



CHAPTER 7

Reducing Risk, Strengthening Resilience

Social Protection and Nutrition

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IN THE MID-1990S, governments and researchers in three countries from very different parts of the world—Bangladesh, Brazil, and Mexico—began moving toward a new type of poverty alleviation program. Struggling to meet the needs of their poor populations through various poverty-reduction initiatives, they wondered whether attaching conditions to those programs would make a difference. What if in exchange for receiving a food basket or a cash voucher, program beneficiaries were asked, for example, to bring their infants to the local health clinic for growth monitoring, or enroll their older children in secondary school? Such a change could not only meet the immediate needs of citizens, but also help improve their longer-term welfare and development, all of which affect nutrition.

Social protection has been around for millennia, but this “conditional transfer” approach goes beyond welfare per se to address human development. Today, social protection is generally understood to encompass three types of public intervention: (1) social safety nets;

(2) state-contingent insurance; and (3) social-sector policies.¹

Social safety nets are targeted, noncontributory programs that transfer resources to poor households that are deprived owing to their income, social status, or nutritional status. These programs include cash transfers through welfare payments, in-kind transfers such as food aid or school feeding programs, allowances or pensions to aid children, subsidized products that are purchased or produced by poor populations, and public works or workfare schemes. In some regions, such as Latin America, cash and food transfers are increasingly linked with nutrition-, health-, or education-related conditionalities, such as requirements to take children for regular health checkups, attend nutrition education workshops, administer nutritional supplementation, or maintain children’s attendance in primary or secondary schooling.

A second component of social protection is publicly provided state-contingent insurance that depends on the occurrence of an adverse event such as illness, drought, or loss of employment. Such



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A woman in the Guerra region of Chad carries a bag of food aid—a form of social protection that can be made more effective in improving people's nutrition.

insurance-based programs pool contributions from individuals or households to protect them against risk and include social insurance (for example, pensions and unemployment programs) or health insurance. These instruments are needed to fill the gaps left by missing insurance markets or market failures in savings and credit markets for the poor.

The third component consists of social-sector policies, including, for example, waived fees for health care facilities; free primary schooling; and preventative malnutrition interventions targeted to poor, pre-school-aged children. These policies originate in the health and education sectors while also complementing social safety net interventions, especially when they are means tested to ensure they provide assistance exclusively to low-income individuals and households.²

Although countries around the world use social protection programs, populations in industrialized countries have more comprehensive coverage, usually through social security. Seventy-three percent of the global population has only partial or no access to social protection coverage.³

There are many pathways through which social protection can have a positive impact on people's nutrition. Some pathways are direct, encompassing nutrition-specific interventions that address the immediate determinants of nutrition. For example, social protection instruments such as food transfers can raise people's overall food consumption and provide them with more diverse diets. If social protection is linked to conditionalities such as behavior change communication on nutrition or supplementation, it can also

directly influence people's nutrition behaviors or knowledge.

Other critical pathways are more indirect, addressing the underlying determinants of malnutrition, such as poverty, through nutrition-sensitive interventions. Arguably, the goal of most social protection interventions is to increase income, enabling families to pay for everyday needs and services and allowing them to spend more money not only on more food and but also on nonstaple foods, including fruits, vegetables, and animal food products (see, for example, Box 7.1). Research suggests that cash, food vouchers, and food transfers significantly improve the quantity and quality of food people consume. The relative impact of cash and vouchers is context specific.

Social protection instruments can also help households become more resilient, and thus improve their nutrition, by building up assets, savings, or investments in human capital such as education that can help them weather future shocks.⁴ When households are more food secure, they are better able to cope with seasonal fluctuations in food security or shocks due to natural or manmade disasters.⁵ By strengthening income security and investing in rural livelihoods, social protection can also help improve agricultural productivity, stimulate local economic development, build resilience, encourage sustainable natural resource use, and promote social inclusion. It can help reduce child mortality, particularly deaths associated with poverty-related causes, such as malnutrition and diarrhea. Further, if properly designed, social protection can benefit women by promoting their economic and social empowerment.⁶

The evidence of the impact of social protection programs on nutrition is mixed. A 2013 systematic review of 15 conditional cash transfer (CCT) programs around the world found on average nominally positive but insignificant effects on nutritional status, in particular on children's

height-for-age, verifying previous researchers' observation that such programs have inconsistent effects on child nutritional status.⁷ These programs have achieved success on many other fronts such as improving education, decreasing child labor, and increasing access to health care (such as vaccinations). Another systematic review of 16 studies of CCT programs, mostly in Latin America, found that such programs can have a positive impact on access to health care, child and maternal nutrition, morbidity risk, immunization rates, and household poverty, particularly in middle-income countries.⁸ These results should be interpreted with some caution, however. Another review, for example, found mixed results on whether cash transfers have a positive impact on growth-related outcomes among children, particularly in Africa south of the Sahara: some studies in the review had small but positive effects on child weight and height, while several others were found to have no significant impacts on child nutritional status.⁹

This chapter focuses on two interventions: PROGRESA/Oportunidades/Prospera in Mexico and various initiatives in Bangladesh that have made measurable improvements in people's nutrition. These stories illustrate how social protection can be part of a multisectoral effort to address both nutrition directly and the key underlying determinants of malnutrition.¹⁰ The PROGRESA results and the Bangladesh experience suggest that social protection may work effectively when twinned with nutrition behavior change communication.

PROGRESA/Oportunidades/Prospera in Mexico

The Programa de Educación, Salud y Alimentación (PROGRESA)—the Education, Health, and Nutrition Program—is a social protection and poverty alleviation program initiated in 1997 by the Mexican federal government.¹¹ In 2002, the name

of the program was changed to Oportunidades, and it was later changed again to Prospera. This program forms part of an integrated, multisectoral poverty alleviation plan aiming to increase the health, nutritional, and educational status of the country's poorest households by helping parents invest in their children in order to break the intergenerational transmission of poverty.¹²

The program intervenes at each of the three core levels of determinants of malnutrition—basic, underlying, and immediate—as outlined by UNICEF's conceptual framework of malnutrition. It does so by addressing household financial resources and food security, maternal and child care and education, child feeding practices, and maternal and child undernutrition. The nutrition-specific intervention consists of a CCT targeting mothers, because research shows that when resources are given to mothers rather than fathers a higher percentage of investments goes toward the health and nutrition of children.¹³ The program aims to increase the nutritional quality and diversity of children's food intake by providing food supplements, as well as by using cash transfers to boost families' ability to buy more nutritious foods, such as meat, eggs, dairy, fruit, and vegetables. This pathway was enhanced by early intervention in cases of child growth faltering as well as continued health and nutrition education for parents. This education component may be key; new research from Bangladesh suggests that social protection may work best when combined with nutrition-oriented behavior-change communication.

Eligible households, selected from rural areas in most states of Mexico, were those considered most marginalized owing to socioeconomic factors or remoteness, although the communities had to have primary and secondary schools and a health clinic to maintain eligibility. The initial program covered 140,500 households in 3,400 areas. In 2000, the program expanded to urban areas,

covering 2.6 million households in 72,300 areas in all states. By 2008, the program covered approximately one-quarter of the Mexican population.¹⁴ Since its inception, the model has been replicated in 52 countries around the world.

After the initial phase of the PROGRESA program, a 2001 evaluation established that after just one full year, the program had a significantly positive impact on nutritional status for those children who also received supplementary food.¹⁵ This result was demonstrated by a one-sixth increase in average annual growth in children between the ages of 12 and 36 months; for children who received the supplements, the probability of stunting was one-third that of children in control groups. The effect was larger for children from poorer communities whose mothers were literate. This result alone has been estimated as increasing subsequent adult lifetime earnings by 2.9 percent.¹⁶ Another study found no significant impact on growth outcomes on children aged 6 to 24 months. It did, however, find that children younger than 6 months at baseline grew a statistically significant 1.5 centimeters taller and gained a significant 0.76 kilogram more than their nonbeneficiary peers after two years.¹⁷ The researchers could not isolate which component of the program caused this effect but concluded that the provision of fortified food was not the main determining factor because the level of food provided was too low.

Other studies also documented nutritional benefits. One compared a group that had benefited from PROGRESA for two years with a group that had participated for only one year. Children ages 0 to 6 months from the first group were taller (with a 1.1 centimeter greater height-for-age) and had a lower prevalence of anemia (44.3 percent compared with 54.9 percent).¹⁸ Another assessment found that PROGRESA boosted intake of iron, zinc, and vitamin A among beneficiary children who consumed a program-provided micronutrient-fortified

BOX 7.1 Ethiopia's Productive Safety Net Programme

The Productive Safety Net Programme (PSNP) is one of the largest social protection interventions in Africa, reaching 8 million food-insecure Ethiopians in 2011 through two components: public works (temporary employment) for households with labor capacity and direct support (unconditional cash or food transfers) to labor-constrained households (see Chapter 16). The overarching objective is to reduce Ethiopia's dependency on annual emergency food aid appeals by building community assets such as roads through public works and providing predictable transfers to households over multiple years. A recent evaluation uses a generalized propensity score method to examine the impact of the duration of PSNP participation. When the program began in 2006, participating households reported, on average, 3.6 months of food insecurity; that number fell to 2.2 months in 2008, representing an improvement of 39 percent. Further, PSNP protected food security and asset levels in the presence of repeated shocks.¹⁹ One study tentatively concluded that the program improved the diet of 75 percent of participants in both quantity and quality; beneficiaries were more likely to consume the required 1,800 calories per day than nonbeneficiaries.²⁰ Preliminary findings show that PSNP improves diet quantity, quality, and diversity by providing additional resources for families to pay for everyday needs and services, allowing them to spend more money on nonstaple foods, including fruits, vegetables, and animal food products.²¹

food, but the rate of use of the fortified food was not high enough to have more than a small effect on the children's mean hemoglobin levels or rates of anemia reduction.²²

Doubling cash transfers to mothers was associated with a substantial 0.20 higher height-for-age Z-score among their children and a lower prevalence of both child stunting and overweight. Citing insufficient data, the researchers recommended future research to explore the pathways by which additional income positively affects child development. The same study found that mothers spent 70 percent of the cash transfer they had received on a higher-quality diet for their children consisting of meat, fruits, and vegetables.²³

According to other studies, mostly non-refereed, there were other nutrition-related health impacts, which provide tentative results. After six months of implementation of Oportunidades, coverage of vaccines against tuberculosis among children less than 12 months old may have increased by 4 percentage points (88 to 92 percent) compared with 2 percentage points among the control groups

(91 to 93 percent).²⁴ During the first six months of implementation of PROGRESA, measles vaccination coverage may have increased from 92 to 96 percent and in low-coverage communities from 75 to 92 percent after 12 months of implementation.²⁵ Findings also suggest that PROGRESA reduced the morbidity, or the rate of illness, among children under 5 years of age by 12 percent, though with no impact on older children.²⁶ After one year of PROGRESA, beneficiary children under 5 years of age were estimated to be 32 percent less likely to be sick with diarrhea than their control peers.²⁷ Finally, PROGRESA may have also affected the use of health services, increasing growth monitoring and promotion visits by 30 to 60 percent for children up to 2 years of age and 25 to 45 percent for children between the ages of 3 and 5.²⁸

Social Protection in Bangladesh

Bangladesh has been home to many social protection initiatives. The SHOUHARDO (Strengthen Household Ability to Respond to Development

Opportunities) program, for example, is one of the world's largest nonemergency food security programs. During its first phase from 2006 to 2010, it served 2 million people (see Chapter 2 on community nutrition and Chapter 12 on Bangladesh). Another example is the Food for Asset Creation (FFA) program, a component of Bangladesh's Integrated Food Security program. FFA pays beneficiaries a daily wage in food plus cash (2 kilograms of wheat plus 20 taka) in exchange for labor on public works.²⁹ Aligned with the Rural Maintenance Programme (RMP), these programs have contributed to the construction and maintenance of rural infrastructure, particularly feeder roads that connect remote villages to major highways. Because

these roads were built at an elevation, they are not washed out by floods and rains, and the government and donors have used this road network to move food to needy communities during emergencies. Preliminary findings show that participation in FFA and RMP increased households' per capita food consumption by a statistically significant 194 and 271 kilocalories per person per day, respectively, relative to matched control groups. Yet another example of a social protection program with a potential for a positive impact on nutrition can be found in the Chars Livelihoods Programme, which works with ultra-poor households in northwestern Bangladesh, reaching more than 1 million people. Women who earned money from the program



Reuters/A. Soomro

A Pakistani man displays a cash transfer disbursed from the government to internally displaced families.

reported spending it on nutrient-rich food such as eggs, meat, fish, pulses, green leafy vegetables, milk, and fruit. After 10 weeks, their children younger than 5 years were a statistically significant 0.7 millimeter taller on average than nonbeneficiaries, were 210 grams heavier, and had a 1.39-millimeter greater circumference of their mid-upper arm.³⁰

One of the more recent social protection research projects coming out of Bangladesh ran in 2012–2014. The Transfer Modality Research Initiative (TMRI), undertaken by the International Food Policy Research Institute (IFPRI) and the United Nations World Food Programme (WFP), investigated how effective various forms of social protection intervention were in improving income, food security, and maternal and child nutrition status. Under the initiative, 4,000 ultra-poor women and their 21,600 family members in the northwestern and southern regions of Bangladesh received five modalities of social protection: cash transfers only, food transfers only, 50 percent food and 50 percent cash transfers, cash transfers and nutrition behavior change communication, and food transfers and nutrition behavior change communication. The nutrition behavior change communication consisted of conveying information to households on the importance of nutrition and diet diversity for health, hand-washing and hygiene, diversifying diets with micronutrients, infant and young child feeding practices, and maternal nutrition.

Preliminary results presented in 2015 suggested that all forms of transfer in both the northwestern and southern regions caused meaningful improvements in nearly all measures of consumption: spending on food and nonfood consumption, calorie intake, and diet quality. Adding nutrition behavior-change communication to transfers may have led to much larger improvements than transfers alone. In the northwest, cash transfers combined with nutrition behavior-change

communication may have led to a decrease of 7.3 percentage points in child stunting over the two years of the study—an achievement almost three times the national average decline. Other forms of transfer had no impact on any measure of the anthropometric status of children.³¹ These results suggest that social protection may be most effective at improving nutritional status when it is combined with behavior change communication.

Lessons Learned

The array of social protection programs around the world demonstrates the potential for great synergies between social protection and nutrition. Social protection interventions, perhaps when combined with behavior change communication, can not only improve food security but also go further to address dietary diversity, child growth and health, illness, and a plethora of other nutrition- and health-related indicators, such as the use of health services and nutrition education. Social protection interventions are especially useful in times of crisis and shocks, to which the poor are particularly vulnerable. They can help smooth volatility in food security throughout a crisis, ensuring that the nutritional and health status of vulnerable households is not compromised and thereby helping prevent a downward cycle of poverty and malnutrition.

One lesson that emerges clearly from these stories is that nutrition needs to be explicitly woven into social protection programs. This approach might mean “sensitizing” a program to add nutrition-related components such as supplementation, behavior-change communication, or nutrition education–related conditionalities. Or it might mean changing the entire focus of a program, such as looking beyond individuals engaged in productive labor—the target of many social protection programs—to ensure that young children are also protected. At the same time, it should also be noted that

integrating nutrition into social protection programs can generate unintended consequences unless care is taken in their design. Mexico's Programa de Apoyo Alimentario (PAL), a CCT and in-kind transfer program, was found not only to improve household dietary quality, but also—owing to the food basket's provision of energy-dense staple and basic food products—to increase total energy consumption among populations that already had a high prevalence of female overweight and obesity.³²

Social protection now features as one of the proposed targets of the Sustainable Development

Goals (SDGs). Target 3.1 in SDG 1 calls for countries to “implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.”³³ This inclusion underlines the growing importance of social protection in the post-2015 development agenda. It is now up to policy makers, researchers, program designers, and implementers to integrate nutrition into social protection, turning it into a transformative tool that can address both the immediate and underlying causes of malnutrition.