B A N G L A D E S H

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Female decision-making power and nutritional status within Bangladesh's socio-economic context

Development efforts have brought about major changes in Bangladesh over the last decade[1-3], yet the nutritional situation of women and children in Bangladesh is still of great concern. Gender equality and the improvement of child nutritional status are related and are centered in the first and third Millennium Development Goal (MDG). This bulletin adds to earlier findings of the Nutritional Surveillance Project (NSP) and shows that female decision-making power is related to improved nutritional status of women and children. Bangladesh's society is still very male dominated, yet the proportion of female-headed households in rural areas increased from 2% in 1996 to 6% in 2005. Although female-headed households had better educated mothers than male-head households, their higher vulnerability surfaces throughout. Occupational characteristics, migration patterns and different priorities in spending their money shed further light on why, at the same time, these households accomplish better nutritional outcomes.

Gender inequality is a serious concern in Bangladesh, as reflected by the poor 'Gender-related development index' (GDI, 105th out of 140 countries) and the 'Gender empowerment measure' (GEM, 79th out of 80 countries)[i3]. The country signed the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which stipulates the agenda for national action to end discrimination against women. Malnutrition and associated child and maternal mortality rates have improved over the past decade; nevertheless, they are alarmingly high, and not on track to achieving the MDGs. In 2005, almost 40% of pre-school age children and non-pregnant women were chronically malnourished in rural Bangladesh[4]. Child and maternal mortality remain high with 77 children out of 1,000 live births dying before the age of five years, and 380 mothers dying per 100,000 live births[5]. These are unacceptably high numbers.

The situation of women in Bangladesh

In Bangladesh's patriarchal society women have low status, limiting their physical mobility and authority in decision-making, including on household expenditures[6]. They are restricted in moving freely outside their village or neighborhood and have low access to education (despite recent progress on school enrollment of girls). They bear the brunt of poverty and suffer from inequalities in key areas, including intra-household food distribution, access to health care, employment and inheritance[7]. Development programs, such

The United Nations Population Fund (UNFPA) stresses[8] that in Bangladesh…
"The promotion of gender equality and the empowerment of women are crucial to the development of sound population and development strategies and essential for sustainable development. […] Gender inequality is recognised in Bangladesh as one of the root causes of women's and girls' poor health status directly affecting the overall development of the nation."

[i] The GDI measures dimensions of a long and healthy life, knowledge and a decent standard of living; the GEM measures political as well as economic participation and decision-making power, and power over economic resources. Higher ranks indicate poorer performance.

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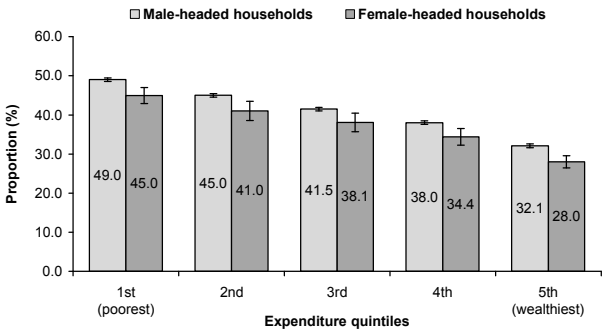

***Figure 1**. Prevalence of stunting among children under 5 years of age in MHH (n=213,581) and FHH (n=10,575) by expenditure quintiles in rural Bangladesh, 2003-2005*

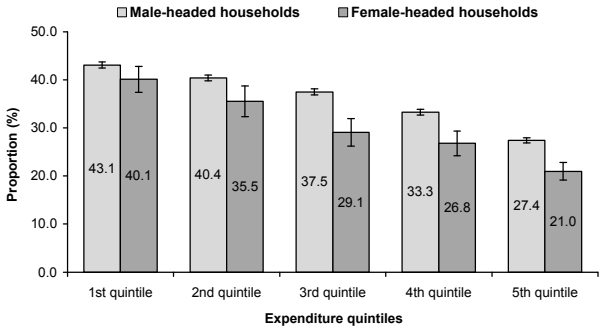

***Figure 2**. Prevalence of chronic energy deficiency (CED) among women in MHH (n=119,614) and FHH (n=6,193) by expenditure quintiles in rural Bangladesh, 2003-2005*

as microfinance and family planning programs and an increased involvement of women in paid employment, e.g. the garments sector, have greatly empowered women and improved their decision-making power[1,9].

Survey methods

Nationally representative data were collected in 2003-2005 by the NSP, implemented by HKI in collaboration with the Institute of Public Health Nutrition through partner organizations. Using a multi-stage cluster sampling, data were collected from 28 rural sub-districts, four within each of the six divisions and the Chittagong Hill Tracts. Data from over 188,000 households, including mothers and children <5 years of age, were analyzed. Five specific indicators are explained in more detail in the **Box**. The data were weighted to account for different divisional population sizes.

***Box**. Definition of specific indicators used*

Female and male-headed households (FHH, MHH): a household was defined as a FHH when the head of the household (its principal decision-maker) was a woman and as a MHH when it was a man. The terms 'decision-maker' and 'head of the household' are used here synonymously but are distinguished from the term 'main income earner'.

Expenditure per capita: households were grouped into expenditure quintiles by ranking them by their total monthly per capita expenditure and then dividing them into five equal-size groups, irrespective of the gender of the household head and separately for each year. The lowest (1st) and the highest (5th) quintile represent the poorest and richest households respectively.

Stunting: an indicator of chronic malnutrition among children <5 years of age, defined as a height-for-age Z-score (HAZ) <-2 standard deviations below the NCHS reference median.

Chronic energy deficiency (CED): an indicator of malnutrition among non-pregnant women, defined as a body mass index (BMI) <18.5kg/m^2.

International migration: international migration (to and from abroad) by any household member within the last year. Data are reported from April 2004 onwards because data were not collected before then.

FHH and nutritional status

Across all quintiles both the prevalence of stunting among children <5 years of age (**Figure 1**) and the prevalence of chronic energy deficiency (CED) in non-pregnant women (**Figure 2**) was significantly lower in FHH compared with MHH. On average, the prevalence of stunting was 4% lower among children of FHH than of MHH; the prevalence of CED was 3–8% lower in FHH than in MHH. Stunting and CED declined from the poorest to the wealthiest expenditure quintile among all households.

Why are households headed by women?

The higher proportion of FHH seen in the first and fifth quintile (5.2% and 7.4%) as compared with the other three quintiles (3.3–4.5%) suggests different dynamics in the socio-economic status (SES) strata: on the one hand, women of poorer households may be the head of the household out of necessity, taking over responsibilities from an absent husband who is

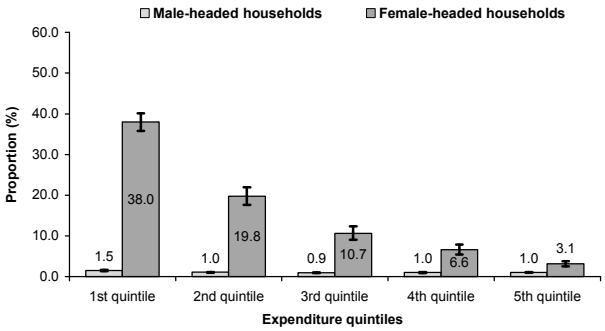

***Figure 3**. Proportion of households with a female main income earner in MHH (n=179,680) and FHH (n=9,951) by expenditure quintiles in rural Bangladesh, 2003-2005*

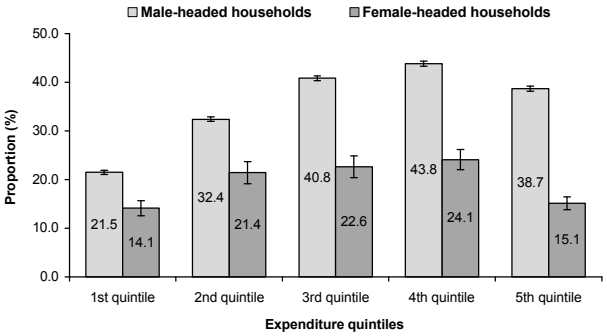

***Figure 4**. Proportion of households that are NGO beneficiaries in MHH (n=179,854) and FHH (n=8,963) by expenditure quintiles in rural Bangladesh, 2003-2005*

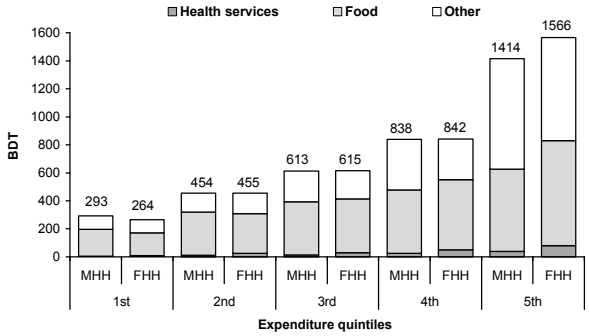

***Figure 5**. Monthly per capita expenditure pattern in MHH (n=70,767) and FHH (n=3,959) by expenditure quintiles in rural Bangladesh, 2005*

or was the main income earner and head of the household. These households may face deprivation in times of permanent (death, divorce, separation) or temporary (migration) absence of a male head. Overall, the proportion of households with a female as the main income earner is higher among poorer households (**Figure 3**). Due to lower wages of female earners and low social regard for poor working women, these circumstances may aggravate household poverty and deprivation. On the other hand, women of wealthier households may head the household out of necessity but also out of choice.

The type of occupation of the main income earner differed between FHH and MHH as well as across expenditure groups. In poorer quintiles, MHH derived their main income mainly from agro-fishery (~40%) and labor (~25%), while in wealthier quintiles it was from agro-fishery (~32%) and business (~30%). In contrast, the main earners of FHH mainly received a salary (35% in first, 74% in fifth quintile). Thus, MHH depended mainly on non-fixed income, while the income of FHH was dominated by fixed-salary work.

How do decisions of FHH and MHH differ?

Maternal education improved with increasing SES, and more mothers in FHH (66.2%) than in MHH (56.1%) had at least one year of schooling. Due to a strong relationship between maternal education and child nutritional status, the higher educational level of mothers in FHH was a likely contributor to the better nutritional status of the children.

Proportionately fewer FHH are NGO beneficiaries than MHH (**Figure 4**), suggesting that FHH are in fact more deprived of the NGO's services and programs and have a less favorable environment than MHH. Also, wealthier households were beneficiary of an NGO more often than poorer households.

International migration of any household member during the past year occurred in ~15% of FHH in the first four quintiles but was higher in the fifth quintile (24%), while fewer migrated internationally in MHH (<5%). This contributed to the households' economic resources to some extent and may have further advanced them through foreign exposure. FHH and MHH had different expenditure priorities (**Figure 5**). While the total expenditure per capita did not differ much, FHH spent more on food and health services than MHH, across almost all quintiles. Findings are presented for 2005 to avoid bias due to inflation, but were similar in 2003 and 2004.

Children of FHH consumed a more diverse diet than those of MHH, consuming micronutrient- and protein-rich foods more often (**Figure 6**). Combined with higher expenditure on health services, this is likely to improve nutritional status of children. Although FHH seem to be more deprived than MHH in terms of development and outside assistance, even with fewer available resources FHH managed to achieve better child and maternal nutritional outcomes likely due to prioritizing expenditures toward improved health and nutrition.

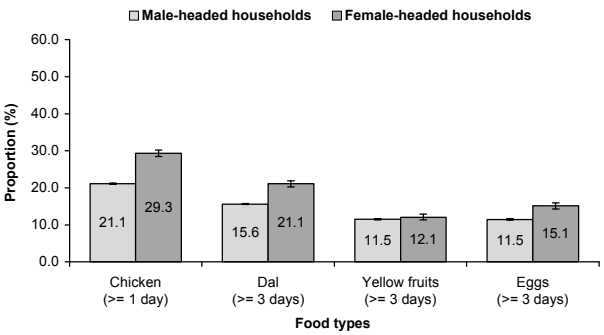

***Figure 6**. Child food consumption patterns (days/week) in MHH (n=214,912) and FHH (n=10,626) in rural Bangladesh, 2003-2005*

Conclusions

- The proportion of FHH in Bangladesh is very small but their impressive performance, within the limits of their socio-economic status, in terms of nutritional status emphasizes that female empowerment is essential for Bangladesh to achieve the MDGs.
- Children and women of FHH have a better nutritional status than those of MHH; however, FHH have less access than MHH to development services, which increases their vulnerability during more difficult times.
- FHH prioritize investments in medical services and food and hence provide better health care and a better quality diet to their children. This concords with findings that women's relative decision-making power strongly affects child nutrition in South Asia.[10]
- A better understanding of the different dynamics in FHH and MHH across socio-economic strata is crucial to designing efficacious development programs. The NSP is a good tool to develop such insight.

Recommendations

- Health, nutrition and other development programs should specifically target women, especially of poorer households. Within these programs, women's empowerment and decision-making power can be increased by actively and systematically encouraging true participatory decision-making within households and providing a forum for discussion within their social network. Behavior change communication by program implementers and communities should integrate this and couples be encouraged to take decisions together.
- Girls need to continue their schooling for as long as possible and be given opportunities to practice their decision-making skills within their families and the community, which will benefit future generations. Program implementers and the communities need to promote this, and schools teachers be trained to support and encourage the girls and their parents.
- The private sector and the Government with assistance from the development partners should create employment opportunities, without social reprimand, among the underprivileged population (women, poor, landless), to reduce poverty and vulnerability, and raise women's empowerment.

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Helen Keller International, Bangladesh
P. O. Box 6066 Gulshan, Dhaka 1212, Bangladesh
Telephone: 880-2-882 3465/882 3494/8827044
Fax: 880-2-885 2137
Email: info@hkidhaka.org

Contacts:

Chantell Witten, Country Director
E-mail: cwitten@hkidhaka.org

Gudrun Stallkamp, Nutrition Program Officer
E-mail: gudrun@hkidhaka.org

Md. Ruhul Amin, Publications Officer
E-mail: amin@hkidhaka.org

Helen Keller International Asia-Pacific Regional Office
33 Club Street, # 11-10 Emerald Garden,
Singapore 069415
Fax: 65-63 99 23 72

Website: www.hkiasiapacific.org; www.hki.org

Contacts:

Nancy Haselow, Regional Director
E-mail: nhaselow@hki.org

Dr. Saskia de Pee, Scientific Advisor
E-mail: sdepee@compuserve.com

Federico Graciano, Communications Officer
E-mail: graciano@singnet.com.sg

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