

POLICY BRIEF

Mothers' Spending Decisions, Ethnicity and Child Malnutrition in Ghana

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1. Situational Analysis of Child Malnutrition in Ghana

Although progress is slow, Ghana has, in the past two decades, recorded improved child nutrition. However, premised on the revised data from the 2008 Ghana Demographic Health Survey (GDHS) and the four earlier surveys (1988; 1993; 1998 and 2003), the proportion of underweight (measured as weight-for-age) children decreased from 23 percent in 1988 and 1993 to 14 percent in 2008. The proportion of wasted (measured as weight-for-height) children has decreased over the past 15 years from 14 percent in 1993 to 9 percent in 2008. However, progress has been slow in addressing the critical indicator, that is chronic undernutrition or stunting (measured as height-for-age). Overall, the proportion of stunted children under 5 years of age (below -2 SD) decreased from 34 percent in 1988 to 31 percent in 1998, and rose to 35 percent in 2003 before decreasing to 28 percent in 2008, while 10 percent were severely stunted (-3 SD).

Reflecting further on the prevalence of stunting using the 2008 GDHS, children aged 18-23 months (40 percent) were most likely to be stunted and those less than 6 months were the least likely to be stunted (4 percent). The level of stunting was higher in rural areas (32 percent) than in urban areas (21 percent). Stunting was highest in the Eastern and Upper East regions (38 and 36 percent, respectively) and lowest in the Greater Accra region (14 percent). In a nutshell, Ghana is still far from reaching the World Health Organization's (WHO) standards for a healthy population. For stunting, the WHO defines a prevalence rate at less than 20 percent as acceptable for a population. With its most recent rate of 28 percent, Ghana falls between the poor and serious status. Rigorous diagnosis of multiple determinants of stunting prevalence at the subnational level precedes improved policy prescription. Mere observations of patterns of child malnutrition in Ghana do not suffice.

The attendant adverse problems associated with child stunting are child mortality and impaired human capital. Stunting accounts for between one third and one half of mortality rates for children under 5 years of age. This constrains the nation's ability to achieve the fourth Millennium Development Goal. Surviving children are exposed to the risk of impairments in cognitive capability, schooling and adult productivity, and have higher exposure to lifelong disease. Impaired human capital of the next generation worsens the nation's prospects for a broad-based economic growth. The risk of intergenerational transmission of poverty is increased.

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2. Recent Government Intervention

The Government of Ghana (GoG), in an attempt to mitigate the problem of child malnutrition, has instituted a number of policies that are either directly or indirectly related to child health. Among some of the policies and initiatives that have been embarked on since 1988 are the Exclusive Breastfeeding Programme, the Safe Motherhood Initiative, National Health Insurance, Creating Wealth through Health, Free Delivery of Health Services in all Health Facilities, the Strategic Document for Child Health, and the establishment of a Nutrition Unit.

3. Determinants of Child Malnutrition

The academic discourse on determinants of child malnutrition in Ghana (referring to national-level studies) is vast and dates back to the first Ghana Living Standard Survey (GLSS) in 1987. Consistent with the arguments in the broader literature, issues such as the mothers' health and education, household characteristics (including income) and community level variables (to be provided by government, such as the above) have been identified as the major socio-economic factors that influence child malnutrition in Ghana. While this brief does not intend to dismiss the validity of any of these factors, it side-steps them in order to rethink the relationship between cultural practices (measured by ethnicity) and the mothers' role in spending decisions on one hand, and on the other, the relationship between mothers' spending decisions and child nutrition. The motivation is premised on the anecdote that mothers tend to spend more on commodities that promote children's health than fathers. It is important to keep in mind that spending decisions in this context are strictly defined as "who (mother or father – measured as 1 if the mother is solely responsible for making such spending decisions and 0 otherwise) makes the decision on the basket of regular items consumed in the household and not decisions on amount to spend and household capital/durable goods".

Academic evidence across the globe suggests that the differing cultural situations of women affect their children's survival. Some anecdotes from South East Asia suggest that practices such as food taboos post pregnancy and childbirth lead to child malnutrition. On the other hand, a plethora of studies based on women's empowerment and intrahousehold decision making (bargaining models) support the argument that a child's health is a function of the mother's empowerment. While such studies have illuminated the academic discourse on the effect of a mother's characteristics on a child's nutrition, the capacity to distil precise policy instruments remains unclear and also the relationship between power, earnings and management of household financial resources remains fuzzy.

In this paragraph, I step back to reflect on the relationship between gender roles in spending decisions, earning and power in a household. This relationship continues to attract wide-ranging debate because of the different theories that have been associated with the linkages. One school of thought argues that earnings drive both power and gender roles in spending decisions, while another perspective suggests that both the source of earnings (either mother or father) and power have a minimal relationship to managing the household resources (in this case who makes the final decision on what to purchase). The former case makes it more likely to associate decision making only with power and earnings while the latter prompts the search for other main determinants that drive gender roles in household spending decisions. It is on the premise of the latter case that this policy brief looks at the issue of cultural factors as one of the major drivers of household decision-making in the Ghanaian context.

I argue in this policy brief that the relationship between ethnicity and the mother's role in child nutrition is either direct or indirect, depending on the nature of cultural practices. Thus, in a setting with cultural practices such as food taboos, restrictions on place of childbirth, age at marriage and gender exclusion, the effect will be direct on the health of the mother (which is the most obvious channel) and this will be transmitted directly to a child's health. Another channel which is less obvious but worth considering relates to the cultural practices that affect the mother's role in the household, thereby constraining her to engage in activities that enhance a child's nutritional status. This brief focuses on the latter argument and concentrates specifically on how mothers' spending decisions affect child malnutrition in the context of different ethnic groups in Ghana.

4. Analytical Evidence in Support of Policy Recommendations

To engage with this analysis, I focus on the Gruma and Hausa ethnic groups. The choice of these two ethnic groups is based on the distribution of the ethnic group across the 10 regions of the country and the prevalence rate of child stunting across the regions. I use the fourth round (2003) of the GDHS. The GDHS is nationally representative and captures variables of interest to this discourse. Regression analyses (Ordinary Least Squares and Instrumental Variable estimations) are used in testing the hypothesis that mothers' spending decisions affect child health through cultural practices. Details of the data structure and econometric analyses are available in the extended/technical version of the paper. To contextualize our results from the regression analyses, we present some descriptive results from the 2003 GDHS. Residents of the Northern region of Ghana include about 74 percent and 21 percent of Grumas and Hausas respectively. In terms of the mothers' role in spending decisions, almost two in every three women among the Grumas do not make spending decisions, while in the case of Hausas, two out of every five women do not make spending decisions. Keeping this in mind, we observed that the prevalence of severe child stunting in the Northern region in 2003 was almost twice that of the neighbouring region (Upper West), which had the second highest prevalence of child stunting.

Based on the above, I engage in further analysis to assess the validity of the hypothesis that child malnutrition is affected by cultural practices related to mothers' spending decisions. Literally, the procedure I use is to find the relationship between cultural practices and mothers' spending decisions as a first step and then follow up with an analysis of the relationship between the mothers' spending decisions and child malnutrition. In both stages, we condition the analysis on the other determinants of both mothers' spending decisions and child malnutrition. Conditioning the analysis on the other determinants of both mothers' spending decisions and child malnutrition ensures identification (isolation) of the effect of cultural practices in the first stage and mothers' spending decisions in the second stage. The result from this analysis corroborates the hypothesis that mothers' spending decisions, when influenced by cultural practices, robustly affect child malnutrition

To carefully isolate the effect of mothers' spending decisions, I consider the following scenarios: (1) mothers belonging to the wealthiest households; (2) mothers having the highest level of education; and (3) mothers belonging to the wealthiest households and having the highest level of education. In each of the cases, I find that the mothers' role in spending decisions results in a reduction in child stunting.

5. Policy Recommendations and Implications

In view of the above findings, I propose the following three policy recommendations.

5.1 Awareness Creation

Creating awareness of the need to evaluate the gender roles of both mothers and fathers within a household is important. The first point of call is to encourage such a discussion between parents in the household, with a clear priority for the child's nutrition. Since household priorities are malleable, a regular review of this exercise is imperative. For instance, since the issue of stunting is most critical when the child's age is between - 9 and 24 months it is important that parents and communities become aware of this critical window for prevention. Hence, in cases where mothers generally are not responsible for spending, I propose that at certain periods in the household's lifecycle especially when children are young, mothers should assume responsibility for spending decisions.

Well-orchestrated communications are essential. The issue of cultural practices is a sensitive one as it measures identity, hence a careful and well thought through approach is imperative. It is therefore important to start with sensitizing the community elders to this finding and to collectively owning the approach to the discussion of gender roles in a household. The support of health workers, women's groups and the broader community would encourage malleability of traditional cultural practices. Also, it is important to appreciate that certain caveats such as working roles, health conditions and other exogenous factors will make it impossible for households to enjoy the flexibility of changing gender roles to suit their priorities at any point in time. Finally, it is important to note that such discussions are a potential source of intrahousehold conflict; hence strategies aimed at changing behaviour should be preceded with counselling for the parents on the ultimate aim of reducing child malnutrition.

5.2 Nutrition Education

The Nutrition Unit should embark on educating the populace on both the medical and non-medical determinants of acceptable nutritional status and should highlight both the short-term and long-term adverse consequences of malnutrition. Immediate effects of chronic undernutrition are deficits in dietary energy for mother and child, impaired protection from disease and deficient childcare. The aim is to develop a culture of discussing nutritional issues at all levels of relationships, especially between parents in a household. The GoG through the Ministry of Health (MoH) should invest in providing households with nutritional charts. Beyond recording essential protection from infections of mother and child, these charts on anthropometric indicators for different age groups of children, should include information on sources of micronutrients and calories, and the frequency of intake for each child. Information on sources of micronutrients and kilocalories should be based on the major basket of food items consumed in different localities in Ghana. Investing in research and development in this area is a useful step as dietary intake changes over time for reasons such as migration and shifts in major economic activities for localities.

5.3 Joint action between NGOs, Development Partners, Vulnerable groups and the GoG

This recommendation is premised on the different stakeholders involved in implementing the above two recommendations. Duplicating and presenting conflicting information, for instance on prevalence rates of child stunting and major determinants of child stunting, will defeat all intended positive effects of any single strategy. This policy brief calls for harmonized interventions and they should involve vulnerable groups that are malnourished.

A final comment on the implications of the above policy recommendations is that the cause of child malnutrition does not end with mothers' characteristics and cultural practices; hence continuous research in this area is important. Among the several issues that are not covered in the GDHS, and that therefore restrict analysis of this issue, are food security and child malnutrition, and an examination of the wage–nutrition hypothesis. My call here is for attention to the role of gender in intrahousehold decision making on childcare. Beyond this I postulate that much greater attention to the need for convergent simultaneous sectoral interventions – via better resource use efficiency – will be a further step in accelerating a reduction in chronic undernutrition. This is a call to revisit the scope of data collection in Ghana and synchronize the GDHS with the GLSS. The potential payoff cannot be ignored; that is, improved diagnosis of multiple determinants of stunting, household and community awareness, and government decision making capabilities at district level that support convergent interventions.