

Baseline Gender Disparities Relevant to a Nutrition Education Strategy in Rural Bangladesh

Emily Hillenbrand¹

¹Helen Keller International, Asia-Pacific Regional Office

Abstract. Gender inequality is an underlying cause of food insecurity and malnutrition in Bangladesh (McNair et al, 2011). However, gender-transformative approaches—those that challenge unequal gender norms—are rarely applied to nutrition education. Most nutrition education targets mothers only, despite the known influence of other household members on nutrition practices (IPPF 2009, Aibel et al 2004, Mitchell 2004). The Nobo Jibon¹ food security project in Barisal, Bangladesh aimed to develop a gender-transformative nutrition strategy. Indicators of “increased equity” were established to complement the nutrition targets. At baseline, a survey among 800 project households explored nutrition-relevant gender norms and practices, including intrahousehold decision-making; men’s nutrition knowledge; and attitudes towards violence against women. The results show that nutrition knowledge and decision-making authority are unequally distributed within the households. Only 2.6% of mothers could make decisions about their own health; just 3.5% could make independent decisions about childcare. Husbands and mothers-in-law play prominent roles in health decisions but have extremely limited nutrition knowledge. All members have high tolerance for violence against women, particularly for arguing with husbands or disrespecting elders. To enable mothers to adopt new practices, the project’s nutrition education strategy should target multiple family members and explicitly confront intra-household inequalities.

Keywords: Nutrition education, Gender transformative approach, Intra-household decision-making

1. Introduction: Integrating Gender Equity Into Nutrition Education Strategy

Gender biases govern men’s and women’s differential access to information, resources, income, and decision-making capacities, all of which determine household food security and nutrition. Structural gender inequality is thought to account for the “Asian enigma” of higher per capita malnutrition rates in South Asia than in Sub-Saharan Africa, despite better overall development indicators in Asia (Ramachandran 2006, Smith et al, 2003). Violence against women (VAW), which is highly prevalent in Bangladesh, has also been correlated with malnutrition and higher rates of child anemia in a number of countries, including India (Ackerson and Subramanian 2008; Morrison and Orlando 2004, WHO 2007). Conversely, there is a strong correlation between societal markers of gender equity and nutrition outcomes. In Bangladesh, higher age of women at marriage and girls’ education attainment were associated with lower rates of stunting among <5 children; the stunting rates were lowest among children whose mothers completed secondary school (FSNSP 2010). Intra-household power relations, cultural gender beliefs, and restrictions on women’s mobility produce disparities in women’s access to food, particularly during food shortages; their health-seeking practices; and their influence over food purchases. Failure to address these intra-household dynamics may result in poorer uptake of nutrition behavior change (Hillenbrand 2010).

Nobo Jibon, a five-year Title II food security project in Barisal Division of Bangladesh, recognized gender inequality as one of the fundamental causes of food insecurity and malnutrition in Bangladesh. To ensure a gender-transformative model, indicators of “increased equity in families and communities” were

¹ Nobo Jibon is a five-year, USAID-funded food security project covering nine upazilas in Barisal Division, Bangladesh. The project is led by Save the Children USA. Helen Keller International (HKI) is the Technical Partner for the MCHN and gender strategy. HKI designed the gender baseline, gender strategy, and indicators of gender equity, as well as the nutrition education approach.

included to measure the success of the Maternal Child Health and Nutrition (MCHN) component. Equity indicators included a) husbands' nutrition knowledge, b) husbands' attendance at ANC visits, and c) percentage of women and men who state that women have at least joint decision-making say on key decisions AND who state that wife-beating is never justified. As part of a gender-transformative approach, the nutrition education would be targeted at husbands and mothers-in-law, as well as mothers. To develop an effective communications strategy for the project, a baseline survey of gender attitudes was administered. The survey was used to establish baseline understanding of intra-household decision-making and knowledge around nutrition as well as to identify cultural gender biases that need to be addressed through the nutrition education strategy.

2. Methodology of the Gender Baseline

The baseline gender norms, attitudes, and practices survey was administered to 802 households with <5 children in the nine Nobo Jibon target upazilas in Barisal, Patuakhali and Borguna districts of Barisal division. Out of 802 households, 505 households were "joint families" (had mother-in-laws living in the same household). Of these, 437 mother-in-laws agreed to participate in the survey. The survey comprised the following sections:

- Demographic information
- A nutrition knowledge test, administered to mothers-in-law and husbands of the respondent
- Men's actual caring practices during pregnancy and post-delivery
- A violence against women (VAW) attitudes section, administered to respondents and husbands
- A decision-making index section, administered to respondents and husbands
- A gender attitudes section, administered to respondents, husbands, and mothers-in-law

Sample size calculations were based on two indicators (attitudes toward violence against women [VAW] and joint decision-making), and an aggregate indicator was constructed by combining the two. The "attitudes toward VAW" indicator is dichotomous: It is 1 if the individual states that beating one's wife is *not* justified for any of the five reasons given in the Bangladesh Demographic and Health Survey (BDHS). It is 0 if the individual said that wife-beating is acceptable for any reason. A generic sample size calculation was used for social issues, where probability is 50-50. According to the calculations, the sample size for the survey should be 799. The data were collected by a Save the Children data collection team in June 2011 cleaned and analyzed using SPSS; the data were analyzed by staff at HKI.

Both the decision-making and VAW sections are identical to the Bangladesh Demographic Health Survey (DHS), allowing comparison to national trends. To assess intra-household nutrition knowledge levels, a 16-question test was written, based on integrated management of childhood illness (IMCI) practices and the seven essential nutrition actions (ENA), which are the frameworks for the MCHN training. Respondents were given a point for every correct answer, and a portion of a point for every part of a multiple-choice question that they answered correctly.

3. Findings

3.1. Intra-household Decision Making

Respondents and their husbands were asked to describe who participates in five large and small household decisions. Two-thirds of women (65%) said that *husbands alone* made decisions about women's own health-care, and 32% said that *husbands alone* made decisions about the child's health-care. Just 5% of women said that they could solely control their own earnings,² and less than 5% said that they had independent say over other household decisions. Women had least autonomy when it comes to major household purchases, with less than 1% of women claiming that they could make such decisions on their own. The only decision over which a significant minority of women (21%) claimed sole authority was over making small household purchases.

When comparing the men's responses to the women's, men were more likely to classify as "joint" decisions that women perceived to be principally in their husband's control. For instance, 71% of men

² The majority of women surveyed were not earning income of their own.

claimed to make “joint decisions” about childcare, while only 50% of women thought that this was a joint decision. Similarly, 53% of women thought husbands alone decided about whether women could visit their relatives; almost 50% of men stated that this was a joint decision. Interestingly, while 21% of women said that they could independently make small household purchases, only 11% of men believed this to be the case, suggesting that in practice, women may make some purchases without their husbands’ knowledge. Both men’s and women’s responses confirm that other family members (in-laws) play deciding roles about daily and large household purchases and about the woman’s ability to visit her own relatives.

The snapshot of decision-making control clearly illustrates that although mothers are considered the primary caregivers of the child, they are rarely the primary decision-makers about questions concerning the child’s health or their own nutrition. Thus, providing nutrition education to the mothers without supporting gender strategy to raise her decision-making status can have limited impact. The discrepancy between women’s and men’s perceptions about decision-making control is a reflection of the intricacy of intra-household bargaining negotiations. By stating that men have sole control over a decision such as child-care or visits to relatives, women may be deferring to men’s prescribed headship, while in practice they may have significant influence over the outcome of the decision. On the other hand, while men may perceive a decision to be “joint,” women may consider it to be a man’s decision, because men control the pocketbook. These discrepancies illustrate the need to merge quantitative with qualitative data to fully understand the bargaining process. Openly triangulating family members’ views on decisions can also be an instructive exercise for the nutrition education strategy and a first step toward challenging the skewed decision-making matrix.

Who usually makes decisions about...?							
Women's responses	Mainly self (wife)	Mainly husband	Couple jointly	Someone else	Husband and someone else	No income	
Woman's own health care	2.6	65.5	20.7	1.2	9.5		100
Spending woman's earnings	5	11.5	18.2	0.1	0.9	63.8	100
Major HH purchases	0.7	40	40.3	2.5	16		100
Purchases of daily HH needs	21	18.5	40.7	5.4	8.5		100
Visits to her family and relatives	0.5	53.9	28.6	2.1	12.3		
Child's health care	3.4	32.9	50.9	0.9	10.7		100
Husband's responses	Mainly wife	Mainly self (husband)	Couple jointly	Someone else	Myself and someone else	No income	
Woman's own health care	0.7	64.4	28.6	2.7	3.4		99.2
Spending woman's earnings	12.3	9.2	20.1	0.1	0.4	57.5	87.7
Major HH purchases	0.1	33.5	45.3	7.5	13.5		99.9
Purchases of daily HH needs	11.6	22.7	51.1	5.5	5.7		88.4
Visits to her family and relatives	0.4	34.3	48.1	5.4	11.7		99.6
Child's health care	5.9	16.5	71.9	1.4	3		94.2

3.2. Intra-household Disparities in Nutrition Knowledge

The Nobo Jibon project aimed for improvements in husband’s nutrition knowledge as a way of a) challenging the gender norm that nutrition and care are solely feminine responsibilities and b) recognizing that husbands in Bangladesh make most food purchases. The baseline knowledge test was also administered to mothers-in-law, who also influence IYCF practices. The indicator measures the proportion of respondents that scored at least 80% on the test. Results show that less than 1% (0.7%) of husbands and less than 5% (4.6%) of mothers-in-law attained that score.

Proportion of respondents who scored 80% or higher on nutrition knowledge test				
Valid responses	Husbands' scores		Mothers-in-law scores	
	Frequency	Percent	Frequency	Percent
Less than 80%	796	99.3	417	95.4
80% or more	6	0.7	20	4.6
Total	802	100.0	437	100

While mothers-in-law generally had better nutrition knowledge than husbands, responses varied widely. Almost all mothers-in-law (94.5%) knew that infants should be put immediately to breast after birth, and most knew about colostrum feeding. However, only 33.8% of men and 44.2% of mothers-in-law knew the appropriate duration of exclusive breastfeeding, and even fewer (25% of men, 18% of mothers-in-law) knew about the correct time to initiate complementary feeding. Just over half (56%) of mothers-in-law and 39% of husbands knew about appropriate breastfeeding of sick children. On micronutrient knowledge, 62% of husbands and 72% of mothers-in-law could name at least one food source of Vitamin A, but very few knew that post-partum women should take a Vitamin A capsule. Both groups were well informed on the signs of anemia and over 75% of both groups knew at least one way to prevent anemia. However, while 71% of mothers-in-law could name at least one food source of iron, husbands (who are generally the food purchasers) were less knowledgeable.

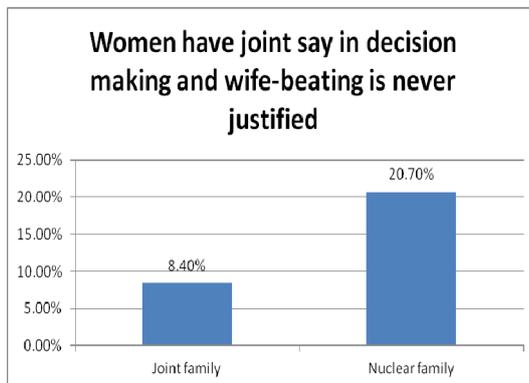
Nobo Jibon nutrition knowledge baseline results		Correct responses	
Q	Variable name	Husband	Mother-in-law
101	Name the first food or drink that should be given to an infant after birth	61.7	52.5
102	When should the newborn be put to the breast after birth?	73.9	94.5
103	What should a woman who has just delivered do with the first yellow breast milk?	54.4	81.7
104	How long should a woman feed her baby ONLY breast milk, without giving water or other liquids or foods?	33.8	44.2
105	At what age should a woman start to give other foods (semi-solids, liquids) in addition to breast milk to her child?	24.7	18.2
106	Name 3 foods that contain a lot of vitamin A? answer A	62.0	72.3
	Name 3 foods that contain a lot of vitamin A? answer B	33.7	37.1
	Name 3 foods that contain a lot of vitamin A? answer C	17.3	23.9
107	When should an adult woman take a vitamin A capsule?	12.7	15.8
108	List one sign of anemia?	82.4	88.6
109	List one way to prevent anemia? Eat iron rich food/ meat/dal	72.8	75.0
110A	Name 3 foods that are rich in iron (for good blood)?_ answer A	35.8	71.0
110B	Name 3 foods that are rich in iron (for good blood)?_ answer B	19.2	34.9
110C	Name 3 foods that are rich in iron (for good blood)?_ answer C	9.5	14.1
111	List one health problems that result due to too little iodine in the diet?	9.5	6.6
112	How much liquid/breast milk should you give a child with diarrhea?	39.4	56.3

Overall, mothers-in-law fared better than husbands on the knowledge test; however, less than 5% of mothers-in-law and less than 1% of men achieved an overall score of 80% on the test. Encouragingly, knowledge about early initiation of breastfeeding, colostrum feeding, and recognition of anemia were relatively high for both husbands and mothers-in-law. However, both target groups need further education on micronutrients—including recognizing the food sources of iron and Vitamin A. Given men's role in food purchases and health-care decisions, it is critical to reduce the knowledge gap in all of these areas.

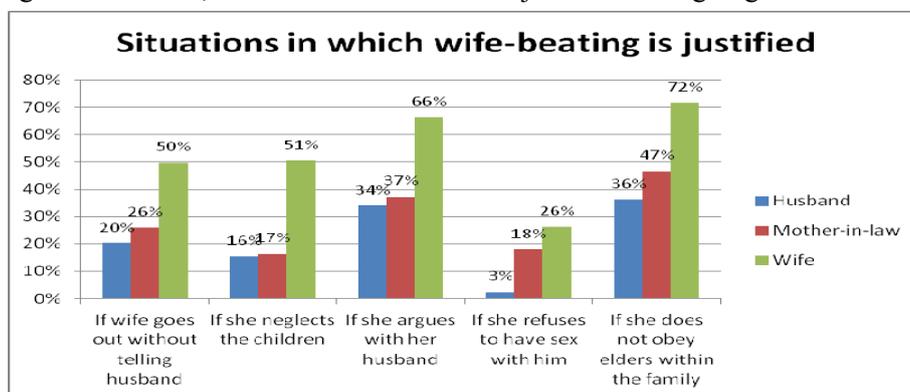
3.3. Attitudes Toward Violence Against Women

One end-line target for “increased equity” in the Nobo Jibon project aims for 25% of households to state that women have at least joint decision-making say in all five decisions AND that violence against women is never justified. The gender baseline used the DHS questions to examine attitudes toward violence against women (VAW). In all categories, the Nobo Jibon respondents were more tolerant of VAW than the national

averages recorded in 2007. All family members believed that disobeying elders was the gravest offense: 72% of women and 46.7% of mothers-in-law believed that disobedience justified beating. On the other end of the spectrum, the majority of family members—particularly husbands—seemed to believe that women have the right to refuse sex with their husbands without physical punishment.



The table below illustrates the degree to which women themselves have internalized and normalized violence. Half the women believed that violence was justifiable if they neglected the children or went out without informing their husband; two-thirds felt VAW was justified for arguing back with their husbands.



The baseline also indicates that in communication around this topic, greater attention may need to be focused at joint families. At baseline, already 20% of respondents from nuclear families meet the endline target, compared to just 8.4% of respondents from joint families. Given the violent consequences for women who disrespect elders, it is logical that women in joint families are less empowered to participate in decisions. Discussions of violence and power need to go hand-in-hand with information about practices that challenge the older generations' beliefs.

4. Implications for Gender-transformative Nutrition Education

The gender baseline highlights some of the key intra-household disparities and gender biases that can prevent or pervert optimal nutrition and health practices. The survey illustrates that although nutrition is normalized as a female domain in Bangladesh and mothers are recognized as children's primary caregivers, they are not empowered to make decisions even within that accepted caregiving role. Resources (including knowledge) and authority to make appropriate decisions are unequally distributed within the household. At baseline, mothers themselves have negligible control over their own health-care or that of their children. Conversely, men (and other family members) have final say over most household expenditures and decisions but do not have the knowledge resources to make appropriate food purchases and health-care decisions. Thus, targeting mothers alone with nutrition education can be highly inefficient and may misrepresent the actual involvement—and interest—of non-primary caregivers in nutrition and health decisions. Providing nutrition education to men and mothers-in-law can give the primary caregivers the support they need to adopt new practices.

Endemic domestic violence also presents an obvious challenge to mothers' uptake of new nutrition practices. Nutrition education often asks mothers to adopt practices that contradict traditional beliefs or that

require women to request husbands to make different food purchases; yet disobeying elders or arguing back with one's husband can justify a violent response. The high tolerance for VAW among women themselves indicates how deeply they have internalized and normalized beliefs about their secondary status. Asking women to make self-care practices (such as eating more during and after pregnancy, taking rest, or spending household resources on health visits) may contradict social expectations about women's altruism, self-sacrifice, and gendered work responsibilities. Thus, empowering women to adopt optimal nutrition practices also requires gender education that makes it socially acceptable for women to value and care for themselves without fear of repercussion.

This baseline confirms that confronting gender inequality is not only intrinsically important but is instrumental to the success of the nutrition education strategy. Providing husbands and mothers-in-law with nutrition education can more equitably distribute intra-household knowledge resources. At the same time, gender training activities that expose skewed decision-making disparities can create the space for communities to recognize and challenge the gender norms and practices that perpetuate malnutrition and food insecurity.

5. Acknowledgements

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