# Gender Relations and Child Nutrition: A study of Intra-household Bargaining in Rural Uganda.

**By**

**Pamela Kampire**

**2013/PhD/067**

**Supervisors**

**Prof. Betty C. Mubangizi**

**University of KwaZulu-Natal**

**Dr. Viola Nyakato**

**Mbarara University of Science and Technology**

**A PhD Proposal submitted in fulfillment of the requirements for the award of Doctor of Philosophy in Development Studies of Mbarara University of Science and Technology**

**August 2014**

# CHAPTER ONE

# INTRODUCTION

## 1.1 Introduction

This chapter explains the background of this proposal and provides a short description of the nutrition situation in Uganda. The chapter also examines the gender relations inside the household and how this can affect child nutrition. Also explained is the rationale for the study and the research questions central to this study.

This study examines the link between gender relations and child nutrition an integral part of intra-household bargaining in rural Uganda. Gender relations in this study is conceived as the independent variable while child nutrition is the dependent variable. Intra-household bargaining is the intermediate variable. The link between the variables can be seen in the conceptual framework in figure 1.

### 1.1.1 Background to the study

#### Gender Relations In and Outside the Household

Hodgson and McCurdy (2001) define gender relations as the mutually constitutive symbolic and material relations of power and authority between men and women in the household and wider socio-economic settings. On the other hand, Baden and Goetz (1998), define gender as the socially constructed roles and responsibilities between women and men. Garcia (2001) links gender to sex and explains that gender is the characteristics and behaviors of a particular sex dictated by society. An example in place is the potential that women have to bear children thus women are culturally seen as suited for domestic work and reproductive activities such as food preparation, taking care of

children, keeping the home clean among others. On the other hand men in many communities and cultures are seen as incapable of doing reproductive work and nurturing and the reason is that it is because they don't give birth.

Gender is seen as a determinant in as far as female and male relations are concerned (Manyire 2009). Gender also determines the entitlements of individual members of the household and the wider community. The way how females and males relate and are related to by people of similar or different sex is governed by norms and social beliefs and these are considered culturally appropriate (Marshall 1994). What it means to be a man or a woman are gender identities that include gender norms that in turn portray gender roles (ibid).

Tinker (1990) asserts that intra and extra household distributional relations influence the rights of household members in relation to skills and resources thought to be important for leading a good life. In most cultures in sub Saharan Africa and in Uganda in particular men are perceived to be the leaders, that is the heads of households. Females are in turn expected to be dependent on men and this is why culturally women still have fewer entitlements than their male counterparts (Manyire 2009).

Gender Relations determine what outcome of behavior, social, economic and political, behaviors, especially if a person wants to engage in economic roles not consistent with the prescribed roles for a person's sex, like women working outside the home (Manyire 2009). Identifying the nature of gender relations not only provides a clear picture of intra-household responsibilities but can also show us if nutrition is bargained for and how, through a broader process. This analysis allows for investigations on how gender

relations influence bargaining for different issues like nutrition among household members. There is need for evidence on the impact of gender relations on nutritional outcomes of children in terms of relative bargaining power within the household. Research is needed to fully understand the link between gender and nutrition. Child malnutrition cannot be understood without considering gender based issues and that's what this study is about.

**Child Nutrition: The situation analysis**

The health of a nation is its wealth thus Uganda as a nation can only progress if its citizens, particularly its children, are well nourished.

Mwangome *et al* (2010), shows that, malnutrition is a factor in 60% of 11 million deaths of children under five years of age, every year globally. They further demonstrate that, malnutrition is the most important issue to consider for the disease burden in developing countries. Mwangome *etal* (2010:167) states that malnutrition causes "long-term detrimental consequences such as impaired cognitive development, growth impairment and poor academic performance, and children most at risk are those aged less than five years living in developing countries". In relation to this Food and Nutrition Technical Assistance (FANTA-2(2010) also notes that, in recent years there has been an increase in malnutrition in Africa. Statistics show that the number of children who are underweight in Africa increased from 26 million in 1990 to 32 million in 2000. The contribution of the global prevalence of childhood under nutrition from Africa will increase from 24.0% in 1990 to 26.8% by 2015(Mwangome et al 2010, FANTA-2 2010). This means that the goal to reduce under nutrition by 50% between 1990 and 2015 may not be met.

According to the Uganda Nutrition Action Plan (UNAP) 2011-2016, malnutrition accounts for 35% of deaths among children under five around the world. Stunting, wasting and growth retardation are major contributors to child morbidity accounting for about two million deaths annually. Black *et al* (2008:243) indicates that malnutrition is the major cause of morbidity for all age groups accounting for 11% of the global disease burden. He goes on to say that, 43% of all death among children under five occur in Africa.

According to the Uganda Demographic Health Survey (UDHS) of 2011, malnutrition in Uganda is widespread with stunting at 33% among children, and there have not been any significant improvements over the years. UDHS (2006) shows that 38% of children under five were stunted. In 2011 stunting was at 33%, wasting at 5% for the children under five, whereas underweight) was at 14% (UDHS, 2011). Uganda's hope to achieve the Millennium Development Goals (MDG) four which is to reduce the mortality rate of children under five, by two thirds between 1990 and 2015, requires significant progress in reducing under nutrition and hunger. Stunting, underweight, wasting and micronutrient deficiencies increase the risk of both morbidity and mortality in children (FANTA-2 2010,Black *et al*, 2008). In Uganda under-nutrition affects over two million children under five years of age (ibid). Stunting still remains a public health problem, and underweight contributes directly or indirectly up to sixty (60%) percent of childhood mortality in Uganda (UN, 2005, UNDP, 2007). Thus, reducing under nutrition in Uganda is critical to save children's lives and achieve MDG four.

Uganda is known for being a food basket for East Africa but with the high levels of stunting and wasting this trend suggests that there is a big problem (UNICEF, 2012). In Uganda a large section of the population experience chronic food insecurity although for some this is seasonal (UDHS, 2006). Namugumya (2012) suggests that the persistent rate- of malnutrition among children under five in Uganda is characteristic of larger problems like inadequate access to food, poor infant feeding practices, poor health, hygiene and sanitation practices.

Adequate nutrition is essential for maintaining a healthy population. The important role nutrition plays in health and development calls for greater commitment and resource allocation in nutrition (Namugumya, 2012). Uganda is a signatory of the millennium declaration 2000, thereby agreeing to achieve the eight millennium development goals (MDGs) by 2015. There has been some progress to date in achieving targets for MDG 1 that is eradication of extreme poverty and hunger, MDG 4 reduction of child mortality, MDG 5 Improve maternal health and MDG 6 combat HIV/AIDS, malaria and other diseases. These relate to and depend on improvements in women and children's nutrition (FANTA-2, 2010).

**Efforts to Reduce Malnutrition in Uganda**

Steps have been taken to create a good policy environment conducive to addressing nutrition challenges in Uganda. Policy documents like the Uganda National Development Plan (NDP) show clearly that child nutrition is a development concern. Strategic planning exercises of both health and agriculture sectors include nutrition activities in the sectoral development strategies (Namugumya 2012). The NDP also incorporated nutrition related activities like establishing national coordination bodies to address nutrition issues and

these receive financial support from the government of Uganda and its development partners (NDP 2010/11-2014/15).

Improving nutrition outcomes is key in the Uganda National Minimum Health Care Package, of the Health Sector Strategic Plan two (Ministry of Health (MOH 2005). The strategy highlights implementation of preventive measures such as immunization, health education, management of childhood illnesses, control of communicable diseases and environmental health.

At the United Nations (UN) summit on the Millennium Development Goals (MDGs) in September 2010 the Uganda government committed to reduce malnutrition in the country through scaling up nutrition (SUN) initiative (FANTA-2, 2010). This led to the designing of the Uganda Nutrition Action Plan (UNAP) through a multi-sectoral approach. The UNAP focuses on the children under five and the women of child bearing age (UNAP 2011-2016).

The other nutritional policies and guidelines in Uganda include the National Food and Nutrition Policy (FNP) (2003) and its goal is to ensure food security for adequate nutrition for all Ugandans. The policy objective is to promote nutritional status through multi-sectoral and coordinated food security and nutrition interventions. The policy also has other nutrition specific objectives.

In addition, there are other policies, strategies and documents on nutrition that show Uganda's commitment to improve the nutrition status of Ugandans, for example the National Food and Nutrition Strategy and Investment Plan (2003), this plan is to operationalize the Food and Nutrition Policy. Others include, the Child Survival Strategy

2009, which shows renewed commitment to accelerating efforts to address the survival of children in Uganda. The national nutrition operational framework 2009 operationalizes the nutrition component of Child Survival Strategy. It aims at scaling up implementation of cost effective nutrition interventions, although it does not show how. The plans are however silent on gender relations at play within households and which could have a significant impact on operationalizing the child nutrition strategy. The national policies in Uganda recognize nutrition as essential for development, though this has not so far resulted in country wide provision of nutrition services necessary in reducing child malnutrition (Mwadime, 2012). Nutrition has featured in the different policies as seen above, but it is not clear how these policies address gender relations in regard to nutrition outcomes, and how these policies are translated into effective programs to achieve reduction in child malnutrition at household level.

### 1.2 Problem statement

In Uganda, there are deliberate efforts such as, implementation of preventive approaches for example integrated management of childhood illnesses, immunization and health education. These and other efforts aim at reducing malnutrition through several development partners and appropriate policies (UNAP 2011-16). However, though a conducive policy environment exists to allow the proliferation of nutrition interventions in rural Uganda, there has been no further enquiry into how such policy, in practice, impacts the intended beneficiaries (Mwadime, 2012). In particular, questions remain unanswered with regard to the gender relations at play within households. Yet gender relations form the basis on which decisions on nutrition within the household are to be made. Accordingly, while the Nutrition Policy targets a composite and seemingly

homogeneous household, it overlooks the gender relations and power dynamics within households. Yet within households variously positioned actors, split on the basis of gender and age, go through a laborious bargaining regime and make trade-offs in order to benefit from nutrition policies and strategies. Knowledge of how decisions are made at the household level, on feeding with regard to gender and age would go a long way in making nutrition policies more effective (Engebresten, 2010).This study intends to establish the influences of gender relations on child nutrition and the role of intra-household bargaining for improved nutrition of children under five.

## 1.3 Objectives of the Study

### 1.3.1 General Objective

The purpose of this study is to examine the influences of gender relations on child nutrition and the role of intra-household bargaining for improved nutrition.

### 1.3.2 Specific Objectives

- To determine the occurrence of bargaining for child nutrition in rural households.
- To explore how rural households perceive gender relations as determinants in bargaining for child nutrition.
- To assess how intra-household bargaining affects child nutrition
- To analyze how intra-household bargaining can be influenced to improve child nutrition.

## 1.4 Research Questions

- To what extent do household members bargain for children's nutrition?

- Do gender relations at household level influence household bargaining for nutrition of children under five?
- Does Intra-household bargaining affect child nutrition?
- How can bargaining at household level be influenced to improve child nutrition?

## 1.5 Theoretical Framework

This study will draw on the bargaining theory by Agarwal (1997) and the intra-household bargaining theory by Sen (1990). The theories illustrate how inequalities among different members of the household affects decision making processes and allocation of resources. Sen (1990) asserts that an individual's entitlements to make decisions and use resources are determined by their position within the household, both in terms of their perceived contribution and their socio-economic position. Where individual women have limited opportunities to earn income outside the household and where child care and domestic duties are perceived as low status contributions, women's bargaining power is reduced and their position is more vulnerable in case of a breakdown in the relationships.

Women's ability to access and allocate resources to their children is affected by intra-household dynamics, such as household structure and composition. Relations between different members of the household differ across cultures and socio economic background especially when household headship, hierarchies and positions of authority are taken into account (Castle 1993).

Koopman (1991) argues that household bargaining takes place through a series of household bargaining models, and not one unitary model. A unitary model assumes that

all household members have the same needs and therefore interventions and policies targeting the household head will reach all members of the household. However, this not necessarily true because different household Individuals have different needs and thus may not benefit from the unitary conceptualization of the household.

Literature on Intra-household dynamics tests the unitary model of household decision making, which shows that the family is treated as though it was one single unit (Duflo 2003). Studies on household bargaining in developing countries estimate the effect of increasing women's resources within the household on variables such as the health outcome for children (Bobonis 2009). The argument here is that greater economic power yields greater bargaining power and therefore allows individuals to direct resource allocation in their preferred area. Additionally, if the bargaining processes are not observed the link between resource allocation and decision making remains obscure. While evidence on this matter is available in form of baseline surveys on household decision making for example (Attanasio & Lechene 2002; Morozumi 2011) very little is known about household bargaining for nutrition outcomes and whether gender relations is an influencing factor. This study will therefore seek to explore how household bargaining on child nutrition is influenced by gender relations in and outside the household.

**Bargaining Model: Agarwal (1997)**

Agarwal (1997) argues that households constitute different individuals who have different tastes and preferences. This makes households places in which different decisions are made, like decisions on production, consumption and resource allocations.

She affirms that there is some evidence that reveals gender inequalities in the distribution and allocation of household resources and tasks.

The bargaining theory demonstrates that "intra-household interaction is characterized as containing elements of both cooperation and conflict" (Agarwal 1997:4). Individual members of the household cooperate when they know they will benefit out of the cooperation. Agarwal 1997:4 asserts that "many different cooperative outcomes are possible in relation to who does what, who gets what goods and services and how each member is treated". Through cooperation and bargaining of the different members of the household some end up benefiting more than others, thus as Agarwal puts it, one person's gain might be another person's loss and this may lead to conflict.

Household members have relations of cooperation and conflict (Sen 1990). Here which individuals in the household get what they want or whose voices are heard depends on their bargaining power. A household members bargaining power is determined by what Agarwal 1997:4 calls "the fall back position" this is "the outside options which determine how well off she/he would be if cooperation failed". The fallback position a person has outside the household will determine the bargaining outcome. Household members bargain over the use of resources and the results depend on their bargaining power and determined by their fallback position. This scenario depends on various factors such as non-wage income, the laws of marriage and family, the parent's wealth among others (Agarwal 1997).Agarwal (1997) asserts that bargaining is determined by the resources owned. Women who own productive resources for example land have a strong fallback position. The stronger the fall back position the stronger the bargaining power. Additionally social norms affect the outcome of bargaining Agarwal (1997). Intra-

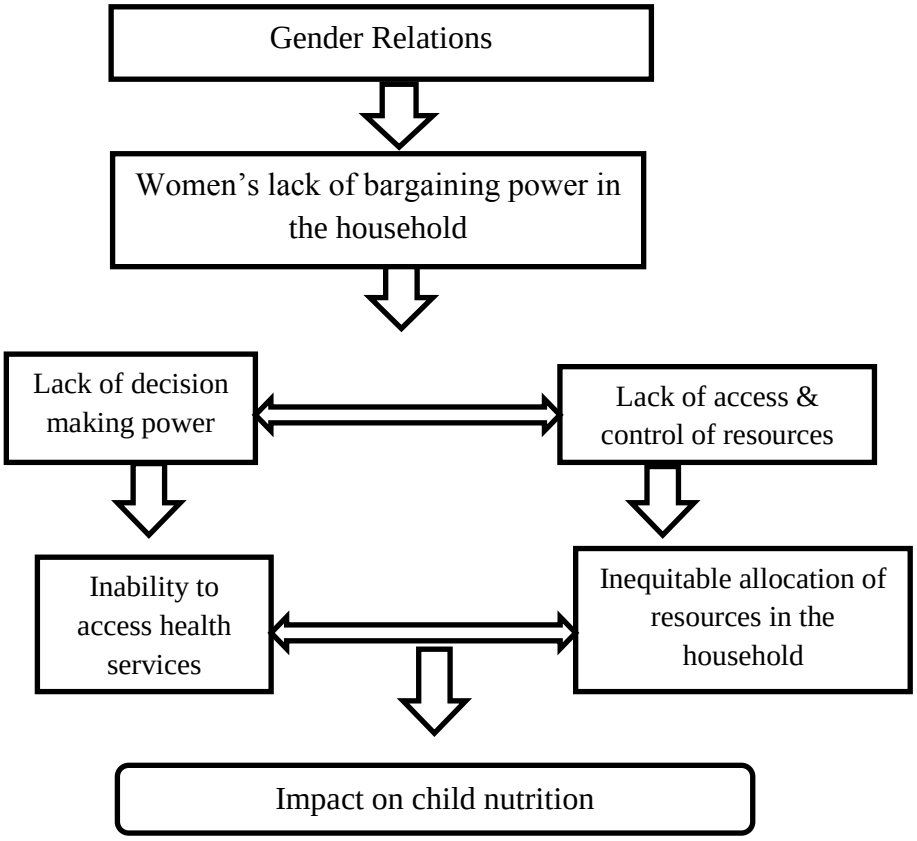
household bargaining may depend also on the outcomes of extra household bargaining with forces such as the community, the market and the state (ibid).

Furthermore, Intra-household bargaining can be determined by who participates in decision making and about what. It is asserted that women who participate in decision making in the household are believed to have stronger bargaining power than those who don't (Agarwal 1997). However, factors such as social norms and perceptions also affect bargaining. Inequalities amongst household members also places some members in a weaker bargaining position relative to others and this is attributed to gender relations (Sen 1990).

The bargaining model is useful in examining gender relations inside the household. The purpose of using this approach in this study is to focus on child nutrition because it is critical to bargaining outcomes. However, most literature on household bargaining mentions little or no say on whether child nutrition is an issue for bargaining.

## 1.6 Conceptual Framework

**The Interface between Gender Relations, Intra-household bargaining and Child Nutrition.**




**Source: Adopted from UNICEF (2011).**

This framework, which draws on Agarwal's bargaining model (1997) and Sen's (1990) views on cooperation and conflict, is used to illustrate how gender relations influence women's bargaining power at a household level. This influence may lead to women's lack of decision making power, lack of access and control of resources, inequitable

resource allocation, as well as the inability to access health services. Directly and indirectly therefore, gender relations impact on children's nutrition.

### 1.7 Significance of the study

The study will contribute to the general assessment of government policies and programmes that have been implemented on child nutrition in the past. Policies include the National Food and Nutrition Policy (FNP) (2003) and the Uganda Nutrition Action Plan (UNAP) 2011. The findings will be significant to policy makers, planners and implementers of gender and nutrition programmes designed to improve the nutrition situation of children. Academically the study will contribute to the existing body of knowledge, which focuses on gender and nutrition; the study will also bring insight into areas for further research.

#### 1.7.1 Justification of the study

Different authors have written about gender and nutrition in different parts of the world including Uganda. Engebresten *et al* (2001) noted gendered perceptions on infant feeding in Eastern Uganda, Meinzen *et al* (2012) documented the importance of linking gender to agricultural programmes for improved nutrition and health while Getaneh (2013) commented on the linkage between rural women's status and child nutrition in Ethiopia. However, these and several other authors did not address household bargaining, gender relations and how these affect children's nutrition in rural households. This study intends to fill this gap and seeks to explore gender relations and its linkage to intra-household

bargaining among rural households and the impact on the nutrition of children under five years.

### 1.7.2 Scope of the Study

The study intends to analyse, from a gender perspective, intra-household bargaining for child nutrition.Theoretically, the study will look at intra-household bargaining, gender relations and child nutrition. The independent variable is gender relations, and the dependent variable is child nutrition. Conceptually, the study will examine the link between the independent and the dependent variables. It will do so using selected areas of Kisoro and Kanungu districts of Uganda.

## 1.8 Operational Definitions of Concepts

These concepts may have varied meanings, but for the purpose of this study, they will be used as defined below:

**Gender Relations:** Are the material relations of power and authority between men and women in the household and the wider community.The key focus of the study is to explore how gender relations may influence intra-household bargaining in the context of child nutrition.

**Gender** is defined as the socially constructed roles and responsibilities between women and men. These socially constructed roles and responsibilities are often times unequal in terms of power, decision making, control and ownership of resources.

**Gendered** can be understood as the different impacts of the socially constructed differences that society has attributed to the males and females.

**Nutrition** refers to the intake of food, considered in relation to the body's dietary needs. Poor nutrition leads to the body's reduced immunity, increases susceptibility to disease, impaired physical and mental development and reduced productivity.

**Malnutrition** can be defined as the imbalance in satisfying nutrition requirements. Malnutrition among children results from inadequate food intake, repeated childhood diseases and improper care. Child malnutrition can affect growth potential and morbidity.

**Intra-household bargaining:** reflects individual's ability to make decisions and use household resources. This is determined by their perceived contribution and position within the household. The inequalities among different members of the household affects decision making processes and allocation of resources (Sen 1999, Agarwal 1997).

**Child nutrition;** refers to the availability of energy and nutrients in the body's cells in relation to the child's body requirements.Child nutrition is affected by food accessibility and dietary intake, breast feeding, prevalence of disease, access to health care, immunization, maternal care during pregnancy, water , hygiene, sanitation, socio economic status and health seeking behavior (Sommerfelt and Stewart, 1994).

**A Child:** Is a human being between the stage of birth and puberty. The UN Convention on the rights of children defines a child as a human being below the age of 18 and Uganda ratified this convention. This study will focus on children under the age of five years, and these stages of childhood development is what is termed as newborn 0-28 days, 28days- 2 years infant and 2-6 years early childhood.

**Households**: These are structures within which decisions are individually made, or within which decisions are jointly made, with a household behaving as one entity.

# Chapter two

# Literature Review

## 2.1 The causes and effects of malnutrition in Uganda

The causes of malnutrition in Uganda are many but the major ones are inadequate dietary intake resulting from maternal and infant feeding practices and the high disease incidence as a result of malaria, diarrhea, acute respiratory infections and worm related diseases (FANTA-2, 2012). UNAP (2012-16:7) states three main causes of inadequate dietary intake and high disease burden: "Household food insecurity related to poor access to the range of foods needed for a diverse diet". The availability of foods that households usually consume is limited according to seasonality, food prices, casual labor earnings which is seasonal and moreover most of these foods are relatively deficient in micronutrients.

The second is "Inadequate maternal and child care. Care related constraints lead to both inadequate dietary intake and a high disease burden in young children". The constraints include women's heavy work load that is, women in most cases do all the household chores, are heavily involved in farm work, do all the caring roles for the children and the sick and may also be involved in petty trade. The other constraint is having too many children which limit a woman's ability to care for all them properly.

Thirdly "poor access to health care and a healthy environment" UNAP (2012-16:8). In some cases young children less than five years do not live in healthy surroundings with access to latrines, safe water, health care facilities plus no or limited access to nutrition

services such as nutrition education and micronutrient supplementation (FANTA-2, 2010).

FANTA-2 (2010) also notes that, gender inequality is a likely cause for persistent malnutrition and morbidity in Uganda. Women in Uganda are marginalized and have limited access to resources thus this undermines their ability to ensure optimum nutrition for their children. Most women are economically dependent on men because they don't own productive resources like land and farm inputs. Most women in Africa and Asia lack decision making powers in the household and often have limited command of household income (Agarwal, 1997).

Uganda has a high incidence of malnutrition especially among pregnant mothers and children. The Uganda PROFILES study conducted by WHO in 2010 shows that, about 28% of men, 49% of women and 73% of young children suffer from iron deficient anaemia, and about 50% of women of child bearing age suffer from micronutrient deficiencies. Under nutrition is said to be contributing approximately 230 child deaths daily in Uganda (Profiles, 2010).

UNAP (2011-16) states that, Malnutrition among women and children generate a number of direct and indirect costs to social and economic transformation. By 2015, iodine-deficiency disorder will have caused about 19,300 children to be born as cretins and 543,000 children to be born with mild or moderate mental disabilities. Uganda loses US$310 million worth of productivity per year due to the high levels of stunting, iron deficiency disorders and low birth weight (UNAP 2011, FANTA-2 2010).

The Uganda Child Survival Strategy estimates that malnutrition directly and indirectly contributes up to 60% of child mortality, making malnutrition one of the most significant contributors to childhood mortality in the country (MOH, 2009). Kikafunda, (1998), indicates that approximately 60% of all deaths of children under 5years of age in Uganda are directly or indirectly attributable to malnutrition. Projections suggest that over 520,000 children will die as a consequence of underweight alone between 2006 and 2015 if something is not done (Uganda Profiles, 2010). Malnutrition in Uganda remains largely hidden and it was not taken seriously until recently.

### 2.2 Malnutrition: A Development Challenge

Malnutrition is a major development challenge in Uganda, affecting all regions of the country in varying degrees. The high levels of malnutrition hinder Uganda's human development (UNAP, 2011-16). Uganda has made a steady progress in economic growth and poverty reduction over the past two decades, despite this, the reduction in malnutrition has been slow (ibid).The heavy cost of malnutrition nationally, hinder development. This has been recognized by the government and development actors and strategies have been put in place to fight malnutrition in Uganda. The UNAP (2011-16:3) suggests two ways to break the malnutrition cycle and these are: "address the nutritional needs of the young child from conception through to 24 months and to ensure the national wellbeing of the mother of the child even before she becomes pregnant".

The National Development Plan (NDP) lays out the development objectives and was set up by the government of Uganda as a framework that is consistent with the millennium development goals. Uganda is committed to achieving its development goals specified in

the NDP and one of the crucial ones is to reduce malnutrition in the next five years (NDP, 2010-15). One of the NDPs themes is socio economic transformation for prosperity and this cannot be achieved if children and women of reproductive age continue to face malnutrition related problems.

Malnutrition is not only a development challenge in Uganda but in most countries in sub Saharan Africa as well, affecting them in varying degrees. The Ethiopian Ministry of Planning and Economic Development MOPED (1999) indicates that 50% of the people in the country are living below the poverty line and cannot meet the minimum nutritional requirement of 2200 calories daily. Getaneh (2013) notes that women of child bearing age and children are vulnerable to malnutrition because of several reason that include: low dietary intake, unequal distribution of resources and particularly food in the household, improper food storage and preparation, social norms, infectious disease and inadequate health care.

### 2.3 Gender and Nutrition

Male involvement is crucial in tackling the problem of malnutrition. A study conducted in Ghana in 2010 found that male participants were disgruntled with the health systems neglect of men. Most men in the study had strong feelings about the importance of breast feeding for the health and nutrition of their children. The study further went on to point out that the decision on whether to breast feed or not did not entirely depend on the mother. There were sanctions and anger directed to the mother who chose not to breast feed. Although male participants had limited knowledge on exclusive breastfeeding, they acknowledged its importance (Engebresten et al, 2010). Inclusion of fathers during

pregnancy and postnatal care was seen as paramount to the improvement of child and maternal nutrition (ibid).

Recent research by Engebresten and others in 2010 in Uganda, shows a growing awareness of the importance of both parents participating in child upbringing and the involvement of men in young children feeding (UNICEF 2011). However, the area of child care and nutrition has been characterized by limited inclusion of men in the majority of the African Communities (Engebresten et al, 2010). Women are usually advised by health workers on infant feeding in the absence of their husbands and have been left with the challenge of choosing the most appropriate young children feeding alternatives even if they are believed to have limited resources (Engebresten et al, 2010).

The choice the mother has to make depends on the advice she has received and the resources at her disposal. The impasse is that even if she is the one to choose the food that the family eats, in most cases she does not always control the conditions and the resources necessary for child feeding. The discrepancies between the advice the mothers receive from the health centers on how to feed their children and what is socially acceptable and preferred in the community is still a dilemma (Engebresten et al, 2010).

According to UNICEF (2008), the health of a child is linked to the health and nutrition status of the mother. The report demonstrates that an undernourished woman will give birth to a baby with low birth weight, which leads to the continuation of poor health and under nutrition. The Kenya UDHS (2003) states that in the Eastern and Southern regions, approximately 14% of infants weigh less than 2.5 kgs at birth. Approximately 26% of all

children under the age of five were underweight and 45% stunted, this results in irreversible physical and mental deficiencies later in life. Under nutrition contributes 50% of all cases of child mortality (Kenya UDHS 2003).

Smith et al (2003:26) state that "women's status is women's power relative to men's in the household, communities and the nation in which they live". In this definition the status of women is relative to that of men. This indicates a notion of un equal power relations which is harmful to children's nutrition. Power is exercised through decision making through a process of bargaining among household members (Sen, 1990). Control over resources is synonymous with the ability to exercise choice (Quisumbing and Maluccio, 2003). Resources include economic, like income, productive assets, and food among others. Where as human resources may include skills, knowledge and education. Additional social resources include: group membership, belonging to social networks among others (ibid).

The definition of women's status and what it entails, addresses inequalities in the abilities of women and men to make choices, this may be reflected in the inequality in control over resources. Social norms, beliefs and values often dictate different roles and acceptable behavior rights and privileges for women and men (World Bank, 2001).

### 2.4 Dietary Intake and Feeding Practices in the 1000 Days Window

Caring and feeding practices are very important for children's nutrition (Engle, 1999). Food preparation, storage, hygiene and sanitation plus psychosocial care all play a crucial role in children's nutrition and health (ibid). Food must be prepared in a special and hygienic manner for the children to eat it and have better health. The appropriate food

should be given to the children at an appropriate time and frequency for the children to benefit from the foods and grow well. Equally important the child must receive care and affection. The child's environment must be clean so as to avoid disease. The important stage in the child's growth and life is the first 1000 days commonly known as the window of opportunity. This is from the moment of conception till the child is 24 months. Here care should be taken including support during pregnancy, labor and delivery and the child should be breast fed in the first hour.

Pregnant women should feed well, have enough rest and prevent illness. Care during pregnancy is very crucial because it affects the nutritional condition of the unborn child and their birth weight (Smith et al, 1999, Engel, 1999). In most societies women are care givers of the young children and of themselves, so they bear the heavy responsibilities of taking care of themselves and their children in terms of what they eat, taking the children to health centers when they fall sick, taking them for immunizations and doing all that it takes for their children's health and wellbeing and on top of this they have to also take care of themselves and the entire household.

Getaneh (2013) argues that inadequate nutrition is the major cause of low birth weight in the developing countries. Fetal growth is also affected by a number of other factors specific to the infant the mother and the situation. Getaneh goes on to say that of all the factors that affect birth weight, maternal nutrition is the most important. Getaneh (2013:268) notes that "nutritional status of mothers both before and during pregnancy is critical in determining the birth weight. Girls of low birth weight are likely to give birth to low birth weight babies as they grow into adults". Access to antenatal care and micronutrient intake is also likely to influence the child's birth weight.

Nyakato (2003) points out that, women face time constraints and this may prevent them from accessing health care when they need to. Women have a heavy workload and receive very little support from their spouses in terms of household work. Most women live in communities where less value is attached to women's health and wellbeing and this hampers their ability to provide adequate care to their children.

A study by Engebresten *et al* (2010) carried out in Eastern Uganda on infant feeding indicate that exclusive breast feeding was very difficult and some women considered it to be time consuming because they had other commitments. A woman's chores were seen as demanding that it was increasingly becoming difficult to exclusively breast feed.

A Report by the MOH-Kenya (2011) indicates that, in most African societies where men are seen as the main providers, they are held responsible for the scarcity of food in the household. It is a man's obligation to contribute extra food for a nursing mother. In the study carried out by Engebresten et al in 2010 in Eastern Uganda on infant feeding this point was emphasized. Both women and men who participated in the study highlighted that neglect, lack of food during breast feeding could cause emotional and physical problems that would affect breast feeding in a negative way, and some mothers may all together stop breast feeding.

### 2.5 Gender Relations, Intra-household bargaining and Child Nutrition

Women in Uganda are the primary care givers and they play a very important role not only in child nutrition but in the nutrition of the entire household. There is evidence in Sub Saharan Africa which indicates that children in households where women have low

or no decision making powers have lower nutrition status (Getaneh 2013). Women's low status in Uganda is manifested in social norms through certain taboos that deprive them of nutrient rich food. Women also suffer from low quantity and diversity of food in their diets (Namugumya 2012).

Food allocations in the households does not favor women and children plus the cultural norms dictate that men be served first (UNICEF 2013).During pregnancy women need to eat well and frequently, they too need to reduce their work loads and rest more but this may not be possible if men are not willing to help them in their work burden due to gender norms that dictate certain work to be done by only women. Therefore women's capacity to care for their children and themselves is constrained given their low intra-household bargaining power and access to resources needed to improve their nutrition and that of their children.

Women's lack of decision making power and control of their fertility are big issues in the control of malnutrition in Africa and in Uganda in particular (FANTA-2 2010). Women are taken as child bearers and only valued when they can have many children to build the man's clan. Frequent pregnancies increase the risk of malnutrition because if children are closely spaced women stop breast feeding early to cater for the next child. Caring for the young children who are closely spaced become difficult in addition to the woman's other roles.

Men are perceived as providers of the needs for their children and the entire household (Tinker 1990). They are supposedly providers of food items, health care, education and clothing. However, in some circumstances men may fail to provide and the whole burden

of ensuring that children are fed, clothed and taken care of becomes a woman's burden. In addition, men in Uganda leave their rural households and go in search for employment but even when they get the jobs, some end up not contributing any money or other resources to the households. Thus women are left to close the gap left by the men and feed their entire households with the little resources they have.

In a situation analysis carried out by FANTA-2 on the nutrition status in Uganda in 2010, it was discovered that some men end up involving themselves in alcoholism and forgetting to take care of the basic needs of their children. Alcoholism was found to lead to an increase in domestic violence thus causing stress to the entire household. Alcoholism and gender based violence affect many families and have major consequences on child care and nutrition (Bhagowalia et al 2012). Targeting mothers alone without involving men and other household members in any nutrition intervention will have limited impact on the nutrition of children. Child nutrition is a shared responsibility; male support is needed in enabling mothers to adopt positive nutrition behaviors.

### 2.6 Gender Relations and Child Care

It is widely known that women have less control of household resources than men and yet the more a woman's control over household resources the more effective her care for the children will be (Smith, 1995). The woman's control over resources gives her the choice to weigh the options and make timely decisions in case of children's sickness. She is more likely to access health services and seek treatment for any illnesses and have the children immunized (Getaneh, 2013). A woman who has control over resources is also

more likely to use the resources to seek for special foods for the children and to feed them appropriately and at the right frequency and time (ibid).

A qualitative study done by Getaneh (2013) in Ethiopia shows that mothers with under five children who can afford healthcare were able to prevent malnutrition, since they could afford to take children for treatment when they were sick compared to the mothers who couldn't. It was also discovered in the same study that care for the women has a crucial indirect role on the care for children through the means of reproductive health. Getaneh (2013) further points out that those women with less access and control of resources are believed to have higher fertility rate and are less likely to space their children, than women of a higher economic status. Caring and feeding a large number of children reduces the quality of care a mother can provide to each new child (Engel, Menon &Haddad, 1999).

Meinzen-Dick *et al (*2012) point out that in many parts of the world, men and women spend money differently. They go ahead to emphasize that women are more likely to spend income on food and health care of their children. In study carried out by Meinzen-Dick and others in 2012 in Eastern Uganda, shows that increasing income of households does not necessarily result into improved nutrition and health status of women and children especially when the income is controlled by men. A World Bank report (2001) indicates that women's bargaining power within the household is likely to influence whether gains in income transforms into better nutrition. Thomas (1997) demonstrates that increasing women's control over productive resources raises agricultural productivity and improves children's health and nutrition. Furthermore, increasing women access to resources and control over household income will have important implications for the

health and nutrition of the entire household but for especially women and children (Agarwal &Srivastava, 2009)

### 2.6.1 Intra-household bargaining power and access to health services

Access and control over resources plus decision making are essential to women's bargaining power within the household. Women's bargaining power reflects both decision making and access and control of resources, and the effect these may have on children's nutrition. This study will establish whether there is a link between intra-household bargaining and child nutrition.

A study carried out in Benin by Rashed *eta al* (1999), using qualitative and quantitative methods show that income in the hands of women may provide better health services for children. A survey of 191 households found that women's income was one of the key variables that predicted household use of a bed net. Interviews involving men and women in 23 Focus Group Discussions (FGDs) and 16 semi structured interviews found that women who earned income were more likely to buy insecticide treated mosquito nets which would be used by their children. The same study discovered that, bed nets bought by the male heads of households were more likely to be used by men themselves as they perceived their own need as greater (Rashed *eta al*. 1999). Women's access to and control of resources has been associated with improvements in children's health and nutrition. In this study I intend to look at ways in which women and men experience access and control over resources and decision making power in the household and how this may influence child nutrition.

Several authors agree that men and women within the household often have different preferences for allocation and distribution of resources. Resources are distributed differently based on the bargaining power each one of them has within the household (Alderman et al 2006; Hoddinott and Haddad 1995; Quisumbing and Maluccio 2003; Quisumbing 2003). The sex of a person who has access to and control over resources has an upper hand in influencing the extent to which resources are allocated to nutrition and health outcomes in a household (Quisumbing 2003).

A study by Getaneh (2013) in Ethiopia demonstrates that the income from sale of livestock especially small ruminants was closely related to child nutrition. He notes that this was because increased household income in the hands of women led to the increase in access to food and health services. There is further evidence that women who have an independent income usually use it for household consumable goods and health services (Thomas, 1997). Getaneh (2013) argues that livestock is an immediate source of income in emergency times when children are sick and they need treatment or even when there is need for paying school fees.

A study carried out in Brazil by Thomas in 1997, shows that income accruing to women has a positive impact on child nutrition than income from men. A woman contributing to household income is seen as a contributing factor to her participation in decision making thereby increasing her bargaining power (Agarwal, 1997). Women's contribution to household resources improves their self-esteem and also changes their status in the community thereby increasing their fallback position and enhancing their bargaining power (Agarwal, 1997, Thomas, 1997). Getaneh (2013) demonstrates that women have better control of resources that are situated around the household like small ruminants,

backyard gardens, poultry and petty trade and these are quickly translated into cash income when the need arises.

Thomas (1997) indicates that child health and survival is much more improved by increasing women's cash income more than that of men. A woman's earned income being taken as a measure of her relative control over household resources. Equally important to note is a study which was done by Levin, Ruel and Morris in 1999 among urban households in Ghana. They found out that women allocated a large share of their income to meeting their children's basic needs, although they earned less than men.

### 2.7 Effects of Women's Relative Bargaining power on Child Nutrition

There has been an established link between improvements in women's education and positive impacts on children's nutrition (Chen & Li 2009, LeVine 2004, Smith and Haddad 2000). Chen &Li (2009) show that more highly educated women benefit from access to resources because they are more likely to earn an income and are able to participate in decision making because of their improved status in the household.

Uddin,Hossain & Ullah (2009) note that although many studies on the effects of mothers education and child nutrition do not make direct comparisons with the effects of the fathers education, some studies have shown a relatively greater impact of a mothers education as compared to the fathers. The benefits of mother's education for child nutrition vary according to geographical settings that is, rural versus urban areas (Bicego & Boerma, 1993). The authors point out that education can be shown to enable urban women to access healthcare services which exist in greater numbers and as compared to rural areas. They also suggest that children in rural settings may benefit less from their

mother's education due to rigid traditional structures, norms and values which may constrain them (Bicego & Boerma 1993).

A study carried out by Jones, Walsh & Buse (2008) on maternal education in East Africa established a link between higher maternal schooling and high immunization coverage. They also discovered that mothers who were educated were able to bargain for better health services. A research carried out by Das Guspat (1990) in rural Punjab also found that maternal education improves child care practices like the use of rehydration therapies and immunization uptake.

As research on maternal education proves, children benefit from their mothers raised income status. It has been discovered that this is related to increase in bargaining power and increased access and control of resources (Rahman, Iqbal & Harrington, 2003). Bargaining power and access and control of resources are interrelated, this is because women in households may have more control over resources when they have greater bargaining power due to their level of education and the reverse is true. On the other hand, some mothers may have access to resources, have a certain level of education, but are not able to influence decisions involved in the use of those resources due to various factors. Therefore, this study intends to explore the bargaining processes that take place inside the household in relation to child nutrition. Why is it that some women cannot make independent decisions in regard to nutrition and specifically to diet diversification and infant feeding? Does this have something to do with gender relations?

## 2.8 Intersection between Gender Division of Labour and Gender Relations

Gender is defined as the socially constructed roles and responsibilities between women and men (Baden and Goetz, 1998). These socially constructed roles and responsibilities are often times unequal in terms of power, decision making, control and ownership of resources. Ellis argues that gender is fundamentally about power, subordination, and inequality. It is also about ways of changing these to secure better equality (2000). The approach to gender recognises the different relations between men and women across cultures, but, insists on the reduction of the social inequalities experienced by women as an overriding goal (Ellis, 2000).

El-Bushra notes that gender as a concept should be seen, not as a politically correct ideology but as "an integral element in a wider search for a deep understanding of human behaviour which concerns itself with physical and emotional needs, perceptions, motivations, relationships and structures" (2000:62). Other concepts such as power and identity explain how people struggle to shape their lives despite the constraints imposed by their roles, positions and personal attributes. El-Bushra (2000) goes on to say that if the concept of gender is to be a useful tool of analysis in development or for the advancement of the women cause, gender research, policy and practise should direct energies towards understanding its complex nature and meaning.

According to Helmore & Singh (2001), the roles of women and men are charged with different meanings in different societies and these meanings are reinforced by traditions that socialise people around their respective gender roles. The gender approach asserts

that it is essential to acknowledge and take into account the distinctive roles of women and the difficulties they face. The different social situations which women face within a household and the unequal sharing of resources should be recognised (ibid). Ellis (2000) points out that gender specific research is expanding appreciation of all people by looking at what makes each sex unique. "Men and women may have collective strategies and when they do, the barriers and obstacles that women experience in their lives and in their economic activities will have an overall depressing impact on the household strategies" (Helmore and Singh 2001:9). To assess what household strategies might be, we need to recognise the issue of gender roles and factor them into these strategies (ibid).

Moser (1993) notes that, it is crucial to recognise that in most cultures women and men have different positions within a household and also have different control and access over resources. Women and men play different roles in society and have different needs. Goetz points out that women often have unequal ownership and access rights to land and other productive resources. Often times their access to resources occurs through the mediation of men (2003). Most feminist scholars argue that, women's participation in decision making in resource use and allocation is in most cases restricted (Ellis, 2000, El-Bushra, 2000, Tinker, 1990)

Moser (1993) further points out that, the gender division of labour provides the underlying principle for differentiating the roles women and men play. It also provides the rationale for the difference in value placed on such roles. Women and men boys and girls have different needs and play different roles within a household and exercise

different levels of access and control over household resources (Moser, 1993, Ellis, 2000, El-Bushra, 2000). Moser maintains that there is a link between the gender division of labour and the subordination of women (1993). There are different roles played by women in society and these include: reproductive, productive and community work. The reproductive roles include domestic tasks like washing, cleaning, cooking among others. Other reproductive roles are childbearing responsibilities plus all activities done in a home to ensure the maintenance and production of the labour force. The productive roles comprise of the work done by men and women for payment purposes whether in cash or in kind, it includes both market production with an exchange value and subsistence production with an actual use value but also with a potential exchange value (Moser, 1993, Kabeer, 1995).

Ellis (2000) explains that evidence seems to suggest that intra household inequality of consumption between men and women is a very important source of gender inequality. Ellis goes ahead to say that "many researchers consider that intra household inequality of consumption between men and women is likely to be of greater significance than inter household inequality based on the sex of the household head" (2000:146). Furthermore, it is possible that the intra household distribution of resources especially money income between women and men makes a big difference to patterns of household expenditure. Research shows that cash income in the hands of women is utilised mainly for the welfare of the family while cash income in the hands of men is most times retained for personal consumption and expenditures (Young, 1992, Kabeer, 1998). Similarly Mencher (1998) cited in Ellis (2000) carried out research on sampled household in south India and

discovered that women spent cash income that comes into their hands entirely on family needs while men retained a significant proportion for personal consumption.

### 2.9 Gender Relations and Intra-household bargaining in Rural Households

Women and men, girls and boys play different roles in their communities. The roles vary from one place to the other. Based on the different roles, society allocates different activities to females and males (CCIC, 1991). The behaviour, activities and interaction between men and women constitute a gender system within a community which suggest that the different components of gender are thought to be interrelated and influence each other. It is therefore important for scholars and researchers alike to understand the different gender dynamics at household level so as to understand the bargaining processes and trade-offs that takes place therein.

According to Muhereza (2001), it is important to note the implications of the different experiences of gender between men and women, boys and girls, so as to know why people behave the way they do. Muhereza further points out that within pastoral households in western Uganda, control exercised over resources has been shifting between the women and men depending on the power relations at the household level (2001). The consequences that the division of labour at the household level has had on both sexes in relation to nutrition will be considered in this study. In some literature related to gender and development, there is a strong argument that, malnutrition disrupts household livelihoods leading to poverty in general. Most women suffer more as they

have to bear the burden of looking for food and taking care of the children and the elderly. However, there is need to look at intra household relations, of material and social reproduction of gender, in the context of changing relations of ownership and access to resources (Byrne, 1996). In addition, it would be useful to assess the allocation of household labour between tasks amongst men and women, girls and boys as well as the elderly, in order to understand the gender dynamics in nutrition among rural households.

Kabeer (1994) maintains that there is widespread interaction inside the household, with household members undertaking diverse and multiple tasks varying according to age and sex. Apart from being a place where socialisation takes place, the household is also a primary site for structuring gender roles and relations as manifested in sexual division of labour and allocation of resources (Muhereza, 2001). Households are not homogeneous they differ in accordance to size and type. They may either be nuclear, or extended, female headed or male headed. As a result the interests and nutritional needs of each member of the household vary (Onyango, Tucker & Eisemon 1994).

According to Muhereza (2001) gender relations among rural households are structured on the basis of a number of issues, like the gender division of labour within the household. He goes on to say that in the different pastoral production for example activities at the household level are subject to gender division. The primary role of the wife in the households is to take care of children and the home, whereas the man's role is supervision of the activities in the entire household. The division of activities is dynamic and it changes with time (Kandagor 2005).

Kajura (2003) argues that the division of labour in households depends on whether the particular commodity for which labour is required is a cash commodity or not. Commodities that are unpaid are predominantly for the women, while those that are paid are taken over by the men (Muhereza, 2001). In some rural communities like most pastoral households children constitute a large percentage of household labour. Children's work in pastoral households is also structured on gender lines. The role of the male youth is herding while that of young females is to provide house help to their mothers by doing domestic chores and milking. The roles of the young children in most rural households are structured around what each sex will be expected to perform when they grow up (Muhereza, 2001).

In addition, Muhereza argues that in typical patriarchal pattern, the way rural households operate in the day to day management of their activities, is mainly a result of the husband's power to define their wives situation (2001). He further observes that "in almost all the pastoral households without exception, young people are subordinated to the old and women to men. While the power that husbands exercise over their households is based on their being male, it is also the result of socially sanctioned power networks acceptable in the entire pastoral society" (Muhereza, 2001:21). In many of the rural household activities there are deeply embedded sexual division of labour, in which women find themselves charged with responsibilities of childcare and domestic work, while the men are preoccupied with other activities (Muhereza, 2001, Kajura, 2003).

Focussing on gender relations at household level and looking inside the households (intra household dynamics) makes women more visible and tackles power relations. Looking at people inside the households means seeing each member as an individual, as a source of production and reproduction of resistance to change and of change (Muhereza, 2001). As observed by Masini & Stratigos (1991) cited in (Muhereza, 2001) it means seeing men and women children and the old people in relation to each other which in the context of this study, implies looking at the way nutrition affects each category with emphasis on children under five years. From the foregoing discussion, it can be established that gender relations is associated with the nutrition status of children. What is not clear is how the individual household member's bargaining power influences how resources are allocated to children's nutrition. This research aims to fill this gap by exploring how gender relations influence the nutrition of children under five.

**Conclusion**

In conclusion, literature suggests that that gender relations i.e. power and material relations that include access to and control over resources may have a big influence on child nutrition. Although men may be earning more than women in most households, they spend more of their income on non-food items, while women are left to cater for food. Further, the literature has shown that income in the hands of women results in better nutrition in the household. Women are the primary caregivers in most households yet they have the least decision-making power and as a result lack control over their fertility and time. Women's lack of time and high fertility rates are critical factors in undermining the health and nutrition outcomes of their children. Literature further

suggests that gender inequality weakens women's capabilities in achieving and ensuring good nutrition for the entire household. Questions however remain as to what extent that gender relations relate to intra-household bargaining among rural households and how these impact on the nutrition of children less than five years. Questions also remain as to how bargaining processes can be influenced to improve nutrition in the household. This research will fill this gap in literature.

# Chapter three

# Methodology

## 3.0 Introduction

This section explains the research design and the methods that will be used to collect data. This section will be presented under the following headings; research design, study area, study population, sampling strategy, methods of data collection, process involved in the research, limitations, ethical issues and data analysis.

## 3.1 Research design

The research design will be comparative, cross-sectional using both qualitative and quantitative methods of research. The comparative aspect will examine different child nutrition patterns and gender relations. Specifically the design will enable comparisons among the three categories of nutrition status among children, severe, mild and normal. The rationale is to establish if the three groups come up with similar responses and assess whether gender relations are a determinant in the nutrition status of the children.

Although quantitative data can easily be analyzed by statistical techniques such as the Statistical Package for Social Sciences (SPSS), more emphasis will be given to qualitative data in order to capture the gender relations. According to Sarantakos (1998:51) qualitative research is flexible; "it is not predetermined by hypotheses and procedures that might limit its focus, scope or operation. Its perception and approach are open in all aspects, namely with regard to its research subjects, the research situation or the research methods to be employed". The researcher will use qualitative methods of

data collection because they capture and inform better on those aspects such as vulnerability and body language, which are difficult to quantify (Kane and O'Reilly-de Brun, 2001).

In addition, qualitative methods will be used to elicit the silent voices of women through verbatim presentation of quotations. Sarantakos (1998:46) points out that qualitative research "attempts to present information gathered verbally in a detailed and complete form not in numbers or formulae". Sarantakos, (1998:47) also argues that, "qualitative methodology tries to capture reality in interaction" thus; more emphasis will be put on qualitative data in order to capture the gender relations in the households.

Quantitative methods of data collection will be applied in those areas, which need quantification such as the socio-economic background of the different respondent's access to and control of resources within households. This information will be collected using a structured questionnaire.

### 3.2 Study Area

This study will be conducted in Kisoro and Kanungu districts purposively selected because of the high levels of poor nutritional indicators. The two districts have the highest stunting levels in South-western Uganda according to recent statistics. Stunting is a severe and irreversible form of under nutrition among children. In Kanungu stunting is at 43.8% (UNICEF 2014) and in Kisoro it is at 51.4% (Nutrition Innovation Lab-Africa (NILA) (2013). In addition, these are also early riser districts in the scaling up nutrition (SUN). Scaling up nutrition (SUN) is an initiative put in place by the government and its partners for the intensification of nutrition interventions in Uganda, and there were some

districts, known as “early risers” set up to take up this initiative in the first phase. Within each district, data will be collected from two purposively selected sub counties with high numbers of malnourished children.

**Table 1: Summary Description and Rationale for Selection of Study Areas**

| | | |
|---|---|---|
| Kanungu(stunting in the district is at 43.8% (UNICEF 2014). | Kirima | This sub county will be selected because of its nutritional problem, which is shortage of food, most households have utilised the land for tea growing and tree planting. The little food grown here is sold off. This may be affecting children’s nutrition. Kirima is a tea growing area and is close to the Congo boarder; the significance of this is that there is a ready market for tea, timber and food crops. Peasants sell at cheap price during the harvesting period to the people in Congo. During the dry season or food scarcity periods they buy the same at very high prices from Congo, food scarcity has an influence on nutrition. It will be interesting to see how bargaining processes unfold in the households since the sub county largely depend on the market. |
| | Kanungu Town council | For comparisons between the nutrition situations among the people living in the rural town and the ones in the rural villages. |
| Kisoro (Stunting in the district is at 51.4% (Nutrition Innovation Lab-Africa(NILA) (2014). | Nyabwishenya | This will be considered because of the poor nutrition status of the communities in the area. In the sub county alone stunting is at 54% (NILA 2013), meaning that for every two children seen one of them is stunted. Additionally, the sub county experiences food shortages due to poor infertile soils. Other challenges there include: poor roads small land holdings and a hilly terrain with over utilised soils. |
| | Kisoro Town Council | This will be selected to check for any contrasts with the deep rural setting of Nyabwishenya. |

Within each Sub county one parish will be selected based on proximity to basic infrastructures such as health facility, roads and markets.

### 3.3 Study population

The study population will be mothers of children under five years with a nutrition condition, and their spouses. This is because; the study wants to establish whether there is a link between gender relations and the nutrition situation of the children. Other respondents will include, other mothers and fathers of children under five, health workers

at the local health facilities, community development officers (CDO's) and the village health teams (VHTs). The age bracket (of all the respondents will be (18) to sixty (60) years, and they will be from the selected sub counties.

### 3.4 Sampling Strategy

Laws *et al* (2003) describes sampling as a process of selecting a limited number of people to represent the larger group. They however go on to point out that it is not only people who are sampled but there are other issues included like location, time and events that you study. Sampling enables the researcher to choose the units of the target population which are to be included in the study (Sarantakos, 1998, Laws et al, 2003). In this research I will use purposive sampling, a non-probability sampling method (Sarantakos, 2005). "Purposive sampling, is where a researcher purposely chooses subjects who in their opinion are relevant to the subject, the choice of respondents is guided by the judgement of the investigator" (Sarantakos, 2005:164).

Four sub-counties in Kisoro and Kanungu districts (Nyabwishenya, Kisoro Town Council, Kirima and Kanungu town council have been purposively selected, basing on their nutrition indicators and location. From each of the sub counties a Parish will be purposively selected based on the rural-urban divide and proximity to a health facility.

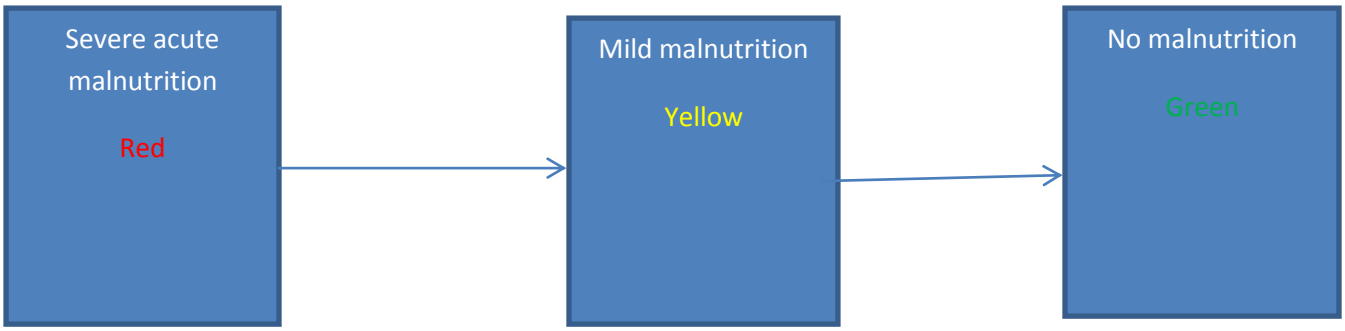
### Sample Size and Selection

All interviews, will take place at the health facility. There will be three FGDs of 8-10 people at each health facility. These will be, mothers of children in 3 categories: severe acute malnutrition (SAM) which is red, moderate malnutrition that is yellow and no

malnutrition which is green. When parents bring children to the health center when they are sick, they are assessed for nutrition with a tape commonly known as mid upper arm circumference (MUAC) tape.

The researcher will carry out, three FGDs per nutrition category red; yellow and green multiply by four health facilities. From these, the researcher will do in-depth interviews of 2 mothers in each category. Using systematic sampling six mothers two from each category in all the four health facilities will be asked to request their husbands to come for interviews.

The reason for interviewing all the categories is to compare whether the three groups come up with the same answers. The main issue is to find out whether gender relations are a determinant in the nutrition status of the children. In addition find out whether intra-household bargaining assists in moving children from one category to another.



| Research method | | Kisoro Hospital | Nyabwishenya Health Center | Kanungu hospital | Kirima health center |
|---|---|---|---|---|---|
| **FGDs** | Mothers of malnourished children | 6 | 6 | 6 | 6 |
| | Fathers of malnourished children | 2 | 2 | 2 | 2 |
| **In-depth Interviews** | Mothers of malnourished children | 4 | 4 | 4 | 4 |
| | Fathers of malnourished children | 2 | 2 | 2 | 2 |
| **FGDs** | Other community women | **Parish near Kisoro hospital** | **Parish near Nyabwishenya H/C** | **Parish near Kanungu hospital** | **Parish near Kirima H/C** |
| | | 3 | 3 | 3 | 3 |
| | Other community men | 2 | 2 | 2 | 2 |
| **In-depth Interviews** | Other community women | 4 | 4 | 4 | 4 |
| | Other community men | 2 | 2 | 2 | 2 |
| **Key Informant Interviews(KIIs)** | | **Kisoro** | **Nyabwishenya** | **Kanungu** | **Kirima** |
| | | 4 | 4 | 4 | 4 |

**Sampling Frame**

According to Sarantakos (1998:141) a sampling frame is "a list of the units of the target population... such as electoral role, student's record, rating records etc." The researcher will obtain a list of the residents from the local councils; and obtain records from the health centres like the register of women who attend antenatal clinics, mothers with

malnourished children who come to the health centres to collect therapeutic foods and for treatment; this will form the sampling frame. This means that the researcher will have two sampling frames, and the sampling frame obtained from the health facility will comprise of the main interest group. Currivan and Roe (2004) have suggested that using this dual-sampling frame is more likely to increase the efficiency of reaching the target group for the study.

### 3.5 Methods of data collection

#### 3.5.1 Primary data collection

Under primary data, the main methods of data collection will include; use of focus group discussions. Focus group discussions "involve persons especially selected owing to their particular interest, expertise or position in the community in an attempt to collect information on a number of issues" (Sarantakos, 1998:180). Focus group discussions can be used to facilitate group discussions; they are often used as part of other methods. They stimulate discussions and information flow (Sarantakos, 1998, Robson, 1993, Laws et al, 2003).

Semi structured interviews are used in qualitative research to allow for a high level of freedom and flexibility in the questioning process (Sarantakos, 1998 p.255). The question structure is not fixed or rigid, allowing change of question order even the addition of new questions where necessary (ibid).

The focus group discussions and semi structured interviews will be geared towards establishing the reactions and answers of the respondents that relate to the sub themes and objectives of the study.

Observation according to Sarantakos, (1998), Laws et al (2003) is one of the oldest methods of data collection often used by Anthropologists. Observation can be used as participant observation or systematic observation (Laws et al, 2003). Participant observation is "learning from living and/or working alongside those you are studying (Laws et al, 2003:304). Systematic observation on the other hand is "where observers look for specific behaviour at specific times and places (ibid). I will use systematic observation to capture those aspects such as body language, the environment and other features, which cannot be easily captured, by the use of interviews. The observation will take place during the FGDs and KIIs and also when I visit the study participants in their homes.

A semi-structured questionnaire will be designed and orally administered to 60 women and 40 men in the sample in the local language. This makes total sample 100. It is felt that the number 100 is representative of the total sample. This is aimed at establishing the socio-economic and demographic characteristics, nutrition and livelihood patterns of the respondents that relate to the sub themes and objectives of the study.

### 3.5.2 Data collection instruments

Robson (1993), describes a topic guide as set of questions to guide the conversation. In this research, a topic guide (for interviews and FGDs) will be formulated within the research objectives. The observation checklist will be done, to spell out issues that will be observed.

### 3.6 Procedures of Data Collection

The sampling method for this study is based on the study parameters. The respondents should be willing to be part of the study. I will approach the leaders of the communities and the health centres to enable me, carry out research in their area. I plan to carry out this study in a period of 12 months; it is hoped that during this time, the researcher will have finished all the processes required in data collection.

When Parents come with their sick children to the health centres for treatment, they are assessed for severe, acute and moderate malnutrition. The children are then registered. The parents with children who are moderately malnourished are counselled, given talks on nutrition, advised on infant feeding/caring practises and given a period in which to come back for review of the children. Those with severe acute malnutrition are admitted, if the health centre can manage the children's condition. If the centre does not have the services, the children are referred immediately to a bigger hospital. The researcher will recruit mothers and fathers of the malnourished children for her study, with the intention of examining whether gender relations and intra-household bargaining were factors in the children's nutrition condition.

The researcher will then follow some selected study respondents to their homes to observe the environment at household level and to engage with them more deeply about what takes place inside the households, with particular focus on bargaining. These will be four in number per district as earlier seen, that is two mothers and two fathers and the

selection criteria will be mothers and fathers who have children under two with severe acute malnutrition (SAM). These will be taken as case studies.

The research will be organised in a way that, respondents will be interviewed on household bargaining, gender relations and nutrition of children under five. The researcher will then do a dietary diversity to check for food frequency and diversity, using a simple household diet diversity score adopted from food and nutrition technical assistance (FANTA-2).

The interviews will take place in venues and times chosen by respondents, so as to ensure their comfort and confidentiality. Confidentiality with FGDs will come with a disclaimer that, in an FGD setting, confidentiality cannot be guaranteed. The interviews and FGDs will take place in the selected sub counties and parishes. All FGDs will be tape recorded with permission from the respondents and will be transcribed by only the researcher, for verification purposes.

### 3.7 Research Limitations

> Sarantakos (1998:53) observes a number of limitations in qualitative research as: problems of reliability caused by extreme subjectivity, the risk of collecting meaningless and useless information, it is time consuming, has problems of representativeness and generalizability of findings, problems of objectivity and detachment and problems of ethics (entering the personal sphere of subjects).

There will be limitations due to the qualitative nature of this research and the sample size. Due to this, the study will not be considered representative and the findings will not be generalised to the wider population. As Sarantakos (1998:27) observes it is “too small to

reflect attributes of the population concerned". Since the study seeks to explore how household bargaining on nutrition is affected by gender relations, some respondents may not be willing to release such information. In relation to this, some members of the households are very suspicious of each other, and the relationship between some of them may be constrained. Interviewing different members of the households from one community and going to another for purposes of this research may create a lot of suspicions and may affect the type of information that will be got. However this will be solved by using the Local Council Leaders in the different areas to clarify to the household members the purposes of the study, and to explain that the researcher is carrying out the research for study purposes only.

According to (Sarantakos, 1998) key requirements for interviews may include, trust and friendship, length of the interviews, competency of the interviewer, and the ability of the respondents to speak out. Some of the respondents might want to be financially rewarded before they can release any information. This will be solved by clearly stating the purpose of the study and where the researcher is from. The interviews will be conducted in the local languages of the research area, this has a potential challenge of translation, and some information may be lost. This will be minimised by working with a local language expert in the area, so as to retain the local meanings of some words as much as possible. The researcher also knows the local languages of the study areas.

Laws et al (2003), argues that there are hard to reach people and there are many challenges involved in penetrating some communities, this applies to this study, due to the nature of the subject matter and the people involved. Kisoro and Kanungu districts are

hard to reach accessing the research area and the needed households may not be easy. This will be addressed by using four wheel drive vehicles and local guides.

### 3.8 Ethical Issues

Sarantakos (1998:21) looks at ethics in research as "the controlling factor, with research being guided by unwritten standards and principles which were left to the researcher to accept or reject". However with research becoming more frequent and more prone to abuse there was increasing need for some regulation (Sarantakos, 1998). A letter of introduction stating the purpose of the research will be obtained from MUST-UTAMU universities. In addition, permission will be sought from the districts administration and sub county leadership plus the local authorities, before the collection of data. Confidentiality will be assured. To maintain integrity of the information presented in the dissertation, reference will be made to all information collected from already documented texts. The purpose of the research and how it will be used will be explained to the respondents from the beginning. As this research will be carried out on individual members of the household, it is very sensitive in nature and ethical considerations will centre on confidentiality, consent, anonymity and voluntary participation (Sarantakos, 1998). When studying vulnerable people their welfare should be central (Sarantakos, 1998, Laws et al, 2003). The type of questions that i will ask, will take this into consideration.

### 3.9 Data analysis

Sarantakos (1998:314) notes that, during qualitative data analysis "the investigator searches for patterns...in form of recurrent behaviour, events etc., and when such patterns are identified, interprets them moving from description of empirical data to interpretation of meanings". Qualitative data will be analysed thematically along the themes of the major variables, for instance, gender relations and intra-household bargaining, social norms and values as determinant's in bargaining for nutrition. Kane and O' Reilly de Brun (200:369) point out stages of data analysis and these are: "data collection, data reduction, finding groupings and relationships, visual data displays and drawing conclusions". In this study, broad categories will be developed to differentiate and describe the ideas expressed by the respondents. These broad categories will further be broken down to indicate the direction of experiences and perceptions.

For quantitative data, at the end of each day, the researcher will edit the completed questionnaires for accuracy, completeness and uniformity. For the closed questions, the answers will be coded in the coding frame. Coded responses will be entered into the computer for analysis using the Statistical Package for Social Sciences (SPSS).

# References


Alderman, H., Hoddinott, J.,& Kinsey, B.(2006).Long-term Consequences of Early Childhood Malnutrition.*Oxford Economic Paper* 58, 450-474.

Agarwal, B. (1997). Bargaining and Gender Relations: Within and Beyond the Household.*Feminist Economics,* Vol.3, No.1, 1-51

Agarwal, S. & Srivastava, A. (2009). Social determinants of children's health in urban areas in India, *Journal of Health Care for the Poor and the Underserved*, 20 (4).68-89

Attanasio,O. & Valerie, L. (2002). Tests of income pooling in household decisions, *Review of Economic Dynamics*, 5, 720-748.

Baden, S. and Goetz, A. (1998). Who needs sex when you can have gender: Conflicting discourses on gender at Beijing. In C. Jackson and R. Pearson (eds.) *Feminist Vision of Development, Gender Analysis and Policy. London,* Rutledge.

Bhagowalia, P., A. R. Quisumbing, P. Menon and V. Soundararajan (2012).*What dimensions of women empowerment mattersmost for child nutrition? Evidence using nationally representative data from Bangladesh.* IFPRI Discussion Paper 01192. Washington DC: International Food Policy Research Institute.

Bicego, G. T. & Boerma, J. T (1993). Maternal education and child survival: A comparative study of survey data from 17 countries, *Social Science and Medicine (1982*), Vol. 36, no. 9, pp. 1207-1227.

Black, R., zulfiqar, H. Bhutta, A. Laura. E. , Caulfield, A. Mercedes de onis, Ezati, M. Mathers, C. Rivera, J. (2008). Maternal and child undernutrition:Global and regional exposures and health consquences.vol.371, no.9608pp243-260.

Bobonis, G. (2009). Is the allocation of resources in the household efficient? New evidence from randomized experiment, *Journal of Political Economy* Vol. 117, no. 3, pp. 453-503.

Byrne, B. (1996). Towards a gendered understanding of conflict:war and ruraldevelopment in Africa, *IDS Bulletin*, Vol. 27, no. 3 pp. 31-38.

Castle, S. E. (1993). Intra household differentials in women status: household functioning and focus as determinants of children's illness management and care in rural Mali, *Health Transition Review*, Vol. no. 3.pp. 137-156.

CCIC (1991).*Development policy and strategy for the development of rural women*.Ottawa, Canadian Council for International Cooperation.

Chen, Y. and Li, H. (2009). Mothers education and child health: Is there a nurturing effect? *Journal of Health Economics*, Vol. 28, no. 2, pp. 413-426.

Currivan, D.B and David J. Roe, D.J (2004). *Using a dual-frame sample design to increase the efficiency of reaching populationsubgroups in a telephone survey* . RTI International 2004. Paper presented at the 59th annual meeting of the American Association for Public Opinion Research

Das Guspta, M. (1990). Death clustering, mothers education, and the determinants of mortality in rural Punjab, India, *Journal of Population Studies*, vol. 44, pp. 489-505.

Duflo, E. (2003). Grandmothers and grand daughters:Old-Age pensions and Intra-household allocations in South Africa, *The world Bank Economic Review* vol. 17, no. 1, pp.1-25.

El Bushra, J. and Pizza Lopez, E. (1993). Working on gender in conflict situations: Some ideas on strategy, In H. O Connell (ed.) *Women and Conflict*, UK, Oxfam.

Ellis, F. (2000).*Rural Livelihoods and diversity in developing countries*, Oxford University Press, Oxford.

Engebresten, I.M.S, Moland, K.M, Nankunda, J. Karamagi, C.A, Tylleskar, T., Tumwine, J. K.(2010).*Gendered perceptions on Infant feeding in Eastern Uganda: Continued need for exclusive breastfeeding support*, Norway, Biomed Central.

Engel, P.L. (1999). The role of caring practices and resources for care in child survival, growth and development: South and South East Asia, Asia *Development Review* vol. 17 (1-2) pp. 132-167.

Engel, P.L., Menon, P. and Haddad, L. (1999). Care and nutrition: Concepts and measurements, *World Development* vol. 27, No. 8, pp.1309-1337.

FANTA-2 (2010).*The Analysis of the nutrition situation in Uganda*, Food and Nutrition Technical Assistance II Project, AED, Washington DC.

Garcia, V. (2001). Coffee production and household dynamics: The popolucas of Octal, veracruz, *Agriculture and Human Values*, vol. 18, No.1, pp. 57-70.

Getaneh, M. (2013). The linkage between rural women's status and child nutrition: A case study of Meskan district Ethiopia. In Prah, M. (ed.) *Insights into ender Equity, Equality, and Gender Relations in Sub-Saharan Africa*, OSSREA Fountain Publishers, Kampala.

Goetz, A.M (2003). The problem with patronage; Constraints on women's political effectiveness in Uganda, In A.M Goetz and S. Hassim (eds.*), No Short cuts to Power, African Women in Politics and Policy making*, London and New York, Zed books.

Government of Uganda (2003).*The National Food and Nutrition Policy*

Government of Uganda (2003).*The National Food and Nutrition Strategy and Investment Plan*

Government of Uganda (2009).*Child Survival Strategy*

Government of Uganda (2009). National Development Plan 2010/11-2014/15

Helmore, K. And Singh, N. (2001).*Sustainable Livelihoods*, Washington D.C, Kumarian Press.
HMIS Report (2011/12).*Outpatient and Inpatient records*, Ministry of Health, Kampala

Hoddinott, J., and Haddad, L. (1995). Does female Income share influence household Expenditures? Evidence from Ivory Cost, *Oxford Bulletin of Economics and Statistics*, vol. 57, no.1 pp. 77-96.

Hodgson, D. and McCurdy, S. (2001). "*Wicked" Women and the Recognition of Gender in Africa*, Portsmouth NH, Heinemann.

Jones, N., Walsh, C. &Buse, K. (2008).*Gender and Immunization*: Abridged Report, London Overseas Development Institute.

Kabeer N. (1995).*Reversed Realities, Gender Hierarchies in Development thought*, London, Verso.

Kabeer, N. (1997). Women wages and Intrahousehold power relations in urban Bangladesh, *Development and Change*, Vol. 28, no.4, pp. 261-302

Kabeer, N. (2005). Gender equality and women's empowerment: A critical analysis of the third millennium development goal, *Gender and Development* Vol. 13, No.1, pp. 13-24.

Kajura, K. S. (2003).*The Effects of Development Interventions on the Welfare of Pastoral Community of Nyabushozi County, Mbarara District,* NURRU Publications, Kampala.

Kane, E. and O, Reilly-de Brun, M. (2001).*Doing your own Research,*London, Marion Boyar.,

Kikafunda, J.K., Walker, A.F., Collet, D. and Tumwine, J. K., (1998).Risk Factors for Early Childhood Malnutritionin Uganda.*Pediatric*, 102(4): 45 – 54

Koopman, J., (1991). Agricultural household models and African agricultural households: Can the data be Squeezed into a unitary household model, *Review of Radical Political Economics* vol. 23. pp.3-4.

Laws, S., Harper, C., Marcus, R. (2003).*Research for development, A practical Guide*, London, Sage and Save the Children.

Levin, C. E., Ruel, M.T, and Morris, S.S. (1999). Working women in urban setting: traders, vendors and food security in Accra, *World Development* vol.27, No.11, pp. 1977-91.

LeVine, R. (2004). Maternal Literacy and Health Behavior: A Nepalese Case Study, *Social Science &Medicine*, Vol. 58, No. 4, PP. 863-877.

Manyire, H. ( 2009).*Liberalization of Agricultural Markets, Livelihood Patterns and Gender Relations in Central Uganda:* The case of Ntenjeru Sub county Mukono District, PhD (Gender Studies) Thesis, Makerere University, Kampala.

Marshal, B. (1994).*Engendering Modernity: Feminism, Social Theory and Social Change*, Cambridge, Polity.

Masini, E., and Stratigos, S. (1991).*Women, Households and Change*, Tokyo, United Nations University Press.

Meinzen-Dick, R., Behrman, J. Menon, P., Quisumbing, A. (2012). Gender a key dimension linking agriculture programs to improved nutrition and healthin F, Shengen and P, Rajul (Eds.) *Reshaping Agriculture for Nutrition and Health*, IFPRI, Washington DC

Mencher, J.P. (1998). Women's work and Poverty: Women's contribution to household maintenance in India. In D. Dwyer and J. Bruce (eds.) *A home divide: Women and Income in the third World*, Stanford, Stanford University Press.

Ministry of Health (2005).*Health Sector Strategic Plan 2, 2005/2006-2009/2010*, Kampala, Government of Uganda.

Ministry of Health Uganda (2009).*Policy Guidelines on Infant and Young Child Feeding forUganda*, Ministry of Health, Kampala

Ministry of Planning and Economic Development MOPED (1999).*Poverty Situation in Ethiopia*, Welfare Monitoring Unit, Addis Ababa, Ethiopia.

MOH-Kenya, (2011).*Formative assessment in Eastern and western Kenya: Engaging grand mothers and men in Infant and young child feeding and maternal nutrition*, Manoff group and Univesity Research Co., LLC.

Morozumi, R. (2012). A test of a unitary model on labor Supply using data on household decision making systems, *Applied Economics*, vol. 44, no. 33 pp. 4291-4300.

Moser, C. (1991).*Gender planning and Development: Theory, Practise and Training,* London, Rout ledge.

Muhereza, E. M. (2001).*Ranches, Restructuring and Changing Gender Relations in Pastoral Households in the Former Ankole Ranching Scheme* CBR Working Paper No. 70, Kampala, Centre for Basic Research Publications.

Mwadime, R. K. (2012) Accelerating national policy making across sectors to enhance nutrition. In *Reshaping Agriculture for Nutrition and Health (eds.),* Washington D.C, IFPRI.

Mwangome, M.,Prentice, A.,Plugge,E.,Nweneka,C. (2010).Determinants of appropriate child health and nutrition practice's among women in rural Gambia, *Journal of Health, Population and Nutrition,* Vol.28, no. 2, pp. 167-172.

Namugumya, S. B. (2012) Advocacy to reduce malnutrition in Uganda: Lessons for Sub-Saharan Africa. In *Reshaping Agriculture for Nutrition and Health (eds.),* Washington D.C, IFPRI.

Nutrition Innovation Lab-Africa (2013). *Assessing the Linkage between Agriculture, Food Security, Nutrition and Health among Women and Children in Rural Ugandan Households,* Makerere University, Harvard University and Tufts University.

Nyakato, V. N. (2013). Gender Inequality in household labor: Implications for demand for maternal health care in Uganda. In: Prah, M. (ed.) *Insights into Gender Equity, Equality, and Gender Relations in Sub-Saharan Africa,* OSSREA Fountain Publishers, Kampala.

Onyango, A. Tucker, K. &Eisemon, T. (1994). Household headship and child nutrition: A Case Study in Western Kenya, *Social Science & Medicine (1982*), Vol. 39, no. 12, pp. 1633-1639.

Profiles (2010).*National Profiles on Local Health Departments*, NACCHO.

Quisumbing, A. R., (2003).*Household decicions, gender and development: A sysnthsesis of Reccent Research,*Washington D C.International Food Policy and Reasearch Institute.Quisumbing, A. R., and Maluccio, J. A. (2003). Resources at marriage and Intrahousehold allocations: Evidence from Bangladesh, Ethiopia, Indonesia, and South Africa, *Oxford Bulletin of Economics and Statistics* vol. 65 no. 3 pp. 283-327.

Rahman, A., Iqbal, I. & Harrington, R. (2003). Life events, social support and depression in child birth: Percepectives from a rural community in the developing world, *Psychological Medicine,* Vol. 33, pp. 226-237.

Rashed, S., Johnson, H., Donggier, P.,Moreau, R., Lee, C., Crepeau, R., Lambert, J.,Jefremovas, V. & Schaffer, C. (1999). Determinants of Permethrin Impregnated Bed nets (PIB) in the Republic of Benin: The role of women in the acquisition and utilization of PIBs, *Social Science and Medicine* Vol. 49, no. 8, pp. 993-1005.

Republic of Kenya (2003).*Demographic Health Survey*, Kenya

Robson, C. (1993).*Real world research,* first edition,Cambridge: Blackwell.

Sarantakos, S. (1998).*Social Research second edition,* Australia: Macmillan.

Sarantakos, S. (2005) *Social Research third edition,* London: Macmillan.

Sen, A. K. (1990). Development as Capability Expansion, In K. Griffin and J Knight (eds.), *Human Development and the International Development Strategy for the 1990s,* London, Macmillan.

Smith, L. C.,Ramakrishna, U., Ndiaye, A.,Haddad, L., Martoreu, R. (2003).*The Importance of Women's Status for Child Nutrition in Developing Countries*, Research Report 3, International Food Policy Research Institute, Department of International Health, Emory University, Washington D.C.

Smith, L. C. (1995).*The Impact of Agricultural Price Liberalization on Human Wellbeing in West Africa: Implications for Intra-household preferences heterogeneity*, PhD Dissertation, University of Michigan.

Smith, L. C., and Haddad, L. (2000).*Explaining Child Malnutrition in developing countries: A Cross country Analysis,* International Food Policy and Research Institute, Washington DC.

Thomas, D. (1997). Incomes, Expenditures and Health Outcomes: Evidence on Intra-household Resource Allocation. In L. Haddad, J. Hoddinott, and H. Alderman (eds.) *Intra-household Resource Allocation: Methods, Models and Policy,*Baltimore, International Food Policy Research Institute John Hopkins University press.

Tinker, I. (ed.) (1990). Persistent Inequalities: Women and World Development, New York, Oxford University Press.

Uddin, M. J., Hossain, M. Z &Ullah, M. O. (2009). Child mortality in a developing country: A statistical analysis, *Journal of Applied Quantitative Methods*, Vol. 4 no. 3, pp. 270-283.

Uganda Bureau of Statistics (2006).*Uganda Demographic and Health Survey*, Macro International, Calverton.

Uganda Bureau of Statistics (2011).*Uganda Demographic and Health Survey*, Macro International, Calverton.

UNAP (2011-2016).*Scaling-up Multi-Sectoral Efforts to Establish a Strong Nutritional Foundationfor Uganda's Development*, Kampala

UNICEF (2008).*The state of the World Children*, UNICEF, New York.

UNICEF (2011). Annual Report, UNICEF, New York.

UNICEF (2013).*Feeding and Caring Practices and Beliefs in Uganda*: *A Qualitative Formative Study on Nutrition in Five Districts,* UNICEF, Kampala.

UNICEF (2014).*Food Security and Nutrition Assessment in Ibanda, Kabale, Kanungu and Pader Districts,* UNICEF-Uganda

World Bank (2001).*Engendering Development:Gender Equality in Rights, Resources and Voice*, Oxford, Newyork.

Young, K. (1992). Household resource management. In Ostegard, L. (ed.) *Gender and Development, Practical Guide*, Rutledge, London and New York.

| | | |
|---|---|---|
| **Final proposal written by:** | Pamela Kampire |  |
| **Approved by:** | Professor Mubangizi B. Claire | |