

# Empowering women to advance maternal, newborn and child health

Empowering women, especially at the community level, is essential both to lowering the number of deaths among children under five and to reaching Millennium Development Goal 5, which aims to reduce maternal mortality by three quarters by 2015. Yet the low status of women in many societies and their limited decision-making power within the household often present serious challenges to achieving significant progress in either area. Analysis of the data from recent Demographic and Health Surveys in 30 countries, for example, suggests that in many households, especially in South Asia and sub-Saharan Africa, women have little influence in health-related decisions in households, whether concerning their own health or that of their children. In Burkina Faso, Mali and Nigeria, almost 75 per cent of women respondents reported that husbands alone make decisions about women's health care. In the two countries surveyed in South Asia, Bangladesh and Nepal, this ratio was around 50 per cent.

This exclusion compromises the health and well-being of all family members, particularly women and children, and is often linked to high maternal and child mortality rates – all five countries mentioned above are among the 60 selected as priority countries for child survival by the Countdown to 2015 (*see Figure 1.17, page 16, for further details*). The situation is often most severe in rural areas or in urban slums, where women are largely illiterate and suffer from socio-cultural barriers to accessing health services, such as restrictions on leaving their homes or on interacting with strangers, and frequently do not have access to a health centre or a health clinic.

For example, in Afghanistan, women are prohibited from receiving health care at hospitals staffed exclusively by male health personnel, while cultural norms restrict women from working and receiving advanced medical training.

A number of community health worker programmes that train primarily women have successfully circumvented gender-based barriers to utilization of health services. In Bangladesh, the community health workers trained by BRAC are married, middle-aged women, and their 'doorstep' health services allow women to circumvent purdah restrictions that prevent them from leaving their homes to access health facilities on their own. In Pakistan, where in 1999 only about half the women of childbearing age were immunized against tetanus, a campaign initiated by the Ministry of Health succeeded in raising that proportion to 80 per cent of a target group of 5 million women by relying on home visits by the Lady Health Workers, who were more acceptable to women than male vaccinators.

Furthermore, interventions that have enhanced women's empowerment and leadership at the community level have been equally important in improving the health status of women and children. In Ghana, the prevalence of Guinea worm disease, which is spread by water and can incapacitate an infected person for months, required a comprehensive eradication campaign. Women volunteers, who were more familiar with the improved water sources than men, conducted door-to-door surveillance, distributed filters, identified potentially contaminated water supplies and provided community education. As a result, incidence of the disease fell by 36 per cent between 2002 and 2003. Similarly, in Puerto Rico, a programme to prevent dengue fever, carried out by WHO and the US Centers for Disease Control and Prevention, relied on community-nominated women to act as promoters. The women made house-to-house visits, interviewing heads of households and inspecting the premises for vector breeding sites. They also engaged in community-awareness activities, including the creation of a dengue prevention exhibit at the local supermarket. Through this strategy, 20 per cent of households joined the campaign.

*See References, page 105.*