Oleosi Ntshebe: Household Structure and Health in Botswana

Discussant comments

A number of papers in this conference use the concept of household structure in their analysis, some examining the relationship between different forms of household structure and socio-demographic outcomes (this paper, Madhavan et al on South Africa) others looking at comparative differences in household structure (Chinese ethnic minorities Lizzy Duan, Asia Esteve and Liu) and others (eg Snopowski & Sear Indonesia, Rivera et al Mexico) look at extra household relationships and particular outcomes.

Two points need to be emphasised in analysis using household structures or extra household relationships as some form of explanatory or outcome variable. First analysts need to be very careful to understand how the data were constructed in the first place via definitions of household and thus who was out and who was in. Although there is much talk of harmonisation and standardisation of definitions and concepts our research has shown that there remains considerable within and between country variation in household definitions used in different data collection exercises. To take a concrete (if slightly extreme) example: in the latest census undertaken in Burkina Faso it was decided that a household could not contain more than one married couple (although it could contain one man and two or more polygamously married wives). This meant that, for example, in the case of a large rural compound with an elderly couple dependent on their son for help, resources and food we would observe two simple nuclear households and if one were recording help provided it would be extra-household. On the other hand if only the elderly father or only the elderly mother were alive and co-resided with the son in the same compound, they would be recorded in the same household (which would be a more complex 3 generational structure) and any help would be intrahousehold. Yet the living arrangements, residential situation and the support provided by the son might be effectively identical in both situations. For reasons such as these it is very important that all research which examines issues around household structure and extra household support is very clear about outlining the definitions of household used to collect the data.

The second point is that it is really important to think through the conceptual framework and the pathways through which household structure (for example) is hypothesised to influence outcomes. Many, many socio-economic factors may be associated with different patterns of household structure and the structure may just be correlated with some totally different factor that is the key determinant of the outcome. In a paper such as this one on stunting and childhood diarrhoea in Botswana, the paper would have been considerably strengthened had the author explored the different pathways by which she thought household structure might influence child health outcomes BEFORE undertaking the analysis. As it is she concludes *'household structure is crucial to supporting child health for long term illness'* but never explains through what routes "grandparent is household head" (which seems to be one of the measures of household structure) might influence both stunting (a long term problem and not necessarily well represented by a cross sectional household measure) and diarrhoea : is it through wealth? – probably not since wealth is controlled for. Is it through the mother's situation and power within the household? Possibly. Is it an indication that there IS no mother present in the household and therefore no-one really looking out for the child?

P4 The author states that *in search of answers for improving child morbidity one concern is that LMIC children brought up in larger, more diverse hhs than in UK or US.* However this seems rather a spurious approach - and one which would be dropped if, as I suggest above, potential pathways of influence are thought through before the analysis is undertaken. Even if one compared children in (say) comparable nuclear households in these different environments (Botswana and the UK) we would find substantial child morbidity differences; different household structures are part of a whole range of different social and economic contexts which are much more important as determinants of morbidity and stunting.

I recognise that this is a piece of analysis which is, as yet, at an early stage, and thus these criticisms may be slightly unfair. I think it is great that the author has found a way of constructing a household from the child's perspective, but she might want to consider refining this further and reflecting on the presence or absence of either mother and/ or father and whether the household structure is likely to give either parent decision-making power and economic power within the structure. Two pieces of recent work in Mali (Ellis 2012, Holten 2013) suggest that in that context (which I know is very different from Botswana) many rural mothers really have little agency at all over health related or sickness related care for their children: this might look as though it is a consequence of their position in the household but in fact is much more to do with social expectations of appropriate moral behaviour and respect for others.

ELLIS, Amy, S. DOUMBIA, S.TRAORÉ, S.DALGLISH, P.WINCH (2013) Household roles and care-seeking behaviour in response to severe childhood illness in Mali **Journal of Biosocial Science**, published on line 22 April 2013 doi:10.1017/S0021932013000163

HOLTEN Lianne (2013) Illness narratives of Therapy Management: the multiple social realities of illness. Ch 7 in: **Mothers, medicine and morality in rural Mali** Lit Verlag, Zurich