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 three developing regions: South Asia, Sub-Saharan Africa (SSA), and Latin America and the Caribbean (LAC).

The study defines women’s status as women’s power relative to men. Women with low status tend to have weaker control over household resources, tighter time constraints, less access to information and health services, poorer mental health, and lower self-esteem. These factors are thought to be closely tied to women’s own nutritional status and the quality of care they receive, and, in turn, to children’s birth weights and the quality of care they receive.

The study sets out to answer three main questions: First, is women’s status an important determinant of child nutritional status in the three study regions? Second, if so, what are the pathways through which it operates? And finally, why is South Asia’s child malnutrition rate so much higher than SSA’s? To answer these questions, this report brings together Demographic and Health Survey data on 117,242 children under three years of age from 36 developing countries. It uses two measures of women’s status: women’s decisionmaking power relative to that of their male partners and the degree of equality between women and men in their communities.

The empirical results leave no doubt that higher women’s status has a significant, positive effect on children’s nutritional status in all three regions. Further, they confirm that women’s status impacts child nutrition because women with higher status have better nutritional status themselves, are better cared for, and provide higher quality care to their children. However, the strength of influence of women’s status and the pathways through which it influences child nutrition differ considerably across regions.

In South Asia, increases in women’s status have a strong influence on both the long- and short-term nutritional status of children, leading to reductions in both stunting and wasting. The human costs of women’s lower status in the region are high. The study estimates that if women and men had equal status, the under-three child underweight rate would drop by approximately 13 percentage points, meaning 13.4 million fewer malnourished children in this age group alone. As women’s status improves in the region, so does the quality of the pathways through which it influences child nutrition. The pathways identified by the study are women’s nutritional status (as measured by body mass index [BMI]), prenatal and birthing care for women, complementary feeding practices for children, treatment of illness and immunization of children, and the quality of substitute child caretakers.

In Sub-Saharan Africa too, women’s status and the long- and short-term nutritional status of children are linked. If women and men enjoyed equal status, child malnutrition in the region would decrease by nearly 3 percentage points—a reduction of 1.7 million malnourished children under three. The pathways to this judicious outcome are largely the same as those in South Asia, except that higher women’s status improves child nutrition only for women with very little relative decisionmaking power and has no influence on treatment of child illness.

LAC exhibits a different pattern from that of South Asia and SSA. Women’s status has a positive effect only
on children's short-term nutritional status and only in those households in which women's relative decision-making power is very low. Women's status has a distinctly negative influence on their BMI in this region, where weight gain is an emerging public health problem. The effect probably reflects the greater tendency among higher status women to "weight watch" and likely does not threaten children's nutritional status. The pathways connecting women's status and children's nutrition include prenatal and birthing care for women, feeding frequency, immunization, and quality of substitute caretakers.

Among the developing-country regions, South Asia's particularly high child malnutrition rate has remained a puzzle. South Asia trails even SSA, despite surpassing that region's record on many of the determinants of child nutritional status—national income, democracy, food supplies, health services, and education. The study indicates that three broad socioeconomic factors help explain this "Asian Enigma": women's status, sanitation, and urbanization. Women's status makes by far the greatest contribution to the regional gap in children's nutritional status. It plays this role not only because it is lower in South Asia than in SSA, but mainly because its positive impact is stronger in South Asia—making its costs in terms of child malnutrition far higher in that region.

The implication of the study's empirical results is clear: in the interest of sustainably improving the nutritional status of children, women's status should be improved in all regions. Doing so is especially urgent for South Asia, followed by SSA. Accomplishing this task requires policies that eradicate gender discrimination and policies that reduce power inequalities between women and men by proactively promoting catch-up for women. Examples include enabling women to gain access to new resources, implementing cash transfer programs that promote girls' education and health care, introducing technologies that save household labor, subsidizing child care for working parents, and initiating programs to improve the nutritional status of adolescent girls and young women. In communities that resist shifts in the power balance between genders, policies can mitigate the negative effects of the imbalance, rather than addressing it directly. Targeting health services to communities where women's status is low is one example of this indirect approach. The study also warns that improving women's status can lead to reduced breastfeeding, which is harmful to child nutrition. Efforts to improve women's status, therefore, must be accompanied by efforts to protect, support, and promote breastfeeding.

This research shows unequivocally that making a decision at the policy level to improve women's status produces significant benefits. Not only does a woman's own nutritional status improve, but so too does the nutritional status of her young children. Raising women's status today is a powerful force for improving the health, longevity, mental and physical capacity, and productivity of the next generation of young adults.

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