

Taking action to improve women's health through gender equality and women's empowerment

Caren Grown, Geeta Rao Gupta, Rohini Pande

Over the past few decades, great strides have been made in improvement of women's health status; more than a decade has been added to life expectancy, and fertility rates in both developed and developing countries have declined substantially,¹ helping to reduce burdens associated with childbirth and childrearing. Despite this progress, more than half a million women—99% of whom live in the developing world—continue to die every year in pregnancy and childbirth due to entirely preventable reasons. Additionally, amid the HIV/AIDS pandemic, women today face new and worsening health risks: 50% of all adults living with HIV/AIDS worldwide are women, and those age 15–24 years are disproportionately affected.

These realities are the result of persistent disadvantages experienced by women. Goal 3 of the Millennium Development Goals (MDGs)—to achieve gender equality and empower women—seeks to rectify those disadvantages through policies and programmes that build women's capabilities, improve their access to economic and political opportunity, and guarantee their safety. Such efforts must complement direct health interventions to assure long-term sustainable improvements in women's health.

Girls' education

For a long time, researchers have recognised that educating girls is important for improving health, reducing gender equality, and empowering women. Indeed, the MDG target for goal 3 is gender parity in primary and secondary schools by 2005 and at all levels of education by 2015. Global commitments to girls' education have focused on primary education. This focus must continue, and international commitments to universal primary education must be met, because primary education results in positive health outcomes that include reduced fertility and child mortality rates. However, post-primary education has strong positive effects on health outcomes and contributes to the broader empowerment of women.^{2,3}

Research shows that education is most beneficial to women in settings in which they have greater control over their mobility and greater access to services.^{4,6} In many parts of the developing world, however, women are not allowed that freedom or the resources to improve their health, and health services are not widely available; where present, they are usually of poor quality. In such situations, primary education alone is usually not enough for women to overcome these multiple constraints. Women can gain the tools and knowledge necessary to overcome these and other obstacles in

improving their own health with secondary or higher levels of education.² For instance, in countries with a strong societal preference for a son, where girls face substantial discrimination and higher mortality risks than boys, post-primary education enables women to reject gender-biased norms or find alternative opportunities, roles, and support structures.^{6–9}

Female secondary education is associated with high age at marriage, low fertility and mortality, good maternal care, and reduced vulnerability to HIV/AIDS. In a global review of early marriage, girls' secondary school enrolment was inversely related to the proportion of girls married before age 18 years.¹⁰ Those with only primary education (7 years or less) are more likely to be married before age 18 years than are girls with higher education.¹¹

Secondary female education is strongly associated with low fertility and child mortality.¹² In a model including data for 65 countries, Subbarao and Rainey¹³ estimated that doubling the proportion of girls educated at secondary level from 19% to 38%, holding constant all other variables (including access to family planning and health care), would have cut the fertility rate from 5.3 children per woman to 3.9 and the infant mortality rate from 81 deaths per 1000 births to 38. Researchers have also shown that women's education improves their use of maternal health services, independent of a host of other factors.^{4,5,14–18} Moreover, findings of studies have shown that secondary schooling always has a positive effect on a woman's use of prenatal and delivery services

Lancet 2005; 365: 541–43

International Center for Research on Women, 1717 Massachusetts Avenue NW, Suite 302, Washington, DC 20036, USA (C Grown PhD, G R Gupta PhD, R Pande ScD)

Correspondence to: Dr Caren Grown cgrown@icrw.org

Rights were not granted to include this image in electronic media. Please refer to the printed journal.

and postnatal care.^{4,16,17} The effect is always much larger than the effect of low levels of schooling.^{4,16,17}

Level of education also affects women's attitudes towards genital cutting. For example, in a study in Egypt, women who had some secondary education were four times more likely to oppose female genital cutting in general, and for their daughters and granddaughters, than were women who had never completed primary school.¹⁹

Studies of HIV in Africa and Latin America have shown that women's education lowers their risk of HIV infection and prevalence of risky behaviours associated with sexually transmitted infections including HIV, and increases their ability to discuss HIV with a partner, ask for condom use, or negotiate sex with a spouse.²⁰⁻²⁴ Primary education has a substantial positive effect on knowledge of HIV prevention and condom use, but secondary education has an even greater effect.²⁵ Girls who attend secondary school are far more likely to understand the costs of risky behaviour and even to know effective refusal tactics in difficult sexual situations.²⁶

Female secondary education can have a crucial role in reducing violence against women, which has severe health consequences, including unwanted pregnancies, sexually transmitted infections (including HIV/AIDS), and complications of pregnancy.^{27,28} In some women, the experience of violence can be a strong predictor of HIV. In a study in Tanzania of women who sought services at a voluntary counselling and testing service centre, those who were HIV-positive were 2.6 times more likely to have experienced violence in an intimate relationship than were women who were HIV-negative.²⁹ Moreover, violence seems to increase the risk of gynaecological disorders, including chronic pelvic pain, irregular vaginal bleeding, vaginal discharge, pelvic inflammatory disease, and sexual dysfunction.³⁰ Although female education clearly cannot eliminate violence, secondary education has a stronger effect than primary education in reducing rates of violence³¹ and enhancing women's ability to leave an abusive relationship.³²⁻³⁴

Other important interventions

In addition to ensuring that girls attain post-primary education, other interventions necessary for gender equality and women's empowerment can also improve health. Improving infrastructure—especially transportation and water and sanitation services—can have substantial benefits for women's health. Accessible and affordable modes of transportation can increase use of health services by women and children.³⁵ Location of water and sanitation services in or nearby women's homes could reduce head, neck, and back injuries caused by carrying heavy water containers. Better-planned sanitation projects also can reduce women's vulnerability to violence. For example, in India, the National Slum Dwellers Federation and Mahila Milan (a



Rights were not granted to include this image in electronic media. Please refer to the printed journal.

Still Pictures

women's organisation) build community toilets managed by local women on a pay-and-use system, which greatly improved safety and cleanliness.

Reduction of women's economic vulnerability by guaranteeing their rights to own and inherit property can also have important welfare effects. For instance, in societies such as Bangladesh, where husbands control most household resources, when women did own assets, household expenditure on children's clothing and education was higher and the rate of illness among girls was reduced.^{36,37} Property ownership can act as a protective factor for women against domestic violence. Research in Kerala, India, showed that 49% of women with no property reported physical violence compared with 7% of those who owned property, controlling for a wide range of other factors such as household economic status, education, employment, and other variables.³⁸

The way forward

Long-term and sustained improvements in women's health require rectification of the inequalities and disadvantages that women and girls face in education and economic opportunity. Several positive actions can be taken to reduce these inequalities and empower women. For education, these include making schooling more affordable by reducing costs and offering targeted

scholarships, building secondary schools close to where girls live, and making schools girl-friendly. Additionally, the content, quality, and relevance of education must be improved through curriculum reform, teacher training, and other actions aimed at transforming attitudes, beliefs, and gender-biased social norms that perpetuate discrimination and inequality. For enhancement of economic opportunity, governments need to guarantee women effective and independent property and inheritance rights, especially to land and housing, both in law and in practice. Because gender inequality is deeply rooted in entrenched attitudes, societal institutions, and market forces, political commitment at the highest international and national levels is needed to institute these policies and to allocate the resources necessary for gender equality and women's empowerment to improve female health.

Contributors

G R Gupta is a coordinator of UN Millennium Project Task Force 3 on education and gender equality. C Grown is a senior associate on the Task Force. C Grown and G R Gupta are lead authors of the Task Force report. R Pande is not affiliated with the Task Force.

Conflict of interest statement

We declare that we have no conflict of interest.

Acknowledgments

The authors thank Sandra Bunch and Aslihan Kes for their help in preparing this article.

References

- UN. World fertility report 2003. New York: UN Department of Economic and Social Affairs Population Division, 2003.
- UN Millennium Project. Taking action: achieving gender equality and empowering women. New York: United Nations, 2005.
- Malhotra A, Pande R, Grown C. Impact of investments in female education on gender equality. Washington: International Center for Research on Women, 2003.
- Elo I. Utilization of maternal health-care services in Peru: the role of women's education. *Health Transit Rev* 1992; 2: 49–69.
- Bloom SS, Bloom DW, Das Gupta M. Dimensions of women's autonomy and the influence on maternal health care utilization in a North Indian city. *Demography* 2001; 38: 67–78.
- Basu AM. Culture, the status of women, and demographic behavior. Oxford, Clarendon Press, 1992.
- Bourne KL, Walker GM. The differential effect of mothers' education on mortality of boys and girls in India. *Popul Stud* 1991; 45: 203–19.
- Govindasamy P, Ramesh BM. Maternal education and gender bias in child care practices in India. New Orleans: 61st Annual Meeting of the Population Association of America, 1996.
- Pande R, Astone NM. Explaining son preference in rural India: the independent role of structural vs. individual factors. Washington: 66th Annual Meeting of the Population Association of America, 2001.
- Mathur S, Greene M, Malhotra A. Too young to wed: the lives, rights, and health of young married girls. Washington: International Center for Research on Women, 2003.
- Population Reference Bureau. The World's Youth 2000. Washington: Population Reference Bureau, 2000.
- Schultz TP. Returns to women's schooling. In: King E, Hill MA, eds. Women's education in developing countries: barriers, benefits, and policy. Baltimore: Johns Hopkins University Press, 1993.
- Subbarao K, Rainey L. Social gains from female education. *Econ Dev Cult Change* 1995; 44: 105–28.
- LeVine RA, LeVine SE, Richman A, Uribe FMT, Correa CS, Miller PM. Women's schooling and child care in the demographic transition: a Mexican case study. *Popul Dev Rev* 1991; 17: 459–96.
- Obermeyer CM, Potter JE. Maternal health care utilization in Jordan: a study of patterns and determinants. *Stud Fam Plann* 1991; 22: 177–87.
- Bhatia JC, Cleland J. Determinants of maternal care in a region of South India. *Health Transit Rev* 1995; 5: 127–42.
- Govindasamy P. Poverty, women's status, and utilization of health services in Egypt. In: Garcia B, ed. Women, poverty, and demographic change. Oxford: Oxford University Press, 2000: 263–85.
- Beegle K, Frankenberg E, Thomas D. Bargaining power within couples and use of prenatal and delivery care in Indonesia. *Stud Fam Plann* 2001; 32: 130–46.
- El-Gibaly O, Ibrahim B, Mensch BS, Clark WH. The decline in female circumcision in Egypt: evidence and interpretation. New York: Population Council, 1999.
- Wolff B, Blanc AK, Gage AJ. Who decides? Women's status and negotiations of sex in Uganda. *Cult Health Sex* 2000; 2: 303–22.
- Fylkesnes K, Musonda RM, Sichone M, Ndhlovu Z, Tembo F, Monze M. Declining HIV prevalence and risk behaviours in Zambia: evidence from surveillance and population-based surveys. *AIDS* 2001; 15: 907–16.
- Gregson S, Terceira N, Kakowa M, et al. Study of bias in antenatal clinic HIV-1 surveillance data in a high contraceptive prevalence population in Sub-Saharan Africa. *AIDS* 2002; 16: 643–52.
- Silveira MF, Beria JU, Horta BL, Tomasi E, Victora CG. Factors associated with risk behaviors for sexually transmitted disease/AIDS among urban Brazilian women: a population-based study. *Sex Transm Dis* 2002; 29: 536–41.
- Jewkes R, Levin JB, Penn-Kekana LA. Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. *Soc Sci Med* 2003; 56: 125–34.
- Global Campaign for Education. Learning to survive: how education for all would save millions of young people from HIV/AIDS. Brussels: Global Campaign for Education Briefing, 2004.
- Herz B, Sperling GB. What works in girls' education: evidence and policies from the developing world. Washington: Council on Foreign Relations, 2004.
- Heise L, Pitangy J, Germaine A. Violence against women: the hidden health burden—discussion paper 225. Washington: World Bank, 1994.
- World Bank. World development report, 1993: investing in health. New York: Oxford University Press, 1993.
- Maman S, Campbell J, Sweat M, Gielen AC. The intersection of HIV and violence: directions for future research and interventions. *Soc Sci Med* 2000; 50: 459–78.
- Johns Hopkins School of Public Health. Ending violence against women: population reports L (11). Baltimore: Johns Hopkins, 1999.
- Kishor S, Johnson K. Profiling domestic violence: a multi-country study. Measure DHS+ project. Calverton: ORC Macro, 2004.
- Sen P. Enhancing women's choices in responding to domestic violence in Calcutta: a comparison of employment and education. *Eur J Dev Res* 1999; 11: 65–86.
- Visaria L. Violence against women in India: evidence from rural Gujarat. In: Burton B, Duvvury N, Rajan A, Varia N, eds. Domestic violence in India. Washington: International Center for Research on Women, 1999: 9–17.
- Ellsberg MC, Winkvist A, Peña R, Stenlund H. Women's strategic responses to violence in Nicaragua. *J Epidemiol Community Health* 2001; 55: 547–55.
- Mwaniki PK, Kabiru EW, Mbugua GG. Utilisation of antenatal and maternity services by mothers seeking child welfare services in Mbeere District, Eastern Province, Kenya. *East Afr Med J* 2002; 79: 184–87.
- Quimsumbing A, de la Briere B. Women's assets and intrahousehold allocation in Bangladesh: testing measures of bargaining power—discussion paper 86. Washington: International Food Policy Research Institute, 2000.
- Hallman K. Mother-father resource control, marriage payments, and girl-boy health in rural Bangladesh: discussion paper 93. Washington: International Food Policy Research Institute, 2000.
- Panda P. Rights-based strategies in the prevention of domestic violence: working paper 344. Washington: International Center for Research on Women, 2002.