Extended Abstract

Women's Status and Child Nutrition: A Comparative Study of Five South Asian Countries

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1.0 Introduction

In 2007, Secretary-General of the United Nations, Kofi A. Annan asserted: "When women are healthy, educated and free to take the opportunities life affords them, children thrive and countries flourish, reaping a double dividend for women and children" (UNICEF). The goal of this research study is to test several hypotheses that are embedded in the above statement by looking at five South Asian countries: Bangladesh, India, Nepal, Pakistan and Sri Lanka

These five countries have deeply rooted patriarchical ideals and have relatively low value for women. Domestic violence, female infanticide and low resource allocation for girl-children are proof of women's relative low status in these societies. However, there are variations among households on how they make decisions and the extent to which family members conform to the social norms. Also, there are different levels of economic development, public services, infrastructure and access to media both within and across these countries that may have different effects on women status and child nutrition. For these reasons, it is worth looking at these countries in a comparative perspective to see how household characteristics affect women's status and in turn affect child nutrition under different economic and political environments.

2.0 Background and Theoretical Framework

2.1 Gender Inequality

According to United Nations' Millennium Development Goals (MDGs), gender equality should encompass equality in the households, workplace and in government and politics. However, when it comes to children, the most important actors in their world are the ones who make important decisions each day. How parents allocate their collective resources determines the levels of nutrition, health care, education and protection that each family member receives (UNICEF, 2007).

In 1979, the Convention on the Elimination of All Forms of Discrimination against Women was adopted by the UN General Assembly. Since then there has been some progress in reducing gender based prejudice. A girl child born in 2009 will probably have a brighter future than a girl born three decades ago. However, the low status of women is still stubbornly entrenched in South Asia. The final report of the 2007 Bangladesh Demographic Health Survey indicates that among married women age 15-49, a third of them reported that decisions regarding their own health were made mainly by their husbands. Another quarter of them reported that decisions regarding household purchases and visits to her family and relatives were also made by their husbands. In India, more than one in two women (54 percent) agree with at least one reason justifying a husband beating his wife (National Family and Health Survey, 2005-06). We see similar patterns in Nepal and Pakistan. In contrast, in Sri Lanka less than 12 percent of married women reported that their husbands make decisions regarding visits to her family and relatives. (Sri Lanka Demographic & Health Survey 2006/07).

2.2 Factors Affecting Intra-Household Decision Making

Studies that examine the dynamics of decision-making process of family often focus on the household. It is assumed that the household functions as a unit in which family members pool their resources to achieve a common set of goals (the unitary model). Another theory looks at the household as a "collective" entity where sometimes conflicting preferences of individuals within the household are combined in various ways to reach a collective choice. According to this theory, decisions often reflect the bargaining power of different household members (Haddad, Hoddinott, and Harold Alderman, 1997). Surveys provide good indication of which family members have more influence in household decisions, but they cannot explain why certain individuals in each household are able to dominate decision-making processes (UNICEF, 2007).

Although gender discrimination in household decision making is rooted in patriarchal attitudes that value the social status of men over women, the extent to which individual households conform to 'traditional' ideas about the roles of men and women varies. Frankenberg and Thomas (2003) showed that major determinants of influence in household decisions include income and assets, age, and access to and level of education. The family member who controls the largest share of the household income and assets often has the strongest say. The woman's age at marriage and the age difference between a woman and her husband also influences the bargaining power. In South Asia, the husbands are approximately five years older than their wives (Smith, 2003). The level education also affects the levels of knowledge, earning potential, self-confidence and assertiveness. South Asia is the region where the education gap is greatest (2.45 years) whereas in Latin America/Caribbean it is only 0.77 years (Smith, 2003). Domestic violence is an equally important factor in assessing power in the household. It threatens the physical and emotional well being of women and forces them to tolerate prejudice and subordinate positions within their households (Chant, 2006).

2.3 Child Malnutrition

Clinically, malnutrition is characterized by inadequate intake of protein, energy, micronutrients and frequent infections, gastrointestinal parasites and other childhood diseases. Children are also malnourished if they are unable to utilize fully the food they eat, for example due to diarrhea or other illnesses (secondary malnutrition). Malnutrition in all its forms increases the risk of disease and early death (World Health Organization, 2000). As a result of malnutrition children may also become stunted, wasted or underweight (Mishra and Retherford, 2000).

The South Asian region by far has the highest number and prevalence of malnutrition in the World. It is home to half of all underweight children under five years old in the developing world. Sub-Saharan Africa, where roughly one child out of every three is underweight, has the second highest rate. Surprisingly, South Asia appears to be doing better than Sub-Saharan Africa in terms per capita national income, per capita food supplies and education levels. This phenomenon is known as the "Asian Enigma" coined by Ramalingaswami, Jonsson, and Rohde (1996). They concluded that high malnutrition in South Asia is due to inequality between men and women.

3.0 Potential Policy Significance of this Study

It has already been established that South Asia ranks low in terms of gender equality and child nutrition. Most studies have focused on comparing one region to another for obvious geographical, economic and cultural similarities. However, we know very little about the differences between gender inequalities in countries that make up the South Asian region. Table 1 shows a few indicators of the status of the MDGs in all South Asian countries. The gender parity index is 0.8 in Pakistan, but it has one of the highest percentages of women in their national parliament. On the other hand, Sri Lankan women have one of the lowest representations in the national parliament, but they have very low mortality rates for children less than five years (13 per 1,000 live births). Clearly, the different levels of economic development, public services, infrastructure, access to media and approachability of people in a large geographical area may have caused these differences. Another reason maybe, a large country like India may have high levels of gender equality in southern states, but that may be counteracted by highly populated northern states where there are low levels of gender equality. It is also evident, while women may achieve high status in one realm (politics) it does not necessarily translate to other realms (household). For this reason, it is important to uncover the underlying factors that influence differential outcomes in a region seemingly similar in terms of norms and values. It is also important to evaluate how much of child malnutrition is explained by gender inequality and also the mechanisms by each country has achieved respective levels of child and maternal health. These findings will give new information to formulate social policies in South Asia.

Table 1. Selected Indicators of Millennium Development Goals (MDGs) in South Asian Countries.

	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Net enrolment ratio in primary education (% both sexes)	N/A	92.1	79.9	94.2	98.1	80.1	65.6	96.7
Percentage of pupils starting Grade 1 and reach Grade 5 (% both sexes):	N/A	65.1	84.4	73.0	N/A	78.5	69.7	92.2
Gender parity Index in primary level enrolment (ratio of girls to boys):	0.6	1.0	1.0	1.0	1.0	1.0	0.8	1.0
Seats held by women in national parliament (%)	27.3	14.8	2.7	8.3	12	17.3	21.3	4.9
Mortality rate of children under 5 years old (per 1,000 live births):	257	69	70	76	30	59	97	13
1-year-old children immunized against measles (%):	68	81	90	59	97	85	80	99
Maternal mortality ratio (per 100,000 births):	1800	570	440	450	120	830	320	58

Source: United Nations Development Program, 2007. MDG Monitor, Track, Learn, Support. http://www.mdgmonitor.org/index.cfm

4.0 Hypotheses

4.1 *What are the individual and community level characteristics that influence a woman's status in the household?*

As indicated by previous research, I would expect that a woman's age at marriage, age gap between the spouses, education level difference between the spouses, earnings, wealth (inheritance), work culture and values will have a significant affect on woman's status in the household.

4.2 *How does women's status in the household translate into child nutrition?*

I expect that, when a woman has relatively higher status, her bargaining power in the household will increase (as reflected by her participation in decision making), and she will use her "power" to allocate resources for the benefit of her children.

4.3 *What explains the large differences in MDG indicators on women status and child health within the South Asian region?*

Government interventions, economic growth, availability of education, health services, religious views, and the ability to approach populations that are dispersed in a large geographical area may explain the disparities.

5.0 Data and Measures

The study employs five nationally representative data sets collected under the auspices of the Demographic Health Survey (DHS) program in Bangladesh, India, Nepal, Pakistan and Sri Lanka. Multivariate analysis will be employed to estimate the effects of individual and community level characteristic on women's status and child nutrition.

Spouses' age gap, education difference, employment, media exposure, resources brought to the marriage, earnings and inherited assets will be used as independent variables when predicting woman's influence in household decision making (Smith et al, 2003). DHS provides series of measures on wives participation in decision making, for example: final say in decisions over woman's own health care, purchases of daily household needs and visits to her friends and family etc. Indicators are chosen based on their conceptual relevance, applicability and availability across the five countries. Factor analysis will be employed to create an index of women's status in the household (Kishor, 1999 & 2000).

To evaluate child nutrition levels, three standard indices of physical growth: (i) height-for-age (stunting), (ii) weight-for-height (wasting) and (iii) weight-for-age (underweight) will be used (Mishra, Lahiri and Luther, 1999). The calculation of three indices of child malnutrition involves comparison with an international reference population as recommended by the World Health Organization (Dibley et al, 1987). All the above variables in DHSs are collected in each country using nearly identical survey instruments and data collection methodologies.

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