the incidence of underweight children under three from 30 per cent to 27.2 per cent, and ensures that a further 1.7 million children are adequately nourished.26

A growing body of evidence, principally from West and Central Africa, suggests that when resources are scarce, women generally prioritize the nutrition of family members above other personal and household issues. Survey results from Cameroon show that income-earning women typically spend 74 per cent of their funds to supplement the family food supply, while men spend only an estimated 22 per cent of their income on food.27 Research from Côte d’Ivoire and Ghana demonstrates that in the event of an external shock, such as surplus rainfall or drought, income received from Côte d’Ivoire and Ghana demonstrates that the distribution of food and profits which crops are grown and lack control over harvesting crops, but rarely own the land on which crops are grown and lack control over the distribution of food and profits.28 In which women tend to specialize, the decline in yields is about 20 per cent.

Throughout much of the developing world, women play an important role in planting and harvesting crops, but rarely own the land on which crops are grown and lack control over the distribution of food and profits.28 In which women tend to specialize, the decline in yields is about 20 per cent.

Increasing women’s access to the means of agricultural production, such as farming land or fertilizers, farm labour, credit and education is therefore crucial to guaranteeing food security and improving the nutritional status of children. Evidence from sub-Saharan Africa indicates that strengthening women’s control over these inputs can increase agricultural output by an average rate of 10 per cent.29

**Women prioritize family health care**

As the primary caregivers for children, women tend to be the first to recognize and seek treatment for children’s illnesses. Yet, as the findings of the Demographic and Health Surveys cited earlier confirm, many women around the world are denied a say in even the most basic decisions on family health, such as whether a child will be taken to the doctor, how much money will be spent on medication and the type of care they themselves will receive during pregnancy.

In households where women are routinely denied these rights, the health of the mother or her child in some cases – determines when and how to seek health care for family members. For instance, a study from Gujarat, India, reports that approximately 50 per cent of women interviewed felt unable to take a sick child to the doctor without the approval of their husband or parent-in-law.30

Women who have greater influence in decision-making can promote better health-care practices for the family. As evidence from Nepal and India shows, even after accounting for differences in education and wealth among the households surveyed, women’s participation in household decisions decreases stunting among children and reduces child mortality.31

Research from Ghana indicates that gender bias in household decisions can influence the quality of medical treatment that sick children receive. A study conducted in the Volta region found that men, typically the household decision-makers in rural villages, tend to treat malaria in children with local herbal remedies and generally regard formal medical treatment as a last resort. Women, in contrast, prefer to treat children immediately with antimalarial drugs from formal medical clinics, which are often located in neighbouring towns and therefore entail travel expenditures in addition to the costs of health care. Those women who lacked economic support from relatives or disagreed with their husbands or family elders about how the children should be treated struggled to obtain appropriate treatment for their ailing children. As a result, the local remedies preferred by men tended to prevail over formal medical treatment, often to the sick children’s detriment.32

Even when women can influence household decisions on medical care, they may still need the help of family members, particularly husbands or mothers-in-laws, to carry out their decision. In Bangladesh, Egypt and India, for example, social norms often discourage or restrict women’s mobility outside of the home. Restrictions on women’s movement can compromise children’s access to emergency health care by preventing women from travelling independently to shops, pharms – or hospitals, and limiting women’s direct contact with unrelated males, including doctors.33

**Women prioritize education**

Empirical research on the links between women’s decision-making power in the household and children’s education is in its infancy. Yet the evidence available indicates that women’s empowerment within the household increases the likelihood that children, particularly girls, will attend school. Recent studies have found that where gender influences outcomes for children, it tends to be related to the gender of the parent who controls the distribution of resources. A study of Brazilian households reveals that girls living with mothers who are educated and decision-makers are more likely to be enrolled in school and kept out of the informal labour market.34

Empowering women to prioritize girls’ education generates positive outcomes that span generations. A UNICEF survey of selected countries across Latin America and the Caribbean, South Asia and sub-Saharan Africa – including Cameroon, Côte d’Ivoire, Eritrea, Guinea-Bissau, Guyana, India and Suriname – finds that on average, children with uneducated mothers are at least twice as likely to be out of primary school than children whose mothers attended primary school.35

The importance of mothers’ education is supported by a separate study of children aged 7 to 14 years in 18 sub-Saharan African countries; the study found that 73 per cent of children with educated mothers were in school, compared with only 31 per cent of children whose mothers lacked schooling.36 Moreover, children with a formally educated primary caregiver are less likely to repeat a grade or leave school early.37

**Figure 2.5 Despite recent improvements, women’s literacy rates are generally lower than men’s**

![Figure 2.5](image-url)

Notes: Adult literacy rate refers to the percentage of persons aged 15 and over who can read and write. * Data refer to the most recent year available during the period specified.

Source: UNESCO Institute of Statistics. The underlying data can be found in the Statistical Tables of this report, page 98.