INTRODUCTION

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The MEASURE *DHS*+ phase of the Demographic and Health Surveys (DHS) project that was initiated in the last quarter of 1997 saw an increased effort to integrate gender into all aspects of the project, including in the content of DHS survey instruments. Accordingly, during the months following the launch of MEASURE *DHS*+, advisory groups of gender experts were constituted to provide input into the revision of the DHS questionnaires. Meetings over the next year led to several recommendations for gender-related changes/additions to the DHS women's and men's core questionnaires, as well as for the formulation of new or the revision of existing gender-related modules. In particular, the advisory groups advocated the inclusion of new questions on women's participation in household decisionmaking and on gender roles. In addition, new, more standardized questionnaire modules were formulated that provided information on women's status, domestic violence, and female genital cutting.

By early 2003, the revised DHS women's questionnaire (which included one or more of the new gender questions) had been implemented in more than 20 countries and the modules had been implemented in several countries. Given the large amount of new DHS gender-related data, it was decided to fund research that would explore the new gender-related DHS data within the context of demographic and reproductive health outcomes. The objective of the activity was to further the understanding of the role of gender in achieving desired population and health outcomes in the developing world. Given the importance of DHS data for the developing world, and the large sample sizes of these nationally representative surveys, any conclusions drawn about the role of gender will have relevance for development policy.

To this end, DHS, with funding from United States Agency for International Development (USAID) under the first phase of the MEASURE contract, invited papers from researchers recognized for their work in the areas of demography, reproductive health, and gender. The researchers were asked to focus on different demographic or health outcomes of interest to them and explore how and whether gender-related factors played a role. It was initially planned that authors would present their papers at a symposium to be held in Washington, D.C., in late 2003. For various reasons, the symposium was cancelled; however, this volume presents the five invited papers (and one written by DHS staff) as a group of working papers. We consider this collection to be a major contribution to the use of research to highlight the role of gender and related issues in achieving desired demographic and health outcomes. It is hoped that all of these papers will be revised and published in peer-reviewed journals and/or books.

To provide a context for the research presented in this collection, this introductory chapter presents information on the types of specific gender data now available in the DHS surveys and highlights the main findings of the papers included in this volume.

1 GENDER IN THE DEMOGRAPHIC AND HEALTH SURVEYS

The DHS surveys have typically provided information on fertility, mortality, family planning, and important aspects of health, nutrition, and health care for women and children, as well as for men, in several countries. Since 1984, DHS surveys have been conducted in over 70 developing countries around the world. The DHS program uses scientific sampling to collect, from

eligible individuals in sampled households, a comparative body of nationally representative information on population, nutrition, and health issues. Cross-cultural comparability of data is derived by implementing a core of near-identical questions across countries; additional country-specific information needs are met by including country-specific questions and/or special DHS modules. Three core questionnaires are commonly used by DHS: a household questionnaire, a woman's questionnaire, and a men's questionnaire. If comparable information is needed for a large number of countries on any given topic, it is important to include relevant questions in the appropriate core questionnaire, because it is these questionnaires that are implemented with little change across countries.

The data traditionally derived from the DHS core questionnaires can be used to develop a large number of indicators that indirectly shed light on gender relations and are commonly used to measure women's status and empowerment (Kishor and Nietzel, 1996). However, until the late 1990s, there were almost no questions that directly explored the gendered context of health and demographic outcomes. As mentioned earlier, in the first phase of the MEASURE *DHS*+ program (the fourth round of the DHS), advisory groups were formed to guide the integration of gender questions into DHS questionnaires. The identification of the gender questions to be included in the core questionnaire had to conform to several DHS-specific constraints, the most cogent of which was that DHS surveys are household surveys and the main focus of the surveys has traditionally been women of reproductive age. Hence, any investigation of gender had to be based on information that pertains to and can meaningfully be collected from individuals in households.[1] Additional constraints included: a) all questions needed to be implementable with little or no change in all DHS countries, b) questions needed to be relevant for understanding population, health, or nutrition (PHN) outcomes and changes in outcomes over time, and c) given the length of the DHS questionnaires and several competing priorities for the limited space on the survey, only a few core questions specifically addressing gender issues could be defined.

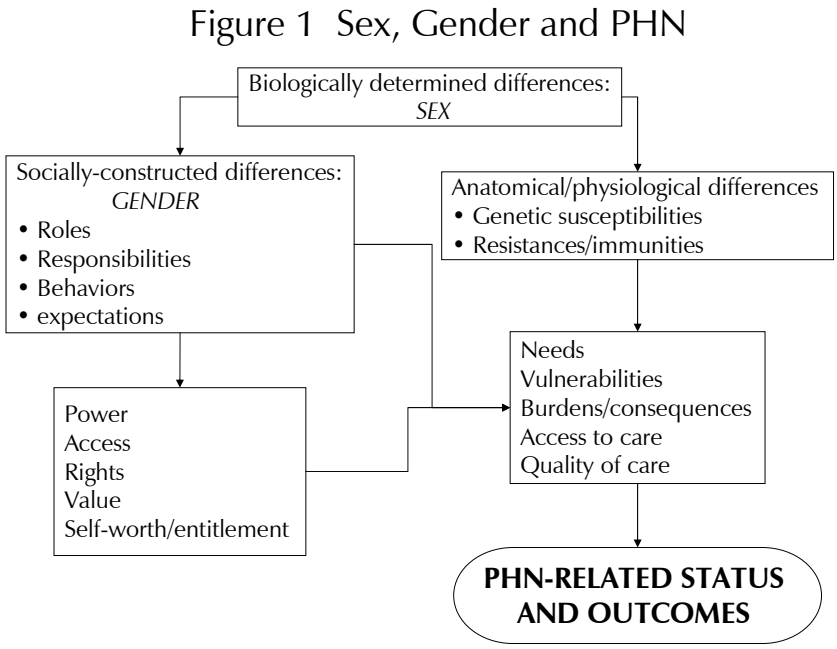
The inclusion of specific gender questions in the DHS questionnaires was guided by a common understanding of what gender is, how it relates to sex, and how sex and gender together and separately have the potential for affecting PHN outcomes. Figure 1 below summarizes these relationships. The biologically determined sex of an individual affects PHN outcomes because of anatomical and physiological differences and genetic susceptibilities and immunities associated with being biologically female or male.[2] By contrast, gender is the socially constructed derivative of sex and encompasses the different roles, rights, expectations and obligations that culture and society attach to individuals according to whether they are born with male or female sex characteristics. Different roles, rights, expectations, and obligations translate into differences in relative power, control of and access to resources, the value placed on survival and health, and the sense of entitlement and self-worth of women and men. While sex points to differences between men and women, gender makes men and women not just different, but also unequal: the rights, roles, and obligations of women tend to be subordinated to those of men. In many instances, gender-based power differentials give men not only greater absolute power than women, but also power over

[1] Once collected, the information can be aggregated to get community-level indicators, but the nature of the information would necessarily reflect the experience of individuals or describe how gender plays out at the household level.

[2] These differences go well beyond the most fundamental difference between the sexes, the ability to bear a child. Examples include women's greater susceptibility to iron deficiency anemia because of menstruation and increased susceptibility to HIV infection than men and men's lower life expectancy at birth compared with women, all else being the same.

women. Such gender differences in power, roles, rights, and entitlement affect women's and men's health, survival, nutrition, and fertility control, because they translate into differences in the kind of work men and women engage in and, relative to men, women's lower control over their bodies and sexuality, greater restrictions in accessing material and nonmaterial resources such as knowledge and information, and greater constraints in accessing needed health care, among other things.

Figure 1 Sex, Gender and Population/Health/Nutrition (PHN)



In keeping with this conceptualization of gender, DHS introduced four sets of gender-related questions into the women's core questionnaire in 1999: questions on women's participation in household decisionmaking, questions on gender-related hurdles in accessing health care, and two sets of questions on women's acceptance of gender-role norms that justify men's control over women. These questions are in addition to questions traditionally included in the DHS that yield several widely used indicators of women's status such as indicators of women's education, media exposure, employment and earnings control, and age at marriage and first childbirth. All of the new questions can be used to monitor women's empowerment within specific gender contexts. A focus on empowerment of women is justified given the gender differentials in power between women and men. Each of the new gender-related questions are discussed below.

Women's participation in household decisionmaking. Decisionmaking in households, particularly who participates in and has control over the process, is an aspect of gender relations that has both cross-cultural and household-level relevance. The choice of decisions to ask about in the woman's core questionnaire was guided by the need to make included decision areas relevant to all women whether they were currently married or not and had children or not, while also covering different aspects of household and individual functioning. Accordingly, the following question is asked of all women:

Who in your family usually has the final say on the following decisions:

Your own health care?
Making large household purchases?
Making household purchases for daily needs?
Visits to family or relatives?
What food should be cooked each day?

Responses are coded as "Respondent"; "Husband/partner"; "Respondent and husband/partner jointly"; "Someone else"; "Respondent & someone else jointly"; and "Decision not made/not applicable."

Most cultures ascribe domestic roles, such as cooking and cleaning, to women. Accordingly, decisions about food were included in the list with the expectation that most women would be making these decisions. The atypical woman would be the one not making the decision, rather than the one making it. Decisions about the two different kinds of purchases (large purchases and purchases for daily needs) were meant to tap into economic decisionmaking in the household, while allowing for variation in participation according to the relative amount of money to be expended and according to whether the decisions are routine or not (purchases for daily needs being more routine than large purchases). Participation in decisions about visits to friends and family was expected to be most culture-specific; this type of decisionmaking is less likely to involve women in cultures where women's freedom of movement is restricted and where their interaction with birth-family members is more closely monitored by husbands and in-laws than in other cultures. Finally, decisions about women's own health care were thought to be fundamental to their self interest and of direct relevance for bringing about PHN-related change.

Hurdles in accessing health care. Women can face several gender-related constraints in accessing health care, constraints that define what is appropriate behavior for women. To measure the extent of these types of constraints, DHS asked all women the following question:

Many different factors can prevent women from getting medical advice or treatment for themselves. When you are sick and want to get medical advice or treatment, is each of the following a big problem or not?

Getting money needed for treatment?
Knowing where to go?
The distance to a health facility?
Having to take transport?
Not wanting to go alone?
Getting permission to go?
Concern that there may not be a female health provider?

The last three of the listed problems are clearly gender sensitive. Gender roles do not always permit women to go alone to places, or to go without permission, or to see male health providers. Few such restrictions apply to men. The first four of the listed problems are likely to be problems for not just women but also men. Even so, with men having greater control over resources than women, it can be argued that problems such as having money for treatment will also be gender sensitive and represent a greater hurdle for women than for men.

Gender-role norms that justify men's control over women. Of particular relevance to demographic and health programs is the need to determine the extent to which women, often the targets of such programs, have control over their own behavior, bodies, and sexuality. Accordingly, the following two sets of questions that explore women's acceptance of norms that subordinate women's bodily integrity and sexuality to men were included in the DHS:

> *Sometimes a husband is annoyed or angered by things that his wife does. In your opinion, is a husband justified in hitting or beating his wife in the following situations:*
>
> > *If she goes out without telling him?*
> > *If she neglects the children?*
> > *If she argues with him?*
> > *If she refuses to have sex with him?*
> > *If she burns the food?*
>
> *Husbands and wives do not always agree on everything. Please tell me if you think a wife is justified in refusing to have sex with her husband when:*
>
> > *She knows her husband has a sexually transmitted disease?*
> > *She knows her husband has sex with other women?*
> > *She has recently given birth?*
> > *She is tired or not in the mood?*

These are both attitude questions, rather than questions that ask women about their own experience. Agreement with the justifications for a husband beating his wife or for a wife refusing her husband sex attests to the socialization of women in traditional gender-role norms that give husbands rights over the behavior and bodies of their wives. The presumption behind these questions is that truly empowered women would not accept such obvious gender inequalities in power; such women would not agree with any justification for a husband beating his wife and would believe that a wife should have the right to decide when and whether she wants to have sex with her husband. Even so, the justifications presented to respondents in both questions were carefully chosen to provide variation in the perceived seriousness of the behavioral-norm violation. For example, even among women who accept the norm that it is a woman's duty to have sex with their husband when he wants to, a wife refusing her husband sex because she has recently given birth is likely to be a less serious gender-role violation than refusing sex because she is "tired or not in the mood." Similarly, not cooking food well or burning the food should be less of a justification for wife beating than neglecting the children even among women who justify wife beating.

In addition to the gender questions in the women's core questionnaire and the men's core questionnaire,[3] gender information is also available through gender-related modules, including the women's status module, the domestic violence module, and the female genital cutting (FGC) module.

[3] Similar gender norm questions and questions about women's participation in household decisionmaking were also added to the men's core questionnaire.

Women's status module. This module contains questions on several topics pertinent to women's status, including the following:

- More information[4] on women's most recent marriage, including the respondent's involvement in the choice of her spouse, how long she knew her spouse before she was married to him, and the type of marriage. In some countries consanguinity in marriage is also measured.

- Co-residence with in-laws.

- Birth family information, including education and employment status of mother and father and interaction with and perception of support from the birth family.

- Additional questions on household decisionmaking that investigate whether women make decisions about their own employment, contraceptive use, and decisions about children's health and welfare and on gender-role attitudes.

- Several financial autonomy measures, including control over money for different types of expenditures, ownership of assets, whether respondent has and operates a bank account, and whether she knows about and participates in any micro-credit scheme.

To date, this module has been implemented in its entirety in only two countries, Cambodia and Haiti. Similar information was sought using an earlier version of the module in the 1995 Egypt survey.

Domestic violence module. This module contains questions that allow the estimation of the prevalence of spousal emotional, physical, and sexual violence, nonspousal physical violence, violence during pregnancy, and violence by women against their husbands. In addition, women who have experienced spousal violence are asked about the timing of the initiation of the spousal violence, frequency of violence, and whether they have ever sought help. Information is also collected on the extent of marital control exercised by the husband. By 2003, this module (or some part of it) had been implemented in six countries. The module comes with a list of recommendations for its ethical implementation.

Female genital cutting module. This module is implemented in countries known to practice FGC and provides information on knowledge and prevalence of FGC. Women who have daughters are asked whether their daughter(s) have been circumcised. If no daughters are circumcised, women are asked about their intentions to circumcise their daughters. Women who have been circumcised are asked about the type and timing of the circumcision and the type of circumcisor. If the respondent has a daughter who is circumcised, similar information is sought about the circumcision of the daughter. Finally, questions are included on perceived advantages and disadvantages of the practice and whether the respondent is in favor of the practice continuing or not.

[4] The DHS questionnaire already provides information on women's current marital status and age at first marriage, spousal age and educational differences, whether the most recent marriage is polygamous, and whether the woman has been married once or more than once. Information on the current spouse's age, education, and employment is also collected.

Four of the six papers in this volume use gender-related information from the women's core questionnaire, one paper draws on both the women's and men's questionnaires, and one paper draws on information contained in the domestic violence module.

2 HIGHLIGHTS OF THE PAPERS INCLUDED IN THIS VOLUME

The first five papers in this volume focus on the new gender questions in the core questionnaire, particularly the questions on household decisionmaking, and examine how women's autonomy and empowerment[5] affect different PHN outcomes of interest. The last paper changes the focus from empowerment and autonomy to gender-based violence. It examines whether PHN outcomes of interest vary by women's experience of domestic violence.

Common to several of the papers is an obvious struggle to define women's empowerment and/or autonomy and then to adequately measure it. Each paper resolves this struggle in different ways: the Basu and Koolwal paper focuses attention on two types of decisionmaking autonomy, that which is altruistic and that which is selfish, and the Desai and Johnson paper focuses on the role of empowerment at the community versus the individual level, while the Matthews et al. and Hindin papers try to resolve the issue through a multidimensional approach to operationalizing autonomy. The papers also differ in the way they situate the search for the relationship between women's empowerment and PHN outcomes of interest: the Desai and Johnson paper seeks to validate the relationship by looking for consistency of results across a large number of countries, the Hindin and Mumtaz et al. papers seek to validate the relationship within and between countries that are being ravaged by similar problems, the Matthews et al. paper examines the validity of the relationship within a matrix of urban/rural and slum/nonslum locales of a single state in India; and the Basu and Koolwal paper also situates the analysis in one state of India but examine two sets of different outcomes. Finally, the PHN outcomes studied by the papers include child health, nutrition and mortality, women's nutrition, maternal care and reproductive health, as well as their risk of sexually transmitted diseases and condom use.

All the papers make important contributions to our ability to define gender issues at the individual and community level and understand how gender-driven differences in autonomy and empowerment and status as well as the experience of violence relate to a wide range of PHN outcomes. The papers are briefly discussed below.

The first paper in this volume, "Two Concepts of Female Empowerment: Some Leads From DHS Data on Women's Status and Reproductive Health," by Basu and Koolwal, is primarily a search for indicators that truly reflect women's empowerment and only secondarily an attempt to determine whether women's empowerment is related to health outcomes. Basu and Koolwal draw a distinction between attributes and behaviors that are instrumental in achieving outcomes desired by others in the family, and hence not likely to be contested (e.g., cooking for the household and looking after children), and other more selfish attributes and behaviors that may bring benefits primarily to women themselves. Although both instrumental and selfish attributes and behaviors are often lumped under a single empowerment category, the authors argue that the presence of instrumental attributes and behaviors does not constitute empowerment. In fact, in the case of

[5] Autonomy and empowerment have different definitions and researchers often draw sharp distinctions between the two. Here we use them interchangeably because the authors of the papers in this volume have chosen to use one or the other, and because irrespective of whether it is called autonomy or empowerment, it is most often measured by women's participation in household decisionmaking.

instrumental behaviors, empowerment would better be represented by information on whether women have the right to not indulge in these behaviors. Do they, for example, have the freedom to choose not to cook food one day or not attend to their children? By contrast, selfish attributes and behaviors, such as those that reflect women's control over their own bodies or health and their ability to indulge in leisure activities, are likely to be truer measures of women's empowerment because they reveal women's ability to do things for themselves even though these may not be of benefit to anyone else and could potentially be resisted by others.

Basu and Koolwal use the 1998-1999 India National Family Health Survey (NFHS-2) data for the state of West Bengal to illustrate the altruistic versus selfish notions of female empowerment and their separate implications for a range of indicators related to women's own health and the health of their children. The paper finds that selfish behaviors and attributes correlate more closely with women's improved food consumption and better reproductive health, all variables that relate to women themselves, than with child health outcomes. In addition, several of the instrumental behavior indicators are uncorrelated or negatively correlated with women's own welfare indicators. Child health outcomes were, as expected, better correlated with a mother's instrumental attributes and behaviors. Accordingly, the authors argue that women's ability to take care of their own health is merely an extension of their ability to self-indulge in other selfish empowerment behaviors, and that such empowerment may not be that which is necessary to achieve desirable child health outcomes.

This paper is an important step forward in our exploration of definitions as well as measures of women's empowerment. It goes beyond the oft-mentioned multidimensionality of empowerment to questioning whether te commonly identified dimensions are indeed all measuring empowerment; equally important, the paper points to the potential for trade-offs between women's own health versus child health resulting from the presence of the different dimensions of empowerment. This latter issue also relates to the question posed in the next paper by Desai and Johnson. They, too, try to identify the pathways by which women's empowerment may be benefiting child health and survival, but approach the question in a different way.

The Desai and Johnson paper, "Women's Decisionmaking and Child Health: Familial and Social Hierarchies," uses a comparative framework of 12 countries to examine the importance of individual and community level empowerment of women for the health and survival of children. For the analysis, empowerment is operationalized in terms of whether women are making household decisions independently or not, with no distinction being made between the different types of decisions. Community-level empowerment is defined in terms of cluster-specific estimates of women's ability to make independent decisions. Three child health outcomes are examined, namely children's vaccination status, nutritional status, and child mortality. The authors argue that women's decisionmaking power might be associated with improved child health outcomes through at least three pathways, namely more efficient decisionmaking by empowered women regarding day-to-day health-enhancing behavior and regarding emergency care, and more child-oriented allocation of household resources when women have household power.

The Desai and Johnson study finds that children benefit from women's empowerment, but they benefit more from living in areas where a large number of women are empowered than from the individual-level empowerment of their mothers alone. In addition, the empowerment of women matters more for some child health outcomes than others, and in some settings than in others.

Women's empowerment has the most consistent positive effect across countries on children's height-for-age and less so on child immunization and child mortality. Since height-for-age is a long-

term nutritional status measure, the authors suggest that perhaps women's empowerment is more critical to the ensuring of day-to-day care and attention to the nutrition and health of children, including infection prevention, and to the ability to divert household resources to ensure the fulfillment of child nutritional needs, than for accessing emergency and other health care for the child. The latter are necessary for the prevention of child mortality and for immunization and, the authors suggest, even less empowered women may be able to work through others in the household to ensure the necessary access.

Desai and Johnson also find that the relationship between women's empowerment and child health varies be region: it is weakest in sub-Saharan Africa and strongest in South Asia, with the Latin American and Caribbean countries falling in between. Accordingly, the authors argue that the relevance and role of women's empowerment may in part be dependent on the historical and cultural gender systems prevailing in different settings.

Perhaps the most important contribution of the paper is to show how the gender context is consistently important for child health outcomes, and in most countries, more important than individual agency. Nonetheless, the dialectic of context and individual agency is not so easily disentangled. While individual agency may be thwarted and rendered ineffective where few women are empowered, community-level empowerment still depends on the cumulation of the empowerment of individual agents. Collective action that aims at empowering communities of women, the authors suggest, is likely to have more far reaching health benefits than the increase in empowerment of isolated agents.

The paper "Village in the City: Autonomy and Maternal Health-seeking among Slum Populations of Mumbai," by Matthews et al., starts from where the Desai and Johnson paper leaves off. They examine the role that direct measures of women's autonomy play in women's timely use of maternal health care services in different groups of populations that would loosely constitute a type of community: slum and nonslum populations in the metropolitan city of Mumbai, India, and other urban and rural populations of Maharashtra (the western state of India in which Mumbai is located).

The paper uses a combination of data from the 1998-99 India NFHS-2 survey for the state of Maharashtra and from the Mumbai Safe Motherhood Survey (MSMS), a small-scale survey conducted in six slum pockets of Mumbai in 1999. Several direct and proxy measures of autonomy are examined for women who have recently given birth. Women in Mumbai slums, much like women in the rest of nonslum Mumbai and urban Maharashtra, are found to have higher autonomy and more timely use of maternal care services compared with women in rural Maharashtra. While this is not unexpected, the paper also finds, unequivocally, that women in Mumbai's slums, who are often recent migrants from rural areas, have higher autonomy and better access to timely maternal care than women in non-Mumbai urban areas of Maharashtra. Thus, the health care advantages of living in Mumbai appear to flow to even the socioeconomically constrained slum population; importantly, this population has also made the transition to higher autonomy. Direct individual-level measures of autonomy, much more so than autonomy proxies such as education, are positive correlates of maternal-care uptake in slum areas; but what is perhaps the most important contribution of the paper is the finding that the role that women's autonomy plays in women's use and access of maternal health care varies by whether women have meaningful health care choices or not. Where women have health care choices, as do even women in Mumbai slums, women's autonomy becomes more important than where health care choices are constrained, as in rural areas.

The Matthews et al. paper makes an important contribution to the autonomy and reproductive health literature. Not only does it emphasize the importance of individual-level measures of women's autonomy in studying women's access and use of maternal care, but it also points to the need for a nuanced, context-specific approach to studying the linkages between women's autonomy and health. Like the Desai and Johnson paper, it argues that the community gender context is important and can be influential in negating the effects of individual-level autonomy; but it then goes on to illustrate the types of communities in which individual-level autonomy is likely to assist in achieving desired health care outcomes and where individual-level autonomy is not effective. It carefully illustrates that in communities, such as the urban slums of Mumbai, where the health care context provides women with real health care options, individual-level autonomy is more important than where such choice is limited as in rural Maharashtra. This paper thus has an important implication for most countries on the path to development: women's autonomy is likely to become more important as development makes more health care choices available even in conditions of lagging economic change.

The Hindin paper, "Women's Autonomy, Women's Status and Nutrition in Zimababwe, Zambia and Malawi," poses a somewhat different question from the others. It first recognizes that an increasing number of populations are faced with a dual crisis: HIV/AIDS and acute food insecurity. If this is a common condition of populations, it becomes imperative to understand the role, if any, that women's status and individual autonomy play in helping them secure enough nourishment to remain healthy in such settings. The three countries included in this paper, Zimbabwe, Zambia, and Malawi, provide just such a setting, with high proportions of adults living with HIV/AIDS and past and ongoing food shortages. The adequate nourishment and health of women has an added importance in these countries, since here, along with all of the other critical roles that women play, women are also often the producers of food.

The paper uses women's body mass index (BMI) to explore the linkages between autonomy and women's nutrition. In particular, the paper explores the effects of women's autonomy and relative status on their likelihood of having chronic energy deficiency (CED), defined as having a BMI <18.5. Several different measures of autonomy are included in the analysis. Women's status relative to their husband is measured in terms of spousal age, educational, and occupational differences. Women's own autonomy is measured by their participation in different household decisions. Unlike the other papers using the DHS decisionmaking information, Hindin defines three different variables: number of decisions in which women have the final say, number of decisions in which the partner has the final say, and number of decisions in which women and partners have a joint say. Women's self-perceived status within the society is proxied by using an index of the number of domains (among a maximum of five) where women see wife beating as justified. By including this variable that reflects community norms about the status of women, Hindin tries to account for the community-level gender contexts discussed and operationalized much more specifically in the previous two papers.

The hypothesis that women with lower autonomy as measured by the patterns of household decisionmaking are at an increased risk of CED is upheld in Zambia and Malawi, but not in Zimbabwe. In Zambia and Malawi, women's CED is related positively to partners making more decisions alone. However, importantly, making more decisions by themselves or having no participation at all from partners also marks women as nutritionally disadvantaged. Hindin suggests that perhaps such women are at higher risk because their partners are unable or unwilling to contribute to the household. This finding also ties in with the Desai and Johnson paper, by

suggesting that complete decisionmaking autonomy in contexts where such autonomy is not the norm may isolate women and increase their disadvantage rather than decreasing it. No such association is found in Zimbabwe, where women have substantially more autonomy than in either of the other two countries.

Despite some important caveats, the conclusion of this paper is that women who have less autonomy are at a greater risk of having compromised nutritional status in societies ravaged by food shortages and disease and where female autonomy is low. This finding has implications that go well beyond the individual woman, since CED diminishes the productive capacity of women who are also often the producers of food. The policy implication is also clear: empowering women in food constrained societies, particularly in countries ravaged by the HIV epidemic, is likely to have benefits for the women, for their families, and for diminishing food insecurity for all.

The paper "Condom Use in Uganda and Zimbabwe: Exploring the Influence of Gendered Access to Resources and Couple-level Dynamics," by Mumtaz, Slaymaker, and Salway, examines the ways in which gender affects the adoption of behaviors that protect against the risk of HIV/AIDS. This paper takes as its point of departure the fact that one of the important consequences of gender construction is the justification of a hierarchy between the two sexes, which leaves women with less access to a variety of social, economic, and political resources than men. Since health and illness are gendered phenomena, the spread of HIV/AIDS has been influenced by gender systems and their inherent inequalities. Gender systems may promote the spread of HIV/AIDS through a number of routes, including reinforcing masculine identities that support dominance, sexual freedom, and sexual satisfaction for men; inequitable resource allocation, which creates women's dependence on men; and creating complex interplays between the norms and realities of partnership formation, which lead to multiple sexual partners and barriers to condom use. However, little is known about the ways in which gendered inequalities in access to resources and couple dynamics ultimately influence the adoption of protective behavior regarding HIV/AIDS.

Accordingly, this paper uses DHS data from the women's and men's questionnaires from Zimbabwe and Uganda, both countries with relatively high rates of HIV/AIDS, to examine the way in which gendered inequalities in access to resources and gendered patterns of interaction between partners are related to the adoption of protective behavior, specifically condom use. The outcome in this study, condom use at most recent sex, is the only feasible protective behavior available to individuals who are in a relationship in which sex is expected. The gender-related explanatory variables include the level of partner communication, patterns of decisionmaking, couple characteristics, and relative resource control in the partnership.

Despite the careful defining of different gender-related variables, this paper does not provide consistent support for the hypothesis that condom use is related to greater autonomy of women, although access to resources, particularly in the form of knowledge, is related to condom use. One of the most relevant factors for condom use is the socio-legal status of the relationship, with condoms being least likely to be used during sexual intercourse between partners who are married to each other. The use of a condom is usually motivated by the need to prevent pregnancy and not from a need to prevent infection. In light of these factors, the lack of a relationship between women's autonomy and condom use spurs the authors to question the validity of the hypothesis in important ways. They question whether gender power measured with indicators pertaining to women's own households and marital relationships should be expected to affect the use of condoms, in light of the fact that condoms are most likely to be used only in non-marital relationships. There is also the

question of whether the use of the condom can necessarily be equated to meeting the desires of the woman alone. Depending on the circumstance, condom use could also reflect men's power over the women with whom they want to have sex but do not want to bear the responsibility for children.

This paper calls attention to the need for a more careful definition of measures of couple dynamics and women's empowerment that can be used to evaluate gender power across relationships of various types. It further suggests that such relationships are better studied through a combination of qualitative and quantitative research.

The final paper in this volume, "Women at the Nexus of Poverty and Violence: How Unique Is Their Disadvantage?" by Kishor and Johnson, uses information collected with the DHS domestic violence module in Cambodia, the Dominican Republic, and Haiti. The paper examines whether and how women who are poor and have experienced domestic violence differ from other women, particularly poor women who have not experienced violence and non-poor women who have experienced violence. Poor women are those living in the bottom quintile of households arrayed according to a widely accepted wealth index. Women in different poverty/violence categories are compared both in terms of their individual, marital, and household characteristics and for selected reproductive health outcomes. The paper finds that women at the nexus of poverty and violence are not unique; they share with other poor women the characteristics that accompany poverty and with non-poor women who have experienced violence, the characteristics associated with violence. Also, for four different reproductive health outcomes, namely, ever having a non-live birth, having a sexually transmitted infection, having an unwanted birth, and contraceptive discontinuation, the paper conclusively finds that domestic violence increases the likelihood of a negative health outcome for all women, poor and rich.

The contribution of this paper is to underscore the need to take seriously the negative effects of domestic violence on women's health. It strongly suggests that domestic violence is not just a problem of the poor and is not just a problem that compromises women's physical health alone. The effects of domestic violence go far beyond to affect other aspects of women's reproductive life, their ability to have only the births they want, their ability to use contraception for as long as they need it, and their ability to protect themselves from sexually transmitted infections. In addition, the paper points to at least one intergenerational effect of violence, in that women who experience violence, rich or poor, are more likely to have ever had a non-live birth.

Together these papers add greatly to our understanding of the ways in which gender issues, situated largely within the household but also in the communities in which the households are located, affect many different demographic and health outcomes. However, the relationships uncovered are not all in the direction that may be predicted by advocates of women's empowerment. In fact, some aspects of women's empowerment are more beneficial for women's own health and share of household resources, including food and leisure, and some for women's access to health care, while others are more relevant to the health of children for whom women tend to be the primary caregivers. The papers also point to the fact that women's empowerment may be more important in settings where, in fact, women have more options than in others. There is also evidence that sometimes what matters is not individual-level empowerment but the empowerment of communities.

The conclusion of this collection of papers is that the gender context of households is important: women's ability to control various aspects of their own lives and the lives of their children remains cogent in achieving a large number of demographic and health outcomes. However,

women's empowerment is most likely to benefit women and to achieve other desired demographic and health goals when empowered women are not isolated but are embedded in empowered communities and have meaningful health and demographic choices.

REFERENCES

Kishor, S. and K. Neitzel. 1996. *The Status of Women: Indicators for Twenty-Five Countries.* DHS Comparative Studies No. 21. Calverton, Maryland, USA: Macro International Inc.