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3 (b): Population, food security, nutrition and sustainable development

Statement submitted by International Federation for Family Development, a non-governmental organization in general consultative status with the Economic and Social Council[2]

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 36 and 37 of Economic and Social Council resolution 1996/31.

[1] E/CN.9/2020/1.
[2] The present statement is issued without formal editing.

Statement

When poverty and hunger are addressed in the family various positive effects on outcomes across a range of Sustainable Development Goals (SDGs) are shown. For instance, addressing measures of poverty and multiple deprivation is linked to the achievement of some SDG targets by facilitating families' abilities to meet the goals related to personal subsistence such as nutrition; access to services and utilities such as health, education, clean water; access to broader learning and labour markets; and offering them the possibility of making better choices as regards cleaner and more sustainable living.

The family environment has been found to be key to developing nutritional habits and preventing chronic illnesses to ensure healthy lives for all its members. In this regard, noncommunicable diseases (NCDs) are chronic illnesses that are not passed from person to person. They are the cause of death of 38 million people around the world each year, with three quarters (28 million) in low- and middle-income countries (WHO, 2015). The four leading causes of NCD deaths are cardiovascular diseases (17.5 million people annually), cancers (8.2 million), respiratory diseases (4 million), and diabetes (1.5 million) (WHO, 2015).

Policies and costs related to NCDs are complex and substantial. Global and country-specific data indicate a wide variation in how cardiovascular disease is addressed around the world, and the services that families are entitled to receive (WHO, 2017). In 2014, 9 per cent of all people over the age of 18 worldwide had diabetes (WHO, 2014). Global health expenditure on diabetes in 2015 was $673 billion, which accounted for 12 per cent of total health costs (IDF, 2015).

Given the important role of lifestyle choices (e.g. diet, physical exercise) on health outcomes, the family environment (including living standards, routines, and joint lifestyle choices) inevitably can play an important role in the prevention and treatment of NCDs, and adaptation to their chronic nature. Many health behaviours are often established in childhood (HBSC, 2010) and carried through to adulthood – parents and other family members therefore can act as early promoters of healthy living.

The International Federation for Family Development has promoted a global research study on the role of family policies in the achievement of the SDGs. The key findings of this study (UNICEF, 2018) recently published include some considerations about this topic.

SDG 1: Poverty, nutritional habits and well-being

Despite variation in the commonality of conditional and unconditional cash transfer programs, there is evidence to suggest that both are effective tools in reaching the developmental goals in different geographical contexts. A meta-analysis of more than thirty thousand articles related to cash transfer programs revealed that conditional programs accomplish the same goals as unconditional programs in relation to health and nutritional outcomes (Manley, et al., 2013).

Furthermore, large-scale reviews of electronic databases and web repositories of key experts and policy organizations found that conditional and unconditional cash transfer programs implemented in a variety of contexts were effective in improving key well-being outcomes, such as monetary poverty, education, health and nutrition, saving, investment and production, employment, and empowerment (Bastagli, et al., 2016; Owusu-Addo, et al., 2018).

Despite the success of cash transfer programs, the same evidence points to shortcomings in achieving the long-term impact in outcomes related to nutrition, learning, and health, including disproportionate gender and in-country regional

effects (Baird, et al., 2013; Manley, et al., 2013). Many studies conclude that in order to achieve transformational change, additional design components are needed to improve the cash transfer programs – such as cash-plus approaches, or access to basic services and support (Bonilla, et al., 2017; deHoop & Rosati, 2014).

Two recent studies from the Overseas Development Institute (ODI) reviewed the evidence of the impact of cash transfer programmes in low- and middle-income countries, by looking at the role of design and implementation features (Bastagli, et al., 2016) and the impact of programmes on women and the families they head (Hagen-Zanker, et al., 2017). The two studies reviewed the evidence across six outcome areas: monetary poverty; savings, investment and production; education, health and nutrition; employment; and empowerment. The review covered literature spanning 15 years between 2000 and 2015 and its findings show positive impacts on, among others, reducing monetary poverty, increasing school attendance and improving health and employment. With this background the authors conclude that cash transfers can be an effective family instrument to enhance the well-being of women, girls and other household members.

Indeed, the review noted that cash transfers lead to male or female-headed households making greater investments in economic assets and increased productive investments. There does not appear to be strong support for differences in the outcomes arising in programs targeting men, women, or based on the age of the recipient. The authors also mention the role of gender-based power dynamics in the household that often influence how the cash transfer is spent. The level and duration of transfers are also important, with higher transfer levels and longer program duration associated with larger impact on food expenditure, savings and investments, educational, health and nutritional outcomes.

Social protection schemes are designed and implemented with the aim of improving the well-being of those who are vulnerable. The review of studies on cash transfers in selected contexts revealed several key anchors for reflection. It shows that overall, cash transfers have a strong potential to address poverty. Considering the diversity of contexts and type of transfers, the review did not identify a single program that increased deprivation among recipients and family members. On the contrary, the evidence shows that cash transfers allow families and household members to improve the margins of various outcomes, such as health, nutrition, education, monetary income, child labour, empowerment, savings, and employment, to name a few.

SDG 3: Healthy habits and family interventions

Family interventions for cardiovascular disease tend to increase patients and their families' knowledge about the disease, including its symptoms, treatment and factors contributing to its evolution such as diet and exercise. This increased knowledge was associated with better psychological functioning and understanding, and better health-related behaviours, such as better nutrition (e.g., reduced sodium intake, reduced fast food and more fruit and vegetable consumption) and increased physical exercise, but there was no direct impact on health.

Additionally, it increased family understanding, communication, support, and treatment adherence. This is consistent with previous studies, such as a review by Reid, Ski, and Thompson (2013) of psychological interventions for patients with coronary heart disease and their partners, which indicated that the interventions resulted in modest improvements in patients' health-related quality of life, blood pressure, knowledge of disease and treatment, and satisfaction with care, and in partners' anxiety, knowledge and satisfaction.

While the psycho-education programmes have been found effective in increasing patients' and families' knowledge, their impact tends to decrease over time.

Thus, it is recommended that programmes and sessions be spread out in time and provided for longer periods of time, so that patients and families are periodically reminded about the effective strategies and behaviours to be used. For example, Lofvenmark, et al., (2011) suggest that heart failure education programmes for family members should be repeated 2–3 times during a period of six months to maintain knowledge level.

Family-centred interventions targeting physical activity and nutrition can generate slightly better obesity-related health outcomes than usual care alone (Duncan, et al., 2016). Reviews of interventions to improve adherence to cardiovascular disease guidelines indicated that the interventions can be effective at improving both adherence and patient outcomes and are often more effective than guideline dissemination alone (Jeffery, et al., 2015). The importance of family support for cardiovascular health promotion is based on mutual interdependence of the family system, shared environment, parenting style, caregiver perceptions and genomics (Vedanthan, et al., 2016). The dyad structure presents an opportunity for health care professionals to integrate their strengths and skills in a collaborative patient-partner centred effort (Ågren, et al., 2012). Thus, family functioning should be assessed, addressed and improved to guide tailored family-patient interventions for better health-related outcomes (Stamp, et al., 2016).

SDG 5: Gender equality and links to other SDGs

Goal 5 of the SDGs aims to achieve gender equality not only as a fundamental human right but also as a necessary condition for achieving peaceful, inclusive, and sustainable development. Although gender equality is enshrined as a stand-alone Goal of its own, it is a cross-cutting issue and is deeply interlinked with many of the other SDGs such as poverty (Goal 1), food security (Goal 2), health (Goal 3), and education (Goal 4).

For example, women still make up a high proportion of people living in income poverty (e.g. Chant, 2006), and gender equality is expected to contribute to the reduction of poverty through improvement in women's income, health, education, and access to and control over land and other resources. Women play a critical role in the global food system, in production, preparation, consumption, and distribution. During the last half decade, while the overall proportion of the population engaged in agriculture is declining, the percentage of females involved in agriculture is increasing (FAO, 2011).

Improving educational opportunities for women has long been known to have a high social return regarding decreasing infant/child mortality and improving children's health and their education. (Shultz, 1995). When women have more influence over economic decisions, their families can allocate more income to food, health, education, children's clothing and children's nutrition (e.g. Doss, 2006, 2014).

Conclusion

The importance of the role of good health and nutrition in day-to-day life in achieving personal and social progress goals across a range of domains, must be underscored. Supporting healthy family environments, and families that can promote healthy nutritional habits, or supporting the treatment of poor health, can contribute to achieving a range of SDGs. Notably the nutrition and healthy eating evidence is all positive, and in each case, includes family or parental involvement. Education or information programmes are common in the interventions. For example, healthy adults are likely to be more productive in work and meet their care responsibilities, compared to their unhealthy counterparts.