2010

Gender, discrimination and child survival

Policy brief

Children's chances of surviving to the age of five are heavily influenced by whether they are a girl or a boy. This is partly because of genetic differences between the sexes, but mostly because of the different status and roles assigned to men and women – or gender differences. Unequal life chances and a failure to address discrimination on the basis of gender is an injustice. It is also slowing progress towards Millennium Development Goal (MDG) 4 – a two-thirds reduction in child mortality by 2015.

Overcoming discrimination, particularly against girls and women, is an urgent development priority in its own right. It is also crucial to child survival. The challenge goes beyond the critical need to reduce the number of women dying in pregnancy and childbirth (as well as better tackle the associated risks for their children) to the very roots of the problem- social and structural discrimination on the basis of sex.

This briefing identifies the different ways in which gender affects children's health and survival, and recommends actions to achieve equitable reductions in child mortality for girls and boys.[1]

Sex, gender and physical determinants of child survival

Although newborn girls have a greater chance than boys of surviving to their first birthday,[2] many developing countries have strikingly high rates of female child mortality. This suggests that adult behaviour that discriminates against girls often starts at an early stage, ranging from medical and nutritional neglect to abuse and infanticide. [3] In 1990 the Nobel prize economist Amartya Sen estimated that 60 million women were 'missing' from the global population as a result of these factors, mainly in South and East Asia.[4] Although the proportion of missing women has gone down slightly – with considerable improvements in West Asia, North Africa and parts of South Asia – the overall number has risen.[5]

In some countries, where there is a cultural or economic preference for boys, sex-selective abortions are skewing the male to female ratio.[6] In China, for example, there are 117 boys born for every 100 girls.[7]

Social and cultural traditions

Socio-cultural norms and traditions often limit women's ability to control household income, gain access to services and participate in decisions. This has a powerful bearing on children's health and wellbeing. For example, gains in women's relative power strongly influence children's nutrition. One study found that if women and men had equal status in South Asia, the percentage of underweight children would decline from 46% to 33% – a reduction of 13.4 million malnourished children.[8] Malnutrition is an underlying cause in 35% of child deaths.[9]

a. Reproductive health and physical integrity

Women's ability to negotiate when and with whom they have sexual intercourse and to manage their fertility has a significant influence on child survival. According to one recent report, up to 30% of women in some countries said their first sexual experience was forced.[10] This has a direct impact on maternal and infant mortality. Women who are able to space births are at much lower risk of mortality or disability during pregnancy and childbirth, and their children are much less likely to die prematurely. Babies born less than 18 months after their preceding sibling are almost three times more likely to die than children born after a three-year gap.[11]

Poor decision making or negotiating power means that in many situations women also have limited control over their access to preventive and emergency obstetric care.[12] According to data from the Demographic Health Surveys (DHS) in many countries husbands make decisions about their wives' healthcare on their own, without any consultation. In Burkina Faso this was the case with 75% of husbands, whilst in Nigeria it was 73% and in Nepal it was 51%.[13]

Women's subordination and lack of power within the household often stems from and leads to early marriage, which usually leads to early pregnancy. An estimated 14 million girls and young women aged between 15 and 19 give birth each year. Girls under 15 are five times more likely to die during pregnancy and childbirth than women in their twenties.[14] If a mother is under 18, her baby's chance of dying in the first year of life is 60% greater than that of a baby born to a mother aged over 19.[15]

Women's lack of control over sexual and reproductive health also makes them more susceptible to HIV and AIDS.[16] Young women make up 67% of all new cases of HIV among 15–24-year-olds.[17] In Africa, women account for 61% of people living with the virus.[18] HIV and AIDS is a particular threat to pregnant mothers, newborn babies and infants; if HIV positive pregnant women are not diagnosed early and receive effective medication then the risk of spontaneous miscarriage increases by 67%.[19]

Harmful religious or cultural practices such as female genital mutilation or cutting (FGM/FGC) also increase the risk to mothers and babies. It is estimated that FGM/FGC is performed on 3 million women and girls every year, and that globally 100 to 140 million women and girls have already undergone the practice.[20] A study across 28 obstetric centres in six African countries found that women who had undergone FGM/FGC were significantly more likely than others to have Caesarean sections, post-partum haemorrhaging, prolonged labour, resuscitation of the infant and low birth weight, and to die during in-patient prenatal care.[21]

b. Income generation and resource control

Traditional gender roles that limit women's ability to work outside the home – especially in parts of South Asia and the Middle East – can also have a negative impact on child survival. When women are free to earn an independent income and have greater control over household resources, their children's health tends to benefit. For example, research from Cameroon shows that income-earning women typically spend three-quarters of their available funds on food for the family, while men spend roughly one-fifth of their income on food.[22] Adequate nutrition is vital for maternal as well as child health. For girls, chronic undernutrition before birth or during early childhood can lead to their own babies being born with low birth weight, reinforcing a vicious cycle of undernutrition.[23] When women have greater control over resources, investment in education also increases,[24] with long-term benefits for children's own development and the wellbeing of their future offspring.[25]

Conversely, doing strenuous or dangerous work for long hours, often in unregulated employment sectors, jeopardises both mothers' health and that of their children.[26] It is important that women have the opportunity to work in safe environments, with sufficient pay to support them and their dependents, and that they have access to childcare.

Ironically men, who continue to dominate decision-making processes in households, economies and governments,[27] are often not included in projects seeking to empower women and equalise opportunities. In one Indian state, researchers found that advocacy campaigns on nutrition were targeted at women, even though about one-fifth of fathers made the decisions regarding their children's nutrition.[28] Men as well as women need to be fully engaged in efforts to reduce gender disparities in child mortality, and to improve children's health.

Institutional discrimination

Women's exclusion from decision-making at the political level also has an impact on child survival. Globally, only 19% of parliamentarians are women, while in the Arab states it is just 8.8%.[29] This can have a direct impact on the provision of specific health services for women and girls. It can also lead to a failure to recognise that women often lack the time to access services due to their triple burden of having to do paid work, unpaid care work and voluntary work.[30] Ensuring that both men and women are fully represented at every stage of political decision-making and policy formulation is crucial to tackling gender inequality in child survival.

One reason for the overall lack of progress towards achieving the MDGs is that gender is made explicit in only two of the goals.[31] As donors and developing country governments start to develop a post-MDG framework for international development, they should build closer links between the human development goals of the UN system and existing gender-related frameworks. These include the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and the Beijing Platform for Action.[32]

Improved data collection, policy and programme monitoring and evaluation are also needed so that inequalities can be clearly identified and redressed. These inequalities are not always readily apparent. For example, recent research from the Global Alliance for Vaccines and Immunizations found that, contrary to previous assumptions about the gender neutrality of childhood immunisation services, there are significant disparities in coverage.[33]

What we are calling for

Overcoming gender-based discrimination is an urgent development priority in its own right. It is also critical to reducing child mortality. Bringing about far-reaching changes in the status of women and girls is often complex and difficult. Many of the structural changes that are needed are beyond the scope of this briefing. However, Save the Children is calling for the following initial steps to reduce the impact of gender on a child's chances of survival.

- **Address demand-side barriers to sexual and reproductive health services** – governments and donors need to ensure that sexual and reproductive health services are delivered in the context of a female-friendly health system where social, cultural and financial barriers are addressed.
- **Improve the quality of data** – governments and donors must invest in better quality, more timely and comprehensive gender-disaggregated data that better enables policy-makers to identify and overcome gender-based barriers to child survival. The creation of the new agency, UN Women, presents an opportunity to formalise and centralise data collection mechanisms, and better facilitate data sharing and dissemination.
- **Strengthen women's voices** – child survival is closely correlated with maternal education and women's ability to make themselves' heard. Donors and governments must make funding and policy changes to promote women's voices at every level – from participation in national parliaments to the ability to hold service providers to account at the local clinic.
- **Address violence against women and girls** – governments, with the support of donors, should implement programmes and pass national legislation to prevent and punish rape and assault, and end harmful practices such as female genital mutilation.
- **Create gender-sensitive development goals** – governments and donors should adopt national strategies and goals to ensure that equitable progress towards MDG 4 is achieved for girls and boys. Governments should include the Beijing Platform for Action and the Committee on the Elimination of

Discrimination against Women (CEDAW) in discussions about a post-2015 development framework.

- **Involve men in efforts to remove gender-based barriers to child survival** – interventions to ensure girls and boys have an equal chance of survival need to engage men and fathers, as well as women and mothers, and draw attention to men's roles as responsible facilitators of better health outcomes for children and women.[34]

Notes

[1] Maternal health, where discussed in this paper, is examined from a social and gender relations perspective. For more information on the biological interconnections between maternal health and child survival, and for discussions on the benefits of a continuum of care approach, see Save the Children (2010) The interdependence of maternal, newborn and child health, Policy Brief, June 2010, London: Save the Children UK.

[2] K Fuse and E Crenshaw (2005) 'Gender imbalance in infant mortality: A cross-national study of social structure and female infanticide', *Social Science & Medicine* 62/2, January 2006, pp 360–74 and, *eg,* I Waldron (1998) 'Sex Differences in Infant and Early Childhood Mortality: Major Causes of Death and Possible Biological Causes' in *Too Young to Die: Genes or Gender?,* United Nations

[3] For a literature review of determinants of child mortality in India see Jatrana, S. (2003) Explaining Gender Disparity in Child Health in Haryana State of India, Asian MetaCentre Research Paper Series, No.16.

[4] Action Aid (2010) Hit or Miss - Women's Rights and the Millennium Development Goals, Action Aid UK: London.

[5] S Klasen and C Wink (2002) 'A turning Point in Gender Bias in Mortality? An Update on the Number of Missing Women', *Population and Development Review*

[6] *Ibid*

[7] T Plafker (2002) 'Sex selection in China sees 117 boys born for every 100 girls', *British Medical Journal* 324:1233

[8] L Smith *et al* (2003) *The Importance of Women's Status for Child Nutrition in Developing Countries*, Research Report 131, International Food Policy Research Institute (IFPRI)

[9] R Black *et al* (2008)

[10] ActionAid UK (2010: 28)

[11] S O Rutstein (1984) 'Effects of preceding birth intervals on neonatal, infant and under five mortality and nutritional status in developing countries', *International Journal of Gynaecology and Obstetrics* Supp 1:S7-24

[12] Access to health is not only dictated by gender; income and disposable resources are also key. In Bangladesh, skilled health personnel attend more than 40% of births among the richest fifth of the population, but only 3.5% among the poorest fifth. Low economic and social status inhibits poor women from seeking urgently needed medical support. ActionAid (2010).

[13] UNICEF (2007) *State of the World's Children*, UNICEF: New York.

[14] United Nations Population Fund (UNPFA) (2004) *State of the World's Population,* UNFPA: New York.

[15] UNICEF (2007)

[16] The feminisation of HIV and AIDS also relates to women's greater biological susceptibility (see E Reid and M Bailey (1992) 'Silence, Susceptibility and the HIV Epidemic', in *AIDS and Society*, International Research and Policy Bulletin, Vol.4 No.1, October/November 1992.

[17] UNFPA (2005) *State of the World's Population*

[18] Action Aid (2010: 28)

[19] Note this is the case for women infected with HIV-1, the most common type. C D'Ubaldo (1998) Association between HIV-1 infection and miscarriage: a retrospective study, AIDS, 12: 9, pp 1087-1093. .

[20] World Health Organization (2006) 'A Factual Overview of Female Genital Mutilation', *Progress in Sexual and Reproductive Health Research*, No. 72

[21] T Adam *et al* (2010) 'Estimating the obstetric costs of female genital mutilation in six African countries'**,** *Bulletin of the World Health Organization* 2010:88 pp 281–88. Family honour, cleanliness,

protection against spells and the insurance of virginity and faithfulness to the husband are often used as rationales to continue the practice and are championed by mothers who see it as in the interests of their daughters, despite the potentially hazardous long-term effects for both their daughter and her subsequent children. See: UNFPA (2007) *A holistic approach to the abandonment of female genital mutilation/cutting* http://www.unfpa.org/gender/practices1.htm

[22] M S Floro and S Seguino (2000) 'Gender Effects on Aggregate Saving: A theoretical and empirical analysis', *Policy Research Report on Gender and Development*, Working Paper Series No. 23, World Bank, p 9

[23] UNICEF (2009) *Tracking Progress on Maternal and Child Nutrition*

[24] M Adato *et al* (2000) *The Impact of PROGRESA on Women's Status and Intrahousehold Relations*, International Food Policy Research Institute

[25] *See* J Hobcraft (1993) 'Women's education, child welfare and child survival: a review of the evidence', *Health Transition Review 3:2* and J C Caldwell (1979) 'Education as a Factor in Mortality Decline: An Examination of Nigerian Data', *Population Studies* 33:3 pp 395–413

[26] United Nations Department of International Economic and Social Affairs (1985), *Socioeconomic Differentials in Child Mortality in Developing Countries*, pp158

[27] UNICEF (2007) p 81

[28] *Ibid*

[29] *See* www.ipu.org/ wmn-e/classif.htm (accessed 29/01/08)

[30] C Moser (1993) *Gender Planning and Development: Theory and Practice*, Routledge

[31] N Jones *et al* (2008) *Gender and the MDGs: A Gender Lens is Vital for Pro Poor Results*, ODI Briefing Paper No. 42, Overseas Development Institute

[32] The Beijing Declaration and Platform for Action are the concluding agreements from the Fourth World Conference on Women: Action for Equality, Development and Peace, Beijing, 15 September 1995. The Declaration recognised that the goals of equality, development and peace for all women everywhere are in the interest of all humanity and that all women and girls' human rights should be fully realised. The Platform for Action called for the international community to recognize the need to take priority action for the empowerment and advancement of women.

[33] While son preference means that many girls miss out on immunisation in South Asia, some boys are not being immunised in parts of Africa as a result of fears about sterility. *See* N Jones *et al* (2010) and N Jones *et al* (2008) *Gender and Immunisation: A Knowledge Stocktaking Report*, Report for the GAVI Alliance Secretariat, Overseas Development Institute

[34] Populations Reference Bureau (2009) *Engaging Men for Gender Equality and Improved Reproductive Health* http://www.igwg.org/igwg_media/engag-men-gendr-equal.pdf