B A N G L A D E S H

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When the decision-maker is a woman: does it make a difference for the nutritional status of mothers and children?

Data from the Nutritional Surveillance Project (NSP) in Bangladesh suggest that when women participate in household decisions they are better able to care for their family. Women are the principal decision-makers in less than one in twenty households that have pre-school children in rural Bangladesh. These households spend more on food and medical care, make better choices of food, and enjoy a better nutritional status, even though they have a lower income than households with a male decision-maker. The findings challenge the rationale of programs that focus on mothers' caring practices without adequate attention to women's low status in society. Women are an integral part of the solution to improving nutrition in Bangladesh and more attention must be given to empowering them to make the decisions that promote the nutrition and health of their families. Nutrition and health surveillance is essential for monitoring the nutritional status of households in Bangladesh and for evaluating the impact of policies and programs designed to reduce undernutrition and social imbalances.

Women in Bangladesh have a lower social status than men. Their low status is deeply rooted in a culture and traditions that place greater value on sons and men. Women's status remains low from one generation to the next because of a preference for sons, and because daughters have less access to food, health services and education. Men are expected to make all the major household decisions regarding the allocation of resources. Consequently, women are often unable to participate at an equal level in decisions that affect the lives of their children and themselves.

Evidence from around the world suggests that women are the 'guardians' of household nutrition mainly because they give greater priority than men to feeding their family when resources and money are scarce.[1] In Bangladesh men typically control the household's money and buy all the food for the family. What are the consequences of women's low decision-making power for the nutritional status of household members in Bangladesh? We can gain insights by comparing households with male and female decision-makers. As very few rural households have a female decision-maker, it is necessary to sample a large number to obtain a sufficient sample size for such an analysis. The Nutritional Surveillance Project (NSP) of Helen Keller International (HKI) and the Institute of Public Health Nutrition (IPHN) is able to provide this information because it collects data from more than 50,000 rural households each year. This bulletin draws together data collected by the NSP in 2000 on the characteristics of households with male and female decision-makers.

Sex of the household decision-maker

The NSP asks rural households to provide the name and sex of the household member who makes the major household decisions. These decisions relate to the management of household resources such as money, labor and food. Households with a male decision-maker are the norm in Bangladesh, and women tend only to become the decision-maker following the death of the husband, divorce, separation, abandonment, or if the husband has temporarily migrated. In 2000, only 3.7% of

***Table**. The median per capita monthly income and expenditure on food and medical care by the sex of the household decision-maker in rural Bangladesh in 2000.*

	Male (*n*=51,871)	Female (*n*=1,972)	
Income (Taka)	357	314	*P*<0.001
Food (Taka)	153	167	*P*<0.001
Medical care (Taka)	9	18	*P*<0.001

the nearly 54,000 households in the NSP sample had a female decision-maker.

The decision-maker is usually the same person as the household head, although this is not always the case. For example, if the male household head has migrated to find work his wife may make the household decisions, while households that have a female decision-maker who is divorced, widowed or separated may have a nominal male head for the purposes of security and protection.

Access to income and credit

The Table shows that the per capita monthly income of households with a female decision-maker was 12% (43 Taka) less than households with a male decision-maker. Why is this so? Most households with female decision-makers do not have a male head and therefore lack a crucial male income-earner. Women often lose access to productive assets such as land following their divorce or the death of their husband. They are also denied access to many forms of gainful employment because they are poorly educated and, for cultural reasons, cannot move freely or independently outside their homes. Those women who do work often find that they are paid less than men for the same job, a sign that their work is undervalued and underrated. Figure 1 shows that the daily wage of male agricultural day laborers is over 50% greater than that of their female counterparts. Gender differences in wages such as these may be partly responsible for the under-investment by households in the education, health and nutrition of girls. In addition, NSP data showed that only 14.4% of households with female decision-makers are members of NGO groups that provide credit compared with 24.1% of households with male decision-makers, despite growing evidence that women are credit-worthy.[2]

Control of household resources

Despite having a smaller income, the Table shows that households with a female decision-maker spent about 10% more on food and 100% more on medical care than households with a male decision-maker. Using the proportion of mothers and children with diarrhea as an indicator of health status, there was no evidence to suggest that members of households with female decision-makers were less healthy than those of households with male decision-makers.

***Figure 1**. The mean daily wage for male (n=5,878) and female (n=174) agricultural laborers in rural Bangladesh in 2000.*

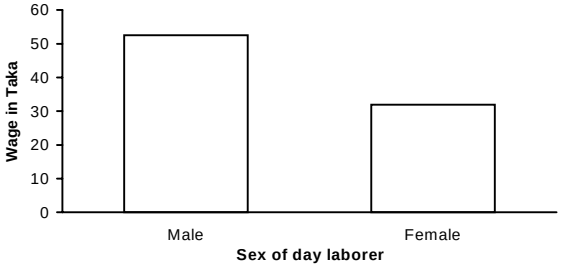
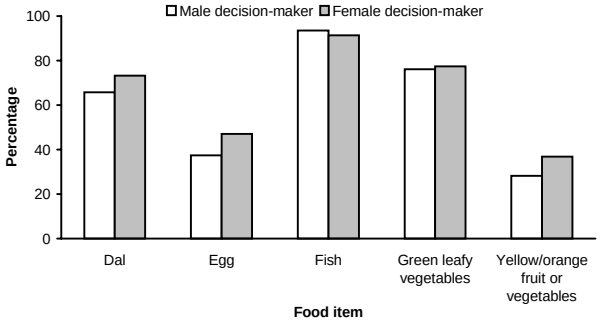


Figure 2 shows that there were differences in dietary indicators as well. Members of households with a female decision-maker were more likely to have consumed *dal*, egg and yellow/orange fruits or vegetables in the previous week than if men made decisions. Households with a male decision-maker were slightly more likely to have eaten fish in the previous week, a costly item if bought, than households with a female decision-maker. These findings suggest that household members are given a more diverse diet when women are in control of household resources. Diverse diets promote better nutritional status because they contain more of the micronutrients and protein that are essential for child growth and to protect against infectious diseases.[3]

Mother and child's nutritional status

As households with female decision-makers spend more of their income on food and health care and have a more diverse diet compared with households

***Figure 2**. The percentage of households that consumed key foods at least once during the previous week by the sex of the household decision-maker in rural Bangladesh in 2000 (n=53,843).[b]*



with a male decision-maker, we would expect that members of these households to have a better nutritional status. This appears to be the case. Figure 3 shows that the percentage of stunted pre-school children was lower by 4-7% in households with a female decision-maker compared with households with a male decision-maker. Furthermore, Figure 4 shows that 8% fewer mothers in these households were undernourished (body mass index <18.5 kg/m^2). If households with male decision-makers had the same percentage of undernourished children and mothers as households with female decision-makers, it is estimated that there would be 720,000 fewer stunted pre-school children and 1.6 million fewer undernourished women of child-bearing age in rural Bangladesh.[a] The disparities in nutritional status between households with male and female decision-makers may have been even greater if female decision-makers had access to the same resources as male decision-makers.

Policy and program implications

In recent years much emphasis has been given to the role of caring practices in promoting child nutrition. The rationale is that households that have good caring practices will make more efficient use of limited household resources to improve the nutrition of their household members, even without major improvements in their socio-economic status or in the effectiveness of the health care system. Programs in many countries, including the Bangladesh Integrated Nutrition Program and the National Nutrition Program, have placed a high priority on interventions to improve the caring practices of mothers. The evidence of the NSP from rural Bangladesh suggests that attention must be given to improving women's status in society so that women are empowered to make decisions that will be best for the nutrition and health of their families. Greater investment in the education and training of girls and women will help give them better employment opportunities and income. It will also help them to improve their communication and negotiating skills, which can be applied in decision-making situations at home.[2] In addition, women's ability to generate income is important in raising their confidence and ability to participate in household decisions.

Empowering women will help with the allocation of household resources but access to food is also important. Recent figures show that the average Bangladesh diet lacks over 300 kcal daily[4], and no amount of education on caring practices will change this situation unless there is an increase in the amount of food that a household has available to share amongst its members. Homestead gardening, income-generating activities and credit facilities will increase the capacity of households to produce or purchase sufficient food. These interventions need to be supported by food and agriculture policies that improve access to an affordable and nutritious diet and by rural developments programs that provide job opportunities for functionally landless households.

The role of surveillance

Awareness of women's status relative to men and the importance of women's status for nutrition needs to be repeatedly reinforced at all levels. One of the best ways to achieve this is to use nutrition and health surveillance to monitor the status of girls and women

***Figure 3**. The percentage of stunted (z-score height-for-age <-2 SD) children aged 0-23 months (n=26,158) and 24-59 months (n=37,051) by the sex of the household decision-maker in rural Bangladesh in 2000.[b]*

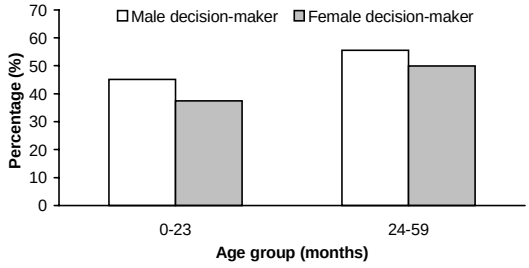
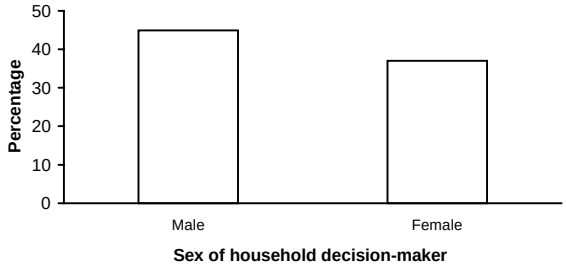


***Figure 4**. The percentage of undernourished (body mass index <18.5 kg/m^2) non-pregnant women (n=49,379) by the sex of the household decision-maker in rural Bangladesh in 2000.[b]*



[a]The estimates use population projections from the 1991 census and assume that the prevalence of undernutrition in women of childbearing age and mothers with preschool-age children is the same.

[b]All differences between households with male and female decision-makers were significant (P<0.001) after controlling for socio-economic and demographic variables relevant to each analysis such as seasonality, household land ownership, total household monthly expenditure mother's education, age and sex of child, age of mother. The only difference not significant was the percentage of households that ate green leafy vegetables at least once in the last week.

relative to boys and men. The NSP collects data from 9,000 rural households every two months on a broad range of indicators on nutrition, health and social status, including several indicators that are sensitive to sex bias, such as the sex of the household decision-maker, the nutritional status of pre-school girls and boys and their mothers, wage rate of men and women, and the education status of mothers and fathers. With over ten years of data already collected, the NSP can monitor long-term trends in these indicators and record progress towards national and international targets for reducing undernutrition, social imbalances and poverty. The large sample size provided by the NSP enables analyses of the situation of sub-groups that form only a small part of the total population to be done, such as households with female decision-maker.

Conclusions

When women are in control of household resources they spend more on food and medical care, provide a more diverse diet and, despite their lower income, they and their children have a better nutritional status. These findings challenge the rationale of programs that focus on mothers' caring practices as a means to improve nutritional status without giving adequate attention to empowering women and household food security.

Recommendations

- Greater awareness needs to be created through advocacy campaigns on the importance of women's decision-making power for the welfare of the household. Programs that improve women's social awareness, increase their access to credit, and provide training on income generation, functional literacy and numerical skills are needed to empower women.
- Policies and programs should focus on interventions to improve household food security, such as homestead food production, income-generating activities, food and agricultural policies and rural development programs.
- Nutrition and health surveillance is essential for monitoring and evaluating policies and programs to reduce undernutrition and social imbalances in Bangladesh.

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