

**Part II. A**  
**Women's Status**  
**and**  
**Empowerment**

- Percent of women who have completed at least four years of schooling
- Percent of women who have weekly exposure to mass media
- Percent of women who earn cash
- Percent of women who mainly decide how their earnings should be used
- Percent of women allowed to go alone to a health center
- Participation of women in household decision-making index

## WOMEN'S STATUS AND EMPOWERMENT

Whereas the sex of an individual is a biological phenomenon, gender is a social construct, defined by societal norms that attribute different roles and values to men and women. Moreover, these sex-specific roles, rights, and obligations are not just different, they also tend to be unequal (Kishor, 1999). We begin the *Compendium* with this section on women's status and empowerment, because these factors influence all subsequent elements in the causal chain that ultimately determines health status.

Unequal gender relations – existing to varying degrees in most if not all countries of the world – feed directly into the status accorded to women in society. Women's status is a term that describes women's situation in both absolute terms and in terms relative to men. The focus of women's status measurement has typically been on women's access to, and utilization of, information and resources (e.g., access to education, access to cash employment). Women's empowerment is a related term that focuses on attention to women's degree of control over their own lives and environments and over the lives of those in their care, such as their children. "Autonomy" is a related concept that also reflects women's control over their lives and environment, as well as status. Although several indicators of women's status and empowerment are available from the DHS core questionnaire or from the women's status module (described in "A Framework for Understanding the Role of Gender and Women's Status in Health and Population Outcomes," Kishor, 1999), we present six that researchers and evaluators have used to date (e.g., field tested). Status and empowerment are intended to reflect the extent to which egalitarian gender relations are achieved.

Gender equity is an end in itself. A recent World Bank publication cites gender equality as a core development issue and objective. Research from economics, law, demography, sociology, and other disciplines demonstrates widespread gender gaps in access and control of resources, economic opportunities, power, and political voice. These gender inequalities not only impose

costs on the health and well-being of men, women, and children, but also diminish a country's prospects for development. In addition to these personal costs, societies that discriminate by gender pay a high price in terms of their ability to govern effectively, to reduce poverty, and to pursue economic progress (World Bank, 2001).

Many groups have challenged the societal structures granting men greater power than women, and they fight for a greater balance between the two sexes in all aspects of daily life. Because of the pervasiveness of gender differentials in societies worldwide, the task of shifting this balance of power is mammoth. Nonetheless, some programs are taking on this challenge to redress gender equities, such as those programs focused on attracting and retaining girls in primary and secondary school.

In this section, we address gender as it relates to reproductive health outcomes. A major theme of the 1994 International Conference on Population and Development (ICPD) in Cairo was that gender equity is the single greatest catalyst to fertility decline. As women gain greater control over all aspects of their lives, they will be motivated and able to control their own fertility, presumably at levels lower than the current ones in most developing countries. By the same logic, greater gender equity will allow women to break down the obstacles to receiving treatment for life-threatening complications of childbirth (e.g., lack of access to family resources, requirement of husband's consent to seek treatment), which in turn will decrease maternal mortality and morbidity.

A parallel line of reasoning is that gender equity directly influences health outcomes, in terms of both the supply and demand for services (illustrated in Figure I.1). This perspective does not diminish the value of gender equity as an end in itself. However, it treats gender in relation to factors that ultimately determine health-seeking behavior, service utilization, and desirable health practices.

For example, gender inequity diminishes the likelihood that women will seek health services or perform healthy behaviors because they:

- Lack knowledge of healthy practices and sources of service;
- Have limited access to resources, including nutrition and health care; and
- Lack control over decision-making as it relates to number of children, protection from STIs, and related topics.

The low status of women also affects **the supply environment** (e.g., service delivery). The lack of available emergency obstetrical care in many parts of the world has been linked to the low value placed on women's lives (Rosenfield and Figdor, 2001). Several studies have demonstrated that women of lower status receive treatment inferior to that of their higher status counterparts, even from the same set of providers at the same facility (e.g., Schuler and Hossain, 1998). Women from ethnic minority groups often experience additional barriers when they seek services, especially if they do not speak the predominant language of that country.

### **Methodological Challenges of Evaluating Women's Status and Empowerment**

- **Health professionals generally acknowledge the role of women's status and empowerment in health outcomes, but they may consider such equity "beyond their manageable control."**

Given the wide-ranging nature of gender differentials in society, many program managers feel they have neither the mandate nor the means to directly change this deeply entrenched set of values. Those who have attempted to develop programs to influence power relations in sexual relationships have frequently faced the viewpoint that gender relations are a component of "culture," which is seen as nebulous, static, and impermeable to intervention (Helzner, 1996; Clark, 1998).

- **The traditional public health approach differs significantly from the women's rights/gender empowerment perspective.**

Applying a human rights framework to RH programs means, among other things, focusing as much on the process as the outcome, incorporating efforts to address the gender and power dimensions of reproductive and

sexual decision-making into every level of program implementation, and building a sense of entitlement among the seekers and the providers of services (Jacobson, 2000). When faced with competing demands for a very limited cache of resources, many program managers are simply not ready to "take on" a human rights-based approach to gender. Instead, they prefer to focus on providing conditions that will circumvent or negate the ill effects of gender inequities (e.g., providing contraceptive methods that women can take without their husbands' knowledge). Were gender equity a more central part of international RH programming, managers might feel a greater urgency to develop indicators to track progress in this area.

- **Some individuals perceive gender as an amorphous concept that does not lend itself to measurement.**

Concepts central to gender inequity – such as value systems, decision-making, and control of resources – seem abstract; they elude measurement. Indeed, the groups assembled to develop indicators of women's status and empowerment in various contexts have experienced difficulty in deciding which elements to measure. One group took the approach of identifying ways that gender inequities hinder the success of RH programs. Whereas this strategy proved logical and feasible, the group disliked defining women's status as a barrier; rather, they preferred to seek positive means to integrate gender into reproductive health interventions (Yinger et al., 2001).

Blanc (2001) cites the lack of useful and practical measures of power relations in her comprehensive review of the balance of power in sexual relationships. Although certain measures have been linked to specific outcomes in some settings, such relationships may not hold in other settings (e.g., whether they would be cross-culturally valid). As Blanc observes, power relations themselves are rarely measured; thus, if a desirable outcome occurs, assigning it to a change in power relations may be impossible.

- **To measure gender inequity, one must have comparisons, not just a single number.**

Documenting gender inequities (for example, in access to resources) with a single number (e.g., percent, mean/median, is difficult, because gender is relational. Gender inequality reflects that women have lower access to

power and resources than men. Higher status women (e.g., service providers) may also discriminate against lower status women clients on the basis of gender, and thereby limit their access to services. Exceptions include selected indicators related to discrimination in the workplace: percent of women in management positions or societal outcomes of gender discrimination (e.g., female infanticide, violence against women). Thus, documenting disparities in gender equity often requires disaggregation and comparisons of data by sex (e.g., males versus females). Improvement in female education (e.g., percent of girls enrolled in school) over time is generally accepted as a sign of progress contributing to the empowerment of women.

- **Programs generally focus on women, the “disadvantaged gender,” with relatively little attention to men’s needs.**

With respect to gender differentials in power and in access to resources, men generally appear to have the advantage. Yet with regard to contraceptive and RH services, programs have largely ignored men. This approach not only has excluded men from active participation in maintaining reproductive and child health, but also has clearly put the burden for doing so on women. The HIV/AIDS epidemic has made evident that exclusion of men is untenable, in large part because such exclusion ultimately contributes to the disadvantage and disempowerment of women.

### **Treatment of Gender in this *Compendium***

Because gender plays such a complex and pervasive role in all aspects of human life, it is challenging to define an exhaustive set of “gender indicators” (for reasons described below). Rather, we treat the issue of gender in four different ways in this *Compendium*.

#### **1. Population-based Indicators of Women’s Status and Empowerment**

In this section we describe selected population-based indicators of women’s status and empowerment that are available from the DHS and other large-scale national surveys. Evaluators can use these indicators in one of three ways. First, the simple tracking of the indicator can document progress (e.g., increasing levels of female education). Second, indicators can serve to document gender differentials in male/female comparisons.

And third, indicators can serve to demonstrate the effect of women’s status on other behaviors or phenomena (e.g., women with less education have lower decision-making power). For a useful presentation of these relationships from DHS data, see Kishor (1999).

The position of “women’s status and empowerment” on the conceptual framework in Figure I.1 illustrates the extensive influence of gender on all subsequent aspects of RH programs. In short, women’s status influences demand for both RH services and the supply environment, and through these factors, reproductive health status.

#### **2. Gender in Managerial Structures and in Service Delivery**

Gender affects two aspects of the supply environment for reproductive health services in measurable ways: the managerial structure and the service delivery system. For example, men generally make higher salaries than do women for comparable work; women often hold the lowest paying jobs in an organization. In terms of service delivery, women of lower status may get treatment inferior to that of their higher status counterparts, even in the same facility. Providers may inadvertently reinforce gender stereotypes through messages they communicate to clients. Although indicators of these phenomena are relatively new, we include a checklist of factors to assess institutions on gender equity and to evaluate service delivery environments on gender sensitivity. (See Part II.H.4).

#### **3. A “Gender Interpretation” of Other Indicators**

Because of the far-reaching influence of gender in all aspects of service delivery, we present a series of boxes in the text of Parts II and III of the *Compendium* that explain how evaluators can interpret other indicators from a gender perspective. Often by disaggregating data by sex (e.g., males versus females), one can identify the effects of gender inequity in a system. The boxes do not present indicators of women’s status and empowerment per se, but rather the boxes indicate how to analyze the results from a gender perspective.

#### 4. Indicators for Gender-Relevant Programs

Part III of the *Compendium* presents indicators for specific areas of reproductive health; we present two sections particularly relevant to gender. The first is male involvement. In the wake of the Cairo Conference, programs worldwide have attempted to incorporate men into RH programming to a greater extent, both to support health-seeking behaviors in their partners and to participate directly by adopting practices that foster improved reproductive health. The second topic is violence against women, which constitutes one of the most harmful physical expressions of gender inequity. Intervention programs on this subject are still very new. According to researchers/evaluators in this area, the data on these indicators can be perplexing and counterintuitive (e.g., the reported rates of violent acts may increase at the onset of programs designed to combat violence against women, precisely because more women are willing to admit to abuse). Moreover, the use of such data could damage the very women the programs seek to help, if interviewers do not handle the data collection carefully. Violence screening and services heighten the need to protect clients' confidentiality and to maintain procedures if confidentiality is violated.

#### Categories of Indicators of Women's Status and Empowerment

The World Bank report entitled *Engendering Development: Through Gender Equality in Rights, Resources, and Voice* (2001) cites three important forms of gender disparity, along with indicators for measurement:

- Social, economic, and legal rights, measured by:
  - Political and legal equality;

- Social and economic equality; and
- Equality in marriage and in divorce proceedings.

- Access to productive resources, measured by:
  - Education – primary and secondary enrollment rates;
  - Health – life expectancy at birth, the burden of disease, gender-related violence, HIV/AIDS;
  - Productive Assets – land ownership, access to information, technology, and financial resources; and
  - Employment and earnings – labor force participation, occupation representation ratio, and relative earnings.
- Voice to influence decisions in their communities and at a national level, measured by:
  - Participation in politics; and
  - Representation in elected office.

The indicators that follow (selected in part because they are available through the DHS) focus primarily on access to productive resources and social equality.

## Indicator

### PERCENT OF WOMEN WHO HAVE COMPLETED AT LEAST FOUR YEARS OF SCHOOLING

#### Definition

This indicator measures the percent of women ages 15-49 who have completed at least a primary level of education. For different countries, primary education may vary from four years to eight to ten years.

This indicator is calculated as:

$$\frac{\text{\# of women ages 15-49 who completed four years of schooling}}{\text{Total \# of women ages 15-49}} \times 100$$

#### Data Requirements

Information on the number of women ages 15-49 who completed primary school and information on the total number of women ages 15-49 surveyed

#### Data Source(s)

Population-based survey such as the DHS or RHS

#### Purpose and Issues

Educational attainment of populations vary greatly among countries. For example, in India, where educational attainment of women is very low, even a measure, such as the percentage of women who are literate can suffice. On the other hand, in countries such as Kazakhstan or Colombia where primary education is almost universal, a more appropriate measure may be the percentage of women who have completed high school.

This indicator is preferable to the percentage of women who have completed primary school, since the number of years required to complete primary schooling varies by country (e.g., five years in Egypt, eight years in Kenya). One must also be wary of calculating completion rates for 15-19 year olds, as many are still in school and, in sub-Saharan Africa, many are still in primary school because of the late age of entry into school and because of having to repeat the grade.

Further analysis of this indicator by age group can provide some indication of a changing climate for female education. Specifically, one would expect women 25-29 to have completed more schooling than older age cohorts have.

Educational attainment is important to gender equity for multiple reasons. It provides women with greater self-confidence and with power of logic to operate in an increasingly complex world. It gives them the cognitive skills and training necessary for participation in the workforce. It exposes them to non-traditional ways of thinking and provides alternative modes for behavior. Though education will not guarantee gender equity, it is an essential step toward it.

## Indicator

### PERCENT OF WOMEN WHO HAVE WEEKLY EXPOSURE TO MASS MEDIA

#### Definition

This indicator measures the total number of women aged 15-49 who report exposure to either radio, television, newspapers, or magazines at least once a week. The indicator is measured for television and radio. Evaluators may add questions regarding newspapers and magazines in addition to (though usually not instead of) television and/or radio.

This indicator is calculated as:

$$\frac{\text{\# of women ages 15-49 reporting exposure to radio or television at least once a week}}{\text{Total \# of women aged 15-49}} \times 100$$

#### Data Requirements

Information on the number of women 15-49 reporting exposure to radio or television at least once a week and the total number of women 15-49 surveyed

The DHS categorizes whether women have been exposed to radio, television, newspapers, or magazines

as “almost everyday, at least once a week, less than once a week or not at all.”

#### Data Source(s)

Population-based survey such as the DHS or RHS (on selected surveys)

#### Purpose and Issues

The mass media are one of the most important sources of information and exposure to new ideas, alternative role models, and non-kin-based power structures. The media play an even greater role in countries where women have low or no education, restricted freedom of movement, low levels of employment outside the home, or employment on the family farm. For men, too, the media are likely to be important, but perhaps less so than for women because men tend to have more alternative sources of information than do the women (i.e., they are more likely to be employed, educated, and able to move freely outside the home). Media exposure can be seen as a source of “empowerment” for women just as education is. In health and family planning research, women’s exposure even to a single source of media, especially if it is television, is a powerful predictor of attitudes, beliefs, and actions, even controlling for education (Westoff and Bankole, 1997).

## Indicator

### PERCENT OF WOMEN WHO EARN CASH

#### Definition

This indicator measures the percent of women aged 15-49 who work either at home or outside the home and earn cash. No minimum quantity is specified.

This indicator is calculated as:

$$\frac{\text{\# of women ages 15-49 earning cash}}{\text{Total \# of women aged 15-49}} \times 100$$

#### Data Requirements

Information on the number of women 15-49 employed earning cash and information on the total number of women surveyed

Note: Evaluators should include women who earn cash for crops in this indicator.

#### Data Source(s)

Population-based survey such as the DHS

#### Purpose and Issues

This indicator may reflect several types of empowering effects: exposure to networks other than kin networks, information from sources outside the family, and direct access to resources in the form of cash earnings. This indicator is preferred to the alternative indicator, the percentage of women who are currently employed, because research tends to find that women who are employed but do not earn cash are more “disempowered” than are women who do not work at all. Women who work without earning cash are likely to work on the family farm or to be in dependent situations, which deprive them any outside sources of “empowerment.”

## Indicator

### PERCENT OF WOMEN WHO MAINLY DECIDE HOW THEIR INCOME WILL BE USED

#### Definition

This indicator measures the percent of women aged 15-49 who mainly decide the use of the income they earn.

“Mainly” refers to the fact that she may receive some input from her husband, brother, or parent but that she maintains a degree of control over her own earnings.

The indicator is calculated as:

$$\frac{\text{\# of women ages 15-49 who mainly decide how their income will be used}}{\text{Total \# of women aged 15-49}} \times 100$$

#### Data Requirements

Information on the number of women who mainly decide the use of their income and the total number of women who work for cash surveyed

#### Data Source(s)

Population-based survey such as the DHS or RHS (on selected surveys)

#### Purpose and Issues

For women, having some money – however little – that they control is important for their real and perceived financial autonomy and rights. Sources of income and the ability to control how that income can be used makes women less dependent on others for financial support and thus increases flexibility in life options.

An alternative indicator is the percentage of women who participate (alone or with their husbands/someone else) in the decision about how their earnings should be used, although this may be less meaningful in measuring financial autonomy and rights.

## Indicator

### PERCENT OF WOMEN ALLOWED TO GO ALONE TO A HEALTH CENTER

#### Definition

This indicator measures the percent of women aged 15-49 who are permitted to visit the health center on their own (i.e., without anyone accompanying them).

This indicator is calculated as:

$$\frac{\text{\# of women ages 15-49 allowed to go to the health center alone}}{\text{Total \# of women aged 15-49}} \times 100$$

#### Data Requirements

Information on the number of women 15-49 who are allowed to go to the health center alone and information on the total number of women 15-49 surveyed

#### Data Source(s)

Population-based survey such as the DHS Women's Status Module

#### Purpose and Issues

A woman's ability to move about outside her home is a critical aspect of her empowerment. This indicator may not be appropriate for all countries, since the lack of freedom of movement is not a universal problem.

However, this indicator may be appropriate for South Asian and Muslim countries where women's freedom of movement may be restricted.

This indicator specifies "health center" as a particularly relevant destination given the subject of this *Compendium* (regarding reproductive health). However, a more detailed measure – reflecting a number of common destinations combined into an index of mobility, based on the number of total places a woman may go – may be useful. Such places may include the local market, a community center or other nearby meeting place, friends' homes in the neighborhood, church/shrine/mosque/temple, or simply anywhere outside the house or compound. For every place a woman may go unescorted, evaluators assign one point. The total score would reflect the total number of places a woman may go alone.

Being able to go alone to a health center may not indicate all that much about a woman's autonomy (i.e., she may be able to go alone and still not be autonomous), but not being able to go places independently is highly indicative of no autonomy.

**PARTICIPATION OF WOMEN IN HOUSEHOLD DECISION-MAKING INDEX****Definition**

This indicator measures women's participation in the following five decisions:

- Determining own health care;
- Making large household purchases;
- Making daily household purchases;
- Visiting family or relatives; and
- Deciding what to prepare for daily meals.

A woman participates in a given decision when she alone or jointly with someone else makes the decision. The index is defined as the number of decisions a woman participates in. It is calculated by giving a score of 1 to each decision a woman participates (and 0 otherwise) in alone or jointly with someone else and then taking the sum. The index value will thus range from 0 (participates in none of the five decisions) to 5 (participates in all five decisions).

**Data Requirements**

Responses to the question "Who in your family usually has the final say on the following decisions: determining your own health care, making large household purchases, making household purchases for daily needs, visiting family and relatives, deciding what to prepare for daily meals?"

**Data Source(s)**

Population-based survey such as the DHS or RHS (on selected surveys)

**Purpose and Issues**

While relatively new, this index is perhaps the most direct measure of women's empowerment since it examines women's participation in at least five crucial decision-making processes. This type of information is now part of the core DHS questionnaire, and certain countries may have additional questions about other important decisions. Evaluators should frame the index in terms of women's participation (alone or jointly) in each of the five major decisions.

The higher the index score, the greater the indication of gender equity in decision-making. Aggregated individual index scores provide a measure of gender equity within regions or countries, or over time.