Importance of Women's Status for Child Nutrition in India

Dr. Pinki Kumari

Assistant Professor (Guest Faculty)

R.S.S. Mahila College, Sitamarhi ,

B.R.A.Bihar University, Muzaffarpur.

Abstract

Developing country malnutrition on its current scale one-third of all children causes untold human suffering. Malnutrition is associated with more than half of all child deaths worldwide (Pelletier et al. 1995). It is the source of a major waste of resources and lost productivity because children who are malnourished are less physically and intellectually productive as adults (Gillespie and Haddad 2001). Malnutrition is thus a primary obstacle to the development process itself. It is a violation of the child's human rights, yet virtually all of it can be prevented.

Increasing evidence indicates that maternal empowerment may be an important determinant of child nutritional status. However, little is known about this relationship in Bihar, India. This study is designed to examine the relationship between women's empowerment, represented by single and summary indicators and child nutritional status in Bihar. Children in India are puzzlingly short relative to their level of economic development. Stunting among Indian children is important because the same early life health insults that influence childhood height also influence adult human capital and health. One candidate explanation for why Indian children are so short is the very low social status of Indian women who, as mothers, feed and care for children in the early life. However, the lacks a well-identified test of this conjecture. This paper applies a novel strategy to identify an affect of women's status on children's height.

***Key word:** Malnutrition, Children in Developing countries, Nutrition, Health and hygiene, Social conditions.*

Introduction:

Developing country malnutrition on its current scale one-third of all children causes untold human suffering. Malnutrition is associated with more than half of all child deaths worldwide (Pelletier et al. 1995). It is the source of a major waste of resources and lost productivity because children who are malnourished are less physically and intellectually productive as adults (Gillespie and Haddad 2001). Malnutrition is thus a primary obstacle to the development process itself. It is a violation of the child's human rights, yet virtually all of it can be prevented. The most immediate manifestation of these differences is an extremely large disparity in the regions' incidences of low birth weight babies. While the proportion of newborns with low birth weight is one-third in India and one-half in Bangladesh. Low birth weight is the best single predictor of malnutrition, since it is associated with poor growth in infancy and throughout childhood.

Women's Status and Care for Children

"women's status." has been associated with women's autonomy, power, empowerment, authority, valuation, and "position" in society, and also simply with women's well-being. Sometimes these components are considered in an absolute sense and sometimes relative to men. Women's status is sometimes referred to as gender inequality or gender equality. Scholars of women's status classify the concept as being "no unitary," "multidimensional," and "multilevel," rendering it impossible to develop a consensus on its definition (Mason 1986, 1993;). While the differential power of women and men outside of their households is not necessarily correlated with their differential power within households, the former influences the latter. As noted above, customs and norms determine who has "voice" in decisions, that is, who participates and thus influences them at all (Agarwal 1997; Katz 1997). Customs and norms set limits on the circumstances under which bargaining can be engaged in, for example, norms may call for silent acquiescence of women when men display anger. They also set the terms of the "outside options" of women and men and thus their ability to negotiate with their husbands. For example, if a woman has no better alternative than to stay with her husband in order to secure her livelihood because of discriminatory labor policies or the lack of enforced laws against domestic violence, then she will not find it in her interest to disagree with him in the case of conflict (McElroy and Horney 1981; Haddad, Hoddinott, and Alderman 1997; Katz 1997; England 2000). National and state divorce laws, of course, also affect women's options for a viable livelihood outside of marriage (Hoddinott and Adam 1998).

In most societies, it is women who are the caregivers for young children and bear the primary responsibility for their health and survival. They are also the primary caregivers for themselves. Yet women with low status relative to men tend to have little control over household time and income, face tough time constraints, have little social support to relieve those constraints, have little knowledge or inappropriate beliefs, and have poor mental health, low self-confidence, and low self-esteem. Moreover, women living in communities where less value is placed on women's well-being than men's may find that reproductive health services for women are unavailable. These circumstances make it difficult to undertake the caring practices that are in their children's best interests. They also hamper women's ability to provide adequate care for themselves, further undermining their ability to give adequate care to their children.

Women's control over resources within households. Simply put, the greater a women control over household economic resources, including the use of her own time, the more effective her care for herself and her children will be. Besides the obvious benefit of having more resources to allocate, control over resources gives her the ability to weigh the costs and benefits of alternative uses of resources so that they are employed in the most efficient manner (Smith 1995). To give some examples, the more control a woman has over her own time and household income, the more likely she is to make a timely decision to treat her sick child after discovering an illness. She is more likely to make use of health services and follow through with treatment recommendations, or to have the child immunized. She may be more likely to obtain a special food for a child, prepare it, and feed it to

the child at an appropriate frequency and with the degree of patience required. She may also be more likely to make use of health services for her own care during illness, for ongoing gynecological care, and for prenatal and birthing care.

Under certain circumstances differences in relative power and thus control over resources within households do not matter in terms of care given to women and children. Sometimes men and women act as one because they have identical preferences. In this situation, household resources are not controlled individually but are pooled. In this case, we would expect to find that women's status has no behavior-related impact on the nutritional status of children. The economic model underlying this state of affairs—the unitary household model has been empirically rejected with sufficient frequency and regularity to lead us to expect an impact of women's status on child nutritional status. Numerous studies have demonstrated that income or assets accruing to women or believed to be controlled by women are more likely than those of men to be allocated to expenditures that benefit children (for example, education), as well as themselves, such as food, clothing, and health care.

Women's Status, Care of Children, and Birth Weights

The lower the quality of care a woman receives, the more likely she is to be malnourished, sick, or injured as the result of violence. Such a woman, in turn, generally has a low energy level, making her less responsive to her child's needs and impairing her ability to carry out essential tasks necessary for proper childcare. For example, a woman who is malnourished may be less capable of breastfeeding successfully (Ramalingaswami, Jonsson, and Rohde 1996; Engle, Menon, and Haddad 1999). Micronutrient deficiencies, especially iron deficiencies, cause fatigue and may affect women's cognitive performance and therefore their ability to adequately care for a young child (Beard 2001). Violence toward women in their homes is widespread; emotional and psychological abuses are even more common.

With regard to children's birth weights, women's health and nutrition ring pregnancy affects children's nutritional status in two ways. First, malnourished women tend to give birth to low birth-weight infants due to intrauterine growth retardation (WHO 1995). In turn, low birth-weight infants tend to remain underweight as children, despite partial catch-up with their adequate birth weight peers (Martorell et al. 1998; WHO 1995). Second, recent evidence suggests that maternal micronutrient malnutrition,

An increase in women's status may also raise the potential for increased domestic or social conflict. When a group of people has had a monopoly on power for a long time and finds this power taken away or shared with another group, it can feel threatened. Increased conflict and tension both within and outside of households may arise. The increased conflict in a household can ultimately lead to its dissolution, which can lower the quality of care given to young children in many ways. Outside the household a change in power relations can set off a backlash from men, resulting in increased physical or psychological abuse of women, which is also

detrimental to the quality of care for children (Riley 1997; Adato et al. 2000; Hobcraft 2000; Isvan 1991; Sen and Batliwala 2000).

Child Feeding Practices

Several key feeding practices are known to be beneficial for the health and nutrition of young children. First, initiation of breastfeeding almost immediately after birth takes advantage of the newborn's intense suckling reflex, which in turn stimulates milk production. Early initiation of breastfeeding also fosters bonding of the mother and child and protects the newborn by providing a rich source of antibodies and nutrients through colostrums, the first milk (Linkages 1999; Newman 1995). Second, breast milk can provide all of the nutrients needed by the young infant, and exclusive breastfeeding ensures adequate growth until six months of age (Cohen et al. 1994). Breast milk also confers passive immunity on the young infant and significantly reduces the risk of infection (IOM 1990). For these reasons, exclusive breastfeeding is recommended during the first four to six months of life, with continued breastfeeding into the second year of a child's life (Brown, Dewey, and Allen 1998).

Growing child's macro and micronutrient requirements, high-quality complementary foods should be introduced by six months of age. The introduction of foods and liquids (nutritive and nonnutritive) other than breast milk before this time not only reduces breast milk intake but also increases exposure to pathogens, especially in the unsanitary environments typical of poor households in developing countries. However, too late an introduction of complementary foods is a key risk factor for malnutrition in children (Huffman and Martin 1994; Martorell 1995). Fourth, young children have relatively high nutrient requirements per kilogram of body weight, but their intake is limited by their small gastric capacity and naive immune systems. They are therefore entirely dependent on their caregiver to ensure that good quality complementary foods are offered frequently (Engle, Menon, and Haddad 1999). Additionally, because of the associated exposure to pathogens and interference with successful breastfeeding, bottle-feeding is not recommended (Newman 1990). Based on the availability of comparable data in the Demographic and Health Surveys (DHS) the indicators of good feeding practices are employed.

Prenatal and Birthing Care for Women

The World Health Organization recommends at least four routine prenatal care visits during pregnancy and delivery by a trained birth attendant. Increasing evidence also supports the benefits of early entry intomprenatal care (Villar and Bergsjo 1997; Ahluwalia et al. 1998). Regional numbers on the use of prenatal and birthing care and, for women who receive any prenatal care,the number of visits and the time to time.

Conclusion:

This paper has provided the conceptual basis on which the rest of the study is founded. Women's status is defined as women's power relative to men's. Because a woman can have a strong influence over decisions within her household but still not be highly valued in the community or society in which she lives (and vice versa), the definition encompasses relative power both inside and outside of households. Women's status influences child nutrition through three major pathways: food security, caring practices for women and children, and health environment quality. The focuses on only one of the pathways: caring practices for women and children. The nature and extent of these practices ultimately affect children's nutritional status by influencing the quality of care children receive and their birth weights.

Malnutrition affects one out of every three preschool-age children living in developing countries. This disturbing, yet preventable, state of affairs causes untold suffering and, given its wide scale, presents a major obstacle to the development process. Volumes have been written about the causes of child malnutrition and the means of reducing it. But the role of women's social status in determining their children's nutritional health has gone largely unnoticed until recently. This study explores the relationship between women's status and children's nutrition in developing countries.

References:

1 World Cancer Research Fund. Food, Nutrition, and the Prevention of Cancer: A Global Perspective. Washington, DC: American Institute for Cancer Research, 1997.

2 Black AE, Goldberg GR, Jebb SA, Livingstone MBE, Cole T, Prentice AM. Critical evaluation of energy intake data using fundamental principles of energy physiology: 2. Evaluating the results of published surveys. European Journal of Clinical Nutrition 1991; 45: 583–99.

3 Heitmann BL, Lissner L. Dietary underreporting by obese individuals—is it specific or non-specific? British Medical Journal 1995; 311(7011): 986–9.

4 Briss PA, Zaza S, Pappaioanou M, Fielding J, Wright-De Aguero L, Truman BI, et al. Developing an evidence-based Guide to Community Preventive Services—methods. The Task Force on Community Preventive Services. American Journal of Preventive Medicine 2000; 18(1): 35–43.

5 DiPietro L. Physical activity, body weight, and adiposity: an epidemiologic perspective. Exercise and Sport Sciences Review 1995; 23: 275–303.

6 Centers for Disease Control and Prevention. Increasing Physical Activity. A Report on Recommendations of the Task Force on Community Preventive Services. Atlanta GA.: Centers for Disease Control and Prevention, 2001.

7 WHO. Weight control and physical activity. In: Bianchini F, ed. IARC Handbooks of Cancer Prevention. Lyon, France: IARC Press, 2002.

8 Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. WHO Technical Report Series No. 894. Geneva, Switzerland: WHO, 2000.

9 Seidell JC. Obesity: a growing problem. Acta Paediatrica Supplement 1999; 88(428): 46–50.

10 Bell AC, Ge K, Popkin BM. Weight gain and its predictors in Chinese adults. International Journal of Obesity and Related Metabolic Disorders 2001; 25(7): 1079–86.

11 Hodge AM, Dowse GK, Zimmet PZ. Obesity in Pacific populations. Pacific Health Dialog 1996; 3(1): 77–86.

12 Bell AC, Swinburn BA, Simmons D, Wang W, Amosa H, Gatland B. Heart disease and diabetes risk factors in Pacific Islands communities and relationships with measures of body fat. New Zealand Medical Journal 2001; 114: 208–13.

13 Seidell JC, Rissanen A, Prevalence of Obesity in Adults: The Global Epidemic. In: Bray GA, Bouchard C, eds. Handbook of Obesity, 2004 (In press).

14 Pena M, Bacallao J, ed. Obesity and Poverty: A New Public Health Challenge. Washington, DC: Pan American Health Organization (PAHO), 2000.

15 Monteiro CA, Mondini L, de Souza AL, Popkin BM. The nutrition transition in Brazil. European Journal of Clinical Nutrition 1995; 49(2): 105–13.

16 Swinburn BA, Ley SJ, Carmichael HE, Plank LD. Body size and composition in Polynesians. International Journal of Obesity and Related Metabolic Disorders 1999; 23(11): 1178–83.

17 WHO Regional Office for the Western Pacific. The Asia- Pacific Perspective: Redefining Obesity and its Treatment. Manila, Philippines: World Health Organization, 2000.

18 Deurenberg P, Deurenberg-Yap M, Guricci S. Asians are different from Caucasians and from each other in their body mass index/body fat per cent relationship. Obesity Reviews 2002; 3(3): 141–6.

19 Sjostrom L. Impacts of body weight, body composition, and adipose tissue distribution on morbidity and mortality. In: Stunkard AJ,Wadden TA, eds. Obesity: Theory and Therapy. 2nd ed; New York: Raven Press, 1992.

20 McKeigue PM. Metabolic consequences of obesity and body fat pattern: lessons from migrant studies. In: Shetty PS, McPherson K, eds. The Origins and Consequences of Obesity. Chichester: John Wiley & Sons, 1996.

21 Popkin BM. The nutrition transition and obesity in the developing world. Journal of Nutrition 2001; 131(3): 871S–3S.

22 Drewnowski A. Nutrition transition and global dietary trends. Nutrition 2000; 16(7–8): 486–7.

23 Jung RT. Obesity as a disease. British Medical Bulletin 1997; 53(2): 307–21.

24 Manson JE, Willett WC, Stampfer MJ, Colditz GA, Hunter DJ, Hankinson SE, et al. Body weight and mortality among women. New England Journal of Medicine 1995; 333(11): 677–85.

25 Zimmet P, Alberti KG, Shaw J. Global and societal implications of the diabetes epidemic. Nature 2001; 414(6865): 782–7.

26 Colditz GA, Willett WC, Rotnitzky A, Manson JE. Weight gain as a risk factor for clinical diabetes mellitus in women. Annals of Internal Medicine 1995; 1221 April: 481–6.

27 Savage PJ, Bennett PH, Senter RG, Miller M. High prevalence of diabetes in young Pima Indians: evidence of phenotypic variation in a genetically isolated population. Diabetes 1979; 28(10): 937–42.

28 Rosenbloom AL, Joe JR, Young RS, Winter WE. Emerging epidemic of type 2 diabetes in youth. Diabetes Care 1999; 22(2): 345–54.

29 Cockram CS. The epidemiology of diabetes mellitus in the Asia-Pacific region. Hong Kong Medical Journal 2000; 6(1): 43–52.

30 Segal L, Carter R, Zimmet P. The cost of obesity: the Australian perspective. Pharmacoeconomics 1994; 5(Suppl.): 45–52.