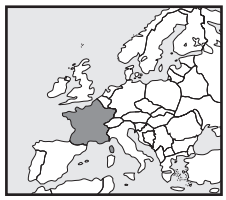
FRANCE

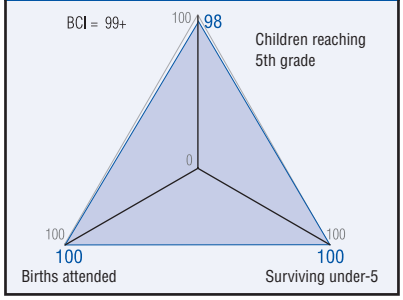
Exclusion persists in one of the wealthiest countries in the world



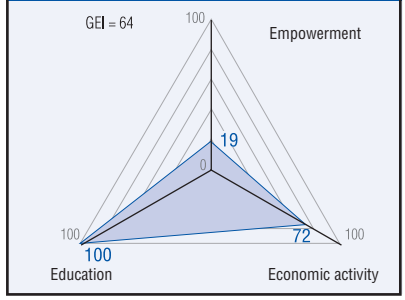
Poverty and exclusion continue to worsen while the economic and social systems continue to reproduce these phenomena. The new government faces the challenge of addressing social inclusion through reinsertion into the labour market and universal access to quality medical care. Regarding development cooperation, aid amounts are inflated by the inclusion of debt cancellation and artificial categories and bilateral efforts must be considered when looking at advances at the multilateral level.

Coordination SUD
Secours Catholique / Caritas France[1]

Basic Capabilities Index (BCI)



Gender Equity Index (GEI)



The presidential and legislation elections in 2007 provided an opportunity for the ALERTE civil society network to demand a clear commitment from the candidates in the fight against social exclusion.

Even though France is considered the fifth richest country in the world, poverty and exclusion persist and continue to worsen. After alternating between left and right wing governments, the situation has not clearly improved since 1994. Civil society organizations confirm that taking emergency measures does not work if at the same time the economic and social systems continue to produce new exclusions.

There are still seven million poor people in a country with a population of 60 million. Poverty has become aggravated in some areas and precarious living conditions have become more generalized with the consequent loss of human, social and economic capacities.

This failure was made possible because our society did not impede it. Even when governments have taken adequate measures, these have not been fully applied. The public powers did not decide to prioritize the eradication of poverty, instead treating it as a misfortune.

The message of the ALERTE group through the election campaign was that "eliminating poverty requires relentless political will to eliminate exclusion at the highest level of the State. This condition is essential in mobilizing all citizens. It does not mean administering exclusion but rather eradicating it, since it is counterproductive for all."[2]

It remains to be seen in which way new President Nicolas Sarkozy, the new government and the new representatives will act with regards to this goal, and how far they will go beyond their declarations.

Guarantee the universal right to social protection

Social protection in France refers to all collective precautionary mechanisms that permit people to face the financial consequences of social risks. It works along three lines of logic: social insurance reserved to those who contribute (protection from loss of income: unemployment, illness, old age, work accidents); assistance (creation of a solidarity fund between persons: minimum wage, assistance to handicapped adults); and universal protection (family benefits). The French social protection system represents more than 30% of the gross domestic product.[3]

Employment: facilitating reinsertion into the labour force and guaranteeing the right to receive training

The labour sector is characterized by increasing fragility due to unemployment, a rise in precarious employment and unwanted part time employment. Of the seven million people who live below the poverty line, three million are poor workers. An important proportion of youth also live in poverty and are affected by massive unemployment, abandon the education system with little training and lack social coverage in the face of the risk of unemployment. Conditions for employment reinsertion and permanency are often rare (due to a lack of infrastructure for childcare, transportation costs, short schedules and very long days).

Our social organizations request:

- That the mechanisms used to reinsert those people furthest from the labour market be simplified, reformulating and streamlining the contracts and improving the public sector's role in the promotion of employment.
- The equal right to training, accompaniment and tutoring be guaranteed, concentrating training in extensive programs and directing those who are looking for employment and waged labourers with low levels of training.

Health: guarantee universal access to preventative and quality health care

Thirteen percent of the metropolitan population admits to having declined some type of health care for economic reasons over the past 12 months with 20% of these cases being declined indefinitely, and the remainder being postponed (IRDES, 2006). The number of cases in which treatment is denied to people belonging to the Universal Health Coverage (CMU) and the State Health Assistance (AME) continues to be high. Access to our health system is not universal.

Our social organizations demand:

- That prevention be considered a priority, raising health professional remuneration to an adequate level, improving health attention at the school and labour levels, and making unemployed people the priority.
- Inequities in health care access, prevention and attention be reduced, developing the existing mechanisms for use of the medical care services and assuring that those people without social coverage can be oriented for a consultation.
- Development of regional programmes to improve access to medical prevention and attention that permits the coordination of actions aimed at people in precarious situations.

1 For this report, Coordination SUD prepared the analysis of France's support to social protection policies in the framework of its cooperation for development. Secours Catholique / Caritas France (member of the Alerte group) developed the national aspect of the report.

2 <www.uniopss.asso.fr/gest-mail-uniopss/commun/Dossier_presse_ALERTE.pdf>

3 <www.vie-publique.fr>

- A high level of coverage for health insurance that should continue to be an obligatory social insurance that each person pays according to their possibilities and receives what is necessary to satisfy their health needs. The financial effort should be augmented exploring new options such as a generalized and progressive social contribution or a company contribution based on added value. Access to CMU and its complementary services should be broadened to all persons with income below the national poverty line, and in particular to the current beneficiaries of the AME. All people with income lower than the minimum wage must be provided with help in order to access a quality complementary health service.
- Penalization in cases where CMU and AME beneficiaries are denied medical attention.

Housing: no one should be obliged to live in the street or in precarious conditions

More than three million people live in precarious conditions or without a roof over their heads. After more than 25 years of insufficient construction and a lack of help from the state, there is a lack of at least 800,000 homes to satisfy existing housing needs. The current reactivation is not adapted to the most modest portion of the population. Additionally, the number of unhealthy homes has risen to 600,000.

Diverse housing laws are applied with much difficulty or not at all, in particular the law that stipulates the provision of 20% of social housing in towns with more than 3,500 inhabitants.

Our organizations propose:

- The creation of a right to housing, so that it can be an effective right accessible by all.
- That housing be considered a true priority, just like employment.
- Social efficiency of the aid programmes to purchase homes be reinforced, and must remain under state control.
- That a supply of economically accessible rentals be guaranteed.
- A universal system be implemented that grants security to those who face the risks of rental.

Development cooperation policy

Rise in aid: an optical illusion

According to the latest figures from the Organisation for Economic Cooperation and Development, in 2006 France assigned 0.47% of its gross national income (GNI), or EUR 8.3 billion (USD 11.4 billion) to official development assistance (ODA). ODA rose 77% between 2001 and 2006. However, if we analyze these statistics in detail, we can state that 'real' ODA, that is to say the costs that really contribute to financing development, progressed much more slowly. In actual fact, the rise in French ODA can be greatly explained by an increase in debt cancellation, similar to what happened in many donor countries. For this reason, ODA is inflated and could be qualified as 'artificial'.

In 2006, debt relief represented 34% of French ODA (EUR 2.8 billion), rising 450% since 2001. In many cases, these cancellations correspond to irrecoverable debts which would never have been paid. For this reason, their cancellation only has a limited impact on the budget of the beneficiary countries. They count more as a simple accounting elimination rather than a real contribution to the financing of development. Overall, the accounting for of these cancellations represents a problem since they do not reflect a real contribution to the development of the country.

Additionally, a growing part of the cancelled debts have been generated by an active policy to support French exportation, whose logic is very different from that of development. For this reason, nothing justifies considering these cancellations as ODA. France includes in its ODA the cost of students coming from developing countries to France for university studies. These costs reached EUR 896 million in 2006, up 98% from 2001. French ODA also includes costs related to the administration of migration flows which reached EUR 458 million in 2006, a 100% increase since 2001. Finally, the costs assigned to the French overseas communities of Mayotte, Wallis and Futuna (EUR 273 million) were also included in the ODA calculation. 'Real' help, which excludes 90% of the debt reductions in order to avoid distorting the ODA indicator, and the total of the artificial costs mentioned, does not represent more than 0.24% of GNI in 2006, at EUR 4.2 billion, and not increasing more than 27% since 2001. Unlike what is officially announced, available development aid remains insufficient in order to finance the Millennium Development Goals (MDGs) and social sectors in particular.[4]

Aid is insufficient for the primary needs of countries

During the period 2004-2005, France designated around 63% of its aid to least developed countries (LDCs) and other low income countries. In the same period, 56% of its aid was granted to countries in Sub-Saharan Africa. This would suggest that France respects its promises to prioritize its aid to the poorest countries and to Africa. However, the French overseas community Mayotte and four medium income countries are among its 10 primary beneficiaries, with these 10 concentrating one third of all French aid. One of these countries is Iraq, which was benefitted by important debt cancellations in 2005. Finally, only two of the beneficiaries (Senegal and Madagascar) are LDCs. The other three low income countries which figure among the 10 primary beneficiaries of French aid were in reality benefited by reductions in debt during this period (Nigeria, Congo and Cameroon).

Neither does the destination of French aid by sector fully reflect the commitments made at the World Forum on Social Development in Copenhagen in 1995 and the International Conference on Financing for Development in 2002 in Monterrey. In 2005, bilateral French investment remained low: only 4% was designated to primary social sectors, 2.2% to primary education, and 0.4% to primary health care.

Beginning in July 2004, France started a reform to concentrate its actions on meeting the MDGs, looking for a greater concentration of aid. In 2005, it adopted seven priority strategies and signed the Framework Partnership Documents (DCP) with each of the French aid beneficiary countries for the next five years. These DCP define two priority sectors where a great part of the resources must be concentrated. Even though education forms part of the sectors of resource concentration in many cases, the same did not occur with health, potable water or sanitation. Additionally, despite concentration efforts, French aid remains very disperse and some transversal activities have remained outside of the concentration sectors.

Multilateral actions working against a balanced commitment in health

In the area of health, France has made consecutive efforts through multilateral channels. Its contribution to the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria has doubled since 2005, with EUR 300 million assigned to this cause in 2007. This makes France the second highest contributor to the fund after the United States. France was also a pioneer in financing the fight against HIV/AIDS, malaria and tuberculosis through the implementation of innovative financing for development mechanisms. In 2006, together with Brazil, Chile, Norway and the United Kingdom, France formed part of the initiative of the International Drug Purchase Facility called Unitaid.[5] This facility, funded by an international tax applied to airline tickets, has the objective of offering long term access to treatments against HIV/AIDS, tuberculosis and malaria and reducing their costs. One of its great advantages lies in the stability and predictability of its financing, guaranteed by the international rate mechanism. In 2007 Unitaid had a budget of USD 300 million, an amount which could reach USD 500 million by 2009.

Despite this consistent investment in the multilateral area, French bilateral efforts in the area of health are insufficient. It is regrettable that France does not look more systematically for a better link between multilateral financing actions and bilateral activities. On the contrary, the embassies that negotiate the DCP often use the argument of multilateral efforts to explain the relative absence of health in concentration sectors of these macro agreements. Nevertheless, the French strategy in the area of health adopted in 2005 insists on the necessity of reinforcing health care systems and considers them one of the four priority areas to support on a bilateral level. This priority does not appear to have been reflected in the facts until now.

(Continued on page 241)

4 For a more detailed análisis of French aid, see the Coordination SUD report *L'APD française et la politique de coopération au développement: Etat des lieux, analyses et propositions*, 2006. Available at : <www.coordinationsud.org/spip.php?article2380>.

5 <www.unitaid.eu/en/>

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The Committee underlined many of the reforms which Canadian groups have long sought including: social assistance at levels adequate for a decent standard of living, increases in minimum wages, assured access to employment insurance benefits and measures addressing food insecurity, hunger, homelessness and inadequate housing (NAPO, 2006).

A national anti-poverty strategy might embody these steps. Twelve years after Copenhagen, Canadians still await it. ■

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GHANA

(continued from page 177)

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CANADA

(continued from page 163)

The Ontario provincial government recently introduced an Ontario Child Benefit.

It is not yet possible to tell whether the Newfoundland and Quebec initiatives will lead either to a cross-country provincial competition at raising the bar of social support and/or to a national anti-poverty strategy.

When Canada appeared before the ICESCR Committee in 2006, the Committee expressed particular concern that amid such a prosperous country, 11.2% of Canadians remained in poverty, including many First Nations, immigrants, women, single mothers and disabled Canadians. Clearly Canada had continued to fail to fulfil its obligations to adequacy of social supports.

Most worrying was the Committee's assessment that Canadian governments treated rights such as the right to adequate social assistance and the right to adequate health care as "principles and programmatic objectives rather than legal obligations." It noted that enforcement mechanisms for these rights were lacking and that governments argue before courts against including Covenant rights among those protected by the Constitution's Charter of Rights and Freedoms.

FRANCE

(continued from page 173)

In March 2007, the Conference on Social Security in Health in Developing Countries took place in Paris. This event, which was organized as a French initiative, developed on the reflections of the eight wealthiest countries in the world (G8) from St. Petersburg in 2006 which called for "an acceleration in international discussions on the practical approaches that permit public, private and community based health insurance coverage in developing countries." We hope that this French initiative is a first step towards rebalancing multilateral and bilateral aid in the health sector, and the benefit of the reinforcement of French actions in the improvement of health systems. ■

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KENYA

(continued from page 189)

The National Food Policy of 1980 built on the need for prudent and focused land reform policy as a requisite for achieving a food-secure nation. Sessional Paper No. 1 of 1986 on Economic Management for Renewed Growth, the Household Food Security and Nutrition Policy of 1988, as well as the National Development Plan 1984-1988, all recognized the need to limit the misuse of land. Through Sessional Paper No. 1 of 1986, the government expressed its intention to establish a National Land Commission to review land tenure, land-use practices and legislation. This came to naught.

The government came to recognize that although food may be available nationally, it may not be accessible at the household level (GoK, 1988).[2] Many factors were acknowledged to be responsible for this situation, not least among them the fact that a significant proportion of the Kenyan population is malnourished as a consequence of inequalities in the distribution of land resources, income inequalities, seasonal food shortages and lack of education and awareness.

2 See also Sessional Paper No. 1 of 1986.