WOMEN STATUS AND CHILD HEALTH AMONG URBAN POOR HOUSEHOLDS IN NIGERIA

BY

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CERTIFICATION

This is to certify that this research was carried out by ADEYEMI OKIKIOLA CALLISTUS with the matriculation NO DSS/13/1167 in the department of demography and social statistics, Faculty of social science, Federal University Oye - Ekiti, Ekiti State. This work has been fully supervised and found worthy of acceptance in partial fulfilment of the award of Bachelor of Science {B.Sc.} degree in demography and social statistics.

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DATE

DEDICATION

I dedicate this work to Almighty God for helping me this far, he has always been my one true friend, father and pillar from the very beginning and alsoto my infatiguable, hardworking, loving, caring and dearest parent, I am deeply grateful.

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I would not be overemphasizing it that my life and all that has turn up to been me as been God and above all to him my heart rejoices in for bringing me to tell of his goodness and mercies for the successful conclusion of this work. I owe my supervisor Prof. Peter Ogunjuyigbe immense gratitude for his fatherly advice, timely corrections among other that have kept me on my toes as it has made me more agile to carrying out this research work despite all odds.

Words cannot express my gratitude to my ever loving parents Omo'Oba and Mrs Adeyemi, my departmental members, and all other member of staffs in the Department of Demography and Social Statistics.

Abstracts

In a developing country like Nigeria with high rate of poverty, there are intense different scholarly and programmatic interest in the effects of urban-poor household women on child nutritional status. This study investigated whether the socio-demographic factors of urban poor women can influenced child nutritional status (Underweight). Using data from the urban samples of Nigeria Demographic and Health Surveys and modeling women status on underweighting status.

Using multivariate models, we found that household living standards are closely associated with three health measures: unmet need for modern contraception, attendance of a trained health care provider at childbirth, and young children's height for age. Neighborhood living standards exert a significant additional influence in many of the surveys we examined, especially for birth attendance.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND OF THE STUDY

As per (Sandoval-Priego et al 2002), Children health status as showed by wholesome status as far as lack of healthy sustenance is one of the present health issues among the under five children that the world right now faces and is related with over 41% of the passings that happen every year in children from 6 months to two years of age in creating nations which add up to roughly 2.3 million. As indicated by World Health Organization in (2001) it was accounted for that 54% of all youth mortality was inferable, straightforwardly or by implication to hunger with Sub-Saharan Africa having a high rate of pervasiveness of the distinctive sorts of unhealthiness, in particular hindering, squandering and underweight (Lutter and Rivera, 2003).

(Dark and Allen, 2008) additionally announced that poor nutritional status of children has been a noteworthy general health issue all through the creating scene and is the basic reason for over 35% of child passings and 11% of the aggregate worldwide sickness trouble. Child malnutrition remains a profoundly common condition in low and center wage nations and a noteworthy segment of the worldwide weight of childhood malnutrition is found in South Asia with an expected 74 million children living with ceaseless malnutrition (hindered development). This weight of malnutrition represents around half of under-five child passings in creating nations. Another nation in Asia with a bigger level of children with incessant malnutrition is Bangladesh. The United Nations Children's Emergency Fund (UNICEF, 2010) revealed that out of the 209 million children that are hindered on the planet, 144 million are in East/South Asia

and the Pacific, 4 million in Central Asia, 12 million in Middle East and North Africa, and 9 million in the Americas and 40 million in sub-Sahara Africa.

Advance in enhancing baby and youthful child bolstering rehearses in the creating scene has been astoundingly ease back because of a few variables like destitution and poor clean conditions. The 2013 NDHS demonstrates that 37 percent of children under age 5 are hindered, and 21 percent are seriously hindered with 22 percent of hindered children in southwest, 18 percent of children in Nigeria are squandered, and 29 percent of children under age 5 are underweight.

Childhood under nourishment remains a general health issue in Nigeria, as the status did not enhance significantly amid the most recent two decades. The ramifications of this unwavering circumstance for the prosperity of children and for the improvement of the country all in all are unsuitable on the grounds that under sustenance adds to the high rates of horribleness, inability and mortality among children (Ene-Obong, 2010). Likewise, under nourishment compels individuals' capacity to satisfy their potential, as it is additionally connected with disabled development, mental advancement and school execution, diminished grown-up estimate and decreased work limit, which thusly impacts on financial efficiency at the national level (Fadeiye et al., 2001).

The National Demographic and Health Survey of 1990 gave data on the nutritional status of children 1-59 months old and recorded the pervasiveness of hindering as 43%, underweight, 36% and squandering 9% (NDHS, 1990). All the more thus, the Participatory Information Collection (PIC) consider, which gave another evaluation of the circumstance, demonstrated that hindering or ceaseless under sustenance was the most pervasive type of under nourishment in

Nigeria, with one out of each two children younger than five years being hindered (52.3%). The commonness rate of underweight was 28.3%, while that of squandering was 10.8% (PIC, 1995).

Later on, the 2003 National Demographic and Health Survey gave the accompanying figures: hindering 38.3%, squandering 9.2% and underweight 28.7% (NDHS, 2003). Further, broadly illustrative information, which exuded from the Nigeria Food Consumption and Nutrition Survey (2001-03) demonstrated that among under-fives, 42% were hindered, 25% underweight, and 9% squandered (FCN, 2004). In 2008, the National Demographic and Health Survey detailed that 41% of children under age five are seriously hindered, and the bigger rates of the hindered children are from the North West locale with 53% (NDHS, 2008). From the audit of these past national information, it gives the idea that there had been little advance in enhancing child sustenance in Nigeria.

Another issue emerging from the information is that reliably, all the national reviews have demonstrated that the predominance of child under sustenance in Nigeria is higher in the country than in the urban ranges. Thus, it gives the idea that country groups in Nigeria are nutritionally more powerless than those in the urban zones. Most country occupants depend specifically on agribusiness for their sustenance and jobs, and cultivating family units possess large amounts of these zones (Adeola, Yinyinade, and Alabi, 2016). Be that as it may, thinks about recording the nutritional status of youthful children in cultivating family units are rare in Nigeria. By and large, a standout amongst the most serious instances of child malnutrition is hindering and under five children constitute the most nutritionally helpless gathering in any group.Childhood stunting is one of the most significant impediments to human development, globally affecting approximately 162 million children under the age of 5 years. Stunting, or being too short for one's age, is defined as a height that is more than two standard deviations

below the World Health Organization (WHO) Child Growth Standards median 3. It is a largely irreversible outcome of inadequate nutrition and repeated bouts of infection during the first 1000 days of a child's life (WHO, 2004). Stunting has long term effects on individuals and societies, including: diminished cognitive and physical development reduced productive capacity and poor health, and an increased risk of degenerative diseases such as diabetes (Black et al., 2013). If current trends continue, projections indicate that 127 million children under 5 years will be stunted in 2025(WHO, 2006). Therefore, further investment and action are necessary to the 2025 WHO target of reducing that number to 100 million (Onis, Onyango, Borghi, and Garza, 2006).

Stunting is a well-established risk marker of poor child development. Stunting before the age of 2 years predicts poorer cognitive and educational outcomes in later childhood and adolescence (Birtcher, 2005) and has significant educational and economic consequences at the individual, household and community levels. Recent longitudinal studies of children from Brazil, Guatemala, India, the Philippines and South Africa associated stunting with a reduction in schooling, where adults who were stunted at age 2 completed nearly one year less school than non-stunted individuals (Yimer, 2000).

Factors that contribute to stunted growth and development include poor maternal health and nutrition, inadequate infant and young child feeding practices, and infection. Specifically, these include: maternal nutritional and health status before, during and after pregnancy influences a child's early growth and development, beginning in the womb. For example, intrauterine growth restriction due to maternal under nutrition (estimated by rates of low birth weight) accounts for 20% of childhood stunting (UNESCO, 2013). Other maternal contributors to stunting include short stature, short birth spacing, and adolescent pregnancy, which interferes

with nutrient availability to the fetus (owing to the competing demands of ongoing maternal growth).

Child's sustenance which is the foundation and one of the essential pointers of child's health is characterized as the admission of nourishment, considered in connection to children's dietary needs. Great nourishment, a satisfactory and very much adjusted eating regimen joined with consistent physical action is foundation of good health. Poor nourishment can prompt diminished insusceptibility, increment defenseless to ailments, impeded physical and mental advancement, and lessened efficiency, World Health Organization WHO (2015). Nigeria positioned eighth on the planet in the pervasiveness of death rates of under - fives, with an amazing figure of 189/1000 of every 2008, WHO (2007). Malnutrition is the hidden reason in over half of these passings, WHO (2005).

1.2 STATEMENT OF PROBLEM

Child health is one of the essential issues in the general public today, in which ladies' status can influence the health of the child. As per World Health Organization (2015), Children speak to the future, and guaranteeing their healthy development and improvement should be prime worry of all countries. Directly, one of the issues of enthusiasm for the world is child health. Here this issue is significantly more articulated in creating nations like Nigeria, Nigeria is at present fighting with child health (child nutritional status) issue, the nutritional status of the children populace is a vital marker of child health and personal satisfaction, reflecting the truth of this specific gathering, as well as, likewise the general public in which the child lives. Malnutrition among children is a noteworthy general health issue in Nigeria. Malnutrition is unfriendly to human advancement and adds to the high rates of horribleness, inability and mortality among children in Nigeria.

As per World Health Organization WHO (2002), two hundred million children are hindered; Women qualities have effect on child health status (child nutritional status). The pervasiveness of hindering in children underneath five years in East Africa midpoints around 48 percent which is the most astounding on the planet. Confirmation likewise demonstrated that the circumstance in creating nations is more regrettable (Administration Committee on Coordination– Sub-Committee on Nutrition ACC/SCN 2000), which is the most astounding on the planet. Proof additionally demonstrated that the circumstance in creating nations is more awful.

An audit of the patterns of the nutritional status of Nigeria children from 1983-1998 demonstrated that the national rustic commonness of hindering increments from 60 percent in 1983 to 64 percent in 1992. Another national study attempted in 1998 with the incorporation of urban territories and children in the age aggregate 3-5 months demonstrated a relative decrease in the extent of hindered children to 52 percent (Fadeiye et al., 2001). A couple of nearby investigations (Getaneh et al., 1998; Genebo et al., 1999; Yimer, 2000) on child nourishment have additionally demonstrated comparative outcomes (a more than 40 percent predominance in hindering) and affirmed that malnutrition, i.e., hindering, is a standout amongst the most critical general health issues. As indicated by (Adeola et al, 2016) 70% of the children were hindered while 54% were extremely hindered.

Malnutrition prompts a decrease in human execution, weakening of health and lessened survival of populaces and ruining the potential for nations to diminish destitution and expand financial improvement. Truth be told, the hidden reason for over portion of all child horribleness and child mortality has been connected with under-nourishment. (Ezzati and Co.2002) Specifically, uncovered that childhood under-sustenance contrarily influences child school

execution and thusly has negative effect on national improvement. Child malnutrition is a present issue of significance in tropical and subtropical parts of the world. As per (Kasirye 2010), child under-nourishment is one of the Africa's most major difficulties for enhanced human advancement and has frustrated the accomplishment of the objective of diminishing child mortality, this is particularly so in the sub-Saharan Africa areas, where it is evaluated that 4.8 million children kick the bucket before the age of 5 every year. As indicated by (Kasirye 2010), Children speak to the future, and guaranteeing their healthy development and improvement should be prime worry of all countries.

In Nigeria in any case, the circumstance is said to be more awful in provincial regions and constitutes a noteworthy health issue in the nation. In spite of the fact that the pervasiveness of underweight, hindering and squandering (2.5%, 12.4% and 9.5 separately) detailed in a current report in Ekpoma is low contrasted with contemplates somewhere else, that of hindering is however troubling. This is because of the way that hindering means long haul irreversible unending undernutrition and was the most widely recognized type of under sustenance among under five children (Ozor et al 2014). The World Health Organization gauges that roughly 150 million children more youthful than 5 years in creating nations are underweight and an extra 200 million children are hindered, (Laura 2004). Under sustenance remains a staggering issue in many creating nations influencing more than 815 million individuals causing more than one-portion of child demise, (Ruel 2003).

This examination in this manner, was intended to explore maternal variables that incline under-five children to malnutrition (hindering). This is vital in light of the fact that nutritional appraisal is basic for exact arranging and usage of mediation programs went for diminishing horribleness and death rates related with malnutrition. To be sure, the significance of child nutritional status is

along these lines all around perceived as it fills in as a marker for following the sustenance and health status of populaces.

1.3 RESEARCH QUESTIONS

1. What is the extent of stunting in Southwest, Nigeria?
2. What is the relationship between women's characteristics (age, education, residence, religion, wealth index .e.t.c) and child health status (child nutritional status) in Southwest, Nigeria?

1.40 OBJECTIVES OF THE STUDY

1. To determine the women demographic statuses of urban-poor households
2. To ascertain the level of nutritional status of under-5 children of urban-poor households in Nigeria
3. To examine whether there are relationships between women status and child health outcomes.

1.4.1 GENERAL OBJECTIVE

1. To examine the determinants of child health status (child nutritional status) in Southwest Nigeria.

1.4.2 SPECIFIC OBJECTIVES

1. To know the extent of stunting in Southwest, Nigeria.
2. To know the relationship between women's characteristics (age, education, residence, religion, wealth index .e.t.c) child health status (child nutritional status) in Southwest, Nigeria.

1.5 JUSTIFICATION

In Nigeria in any case, the circumstance is said to be more awful in provincial regions and constitutes a noteworthy health issue in the nation. In spite of the fact that the pervasiveness of underweight, hindering and squandering (2.5%, 12.4% and 9.5 separately) detailed in a current report in Ekpoma is low contrasted with contemplates somewhere else, that of hindering is however troubling. This is because of the way that hindering means long haul irreversible unending undernutrition and was the most widely recognized type of under sustenance among under five children (Ozor et al 2014). The World Health Organization gauges that roughly 150 million children more youthful than 5 years in creating nations are underweight and an extra 200 million children are hindered, (Laura 2004). Under sustenance remains a staggering issue in many creating nations influencing more than 815 million individuals causing more than one-portion of child demise, (Ruel 2003).

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1.6 OPERATIONAL DEFINITION OF TERMS

Women: An adult female person, distinguished from a girl, which is capable of taking care and bearing children.

Women Status: Women's status can be defined as ability to access resources and information about their lives, health care, as well as the health of their children, in household, communities and nation in which they live.

WHO: World Health Organization.

Malnutrition: *This is a condition that results from eating a diet in which nutrients (calories, protein, and micro nutrients) are not enough such that diet causes health problem such as in physical and mental development.*

Under nutrition: It can be defined as the outcome of poor feeding of infants and young children, insufficient food intake leading to infectious preventable diseases. Undernutrition can also include being underweight for one's age, too short for one's age (stunted), dangerously thin (wasted), and deficient in vitamins and minerals (micronutrient malnutrition).

Child: A child is a human between the stages of birth and puberty.

Child health: Child health encompasses the physical, mental, emotional and social well-being of children from infancy through adolescence. .

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

This section reviewed related materials and studies on health and child health, child malnutrition status.

2.2 HEALTH AND CHILD HEALTH

The most regularly cited meaning of health is what was formalized by the World Health Organization (WHO) over 50 years prior. As per WHO (1948), Health is a condition of finish physical, mental and social prosperity and not only nonappearance of sicknesses or ailment.

Ottawa Chapter for Health Promotion (1986), suggested that children's health is the degree to which singular children or gathering of children are capable or empowered to create and understand their possibilities, fulfill their requirements and create limits that enables them to cooperate effectively with their organic, physical and social condition. Child health alludes to the period amongst birth and five years of age when children are especially powerless against ailment, sickness and demise. From one month to five years old, the primary driver of death are pneumonia, loose bowels, jungle fever, measles and HIV. Children's health includes the physical, mental, passionate and social prosperity of children from early stages through puberty. Malnutrition is evaluated to add to more than 33% of all child passings.

2.3 CHILD NUTRITION STATUS

Children are operationally defined as a baby between 0 and 5 years. They are otherwise referred to as under-5s and constitute one of the vulnerable groups in any given population. The peculiar feeding processes include breastfeeding (usually exclusive between 0-6 months), complementary feeding (6-9 months) and introduction of normal adult family diets. It should be added at this point that any default in the feeding pattern at this stage in life may jeopardize subsequent nutritional status in later life, with high risk of developing any of the non-communicable diseases including obesity and its other attendant problems. Nutrition is a fundamental pillar of human life, health and development across the entire life span. From the earliest stages of foetus development, at birth, through infancy, childhood, adolescence, and into adulthood and old age, proper food and good nutrition are essential for survival, physical growth, mental development, performance and productivity, health and well-being(FAO/WHO, 1992 and WHO, 2000). Thus, being nutritionally vulnerable, under-5 children's nutritional status is generally accepted as an indicator of the nutritional status of any particular community (Davidson et al., 1975). This is due to their easy susceptibility to malnutrition and infection (Akinlosotu and Hussain, 1985; Uppal et al., 2005). Children in this age group require a high supply of nutrients since they are usually very active and their growth is rapid. Also during this period, under-nutrition in the form of kwashiorkor, marasmus, anaemia and xerophthalmia are not uncommon (Ene-Obong, 2001).

It has been estimated that approximately one out of every three Under-5 children is chronically malnourished and thereby subjected to a pattern of ill health and poor development in early life (UNICEF, 1998), with malnutrition being associated with more than half of all deaths of children worldwide (Sobo and Oguntona, 2006).

Early childhood starts from foetus to new birth and then through postnatal life. In intrauterine life, the nutritional status of the unborn foetus depends largely on the adequacy of the dietary intake of the mother and this determines the outcome of birth of the new born. postnatal life is a continuum in human development. Normal growth and development depend largely upon the nutritional status of the new born which is in turn related directly to the nutrition of the mother and inherited characteristics, and to the dietary intake of the infant (Krauss and Mahan, 1982). In early childhood, nutritional status is of paramount importance for a child's later physical, mental and social development. From birth to 4-6 months of life, breast milk is the sole or prime source of nutrients and optimal breastfeeding practice becomes a critical factor in child survival and development (Onyesili, 2000). Breast milk contains all nutrients, antibodies, hormones and antioxidants that an infant needs to thrive UNICEF (1998). Early initiation within half an hour of birth will ensure that the protective antibodies in the colostrums are available rapidly to the infant, because after 24 to 48 hours, the level of antibodies in breast milk diminishes.

Nutritional status during childhood is crucial for human development as it affects every phase of human life, the elevation of childhood nutrition therefore assist in the goal to reduce child mortality considering the report by WHO (2005) and (Pelletier et al., 1995) that malnutrition is an underlying cause of an estimated more than a half of all deaths of under five children.

Malnutrition currently gives accounts of about half of the 10 million deaths each year among under-five children in the developing world. Malnutrition is strongly associated with poverty because levels of malnutrition are higher in poor countries than in better-off countries (World Bank, 2000).

Malnutrition arises from a complex of nutritional, social and biological deprivation and is manifested in various forms such as stunting (short stature), underweight, muscle wasting, growth retardation, diminished fat and ill health with high mortality rate (Onimawo et al., 2006). Growth is an increase in size, its progress is mainly structural, and can be measured with some degree of reliability in terms of height, weight, age etc. (Apley, 1979). There are wide variations in the rates at which the height and weight of children are subsequently attained. This is as a result of several factors such as quality and quantity of food, family income, family size and genetic constitution which may contribute to these variations (Beaton et al., 1990). Growth assessment has been identified as the most important measure for evaluating the health and nutritional status of Under-5 children through anthropometric measurements (Apley, 1979). The reason for this is that anthropometric indicators of growth not only provide information on health and nutritional status, but is also an indirect measure of the quality of life of an entire population (Shetty and James, 1994).

Malnutrition is a pathological condition brought about by the inadequacy or over consumption of one or more of the essential nutrients necessary for survival, growth, reproduction as well as productivity at work (UNICEF and FGN, 2001).

The inadequate or excessive intake of nutrients may result from disease factors that affect digestion, absorption, transport, and utilization of nutrients (UNICEF, 1990). Malabsorption of nutrients may result from genetic cum environmental conditions or illness. The most critically vulnerable groups are the developing foetus, preschool children, women before and during pregnancy, and lactating women (UNICEF, 1998).

Malnutrition affects all levels of development physically, mentally, socially, psychologically and physiologically. It thus multiplies the effect of prevailing disease or mortality in children and infants (Huffman and Marlin, 1994). In the developing nations, malnutrition usually makes its greatest impact on preschoolers. Under-5 children mortality accounts for nearly 50% of total deaths, and careful examination has shown malnutrition as the major underlying factor (Whitehead and Rowland, 2002). Studies by many researchers have shown that it is during the preschool years that under-nutrition in the form of kwashiorkor and marasmus are most prevalent. This is because these children are in the state of life when growth is rapid, nutrient requirements are high and the diets likely to be given are inadequate. Also, at this stage of life, there is continuous stress from bacterial, viral and parasitic infections which contribute to malnutrition. The presence of malnutrition reduces the resistance of the child to infections and infectious diseases, resulting in reduced food intake and poor nutrient absorption, which in turn result in stunted growth depending on the severity of the malnutrition.

Children below 5 years of age have been specifically studied because their health status is a sensitive indicator of overall community health, particularly among the disadvantaged group in the population. The preschoolers especially those at the second year of life are 'transitional' as regards diet, immunity to infections and psychological dependency (Pyke, 1979). This period which is characterized by a high nutrient need, particularly that of protein for swiftly increasing muscle tissue, Is also a period when several meals a day are required and when food should be easily masticable and digestible.

Malnutrition does not often exert equal impact on all population groups. Certain factors and circumstances dictate the target of occurrence (Keke, 1990). The causes of malnutrition are multidimensional and include both food and non-food factors such as low income, uneven

household food distribution, poor sanitation, infection, inadequate food production, marketing and preservation as well as poor knowledge of nutrition (Chen and Dseusa, 1981). Some of the reported effects of malnutrition and its various manifestations include stunted physical growth, retarded mental achievement, and low productivity, low resistance to diseases and infections with high morbidity and mortality rates especially in children (Nnayelugo, 1992).

Malnutrition is an umbrella term which covers under- and over-nutrition. Under nutrition can manifest itself in different forms and affect the physical and mental development of children in different ways (Arifeen, Black, Caulfield, Antelman and Baqui, 2001). Each type of under nutrition depends on age, duration and nutrient composition of diet.

- The most basic kind is called 'protein energy under nutrition' caused by a diet lacking in energy and protein due to a deficit of all major macronutrients, such as carbohydrates, fats and proteins. Marasmus is caused by a lack of protein and energy with sufferers appearing skeletally thin. In extreme cases, it can lead to kwashiorkor.
- Other forms of under nutrition are usually the result of vitamin and mineral deficiencies (micronutrients), which can lead to anemia, scurvy, pellagra, beriberi and xeropthalmia and, ultimately, death (Arimond and Ruel, 2014).

Malnutrition is most commonly identified through measurement of growth and body composition, known as anthropometric indicators. Underweight, stunting, and wasting, are the nutritional status conditions measured in an anthropometric assessment.

- Stunting (Height for age) is a measure of linear growth. Stunting refers to shortness, and reflects linear growth achieved pre and postnatal with its deficits. It is generally assumed to indicate long-term, cumulative effects of inadequate nutrition and poor health status.

Height for age (HFA) is considered a measure of past nutrition, because a child, who is short today, maybe did not have adequate nutritional intake at some point in the past.

- Underweight (Weight for age) is the most common assessment of child nutrition status. It is routinely collected in growth promotion programmes, and is a good indicator for children under 24 months because of the need to do precise measurements of weight for these age groups. Weight for age (WFA) is a simple index, but this index does not take height into account. Children who are taller would be expected to weigh more than other children, just as children who are shorter would be expected to weigh a little less and still be healthy.
- Wasting (Weight for Height) is a measure of acute or short-term exposure to a negative environment. It is sensitive to changes in calorie intake or the effects of disease. Wasting can be calculated without knowing the age of a child. Weight for height (WFH) is a measure of current body mass. It is the best index to use to reflect wasting malnutrition, when it is difficult to determine the exact ages of the children being measured. A child is considered malnourished or severely undernourished if any of these indices fall below the accepted median values set by the World Health Organization international reference (De Onis, Onyango, Borghi, Garza, C. 2006).

2.4 OVERVIEW OF CHILD NUTRITION STATUS (MALNUTRITION) IN SUBSAHARAN AFRICA

Malnutrition prevalence; height for age of children under 5 in sub-Saharan Africa was last measured at 35.74 in 2014, according to the World Bank. Prevalence of child malnutrition is the percentage of children under age 5 whose height for age (stunting) is more than two standard deviations below the median for the international reference population ages 0-59 months. For children up to two years old height is measured by recumbent length. For older children height is measured by stature while standing. The data are based on the WHO's new child growth standards released in 2006. Many countries, including Malawi, Rwanda, Senegal and the United Republic of Tanzania, have made considerable and encouraging progress. With external support, and interventions for preventing malnutrition and improving nutrition, Niger made remarkable progress though, 44% of children suffer from stunting. The percentage of stunted children in sub-Saharan Africa fell from 48% to 38% between 1990 and 2013. Many countries, including Lesotho, Mali and Niger, have made noticeably strong progress since 2000, but still report 39%, 28% and 44% of under-5 children suffering from stunting in Sierra Leone and Zimbabwe, where the stunting rate has worsened, (UNESCO, 2013).

In the past two decades, child and maternal malnutrition has declined almost by half, child malnutrition still imposes the greatest nutrition-related health burden at global level, 161 million children are stunted due to chronic malnutrition, 99 million children are underweight, and 45% of child deaths are caused by child and maternal malnutrition. Developing regions have the highest prevalence of stunting in children under the age of five with 34% in western Africa, 32% in central Africa, 41% in eastern Africa, and 30% in southern Africa (FAO, 2014).

2.5 OVERVIEW OF CHILD NUTRITION STATUS IN NIGERIA

The nutrition situation in Nigeria is the result of several adverse and interrelated factors (social, economic, and environmental) acting in synergy, Nigeria accounts for nearly one-fourth of Sub-Saharan Africa's poor nourished children, it is a region where the number of malnourished children is forecast to Increase by more than 30 percent to reach 40 to 45 million by 2020 (WHO 1997 and Pinstrup Andersen et al. 1999). Moreover, more than 50 percent of all childhood deaths have under nutrition as an underlying factor in Nigeria (NPC/UNICEF, 1998). Nutritional deficiencies contribute to the high rates of morbidity, mortality, and disability in Nigeria. Like almost all other developing countries in the world, Nigeria has committed itself to providing equitable access to health and nutrition care for all socioeconomic groups of people living in different geographical locations of the country (Adeola et al., 2016).

Malnutrition among Nigeria's children is a serious problem throughout the country:

- Each year about 1 million Nigerian children die before their 5th birthday. Malnutrition contributes to nearly half of these deaths (Black et al, 2013).
- Rates of stunting in Nigeria have stagnated for more than a decade. About 2 in 5 Nigerian children are stunted, with rates of stunting varying throughout the country (NPC and NDHS, 2013).
- Almost 30 percent of Nigerian children are underweight. This is more than double the proportion of neighboring Ghanaian children who are underweight (NPC and NDHS, 2013).

- The percent of children in Nigeria, who are wasted, or too thin for their height, has steadily increased over the last decade, rising from 11 percent in 2003 to 18 percent in 2013 (NPC and NDHS, 2013).
- Up to 1 million Nigerian children under age 5 are affected by severe acute malnutrition (SAM) each year (Children's Investment Fund Foundation, 2014).
- Nearly 4 out of 5 Nigerian children do not meet the World Health Organization's recommendation for exclusive breastfeeding during the first 6 months of life (NPC and NDHS, 2013).
- About 70 percent of children ages 6 to 23 months are not receiving the minimum acceptable diet in Nigeria (NPC and NDHS, 2013).

One of the yardsticks to determine the level of development of any country is to consider the nutritional status of the under-5s. The under-5s are most at risk of malnutrition because they are more vulnerable to adverse environmental conditions and respond rapidly to dietary changes. They are also more at risk of becoming ill, which will result in weight loss. Consequently, their nutritional status is considered a good gauge for population-based assessment of level of malnutrition. During the developmental years, children are susceptible to skeletal growth failure in ways that adults are not when there is acute or chronic malnutrition, which are good reflections of short-term and long-term malnutrition. Data from nutritional survey of under-5s are therefore used to draw conclusions about the situation of the entire population and not just that age group. According to the 2013 NDHS enumerated the nutritional status of under-5 children in Nigeria is as follow:

- 37 percent of children under five are stunted and 21 percent are severely stunted.
- Overall, 18% of the children in Nigeria are wasted, and half of them severely wasted.
- 29% of all children in Nigeria are underweight; almost 1 in 10 of these children are severely underweight.
- Percent of Children Stunted by Region, NDHS 2013 South west 22%, south east 16%, south south 18%, north east 42%, north west 55% and north central 29%.

2.6 FOOD INSECURITY AND CHILD MALNUTRTION

Food insecurity is a major problem worldwide and it is especially widespread in sub-Saharan Africa of which Nigeria is a major part. Food insecurity and malnutrition are two sides of the same coin and one cannot analyze one without analyzing the other. Food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life and Food insecurityby contrast, exists when people do not have adequate physical, social or economic access to food as defined above (World Food Summit 1996 and FAO, 1983). Food insecurity, as measured in the United States, refers to the social and economic problem of lack of food due to resource or other constraints, not voluntary fasting or dieting, or because of illness, or for other reasons. This definition was supported by the ethnographic research conducted by (Shariff et al., 2000). Food insecurity is measured as a household-level concept that refers to uncertain, insufficient, or unacceptable availability, access, or utilization of food and research has shown that food insecurity is associated with adverse health and developmental outcomes in children (World Food Summit 1996 and FAO 1983). The United nation sustainable development revealed that Poor nutrition causes nearly half (45 per cent) of deaths in children under

five 3.1 million children each year, one in four of the world's children suffer stunted growth, In developing countries the proportion can rise to one in three, 66 million primary school-age children attend classes hungry across the developing world, with 23 million in Africa alone.

2.7 EFFECT OF NUTRITION EDUCATION ON NUTRITION STATUS

Educating the women on the special needs of the under- five children and utilizing them for child's growth surveillance have been effective in preventing malnutrition (Gopaldas and theos 2009). The more targeted pre-school programme in developing countries select children on the bases of second or third degree malnutrition. Other programmes use improvement in growth (weight, height) above what is observed in a control as a means of assessing impact.

Nutrition information and education are needed so that people can make informed choice about the foods they grow, purchase and eat the success of food-based strategies to eliminate micro-nutrients deficiencies will rest on the willingness of individuals to change their dietary behavior.

2.8 WOMEN'S STATUS AND CHILD HEALTH

2.8.1 WEALTH INDEX AND CHILD HEALTH

Wealth has important inference for family and child health, the wealth index of the family's will reflect to the ability to respond to the social economic that can negatively have an impact on the child's health (Shariff et al., 2000). Income depends on the resources that will be available to the family to fulfill their food, housing and health needs, income is positively and negatively associated with child health (Shariff et al., 2000).Wealth is a comprehensive measure of access to financial resources, families with the same level of yearly income would be categorized as

social economically equivalent even if there were large differences in the family's quantities of accumulated assets

2.8.2 LEVEL OF EDUCATION AND CHILD HEALTH

Maternal education has shown to have a stronger effect on child health than paternal education and paternal education also an effect. It has been considered a strong measure of social economic status (Shariff et al., 2000). It predicts better job, higher incomes and better societies and the female education participation maybe low or less important than a man's education. Increased education has shown to reap increasing financial, professional and socio economic rewards for those that pursue it and those rewards offer financial, behavioral, additional resources and strong impact on the health of their children. Thus educated mothers are likely to have access to more financial resources to invest in child health (Shariff et al., 2000). Better educated mothers are more likely to know more about how to handle child health issues, educated mothers have higher bargaining power over the household's resources. Therefore, they can positively impact their children's health (Glewwe, Paul, and E. Miguel. 2008).

2.8.3 RELIGION AND CHILD HEALTH

Religions also do affect the health of a child positively or negatively. According to Child Development Supplements (CDS), it was observed that those that are religiously biased have a higher level of overall health. Religion can have positive effects on child health by influencing the child and also the parent's behavior by regulating their social and psychological way and also religion can discourage bad behavior in one way or the other. For example, alcohol consumption in which some religion does not allow that. It can also be in the negative level in which some

religion does not allow the services of doctors and hospitals and it will affect the health of the child, they discourage vaccinations and many others (Perkins 2001).

2.8.4 OCCUPATION AND CHILD HEALTH

Mothers exert strong influence over child health and nutrition. This has been proven by a study done by (Johannsenet al 2006) which stated that child's weight was found to be closely related to mother's BMI but not fathers. Feeding practices play a vital role in determining child health and food preferences in later life. Better child nutritional status was also associated with better educational achievement among children in Malaysia (Shariff et al., 2000). A study done by (Miller and Han 2008) claimed that, mothers with irregular working shifts will have disruption in meal preparation and activity routines. The study also reported that child's BMI increased significantly if their mothers worked at irregular schedule. Thus, children of employed mothers were more likely to have poor dietary habits and spent more time engaging in sedentary activity compared to children of unemployed mothers (Hawkins et al., 2009).

2.8.5 PLACE OF RESIDENCE AND CHILD HEALTH

In the aspect of residence: the socio-economic differences between urban and rural areas have a strong impression, residents of urban areas are generally better off educationally, financially and physically. The advantage is largely due to improvements in public health and the readily available access to the information and resources necessary for preventative and curative care urban environment usually a trade centers have much wider areas of food to choose from (Sobo et al., 2006) and this gives better chances to have more balanced nutritional sources.

Automatically, children living in urban areas have better health than those living in rural ones (Sobo et al., 2006).

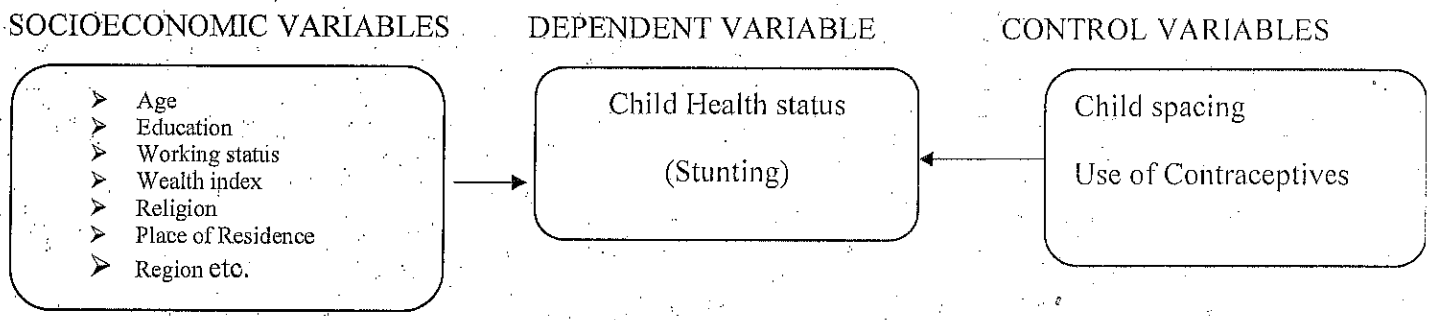
2.9 THEORETICAL FRAMEWORK

Using a Bio-logical theory which was propounded by Urie Bronfenbrenner in 1986, the bio-ecological model of human development can be used to both children and maturing adults. He first propounded a theory with Stephen J. Ceci in 1994 which is an extension of Bronfenbrenner's original theoretical model of human development which is called Ecological System Theory. Bronfenbrenner's also developed the bio-ecological model after noticing that the individual was overlooked in other theories of human development, which were largely focused on the content of development by the environment.

The history of bio-ecological system theory is divided into two periods which are, firstly, The Ecology of Human Development in 1979 and the second was described as a time of criticism and evaluation of the original work of Bronfenbrenner. The first period came because Bronfenbrenner did not focus on the role of context in terms of development. He argued that the environment in which children live is important because development can be shaped by the children's interactions with that environment, he also said to his colleague that they should study development in terms of ecological contexts that is the environments of children for example; schools, homes and daycares. Researchers took that advice and it flourished in the early 1980's which it focused on the context. Later on, Bronfenbrenner saw that research has focused more on the context not development, then in his theory, he emphasized on the development. This theory went through a series of transformations and elaborations until 2005 when Bronfenbrenner died.

Bio-ecological systems theory focuses on the interactions and influences of the outside environment on the child's development; this theory differs from other major theories in that it emphasizes the influence of the outer world (community, school, and political systems). Urie Bronfenbrenner suggests that all settings need to be considered when explaining child development. This theory typically represent a ring in which there are different interactive system. The first layer of the ring suggest the most influence on the child's development and it consists of the family, school, child care providers, peers, and all experiences and influences that have a direct affect on the child's immediate environment. The second layer is the interaction that is parents are affected by child care and child care are affected by parents. The third layer in the bio-ecological system is depicts additional ecological system that affect the child development more directly. The ecological systems are legal services, social services, neighbors, extended family, work place, and they don't actually touch the child's life, they indirectly affect the child experience. The last layer in the bio-ecological system contains law, customs, and values of a particular society or cultural system, even though these institutions don't directly affect the child and also have strong influence on the child. This theory has been viewed as culturally sensitive in that it focuses on all of the influences (socially, political and economic contexts) in which development occurs. In order words, positive child development occurs when all influence both.

2.10 CONCEPTUAL FRAMEWORK



Source: Author's Construct, 2016

Looking at this diagram above, illustrates the independent variable, intervening variable and dependent variable which affects each other positively or negatively. Independent variable affects the intervening variable which will in turn determine the dependent variable taking the variables into consideration the (Age, education, working status, religion, place of residence, wealth index status, knowledge of contraception, number of living children, CEB) will influence Child spacing and use of contraceptive and will determine whether the child will have a better health or not. The age of the mother matters and shows if the health of the child will be positive or negative. Better or good education predicts a better job, higher incomes and also good societies. When there is an increase in education it will promote the financial, professional and socio-economic (Arifeen et al., 2001) therefore, level of education affects the health of the child. Wealth index will affect the ability or have an impact on the health of the child either positively or negatively (Arifeen et al., 2001).

2.11 STATEMENT OF HYPOTHESIS

H_0: There is no significant relationship between women characteristics (age, education, residence, religion, wealth index, birth spacing, knowledge of contraceptive, use of

contraceptive, employment status, and number of living children, CEB) and child health status in Urban, Nigeria.

2.12 RESEARCH VARIABLES

- Dependent variable: child health status as measured by nutrition (stunting).
- Independent variables: age, education, residence, religion, wealth index, birth spacing, knowledge of contraceptive, use of contraceptive, working status, and number of living children, CEB.
- Intervening variables: child spacing and use of contraceptive.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter seeks to explain the plan and approach for executing the research work. It covers the description of the study area, target population, source of data, sampling design and sample size, method of data collection, measurement of variables and method of data analysis.

3.1 Description of the Study Area

Nigeria is a West African country located between latitudes 4°16' and 13°53' north and longitudes 2°40' and 14°41' east. It is extends from Gulf of Guinea in the south to the fringes of the Sahara Desert in the north. The country is bordered by Niger Republic and Chad in the north, Cameroon on the east, and the Republic of Benin on the west. With a population of 140,431,790 (NPC, 2006), Nigeria is the most populous country in Africa and the 14th largest in land mass (World Bank, 2012). Nigeria has great geographical diversity, with its topography characterized by two main land forms: lowlands and highlands. The uplands stretch from 600 to 1,300 meters in the North Central and the east highlands, with lowlands of less than 20 meters in the coastal areas. The lowlands extend from the Sokoto plains to the Borno plains in the North, the coastal lowlands of western Nigeria, and the Cross River basin in the east. The highland areas include the Jos Plateau and the Adamawa Highlands in the north, extending to the Obudu Plateau and the Oban Hills in the southeast. Other topographic features include the Niger-Benue Trough and the Chad Basin.

Nigeria has a tropical climate with wet and dry seasons. Its climate is influenced by the rain-bearing southwesterly winds and the cold, dry, and dusty northeasterly winds, commonly referred to as the Harmattan. The dry season occurs from October to March with a spell of cool,

dry, and dusty Harmattan wind felt mostly in the north in December and January. The wet season occurs from April to September. Nigeria marked its centenary in 2014, having begun its existence as a nation-state in 1914 through the amalgamation of the northern and southern protectorates. Before this time, there were various cultural, ethnic, and linguistic groups, such as the Oyo, Benin, Nupe, Jukun, Kanem-Bornu, and Hausa-Fulani empires. These groups lived in kingdoms and emirates with sophisticated systems of government. There were also other strong ethnic groups such as the Igbos, Ibibios, Ijaws, and Tivs. The establishment and expansion of British influence in both northern and southern Nigeria and the imposition of British rule resulted in the amalgamation of the protectorates of southern and northern Nigeria in 1914.

3.2 Target Population

The category of eligible respondents in this study is women from urban-poor household in all the 6 geo-political regions of Nigeria.

3.3.1 Quantitative Data Source

This study analyses data from the women recode data of the NDHS 2013.

3.4.1 Sample Design for the 2013 NDHS

The 2013 NDHS will be nationally representative. The survey used as a sampling frame the list of enumeration areas (EAs) prepared for the 2006 Population Census of the Federal Republic of Nigeria, provided by the National Population Commission. It also provided population and health indicator estimates. The sample design allowed for specific indicators to be calculated for each of the six zones, 36 states, and the Federal Capital Territory, Abuja.

All women age 15-49 who were either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. In a subsample of half of the households, all women age 15-49 that were

either permanent residents of the households in the sample or visitors present in the households on the night before the survey were eligible to be interviewed and each household were randomly selected to be asked additional questions regarding child health.

3.4.2 Sample Size

All women age 15-49 who were either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. Out 26,190 mothers who had at least one child only 1,351 women who were urban-poor households. Thus the sample size for this study were only 1,351 women.

3.5 Measurement of Variables

The analysis will examine the women status and child health among urban-poor households in all 6 geopolitical regions in Nigeria, the general binary logistic regression model will be use for the multivariate analysis is:

3.5.1. Dependent variable: Child Health

This study uses the concept ofWorld Health Organization which was calculated using growth standards published by WHO in 2006. The growth standard were generated through data collected in WHO Multicentre Growth Reference Study (WHO, 2006). The three nutritional status indices which were expressed in standard deviation units from height-for-age((stunted status), weight for height (wasted status) and weight-for-age (underweight status). This study focus only on weight-for-age which was composite index of height-for-age and weight-for-height which takes into account both acute malnutrition (wasting) and chronic malnutrition(stunting) but it does not distinguish between the two. The children whose weight for

age is below minus three standard deviations (-3SD) from the reference median are considered severely underweight while others are not.

3.5.2 Independent variables

Socioeconomic characteristics

Age: The age of women will be measured from the NDHS using the grouped age of respondents in five year age group 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, and 45-49.

Place of Residence: Only Urban.

Level of Education: This is a categorical variable that is will be divided into four categories. These are No Education, Primary, Secondary and Higher Education.

Religion: The religion of the respondents would be measured in three categories; the first groups were Christians, which will be the combination of Catholics and other Christians and will be coded as 0 = Christian, the second group will be Islam, will be coded as 1 = Islam, the last group are the traditionalists, which will be coded as 2 = Traditional.

Wealth Index: The wealth index is a categorical variable, which considered only the poor households

Children Ever born: This will beCoded as variable v201 in the NDHS dataset, for the purpose of this study it was recode as 1" None 2"1-4 and 3" 5+

Decision Making: This study measured the extent of couple's participation in household decision making in the following areas; (a) who makes decision on health care, (b) who makes the decision on family visits. Response for the women were recoded as 1 "Wife alone", 2 " Husband alone", 3"Joint decision"

3.6 Data Processing and Analysis

The NDHS datasets from 2013 women recode will be processed and analyzed using Stata application package (STATA 12.0). The data processing will be necessary before the proper analysis in order to measure the variables in this study accurately as well as to make the analysis well presentable and easily interpretable. The tools for data manipulation were employed on the STATA application package to achieve this task.

Univariate analysis will be carried out using tables of frequency distribution to describe the background characteristics of the respondents and the bivariate analysis will be done using the Chi-square (χ^2) test to show the association between use of child health and the various socio economic and demographic characteristics that are categorical variables in the datasets. Furthermore, logistic regression is used in the multivariate analysis to identify the strength of association and examine predictors of child nutritional status among urban-poor households in the study area.

CHAPTER FOUR

DATAPRESENTATIONAND ANALYSIS OF RESEARCH FINDINGS

4.0. INTRODUCTION

This chapter concentrates on the presentation of results and data analysis of research work on women status and Women Status and Child Health (Underweight) Amongst Urban Poor Households in Nigeria.

The analysis of the study was done in line with the research questions raised for this project work. The socio-demographic characteristics of the women as well as the nutritional status of their under-five children were identified.Chi-square and logistics regression were used to validate the relationship between child health and influencing factors among urban poor households.

4.1 THE FREQUENCY DISTRIBUTION AND PERCENTAGE OF WOMAN SOCIO-DEMOGRAPHIC CHARACTERISTICS

This section focuses on the descriptive statistics of the socio-demographic characteristics of the sampled urban poor household in Nigeria.

TABLE 1: UNIVARIATE ANALYSIS OF RESPONDENTS

Variable	Frequency	Percent
Nutritional Status		
Underweight	623	71.44
Normal	249	28.56
Religion		
Christian	367	42.37
Islam	481	55.49
Traditional	19	2.14
Women Educational Attainment		

No Education	463	53.08
Primary	297	34.11
Secondary	111	12.69
Higher	1	0.13
Household Decision Child Health		
Mother	38	4.76
Father	183	22.96
Both	578	72.28
Family Type		
Single Parent	73	8.34
Married	799	91.66
15-19	31	3.50
20-24	145	16.66
25-29	206	23.64
30-34	203	23.33
35-39	168	19.30
40-44	83	9.49
45-49	36	4.08
Employment		
Unpaid	192	22.04
Paid	680	77.96
Region		
North-Central	41	4.69
North-East	149	17.05
North –West	304	34.84
South- East	360	41.28
South-South	16	1.81
South West	3	0.33
Children Ever Born		
1-2	189	21.71
3+	682	78.29
Ethnicity		
Yoruba	4	0.49
Hausa	357	41.70
Igbo	363	44.07
Others	147	16.81

The study found that more than 28% of children of urban-poor women are underweight leaving only 71% having normal weight. Other socio-demographic

characteristics of the urban poor household revealed that most of the mothers could not afford basic education as majority had no formal education (53%) and less than 1% had higher education. The religion affiliation of respondents disclosed that majority were Muslim (55.49%) while Christianity were (42.37%) and other religion (2.14%) were urban poor household. Fewer percentage of (4.76%) could handle decision on their healthcare of themselves and that of their children without their husband as majority depend on their spouse (72%) while 23% of urban poor women leave the decision for their husband totally. Although (77.96%) of urban poor household said they were engaged in paid jobs, but the most unfortunate things was that their paid employment can only be in manual jobs because they lack formal basic education. Majority of these same sampled respondents were married(91.66%) and most of them had more than 3 children(78%) the factor that account for their poor nutritional status of their children.

The age of sampled respondents disclosed that majority were less than 25-29 years in age (21%), followed by 30-34years (14.9%) while the least urban poor household were from age 15-19years(3.50%). Furthermore, majority of the urban poor household were from South-East (41%) followed by North-West (34.84%) while the least was from South West of which less than 1% were the urban poor household.

4.2 BAVARIATE ANALYSIS OF URBAN POOR HOUSEHOLD CHARACTERISTICS ON CHILD NUTRITIONAL STATUS

This section focuses on the bivariate analysis of the socio-demographic characteristics of the sampled urban poor household in Nigeria on the nutritional status of their children, to examine whether there are relationships between women status and child health using chi-square test statistics:

Bivariate Analysis

Socio-Demographic Variables	Underweight Status		Total
	No	Yes	
Religion Christian	50.15	23.04	42.37
Islam	47.28	75.86	55.49
Tradition	2.56	1.10	2.14
	Chi-square (χ^2)=**57.394,**	**p= 0.000**	
Education No education	44.95	73.41	53.08
Primary	39.83	19.78	34.11
Secondary	15.10	6.64	12.69
Higher	0.11	0.17	0.13
	Chi-square (χ^2)=**56.9076, P = 0.000**		
Decision on Health Mother	6.22	1.33	4.76
Father	25.53	16.89	22.96
Joint	68.25	81.78	72.28
	Chi-square (χ^2)= **17.5583, P = 0.0055**		
Single Parent	9.91	4.41	8.34
Married	90.09	95.59	91.66
	Chi-square (χ^2)= **6.8943, p=0.0307**		
NorthCentral	5.13	3.56	4.69
North East	16.08	19.49	17.05
North West	27.1	54.20	34.84
South East	49.10	21.71	41.28
South South	2.13	1.03	1.81
South West	.46	0	0.33
	Chi-square (χ^2)=**72.676, P = 0.000**		
15-19	3.69	3.0	3.50
20-24	16.38	17.35	16.66

25-29	23.04	25.12	23.64
30-34	23.54	22.78	23.33
35-39	18.82	20.52	19.30
40-44	10.43	7.15	9.49
45-49	4.09	4.07	4.08
	Chi-square (χ^2)= **2.919, p=0.8527**		
Unpaid	22.46	20.97	22.04
Paid	77.54	79.03	77.96
	Chi-square (χ^2)= **0.2261 p=0.7354**		
Monogamy	71.54	54.27	66.39
Polygamy	28.46	45.73	33.61
	Chi-square (χ^2)= **21.7222, P = 0.0035**		
CEB			
1-2	22.30	20.23	21.71
3+	77.70	79.77	78.29
	Chi-square (χ^2)= **0.4401, p=0.6614**		
Yoruba	0.59	.24	.49
Hausa	33.75	59.12	40.99
Igbo	49.69	21.71	41.70
Others	15.97	18.92	16.81
	Chi-square (χ^2)=**61.3336, P = 0.000**		

The percentage distribution of sampled urban-poor household by under –weight status of the children, it was found that as the education of women increases the under-weight status of their children decreases from no education (73%) to Secondary education (6%). This shown a significance relationship between education of urban-poor women and nutritional status as the chi-square (X^2)=56.615, p=0.000. This implies that education of urban poor women can influence their children nutritional status (underweight). Also, Pearson Chi-square (X^2 =2.91, Pr =0.8527) for age of women and nutritional status of children revealed that there is no association between the age of women and their nutritional status although majority of the sampled women whose children are underweight were mother from age 25-29(25.1%), follow by age 30-49years in a reduction trends of 22.78%, 20.5%, 7.2% to 4%. Moreover ages 30-34years has highest no underweight status (23.8%) followed by age 25-29 with (23.04%) and later decline to 4.1% at age 45-49years.

The marital status of urban poor household also influence their children nutritional status as 95.58% of married women had underweight children while only approximately 4% of the single mother had underweight children. This shown a significant relationship between marital status and nutritional status of children as X^2=6.89, p-value=0.03. Thus disclosed that the married mothers tend to give their cares that could aid nutritional status of their children than single mothers. Majority of underweight children were from North-West (54.2%) followed by South-East (21.7%) while South West were just 1.03% with X^2=72.67 p=0.000, which signified statistical evidence to reject Null hypothesis at 5% level of significance. This implies that the region that a woman come from could predict whether her child would be underweight or not.

Hypothesis

There is no relationship between women status and child health(underweight) among urban poor households.

Child Health	Odds Ratio	P>z	[95% Confidence Interval]	
			Lower	Upper
Religion Christianity	1.0(RC)			
Islam	.739	0.594	.2439043	2.242707
Others	.890	0.833	.3014991	2.628681
Education Not Educated	1.0(RC)			
Primary	.519**	0.008	.3191962	.845393
Secondary	.459*	0.027	.2305712	.9152544
Higher	1.694	0.719	.0960813	29.90199
Mother	1.0(RC)			
Father	1.874	0.232	.6692269	5.250962
Joint	2.104	0.152	.7610542	5.821919
Region North Central	1.0(RC)			

North East	1.928	0.123	.8379575	4.437273
North West	2.692*	0.019	1.174936	6.171277
South East	1.006	0.991	.3297847	3.072537
South-South	1.890	0.371	.4689963	7.61918
South- West	1.0			
Age 15-19	1.0(RC)			
20-24	.782	0.647	.2729649	2.241118
25-29	.799	0.674	.2829509	2.261768
30-34	.716	0.528	.2535681	2.022488
35-39	.633	0.400	.2185753	1.8351
40-44	.413	0.140	.1276509	1.337858
45-49	.281	0.059	.0754623	1.047212
Employment Paid	1.0(RC)			
Unpaid	1.302	0.210	.8620407	1.966957
Marriage Type Monogamous	1.0(RC)			
Polygamous	1.461*	0.037	1.0230	2.086447

*P<0.05 **p<0.01 ***p<0.001

The multivariate analysis revealed a significant likelihood relationship that exist between urban-poor women status and children nutritional status (underweight), it was very paramount to note here that educational attainment, region of residence and marital status of women has significance odd ratio at 5% level of confidence toward children having poor nutritional status (underweight). The women who had primary education are less likely to have underweight children with (OR=0.519, p-value=0.008) compare to not educated women in reference category.

Furthermore,it was revealed that secondary educated women are 0.459 times less likely to having underweight children compare to not educated urban-poor women (RC). This implies that education could help urban poor mothers to improving their children nutritional status.

In Nigeria urban poor women who practice Islamic religion were 0.73 times less likely to have underweight children compare to women who are Christian (RC). Also it was revealed from the table above that urban -poor women has the following respective Odd Ratio (OR) from North-East (OR=1.92, p=0.123)), North-West (OR=2.69, p=0.019), South-East(1.006, p=0.99), South-South(OR=1.890, p=0.371) show that they are more likely to have underweight children than urban-poor women compared to North Central(RC), but urban-poor women in South-West were omitted from the Odd Ratio of underweight children although not significant than those from the North-Central (RC).

It was not a surprise to see that the women within ages 20-24years 0.78 less likely to have underweight children than women within age 15-19years(RC). Also, those within ages 25-29years(OR=0,799,p=0.647), 30-34years(OR=0.716,p=0.528), 45-49years(OR=0.28, p=0.059) were all less likely to have underweight children.But urban-poor household who were in polygynous family types are 1.46 more likely to have underweight children than those in monogamous marriage. These results have the found support from the work of Montgomery & Hewettwho found that

household living standards are closely associated with three health measures: unmet need for modern contraception, attendance of a trained health care provider at childbirth, and young children's height for age. Neighborhood living standards exert a significant additional influence in many of the surveys they examined, especially for birth attendance (Montgomery & Hewett, 2005).

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECCOMENDATIONS

5.0 INTRODUCTION

This chapter is devoted to the presentation of the summary of findings, conclusion and recommendations drawn from the analysis of the research study on women status and child health (under –weight) among urban poor household in Nigeria.

5.1 SUMMARY OF FINDINGS

The study found that more than 28% of children of urban-poor women are underweight leaving only 71% having normal weight. Other socio-demographic characteristics of the urban poor household revealed that most of the mothers could not afford basic education as majority had no formal education (53%) and less than 1% had higher education. The religion affiliation of respondents disclosed that majority were Muslim (55.49%) while Christianity were (42.37%) and other religion (2.14%) were urban poor household. Fewer percentage of (4.76%) could handle decision on their healthcare of themselves and that of their children without their husband as majority depend on their spouse (72%) while 23% of urban poor women leave the decision for their husband totally. Although (77.96%) of urban poor household said they were engaged in paid jobs, but the most unfortunate things was that their paid employment can only be in manual jobs because they lack formal basic education.

The percentage distribution of sampled urban-poor household by under –weight status of the children, it was found that as the education of women increases the under-weight status of their children decreases from no education (73%) to Secondary education (6%). This shown a significance relationship between education of urban-poor women and nutritional status as the chi-square (X^2)=56.615, p=0.000. This implies that education of urban poor women can influence their children nutritional status (underweight). Also, Pearson Chi-square (X^2 =2.91, Pr =0.8527) for age of women and nutritional status of children revealed that there is no association between the age of women and their nutritional status although majority of the sampled women whose children are underweight were mother from age 25-29(25.1%), follow by age 30-49years in a reduction trends of 22.78%, 20.5%, 7.2% to 4%. Moreover ages 30-34years has highest no underweight status (23.8%) followed by age 25-29 with (23.04%) and later decline to 4.1% at age 45-49years.

The marital status of urban poor household was also found to influence their children nutritional status as 95.58% of married women had underweight children while only approximately 4% of the single mother had underweight children. This shown a significant relationship between marital status and nutritional status of children as X^2=6.89, p-value=0.03. Thus disclosed that the married mothers tends to give their cares that could aid nutritional status of their children than single mothers.

The multivariate analysis revealed a significant likelihood relationship that exist between urban-poor women status and children nutritional status (underweight), it was very paramount to note here that educational attainment, region of residence and marital status of women has significance odd ratio at 5% level of confidence toward children having poor nutritional status (underweight). The women who had

primary education are less likely to have underweight children with (OR=0.519, p-value=0.008) compare to not educated women in reference category. Furthermore, it was revealed that secondary educated women are 0.459 times less likely to having underweight children compare to not educated urban-poor women (RC). This implies that education could help urban poor mothers to improving their children nutritional status.

5.2 CONCLUSION

It is without any doubt that household living standards are closely associated with child health it was found that women status influence child nutritional in many of the surveys (Montgomery & Hewett, 2005). Thus this study conclude that base on the facts from the result that some factors such as educational status, marital status, age and number of children ever born influenced children underweight status while factors like religion, decision on health and types of family have no influence on children nutritional status.

5.3 RECOMMENDATION

The findings suggest that there should more attention to the urban poor household in improving child nutritional status considering thesefactors such as their education, marital status, age and number of children ever born. The most common responses have been to diversify productive urban development to some other rural-urban area but the scope for such diversification should put into consideration the education of mothers, therefore, different degrees of perception towards urban area. The other recommendations for this study are stated below.

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WOMEN STATUS AND CHILD HEALTH (UNDER-WEIGHT) AMONG URBAN POOR HOUSEHOLDS IN NIGERIA CHAPTER ONE 1.0 INTRODUCTION 1.1 BACKGROUND OF THE STUDY As per (Sandoval-Priego et al 2002), Children health status as showed by wholesome status as far as lack of healthy sustenance is one of the present health issues among the under five children that the world right now faces and is related with over 41% of the passings that happen every year in children from 6 to two years of age in creating nations which add up to roughly 2.3 million.

As indicated by World Health Organization in (2001) it was accounted for that 54% of all youth mortality was inferable, straightforwardly or by implication to hunger with Sub-Saharan Africa having a high rate of pervasiveness of the distinctive sorts of unhealthiness, in particular hindering, squandering and underweight (Lutter and Rivera, 2003).

Child malnutrition remains a profoundly common condition in low and center wage nations and a noteworthy segment of the worldwide weight of childhood malnutrition is found in South Asia with an expected 74 million children living with ceaseless malnutrition (hindered development).

This weight of malnutrition represents around half of under-five child passings in creating nations.

Another nation in Asia with a bigger level of children with incessant malnutrition is Bangladesh.

The United Nations Children's Emergency Fund (UNICEF, 2010) revealed that out of the 209 million children that are hindered on the planet, 144 million are in East/South Asia and the Pacific, 4 million in Central Asia, 12 million in Middle East and North Africa, and 9 million in the Americas and 40 million in sub-Sahara Africa.

Advance in enhancing baby and youthful child bolstering rehearses in

http://en.wikipedia.org/wiki/Food_and_drink_prohibition

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