REALISING THE NUTRITION POTENTIAL OF SOCIAL PROTECTION: PROGRESS AND CHALLENGES

SUMMARY

Ethiopia has made significant progress towards reducing poverty over the last several years. However, it remains one of the poorest countries in the world, with rural areas suffering from pervasive levels of deprivation and seasonal hunger. Children are particularly vulnerable.

Five underlying factors are key to understanding the causes of child malnutrition in Ethiopia: insufficient food availability; inadequate provision of a healthy environment (eg, poor water, sanitation and hygiene); maternal wellbeing and quality of caring practices; women's decision-making power and control of resources; and political economy factors.

Community-based, informal social assistance has a long tradition in Ethiopia. And over the past decade, there has been a growing policy momentum around social protection programmes, spearheaded by a concern to move away from a dependency on emergency food aid and, more recently, by government efforts to protect the most vulnerable from the impacts of the global food, fuel and financial crises of 2008 through a range of social protection programmes. Social protection programmes have proved to be very beneficial to households, but they need to be designed in a more nutrition-sensitive way, with a strong focus on infants, pregnant women and lactating mothers.

Tackling child malnutrition remains a pressing challenge that requires improved food security, behavioural and attitudinal changes and improvements to basic services. This paper recommends that: progress must be sustained, through the adoption of the social protection policy and implementation strategy; coverage of the Productive Safety Net Programme must be expanded and weaknesses in its design and implementation addressed; synergies between social protection and nutrition policy and programmes need to be developed; government policy must promote mothers' economic and social empowerment through social transfer schemes; and, policy and programme monitoring and evaluation must be improved.

INTRODUCTION

Social protection is increasingly seen as an important component of poverty reduction strategies and efforts to reduce vulnerability to economic, social, natural and other shocks and stresses. A growing evidence base suggests that social protection programmes can play an important role in strengthening access to and demand for quality basic services and social welfare services by the poorest people through childhood and beyond (see Fiszbein *et al*, 2011; Barrientos and Scott, 2008; Sampson, 2009). Social protection can also facilitate a better balance between caregiving and productive work responsibilities. This is critical both in terms of fulfilling children's fundamental right to survival (articles 26 and 27, UN Convention on the Rights of the Child and in the Universal Declaration of Human Rights, and article 9 of the International Covenant on Economic, Social and Cultural Rights) as well as for the achievement of the Millennium Development Goals (MDGs), especially the child-focused targets, including MDG 1's goal of halving child malnutrition (underweight rates) by 2015 (Jones and Holmes, 2010).

In the context of the 2008 global food, fuel and financial crises, the scale and depth of children's vulnerability to hunger and malnutrition has been underscored, posing a complex but urgent development challenge. Despite steady reductions, every year 7.6 million children

die before their fifth birthday, most of them from preventable diseases and undernutrition (IGCME, 2011). Recent analysis by Save the Children based on World Bank projections and using data for 98 developing countries, shows that a severe escalation of the eurozone crisis could push an extra 32 million people into hunger by 2013 (Save the Children, 2012).

Child-sensitive social protection programming offers an important set of tools to begin to address this problem more systematically, and it is on the links between child nutritional vulnerabilities and social protection approaches that this briefing paper focuses. We begin by mapping the broader poverty and vulnerability context in Ethiopia, then turn to a review of evidence on the patterning and underlying causes of child malnutrition in the country, before discussing the strengths and weaknesses of the social protection infrastructure in place and the extent to which it is contributing to addressing child malnutrition.

CONCEPTUALISING CHILD-SENSITIVE SOCIAL PROTECTION AND LINKS TO CHILD SURVIVAL

Social protection refers to both public and private interventions that support communities, households and individuals in their efforts to prevent, manage and overcome risks and vulnerabilities. A child-sensitive approach to social protection necessitates a comprehensive understanding of the multiple and often intersecting vulnerabilities and risks that children and their caregivers face (Jones and Holmes, 2010).

Social protection can be conceptualised not only as being protective (protecting a household's level of income and/or consumption), but also as preventive (preventing households from resorting to negative coping strategies that are harmful to children, such as pulling them out of school and involving them in child labour), and promotional (promoting children's development through investments in their schooling, health and general care and protection) (Guhan, 1994). Devereux and Sabates-Wheeler (2004) have argued that social protection can also be transformative, helping to tackle power imbalances in society that encourage, create and sustain vulnerabilities, and to support equity and empowerment, including that of children and young people.

Social protection and nutrition links

In terms of addressing hunger and nutritional deficits more specifically, when informal coping mechanisms are close to reaching their limits, formal social protection becomes increasingly important. Social protection can support food security and nutrition, both directly and indirectly in a number of ways.

The underlying causes of food insecurity and malnutrition reflect a variety of interconnected economic and social risks and vulnerabilities. Child malnutrition can be the result of inadequate availability of food, but often is the result of household access to food supplies and how the utilisation of those supplies is negotiated within the household (Holmes and Jones, 2010). Depending on the type of assistance (food, cash, productive inputs, etc), social protection can help to address the causes of child malnutrition at both macro and micro levels (see Table 1 for examples).

At macro level, safety-net instruments such as cash transfers can play a key role in crisis response and act as part of a national stimulus package to help confront potential downturns. Various countries expanded coverage, increased the transfer amount or introduced new programmes during the food, fuel and financial crises. Brazil's Bolsa Familia programme both expanded coverage and increased funding amounts and Senegal introduced a new programme, the Social Cash Transfer and Nutritional Security, in order to increase resilience during the crisis. The Kenyan government also accelerated the scaling up of its orphans and vulnerable children cash-transfer programme (OVC-CT) (Fiszbein *et al*, 2011: 596-7).

At micro level, social protection programmes have been shown to have a positive effect on household aggregate consumption, as a large proportion of cash transfers are spent on food and in many cases enable households to increase resilience through the purchase of assets (such as livestock holdings or agricultural inputs), which also help to increase productivity, thus freeing household income for other priorities (Holmes and Jones, 2010).

It is important, however, to also consider in the case of nutrition the specific lifecycle stages at which social protection interventions around nutrition would be most critical. There is a growing consensus that the most cost-effective nutrition interventions focus on the brief 'window of opportunity' during the 1,000 days of a child's life from conception to 24 months of age. A recent series on child health in *The Lancet* highlighted the role of cash transfers that condition mandatory attendance at preventive healthcare services and health and nutrition education sessions designed to promote positive behavioural changes, citing Nicaragua's Red de Protección Social, Ecuador's Bono de Desarrollo Humano and Mexico's Oportunidades programmes as promising examples aiming to integrate early childhood development as core components. In general, however, very few social protection instruments directly target this critical period, or include complementary nutrition components or articulation with services such as prenatal care, breastfeeding promotion programmes, consultations for mild illnesses, parenting education, and early intervention for at-risk children under three years of age (Engle *et al*, 2011).

Table 1: Social protection to improve child nutrition

TYPE OF SOCIAL PROTECTION	EXAMPLES OF MEASURES THAT WILL SUPPORT IMPROVED CHILD NUTRITION
Social assistance to poor children and households includes regular, predictable transfers (eg, cash or in-kind, school feeding programmes, health service vouchers) from governments and non-governmental entities, aiming to reduce poverty and vulnerability, increase access to basic services and promote asset accumulation to increase resilience	• school feeding programmes • cash transfers with specific conditionalities to use nutritional supplements • unconditional cash transfers, which enhance household consumption in general • food-for-work programmes, provided children are not involved in completing work quotas • food subsidies to households during drought, flooding or financial crises • vouchers or grants to purchase seeds, fertilisers and other agricultural inputs • child support grants for parents or caregivers who earn below the minimum wage • health voucher schemes for reproductive health and family planning services, including training on safe hygiene practices • health vouchers for people living with HIV or AIDS • feeding programmes for people living with HIV or AIDS • food rations and supplies for orphans and vulnerable children (OVCs)
Social insurance to protect children and their families against the risks and consequences of livelihood, health and other shocks. This typically takes the form of subsidised risk-pooling mechanisms, with potential contribution payment exemptions for the poor	• social health insurance with universal coverage • exemptions to contributory health insurance programmes for households with children under 5 years • insurance schemes against climate-induced shocks and natural disasters

Social welfare services for marginalised groups of children who need special care, including child fostering systems, child-focused violence prevention and protection services, rehabilitation services after trafficking, and basic alternative education for child labourers	• protective services for OVCs and most vulnerable children (MVCs) living outside adult care
Social equity measures to protect children and their families against social risks such as discrimination or abuse, including anti-discrimination legislation (eg, laws to protect children from trafficking, early child marriage, harmful traditional practices or to ensure special treatment and rehabilitation services for young offenders). These measures also include affirmative action measures (eg, scholarships for children of minority ethnic or indigenous communities) to try to redress past patterns of discrimination	• legislation to protect the rights of OVCs • legislation to protect the rights of people living with HIV • legislative measures to promote gender equality

OVERVIEW OF POVERTY AND NUTRITIONAL VULNERABILITY IN ETHIOPIA

Ethiopia has made significant progress towards reducing poverty over the last several years. With an annual GDP of 11% (UNICEF, 2012) – and a decade-long commitment to a comprehensive poverty reduction strategy – poverty rates have fallen from 44.2% at the beginning of the millennium to 29.6% in 2010/11 (*ibid*). Despite this progress, however, Ethiopia remains one of the poorest countries in the world, with rural areas suffering from both pervasive levels of deprivation and seasonal hunger. According to a recent study conducted by Save the Children (2012), at the beginning of the decade approximately one-third of the population lived below the poverty line – with a similar proportion being food poor. Children are particularly vulnerable; in 2005, the child poverty head count index was estimated at over 40% (UNICEF, 2012).

Given that subsistence farming is the main source of livelihood in Ethiopia, poor households are highly vulnerable to external shocks. This includes vulnerability to both economic risks, such as rising fuel prices, and environmental risks, such as droughts and climate change. Rural areas, which have limited market access due to poor infrastructure, and which suffer from land degradation and a lack of formal insurance mechanisms (Dercon *et al,* 2008), are particularly vulnerable. Moreover, the recent drought and spike in food prices has had a devastating impact on food security in the southern regions of the country, leaving an estimated 4.5 million people in need of emergency food assistance (World Food Programme, 2011). Children are particularly vulnerable to malnutrition as the crisis worsens.

Child malnutrition trends

In Ethiopia, child malnutrition remains an acute and widespread challenge. A recent UNICEF study describes malnutrition as "a major threat to the survival and development of Ethiopian girls, boys and women" (UNICEF, 2012:23). According to the latest Demographic and Health Survey (DHS) data, 29% of Ethiopian children are underweight and 9% are severely underweight (Central Statistical Agency, 2011). The same data indicate that nearly 45% are stunted and 10% are wasted. These figures are among the highest in the world and are severe even by African standards (WHO, 2010).[1] Micronutrient deficiencies among children are also widespread: 44% of children age 6–59 months are anaemic, with 3% suffering severe anaemia (EHNRI, 2010). In 2009, the World Health Organization found Ethiopia's progress towards MDG 1 to be "insufficient" and off track (Taylor, 2012). Given that over half the deaths of children under five are the result of malnutrition, these trends are worrisome (Mekonnen *et al,* 2005).

Demographic and socio-economic factors render some children more vulnerable to malnutrition than others. Wasting, for example, is more common among the children of mothers with no education – and least common among those whose mothers have a secondary education (11% versus 3%) (Central Statistical Agency, 2011). Additionally, rural children are more likely than their urban peers to be both wasted (10% versus 6%) and stunted (46% versus 32%) (*ibid*). Finally, gender plays a role in child malnutrition, with boys more vulnerable than girls. They are more likely to be both underweight (31% versus 27%) and wasted (11% versus 8%) (*ibid*).

Underlying causes of malnutrition

Malnutrition, in Ethiopia and elsewhere, is caused by multiple, complex factors (Mekonnen *et al*, 2005). While inadequate food intake and disease are clearly the most proximate causes, these obvious factors are shaped by a variety of distal determinants. We identify five underlying factors that are key to understanding the causes of child malnutrition in Ethiopia:

Insufficient food availability

Children's nutrition cannot be ensured if households do not have adequate food security. One of Ethiopia's biggest challenges is that nutritious and affordable foods are often unavailable (MoFED, 2010).

The country's chronic food insecurity is the result of a combination of socio-economic and environmental factors. In recent decades, Ethiopia has experienced a significant decline in food productivity per household. Long-term trends, such as the interaction between environmental degradation, high population growth, diminishing land holdings and lack of on-farm technological innovation have caused this decline. Since the 1960s, the population has increased almost threefold, whereas per capita food production and landholding has declined by 42% and 68%, respectively (Benson *et al*, 2005). The majority of small-scale farm households are unable to produce a food basket that is diverse and nutrient rich. This leaves them increasingly dependent on their ability to acquire food from other sources (*ibid*).

Food deficiency is also a result of more periodic conditions, including drought and price hikes. Woldehanna (2009) for example, found that aggregate shocks had a detrimental impact on children's height for age (Garde and Yablonski, 2012). Dercon and Hoddinott (2003) found that young preschoolers were particularly vulnerable to these periodic shocks, presumably because of their growth demands.

Finally, income poverty itself is a key barrier to food security – with the diets of poor people suffering in terms of both quantity and quality. Save the Children's Cost of Diet study (Chastre *et al,* 2007) found that a significant proportion of Ethiopian families in some communities could not afford to feed their families a nutritious diet even if they spent all of their income on food. Similarly, the Young Lives study in Ethiopia (Mekonnen *et al*, 2005) found that rural poverty was a major contributing factor to child malnutrition. As one Uduga mother emphasised, landlessness precludes families from even subsistence living. This, in turn, means that providing adequate food can consume the family income. Conversely, research has shown that rural households with more livestock are less likely to have children who are wasted or underweight.

However, household food security is necessary – but insufficient – to meeting children's nutritional needs. Other drivers must also be considered.

Inadequate provision of a healthy environment (poor water, sanitation and hygiene)

A healthy environment is also key to child nutrition. Clean water, sanitation and good hygiene practices are critical to children's health and nutrition status – as chronic diarrhoea and parasite infestation undermine even the healthiest of diets (Mekonnen *et al*, 2005).

While Ethiopia's access to potable water has improved significantly on a national level, from 19% in 1990 to 65.8% in 2010, there is still a considerable gap to bridge. Indeed, access to improved water in rural areas remains considerably lower compared to urban locations (62% rural versus 91.5% urban) (MoFED, 2010). Trends in sanitation are similar, rising from 4% in 1990 to 60% in 2009 (56% rural versus 88% urban) (*ibid*). Inadequate hygiene also affects children's nutrition. Recent research suggests that only about 20% of Ethiopians are regularly washing their hands at critical times. Hand washing with soap is still limited due to a combination of educational deficits and poverty. While educated mothers are better informed, and more likely to prioritise soap use than uneducated mothers, poverty often determines whether soap is an option (Mekonnen *et al*, 2005). Given that Silva (2005, quoted in Mekonnen *et al*, 2005) found that adequate water and sanitation significantly determined the probability of a child being underweight in Ethiopia, water, sanitation and proper hygiene clearly need to be prioritised by policy.

Maternal wellbeing and quality of caring practices

Maternal health and nutrition: Poor maternal health and nutritional status constitute another key driver of child malnutrition. In Ethiopia, the combined effects of chronic food insecurity and high fertility (total fertility rate of 5.9 children per woman) translate into the generally poor nutritional status of women. According to the Demographic and Health Survey (DHS) (Central Statistical Agency, 2005), over one-quarter of women are chronically malnourished (BMI <18.5 cm) and three-in-ten women and adolescent girls aged 15–19 are undernourished. Women's nutrition is critical to children's nutrition as it is vital to both foetal growth and adequate lactation.

Maternal health-seeking behaviour also plays an important role in child nutrition. Antenatal care, for example, has been found to significantly reduce the risk of stunting (Save the Children, 2009). The Ethiopian healthcare system is underdeveloped. Although estimates are that it provides basic services to nearly 90% of the population, the rate of consultation is significantly lower. Current official statistics reveal that only six-in-ten Ethiopians with a health problem sought treatment (Central Statistical Agency, 2012). Notably, antenatal care coverage is woefully low – only two-fifths of women receive care (WHO, 2010). With a regional average closer to three-quarters, Ethiopia has the third worst track record in the world (*ibid*).

Cultural practices related to nutrition during pregnancy may also exacerbate women's low nutritional status. Primary research conducted by the Save the Children (forthcoming) in over 100 locations around the country found that women avoid eating nutritious foods during pregnancy for fear that the baby will be large and labour more difficult. Child marriage and adolescent pregnancy also increase nutritional vulnerability – as girls have not yet finished growing themselves (Benson, 2005).

Maternal education and knowledge: In Ethiopia there is a direct, positive relationship between women's education and child nutrition. For example, DHS data (Central Statistical Agency, 2012) reveal that the children of uneducated mothers are eight times more likely to be underweight than the children of mothers with secondary education (32% versus 4%).[2]

As mothers are primary caregivers in most Ethiopian families, their knowledge about nutrition is important to children's nutritional status (Christiaensen and Alderman, 2004). IFPRI, for example, found that inadequate breastfeeding practices and poor complementary feeding were major contributors to child stunting (Benson ed, 2005). Although 52% of children under six months (aged 0–5 months) are exclusively breastfed in Ethiopia (MoFED, 2010), only 4% of children aged 6–23 months are exposed to recommended dietary diversity (four or more food groups). Weaning options for babies are particularly limited for poor households – which frequently must rely on low-quality food, such as injera (pancake-like bread made of cereals), which infants cannot digest (*ibid*).

Irrespective of poverty, certain traditional practices are also found to be harmful to children's nutrition. For example, among some ethnic groups, newborn babies are made to swallow

raw butter, which is believed to clean up the digestive system (Benson ed, 2005). Young Lives has also documented other harmful practices, such as the removal of milk teeth and uvula as a 'cure' for diarrhoea. Such practices can cause blood loss and infection, as well as reduce a child's ability to eat solid food (Mekonnen *et al*, 2005).

Women's household decision-making power and control of resources

International evidence highlights that mothers who have more autonomy and decision-making power within the family are more likely to have well-nourished children (Begin *et al*, 1997; quoted in Jones *et al*, 2010). In Ethiopia, women's low social status means that they often have little control over family resources, which can be devastating to their children given that they are typically the primary caregivers.[3] The 2005 Participatory Poverty Assessment found that "men had absolute control of decisions and income management in 75% of households interviewed" (MoFED 2005, quoted in Jones *et al*, 2010). Control over income matters. In some cases, men are more likely to spend on personal items such as alcohol and cigarettes (*ibid*). Women, on the other hand, are more likely to use the family income to provide nourishing food for their children (*ibid*).

It should be noted, however, that while women's employment can bring multiple advantages to families and children, it may also have unintended consequences in that employed women may have less time to provide care for their children. Where community childcare mechanisms are inadequate, children may be left to fend for themselves or in the care of their older siblings. It is thus vital, when promoting women's economic empowerment, to carefully consider these related issues (Jones *et al*, 2010).

Policy factors

Tackling child malnutrition remains a pressing challenge that requires improved food security, behavioural and attitudinal changes and improvements to basic services. Political economy factors, however, also play a critical role in shaping children's nutritional outcomes. Although Ethiopia has experienced multiple food emergencies over the past several decades, it has only recently developed a more comprehensive and harmonised approach to addressing malnutrition, by shifting the nutrition agenda from one based on food security to one founded on a multi-sector approach (MoFED, 2010; Taylor, 2012). The National Nutrition Strategy (NNS) and the National Nutrition Programme (NNP) are two key policy instruments that have been developed to spearhead this process. Launched in 2009, the NNP is focused on accelerating progress and addressing malnutrition by tackling both the immediate and underlying causes of malnutrition. The programme aims to reduce stunting by 4% in two years (Acosta and Fanzo, 2012). This is to be achieved through a basic package of high-impact interventions such as vitamin A supplementation and de-worming, as well as a comprehensive, preventive community-based nutrition intervention package that links humanitarian food security interventions with the Productive Safety Net Programme (PSNP) (MoFED, 2010).

The effective implementation of these recent laudable policy developments depends on a number of factors (Taylor, 2012). First, Taylor argues that strong political leadership is required to raise awareness among policy actors about the need to move beyond a crisis agenda towards a longer-term solution to malnutrition. Such a shift requires a strong mandate by the Ministry of Health, where leadership may be hampered by the current lack of senior-level nutrition specialists. Second, Taylor notes that while the new policy framework needs to be underpinned by a strong financial commitment, the NNP, two years on, is still lacking a line in the national budget.[4] Third, effective coordination structures are yet to be initiated. Currently, nutrition activities depend on donors' encouragement and facilitation, with coordination being very limited between the agendas of the Ministry of Health, nominally in charge of all nutrition activities, and other interested ministries, such as the Ministry of Agriculture and Rural Development (MoARD). Lack of systematic coordination is also replicated at municipal and community levels.

Malnutrition is not only a key underlying cause of child mortality, it also has lifelong consequences on physical and cognitive functioning (Harper *et al*, 2009). Malnourished children are left with lifelong deficits that make it more difficult for them to learn. This, in turn, affects their earning potential throughout their lives. People who were malnourished as children require additional healthcare services and divert the time of caregivers from income-generating activities (Grantham-McGregor *et al*, 2007; Strauss and Thomas, 1998; Victora *et al*, 2008). Together, these facts highlight the importance of accelerating efforts to address child malnutrition. These efforts must include social protection interventions, a discussion of which we now turn.

SOCIAL PROTECTION INFRASTRUCTURE

Informal social protection

In Ethiopia, community-based informal social assistance has a long tradition. There are a wide range of support mechanisms within the family and extended family and in other social institutions that provide care for the most vulnerable in the community. For example, Gudifecha is a tradition by which better-off relatives look after the children of poorer relatives. Various social institutions (eg, the Busa Gonofa, Idirs) support families in crisis by either transferring resources (usually grains) to people who are not managing to cope or providing psychosocial support. Ikubs are pooled revolving funds often invested in building assets to support members (UNICEF, 2012).

In some regions, community care coalitions (CCCs) at kebele level collect voluntary contributions – both cash and/or in-kind – that are allocated for social protection actions. Recently, some CCCs are being given formal recognition by regional governments. While these informal mechanisms are important social support mechanisms in Ethiopia, their ability to protect people is somewhat limited in scope and impact, highlighting the need for a complementary national social protection policy and action (*ibid*).

Formal social protection

Over the past decade, there has been a growing policy momentum around social protection issues in Ethiopia. This has been spearheaded by a concern to move away from a dependency on emergency food aid and, more recently, by efforts to protect the most vulnerable from the impacts of the global food, fuel and financial crises. In 2004, the Ethiopian government introduced its National Food Security Programme (NFSP), which includes its flagship social transfer programme (comprised of public works for able-bodied adults and direct transfers for adults and dependants unable to carry out the physical labour needed at the public works sites due to illness, disability, age (ie, children, older people), pregnancy and lactation), known as the Productive Safety Net Programme (PSNP). The PSNP signifies a critical policy shift towards longer-term sustainable solutions rather than emergency-based relief, in line with the new nutrition policy, discussed above. This is to be achieved through more stable and predictable cash and/or food-based transfers targeting the chronically poor and food insecure households (Garde and Yablonski, 2012). With a reach of approximately 8.3 million people, the PSNP is the largest social protection programme in Africa (outside of South Africa, where the Child Support Grant reaches 10 million children) (Taylor, 2012; Aguero *et al*, 2007).

While the establishment of the PSNP represents an important policy commitment towards a more regular and systematic safety net approach, until recently, social protection instruments were being implemented in a policy void (MOLSA, 2012). Consequently, a harmonised and integrated social protection response at national level has been lacking, characterised by varying and inconsistent policy interpretations at ground level. Moreover, limited budgetary allocations, weak national and regional partnership forums, limited implementation guidelines and action plans also depict the current system (UNICEF, 2012). Within this context, there has

been a growing recognition of the need to develop an overarching national social protection framework in order to deliver more effective and sustainable social protection outcomes (MOLSA, 2012; Teshome, 2010).[5] As a result, the government has just drafted a new national policy on social protection. This document will provide the legal, institutional and fiscal framework for the coordination and provision of social protection services in the country (MOLSA, 2012). At the same time, there are a wide range of social protection interventions implemented across the country, including both informal and formal social protection actions. (See Table 2 for an overview of interventions.)

Table 2. Formal social protection interventions

TYPE OF SOCIAL PROTECTION INSTRUMENT	PROGRAMME EXAMPLES	PROGRAMME DETAILS
SOCIAL ASSISTANCE TO POOR CHILDREN AND HOUSEHOLDS	Productive Safety Net Programme (PSNP)	The PSNP is Ethiopia's key public work scheme, implemented by the government of Ethiopia with significant international financial support. It provides predictable cash and/or food transfers during lean months to smooth consumption in these households, and protect and help them grow their assets, thus improving their resilience to shocks. The PSNP provides 8.3 million chronically food insecure households in 319 woredas. It also provides direct support to those households that are unable to work but which require social protection. These households constitute 20% (about 1.3 million) of total beneficiaries; most of this group are not expected to graduate.
	Enhanced Outreach Strategy (EOS)/Targeted Supplementary Food (TSF)	EOS/TSF is a joint programme between UNICEF, the Ministry of Health, DRMFSS and WFP. The goal of the programme is to rehabilitate Moderate Acute Malnutrition (MAM) in children under five, pregnant women and nursing mothers. Food is provided to these women and children who are diagnosed as undernourished following a screening conducted as part of Ethiopia's Enhanced Outreach Strategy for Child Survival Initiative or during Child Health Days. Since 2004, the EOS/TSF programme has reached 2.9 million children and 0.6 million pregnant and lactating mothers (UNICEF, 2012).
	Tigray Cash Transfer Programme	This programme has been recently initiated by Tigray regional state and UNICEF to improve the quality of lives of vulnerable children (and orphans in particular), the elderly and people with disabilities. By building mainly on existing activities, it aims to enhance their access to essential social welfare services such as healthcare and education in two selected woredas, including one urban (Abi Adi town) and one rural (Hintalo-Wajirat woreda) location. An estimated 169,540 (4% of the regional population) will benefit from this programme directly or indirectly. In addition to facilitating access to social welfare services, the programme design also encompasses referrals to other support mechanisms depending on the needs of each family (UNICEF, 2011).
	School Feeding Support	In the education sector, school feeding support is being rolled out to attract children into the free service. Assistance is provided to 605,538 students in 1,187 schools of six regions chosen on the basis of low enrolment in chronically food insecure areas and budget limitations (UNICEF, 2012).
	Health fee waiver	In the health sector, fee waivers, approved by woreda government, are granted to many of the most vulnerable to allow access to health services. Services related to outpatient therapeutic feeding of severely malnourished children, communicable diseases such as TB, HIV and AIDS, and services such as immunisation, maternal and neonatal healthcare are provided free of charge. The provision of free family planning is also included. A review of the health fee waiver system finds the scheme "excessively time consuming and bureaucratic and thus discourages health-seeking behaviour among targeted households".

	Children in Local Development / Food for Education (CHILD/FFE)	CHILD transforms schools into centres for local development by using them as a platform to introduce health, nutrition and environmental rehabilitation initiatives, an essential package of 12 interventions. FFE works to increase enrolment and attendance in primary schools and to reduce drop-outs and gender disparity by providing school meals and take-home rations for girls. The school meals programme covers chronically food-insecure districts, where access to education is lower, in the Afar, Amhara, Oromia, SNNPR, Somali, and Tigray regions. Pastoral areas are prioritised because education indicators are particularly poor.
SOCIAL INSURANCE TO PROTECT CHILDREN AND THEIR FAMILIES	Social and health insurance proclamation	Social insurance is based on the principle of risk sharing and involves the pooling of contributions by individuals to state or private providers in return for a pay-out if there is a setback or change in circumstances. The Ethiopian government has issued a proclamation on social health insurance for formal sector employees and pensioners with the aim of providing quality and sustainable universal healthcare to beneficiaries through pooling risks and reducing financial barriers at the point of service delivery. This scheme, however, remains very limited in scope, as it covers only 1% of the population (Teshome, 2010).
	Community-based health insurance (CBHI)	This scheme will be piloted and then scaled up based on the lessons drawn during piloting. Preparatory activities for piloting in 13 districts (covering 1.45 million people) have been finalised and the scheme's services are now being provided to its members. Starting in 2013/14, CBHI will be scaled up, expecting to cover about 40% of people (35 million) by the end of the 2014/15 financial year.
SOCIAL WELFARE SERVICES FOR MARGINALISED GROUPS OF CHILDREN	Community Care Coalitions (CCCs)	Kebele committees, called community care coalitions (CCCs) serve as home-grown social protection committees accountable for putting in place community-managed care for those who are unable or should not work, such as orphans, the elderly, disabled people or those who are sick. The regional government helps kebeles strengthen and formalise the coalitions.
	Various welfare initiatives	The Bureaus of Labour and Social Affairs, often together with Bureaus of Women, Children and Youth and with Women's Associations, to manage social welfare programmes that target households with children who are defined as vulnerable.
SOCIAL EQUITY MEASURES TO PROTECT CHILDREN AND THEIR FAMILIES	The National Plan of Action for Children	The National Plan of Action for Children (2003–2010 and beyond) is a key child policy document that focuses on four themes: promoting healthy lives, providing quality education, protection against abuse and violence, and combating HIV and AIDS.
	The Family Code	The recently revised Family Code includes issues such as early marriage, adoption, affiliation and maintenance. It rectifies the previously discriminatory marriageable age for boys and girls and prescribes the age of 18 as the marriageable age for both sexes. According to the Committee on the Elimination of All Forms of Discrimination, all regions – apart from Gambella and Somali – have put into effect modified regional family laws (UNICEF, 2012).
	National Action Plan on Gender Equality	The main rational of this plan was to integrate gender mainstreaming commitments into key national policies including the MDGs, the Plan for Accelerated and Sustained Development to End Poverty, the Ethiopian Constitution and the budget. It provides a roadmap for participation by civil society and the private sector.

IMPACT OF SOCIAL PROTECTION SCHEMES ON CHILD NUTRITIONAL OUTCOMES

Emerging international evidence suggests that social protection can play an important role in enhancing children's wellbeing, including their nutritional status (Jones and Holmes, 2009; Save the Children, 2012). Social transfer interventions have been increasingly adopted by policy actors in middle as well as low-income country contexts, as a way of meeting food and other basic needs (Bailey and Hedlund, 2012). Rigorous evaluations of the cash transfer programmes in Mexico, Nicaragua and South Africa, for example, demonstrate significant improvements in children's height-for-age, resulting from the interventions (Fiszbein and Schady, 2009). We now turn to a discussion of programme impacts in Ethiopia, focusing mainly on the National Food Security Programme (NFSP), and on the PSNP in particular, since the latter has been the most rigorously assessed programme to date.

Overall, available data suggest that in terms of child- and gender-specific outcomes, the NFSP, and the PSNP in particular, have led to a number of positive results. First, social transfers have been found to have a positive impact in terms of addressing household food insecurity with important benefits for children. Jones *et al* (2010) found that participation in the PSNP increased the quantity, regularity and in some cases quality of household food consumption. Families who received at least half of the intended transfers through the PSNP public works system were significantly more likely to consume the required 1,800 calories per day than non-beneficiaries. The PSNP also protected many Ethiopian families from hunger during the 2011 food price rises, through provision of temporary assistance and cash provisions. This allowed people not only to better cope with shocks but also to ensure that children were more able to concentrate in school because they were better fed (Save the Children, 2012).

Similar findings are reflected in the Young Lives monitoring study in Ethiopia. As demonstrated in Table 3, social transfers were found to enable poor people to access more and better-quality food (Yablonski and Woldehanna, 2008). Also, a study led by the Bureau of Health in Southern Nations Nationalities and People's Region in 2008 found that the children in PSNP households were no more likely to require treatment for severe malnutrition than non-PSNP households, showing the positive impact of the PSNP in protecting children from malnutrition.

It should be noted, however, that there are potentially negative effects of the PSNP too. Young Lives research raises concerns about unintended impacts of the PSNP on child labour and education. The study by Yablonski and Woldehanna (2008) finds that participation by households in the PSNP actually increased the amount of time children spent on work to reach the labour quotas (on average by almost 15 minutes per day) and decreased their time for school and studying, with girls slightly more affected. While specific links to nutritional outcomes have not been documented, potential risks need to be considered and carefully monitored.

Table 3. Families' perceptions of benefits from different components of the National Food Security Programme

	AGRICULTURAL EXTENSION	CASH AND FOOD FOR WORK
BETTER-QUALITY FOOD	27.21%	10.99%
MORE FOOD	55.78%	57.23%

Source: Yablonski and Woldehanna, 2008

Second, social transfers within the PSNP have also been found to have led to asset protection, helping families avoid corrosive coping strategies to deal with shocks. A significant number of beneficiaries reported that having received a basic income or food basket helped them

protect their productive assets (eg, livestock and land), avoid low-paid and insecure casual labour and/or not sacrifice school fees or health costs just to feed their children in the context of crisis (Save the Children, 2012; Slater *et al*, 2006).

Third, protected investments in human capital development are also more likely to result from social transfers. Within the PSNP, households reported increased use of healthcare and increased enrolment and longer attendance of children in school (Garde and Yablonski, 2012; Slater *et al*, 2006). For example, the PSNP cash is being directly used to finance education and health services, with 29% using it for health services and 15% for education. It should be noted that children's investment in education in particular appears to be a very high priority for women beneficiaries who view it as less risky than other types of investment (Slater *et al*, 2006; Jones *et al*, 2010). Moreover, the programme has helped households to meet immediate household needs, such as soap and salt, which have potential benefits for child nutrition. Slater *et al* (2006) argue that "whilst these investments may not directly help with food security, they can be seen as longer-term investments in food security and poverty reduction."

Fourth, in addition to material benefits, participation in the PSNP has been described as having positive psychosocial effects. Qualitative evidence suggests that even a minimal safety net provides a greater psychological security in times of crisis as families – and women especially – feel better able to cope with anxiety about providing for food security (Jones *et al*, 2010).

There have also been some important gender empowerment effects with likely positive spillover effects on child wellbeing, including their nutritional status, as highlighted by Jones *et al* (2010). These include:

The PSNP has a strong focus on addressing the poverty of female-headed households and encouraging women's participation in public works activities, thus impacting positively on women's economic empowerment.

At design level, the PSNP recognises that women face higher levels of time poverty than men and should therefore be allowed more flexibility in terms of working times so that they can accommodate their domestic work and care responsibilities. Likewise, there are attempts within the programme to use public works to develop assets to reduce women's time poverty, including the creation of community water sources and fuel-wood sources.

There is also a provision of direct support during late stages of pregnancy and lactation if a household is labour-constrained, as well as provision of community crèches to enable women with small children to work.

This said, Jones *et al* (2010) also noted a number of important design weaknesses and implementation shortcomings, which have meant that programme efforts to address gender inequalities have been limited within the household and community:

First, there is a limited emphasis on addressing unequal decision-making structures within male-headed households about the use of household resources (income, labour, assets). While qualitative findings suggested that some women have been accorded more respect from their husbands as a result of their participation in public works activities, the general agreement was that, overall, households maintained traditional gender roles and responsibilities. The PSNP payment modality is partly responsible for preventing a positive change in intra-household dynamics. Payments from PSNP work go to the head of the household, even if in male-headed households women and children are doing the bulk of the public works activities.

Second, PSNP provisions designed to lighten the burden on pregnant and lactating women and relieve women's time poverty are poorly implemented (Frankenberger, 2007, quoted in Jones *et al*, 2010). For example, provisions for women to turn up late to public works activities and/or leave early are unevenly practised, if at all, and childcare facilities have been established in very few cases (Government of Ethiopia, 2008, quoted in Jones *et al*, 2010).

Developments of gender-sensitive assets within public works schemes are rarely prioritised in decision-making processes. Thus, while women's participation in Food For Work may improve children's nutritional outcomes, it may lead to a deterioration in the participants' own nutritional status, an increase in time burden as well as a reallocation of time away from the production of home goods, again with implications for child health and nutrition.

GAPS AND CHALLENGES

The government of Ethiopia has shown a strong commitment to raising the national profile of the social protection agenda. The new social protection policy marks an important step towards an explicit social protection framework. Likewise, the establishment of the PSNP represented a critical paradigm shift towards a more predictable and systematic safety net approach. In addition to the PSNP, Ethiopia has an impressive portfolio of other social protection instruments (see Table 2).

Nevertheless, despite these efforts to drive the social protection agenda nationally, more tangible commitments are still needed to translate the policy into practice. Notably, at the time of writing this briefing paper, the social protection policy has not yet been approved. As a result, there remains considerable fragmentation of social protection interventions across the country. A weak understanding and lack of consensus on the socio-economic and political rationale for social protection, and its specific mechanisms among the various policy actors and civil society, underpin this (Teshome, 2010; MOLSA, 2012). Strong political leadership will be required to ensure that policy is adopted and a broad political consensus built around the role that social protection should play in meeting poverty and nutrition challenges.

This briefing paper has also identified the gaps in the current package of social protection programmes in addressing the needs of vulnerable populations and tackling child malnutrition. Two specific issues warrant attention. First, the current coverage of the Food Security Programme does not address all people with a right and need for social protection. While the PSNP certainly has impressive coverage (reaching 8.3 million households) it still remains limited in scope, vis-à-vis the country's level of poverty and food insecurity (Teshome, 2010). The programme, for example, does not cover the urban poor, despite increasing concerns that this group is severely stressed by rising food prices. Similarly, the Social Insurance Scheme is acutely limited in scope, covering only 1% of the population (Teshome, 2010).

Second, the evidence presented in this briefing paper suggests that, despite child malnutrition remaining an acute challenge in Ethiopia, insufficient attention has been given to how social protection interventions can best contribute to tackling the issue. Specifically, the extent to which existing social protection programmes are, or have the potential to, reach the groups most vulnerable to malnutrition (children up to two years of age, pregnant women and lactating mothers) has been limited. As discussed elsewhere, a very large body of evidence indicates that priority should be given to preventing/treating malnutrition during the first 1,000 days between conception and the first two years of a child's life. Yet, apart from the EOS/TSF and health waiver schemes, no other social protection instruments directly target this critical period. The PSNP has been found to have a positive impact in terms of addressing household food insecurity with important benefits for children, but it does not target the nutritional needs of the groups most at risk. Likewise, the school feeding scheme primarily targets school-aged children, while the CHILD/FFE is designed to raise children's enrolment, attendance and concentration at school, not to reduce malnutrition in the most vulnerable groups.

Given these findings, more concerted efforts to design social protection programmes in a more nutrition-sensitive way are clearly needed, with a strong focus on infants, pregnant women and lactating mothers. Related to this is a need for a better monitoring of maternal and child nutrition indicators in the evaluation systems of all social protection programmes,

to assess both direct and indirect programme impacts. In the following section, we propose specific recommendations to tackle these policy and programmatic gaps and challenges.

CONCLUSIONS AND RECOMMENDATIONS

Ethiopia has made substantial progress in developing a national commitment to social protection, and designing and implementing a food security programme, which has demonstrated positive effects on child nutrition outcomes. However, there is still much to be done to reach the poorest and most vulnerable children, especially in terms of effectively operationalising policy commitments at scale and addressing the multi-dimensionality of child malnutrition. We therefore conclude with the following policy and practice recommendations.

1. Advance the adoption of the social protection policy and implementation strategy

As a critical step to establishing a more comprehensive and coherent social protection system, it is important that the draft national social protection policy is further advanced, through the preparation of an implementation strategy. This will ensure a long-term commitment of both financial and organisational resources required for their effective implementation. Particular attention should be given to strengthening the role of the Ministry of Labour and Social Affairs to act as a key facilitator in garnering consensus among the key ministries on the design of the national strategy and action plans. Promoting the awareness of social protection policy and programmes among key state and civil society actors is also critical in order to increase demand for social protection programmes as well as to hold the government accountable for its social protection policy commitments.

While the support communities receive from federal and regional government has increased markedly in recent years,[6] budgetary frameworks and allocations are largely non-transparent. Moving forward, in the short term the government may consider reviewing legislation to clarify accountabilities for social protection. This could lead to agreements on how to improve current budget allocations and make more strategic choices regarding accountabilities and budget requirements. In the medium term, efforts should be made to address gaps in institutional capacity and put in place detailed and region-specific strategies and action plans. With regard to strengthening institutional capacity, this may include strengthening legal authority to enforce requirements for sector-wide engagement and accountability; and increasing human resource capacity through tailored capacity-strengthening initiatives to effectively design, implement and coordinate social protection interventions.

2. Expand the coverage and address weaknesses in the design and implementation of social transfers

While the PSNP has demonstrated important impacts on children in terms of nutrition and human capital development, as well as gender outcomes, a number of design and implementation issues need to be addressed to ensure stronger effects. First, even though the PSNP has a broad scope covering 8.3 million chronically food insecure households, it focuses only on chronically food insecure rural households in drought-prone woredas. The current coverage does not address vulnerable households in other woredas, including those vulnerable to sudden onset shocks. Increasing urban poverty and population growth are also emerging challenges requiring policy responses and some form of urban social safety net programme (UNICEF, 2012). To reach the target of reducing malnourishment and hunger by 2015, more concerted action in this direction is required. However, such a scale-up would necessitate institutional strengthening, better targeting of vulnerable populations, including children, and the mobilisation of additional funds.

Second, urgent steps need to be taken to ensure the timeliness and predictability of PSNP payments. A 2006 review of the PSNP revealed that late payments lead to a variety of

corrosive coping mechanisms, which undermine many of the developmental gains described in previous sections (Slater *et al*, 2006). While initial problems in PSNP implementation related to effectiveness and transparency of targeting processes and the timeliness of transfers have seen significant improvements over time, these improvements have been very uneven across regions (Gilligan *et al*, 2009, quoted in Garde and Yablonski, 2012). Further investment in capacity development, and improved planning and systems are needed to address these issues.

Finally, the government may also consider increasing the amount of the transfer. A few evaluations (Jones *et al*, 2010; Slater *et al*, 2006) have found that the current value of the cash transfer is low, especially in the context of the global food price crisis, and is only able to support household needs to a limited degree. As a result, negative coping strategies such as distress sale of assets persist in many households, especially in an effort to provide for children's education expenses and to cover family members' healthcare needs. During 2007–08, for example, the purchasing power of the PSNP payment drastically decreased for households receiving cash (Gilligan *et al*, 2009, quoted in Garde and Yablonski, 2012). This leads to increasing demands from beneficiaries to receive food instead of cash. As far as resources permit, cash transfers should reflect the cost of a nutritious diet and respond to price increases.

3. Promote synergies between social protection and nutrition policy and programmes

Opportunities to create links between nutrition and social protection policies and programming need to be actively sought by government and development partners. At policy level, nutrition can be more explicitly mainstreamed into the social protection framework. Strong political leadership and a promotion of inter-sector cooperation will be critical to ensure this, owing to the cross-sector nature of nutrition and food security. Bodies set up to coordinate social protection and nutrition actions can play a critical role in facilitating cooperation across government ministries and agencies, facilitating effective funding allocations, and monitoring progress (Acosta and Fanzo, 2012). To that end, a multi-sector National Social Protection Steering Committee (NSPSC) needs to be established urgently, as promulgated in the draft social protection policy (MOLSA, 2012). The NSPSC may provide an appropriate forum to discuss and agree on how nutrition can be more explicitly integrated into social protection programmes and forge consensus among relevant stakeholders. This would entail strengthening the functions, capacities and funding available to the NSPSC to play that role effectively.

At programme level, the potential for social protection to impact on nutrition can be maximised by promoting links to complementary nutrition programmes and more targeting of pregnant women, and breastfeeding mothers and children up to the age of two. There are a number of ways to achieve this. First, the government may consider expanding a definition of social transfers within the PSNP to include in-kind transfers, such as nutrition supplements to children aged 4–24 months and to pregnant women. Second, more attention could be given to designing existing programmes in a way that addresses the range of underlying factors causing malnutrition, beyond access to food. This is important, considering that – in addition to income and food availability in Ethiopia – the evidence on malnutrition causes points also to factors that are associated with improved caring and feeding practices, access and take-up of healthcare, and the household and community environment (eg, water and sanitation). To broaden its scope, health and nutrition training sessions could be incorporated into the social transfer programme – whether as a condition or as part of well-conceived behavioural change and communication efforts. Importantly, in this regard, in 2010 the definition of public works labour was expanded to include nutrition-related and health promotion activities and, so far, in seven woredas in Tigray, community health extension services have been included as public works activities on a pilot basis. This has entailed the training of a select number of PSNP participants to provide messages on nutrition,

tuberculosis, malaria and HIV-prevention at public works sites (Jones *et al*, 2010). While this is a very positive recent development, a more concerted effort is needed to ensure that nutrition becomes a standard part of the programme's links with complementary services. In addition, social protection and nutrition programmes could be further linked through more strategic use of community conversations and dialogue opportunities in programme-related spaces such as community meetings on public works sites or payment points to promote behaviours that support good nutrition.

4. Promote mothers' economic and social empowerment through social transfer schemes

Given the critical role that women play in children's nutrition, where possible social transfers should be delivered in a manner that increases their control over family resources and supports their contribution to ensuring a nutritious diet for the family. Accordingly, efforts to tackle child malnutrition need to be concerned with not only improving household income and/or access to food, but also with intra-household distribution of power and resources and the introduction of mechanisms to allow women to better balance their caring and productive work responsibilities. Regarding revisions to programme design, the government may consider targeting social transfers to women in male-headed households so as to tackle unequal intra-household dynamics and strengthen women's control of resources.

While the PSNP exhibits a number of gender-sensitive design features, considerable efforts are needed to ensure that there is both adequate awareness of these programme components and sufficient human and financial resources to implement them. Specifically, this may include investing more resources in providing capacity building for officials to increase their knowledge about the gender dimensions of the programme at all levels. Training may focus on promoting understanding of both gendered economic and social risks and vulnerabilities and the way they intersect. Strengthening inter-sector coordination is also vital to promote this understanding. Lastly, in order to reduce women's time poverty, there is an urgent need to establish adequate childcare facilities as well as raise awareness about the value of community childcare so as to encourage higher demand among parents.

5. Improve policy and programme monitoring and evaluation

A robust impact evaluation system for the national social protection framework is acutely needed. A broader set of nutrition indicators reflecting interventions from social protection, agriculture, and education, should also be developed and collected to ensure an assessment of multi-sector approaches to nutrition. Likewise, nutrition indicators need to be integrated into social protection programming.[7] More specifically, consistent monitoring of dietary intake within the PSNP would provide insight into whether improved access to food at household level benefits malnourished children.

A more effective knowledge management system is key to tracking progress and making adjustments to policies and programmes. Also, the evidence of impacts can be used to foster political support and secure the increased resources needed for scale-up (Jones and Holmes, 2010). In order to facilitate such learning, knowledge management systems and capacity among government and donor agencies to collect, analyse and use the data need to be strengthened.

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Notes

1 The global average rate of children under five years of age who are underweight was 16% in 2006-10 (UNICEF, 2012b). The average for Africa was 19% during the same period (ibid).

2 Literacy rates for rural women are just 19%, compared with 43% for men and, although the national aggregate gender gap appears to have closed for net primary school enrolment rates, in 2007 rates for both girls and boys stood at 45% (UNICEF, 2007, quoted in Jones et al, 2010).

3 Ethiopia scores poorly on gender development measures: the country's ranking on the Gender-related Development Index, which measures gender disparities in basic human development, is 132nd out of 155 countries, whereas the ranking on the Gender Empowerment Measure, which reveals the extent to which women take an active part in economic and political life, is 85th out of 109 countries (UNDP, 2009 quoted in Jones et al, 2010).

4 According to Acosta and Fanzo (2012), a programme budget was instituted within the Ministry of Health (MoH) in 2011, with an objective to move toward a more results-based approach to nutrition.

5 A number of important regional policy documents (eg, 2008 Africa Union's (AU) Social Development Policy Framework), have given prominence to the role of social protection in Ethiopia (Teshome, 2010).

6 According to Child Policy Forum research (2011), Ethiopia spends about 6.5% of its GDP on social protection, which constitutes a relatively high share of its total income and is better than many African countries.

7 The absence of accurate and timely data has been a major limitation in Ethiopia (Acosta and Fanzo, 2012). For example, nutrition indicators are not yet active in the national reporting systems.

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Photo: Frederic Courbet/Panos

Maritou, whose husband died seven years ago, provides for her daughter by farming a small plot of land and is supported by the Productive Safety Net Programme.

This briefing is part of a set of eight country briefings produced to accompany Save the Children's report *A Chance to Grow: How social protection can tackle child malnutrition and promote economic opportunities.*

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