root causes of problems that are notorious in their communities by identifying the risk factors for better management [27]. In the case of cervical cancer prevention, this means that the community members would be working together towards uprooting the main reasons for low participation in screening programmes. In addition, members of the communities may serve as role models or champions that advocate for healthy behaviours and work together to create sustainable support structures that will promote positive health outcomes.

Effective supportive structures within communities, particularly play a huge role in supporting prevention programmes. Sometimes referred to as so support networks, they are important for establishing support for women affected by cervical cancer and provide emotional support while serving as platforms for education and awareness [26]. Through direct collaboration with community people, these structures are able to modify their initiatives according to the unique requirements and cervical cancer was linked to humiliation in Zambian research, whereas in a Ugandan study, people with the disease experienced family abandonment. There have also been reports of stigma in high-income nations. Because they were single and did not want to give the impression that they were involved in sexual activity, Muslim women in London were reluctant to screen out of fear and humiliation. In a different study conducted in the United Kingdom, cervical cancer screening is stigmatised due to its link to HPV and the belief that it indicates that women are not taking enough care of their health [28]. In a South African study, it was revealed that women who received a positive result from a pap smear mean that a person is HIV positive and thus viewed as proof of infidelity [29]. It is through informed social support networks that women may be able to freely get involved.

5. Challenges in disseminating health information

For women from LMICs, the challenges to access may be exponential due to the difficulty in accessing women in those regions. Also, achieving better health outcomes requires effective communication, which is undeniably a cornerstone of quality healthcare. It is through communication that healthcare providers are able to create bonds and relationships with patients, and those bonds will eventually help to create therapeutic relationships that will in turn lead to better patient outcomes. The information exchange that will take place between the healthcare providers and patients can assist greatly with medical related decision-making like self and disease management [30]. Despite the benefits of health communication strategies, several challenges still exist which prevents free flow of information about health. With varied reasons for the low dissemination, it is a fact that when resources are limited, the health outcomes would be poor too.

In cervical cancer information dissemination, it has been found that women face several challenges, some of which are deep rooted in the health system, thus making cervical cancer screening difficult to access. Limited access to health information has been cited as one of the main hindrance to cervical cancer screening as well as poorly resourced health system that do not have functional screening policies as well as policies that are generally poorly implemented [14]. Because of these poorly implemented strategies, women, remain without the knowledge about cervical cancer screening prevention and treatment.

Infrastructure challenges that prevail in remote areas poses a challenge to the dissemination of health information, particularly in the era of technology where information is digitised for increased accessibility. This, however, adds to the challenges as facilities that are not well-resourced, may not be able to take advantage of this feature. Worldwide, it can be observed that information technology has opened doors for opportunities to disseminate health information easily. With the fast-growing internet, mobile technologies, Artificial Intelligence (AI) and many other technological advancements, health information has become easily accessible for many people. Health informatics too, made if possible, for healthcare practitioners to evaluate public and population data by combining information from a wide range of sources to

be able to make patients understand health information. Despite all of these, it is still difficult access health information due to the data and reporting inconsistencies that exist [31]. A study by Berardi et al. [32], investigated the challenges around the implementation of digital technologies that were specifically for mental healthcare systems. In their findings, they found that implementation of these digital resources was prioritised, but implementation was affected by the perception of digital technologies. It was also seen as a burden of care for both the healthcare provider and patients, hence the slow appreciation for it. Digital technologies, when used in conjunction with remote consultations to treat patients, to collect and share health information, have great prospects of strengthening the mental healthcare systems. The same can be said even for cervical cancer treatment, management and information sharing. Recent studies have depicted three key factors that play a key role in cervical cancer mitigation and its impact. This includes the development of awareness and effective screening and treatment. For information sharing, it is suggested that messages drawn from established organisations working with cervical cancer awareness programmes need to be augmented with fact-based awareness messages for greater impact [32].

When information is researched and sought for public knowledge and empowerment, it is important that it be available to them in a format that can be easily understood. This means that effective translation of findings from health research should be prioritised, but because the practice of medicine has been slow in many LMICs, translating data to simple and understandable language is still difficult to do. When looking deeply into the challenges that prevent this from happening, one will find the commonly known problem of healthcare systems that are under-resourced, leading to inadequate personnel to respond to those specific health needs [33]. Translation of information may, as a result, increase the amount of health information that is available for healthcare professionals as well as the communities. Providing access to relevant, accurate and timely information about health is key for health promotion within different contexts, and this was a lesson taken from the recent COVID-19 pandemic, which too the world by storm during the year 2020. It showed that the most valuable resource for the health system is relevant health information that enables citizens to make decisions about the best methods of addressing health problems. But still important to consider is that public understanding to health communications is key when creating health information for diverse groups in need of relevant health information [34].

6. Health communication strategies

Effective health communication is essential for increasing awareness and promoting preventive measures against cervical cancer. The Office of Disease Prevention and Health Promotion [35] believes that health communication is crucial for the health and well-being of all individuals because health information is written in a more complex fashion, making it difficult for people to use and understand. It is important that healthcare professionals communicate clearly, share easy-to-understand information, use teach-back methods, and opt for shared decision-making, as that can make people feel empowered to make informed health decisions. These health communication strategies can help to improve health outcomes more, especially for health users with limited health literacy skills or the use of English. In its strategy, health communication employs verbal and written strategies that can be used to influence and empower communities to make better choices when it comes to their health. Several strategies can be employed to enhance health communication, particularly in low-income communities.

6.1 Community engagement

Community engagement involves actively involving community members in the research, planning and execution of health communication initiatives within a limited scope. This approach ensures that messages are culturally relevant and resonate with the target audience [36]. Because of the high incidence of cervical cancer in Sub-Saharan Africa (SSA), this approach may be particularly useful as it encourages the community to collaborate in the research rather than being regarded as research subjects. Also, initiatives like community engagement, can specifically empower women by fostering autonomy, health literacy, and self-advocacy regarding cervical health. Thus, it addresses how health communication can lead to behavioural change and empowerment in a broader sense. It usually helps to minimise the effect of existing distrust of researchers that may exist within the communities [37].

Research by Habila, Kimaru, Mantina, Valencia, McClelland, Musa, Madhivanan, Sagay and Jacobs [26] studied articles that were published between 2005 and 2019 in six African countries (Kenya, Senegal, South Africa, Zambia, Nigeria and Ghana) to explore the application of the CBPR framework for cervical cancer prevention and control. The principles portray the significance of partnership between the community and researcher that is expected to attract the relevant target audience and encourage them to take action that addresses community needs. According to one of their selected key findings, the community-engaged method was acceptable in all nine trials because researchers exploited the social networks that already existed among community partners to disseminate information about cervical cancer and how to avoid it. These community organisations served as a venue for the study as well as a setting for the eventual adoption of community-based cervical cancer prevention initiatives. For example, in order to raise awareness of cervical cancer and encourage screening, community health workers, religious leaders, and tribal leaders may be used to identify and engage the targeted population [26].

After raising awareness, it is always encouraged that women take part in screening interventions, but it has been determined that acceptability and uptake of cervical cancer interventions are often affected by factors such as knowledge gaps relating to the symptoms experienced as well as the steps to take afterwards. To mitigate this, alternative strategies are needed to address the inadequacy in trained healthcare professionals to be able to conduct cervical cancer screenings, particularly for the rural and remote communities. The adoption of community health workers (CHWs) as a strategy can be effective for reaching communities and this intervention promises unique improvements in cultural legitimacy, trust and acceptability of cervical cancer screening initiatives within communities. These CHWs, when trained well and placed strategically within communities, may be able to deliver community-based screening and treatment programmes for cervical cancer for increased knowledge and participation [38].

6.2 The use of technology

In the era of innovation, digital and Artificial Intelligence (AI) technologies, there is a remarkable potential to accelerate the process of eliminating cervical cancer elimination using current innovations. This has been evident during the coronavirus (COVID-19) pandemic when the world experienced a surge in the use of technology for things like health education, surveillance, testing, results and overall healthcare delivery. That was just an introduction to the possibilities and how the power of technology can be adopted to address some of the public health challenges [39].

The integration of mobile applications and machine learning can also become essential as they offer opportunities for monitoring, educating and engagement between healthcare personnel and their patients. These platforms provide personalised healthcare services to professionals, which in turn leads to them being able to manage their patient's health better as data would be available in real time. In addition, these technologies can help with the analysis and interpretation of health information that may be complex thus improving diagnostic accuracy and supporting the creation of custom plans of treatment [40].

In an effort to address cervical cancer awareness and promotion issue, social media can be considered as an additional method because it has been used to communicate public health information, campaigns [41], recruit and deliver health behaviour change interventions and monitoring disease outbreaks [42]. These efforts have led to an increase in cervical cancer knowledge, awareness and behaviour change. Equally, for cervical cancer prevention, social media can be used for a similar purpose and may help to inform public health promotion professionals and health communicators who are responsible for educating communities on HPV testing and prevention as well as the significance of screening for cervical cancer [43].

6.3 Educational workshops

Effective interventions that are appropriate for use in regions with limited infrastructure and that relate to requirements and challenges of healthcare practices in rural areas should be created and put into practice in order to increase cervical cancer screening among rural populations [44]. Organising educational workshops that focus on cervical cancer prevention can empower women with knowledge about the disease. Evidence from Zhang et al. [44] shows that educational interventions can promote cervical cancer screening as they reflected on the efficacy of educational workshops on increasing participation in cervical cancer. It was revealed that these interventions can contribute to increasing screening participation.

For health communication to be effective, it needs to be regarded as a continuous activity requiring constant effort not only for the benefit of the patients and health information consumers but even to keep knowledge of the health providers up to date. For cervical cancer prevention and control programmes, it is key to meet the following education objectives:

- i. To inform communities about the basics of cervical cancer, its nature and causes. Because HPV is the biggest influencer of cervical cancer, it has to be central to the discussions.
- ii. To promote HPV vaccination programmes for young girls when they are made available in their communities.
- iii. To promote screening campaigns for women who are of the relevant age and eligible for screening.
- iv. To ensure that women who receive positive results start treatment immediately.

- v. To increase awareness that focuses on the signs and symptoms of cervical cancer and encourage women to consult with a health professional if they see them.
- vi. To address ignorance, fear, embarrassment and stigma related to HPC and cervical cancer [45].

Taking into consideration these objectives can actually help to align programmes accordingly. As Ndubuisi, Maphasha and Okeke [12] highlighted, educational programmes that are conducted by the Department of Health in collaboration with universities or colleges can develop and implement comprehensive educational programmes that can be used to raise awareness for female students. The students concerned stand a chance of benefiting from these programmes if special focus is put on educating them about HPV comprehensively while at the same time addressing the misconceptions which are often seen to be preventing women from participating in screening and awareness campaigns.

7. Conclusions

In conclusion, addressing cervical cancer in low-income communities requires a multifaceted approach that is centred around evidence-based and effective health communication, cultural sensitivity and community engagement. The recurring challenges ranging from limited access to healthcare and illiteracy to cultural barriers necessitate a collaborative effort between healthcare providers, policymakers and the communities themselves. A study by the Wellspring Centre for Prevention [28] ascertained direct communication as the best method to target community people who experienced humiliation and abandonment when they engaged on conversations and activities related to cervical cancer due to stigma that is attached to it. Through such initiatives, structures working in disease prevention and management are able to modify their initiatives according to unique requirements of cervical cancer communication. Tailored health communication strategies that respect cultural beliefs and promote community-based interventions are promising to overcome these challenges. By fostering partnerships, raising awareness and empowering women with knowledge, it is possible to significantly reduce cervical cancer incidence and mortality rates in these vulnerable communities. Ultimately, bridging the health communication gap can lead to sustainable cervical cancer prevention efforts and improve the overall health outcomes for women in low-income communities.

Conflict of interest

The author declares no conflict of interest.

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Chapter 6

Refugee Welfare in Kenya: Challenges and Solutions

Abulogn Ojulu Okello

Abstract

This chapter delves into the intricate terrain of refugee welfare in Kenya, exploring the challenges faced by refugees and the solutions devised to alleviate their plight. Kenya's experience in hosting refugees offers a compelling narrative, shaped by conflicts, environmental disasters, and economic instability. Established camps like Dadaab and Kakuma strain resources and infrastructure, leading to tensions between refugees and host communities. Lack of documentation exacerbates vulnerability, impeding access to essential services and legal protections. Additionally, scarcity of clean water, insufficient food supply, inadequate shelter, and healthcare facilities compound refugee hardships. Despite government and international efforts, challenges persist, including donor fatigue and limited integration opportunities. This exploration of refugee welfare in Kenya highlights barriers and proposes solutions to inform future policy and practice, crucial for ensuring the dignity, security, and well-being of refugees both in Kenya and beyond.

Keywords: Kenya, welfare, service, refugee, unemployment, documentation, camp

1. Introduction

In a world marred by inequality, injustice, and a lack of freedom, our once beautiful planet, along with its people and nature, now grapples with the ravages of war, climate change, droughts, and economic hardships. These factors, along with political persecution, ethnic conflicts, and environmental degradation, have driven a mass exodus of individuals fleeing from conflict zones, climate-related disasters, and economic adversity across the globe [1].

In Kenya, the influx of refugees has remained relentless since the establishment of its two largest refugee camps: Dadaab and Kakuma in 1991 and 1992 [2]. Kenya's storied history of providing refuge underscores its pivotal role in addressing the global refugee crisis. Despite Kenya's unwavering commitment to offering sanctuary to those escaping conflict, persecution, and instability, significant obstacles persist. These include strained resources and infrastructure, impacting both refugees and host communities. Alloush et al. [3] discuss the impact of Overcrowded camps with limited access to essential services such as healthcare and education paint a stark picture of hardship and adversity for refugees in Kenya. In response to these challenges, host

communities have voiced their grievances through demonstrations, often directed at the United Nations High Commissioner for Refugees (UNHCR).

The Refugee-Host communities' tensions and conflicts have escalated in the recent past around the globe. The tension and conflict are majorly caused by the shared limited resources and lack of Refugee-Host Community projects. In most cases, the host community views refugees as threats to their resources which include land, wood, jobs, and water especially as the refugee population increases. In the Kenyan context, the host community (the Turkana people) believes that refugees receive special treatment since they are unable to access free essential services, such as education, health, water, and free food which is readily available to refugees in Kakuma Camp [4].

Conversely, refugees lament the perceived mismanagement of resources by both the host government and UNHCR staff, citing concerns about diverted funds meant for their livelihoods. Kenya's government, in collaboration with international organizations like the UNHCR, has implemented policies aimed at addressing refugee issues and integrating them into society. The socio-economic impact of hosting refugees has led to challenges such as reduced employment opportunities and strained public services in host areas across the four countries (Ethiopia, Kenya, Rwanda, and Uganda) where the host population often struggles with limited access to basic social services, poor livelihood opportunities, and low agricultural production [5]; poor education levels, few jobs, and subsistence-style agriculture production are common.

As Kenya's enduring status as a host country enters its fourth decade, donor fatigue looms, resulting in dwindling support as refugee camps transition from temporary to protracted settlements [6]. Consequently, refugees face dire circumstances, grappling with inadequate access to basic services, such as water, healthcare, education, and psychosocial support. Within the refugee population, certain groups are particularly vulnerable, including single mothers, orphans, persons with disabilities, and unaccompanied minors, highlighting the urgent need for comprehensive solutions to address refugee welfare in Kenya [7].

Yet, amidst these challenges, there have been remarkable efforts to mitigate the suffering of refugees and foster their integration into Kenyan society. Integration, seen as one of the durable solutions for refugees alongside resettlement and voluntary repatriation, holds the promise of transforming their lives [8]. By integrating refugees into Kenyan society, opportunities abound for them to engage in farming and business ventures, and secure jobs within the private sector, government, or NGOs. However, despite being a frequently discussed topic among NGOs, refugees, and the government, tangible progress toward integration remains elusive. Today, when visiting camps like Dadaab and Kakuma, one cannot help but notice the prevalence of churches; they serve as beacons of hope for refugees, offering glimpses of a better future. While numerous policy initiatives and grassroots interventions have emerged to address refugee needs, many remain confined to the realm of discussions and recommendations on paper.

In the upcoming chapter, I delve into the details of the challenges and solutions within the realm of refugee welfare in Kenya. This chapter will provide a thorough examination of the hurdles faced, as well as potential remedies, under the main theme of "Refugee Welfare in Kenya: Challenges and Solutions." Additionally, I will explore policy recommendations that serve as a pathway forward toward sustainable resolutions for Kenya's refugee population, with a specific focus on the Dadaab, Kakuma, and Kalobeyei settlement camps.

To achieve this, the structure of this chapter is designed to provide a comprehensive and detailed examination of the refugee situation in Kenya. It comprises five sections:

Introduction, Research Methodology, UNHCR and Other NGO Partners Services in Refugee Camps (Kakuma, Dadaab, Kalobeyi Settlement Camp) and Urban Center (Nairobi), Challenges Faced by Refugees in Kenya, and Conclusion. These sections are organized to facilitate a clear understanding of the various aspects under consideration. The Introduction sets the stage by providing background information on the refugee situation in Kenya, explaining the significance of the study, and outlining the key objectives of the chapter. The Research Methodology section outlines the methods and approaches used to gather and analyze data. Following this, the UNHCR and NGO Services section provides an overview of the services offered by UNHCR and its partners in Kakuma, Dadaab, Nairobi, and Kalobeyi settlement camps, highlighting their scope and impact. The Challenges Faced by Refugees in Kenya section is subdivided into seven subsections, each addressing a specific challenge: lack of refugee documentation, lack of clean water, insufficient food supply, inadequate shelter, inadequate health facilities, limited job opportunities, and lack of access to education. Finally, the chapter concludes with a Conclusion summarizing the key findings, and Recommendations, which offer suggestions to improve the conditions for refugees in Kenya.

This chapter will make several significant contributions to the literature on refugee welfare. Firstly, it provides a detailed analysis of the services provided by UNHCR and NGO in the refugee camps and in the Urban, offering insights into their effectiveness and areas needing improvement. Secondly, by categorizing and examining the specific challenges faced by refugees—such as lack of documentation, insufficient food supply, and limited access to education—it highlights the multifaceted nature of refugee hardship. This detailed understanding helps to identify gaps in current support systems and suggests targeted interventions. Lastly, the chapter's comprehensive approach in combining empirical data with practical recommendations bridges the gap between academic research and policy implementation, contributing to more informed and effective strategies for enhancing refugee welfare.

2. Research methodology

The research method employed in this study involved conducting interviews to gather information from refugees in Kakuma, Kalobeyi, Nairobi, and Dadaab. Interviews were chosen as the preferred method for data collection due to its effectiveness in qualitative research, allowing participants to share their experiences and insights. Semi-structured interviews were selected to provide flexibility for both the interviewer and the participants, enabling open-ended questions and facilitating a “give and take” interaction. This approach allowed participants to express themselves in their own words and at their own pace. Each interview lasted between 30 and 45 minutes, and while some participants were proficient in English, translators were utilized to overcome linguistic barriers in Dadaab, Kakuma, and Kalobeyi since they are multilingual regions.

As a refugee who has lived in camps, I have a deep understanding of what has been taking place there. My time spent in Dadaab, Kakuma, Kalobeyi, and Nairobi has allowed me to easily identify my target participants for a study surrounding Refugee Welfare in Kenya, including challenges and solutions. Consequently, the participants for this study were selected from among the refugee population. I extended personal invitations to the selected participants and met with them before the interviews to establish an environment of trust. For those in Dadaab, initial meetings were conducted prior to the interviews. Based on their willingness to participate, I scheduled the interviews accordingly.

The interview process varied slightly across locations, with Dadaab participants connected through Zoom meetings, while face-to-face interviews were conducted in other locations. Participants were selected to ensure diversity, encompassing both genders, refugee staff, unemployed individuals, and national staff from different organizations, with the aim of capturing a comprehensive range of perspectives. Specifically, two females and one male participants were chosen from each location; in Kakuma, Kalobeyei, and Nairobi Urban Center, the selection included two females, two males, and two Refugee staff serving as incentives staff, along with two unemployed individuals (one male and one female) and three national staff (one female from DRA, one from Peace Winds Japan, and one male head teacher in Kalobeyei) while in Dadaab ten participants were selected of which five females and five males. **Table 1** provides general information about the interviews and their findings.

Refugee settlement camps	Number of interviews	Interviews' dates	Main outcomes/finds of the interviews
Kakuma	11	April 21–April 23, 2024	Participants reported significant delays and obstacles in obtaining necessary documentation, which hindered their access to services like third country opportunity, scholarship, and work permit. Participants expressed concerns about the inadequate food rations, leading to malnutrition and food insecurity. The interviews highlighted the overcrowded living conditions and poor quality of shelters, which were not suitable for the harsh weather conditions.
Kalobeyei	11	April 25–April 27, 2024	Residents of Kalobeyei faced severe shortages of clean water, affecting their health and hygiene. Similar to Kakuma, food scarcity was a major issue, with rations not meeting the nutritional needs of the population. There were significant barriers to education, including a lack of school fees, and educational materials, which limited the educational opportunities for children and youth. Participants highlight the prolonged and arduous process of securing appointments with the UNHCR, as well as the intense competition and long waits faced by refugees seeking aid from various organizations, leading to heightened stress and uncertainty in already difficult living conditions
Nairobi	11	April 29–May 2, 2024	The participants highlighted the critical importance of refugee documentation in Nairobi, highlighting its role in establishing identity, nationality, and legal status, which are essential for accessing education, healthcare, employment, and legal protection. The majority of participants who have businesses in Nairobi reported experiencing policy harassment because most of them operate without a business permit. A key finding from the refugees in Nairobi is that rental issues are a significant problem. Often, refugees' rented rooms are locked by landlords due to unpaid rent, and as a result, both children and parents sometimes go without food and shelter.

Refugee settlement camps	Number of interviews	Interviews' dates	Main outcomes/finds of the interviews
Dadaab	10	May 4–May 5, 2024	One main outcome of the interview is the restriction on refugee movement due to Kenya's encampment policy. Participants interviewed in Dadaab highlighted that refugees are not allowed to leave the camp and travel to Nairobi, underscoring the significant limitations placed on their mobility. Participants who were interviewed mentioned the problem of limited access to higher education opportunities for students who did not achieve a university entrance grade of C+ or above. As a result, many youths have turned to drugs and theft. There were few health posts in Dadaab with adequate staff but no medication. Participants reported that many healthcare staff have opened private clinics within the camp and are diverting hospital drugs to these clinics for profit.

Table 1.
Information of the interviews.

The interviews were recorded and transcribed to accurately capture the information shared by the participants. Each interview transcript underwent analysis to identify major ideas and shared themes. In this analysis, I evaluated the content of both the collected data and relevant literature, identifying specific relationship patterns ([9], p. 10). The collected data from the field and explored literature were critically assessed to ensure quality and relevance to the research questions. Patterns of similarities and differences were identified, findings were interpreted considering the research locality, recommendations were formulated, and the work was presented for peer debriefing to ensure trustworthiness before final submission. Subsequently, the meaning was extracted from each interview, and these meanings were grouped based on relevance. Pseudonyms were employed to safeguard the identity of the participants.

3. UNHCR services in Kakuma, Kalobeyei, Nairobi and Dadaab

As mentioned earlier, resources are limited in the Dadaab, Kakuma, Nairobi, and Kalobeyei settlement camps, making it challenging to distribute aid effectively. These camps host over 87% of the refugees assisted by the UNHCR, the main organization responsible for providing assistance and protection to refugees and other persons of concern [10]. Accessing UNHCR services can be a difficult process for beneficiaries.

Firstly, scheduling an appointment with a UNHCR officer can take 2–3 weeks. To begin, refugees must ensure their phone number is active in the UNHCR database. This involves updating their phone number through a process called enrollment and providing their details to the officer in charge. The system then verifies their phone number, and once confirmed, they can book an appointment, which typically takes a minimum of 3 weeks.

The most challenging part is queuing up, as many refugees seek to benefit from these services. Some refugees go to the gate in the evening and sleep there to secure a spot. Names are recorded three times during the night—once in the evening, at

midnight, and early in the morning for confirmation. This process ensures that refugees get a slot for the day's limited appointment spaces, as only 30 people are allowed to book appointments each day. Once inside the compound, refugees can speak to a UNHCR officer to request assistance, report a protection case, or inquire about durable solutions. The three durable solutions are resettlement, repatriation, and integration. Most refugees approaching the UNHCR are seeking resettlement, although this option is difficult to attain.

While in Nairobi, refugees are not allowed to visit the offices of the Department of Refugee Services (DRS) and UNHCR directly. Instead, they are required to book an appointment through the hotline 1517 to access services, such as new asylum registration, renewal of refugee identification, reporting lost identification cards, resettlement case confirmation, refugee status determination interviews, and other refugee services. When calling the hotline, an interpreter answers the call, collects the necessary details, and informs the caller that they will receive a message from the office. However, this message can take a long time to arrive, sometimes 3 weeks or more. In some cases, refugees who have not received a message still show up at the main gate of the DRS office on General Mathenge Road. Without an invitation message, they are not allowed inside the office. The location of General Mathenge Road is far from where many refugees live, such as those in Ruiru, Kiambu, who must pay 500 Kenyan shillings for transport to reach the office. This situation creates significant difficulties for refugees in Nairobi, highlighting the need for the UNHCR to improve its system.

In contrast, the system in Dadaab is different. Refugees can go to the main gate of the UNHCR compound and wait for UNHCR and DRS staff to report to their offices. Refugees are then allowed inside the compound to wait in a shaded area and are assisted in turn.

Other NGOs, such as the Department of Refugee Services in the camps (DRS), Red Cross Kenya, and the World Food Programme (WFP), encounter similar challenges in providing services. Unlike the UNHCR and DRS in Nairobi, these organizations do not use a computerized appointment system. Instead, refugees must present themselves early in the morning and queue for many hours to receive assistance. This process is fraught with difficulties, adding to the strain on refugees as they wait for the essential services they need. These bureaucratic hurdles and logistical challenges significantly affect refugee welfare in Kenya. The struggle to access necessary services exacerbates the already difficult living conditions in the camps, contributing to stress and uncertainty. Addressing these inefficiencies is crucial to improving the welfare of refugees, ensuring they receive timely assistance and support, which is vital for their dignity, security, and overall well-being.

4. Challenges faced by refugees in Kenya

4.1 Lack of refugee documents

The importance of acquiring refugee documentation cannot be overstated, as it serves as the primary means of establishing identity, nationality, and legal status for individuals forced to flee their homes. Without valid documentation, refugees in Kenya face numerous barriers to accessing education, healthcare, employment, and legal protection [11]. The lack of official recognition and legal status leaves refugees vulnerable to exploitation, discrimination, and even arrest, further compromising their overall welfare and poses significant challenges for those seeking safety and

stability. Legal and administrative barriers, as well as the denial of access to essential services and rights, exacerbate the already difficult journey of refugees. It is imperative to address these challenges and find solutions to ensure that refugees are able to rebuild their lives with dignity and security [12]. Furthermore, the lack of refugee documents also hinders their access to basic rights. This includes the right to work, the right to education, and the right to healthcare. Without proper documentation, refugees are often marginalized and excluded from society, unable to fully integrate and contribute to their host communities.

The refugee crisis in Kenya has been a significant and longstanding issue, with thousands of refugees from neighboring countries seeking safety and asylum within the country's borders. The ongoing crisis has impacted the welfare of both the refugees in Kenya and the host communities, posing numerous challenges for the Kenyan government, humanitarian organizations, and the refugees themselves [6]. The impact of this large refugee population on Kenya's resources and infrastructure has increased the demand for services such as healthcare, education, and housing, has strained the capacity of the Kenyan government, and has led to tensions between refugees and the host community. Additionally, the presence of refugees has also been linked to security concerns, further complicating the situation [4]. Not only this, but Lack of documentation also makes it difficult for refugees to prove their legal status and limits their rights and access to legal protections in Kenya, leaving them vulnerable to exploitation and abuse.

In most cases, refugees are at risk of being caught by police if they are found in town without proper identification or if they violate the encampment policy by leaving the camp without the appropriate travel documents issued by the Department of Refugee Services. These travel documents are granted only for specific reasons, such as seeking medical treatment unavailable in the camp, pursuing education, resettlement follow up, or visiting family. Without these documents, refugees risk being arrested, brought back to the camp, taken to court, or having to pay bribes to the police for their release [10].

This encampment policy forced refugees to remain in the camps against their wishes. The Kenyan government enforces these restrictions to prevent refugees from becoming stranded in Nairobi, where they might struggle to afford rent and basic living expenses. Additionally, the encampment policy was implemented to prevent terrorism in Kenya, following government concerns that the Dadaab refugee camp had been used as a hideout for terrorists [13]. This measure severely impacts the social welfare of refugees, leading to feelings of hopelessness and despair as they are unable to pursue their aspirations and improve their living conditions.

So the issue of refugee documentation is of critical importance in addressing the welfare of refugees in Kenya and plays a crucial role in the security and stability of the refugees in the country. It helps in the identification and verification of refugees, which is essential for the management of refugee populations and the prevention of security threats. However, getting these documents may take a long time, but according to DRS upon arrival in the country of asylum the documentation process takes only 3 months but sometimes can reach to years while waiting for refugee status determination due to backlog and funding constraints. The importance of refugee documentation cannot be overlooked, as it is fundamental to the overall welfare and protection of refugees in Kenya. The importance of refugee documentation in Kenya cannot be overstated. Without proper documentation, refugees face numerous challenges in accessing essential services such as healthcare, education, and employment.

4.2 Lack of clean water

In refugee camps like Kakuma and Dadaab, access to water is one of the major needs for refugees to live better lives; no one survives without water. The need for water in the camps is essential for farming, drinking, religious activities, and maintaining the environment. Therefore, the availability of water is one of the most critical services in the camps [14]. In the Kakuma refugee camp, UNHCR and the government of Kenya are the main donors in charge of water supply. However, UNHCR is not directly involved; instead, they partner with Peace Winds Japan to manage the direct water supply to refugees while in the Dadaab refugee camp, Care International Kenya supports UNHCR in providing access to water for refugees.

The provision of water in Kakuma faces numerous challenges. Frequent conflicts occur at tap stands where refugees line up for water, exacerbated by limited access schedules [15]. Kakuma hosts thousands of refugees who rely on six main boreholes. These boreholes also supply water to the Kalobeyi settlement camp and the host community. The host community, including those with livestock such as goats and camels, also requires water due to the dryness of Turkana land and the insufficient government water supply. Consequently, they often tamper with the main pipeline that supplies water to Kalobeyi, sometimes causing water shortages for several days to weeks. During these shortages, refugees are compelled to dig holes in water canals (Laga) to find drinking and cooking water. Additionally, groundwater can be saline and of poor quality, increasing the risk of waterborne diseases.

Additionally, the continuous influx of asylum seekers exacerbates the water scarcity problem. Water is sometimes trucked into the camps from Kakuma main town, but its quality can be poor, and drivers often sell it at a profit. The lack of clean water leads to severe health problems, including waterborne diseases like cholera, which, alongside malaria, is one of the main diseases in Kakuma and Kalobeyi, further worsening the already dire living conditions in the camps [16]. Business owners in the camps, such as shop and hotel owners, also contribute to the problem by purchasing large quantities of water, thereby preventing others from accessing it. Some even resell the water, further limiting its availability.

The experience in the Dadaab refugee camp can be different, refugees in Dadaab depend on borehole water and the time allowed for fetching water is very limited that causes some households missed water. The existing water infrastructure is insufficient and often subject to damage or sabotage, further complicating the water supply [17]. In November, illegal borehole sinking near Ifo camp contaminated a dam, leading to a temporary water crisis. UNHCR and CARE have since installed water purification systems at the dam, which are now operational.

In refugee camps, the absence of water severely affects daily activities such as cooking, cleaning, and personal hygiene, illustrating the gravity of the situation. There is a pressing need for sustainable water management solutions, such as better infrastructure, desalination projects, or partnerships with technology companies to provide long-term solutions. Specific policies and initiatives by the Kenyan government and international organizations could significantly improve water access in refugee camps. A joint assessment conducted in 2008 by UNHCR, UNICEF, and CARE in seven Kenyan refugee camps found that while quantities of water available met minimum emergency standards, the quality of water in both camps and host communities was often below the acceptable quality, due to contamination during collection, transport, and storage. This leads to waterborne diseases like diarrhea and cholera for thousands of refugees each year, particularly children.

The limited access to resources afforded to the refugees is a persistent problem for people living in camps. It has negative implications for every aspect of life, including difficulty in finding clean water, insufficient food, and inadequate shelter. Clean water is an essential element necessary for life and good health. Unfortunately, many refugees have only limited access to water, the quality of which often does not meet minimum standards for drinking and cooking.

Lastly, in terms of weather, Kakuma, Dadaab, and Kalobeyi are located in a semi-arid area. Not only it lacks of water but the soil characteristics also make the situation worse. On one side, the infiltration levels are low, increasing the flood risk and jeopardizing the provision of underground water, as they dry and are not refilled. On the other, this fact makes agriculture a difficult issue as the soil is less and less fertile, losing quality year after year [18].

4.3 Insufficient food supply

The decline of general food security throughout the country due to poor rains, depreciating economic conditions, and decreased humanitarian funding has impacted refugees as well. High global food prices and the devaluation of the Kenyan shilling have greatly affected the humanitarian food pipeline to Kenya. In 2012, the World Food Programme (WFP) reported a global ration reduction of 80% for refugees in Kenya due to underfunding. This has led to negative coping strategies, including skipping meals, reducing portion sizes, and distress-related migration to urban areas in search of food and work.

The global increase in refugee migration, particularly in Africa, is largely driven by conflicts. In Kenya, refugees are continuously arriving in Kalobeyi and Ifo 2 in Dadaab. However, the influx of refugees coincides with a global funding crisis, making it challenging for donors to fully support refugee camps like these. The World Food Programme (WFP), responsible for providing food aid, utilizes an electronic transfer system called Bamba chapa to allocate funds for refugees in the Kalobeyi settlement camp [19]. In 2017, when refugees from Dadaab were relocated to Kalobeyi due to insecurity, the UNHCR, in collaboration with WFP, introduced electronic money transfers, initially providing refugees with 2000 shillings per person. However, due to funding constraints, this amount was reduced to 1050 shillings, causing considerable tension within the camp and prompting refugees to protest against the decision [20]. The settlement program, particularly in Kalobeyi, aimed to promote self-reliance among refugees, thereby reducing their dependence on WFP assistance and facilitating agricultural activities. However, the arid land in Turkana is not conducive to farming. To address this, the Food and Agriculture Organization (FAO) dug large holes to collect rainwater for irrigation and distributed 1000 water tanks to each household. Unfortunately, many of these water tanks are now missing, as some refugees sold them to purchase additional food, highlighting the ongoing struggle with insufficient food supply within the camp.

It is recognized that the WFP is under enormous strain to feed all the world's hungry, and one of the places they have sometimes had to cut food rations is in the refugee camps. In recent years, the WFP has had to launch emergency appeals for funds, warning that they will have to cut rations to refugees in Kenya and several other countries due to insufficient funds [21]. This inability to live a life of minimum acceptable standards has caused many refugees to either return to extremely insecure and unsafe situations in their country of origin or to push for the right to be self-sufficient and lift their reliance on aid and food donations. This is a difficult process that

many countries are reluctant to allow, as refugees essentially move from a dependent to a more independent existence.

Many refugees are not able to work to earn money to buy food, which makes them dependent on food distributions and extremely vulnerable if the food pipeline is ever broken. Many have had to sell portions of their food rations in order to meet other needs, such as school fees. This obviously has a negative impact on the health and nutrition of the family. The effect of this is often manifested through children, with reports from various medical NGOs that up to 50% of the child population in some refugee areas suffer from malnutrition. There can be a lack of energy foods such as maize and cooking oil, with refugees having to survive for long periods on inadequate food. This has a huge detrimental impact on the health of the population, affecting both physical and mental development. As a result of inadequate food available from the World Food Programme, there is a high level of poverty within the camps, this becomes worse with the existence of illegal activities causing insecurity among the refugees. Some of the refugees engage in selling allocated food rations instead of consuming them, brewing and distributing illicit alcohol, theft and banditry, and assault and battery.

These activities are all symptoms of the high levels of poverty causing frustration and desperation among the refugees. According to the data from the United Nations World Food Programme, the food security situation among the refugees worsened in 2018 due to funding shortages from all sources, a reduction in size and period of assistance entitled to in-kind food rations. Infant and Young Child Feeding practices, care practices, and WFP nutrition supplementations for preventing and treating moderate acute malnutrition cases have deteriorated due to the unavailability of supplementary and therapeutic food on the market. This is in part caused by high dependency on food aid and a reduction in opportunities for self-reliance.

The refugees in Kenya often live in a severe state of poverty. According to the UNHCR, 43% of the refugees in Kenya live below the poverty line, making up to \$1.25 a day. This is basically survival. The poverty not only causes hunger and health issues but also tensions within the communities and families.

4.4 Inadequate shelter

The provision of adequate housing is recognized under international human rights law as a fundamental right, enshrined under Article 25(1) of the United Nations Universal Declaration of Human Rights. Housing is an essential aspect that significantly impacts an individual's quality of life, health standards, and psychological well-being [22].

The issue of inadequate shelter for refugees in camps, such as Kakuma, Dadaab, and Kalobeyi, is multifaceted and challenging. Refugees, who flee their homes with little to no possessions, arrive at these camps in desperate need of housing and other basic necessities. Agencies like Peace Wind Japan and the Norwegian Refugee Council play critical roles in providing shelter, but the solutions are often temporary and insufficient [23]. UNHCR, along with governmental and private donors, are the main bodies supporting these implementing agencies in both Kakuma and Dadaab [24]. The types of houses in Dadaab, Kakuma, and Kalobeyi vary greatly based on the nature of the camps.

In Dadaab and Kakuma, when refugees and asylum seekers arrive, they are given a plastic sheet, poles, timbers, and plots of land to build their houses alone, without much support from agencies apart from non-food items. Within 4 months, the plastic

sheet used for roofing often tears due to the harsh temperatures in Kakuma and Dadaab, reducing its lifespan to less than 4 months [25]. The problem with Kakuma's plastic sheet housing is exacerbated by its structure, as it is covered on the top and surrounded by plastic sheets, making refugees vulnerable to theft. Thieves use knives and razors to gain access inside the houses at night to steal phones and other valuables. Some individuals even believe that thieves use magic to penetrate the houses without waking the residents. In Dadaab, houses are covered with plastic sheets but surrounded by kamoras (small trees) sold by Somalis, which provide some protection against thieves. However, the plastic sheets sometimes leak during the rainy season.

In Kalobeyei, refugee structures are built permanently and vary in size (sizes 1–3 have one room, while size four and above have two rooms: a living room and a kitchen). Refugees who were relocated from Dadaab or who arrived in the camp before 2022 were given the opportunity to have these houses. Those who arrived later were provided with iron sheets and plastic sheets. While refugees appreciate these building structures, they come with numerous challenges. Since the houses are made of stone, they absorb heat during the day, making it difficult to sleep at night. Some refugees experience health issues such as heart attacks and excessive sweating due to the extreme temperatures. Overall, refugees frequently face inadequate shelter that fails to protect them from extreme weather conditions. The challenges are compounded by limited resources, skilled labor, and land availability in refugee-hosting areas. Moreover, as new conflicts and crises arise in neighboring countries, the influx of refugees exacerbates overcrowding in camps, leaving little space for new arrivals and straining existing resources.

To address these issues, it is crucial to implement more sustainable and resilient housing solutions. This could involve investing in durable materials that withstand harsh climates, employing innovative construction techniques, and ensuring that new housing developments are designed with the refugees' safety and comfort in mind. Additionally, increasing collaboration between international organizations, governments, and private donors can help mobilize the necessary resources and expertise. By prioritizing the provision of adequate, long-term shelter, we can improve the living conditions of refugees, providing them with the stability and security they need to rebuild their lives and move toward a more hopeful future.

4.5 Inadequate healthcare facilities

The healthcare situation in Kakuma and Kalobeyei refugee camps presents significant challenges that require urgent attention and innovative solutions. The primary issues revolve around the global health framework, Kenya's primary healthcare system, specific refugee healthcare needs, UNHCR funding, the absence of medicines, and the distribution of medical professionals. Globally, health is a critical concern, especially in refugee camps where populations are vulnerable and often in poor health upon arrival [26]. In Kakuma and Kalobeyei, the global standards for health services are difficult to maintain due to resource constraints. Refugees face numerous health issues, including malnutrition, infectious diseases, and psychological trauma. Meeting global health standards requires substantial investment and coordination among international agencies, NGOs, and the Kenyan government.

Kenya's primary healthcare system is decentralized, with 47 counties managing their own healthcare services. In theory, this allows for tailored healthcare services that meet local needs [27]. However, in practice, the system is plagued by inconsistencies and resource disparities. Refugee camps like Kakuma and Kalobeyei are

particularly affected due to their remote locations and the immense pressure on the local health infrastructure. UNHCR, the United Nations Refugee Agency, plays a pivotal role in funding and supporting healthcare services in refugee camps. Despite their efforts, funding is often insufficient to meet the growing needs. The healthcare facilities in Kakuma and Kalobeyei are under-resourced, leading to inadequate medical care. Refugees frequently face long wait times, limited access to specialists, and a shortage of essential medicines.

One of the most pressing issues in Kakuma and Kalobeyei is the absence of adequate medicines. Chronic shortages mean that even basic treatments are often unavailable. This absence exacerbates health problems, leading to preventable complications and higher mortality rates. The supply chain for medicines is disrupted by funding shortages, logistical challenges, and regulatory hurdles. Moreover, Kenya suffers from a severe imbalance in the distribution of medical professionals. Approximately 80% of medical professionals are based in urban areas, while only 28% of the population, including refugees, live in these areas [28]. This leaves a significant gap in rural and remote regions like Kakuma and Kalobeyei. The shortage of healthcare providers means that refugees often seek medical help from surrounding local communities, where cultural and language barriers can lead to misdiagnoses and incorrect treatments.

In Kenya, the private healthcare sector operates on a “pay-for-service” basis and is often prohibitively expensive. Public healthcare facilities, while not charging for consultations, suffer from poor standards of care. This includes inadequate diagnostics, lack of medicines, and a general expectation for patients to provide basic medical supplies. Refugees, who typically lack financial resources, are thus caught in a dilemma between high costs and poor quality of care. To address these challenges, several steps have been taken. Increasing international funding and support from UNHCR and other donors is crucial to improving healthcare services in the camps. Streamlining the supply chain for medicines to ensure a consistent and reliable supply of essential drugs is also necessary.

Additionally, focusing on training more healthcare workers and incentivizing their deployment to rural and refugee camp areas can help mitigate the shortage of medical professionals. Leveraging technology, such as telemedicine and mobile health clinics, can bridge the gap between urban and rural healthcare services. Strengthening local healthcare systems through collaboration with local governments can enhance the capacity of public healthcare facilities in and around refugee camps. Addressing these issues requires a coordinated approach involving the Kenyan government, international agencies, and local communities. By implementing these strategies, we can improve the healthcare outcomes for refugees in Kakuma and Kalobeyei, ensuring they receive the care and support they need to rebuild their lives.

4.6 Limited job opportunities

The issue of limited job opportunities for refugees in Kenya presents a multifaceted challenge that exacerbates their already precarious living conditions. In Kenya, many local citizens, including those with impressive educational credentials, struggle to secure employment. This competitive job market leaves even fewer opportunities for refugees, who face additional barriers. While organizations such as the UNHCR and various NGOs do create job opportunities, these positions are often prioritized for Kenyans from other regions and the host communities around the refugee camps, further marginalizing refugees. A significant hurdle for refugees is the difficulty in

obtaining necessary documentation, such as work permits. The process is fraught with restrictions and bureaucratic red tape, making it hard for refugees to gain legal employment. Furthermore, Kenya's encampment policy severely restricts refugees' movement, preventing them from seeking better job opportunities elsewhere in the country. Within the camps themselves, corruption is rampant. Often, those who are able to pay bribes can secure jobs, regardless of qualifications, sidelining deserving candidates who lack financial resources.

This is one of the factors that encourage refugees who have attained higher education to consider returning to a homeland they barely remember and that offers minimal prospects for sustainable living. In response to these dire circumstances, some refugees attempt to find work in neighboring countries like Uganda, Ethiopia, and Southern Sudan, where linguistic and cultural similarities exist. However, this move is fraught with risks, including the potential for insecurity and forced recruitment into militia group. Additionally, refugees face societal challenges, including negative perceptions among Kenyans who believe that refugees are taking their jobs. This sentiment has sometimes erupted into violence, with outbreaks targeting refugees in cities like Nairobi, Nakuru, and Mombasa. Such incidents not only threaten the physical safety of refugees but also restrict their ability to move freely and seek employment.

The 2006 Refugees Act theoretically grants refugees the same employment rights as other foreign nationals, contingent upon obtaining work permits. However, in practice, the issuance of these permits has been significantly curtailed as part of government efforts to control refugee influx. This restrictive policy environment leaves refugees with limited avenues to build a livelihood, compelling them to live in a state of perpetual uncertainty and dependency. The compounded effects of bureaucratic barriers, societal hostility, and restrictive policies highlight the urgent need for more inclusive and supportive frameworks to improve refugee welfare and integration in Kenya.

4.7 Lack of access to education

Refugees in Kenya face significant barriers to accessing quality education, primarily due to a lack of infrastructure and financial resources. Education is crucial for the successful development of refugee children, enabling them to rebuild their lives and contribute to their communities. However, multiple factors deter access to education for refugee children in Kenya.

According to the principles outlined in education frameworks within the African Union (AU), especially on 37 AU SUMMIT February 18, 2024, education is deemed a fundamental human right and plays a critical role in the global landscape. For displaced communities worldwide, access to education is often hindered by various challenges, including political instability, limited resources, and discriminatory practices. Policies related to education within the frameworks of the Organization of African Unity (OAU) and the African Union (AU) emphasize the importance of inclusive education for all, including refugees. Despite these policies, the implementation remains inconsistent across the continent.

In Kenya, the constitution and human rights frameworks underline the right to education for all children, including refugees [29]. However, the reality on the ground is starkly different. Refugee children in camps, such as Kakuma, Kalobeyei, and Dadaab, often attend schools run by the United Nations High Commissioner for Refugees (UNHCR) or non-governmental organizations (NGOs). These institutions,

despite their best efforts, struggle with limited resources and are often unable to provide quality education.

The UNHCR and the Global Compact for Refugees emphasize the importance of education for refugees, aiming to integrate them into national education systems and improve educational outcomes. However, these efforts face numerous challenges. One of the most pressing issues is the quality of education provided in refugee camps. According to the Global Education Compact Fact Sheet [30], statistics indicate that one in five refugee children will not complete primary education, and the numbers dwindle further at higher levels. Only 1% of refugee children progress to tertiary education, highlighting a severe gap that needs addressing.

As we all know, education provision in refugee camps is free because life in the camps is difficult, and affording school and tuition fees is nearly impossible for refugees. However, in Kalobeyei, Kakuma, and Dadaab camps, parents are required to pay for their children's high school fees. In Kakuma and Dadaab, many refugees can afford these fees as these camps have been in existence for nearly 33 years. The lives of refugees in these camps have improved, with many having relatives abroad through third-country resettlement opportunities via UNHCR. Additionally, many refugees run small businesses or work with NGOs as incentive staff, enabling them to fund their school fees.

In contrast, refugees in the Kalobeyei settlement camp which was established in 2016, refugees are new to the environment and still building their lives. As a result, they struggle to pay the required 3000 Kenyan shillings per student. The financial burden is further exacerbated by strict food ration reductions. Consequently, I have witnessed parents and students being sent home due to an inability to pay school fees. Education is a key factor in improving refugees' futures and their communities. The absence of refugee students in school can lead to a loss of hope, which is crucial for surviving life in the camps. In general, refugees live on hope; without it, life in the camp would be unbearable. Additionally, the opportunity for higher education after completing secondary school remains a significant challenge.

In camps like Kakuma, Dadaab, and Kalobeyei settlement camp, students who perform well in secondary school are eligible for scholarships. For example, the DAFI program offers scholarships to those with a minimum grade of C+ for Kenyan universities, while international universities, such as those in Canada, often require a B+ or higher. However, students who achieve lower grades, such as a C plain or below, are frequently excluded from these scholarship opportunities.

UNHCR, along with various education partners, including universities both within Kenya and abroad, strives to provide higher education opportunities [31]. Despite these efforts, significant challenges persist. One major issue is the authentication of degrees obtained from foreign universities. Refugees who graduate from institutions outside Kenya often face difficulties when applying for jobs or returning to their home countries to seek employment. The process of verifying educational documents, particularly those obtained through distance learning or online programs, can be complex and time-consuming. Many graduates find themselves unable to secure jobs due to the lack of authenticated documents from the respective foreign ministries. Additionally, even within Kenya, employers are often reluctant to recognize degrees obtained from foreign institutions, making it difficult for refugees to find employment. The overall job market for refugees in Kenya is highly challenging, as legal documents like work permits are required but are notoriously difficult to obtain. Despite policies that theoretically allow refugees to receive work permits, the actual process is fraught with obstacles and often

requires additional support and resources [32]. These barriers highlight the urgent need for more streamlined processes and better support systems to help refugees access higher education and employment opportunities both within Kenya and internationally.

As a result of this, youth in refugee camps face additional challenges, including drug abuse and limited opportunities for higher education. These issues are compounded by a lack of qualified teachers and youth workers, who are often unemployed despite their crucial role in fostering the next generation's success. The influence of media on education is also a concern, as it can both positively and negatively impact refugee children's educational aspirations and opportunities.

In conclusion, improving access to education for refugees in Kenya requires a multifaceted approach. It is essential to enhance the infrastructure and funding for refugee education, ensure the proper implementation of inclusive policies, and address the quality of education provided. Additionally, there needs to be a concerted effort to integrate refugees into the national education system, offering them the same opportunities as other children in Kenya. Only through such comprehensive measures can we hope to secure a brighter future for refugee children in Kenya and beyond.

5. Conclusion

Finally, there are some signs of a more pro-refugee Kenyan civil society. The very fact that KANERE has been allowed to exist and become an active voice is a positive step. An award-winning film by a Kenyan woman, "For a Few Beautiful Souls," has drawn attention to refugee issues through the story of a Somali girl. It is just the sort of cross-border cultural "invasion" that Kenya needs before policy and attitudes can really begin to change. The prospects for all these hopeful signs, however, are contingent on the international political climate and the face of terror in East Africa. The Kenyan government cannot be held solely responsible for xenophobia toward Somali refugees when it is in the global interests of Western states to stigmatize and securitize all things Muslim and Somali. But it is to be hoped that the international community will show more willingness to understand the situation and work toward policies that are not made with a short-term mentality and at the expense of refugees and the marginalized.

Kenyan refugees and other marginalized groups have been the losers in policies of decentralization that have created local fiefdoms and undermined the central government. But it is precisely the decentralization process that may provide a chance for more inclusive policies. Figures like the DC in Kieni West show that it is not impossible to have open discussion about the needs of marginalized groups and that there are local officials who are not indifferent to their plight. But for these processes to be sustainable, it requires support from higher levels and a change in incentive structures for government and civil servants.

The refugee situation in Kenya is complicated, not least by the conflicting needs of different groups and the policies of foreign states and organizations. No quick fix is to be expected, and the UNHCR must work within the constraints of international policy and public opinion. But it is a cause for optimism that new approaches to refugee welfare can emerge from the shadow of the encampment and that a more open and inclusive refugee policy is possible in Kenya. With the right encouragement, the KANERE program suggests that the two can be mutually supportive and that there are feasible alternatives to the encampment.

Addressing the multifaceted challenges faced by refugees, including the lack of documentation, clean water, sufficient food supply, adequate shelter, healthcare facilities, job opportunities, and access to education, requires a comprehensive and coordinated approach from governments, international organizations, NGOs, and local communities. Here are some recommendations and policy changes to consider:

1. Streamline and expedite the process for obtaining refugee documents to ensure that all refugees have legal status and access to services.
2. Invest in water infrastructure projects such as boreholes, wells, and water treatment facilities to ensure access to clean and safe water for refugees and host communities.
3. Implement food assistance programs, including food distribution and nutritional support, to address hunger and malnutrition among refugees.
4. Develop sustainable housing solutions, including upgrading existing shelters and constructing new refugee settlements, to provide safe and dignified living conditions.
5. Increase investment in healthcare infrastructure and personnel to improve access to primary healthcare, maternal care, mental health services, and emergency medical treatment for refugees.
6. Foster partnerships with local businesses and industries to create job opportunities for refugees, including vocational training programs and initiatives to support entrepreneurship and self-employment.
7. Ensure that all refugee children have access to quality education by building schools, providing teacher training, supplying educational materials, and implementing initiatives to overcome barriers to enrollment, such as language and transportation challenges.
8. Strengthen coordination among government agencies, international organizations, NGOs, and local stakeholders to ensure that policies and programs are aligned and effectively implemented. Additionally, increase funding for refugee assistance programs to meet the growing needs of displaced populations.

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Perspective Chapter: Post Modern Case Management – Towards Compassionate, Person-Centred Community Aged Care in Australia

Michelle Manning Hutson

Abstract

The Australian government is undertaking significant reforms of the community aged care services system, undergoing a series of community consultations to provide cost effective, value for money, personalised aged care services for older Australians. Central to the delivery of these services are the aged care workers who draw together the various community aged care services, providing bespoke community based aged care packages tailored to individual needs. A key role of these coordinators is to ensure value for money, with preventative care key to limiting morbidity and mortality. The compassionate, individualised care provided by case managers promotes satisfaction with care and improved health outcomes for older Australians. Case management is evolving and there is significant benefit to older people with improved clinical oversight of community aged care, introducing appropriate mandatory minimum qualifications and embracing new and emerging technologies.

Keywords: case management, community aged care, person centred care, coordination of care, government funded, aged care policy

1. Introduction

The Australian aged care landscape has changed significantly over the last 50 years, reflecting a massive government investment towards supporting older Australians to have improved wellbeing and independence as they age. While working Australians pay taxes, these funds are distributed and managed across the health landscape, including promoting good health outcomes in older age. There is a strong base of research supporting these policy decisions which describe the implementation of evidence based and value for money community healthcare supports. In addition to strong evidence based medical support for ageing well, there is a clear need to drive contemporary practice towards compassionate, kind, and value for money care.

This work seeks to describe the historical changes and reforms leading to the current state of coordinated, community aged care services and envision the future of government funded community aged care. By exploring the evolution of research

and policy contexts over the early 2000s, we will see the role of the case manager in a practice framework grounded in individualised, coordinated, multidisciplinary care and to look towards a future state where technology is leveraged to promote greater satisfaction with care, improved health outcomes and cost efficiencies for care provision. The Australian government is undertaking significant reforms of the community aged care services system, undergoing a series of community consultations to provide cost effective, value for money, personalised aged care services for older Australians [1]. Central to the delivery of these services are the aged care workers who draw together the various community aged care services, providing bespoke aged care packages tailored to individual needs. A key role of these coordinators is to ensure value for money, with preventative care playing an essential part in limiting morbidity and mortality and improving quality of life. Case management is evolving and there is significant benefit to older people to improve clinical oversight of community aged care and introducing appropriate mandatory minimum qualifications.

The role of case management is varied, and is provided in a broad range of contexts including aged care, disability, chronic disease management and medical recovery. The description of case management in the literature is highly variable, reflecting the diverse role and settings in which case management is provided [2, 3]. The case manager's role is to co-ordinate different strands of clinical and non-clinical care based on the individual needs of the person, based on a sound biopsychosocial assessment of their holistic care needs. Central to effectively implementing this investment is the care coordination role, ensuring delivery of services in alignment with government policy and providing consistent care based on strong relationships and rapport with a key support person.

Australian aged care services and the case management role have evolved from the early days before Home and Community Care in Victoria, Australia, through the aged care reforms leading to the implementation of Support At Home for older Australians and beyond; outlining the impact and importance of delivering aged care with a person-centred and compassionate approach.

2. The Evolution of Aged Care in Australia: Key reforms and influences on current practice

Following the introduction of the Aged Care Act 1987 which set the stage for investment and integration of a variety of aged care policies and services, Community Aged Care Packages (CACP) were introduced to Australians in 1992 [4]. These CACPs aimed to integrate low level aged care residential services but provided in the older person's home, and the funding model reflected this investment in service provision without the concomitant commitment to building and development of new care facilities [4]. This novel model of service centred the service delivery in the person's community and represents the early beginnings of ageing in place, supported by care coordination and individualised care in the home [5]. With the advent of the Aged Care Act in 1997, the further policy framework set the scene for greater investment in aged care with consumer direction and a changing focus to choice and flexibility in care provision [5]. The new legislation began to consolidate previous investments and bed in principles of consumer directed care and more adaptable and individualised care. Following a highly successful pilot program for the high care equivalent of the CACPs program, Extended Aged Care at Home (EACH) was

introduced nationally to provide an alternative to high care residential aged care, including specialist dementia support [4].

The changing face of service provision continued to progress towards the notion of personalised, highly customizable community care, with the Australian Government Productivity Commission Inquiry into Aged Care looking to understand the future needs of the aged care system, to better meet the needs of special needs groups and to ensure sustainability and quality of care into the future [6]. The Caring for Older Australians inquiry of 2011 recommended a simplified aged care gateway, with funding for individualised services, increased choice and control for older people over the provision of their aged care services and improved quality of care [6]. Following the recommendations of the Inquiry, My Aged Care became the single gateway for care and services for older Australians, the Home Care Packages Program provided modular “levels” of care, provided as bespoke, individually tailored community care packages.

In 2018, a Royal Commission into Aged Care Quality and Safety was established, inquiring into quality of aged care services in Australia, whether those services were meeting the needs of community, and how they could be improved in the future [7]. The Royal Commission looked at Australia’s changing demographics as the population ages, service delivery environments including community and residential settings and the challenges of workforce and regulation [7]. Access and quality remain challenges to be addressed by the aged care reforms, including oversight of service provision and sustainability of funding [7]. The Commission report highlighted the key themes of dignity, respect, connection and quality of care, highlighting self determination, quality of life and care that leaves people feeling seen and heard [7]. In their inquiry, the Commission found that care management is a critical part of the face to face presence that older Australians value as part of the delivery of comprehensive aged care [7].

A new Aged Care Act is expected to be passed by the Australian Government in 2025, addressing a number of the recommendations made by the Royal Commission into Aged Care Quality and Safety, with an aim towards ensuring sustainability of aged care funding into the future. These changes are mooted as “historic reforms to ensure viability and quality of aged care” as Australians continue to age, and \$AU5.6 billion of services are proposed to reach 1.4 million older Australians by 2035 [8]. In addition to this investment, the reforms aim to save \$AU12.6 billion over the next 11 years as older Australians are asked to make additional means tested contributions to care, including a “no worse off” principle for Australians already engaged with community or residential aged care services [8]. The Support at Home will provide support for clinical care, independence and every day living, with the Government committing to pay for 100% of clinical care services such as nursing or occupational therapy [8]. Given the potential for recipients of aged care services to pay more, it may be expected that they are seeking a more personalised experience of care, driven by revised National Quality Standards—aiming to put more “care” back into aged care.

These continued evidence based, consultative aged care reforms continue to drive the Australian aged care landscape towards the goals of cost effectiveness, value for money and highly personalised care. There remains incredible opportunity for older Australians to engage with a highly participative assessment and care planning process as they understand how best to use this investment in care towards specific care plan goals and optimise health related quality of life.

3. Influences on contemporary practice in Victoria, Australia: HACC and the Active Service Model

Victoria is a state in Australia with a large population base and an ageing population. The Home and Community Care Program (HACC) was established in 1985 as part of a jointly (State and Commonwealth) funded program targeting the basic care needs of frail older people, people with a disability and those in a caring role living with Victoria [9]. The HACC program was largely provided by local government departments who provided assessment, care planning and service delivery within their municipalities with the goal of minimising premature admission for older people and people with disabilities to long term residential care [9]. HACC policy aligned with reforms in health services to improve care for older people, taking into consideration existing funding streams including primary health, chronic disease management, mental health and disability [9]. The HACC approach centred around the person, with a focus on providing early intervention, comprehensive assessment and optimising sharing of information across services, improving self management skills, providing goal oriented care planning, social inclusion and community engagement under the guidance of the Victorian Service Coordination Practice Manual (Strengthening Assessment and Care Planning) [9]. The philosophies driving HACC care included person centredness, focus on supporting sustainability of informal care arrangements, promoting independence, a partnership approach, comprehensive care planning and service delivery and a focus on optimising systems [9].

The HACC program drew heavily on the Active Service Model (ASM) and influences on HACC assessment practice included research informing the broader policy context, and program specific policies, frameworks and guidelines which influenced day to day practice [9]. Emerging research based drivers of the ASM approach included increasing demand, addressing funding and service inequalities across regions and a wellness promotion approach. The ASM approach represented a transformative approach to aged care that emphasises a person-centred and multidisciplinary framework. The ASM, introduced in the early 2000s, prioritised maintaining and enhancing an individual's functional capacity through tailored interventions, rather than merely addressing immediate needs and provided standardised tools for practitioners used across the state [9].

The HACC program and ASM integrated various professional disciplines—such as occupational therapy, physiotherapy, and nursing—to create comprehensive care plans that support independence and quality of life. The HACC program complemented this by providing a wide range of in-home and community-based services designed to support older Australians and people with disabilities in maintaining their autonomy. This revolutionary approach shifted the focus from reactive care to proactive, personalised support, fostering a holistic care environment that better addresses the diverse needs of individuals while promoting collaboration among healthcare professionals—ultimately cementing the biopsychosocial approach to ageing well in the community.

HACC assessments were designed to be broad based and holistic, addressing biopsychosocial needs, aspiration and goals, strengths and capabilities and centre the person in their social context [8]. Care planning was intended to be collaborative and goal directed with entry, exit and review processes and collaboration between agencies. Regular review progressed towards achieving goals and could lead to service cessation [9]. As the Australian aged care landscape moved towards a single point of entry via My Aged Care, there was a strong advocacy push to include the

strengths based and consultative influences of HACC in the new national assessment model. Ultimately, the services provided by HACC were transitioned to two federally based funding streams under the newly formed National Disability Insurance Scheme and under the broader umbrella of the My Aged Care service reforms.

4. Situating case management in community aged care

Case management is a generalist practice in health related disciplines which provides support including assessment, care planning, service finding, review and reassessment, and care coordination. This work can occur in a variety of contexts, and can broadly be grouped into settings including brokerage, clinical (incorporating rehabilitation), chronic care management (long term, integrated care), strengths based case management or assertive/intensive case management where the person is compelled to engage with services [2]. The role of case management calls on practitioners to engage in both soft skills including supporting individuals, families and stakeholders, but also calls upon significant resource management skills. In a study of community aged care case managers, practitioners reported spending the bulk of their time coordinating care and communicating with clients, families, care providers and other stakeholders [10]. While client engagement (intake) and the initial assessment role is important, case managers report spending more time in the monitoring and review cycle, understanding how care and services are effectively meeting individual needs—and refining the tailored care plan to better meet the needs of the person and within the resources available to them [10].

Case management practice has evolved significantly over the years, adapting to changes in the provision of healthcare needs, the ageing population, technological advancement and evolving healthcare policy. While case management practice may have been borne of the practices of social work, modern case management has evolved to incorporate multidisciplinary care teams, centring the person as the key driver of care. Globalisation has led to managed care, value based health care, increasing health literacy of the general public and the proliferation of technology and social media all having influences on how people interact with healthcare systems.

As case management continues to evolve, it is likely that practitioners will focus more on personalised approaches, drawing on proactive approaches including preventative care as additional research confirms the health economic rationalisation for preventative upstream care preventing more expensive later interventions. Case management has evolved from a role focused primarily on social support to a sophisticated, multifaceted practice integral to modern healthcare systems, emphasising efficiency, patient-centred care, and technological integration. As we move into the next decades, there will be opportunities to beyond artificial intelligence and into generative intelligence and predictive analytics as part of the care planning process, optimising models of care and facilitating careful tailoring of interventions to best anticipate and meet individual client needs. Case managers have always addressed the social determinants of health as part of their comprehensive biopsychosocial assessment and increasing the proactive multidisciplinary approach to care needs provides opportunities to increase efficiency of care and improve quality of life for older people.

5. Towards a person-centred approach to case management

Lukersmith described and proposed the person-centred community-based model of case management to describe a style of case management which draws on a generalist case management role, using a proactive and preventative biopsychosocial approach to engage the person to achieve their goals as part of the Case Management taxonomy [11]. Byrne highlights a lack of clear definition in the literature around person centred practice in health overall [12]. While in nursing, case management is recognised as conceptually strong, Byrne posits that person centred care is generally poorly operationalised [12]. Aged care case managers maximise choice and independence and allow individual risk, valuing dignity of risk in the community. There is a need for clear definitions to better operationalise person centred case management—the Australian Quality Commission on Safety and Quality in Health Care standards describe requirements for providers to implement this approach to care, but the considerable variability in the literature demonstrates clear opportunities for further research and evaluation, defining the minimum standard of person centred care [13].

Aged care case managers have a strong history of undertaking holistic, individualised assessment and care planning to meet client needs. Tools such as standardised assessments and reporting tools facilitate these broad based assessments and allow information to be shared consistently across services, supported by regulatory bodies. Regulators also have a role in strengthening and developing practice, driving improvement across the sector [7, 13]. As national standards continue to emphasise respect, dignity and choice, this continues to drive individualised, value for money care. While the standards emphasise community and family involvement and person-alisation of services, the continued role of individuals and the community in evaluation and continuous quality improvement remains crucial.

As Australians continue to age and there are more people wishing to stay at home for longer, it is crucial to ensure that chronic disease management is integrated into community aged care. The Australian Quality of Care Principles discuss the need for improved clinical oversight to underpin community aged care, ensuring timely access to clinical input to reduce burden of disease and optimise chronic disease management [14]. There are obvious benefits to care recipients with improved long term care outcomes, a reduced burden on strained health systems when there is proactive and early management in the community and ultimately, reduced burden on government funded health services as proactive and preventative care minimises hospital admissions and downstream more expensive clinical interventions. A fundamental part of the clinical workforce in community aged care are specialised registered nurses who are able to provide clinical input and oversight for care management at home, including administering evidence based assessments and tools to ensure optimised service delivery and enhance ability to research. The Quality of Care Principles highlight the importance of personalised care plans that are regularly reviewed and updated based on individual needs and preferences, promoting a highly personalised approach to care, with adequate consideration of dignity and choices [14].

By ensuring that older people have access to information about their health and disease management, the clinical team provide significant improvements to health literacy, facilitating informed decision making about care and participation in care. Supplementing the comprehensive assessment of the case manager, nurses are able to provide enhanced clinical oversight with detailed assessment of health conditions, functional status and changing care needs, ensuring care planning is based on the most up to date and comprehensive information—and ensuring that care planning

remains dynamic and responsive. By working collaboratively, case managers and nurses are able to better integrate a person's medical and psychosocial needs, and timely review means older people have access to high quality evidence based interventions, leading to better health outcomes. The close input of nurses also facilitates dignity of risk, as older people understand potential risks associated with choices and facilitates closer monitoring of potential risks. Regular clinical oversight permits prompt identification of health changes or emerging concerns, allowing for timely interventions and referral to the older person's medical team.

6. Providing additional tools for practice: Introducing mandatory minimum qualifications for case managers

In Australia, case management is not classified as a protected qualification, meaning there is no statutory requirement for practitioners to possess specific credentials or meet minimum educational standards to work in this role. This lack of regulation can result in significant variability in the qualifications and competencies of individuals performing case management functions.

The case management field, which involves coordinating and overseeing comprehensive care for individuals with complex health needs, would benefit considerably from the establishment of minimum educational standards. Implementing such standards would ensure that practitioners possess a foundational level of knowledge and skills critical to effective case management. This would enhance the consistency and quality of care provided, reduce the potential for suboptimal case management practices, and ultimately lead to better health outcomes for clients.

Moreover, standardised educational requirements would support professional development within the field, fostering a more skilled and competent workforce. This would contribute to the overall integrity and credibility of case management as a profession, facilitating improved service delivery and client satisfaction. Moo [15] highlights that case managers come from a variety of employment backgrounds, having differing skill levels and experience from completion of year 12 through to formal allied health qualifications. Moo proposes that it is likely that staff without formal qualifications in allied health or care provision would likely benefit from additional training, whether on the job or completion of formal case management qualifications [15].

In Australia, case managers have the opportunity to join the Case Management Society of Australia, which offers a series of qualifications through its certification programs, however membership is voluntary and completion of any additional qualifications is not mandatory [3]. The Case Management Society of Australia's framework is designed to promote competency based, clear standards for education, experience and practice for case managers across a variety of fields [3]. By offering a framework to help standardise qualifications of case managers across Australia, the society aimed to foster a consistent level of expertise across the field and improve the quality of case management services.

7. Contextualising compassionate care as value for money care

Trzeciak et al. famously hypothesised that compassion improves health outcomes and promotes overall wellbeing by fostering stronger relationships between individuals and their supports [16]. Supportive relationships promote collaborative

care through improved communication and understanding—and efficiency of care [16]. These ideas are supported by Montori's call for a patient revolution, espousing the ideas that shared decision making and personalised care drive improved health outcomes for people, reduce cost of care and minimising burden of care [17]. It is not difficult to imagine how the drivers of careful and kind care are integral to ensuring high quality community aged care services.

In an environment of economic rationalisation, quality of care is an important driver of satisfaction with care and reduced cost burden downstream—by ensuring that compassionate, caring case managers are available to listen, understand and carefully tailor bespoke aged care services, the investment in aged care results in improved health outcomes, reduced burden on acute medical settings and reduced overall cost of care for ageing Australians. As older Australians identify the face to face presence provided by the case manager as something they value in the delivery of comprehensive community aged care, this highlights the value of the compassionate and skilled case manager as a central part of sustainable community aged care.

8. Conclusions: Future directions for best practice in case management

As the government investment of funds increased the amount and availability of care for older Australians, the guiding Quality Standards continue to drive improved care outcomes, safety and quality of care [13]. Value based health care principles underpin the delivery of services and support which are important to older Australians receiving care, but also are based on providing value for money. By ensuring there is a clear vocational education pathway for case managers, and consolidating qualifications and training opportunities, older Australians can feel confident that the individuals coordinating their care have expertise in the delivery of personalised aged care services. In addition, supporting standardised competencies permits career development within the field, and encourages retention and job satisfaction within the aged care sector.

There is significant benefit into funding additional research into what best practice person centred aged care case management looks like—improving homogeneity in case management is a long acknowledged challenge as there is little consensus on terms and activities undertaken by those workers identified as “case managers” [2]. This improved understanding of what excellence in case management care looks like further drives the policy on safe, high quality aged care and provides a strong evidence base for any further investment into aged care. By understanding how older people want to be supported, the tools which are of benefit to them and the services promoting greatest health outcomes, older Australians are then receiving the best value for money in terms of investment in care. In addition, there are excellent opportunities to promote integration across sectors and settings as research continues into settings such as disability and acute care—given the variability of community based case management, there are significant opportunities for case managers to learn from other fields.

Broader cultural factors favouring implementation of highly person-centred and compassionate case management include valuing the satisfaction, wellbeing and quality of life of older people—and better understanding of how to work effectively with a case manager to achieve optimised health outcomes. As health literacy improves for people and they are more engaged with access to health information and become confident making decisions about care, this creates an environment

where highly personalised case management can be operationalised effectively. Similarly, by ensuring that the aged care professionals are able to leverage technology to improve efficiency and support data driven decision making, this creates new opportunities for organisations to create a culture deeply valuing space for unhurried conversations about goals of care, rather than simply increasing throughput. To meaningfully provide aged care practitioners the conditions for compassionate, person centred care, governments must value—and organisations must ensure—adequate time, funds and resources are available in order to yield opportunities for greater satisfaction with care.

As technology continues to evolve, there are exciting opportunities for older Australians to become more active participants in the planning of and decision making around their own care. This changing technology gives older people choice and control in the telling and retelling of their stories. Whether simply from having improved access to health or care portals, by creating better digital links with their services providers or integrating across services, through to self management, the next decades of care are likely to involve more integrated technology for older people and their case managers. Health literacy continues to improve and case managers are primed to support older people to make more decisions about the delivery of their care.

Beyond this, there are exciting opportunities for case managers to leverage technology to support assessment and care planning, using predictive and generative artificial intelligence technology to support evidence based decision making and optimising client budgets. New technology provides opportunities for health surveillance, information and management and this data can potentially be integrated into existing client management software, or inform future AI-powered models to complement the work of the multidisciplinary team [18]. Technology potentially facilitates more meaningful integration of the assessment of the care experience, allowing older people or their carers to provide regular, measurable feedback on their experiences of care. Generative artificial intelligence may potentially be integrated into client management systems, providing real time information on optimising care and improving health outcomes. While this may free up time for the practitioner to spend more face to face time with clients, engaging, listening and understanding, it also opens up exciting opportunities for older Australians living in rural and remote communities as key members of a team offering electronically delivered care.

In addition, increasing individual choice and control allows older individuals to independently manage their own care, moving further beyond Consumer Directed Care and into self management [19]. While new technology comes with risks such as questionable quality of information, AI errors based on inaccurate technology, spreading of disinformation or bias in models, case managers are naturally poised to mitigate these risks as they have strong knowledge of the individual and their care needs. Improvements in consumer directed care offer increased choice and control, increasing flexibility but care provision is ultimately at the discretion of the provider, self management of care provides further opportunities for choice, convenience, control and potentially, less fees to providers.

Many countries around the world offer some variation on the case management model of care in health service delivery, and there are opportunities for learnings on optimised care in different community contexts. In future years, it seems likely that the case management perspective has potential to drive aged care reforms when governments and health systems strongly value client led approaches to care, well integrated services with seamless coordination and data driven decision making with

a focus on health economics and satisfaction with care for both the consumer and the aged care practitioner. By creating an aged care system where older people feel valued and supported, it drives retention and satisfaction with work for aged care practitioners and builds stability and sustainability in the system.

The Australian age care landscape has evolved significantly since the early Government investments in care which predate the Aged Care Act of 1987. Working Australians have paid income taxes to fund a vision of quality care as they age, and there is strong evidence based policy to underpin this vision of ageing well. The significant, “once in a lifetime” aged care reforms proposed for 2025 and beyond are based on a strong history of individualised care, based on a biopsychosocial assessment of care which centres the older person and their community in the context of their changing care needs. As part of the highly personalised care plan, case managers work with older people to provide collaborative and consultative assessment and care planning to ensure that their needs are met. While case management is a generalist practice within health related disciplines, there are tremendous opportunities to standardise practice, with consolidation of qualifications and clear competencies for those providing case management in aged care. Beyond this, there are exceptional opportunities for case managers to leverage technology to provide better, more collaborative community aged care. The face to face care provided by case managers is highly valued by older Australians, affirming that there is a strong economic rationale for compassionate, kind care. As the population ages, community aged care case managers continue to offer great value for money as part of a multidisciplinary team, as well as improving health outcomes and increasing satisfaction with care. There is a strong economic imperative for compassionate, individualised case management in community aged care.

Conflict of interest

The author declares no conflict of interest.

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Up-to-date perspectives on the development of welfare systems are much needed, considering the changes in the past two decades brought about by the Covid-19 pandemic, the 2008 Great Recession, the emergence of ultraright groups in mainstream politics worldwide, the expansion of migratory patterns, among other factors. The book focuses on the impact of global and local welfare policies and programs on groups such as refugees, employees, and the ageing population. Welfare innovation is a pivotal topic of this book, which covers issues such as new welfare services (cash-transfer programs), context-specific policies (age management), and novel policy motivations (ethical commitment, human rights protection). These subjects are applied to numerous countries, including Australia, Brazil, the Czech Republic, Norway, South Africa, and Kenya. The book's analysis of welfare institutions, policies, and services offers an opportunity to consider the evolution, reforms, and challenges of welfare systems worldwide. Additionally, the book helps us understand the importance of adopting new approaches to various components of social welfare in response to the demands of rapidly changing contexts.

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