Effects of women decision making power on rural children nutritional status in Ogun State of Nigeria

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SUMMARY

Women's authority over specific family decisions tends to increase their financial security and power, which has an impact on their children's general health and well–being. A multistage sampling process was employed to choose 120 households. Primary data on the children's nutritional status, the household's socioeconomic characteristics, and women decision–making were gathered using a well–structured questionnaire. The children's mean body mass index was 9.62 kg/m^2, indicating underweight. It was also demonstrated that women had little influence over the quantity of farm produce consumed or sold, nor the number and spacing of their children. On the other hand, rural women make decisions about the daily diet of the home, the education of the children, the kind of medical assistance the child receives while ill, and the amount of parental guidance the youngster receives. However, the women decision making index (WDMI) which measures the negotiating power of women was 0.537. With the age of the mother, gender of child, women decision–making index, farm size, farmers association, and farming experience influencing the children nutritional status. Therefore, as it tends to improve the nutritional outcomes for children, it is advised that women be given more control.

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1. Introduction

Improving women's ability to make decisions in their own homes can boost their financial stability and negotiating power, which may have a big impact on their kids' health and happiness. Research on bargaining in the context of households demonstrates that women's security–related assets may boost their negotiating power by strengthening their fall–back position, which can change intra–household spending patterns even in situations where the household budget remains constant (Agarwal, 1994; Pitt et al., 2006; Deere and Twyman,

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2012). Women's intra–household bargaining power has a major impact on the nutritional status of their children (Cunningham, 2015; Kulkarni et al., 2020). Bargaining power is the relative social and economic standing of a woman in a home with regard to her ability to manage and access resources as well as her ability to make decisions (Doss, 2013; Kulkarni et al., 2020). The capacity of a woman to make choices on her own is known as maternal autonomy, and it has been linked to better nutrition outcomes for her children. More independent women might decide to put their kids' dietary needs first (Malapit et al., 2015). Children's nutritional status and women's negotiating power in households are correlated in a complex way that is influenced by gender, socio–cultural, and economic factors.

Women's negotiating power is a critical factor in determining the nutritional outcomes of children since they frequently take on the primary role in family care giving and food distribution. Research indicates that women with greater negotiating power are inclined to distribute resources, such as food, in a way that enhances their offspring's nutritional well–being (Duflo, 2012). This highlights how crucial it is to provide women in households the authority to decide on nutrition–related matters. Decision making women are more likely to guarantee that a range of nutrient–dense foods are available, which improves the nutritional outcomes for children (Malapit et al., 2015). The power of mothers to make healthcare decisions affects children's access to preventative care and other health services. Research reveals that empowered mothers are more likely to seek medical attention when needed, which improves the health and nutritional quality of their children (Smith and Ramakrishnan, 2007). Women who are empowered have a significant role in ending the intergenerational cycle of malnutrition. Research indicates that women who possess the ability to make their own decisions make decisions that have a beneficial impact on the nutritional condition of their offspring, resulting in long–term benefits in subsequent generations (Mason et al., 2012). Understanding these intra–household bargaining patterns is crucial when developing policy since the effects of the policy can differ depending on the intra–household relationships that a household bargaining model may look at. Women having greater negotiating power can obtain knowledge, make informed decisions, and follow advised practices to lower the rate of malnutrition. Women's bargaining power has been found to be significantly influenced by their level of education. Children's nutritional outcomes are improved because educated mothers frequently hold more decision-making power (Smith and Haddad, 2000). Gaining more economic, social, and human capital through bargaining power gives women the advantage over men when it comes to child rearing and nutrition (Engle et al., 1999). The standard of care given to children is one of the three main determinants impacting their nutritional health, together with home food security and the physical environment, since women are typically the primary caregivers for children. Therefore, the ability of women to make decisions in this domain significantly influences the quality of child nutrition. But women's empowerment also has a knock-on effect since it impacts their own nutrition and health, which are vital for giving kids the attention they require at every developmental stage (Smith et al., 2003).

Malnutrition is a major cause of resource waste and productivity loss since undernourished children are less productive as adults both physically and intellectually (Gillespie and Haddad, 2001). As a result, it seriously impedes the actual development process. The causes and remedies for child malnutrition have been extensively explored, but up until recently, the significance of women's status in influencing their children's nutritional health was largely disregarded. However, there are notable regional variations in the extent to which women's status influences newborn nutrition and the pathways via which it does so.

Empirical validations have demonstrated a robust, positive relationship between high women's status and children's nutritional status (Smith et al., 2003; Amgusi et al., 2016; Galie et al., 2019). A large portion of this research depends on incredibly vague standings for female bargaining power. Accurately assessing women's negotiating power is challenging due to the context specificity, multidimensionality, and complexity of evaluating a "process" (Malhotra et al., 2005). The question of how a child's caregiver's capacity and well–being – ypically the mother – affect the child's health and nutrition has received far too little attention in this regard. Despite being obviously relevant, hardly much research has been done on this question. The multifaceted phenomena of women's negotiating power's effect on children's nutritional status is influenced by a number of different elements. Women can make better decisions that will improve their children's nutritional well–being if they are empowered through education, economic opportunity, and cultural standards. Recognizing and resolving gender-based differences in bargaining power is essential to promoting long–term favorable nutritional outcomes as worldwide efforts to combat hunger continue.

The purpose of this research was to answer the following question: is the degree to which women's bargaining power affects children's nutritional status a defining characteristic of their position? Therefore, understanding the linkages between women's power relative to men within homes and child nutrition in the research region becomes necessary in order to test the hypothesis that the mother's intra–household bargaining power is affecting the kid's health and nutritional status experimentally. Effective treatments must acknowledge and address factors that impede women's decision-making, such as cultural norms and uneven power dynamics. To improve child nutrition, policymakers should concentrate on programs that empower women, advance gender equality, and increase women's involvement in decision making processes (Malapit et al., 2015).

2. Literature review

Child nutrition is impacted by women's economic empowerment, which includes their access to employment opportunities and income. Financially independent women are more likely to make nutritional and health–related investments for their offspring. Gender roles and cultural norms greatly influence women's negotiating power and, in turn, the nutritional results for children. According to Heise et al. (2019), tackling gender stereotypes that impose restrictions is essential to advancing fair resource distribution in homes and creating an atmosphere that supports better nutrition for children.

In addition to changes in the budget constraint, variations in the utility function brought about by relative power shifts within the home also affect the health of children. Maitra (2004) and Lépine and Strobl (2013) assert that parents, more especially, the mother and father determine the degree of achievement in a child's health. Highly empowered women may have more control over household food budgets, how food is allocated, and how they choose to feed their children than do women with less bargaining power, which could improve diets and nutritional status (Jones et al., 2019). The definition of the mother's relative negotiating power is her power within the union less the reserve utility for convenience. The parents select market and non–market based goods, and the households are faced with the utility maximization problem of maximizing the difference between their utility level and their reserve utility, the latter of which represents each parent's utility outside of the union (Lépine and Strobl, 2013). Therefore, it is not surprising that improved ideal newborn and early child

feeding practices (Ickes et al., 2017) and higher household and personal dietary diversity are associated with women's empowerment (Amgusi et al., 2016; Galie et al., 2019). What really defined the parents' bargaining power were their distinct characteristics, which included their level of productivity, occupation, human capital in terms of education combined with the parents' social status, and a vector of prices that are thought to proxy the area's prices, especially the costs of food and medical services, among many other factors. Incorporating women's empowerment into social and behavioral techniques for promoting nutrition may result in a change in women's position as "last and least" in food priorities (Gittelsohn et al., 1997; Ruel and Alderman, 2013; Carlson et al., 2015).

The idea that bargaining power is influenced by other unobserved parenting aspects may be challenged by the submissive behavior of women in marriage as observed in a typical Nigerian household context (Maitra, 2004). It should not be entirely disregarded, though, as there is a possibility that women will be more able to negotiate because they are mothers by nature and because the husband has failed to fulfill his socially expected role as the household's financial provider and raise the children. Therefore, the relationship between negotiating power and parenting style is yet unknown a priori.

3. Variables and methodology

A multistage sampling strategy was used for this investigation. Due to its cost–effectiveness, logistical viability, lowered sample frame needs, geographic representation, administrative ease, enhanced precision, and sampling design flexibility, multistage sampling approaches were adopted (Scheaffer et al., 2011). Because of these benefits, multistage sampling is especially appropriate for large and diverse populations, for whom other methods of sampling might not be feasible. Using a table of random numbers, the first stage involved selecting at random 25% of the four Agricultural Development Programme (ADP) zones in the Ogun State, with Abeokuta zone selected. Selecting two blocks at random from the chosen ADP zone was the second stage. Subsequently, three randomly chosen cells were chosen from the designated blocks, and the last stage involved choosing twenty randomly chosen houses from the cells, making a total of 120 households in the sample. Descriptive and inferential statistics were used to analyze primary data on the socioeconomic features of the homes, the nutritional status of the children, and decision making.

Children under five years old's nutritional status was assessed using their body mass index (BMI). Estimates of the children's nutritional results are provided by BMI. Plotting BMI percentiles is a typical practice on growth charts created by agencies like the Centres for Disease Control and Prevention (CDC) and the World Health Organization (WHO). These graphs enable the categorization of nutritional status based on percentiles by comparing a child's BMI to a reference population (CDC, 2021). According to the WHO (2006) BMI is a recognized anthropocentric metric for evaluating children's nutritional health. It is computed as weight in kilograms divided by the square of height in meters. In order to distinguish between underweight, normal weight, overweight, and obesity, it offers a quantitative measure:

$$BMI = \frac{weight\ (kg)}{height\ (m)^2}. \tag{1}$$

The youngsters were divided into three categories based on their BMI: underweight, healthy weight, and overweight. Youngsters who have BMIs below the fifth percentile are

frequently labeled as underweight or malnourished. This percentile is essential for identifying kids who might be struggling with growth and development issues or be at danger of consuming too little calories. Kids who fall between the 5th and 85th percentiles on the BMI scale are deemed to be of a healthy weight. Based on the growth charts supplied by organizations like the World Health Organization (WHO, 2006) and the Center for Disease Control and Prevention (CDC, 2021), this range is considered normal weight for their age and sex. Children who have a BMI that is at or above the 85th percentile are often considered overweight, while those who have a BMI that is at or above the 95th percentile may be considered obese. A crucial cutoff point for determining which kids are at danger of being overweight or obese–diseases linked to multiple health complications is the 85th percentile.

The women decision making index (WDMI) was used to gauge the decision making power of women. This score measures the extent to which women engage in household decision making. The ladies were asked to respond to a series of inquiries concerning household decision making. The entire number of points (n) was computed and divided by the total number of questions (q) to represent the respondents' household decision making index, as follows:

$$WDMI = \frac{n}{q}. \tag{2}$$

The degree of women's involvement in household decision making increases with the WDMI's proximity to 1, whereas the degree of women's involvement decreases with the value closest to 0.

A multinomial logistic regression model was used to estimate the impact of women's bargaining power on the nutritional outcomes of the children involved. A strong statistical method for modelling associations between one or more independent variables and a categorical dependent variable with more than two unordered categories is multinomial logistic regression. By extending binary logistic regression, this technique makes it possible to analyze complicated categorical outcomes (Agresti, 2003). Multinomial logistic regression makes the same assumptions as binary logistic regression, namely that there is a linear connection between the predictor variables and the log–odds of the outcome categories. It also presupposes that there is no separation in the data and that multicollinearity is not perfect (Allison, 2012). In accordance with Obalola et al. (2021) the fundamental model is expressed as:

$$P_{ik} = \frac{e^{\beta_j X_i}}{1 + \sum_{k=1}^{j-1} e^{\beta_k X_i}}, \tag{3}$$

where $\beta_j X_i$ is linear predictor function in explicit form:

$$\beta_j X_i = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \beta_3 x_3 + \cdots + \beta_9 x_9 + u. \tag{4}$$

while β_j is a vector of parameter that relates independent variables X's to the probability of being in group j where there are k groups considering following specification: K = nutrition outcome (defined as 1 if healthy, 2 if under weighted and 3 if over weighted), x_1 = age of the mother (years), x_2 = gender of the child (1=male or 0=female), x_3 = household size (number of person), x_4 = education attainment of the mother (years), x_5 = women decision making index (WDMI score), x_6 = farm size (hectare), x_7 = farming experience (years), x_8 = cooperative membership (1 = member or 0 = otherwise) and x_9 = farmers'association (1 = member or 0 = otherwise).

4. Results and discussion

The majority of the women (55.83%) in Table 1 are still relatively young, active, and nimble, which may have a beneficial impact on how they make decisions for the home. The women were all married, and given that the majority of them (64.16%) claimed that their households had between one and six people in them, with an average of seven, it is likely that they sought to have a high feeling of responsibility owing to family needs. People who are educated appear to be exposed to concepts that could improve the well-being of their household. With a few exceptions, it can be stated that the women lacked formal education, with 32.5% having only completed elementary school and 27.5% finishing secondary school. Being able to exercise one's right to farmland and chooses what to plant to increase household income and consumption is severely limited because the majority of rural women (65%) do not own their farmlands, making it difficult for them to exercise this right. This inevitably influences the decisions they make in their home. According to reports, women have access to an average of 0.4 hectares. This suggests that the majority of rural women were smallholders, controlling less than one hectare of land.

Table 1. *Socioeconomic characteristics of the women (n=120)*

Variable	Frequency	%	Mean
Age			34.98
< 30 years	29	24.17	
30–40 years	67	55.83	
41–50 years	23	19.17	
> 50 years	1	0.83	
Household size			7.05
1–6 persons	77	64.16	
7–12 persons	32	26.67	
> 12 persons	11	9.17	
Level of education			
Non–formal	48	40.00	
Elementary	39	32.50	
Secondary	33	27.50	
Farm ownership			
Doesn't own farmland	78	65.00	
Own farmland	42	35.00	
Farm size			0.405
< 1 hectare	107	89.17	
1–2 hectares	9	7.50	
> 2 hectares	4	3.33	

The study aimed to measure the welfare level of children under five years old using the body mass index (Table 2). The results showed that 15% of the children were healthy weighted because their BMI fell between 10.36 and 15.27 kg/m^2, or between the fifth and 85th percentiles; 80% of the children were underweighted because their BMI fell below 10.36 kg/m^2, or below the fifth percentile; and 5% of the children were overweighed because their BMI fell above 15.27 kg/m^2, or above the 85th percentile. With a mean BMI of roughly 9.62

kg/m^2, most of the kids appear to be underweight.

Table 2. *Nutritional classification of the children less than five years old*

Body mass index (kg/m^2)	Frequency	%
Overweight	6	5.00
Underweight	96	80.00
Healthy weight	18	15.00
Mean	9.62	
Minimum	7.04	
Maximum	18.62	
5th percentile	10.36	
85th percentile	15.27	

Table 3. *Women bargaining decisions*

Decision	Frequency	%
Number and spacing of off springs		
No	89	74.17
Yes	31	25.83
Volume of farm produce consumed or sold		
No	82	68.33
Yes	38	31.67
Cost of expensive purchases		
No	109	90.83
Yes	11	9.17
Daily household meals		
No	8	6.67
Yes	112	93.33
Children education		
No	57	47.50
Yes	63	52.50
Type of health care aids		
No	53	44.17
Yes	67	55.83
Child's first point of call		
No	39	32.50
Yes	81	67.50
Parental guidance to child		
No	24	20.00
Yes	96	80.00
Cost of less expensive purchases		
No	39	32.50
Yes	81	67.50

According to Table 3, the majority of rural women (74.17%) do not determine the number and spacing of their children, the quantity of farm produce to be consumed or sold in their homes (68.33%), nor do almost all (90.83%) foot the bill of expensive purchases in their homes. However, the majority (93.33%) of the rural women make decisions about the daily diet of the household, the education of their children (52.50%), the kind of medical care they receive when sick, and much more (55.83%). They also frequently foot the bill for less expensive household purchases like food (67.50%) and provide their children with more parental guidance (80%).

The women's decision power was measured using the women decision–making index. With a mean value of 0.537, the findings showed that rural women in the research area made 53.7% of the decisions in their households on average (Table 4). The rural women's decision index ranges from 11.1% to 88.9%, at the lowest and the highest, respectively. It follows that the majority of rural women make more than half of the decisions in their home, which will likely improve the nutritional results for their children.

Table 4. *Women decision making index*

Decision–making index WDMI	Value
Mean	0.537
Minimum	0.111
Maximum	0.889

Multinomial logistic regression was utilized to investigate the impact of women's negotiating power on the child nutritional outcome categories, with overweight serving as the reference category. At the p–value less than 1% significance level, the chi–square statistic showed how well the model fit the overall data. The model was shown to be statistically significant according to the Wald chi–square, and the pseudo R^2 indicated that the explanatory variables that were significant together accounted for 24.9% of the variation in the welfare categories. The child outcome category was negatively correlated with the marginal effects of the mother's age (-0.006), the kid's gender (-0.052), the women's decision–making score (-0.312), and the size of the farm (-0.032). This suggests the possibility that the child will be under weighed by each of these factors, coefficients will decrease with a unit increase in these variables. The decision making index revealed a lower likelihood of been underweight, that is, there is about 31.2% decrease in likelihood of been underweight as a result of increase in decision making power of the women. The study examined the marginal impacts of farmers association and found that children of rural women who are members of the association have a 2.8% higher likelihood of being underweight when compared to their non–member counterparts.

When comparing children who weigh healthily to those who are overweight, the outcome category is adversely correlated with the child's gender and farming experience. The probability that a male infant will weigh healthily is 6.4% lower than that of a female child, according to the genders' marginal effects, and this difference is significant at 10% significance level. This suggests that compared to female children, male children are less likely to be weighed healthily. Once more, a year's worth of agricultural experience gained by rural women is expected to decrease the likelihood of a healthy kid by 2.3%; this difference is statistically significant at 5% level. On the other hand, a distinct stance represents the farmers' association and the decision–making index. There is a 30.8% rise in the likelihood that the

child will be weighted healthily for every unit increase in the women's bargaining power. Similarly, children of rural women who are members of farmers associations have a 17% higher chance of being healthy weighted than children of rural women who are not members of farmers associations. This is explained by the ease of financing availability for women who are members of farmers associations. Their children's welfare situation should improve as a result.

Table 5. *Effects of women's decision–making on the child nutritional outcomes*

Reference: overweight	Underweight			Healthy weight		
Variable	Coefficient	t–value	Marg. eff.	Coefficient	t–value	Marg. eff.
Age of mother	-0.218^{***}	-2.600	-0.006	-0.060	-1.130	0.000
Gender of child	-2.349^{*}	-1.680	-0.052	-1.130^{*}	-1.660	-0.064
Household size	0.099	0.830	0.000	0.096	0.990	0.009
Education of mother	0.155	1.380	0.001	0.136	1.400	0.012
Decision–making index	-7.683^{***}	-3.770	-0.312	5.203^{***}	3.250	0.308
Farm size	-1.206^{*}	-1.890	-0.032	-0.425	-1.480	-0.012
Farming experience	0.015	0.140	0.007	-0.171^{*}	-2.140	-0.023
Cooperative membership	1.091	0.950	0.017	0.734	1.280	0.057
Farmers association	2.524^{**}	2.040	0.028	1.982^{**}	2.330	0.170
Constant	11.008^{***}	3.430		5.822^{**}	2.190	
Prob>chi–square	0.000^{***}					
Pseudo R^2	0.249					
Wald chi–square(20)	66.480^{***}					

Note: $^{*}p < 0.1$, $^{**}p < 0.05$, $^{***}p < 0.01$ denote 10%, 5% and 1% significance levels

5. Conclusion

The results of this study highlight how important it is for women to have decision making authority in their homes since it shapes power relationships, economic security, and ultimately the health and well–being of their offspring. The study explored the complex links between women's decision making, socioeconomic conditions, and children's nutritional status by using a multistage sampling approach within 120 rural households in Ogun State of Nigeria. The children's underweight status, as indicated by their mean body mass index (BMI) of 9.62 kg/m^2, raises serious health concerns. It's interesting that the study showed that women had no influence over several aspects of reproductive decisions, including the quantity of farm produce sold or consumed and the number and spacing of offspring. But in important areas like setting the daily household food, influencing children's education, directing healthcare decisions for their offspring, and offering vital parental counsel, women demonstrated influence and decision making ability. Women clearly have a say in these important areas, as evidenced by the household decision making index, which shows women's bargaining power at 0.537. The research shed additional light on the complex relationships between women's negotiating power and child welfare, taking into account several factors such as the mother's age, the kid's gender, the decision making index, farm size, farmers association and farming experience.

The study recommends greater empowerment of women in households in light of these findings. There may be benefits to giving women more influence over decision making,

especially when it comes to enhancing children's nutritional status. Women can help create safer and healthier environments for their children, as they become increasingly important decision makers when it comes to everyday needs, education, healthcare, and parenting. The study's conclusion emphasizes the critical connection between women's ability to make decisions, child well–being, and nutritional results. Policymakers and communities may both make a substantial contribution to the general development and well–being of children by recognizing and valuing the role that women play in home decision making. In addition to being necessary for gender fairness, the need for greater control and empowerment for women is also a means of fostering stronger, healthier communities.

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Utjecaj moći odlučivanja žena na status uhranjenosti ruralne djece u državi Ogun u Nigeriji

SAŽETAK

Autoritet žene nad određenim obiteljskim odlukama povećava njihovu financijsku sigurnost i moć, što utječe na opće zdravlje i dobrobit njihove djece. U odabiru 120 kućanstava korišten je višefazni proces uzorkovanja. Primarni podaci o statusu uhranjenosti djece, socioekonomskim karakteristikama kućanstva i odlučivanju žena prikupljeni su pomoću dobro strukturiranog upitnika. Prosječni indeks tjelesne mase djece bio je 9,62 kg/m^2, što ukazuje na pothranjenost. Također, pokazano je da su žene imale nizak utjecaj na količinu konzumiranih ili prodanih poljoprivrednih proizvoda, niti na broj djece. S druge strane, ruralne žene donose odluke o dnevnoj prehrani u kući, obrazovanju djece, vrsti medicinske pomoći koju će dijete dobiti dok je bolesno i o količini roditeljskog nadzora koje dijete dobiva. Međutim, indeks odlučivanja žena (WDMI) koji mjeri pregovaračku moć žena bio je 0,537. Uz dob majke, spol djeteta, indeks odlučivanja žena, veličinu farme, udrugu poljoprivrednika i iskustvo u poljoprivredi, utječu na prehrambeni status djece. Stoga, budući da se nastoji poboljšati prehrambeni status djece, savjetuje se da žene imaju veće kontrole.

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