Sexual and Reproductive Health and Rights:
Identifying the Contexts of Women's Empowerment and International Development

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Fall 2013

SIT Switzerland: International Studies and Multilateral Diplomacy
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Abstract

In 1994, the International Conference on Population and Development established the Cairo Programme of Action to embrace women's empowerment as one of the fundamental components of development, including the recognition that sexual and reproductive health and rights are an important part of the development agenda. However, twenty years after the ICPD sexual and reproductive health and rights remain largely neglected in development initiatives. There are vast inconsistencies between knowledge, policy and practice in ensuring sexual and reproductive health and rights, which is primarily due to a lack of understanding of the social and structural contexts that inhibit sexual and reproductive health and rights. There are three broad examples of these contexts that can provide insight into why it is remarkably difficult to ensure sexual and reproductive health and rights in developing countries: cultural and religious factors, political will, and program capacity. Realizing how these contexts impact sexual and reproductive health and rights can help illuminate comprehensive strategies for the international community to consider in the effort to address sexual and reproductive health and rights in the post-2015 development agenda.

Table of Contents

Preface

When I tell others that I have chosen to dedicate my life to human rights advocacy, I am often asked about which human right I am most passionate. I have always found it to be an absurd question, because all human rights are so intertwined that to separate them is an impossible task. One cannot employ basic logic to advocate for a singular human right without in effect advocating for the rest. As I become increasingly informed of the world, I am realizing that while humanity has a long way to go in regards to human rights, progress has more or less proven unstoppable, and sometimes exponential. Yet there are several aspects of women's rights that have oddly remained stagnant or even regressed. I have grown fascinated with the question of why, as the largest population facing human rights violations that by sheer number is not even a minority, women continue to have the longest, hardest-won battle for dignity and equality. I decided to investigate this anomaly, focusing on sexual and reproductive health and rights because I believe there is something to be said for the one facet of the struggle for women's rights that lies at the heart of what exactly it means to be a woman. Along the way, I have discovered that perhaps the question of passion is not so absurd after all.

Throughout my analysis, I will refer to "sexual and reproductive health and rights" as "SRHR." I make a point to not abbreviate "sexual and reproductive health and rights" to "reproductive health," as such an abbreviation does not recognize the importance of reproductive health, sexual health, reproductive rights, and sexual rights as distinct elements of human rights, particularly those of women. It is often the case that sexual health, reproductive rights and sexual rights have been swept aside in the women's rights rhetoric by a focus on reproductive health, as the latter is the least political of the four concepts, albeit still very political. It is my

opinion that this does a disservice to women's rights and that these four concepts must be defined individually as well as collectively to ensure that each is held to the highest standard both in policy and in practice. In addition, I do not claim to have all of the answers about why sexual and reproductive health and rights have been slow to progress. Indeed, one of the main ideas to take away from this analysis is that the concept is so broad and so deeply rooted in social and structural contexts that there is no all-encompassing answer. My analysis is only an attempt to provide insight into a few select observations on the topic and to, hopefully, inspire others challenge what they think they know about the state of women's rights today.

Acknowledgements

I would like to thank my Academic Directors, Dr. Csurgai and Dr. Lambert, and Academic Coordinator, Aline, for their continued support and advice during this research period. They were available and approachable, but still encouraged my fellow students and me to be as self-reliant as possible in our research. I would additionally like to thank the kind and inspiring women, Dr. Gabriela Montorzi, Dr. Amy Lind, Ms. Hendrica Okondo, Dr. Fenneke Reysoo, and Ms. Paola Cagna, who all graciously agreed to take the time out of their busy schedules for an interview with a less-than-important undergraduate student. My conversations with them were far more holistically beneficial than I could have anticipated, and they are the reason I can now say that I believe I have, in fact, found where my passion lies in human rights work.

Abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
COHRED	Council on Health Research for Development
FGM	Female genital mutilation
FWCW	Fourth World Conference on Women
ICPD	International Conference on Population and Development
MDG	Millennium Development Goal
NGO	Nongovernmental organization
SRHR	Sexual and reproductive health and rights
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
WHO	World Health Organization
YWCA	Young Women's Christian Association

Literature Review

The most important and relevant publications related to sexual and reproductive health and rights that I reviewed in preparation for this project were generally progress reports published by inter-governmental and nongovernmental organizations whose work are related to gender, health, development, or any combination of the three. All of these reports had been published within the past ten years, and the majority of them included statistics pertaining to indicators of sexual and reproductive health and rights in developing countries and the work that the given organization has done in recent years to improve SRHR outcomes. Several also contained basic policy recommendations for the international community to consider. SRHR indicators discussed in the publications included maternal mortality, use of contraceptives and unmet need for family planning, child marriage, adolescent birth rate, unsafe abortion, sexual violence, female genital mutilation, and HIV/AIDS. Several United Nations agencies comprised the organizations that produced the majority of this data, including United Nations Development Programme, World Health Organization, United Nations Population Fund, and UNAIDS.

I also reviewed several monographs in order to gain insight into the previous research that has been conducted on SRHR outcomes in developing countries. The general consensus of the research appeared to be that the Cairo Programme of Action is an important reference for incorporating SRHR in the development agenda, that SRHR outcomes have been poorer than hoped for over the past twenty years, and that SRHR has been largely left out of the development agenda. Many discussed the need and potential strategies to address the social and structural inequalities that lead to poor SRHR outcomes. However, most approached the topic through a lens of reproductive health alone. Several included a call to action on reproductive rights, but the majority of them did not strongly examine sexual health and sexual rights. All of the

monographs I reviewed tended to focus their analyses of SRHR indicators on maternal mortality, unmet need for family planning, and HIV/AIDS, and while many argued for the need to understand SRHR outcomes in their social and structural contexts, they often did not illustrate examples of the contexts to which they were referring.

Research Questions

As sexual and reproductive health and rights is already a significantly broad topic, I decided to limit my analysis to the state of SRHR in developing countries because they unsurprisingly have worse SRHR indicators overall than developed countries and are consequently the battleground in current negotiations on the subject.

The principal research questions that I aim to explore are:

1. Why has SRHR not been successfully incorporated in the development agenda since the ICPD?
2. What are the social and structural forces that impact sexual and reproductive health and rights in developing countries?
3. How can the international community amend the discrepancies between knowledge, policy and practice that result in poor SRHR outcomes?

Most of the research on the relationship between development and sexual and reproductive health and rights that I have encountered has discussed the need for SRHR in the development agenda and that a significant reason why SRHR has been overlooked is due to a lack of understanding regarding the underlying social and structural forces that determine SRHR outcomes, but most do not define what those forces are. I intend to examine several of these forces in greater detail in order to provide insight into how they are negatively impacting SRHR in developing countries, particularly of women and girls, and to encourage a thoughtful dialogue on strategies for improving the state of SRHR in developing countries. I use several of the same SRHR indicators in my analysis as other researchers have because these are the SRHR outcomes

for which data exist. However, I aim to incorporate a more comprehensive analysis of select SRHR indicators that are often included in the data reports of organizations but were often not included in the monographs that I reviewed.

Research Methodology

In order to conduct this research, I consulted several different types of data. Previous literature on the topic of SRHR and development has often taken the form of secondary sources as monographs and academic journals. These works I used to establish a basis for my own analysis by reviewing the common critiques of development policies and practices. Additionally, I reviewed numerous progress reports of health- and development-oriented international organizations from within the past ten years in order to gather primary data on the current state of SRHR in developing countries.

To retrieve many of the monographs and academic journals, I found that the United Nations of Geneva library catalogue contained the largest and most contemporary selection. I spent a considerable amount of time conducting my research in the UNOG library for this reason. I was also able to find many of the progress reports on the official websites of relevant organizations, such as UNFPA, WHO, and UNDP. The nature of the research was such that the most relevant documents were also the most recent.

A second method of obtaining primary sources that I employed was to conduct formal interviews in the multidisciplinary field of gender, health and development. The substance of the questions asked indicated that formal interviews would be more conducive to the research topic, as many questions directly pertained to the field work of the experts and their affiliated organizations. My initial contact with each of the participants was via formal email, explaining my research and intention to conduct an interview. All of the participants were contacted after searching for relevant organizations on the Internet. Due to time constraints and accessibility of the experts, many of the experts were unavailable to meet and I was able to conduct only five formal interviews.

The major ethical considerations I took into account while conducting my research were, firstly, the political and cultural sensitivities of the research subject, specifically as I formulated my interview questions to participants. Obtaining objective and well-informed data from the participants, as well as preventing controversial information from affecting their work, were of utmost importance in my research. In addition, I considered the inconsistencies in terminology that is often characteristic of the topic to ensure that my own frame of reference and those of my participants remained as consistent as possible during the interviews.

Analytical Framework

The analytical framework of this research project was based on the definitions of sexual and reproductive health and rights as affirmed by the International Conference on Population and Development in the Cairo Programme of Action in 1994 and by the Fourth World Conference on Women in the Beijing Platform for Action in 1995. The definitions of the four main concepts are as follows:

Reproductive and Sexual Health

> Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases. (ICPD Programme of Action, paragraph 7.2)

Reproductive Rights

> Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (FWCW Platform for Action, paragraph 95)

Sexual Rights

> The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require

> mutual respect, consent and shared responsibility for sexual behaviour and its consequences. (FWCW Platform for Action, paragraph 96)

Introduction

The International Conference on Population and Development was held in Cairo in 1994, where 179 UN member states convened to establish a twenty-year Programme of Action to recognize and promote the empowerment of women and universal access to education and health care as fundamental components of a holistic development agenda. Prior to the ICPD, neo-Malthusian theories dominated the discourse surrounding poverty and development, viewing women as instruments of population control through family planning initiatives centered on contraceptives and forced sterilization. By contrast, the early 1990s were characterized by progressive international women's rights movements that produced the ICPD and it's Programme of Action. It was considered revolutionary at the time because it acknowledged development as a task of providing human rights, most notably SRHR, instead of viewing development as a product of achieving demographic targets. The Cairo Programme of Action called for women's rights, equality and empowerment as the ultimate goals themselves, which should be understood within the complex interaction between population, poverty and sustainable development. The Programme was then followed in Beijing in 1995 by the Fourth World Conference on Women, which adopted a Programme for Action that reasserted the ICPD's definition of reproductive and sexual health and enumerated more inclusive definitions of reproductive and sexual rights.[1]

It has now been nearly twenty years after the ICPD, yet SRHR indicators in developing regions remain disheartening. Maternal mortality continues to be a serious problem, especially in Africa where about 56% of maternal deaths occur. In 2010, 429 women died per every 100,000 live births in the region. The rate was 42% lower than it was in 1990 at 745 deaths, yet

[1] Laura Reichenbach and Mindy Jane Roseman, "Global Reproductive Health and Rights: Reflecting on ICPD," *Reproductive Health and Human Rights: The Way Forward*, (Philadelphia: University of Pennsylvania Press, 2009), 4-11.

it falls far short of the MDG target to reduce maternal deaths by three quarters between 1990 and 2015. The rate of maternal deaths even increased in nine Africa countries, the most occurring in Chad and Somalia at more than 1,000 deaths each per 100,000 live births in 2010.[2] Worldwide, more than 140 million women aged 15 to 49, married or in union, have an unmet need for family planning, meaning these women desire to delay or avoid pregnancy yet are not using any form of contraception.[3] Roughly 3.2 million women in developing countries between the ages of 15 and 19 have unsafe abortions each year, and about 36,000 women and girls in sub-Saharan Africa die from unsafe abortions every year while millions more suffer long-term health consequences.[4] Child marriage is another critical SRHR indicator with one in nine girls in developing countries married by age 15. That rate rises to one in three in Chad and Niger and one in six in Ethiopia. Child marriage is often the root cause of many other poor SRHR indicators, including adolescent pregnancy, which is currently at a rate of over 12.4 million births per year to girls between the ages of 15 and 19 in developing countries.[5] Female Genital Mutilation, under the broad category of violence against women, is a crime under international law but up to 140 million women and girls are living with the consequences of FGM today and an estimated 3.3 million girls are at risk of FGM every year.[6]

It is clear that many of the rights outlined in the Cairo Programme have still not been realized in developing regions despite the initial enthusiasm among the international community.

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[2] United Nations Development Programme, *MDG Report 2013: Assessing Progress in Africa Toward the Millennium Development Goals* (Addis Ababa: UNDP, 2013), 14-15 (Joint Publication of United Nations Economic Commission for Africa and African Union).
[3] Inter-Agency and Expert Group on MDG Indicators, *The Millennium Development Goals Report 2013* (New York: United Nations Department of Economic and Social Affairs, 2013), 32.
[4] United Nations Population Fund, *The State of World Population 2013: Motherhood in Childhood: Facing the challenges of adolescent pregnancy* (New York: UNFPA, 2013), 20-21.
[5] Ibid., 10-13.
[6] World Health Organization, *Understanding and addressing violence against women: Female genital mutilation* (WHO, 2012), 2.

Whether SRHR has been included in policy and not translated into practice, or whether it has not been included in policy at all, the forces determining SRHR outcomes are deeply entrenched in society, interactive on both national and international levels, multisectoral, and often obscure. While conducting my research, I identified three themes—cultural and religious factors, political will, and program capacity—that can explain many of the deep social and structural reasons why sexual and reproductive health and rights have been slow to progress in developing countries. Additionally, I encountered several strategies proposed by experts and employed in organizations that can offer perspectives for the international community to consider in its negotiations regarding the inclusion of SRHR in the post-2015 development agenda.

Analysis

Cultural and Religious Factors

Outlining the current debate surrounding SRHR and development is the recognition that the agenda must take into account the social and cultural contexts that shape gendered power relations, which in turn shape SRHR outcomes both nationally and internationally. These contexts often take the form of cultural norms and taboos that stigmatize women's reproductive health and sexuality. Two noteworthy examples are child marriage and female genital mutilation. Cultural and religious barriers to women's health and rights are the most adverse challenges to ensuring SRHR, and the most difficult to overcome. The cultural tendency to reduce women's province to childbearing and domestic work leads to the corrupt belief that providing SRHR services to women encourages promiscuity and an overall disregard for their responsibilities as wives and mothers. According to Hendrica Okondo, however, this apprehension is wholly unfounded. As the Global Programme Manager for SRHR, HIV and AIDS for World YWCA, Okondo has long worked closely with women in Africa and the Middle East who desire and desperately need these services. In Okondo's first-hand experience, the women who seek contraceptives, abortion, or any other form of sexual and reproductive health services are not the unmarried, irresponsible women that policy makers and religious leaders believe them to be. More often than not, they are child brides. To put it in Okondo's own words, they are the young women and girls who are "married at twelve, pregnant at thirteen, and dead at fourteen."[7]

The misguided cultural and religious assumptions of women's SRHR have lead to detrimental long-term consequences. Young women and girls are dying and suffering lifelong injury and disability as a result of the lack of comprehensive SRHR education and access to

[7] Hendrica Okondo, Interview by Kailey Mrosak, Formal interview, Geneva, November 6, 2013.

services. In many cases, taboo policies also force girls out of school once they become pregnant. Lack of adequate information about sexual health increases their vulnerability to coercive sex and the consequences thereafter. Many young women that Okondo has worked with have recounted stories about how adolescent boys would tell them that they were taking a contraceptive pill in order to convince them to have sex. In other instances, boys would bribe girls with commodities as basic as ten dollars worth of cell phone minutes. In both cases, the girls did not know any better because they had never received contraceptive education, and too many of them ended up pregnant with no recourse as a result.[8] Furthermore, often when SRHR services are available many policies in developing countries require the consent of a woman's husband or father in order to access them, rendering it nearly impossible for women to receive the care that they need. Even without such restrictive policies, many women are too afraid to go to clinics to receive proper care for fear of stigmatization and retaliation from family and members of their community.[9]

The entrenched double standards and social judgment women face due to cultural and religious norms are the most basic obstacles to improving SRHR in developing countries. Indeed, the most socially and religiously conservative countries in developing regions also tend to have the worst indicators of SRHR. Nigeria, for example, is a country whose culture is largely based on strict interpretations of Islam, and it also happens to be one of the worst performing countries in SRHR indicators. The maternal mortality rate in Nigeria remains relatively high compared to other developing countries at 630 maternal deaths per 100,000 live births.[10] As of 2004, 20% of girls in Nigeria were married before age 15 and 40% before age 18, and nearly one

[8] Ibid.
[9] Fenneke Reysoo, Interview by Kailey Mrosak, Formal interview, Geneva, November 12, 2013.
[10] Independent Expert Review Group, *Every Woman, Every Child: Strengthening Equity and Dignity Through Health* (WHO, 2013), 25.

in four married girls in Nigeria had given birth by age 15.[11] In Okondo's negotiations with Nigerian policy makers, many of them brush off the idea of enforcing the legal minimum age of 18, simply saying, "it's our culture," often in reference to a religious principle that a woman must accept a man's marriage proposal.[12]

At the same time, broad social and political progressive movements within a country do not always coincide with progressiveness in women's health and rights. Dr. Amy Lind, a visiting professor at the Geneva Graduate Institute of International and Development Studies, has dedicated a large part of her career to researching gender, sexuality and human rights in Latin America. Dr. Lind has often found through her research national and international paradoxes in progressive human rights movements, perhaps most notably in the case of homosexuality and abortion. After crippling debt in the 1980s followed by failing structural adjustment programs, Latin America was the first developing region to critically challenge the neoliberal movement and embrace a more leftist human rights approach to development. However, this switch to the left produced an unexpected contradiction in policies. While the region is becoming more pro-homosexuality, it is simultaneously becoming less pro-women's rights. The countries have begun to associate decriminalization of homosexuality with economic and political stability, signs of a "developed" country, but women's rights are contrarily not viewed in this light. Latin America has adopted some of the most restrictive abortion policies worldwide, with the majority of the countries prohibiting abortion entirely or only with the exception of saving a woman's life.[13] This is why it is essential to understand SRHR within the cultural contexts of individual

[11] UNFPA Nigeria, "Early Marriage in Nigeria," last modified 2004, http://nigeria.unfpa.org/nigeirachild.html.
[12] Okondo, Interview.
[13] Center for Reproductive Rights, *World Abortion Laws 2009 Fact Sheet* (New York, 2009).

countries, as certain countries are more receptive to certain aspects of SRHR than others.[14] It is this complexity that renders it remarkably difficult to define SRHR, measure SRHR indicators, and effect long-term change.

Political Will

Often resulting from cultural and religious influences, the lack of political will to ensure SRHR is an overwhelming challenge itself. It causes a vast disconnect between reality and policy and between policy and practice that is detrimental not only for women, but for everyone. Political will exists enough for the majority of countries to sign and ratify international human rights instruments like CEDAW, the Cairo Programme of Action, the Beijing Platform of Action, and even the Universal Declaration of Human Rights for that matter, yet many of the principles in these documents are not being translated into practice. Hendrica Okondo explains how this discrepancy is clearly exhibited with the Maputo Protocol. Ratified by fifteen members of the African Union in 1995, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa includes articles on the elimination of sexual violence, child marriage, unsafe abortion, and harmful practices like FGM, yet these violations of women's rights remain widespread throughout the region.[15]

Many critics of the current state of SRHR would argue that the international agreements themselves are even inadequate instruments for women's rights. As Dr. Reysoo points out, sexual rights are not addressed in the Cairo Programme at all, and the right to safe abortion is inconclusive due to Catholic lobbying during the ICPD negotiations, ostensibly incorporated to

[14] Amy Lind, Interview by Kailey Mrosak, Formal interview, Geneva, November 5, 2013.
[15] Okondo, Interview.

the extent that "everyone can decide [on an abortion] except the woman herself."[16] The Catholic lobby has proven to be a formidable political force in negotiating women's SRHR over the past twenty years. According to Hendrica Okondo, "Catholics have consistently been the only ones who have a problem with abortion and contraception, although it is growing now among American Evangelists. The women's rights movement has never had so much difficulty until the United States politicized it."[17] This is in large part due to Bush Administration policies that have significantly regressed on women's reproductive rights, as well as the American Evangelist Movement within the last five years, because the political rhetoric has come to equate women's reproductive health with conservative religious beliefs about abortion and sexuality. The regressive policies of the United States have had damaging effects on SRHR policies the world over, both as an important voice in international negotiations and as the largest foreign aid donor through USAID. For example, the Global Gag Rule, which has been enacted and rescinded along party lines since the Reagan Administration in 1984, has suppressed many NGOs working to provide SRHR services in countries around the world for having any possible tie to safe abortion, whether performed or promoted. Cutting off the funding of these organizations consequently limits their capacity to provide contraceptives and sex education services as well, at times merely for the fear of losing funding altogether.[18]

Dr. Lind argues that lack of political will is the largest difficulty in ensuring SRHR because the absence of support forces advocates to frame SRHR in terms of economic need and poverty reduction instead of basic human rights. It compels the SRHR movement to compartmentalize just to make it into the agenda at all, such as separating family planning, maternal mortality, HIV/AIDS, and FGM into non-interactive initiatives instead of promoting

[16] Reysoo, Interview.
[17] Okondo, Interview.
[18] Lind, Interview.

women's health and rights in their entirety. The resultant norm setting narrows the focus of reproductive health indicators and targets strictly to safe childbearing and family planning, as illustrated in the MDGs, because this approach is the least controversial. With the advent of the MDGs in 2000, attention to the Cairo Programme of Action has continued to decline. Paola Cagna is a research assistant at UNRISD, a research institute that studies the social dimensions of development issues and their influence on development policies. She argues that the main gaps in the MDGs are a product of sexual health being reduced to maternity and sexual and reproductive rights being altogether ignored in the agenda, even though it is clear that sustainable development cannot be achieved without them. Cagna believes that this produces a narrow image of women solely as mothers and disregards the broad range of women's health and rights that must be addressed. Consequently, the SRHR inequalities women face in developing countries that are commonly articulated on the ground are not being translated into development policy at the government level.[19]

Dr. Fenneke Reysoo is the Scientific Director of the Research Programme Gender and Global Change at the Geneva Graduate Institute of International and Development Studies and she worked closely with the ICPD and Beijing negotiations. Dr. Reysoo argues that a partial reason for the lack of enumeration of SRHR in the current development agenda is a deep absence of awareness of the fundamental differences between the four components of SRHR—sexual health, reproductive health, sexual rights, and reproductive rights—and of why it is necessary to understand the terms separately in order to ensure that no indicator of SRHR is overlooked, which is exactly what has happened in the last fifteen years. It then becomes increasingly difficult to incorporate rights into the understanding of reproductive health.[20] Additionally, state

[19] Paola Cagna, Interview by Kailey Mrosak, Formal interview, Geneva, November 14, 2013.
[20] Reysoo, Interview.

governments and NGOs are forced to frame SRHR initiatives in vertical, demographic targets and to avoid the most controversial issues, such as abortion, for fear of losing funding from international donors. According to Dr. Reysoo, the perversity of target orientation is that governments, health providers and users are given incentives to meet goals, such as providing a number of contraceptives to women or performing a number of sterilizations. Rather than improving real SRHR outcomes, this approach takes away from the quality of services and encourages health providers to influence women's choices of contraception, which undermines the basic right, as outlined in the Cairo Programme of Action, of individuals and couples to make informed decisions about their sexual and reproductive lives.[21]

Program Capacity

Target oriented SRHR initiatives are not the only vertical development agendas producing poor SRHR outcomes. Global Health Initiatives that concentrate on specific diseases or health issues through humanitarian funding efforts, such as Global Fund to Fight AIDS, Tuberculosis and Malaria; Global Polio Eradication Initiative; Roll Back Malaria; Stop TB; and Global Alliance for Vaccines and Immunizations, are well-intentioned development programs but they are also well known to take funds away from the kind of multisector capacity-building programs that broad concerns like SRHR desperately need. These disease-driven programs are attractive to international donors because they are easily defined and quantitatively measurable.[22] SRHR has an uphill battle in competing in this context because it involves a considerable breadth of health and rights indicators, and it is therefore difficult to define. In addition, SRHR

[21] Ibid.
[22] Arlette Campbell White, Thomas W. Merrick, Abdo S. Yazbeck, *Reproductive Health: The Missing Millennium Development Goal: Poverty, Health, and Development in a Changing World* (Washington D.C.: World Bank, 2006).

indicators are mainly qualitative, which renders them exceptionally difficult to measure. The success of an SRHR program is not simply the number of contraceptives a health clinic provides, but rather the overall well-being, comprehensive education and unobstructed access to services in all capacities of health and rights for all members of society. How does one measure quality of life to such a degree?[23]

Indeed, vertical health programs are far more attractive alternatives, and as these initiatives are already competing with each other for funding, little room is left to devote the time and energy to strengthening the sustainability of health systems in general. International donors are spread thin with too many alternatives, and developing countries are tied down by the information demands of the programs. Today's picture of development does not illuminate the social or systemic forces such as poverty and discrimination that lead to poor health outcomes in the first place. Instead, they channel investment into the outcomes themselves, effectively offering a bandage where preventive medicine is needed, and often they invest in the same limited set of outcomes. Dr. Gabriela Montorzi is the Programme Manager of COHRED Tech, part of the COHRED organization that works with developing countries to strengthen their research and innovation systems. She explains that COHRED refers to this short-sighted development phenomenon as the "10/90 Gap," in which 90% of the world's resources go toward 10% of the world's problems.[24] A prime example of this imbalance is the current international spending on HIV/AIDS. Potentially the largest vertical health initiative in history, its dramatic rise in funding in recent years has noticeably accompanied a simultaneous decline in funding

[23] Reysoo, Interview.
[24] Gabriela Montorzi, Interview by Kailey Mrosak, Formal interview, Geneva, November 5, 2013.

toward other health issues, including SRHR.[25] Dr. Montorzi describes an example from her home country, Argentina, where she has noticed a significant increase in funding toward HIV/AIDS programs, which is not a major problem in the country, while more pressing health concerns are being neglected.[26]

One contributing factor to SRHR being overshadowed by other global health initiatives is the lack of comprehensive research on SRHR. Not only is SRHR difficult to measure, but also there is little incentive to prioritize SRHR because the current research is disinclined to grasp the social and structural dimensions of women's health and rights that link SRHR to all development goals, including poverty reduction, universal access to education, and environmental sustainability. Most of the research is instead confined to the more easily quantifiable clinical analyses and individual risk factor assessments, which do not necessarily have consequences in other sectors of society. SRHR is therefore not given high importance in the development agenda.[27]

The lack of research incentives is detracting from development in the health sector, according to Dr. Montorzi, as research is the means by which societies can conduct self-assessments and find solutions to problems. COHRED recognizes a key distinction between health research and research for health. The former focuses primarily on the innovation of medical technology, while the latter takes into account the social and cultural contexts that determine health systems capacity in a given country. Health research is necessary as well, of course, but research for health is the one that has been pushed to the side in the development

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[25] Laura Reichenbach, "The Global Reproductive Health and Rights Agenda: Opportunities and Challenges for the Future," *Reproductive Health and Human Rights: The Way Forward* (Philadelphia: University of Pennsylvania Press, 2009), 33.
[26] Montorzi, Interview.
[27] Guang-zhen Wang, *Reproductive Health and Gender Equality: Method, Measurement, and Implications* (Farnham, England: Ashgate, 2010), 3.

agenda, and it is the one that developing countries especially need. As Dr. Montorzi has seen in her work with several countries in Africa, a lack of resources for research is not the problem these countries face, but rather a lack of awareness about the importance of prioritizing research for health.[28]

Another problem Dr. Montorzi has observed is the often irresponsible programming of research oriented global health initiatives. She argues that developed countries often approach low income countries wanting to do research on a specific issue. The developed country provides the resources to conduct the research, but once the project is finished the developed country leaves and does not bequeath any foundation for the low income country to build upon their health systems. Dr. Montorzi describes this occurrence as a form of, albeit unintended, exploitation because the low income country becomes impoverished as a result, as resources are channeled into the specific research project while other areas of the society are left unattended and the system remains unsustainable when the developed country leaves. It is a formula for short-term gain and long-term destruction, while what is needed is a win-win relationship with proper training, realistic and competitive compensation, and especially local ownership as foreign aid often leads to passivity of the developing country in question.[29]

Strategies to Consider

In addressing cultural and religious factors, World YWCA employs several noteworthy strategies that the international community could build upon. The organization principally dedicates itself to empowering young women by creating safe spaces in local communities for women to share their experiences, training young women to be leaders in the advancement of

[28] Montorzi, Interview.
[29] Ibid.

their rights, fostering intergenerational dialogues among women, and providing unbiased SRHR information to women and girls. World YWCA also engages young men and boys in sex education to encourage a healthy understanding of masculinity and respect for women and girls. Furthermore, the organization works closely with policy makers and religious leaders to disprove cultural taboos and myths that are harmful to women and girls, such as child marriage.[30] In speaking to these influential men about ending child marriage, Hendrica Okondo often argues against the cultural standard that women must accept a marriage proposal as justification for child marriage because these girls are too young to be able to make such a life-defining decision. FGM is similarly based on the belief that it is a religious requirement. While it originated in rural tribes in Egypt, it has been absorbed by Islamic and Catholic doctrines in both the Middle East and Africa. FGM practices have proven remarkably difficult to eliminate, which is why Okondo refers to it as "patriarchy and oppression at its best." Monetized, professionalized, and strongly upheld in religious rhetoric, it has become a rite of passage in which women have assumed an important role in society as the ones who perform the practice. World YWCA works to provide evidence based information to these women to raise awareness about the devastating consequences of FGM and to expose the myth that it is rooted in religion.[31]

Providing evidence based information to local and global policy makers about the importance of SRHR to development is essential to convincing governments to take SRHR seriously. Dr. Lind argues that one method is to mobilize the NGO sector, as its lobbying capacity is highly influential in priority setting at the policy level, especially within the United Nations.[32] The caveat to this approach is to also ensure that policy makers are not similarly influenced by external ultra-conservative groups. A strategy to diffuse information that World

[30] Okondo, Interview.
[31] Ibid.
[32] Lind, Interview.

YWCA employs is to bring young women to the platform of national, regional and global negotiations on health and women's rights to tell their own stories directly to the policy makers. This can often be the most effective way to ensure that the voices of young women and girls are heard by the men who make the decisions and to close the gap between knowledge and policy.[33]

Of course, strengthening research capacity is also necessary for addressing the discrepancies between knowledge, policy and practice. Dr. Montorzi believes that this begins with shifting the way in which research is viewed. It is often seen as apart from everyday life and only accessible to a selective group of society. However, Dr. Montorzi argues that even if a person does not have the ability to conduct research, one still has the right to demand that her or his government prioritizes it. Research should also not be purely reactive to societal processes but should be proactive in anticipating future processes. As COHRED is well aware, capacity-building in research systems involves sustainable training, context-specific priority setting, strong partnerships among stakeholders, management of resource flows, and ethics monitoring.[34] In addition to research for health, prioritizing research on the social and structural forces that drive or inhibit development and human rights is key to promoting the inclusion of SRHR in development policies, and this is the strategy of UNRISD. Through her work with the institute's research theme on Gender Dimensions of Development, Paola Cagna has found that this type of research is necessary in order to understand how conservative religious forces are influencing the articulation of SRHR in different countries. Cagna argues that the promotion of SRHR must be context-specific in order for it to be effective, and research on the social dimensions of development is the first step to this advancement.[35]

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[33] Okondo, Interview.
[34] Montorzi, Interview.
[35] Cagna, Interview.

Conclusion

In light of the unsuccessful MDGs relating to women's rights and equality, sexual and reproductive health and rights have been reinvigorated in negotiations regarding the post-2015 development agenda. The international community is beginning to realize that development goals cannot be achieved without an approach based on human rights, particularly the rights of over half of the human population. It is even more important that the social and structural contexts, such as cultural and religious factors, political will, and program capacity, that influence human rights are well understood and accounted for in development policies and programs. This includes working directly with influential cultural leaders to combat harmful beliefs and practices, providing evidence based information to policy makers, and strengthening research capacity.

SRHR must be placed at the forefront of any human rights approach to development, whether that means embracing gender rights as a stand-alone development goal or as a principle addressed in all development goals. Sexual and reproductive health and rights are fundamental to development and to the realization of all human rights because women's sexuality and reproductive nature are arguably the foundation of all oppression, inequality, and human rights violation women have faced for centuries. To recognize women's sexual and reproductive autonomy and right to health is to acknowledge women's most basic humanity and all of the rights they are entitled to therein. If we do not recognize the value in protecting our right to autonomy over our own existence, all other rights that we are entitled to as human beings, including the right to development, will remain elusive to us.

Ensuring women's rights and equality requires addressing openly and honestly the cultural, religious, political and structural barriers to SRHR. It requires respecting that

knowledge and information are transformative forces that should not be brushed aside as an inconvenience. It requires holding ourselves accountable for a system that is failing women and girls. As Hendrica Okondo poignantly explains, it is not our right to morally judge the women and girls dealing with adolescent pregnancy, unsafe abortion, or other poor SRHR outcomes. They are in this position because we have failed them, and it is our responsibility to protect and provide for them.[36]

[36] Okondo, Interview.

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ISP Work Journal

September

Sunday, September 1
Typed temporary ISP proposal

Friday, September 6
Advising meeting with Dr. Csurgai to discuss proposal

October

Tuesday, October 8
Typed final ISP final proposal

Tuesday, October 15
Advising meeting with Dr. Lambert to discuss proposal

Monday, October 21
Began ISP study period: collected data at UNOG library

Tuesday, October 22
Read monographs on topic at UNOG library
Sent five emails to potential interviewees

Wednesday, October 23
Read monographs on topic at UNOG library

Thursday, October 24
Read monographs on topic at UNOG library
Sent seven emails to potential interviewees

Friday, October 25
Read monographs on topic at UNOG library

Saturday, October 26
Research at home: read SRHR progress reports published online by organizations

Sunday, October 27
Research at Boréal Coffee Shop in Geneva: read SRHR progress reports
Sent seven emails to potential interviewees

Monday, October 28
Research at UNOG library: read SRHR progress reports
Sent three emails to potential interviewees
Set up an interview with Dr. Gabriela Montorzi

Tuesday, October 29

Met with Dr. Csurgai to discuss literature review
Research at UNOG library: began critical analysis of data
Sent six emails to potential interviewees
Set up an interview with Paola Cagna

Wednesday, October 30

Research at UNOG library: critical analysis of data
Sent four emails to potential interviewees

November

Sunday, November 3

Research at Boréal Coffee Shop: critical analysis of data
Sent two emails to interviewees

Monday, November 4

Research at UNOG library: organized data on SRHR statistics
Set up an interview with Hendrica Okondo
Prepared for interviews with Dr. Montorzi and Dr. Lind

Tuesday, November 5

Interview with Dr. Gabriela Montorzi

Questions asked:

1. Can you elaborate on the specific projects of COHRED Tech in Africa?
2. How does COHRED view research and innovation in the context of health, equity and development?
3. What is COHRED's principle of "responsible programming?"
4. What is the "10/90 Gap?"
5. How does COHRED work with developing countries to strengthen capacity-building and training?
6. What do you believe are the major challenges to implementing health research systems in developing countries?

Interview with Dr. Amy Lind

Questions asked:

1. How has SRHR been defined, negotiated and enforced in developing countries?
2. What do you see as the major challenges to adopting a more comprehensive understanding of SRHR?
3. Can you tell me more about your research on gender, sexuality and development in Latin America?
4. How does cultural relativism factor into improving SRHR?
5. What are the difficulties you see in ensuring SRHR in the development agenda?
6. What are some strategies for more effective global governance on SRHR?

7. How does research interact with SRHR outcomes?

Prepared for interview with Hendrica Okondo

Wednesday, November 6

Interview with Hendrica Okondo

Questions asked:

1. Can you tell me more about your work as Global Programme Manager of SRHR, HIV and AIDS for World YWCA?
2. Has there been strong political will and/or resource investment to improve SRHR in developing countries?
3. What do you see as the major challenges to integrating SRHR into the regions and communities you work with?
4. How does World YWCA promote the leadership of young women in SRHR policies and programs?
5. What aspects of SRHR do you see receiving the least attention right now and why is this occurring?
6. How does World YWCA account for social and cultural norms and behavior that determine SRHR outcomes?

Research at UNOG library: began outline of analysis on contexts of SRHR

Sunday, November 10

Research at home: further developed outline

Monday, November 11

Prepared for interview with Dr. Reysoo

Tuesday, November 12

Interview with Dr. Fenneke Reysoo

Questions asked:

1. Can you tell me more about your work with the ICPD and Beijing?
2. What was the negotiation process on SRHR like during these conferences?
3. How have you seen the positions of the international community on SRHR evolve since the ICPD?
4. What do you see as the major challenges to implementing comprehensive SRHR services in developing countries?
5. How have the MDGs affected the progress of SRHR?
6. What are some strategies for better global governance of SRHR?

Research at UNOG library: began rough draft of analysis

Wednesday, November 13

Research at home: rough draft of analysis

Prepared for interview with Paola Cagna

Thursday, November 14

Interview with Paola Cagna

Questions asked:

1. Can you tell me more about the work of UNRISD and its Gender and Development Programme?
2. What are the often overlooked social dimensions development and women's empowerment?
3. How does UNRISD help strengthen the research capacity of developing countries?
4. What are the politics surrounding resource allocation to women's health and rights in development programs?
5. What do you perceive as the major challenges to ensuring SRHR in development policies?
6. How is SRHR being debated in the post-2015 development negotiations?

Research at UNOG library: began typing analysis

Friday, November 15
Research at UNIGE: typed analysis

Saturday, November 16
Research at home: typed analysis

Sunday, November 17
Research at home: typed analysis

Monday, November 18
Research at home: finished typing analysis
Began preparation for presentation

Tuesday, November 19
Prepared for presentation

Wednesday, November 20, 2013
Presentation to SIT class

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SIT Study Abroad: Switzerland
ISP INTERACTIVE RESEARCH
INTERACTIVE LOG
(4 interviews are required: 3 formal + 1 informal)

Name __Kailey Mrosak_____ Semester ___Fall 2013___

Organization	Key contacts	Address	Telephone or email	Brief description of your interactive research	Date(s) & time	Formal/informal interview
COHRED	Dr. Gabriela Montorzi	1 – 5 Route des Morillons PO Box 2100 1211 Geneva 2 Switzerland	montorzi@cohred.org	Met at COHRED Group office to discuss work of the organization and the importance of research for health	5/11/13 10:30am-11:30am	Formal
Geneva Graduate Institute	Dr. Amy Lind	Chemin Eugène Rigot 2 1211 Geneva Switzerland	amy.lind@graduateinstitute.ch	Met at Maison de la Paix cafeteria to discuss gender, sexuality and development in Latin America	5/11/13 2:00pm-2:30pm	Formal
World YWCA	Ms. Hendrica Okondo	16 Ancienne Route 1218 Grand Saconnex Geneva Switzerland	hendrica.okondo@worldywca.org	Met at ILO cafeteria to discuss the work of YWCA and cultural barriers to SRHR	6/11/13 9:00am-11:00am	Formal
Geneva Graduate	Dr. Fenneke	Chemin Eugène	fenneke.reysoo@graduateinstitute.ch	Met at Maison de la Paix office to	12/11/13 11:00am-	Formal

Institute	Reysoo	Rigot 2 1211 Geneva Switzerland		discuss the ICPD and the implementation of SRHR in development initiatives	12:00pm	
UNRISD	Ms. Paola Cagna	Palais des Nations, 1211 Geneva 10 Switzerland	CAGNA@unrisd.org	Met at Maison de la Paix library to discuss the need for research on social dimensions of development	14/11/13 12:30pm-1:30pm	Formal