women’s leadership in decision-making structures for global health.

Q: You say that women carry a lot of the hidden costs of health care. What do you mean by this?

A: When a government adopts community-based care, we know that really means “women-based” care. The system shifts the responsibility to the household and it’s usually the women who provide the care, the feeding, the washing and the psychosocial support. The care work that women do at times invisible but it requires more significant conversation, review and analysis. Community-based care is so important for disabled, mentally ill, terminally ill people, people with HIV, but it’s so under resourced as part of the health infrastructure, especially in poor communities. Women are the social protection network when people can’t afford the hospital bills.

Q: Where do you see the Global Strategy can make a difference to women’s health?

A: The strategy needs to step out of the orthodox health arena and look at how other sectors can be entry points for interventions with health outcomes. For example, child marriage might not be seen from a health perspective but, by ending this practice, girls are able to have babies when their bodies and minds are ready, when they’ve finished their education, and when they have the means to take care of themselves and their baby.

Q: You mention technology as another sector that could play an important role in tackling maternal mortality in developing countries. In what way?

A: In Africa, mobile phone coverage is high so it should be possible to give all community birth attendants a mobile phone in their basic kit. They can use this phone to call for assistance if there are complications, send an SMS to make appointments for the woman for follow-up at a health clinic or simply use the phone to record the birth. This kind of technology could also help to collect vital registration information. It’s a question of choice: policy-makers may decide to buy one military tanker or a helicopter or, for the same amount of money, train thousands of midwives and provide them with mobile phones for a year. A nation that prioritizes its people in terms of their health and education is much more secure than one that prioritizes a stronger military.

Q: How can the people in communities influence policy-makers?

A: The more communities have access to health information, the more they can demand quality services. A country may have all the laws, big referral hospitals and sophisticated laboratories but, if the people in the villages don’t have basic information, they may not be able to access or demand these services. Once awareness is raised, this creates demand for the services and citizens can start to shape priorities for national budgeting and policies.

Q: And how can governments influence people in the communities to improve health?

A: Public health and prevention campaigns are best held in the community. A good example is sanitation. I remember in my own lifetime how we changed practices in Zimbabwe. People used to wash their hands all in the same bowl without throwing out the water until a huge anti-cholera campaign totally shifted practices on hand washing in the family setting and big gatherings. A new norm was established, changing behaviour that is so important. With better investment in the community, we can shift the notion that health is only about services in the clinics, pharmacies and doctors. Health is about everyday behaviours, decisions, relationships, how I relate to others and what information I can pass on to them.

Q: YWCA was founded in the 19th century to support young, single women who were living away from home. What is most needed these days to support young women?

A: We must invest in young people. It’s when we receive most of the information and when we need to make good decisions for health later in our lives. That’s where we have the greatest opportunity demographically if we look at the world’s population. During the Commission I had many discussions with Dr Chan about how we need an MDG 5b target [universal access to reproductive health] for adolescents. It’s usually the time of first sexual experience and the first baby for many. It’s so important that it’s a good experience for these young women, that they receive good quality antenatal care and that they are respected.

My philosophy of working is to always ask: how does it affect the woman in the village?

Q: Do you find it challenging trying to address sensitive reproductive health issues in the constraints of a faith-based organization?

A: YWCA is a feminist, progressive women’s rights organization that at the same time has to work within faith communities. In fact this situation allows us to lift some of the positive aspects of culture and faith to advance women’s rights while at the same time addressing the things that need to change within our traditions. As an organization, we are very comfortable working with women on sexual reproductive health and rights issues. I know that the United Nations sometimes struggles with putting these issues together. Some issues are very sensitive, such as pregnancy termination and same-sex relationships, but we cannot run away from them. We have to recognize that people experience these things every day. We need policies that protect their rights. At times public policy forgets that people are just looking for basic dignity and respect, it’s not that complicated.