Social Protection & Gender Equality Outcomes Across the Life-Course

A Synthesis of Recent Findings on Health and Nutrition
Acknowledgements
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Introduction
This brief is an extract from the paper ‘Social Protection & Gender Equality Outcomes Across the Life-Course: A Synthesis of Recent Findings.’ It is focused on evidence relating to health and nutrition. The full paper can be accessed here or here.

How might social protection support gender equality in health and nutrition?

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With maternal health central in the evidence base on social protection and health—both for its own sake and because mothers’ health and nutrition determine child outcomes—many health indicators are inexorably gendered (see Figure below). In other ways, however, attention to gender and gender equality is absent from social protection evaluation evidence relating to the health sector. Indicators of food security, for example, are often captured only at the household (rather than the individual) level. In addition, indicators of children’s outcomes (such as mortality and stunting) are rarely disaggregated by sex, sometimes even in contexts where there is reason to believe that girls may be particularly disadvantaged due to cultural practices. Boys’ and men’s roles in reproductive and child health are not systematically considered. These gaps limit our ability to draw conclusions about the contribution of social protection programming in supporting gender equality in health and nutrition.

What does the recent evidence say about how social protection supports health and nutrition?

Early childhood (under 5 years)
Nutrition interventions targeted during the first 1,000 days after conception have proven essential to reduce stunting among young children and shaping child (and ultimately adult) health (see Box 1). The effectiveness of these nutrition interventions may be further enhanced through cash transfer or public works programming that improves household food security by increasing affordability of nutritious foods and dietary diversity as well as uptake of health services (perhaps especially—with caveats—when uptake of those services is directly

Positive outcome indicators for health and nutrition

- Reduced infant/under-5 mortality
- Improved feeding practices
- Reduced stunting/improved height
- Improved uptake of vaccinations

- Delayed sexual debut
- Reduced risk taking
- Improved SRH knowledge

- Improved access to health care
- Reduced out-of-pocket expenditure
- Reduced mortality
- Reduced illness
- Improved diet

- Improved uptake of contraception
- Improved uptake of maternal care
- Improved uptake of facility delivery
Health insurance may also improve child health outcomes, by covering general health costs and by protecting individual or household budgets from catastrophic health shocks that can force people into negative coping mechanisms and deeper poverty but evidence is not only thin, but often contradictory. Evidence shows that:

- Social protection can contribute to reduced under-five mortality by improving household food security and feeding practices and uptake of preventive (such as skilled delivery and vaccinations) and curative services. In some cases (perhaps most often in Latin America and Asia), it also improves young children's growth.
- Impacts are derived through reduced poverty (and improved consumption), targeting the first 1,000 days, and ‘plus’ programming aimed at behaviour change directed at care (e.g. feeding practices and care-seeking).
- Non-effects—which for many programmes include the anthropomorphic indicators that improved diet ought to impact— are primarily the result of too little attention to (un)healthy environments, supply-side deficits (e.g. poor quality health services or providers that do not take adequate account of cultural preferences), insufficient value of the transfer (or insurance), and insufficient information and out-reach to the most vulnerable.

Middle childhood (5-9 years)

There is limited evidence that addresses how social protection can improve health and nutrition outcomes in middle childhood as opposed to early childhood, largely due to evaluations’ focus on the educational outcomes of school-aged children. That said, research from LMICs around the world suggests that both cash and school feeding can improve longer-term outcomes for children. Positive impacts require that transfers are large enough vis-à-vis household consumption and can be further enhanced if accompanied by information aimed at shifting specific parenting practices. School feeding programmes have the potential to improve targeted dietary behaviours. As above, there is limited and mixed evidence about the impacts of health insurance. Evidence shows:

- Social protection can reduce childhood illnesses and improve dietary diversity; as above, in some contexts it may improve growth outcomes.
- Impacts are derived through reduced poverty (and improved household consumption) and further enhanced via ‘plus’ programming supporting access to information that can help to impact caregivers’ behaviours vis-à-vis nutritional practices and/or uptake of health services for their children.
- Evidence on social protection in health and nutrition has traditionally focused on outcomes born of under-nutrition, such as food insecurity, wasting and stunting. However, in a growing number of LMICs poor nutrition now manifests as overweight and obesity. This suggests the need for deeper understanding of the pathways, design changes and complementary interventions that could address the drivers of all forms of malnutrition.

Adolescence (10-19 years)

Evidence on the impact of social protection programmes on adolescent health is also scarce, outside of impacts on sexual and reproductive health. This is in keeping with the broader limited visibility of adolescents within the sector. There is, however, evidence—primarily from sub-Saharan Africa—that unconditional cash transfers can reduce risky sexual behaviour (especially for girls) and mixed evidence that it can reduce boys’ substance abuse. Evidence shows:

- Social protection can reduce risky sexual behaviours and improve adolescents’ knowledge of SRH, which can translate into...
reduced rates of adolescent pregnancy and sexually transmitted illnesses (STIs), including HIV. Social protection can also improve adherence to anti-retroviral (ART) protocols, improving the health of HIV+ adolescents.

- Impacts are derived through reduced poverty, plus programming aimed at behavioural and norm changes for caregivers and adolescents, keeping adolescents (especially girls) in school and linking adolescents with health care services.

- Non-effects are primarily the result of supply-side deficits, including those that render services ‘un-friendly’ to adolescents; inattention to the social norms that shape adolescent health, especially sexual health; and evaluations that are not designed to track individual adolescent outcomes.

**What does the recent evidence say about how social protection contributes to gender equality outcomes in health and nutrition?**

- **Early childhood**: Despite evidence that social protection can contribute to improved health for young children, there is no evidence that addresses how programming might directly contribute to gender equality, despite some evidence that this might be needed (for example, due to son preference). Indeed, no studies disaggregate by child sex.

- **Middle childhood**: Despite the potential for increasingly divergent health outcomes between girls and boys, due to son preference and gendered activities (for example, boys having more accidents because they have greater mobility), only a few recent studies disaggregate outcomes by child sex. One, in Kenya, found that a UCT improved boys’ health more than girls’, with no explanation posited by the authors. Another, an Indian CCT designed to address son preference and targeting mothers as beneficiaries, found that cash can shift mothers’ valuation of girls as well as lead to improved uptake of health services for girls (fathers were not included in the study).

- **Adolescence**: Although contexts vary, risky adolescent behaviour (such as early sexual debut, drug use or exploitative (transactional) sex) tends to be gendered, suggesting that social protection could take an increasingly...
individual—and gendered—approach during the second decade of life. This is especially true of ‘plus’ components aimed at behaviour change (though the provision of information as well as through enhanced linkages with services), but may also be required of core programming given that there is evidence that impact pathways also diverge during adolescence. There is evidence, for example, that cash reduces girls’ (including those living with HIV) risky sexual behaviour more than boys’ (suggesting that girls take risks to alleviate poverty and boys take risks to demonstrate masculinity) and that girls’ SRH outcomes more sensitive than boys’ to improved access to education.

3.4 Implications of the evidence base for how to use social protection to support health and nutrition outcomes that contribute to gender equality

1. Capitalise on the first 1,000 days, ensuring that adolescent girls and women are well nourished before and during pregnancy, and that mothers, infants and toddlers have all necessary nutritional support and healthcare.

2. Sustain and scale up cash transfers and health insurance to continue reducing death and illness among under-fives.

3. Aim broader:
   - Ensure that social protection programmes are better aligned with the most common context-specific causes of ill-health and death across the life course.
   - Step up transfers and school feeding, reaching more people with more sustained support.
   - Expand culturally sensitive health insurance/waivers, taking into account the barriers which can prevent enrolment, and covering the cost of transport to medical services and medication.

4. Use ‘plus’ programming to address the social determinants of health:
   - Ensure that parents—mothers and fathers—receive information on feeding and care practices, care seeking, and hygiene and sanitation, and directly address gender norms and how they may shape context-specific cultural practices that may disadvantage girls or boys (and women or men).
   - Teach children how to eat well and stay healthy—by pairing health education classes with provision of healthy school meals and/or take-home rations and spaces for active place.
   - Ensure that adolescent girls and boys are provided with comprehensive health and sexuality education, as well as services that support good health, including sexual and reproductive health. Take care to directly address the gender norms that leave girls and boys vulnerable to different health risks.
   - Support women’s gendered needs with ‘plus’ components that focus not only on women’s and children’s health needs (such as delivery options and feeding practices) but on gender norms more broadly (such as reducing violence and promoting empowerment).
   - Make visible (including to men themselves) and support men’s gendered needs, by shifting the masculine norms that leave them vulnerable to risks such as substance use and prevent them from accessing timely health care
   - Work with healthcare providers to ensure that they know how to communicate accurate knowledge to people of all ages and are comfortable discussing sensitive topics.

5. Ensure that increased demand for health services is matched by improved supply—working to support systems to scale up both ‘hard’ health infrastructure (such as clinics and ambulances) as well as investing in strengthening provider capacity to improve the quality of services.

6. Invest in disaggregated data that makes gendered health outcomes more visible, and target programmes accordingly.
ENDNOTES

1. de Groot et al., 2017; Mishra and Battistin, 2018; Manley, 2020; Wrottesley, 2015; Tasker, 2020
2. Mishra and Battistin, 2018; Erlangga, 2019; van Hees et al., 2019; Bhageerathy et al., 2016; Williams et al., 2017; Stewart et al., 2021
3. de Groot et al., 2017; Mishra and Battistin, 2018; Manley et al., 2020
5. Tasker et al., 2020; Ahmed et al., 2016; Mishra and Battistin, 2018; Manley et al., 2020
6. Renzaho et al., 2019; Raghunathan et al., 2017; Byrd et al., 2019; Chakrabarti et al., 2020; Williams et al., 2017
7. Huang, 2017; Zenebe, 2018; Harake, 2018
8. Lopez-Arana et al., 2016; Fiszbein and Schady, 2009; Bastagli et al., 2016; Micha et al., 2018
9. van Hees et al., 2019; Bhageerathy et al., 2016; Williams et al., 2017; Stewart et al., 2021
10. Huang et al., 2017; Zenebe et al., 2018; Lopez-Arana et al., 2016; Bosworth et al., 2016; Pearson et al., 2016
12. Jaacks et al., 2017
14. Taaffe et al., 2017; Heinrich et al., 2017; Handa et al., 2017
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16. Toska et al., 2016; Cluver et al., 2013, 2014, 2015, 2018, 2019
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19. Servan-Mori, 2016; Ombere, 2018
20. Glassman, 2013; Rahman, 2018; Mukhopadhyay, 2016; Debnath, 2021
21. Peterman et al., 2019
22. Van Hees et al., 2019
23. Houngbe, 2019; Raghunathan, 2017; Wang, 2017; Achyut, 2016; Hunter et al., 2021
24. Evans, 2017
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26. Rao et al., 2020; Sabde et al., 2018; Urquieta-Salomón et al., 2020’ Lopez-Arana et al., 2016
27. Dasgupta et al., 2016; Jayachandran et al., 2017; Sharaf et al., 2019
28. Tyler et al., 2017; UNICEF; 2021
29. Huang, 2017
30. Gong et al., 2019; Nkhoma et al., 2020; Handa et al., 2017; Heinrich et al., 2017
31. de Brauw, 2020; Houngbe, 2019; Raghunathan, 2017; Achyut, 2016
For readers less familiar with the literature on social protection, health and nutrition, and gender, the following will provide useful detail and further insights.

- Cruz et al. (2017) for an overview of the strengths and weaknesses of conditional cash transfers.
- Erlangga et al. (2019) for understanding the potential of health insurances in increasing access to health care facilities and improving financial protection and health status in different contexts.
- Tasker et al. (2020) for a brief review of why targeting the first 1,000 days of life is crucial for the child’s future development.
- Kumar et al. (2018) for how women’s groups can contribute to young child feeding practices.
- Manley et al. (2020) for how cash transfers can reduce stunting among young children.
- Mishra and Battistin (2018) for an accessible overview of how cash transfers can impact children’s outcomes across a variety of indicators.
- Prasad and Santhanam (2020) for an interesting case study of how cash transfers contributed to gender-transformative change in India.
- Taaffe et al. (2017) for a review of the role of cash transfers in reducing risky sexual behaviour.
- Micha et al. (2018) for a review of how school food environment policies (including direct catering, competitive food/beverage standards, and school meal standards) contribute to the nutritional status of children.
- Wang et al. (2017) for a review estimating the impact of health insurance status on the use of maternal health services in three developing countries.
- Van Hees et al. (2019) for a review of the evidence on health insurance schemes’ inclusivity, in light of the Sustainable Development Goals and Agenda 2030’s commitment to ‘leave no one behind’.
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A SYNTHESIS OF RECENT FINDINGS ON HEALTH AND NUTRITION


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