



Drivers of change: Examining the effects of gender equality on child nutrition



Aakanksha Sinha^{a,*}, Ruth G. McRoy^a, Barbara Berkman^a, Melissa Sutherland^b

^a School of Social Work, Boston College, MA, USA

^b Connell School of Nursing, Boston College, MA, USA

ARTICLE INFO

Article history:

Received 9 August 2016

Received in revised form 9 March 2017

Accepted 11 March 2017

Available online 18 March 2017

Keywords:

Child nutrition

Gender

Nutrition

Food security

India

ABSTRACT

India has the world's highest burden of child undernutrition. Lack of income is considered as one of its primary causes. However, evidence suggests that despite steady economic growth and investments in social services directed towards child welfare, undernutrition rates continue to rise. Thus indicating, that there are other societal factors impacting child undernutrition. Previous studies indicate that countries with higher gender inequality have worse health outcomes for women and children. India, particularly in the northern states, has deep-rooted gender biases, leading to disproportionately worse outcomes for women and children. This study uses cross sectional data from the India National Family Health Survey Round-3 (NFHS-3) to examine the immediate and underlying effect of gender inequality on child nutritional status. The sample includes urban married women between 15 and 49 years ($N = 9092$) who have at least one living child between 0 and 5 years. Findings highlight the significant effect of autonomy and health related awareness on child nutritional status, when the relationship is mediated by maternal health. Implications for policy and practice are provided.

© 2017 Elsevier Ltd. All rights reserved.

India has the world's highest burden of child undernutrition (World Bank, 2013). The under-5 undernutrition rates is approximately the same as that of the overall South Asia region average (43%) and is five times more than that of China and twice of sub-Saharan Africa (World Bank, 2013). Some of the major determinants of child undernutrition in India include, sex, caste, socioeconomic status, inadequate calorie intake, quality of living, birth order, parental education, maternal characteristics, geographical location, and access to health care (Fenske, Burns, Hothorn & Rehfuess, 2014). India suffers from a malnutrition paradox, as despite the steady economic growth, there are persistently high rates of child undernutrition (Dreze & Sen, 2013; Ramalingaswamy, Johnson & Rohde, 1996). As of 2015, India had a 7.4% growth rate and increased its Gross National Income (GNI) from \$980 per capita in 1993 to \$5350 in 2015, making it one of the largest emerging economic markets (World Bank, 2015). On the contrary, it has approximately 61 million stunted children under-5 years, which makes up 34% of the total global stunting rates (WHO, 2014). Stunting is one of the primary indicators of prevalence of child undernutrition (Black et al., 2008). Several studies have attributed lack of income as the most immediate and direct cause for poor nutritional status of children in India

(Cunningham, Ruel, Ferguson & Uauy, 2015; Klasen, 2006; Nandy, Irving, Gordon, Subramanian & Smith, 2005). However, when compared to sub-Saharan Africa, which has a significantly poorer economy, India fares worse on both children and women's human development indicators (Dreze & Sen, 2013; Ramchandran, 2007).

Ramalingaswamy et al. (1996) coined the term 'Asian Enigma', to explain this pattern of increasing malnutrition rates in India despite economic growth. According to Ramalingaswamy et al. (1996), the rapid increase in malnutrition rates were not due to popular beliefs such as government neglect, vegetarian diet, income poverty, food production, measurement of growth or economic inequality. Instead, the deep rooted social values particularly related to gender inequality have a greater role to play.

This paradox thus suggests that, factors besides socioeconomic status need to be taken into consideration when exploring reasons behind child undernutrition. Status of women in the society has been highlighted as a potential explanation for the prevalence of child undernutrition (Black et al., 2008; Osmani & Sen, 2003; Ramalingaswamy et al., 1996; Smith, Ramakrishnan, Ndiaye, Haddad & Martorell, 2003). According to Osmani & Sen (2003), although gender inequality is prevalent globally, deep-rooted gender biases in certain countries such as India, drastically impacts the well-being of their population.

The current study highlights the impact of maternal caregiver characteristics on child nutritional status. It uses aspects of two specific theoretical frameworks, namely, the ecological systems theory, and the

* Corresponding author at: School of Social Work, Boston College, McGuinn Hall, 140 Commonwealth Avenue, Chestnut Hill, MA 02467, USA.
E-mail address: sinhaa@bc.edu (A. Sinha).

positive deviance approach to explore the role of gender norms, specifically, maternal autonomy and health related awareness on the nutritional status of children. The overall objective of the study is to depart from an overemphasis on income poverty to justify the persistence of high rates of child undernutrition. The study aims to provide an insight on the detrimental impact of the deep rooted social and cultural values related to gender equality on women's health which in turn effects the health of the child, thus leading to a cycle of deprivation.

1. Literature review

1.1. Consequences of poor child nutritional status

Poor nutritional status during childhood, negatively impacts individuals in early life, as well as throughout their life cycle. Nutrition and child welfare literature have repeatedly highlighted the importance of proper diet and care during the first thousand days of the child, starting from conception till age two (Apodaca, 2010; Black et al., 2008; Cunningham et al., 2015; Osmani & Sen, 2003; Muchu, 2012). Lack of proper nutrition has harmful effects on cognitive and physical development (Alderman, Hoddinott & Kinsey, 2006; Apodaca, 2010; Coleman-Jensen, Gregory & Singh, 2014; Zaslów et al., 2009). Some of the common outcomes of undernutrition include stunted growth, lack of development of essential organs, low academic achievement, behavioral concerns such as depression, anxiety and, other psychosocial deficits (Howard, 2010; Nord, Andrews & Carson, 2009; Zaslów et al., 2009).

1.2. Causes of poor child nutritional status

The causes of child undernutrition are multidimensional and complex. UNICEF (1990) has identified global basic and underlying factors that lead to child undernutrition, such as, low socioeconomic status, ineffective governance, employment status, low educational attainment, poor sanitation, demographic characteristics such as household size, sex of head of household, birth order of children, sex of child, and housing status as plausible explanations for undernutrition and child mortality. Other studies such as Cunningham et al. (2015); Engle et al. 1999; Klasen, 2006; Nandy et al., 2005; Pryer, Rogers & Rahman, 2003; Smith & Haddad, 2003; Smith et al., 2003, have also highlighted the similar factors.

Other scholars such as Smith et al. (2003) and Engle et al. (1999) argue that factors beyond demography and income need to be recognized in order to fully understand the issue of malnutrition. A seminal paper by Ramalingaswamy et al. (1996) was one of the first works to negate the importance given to income and other financial assets as primary determinants of child undernutrition, particularly in South Asian countries. They emphasized the role of maternal autonomy and status of women as determinants of child nutritional status (Ramalingaswamy et al., 1996). Similarly, Engle et al. (1999) emphasized the role of the caregiver and defined the resources that were needed to provide optimal care to herself as well as to the child. Some of the resources included education, physical and mental health, autonomy, social support and family economic resources (Engle et al., 1999). More recently, findings from a cross-national study by Smith et al. (2003) indicated that if women and men had equal status, the global underweight rate for children under 3 years of age would drop by approximately 13%, thus saving 13.4 million children from poor nutritional outcomes.

1.3. Maternal autonomy and child nutritional status

According to Arulampalam, Bhaskar & Srivastava (2015) autonomy can be broadly defined as a woman's decision-making power, mobility and, control over resources. Although the relationship between maternal autonomy and child nutritional status has been recognized by major international policy makers, such as the United Nations, WHO,

International Food Policy Research Institute, World Food Programme (WFP), there is dearth of scholarly literature that explores this relationship. A study by Shroff et al. (2011) indicate that mothers with higher autonomy, measured by access to money and freedom to choose to go to the market; were less likely to have malnourished children irrespective of their socioeconomic status. Another study by Imai, Annim, Kulkarni & Gaiha (2014) found similar results. It indicated that the bargaining power of the mother, which was measured by ratio of mother's schooling years to the father's schooling years, had a significant positive effect on the nutritional status of the children. Desai & Johnson (2005) highlighted the effect of women's decision-making on the day-to-day life of the household, including diet and quality of care provided to the child.

Some empirical evidence has suggested a negative impact of women's autonomy on child nutrition (Engle et al., 1999; Sethuraman, Lansdown & Sullivan, 2006). Findings from Bose (2011) and Sethuraman et al. (2006) suggest that maternal employment is associated with poor nutritional status of children, as mothers have reduced time available to provide care. However, substantial evidence from maternal and child welfare research indicates that when women's autonomy is measured as control over resources and ability to make decisions in the household, rather than employment alone, it has a positive influence on children's overall well-being (Engle et al., 1999; Sen, 1999; Sethuraman et al., 2006; Shroff et al., 2011).

1.4. Maternal health awareness and child nutritional status

Maternal health awareness is closely related to maternal autonomy. The World Health Organization (2014), in their 'Global Strategy for Infant and Young Child Feeding' indicated that, for children to have positive nutritional and health outcomes it is imperative for the primary caregivers to have access to consistent information on various care practices. Additionally, Victoria et al. (2008) in their study to evaluate maternal and child health in Brazil, recommended that maternal health awareness is an important determinant of child health, as it influences the overall quality of care, type of food and health services that are provided. UN Secretary Ban Ki-moon presented similar suggestions in his joint action plan report on the Millennium Development Goals (UN, 2010). A review of 4182 studies by DeWalt & Hink (2009) highlighted a strong correlation between maternal health awareness and child health outcomes. However, it should be noted that most studies primarily explored the role of literacy or academic achievement to determine maternal and child health outcomes (Arulampalam et al., 2015; Cunningham et al., 2015; DeWalt & Hink, 2009; Gundersen & Ziliak, 2014; Nandy et al., 2005; Pryer et al., 2003). These studies have indicated a strong correlation between maternal education variables such as, years of schooling completed, literacy and the highest education degree received and child health outcomes. However, they have not highlighted the specific role of health related awareness. The lack of a cohesive measurement for maternal health awareness is a major challenge in predicting its impact on maternal and child health. To bridge this gap, Nutbeam (2000) developed a conceptual framework of health literacy and its relationship with maternal and child health outcomes. The conceptual model suggested that improved health literacy or awareness, will lead to (i) engagement in social action for health, (ii) changed health behaviors and practices, and (iii) participation in changing social norms and practices. According to him, these actions would lead to improved health outcomes, healthy choices and opportunities. Following Nutbeam's (2000) there were a few studies that measured health awareness by using indicators such as postnatal education, antenatal education, HIV/AIDS awareness and reproductive health awareness (Barua & Kurz, 2001; Kalichman & Rompa, 2000; Renkert & Nutbeam, 2001). These studies provided greater insight to the relationship between maternal health awareness and child health outcomes.

Download English Version:

<https://daneshyari.com/en/article/4936433>

Download Persian Version:

<https://daneshyari.com/article/4936433>

[Daneshyari.com](https://daneshyari.com)