Understanding the Links Between Sexual and Reproductive Health Status and Poverty Reduction

Led by Nata Duvvury (NUI Galway) and Phil Oxhorn (McGill)

This final report was commissioned by the United Nations Population Fund and prepared jointly by the Institute for the Study of International Development, McGill University, and the National University of Ireland, Galway.
Understanding the links between sexual and reproductive health status and poverty reduction

I. Introduction

The interrelationship between poverty and sexual and reproductive health status (SRHS) is widely noted in academic, policy and programmatic discourses, though none establishes causality. The primary emphasis in these discourses is that poor SRHS is an outcome of poverty, and thus can be addressed through poverty reduction programmes. The purpose of this brief is to understand what factors contribute to the interrelationship between SRHS and poverty, with a specific focus on understanding how SRHS impacts household poverty. Future studies may then focus specifically on these factors in order to address issues of causality.

This brief is based on desk research involving two sources of data: 1) a review of global literature and 2) three country case studies. The global literature review examined literature documenting the nature, extent and strength of the interrelationship between poverty and SRHS. The literature search was conducted using keywords from different disciplinary perspectives demography, economics, development, women’s studies, sociology, human rights and public health. Key databases such as JSTOR, PubMed, MEDLINE and Elsevier Science Direct were consulted, as well as the specific library databases at National University of Ireland, Galway and

1 Brief prepared by research teams from NUI Galway and McGill University led by Nata Duvvury (NUI Galway) and Phil Oxhorn (McGill).
McGill University. Researchers at McGill compiled an annotated bibliography of literature on India.

The three country case studies were undertaken in Brazil, Ghana and Lebanon. Consultants in each country undertook an extensive search of academic, policy and programmatic literature including journal publications, research reports, policy briefs, and non-governmental organization (NGO) reports. The literature search in each country followed the same method as the global literature review, including identifying keywords from different disciplines and exploring different databases. In addition, the consultants searched grey literature through contacting various NGOs and research institutions. They also obtained statistical information from governmental and institutional databases. All country case studies explored three key questions: 1) Is there literature that demonstrates the impact of poor SRHS on poverty? 2) What factors have been highlighted in the literature as influencing the relationship between SRHS and poverty? 3) Are there trade-offs involved for women between education, fertility, status and work participation? and 4) Do programmes by civil society organizations, such as micro-credit or income-generating programmes, promote sexual and reproductive health?

The literature review and the country case studies indicate a surprising lack of research on the impact of SRHS on poverty, whereas there is a significant body of literature establishing poor SRHS as a consequence of poverty. What little literature is available about the impact of SRHS on poverty dates to the time of the Cairo conference in 1994, which first shifted the agenda from a population-poverty focus to one of
broader reproductive health. The critical role of gender norms, and the harmful and discriminatory practices, in relation to poor sexual and reproductive health of women were clearly articulated at the conference. Despite this, the literature review suggests that the research agenda is still framed within population discourse rather than sexual and reproductive health and rights. Consequently, this research has focused on establishing the impact of declining fertility (i.e. the benefits of demographic transition), identifying the factors contributing to lower fertility, and assessing programme effectiveness in leading to a sustained decline in fertility. A significant departure from previous research is the inclusion here of women’s autonomy and decision making, and not just education or employment, as important factors in fertility decline. However, much of the existing literature does not fully consider the interaction between gender norms and institutions.

Through our overview of existing studies on both SRHS and poverty education, combined with an examination of three case studies (Brazil, Ghana and Lebanon), we develop a conceptual framework that elucidates what factors contribute to the interrelationship between SRHS and poverty reduction. Specifically, we argue that interactions between institutions (e.g. state, familial, economic, religious), rights (e.g. sexual and reproductive, family planning, social, political), and gender norms (e.g. masculinity/femininity, gender division of labour, norms of sexuality, value of girls,) contribute to SRHS (total fertility, maternal mortality, HIV/AIDS, malnutrition, reproductive morbidity, etc.) and poverty reduction (income, intra-household distribution, etc.). Gender norms can result in harmful and discriminatory practices such
as early marriage, gender-based violence, son preference, and unequal access to and control of resources, all of which impact directly on SRHS. Furthermore, gender norms can directly impact on poverty through limited access to and control over both tangible (income, credit, property) and intangible resources (education, social capital), restricted opportunities in terms of labour force participation, and curtailed participation in decision making. We further argue that central to understanding the interactions between institutions, rights and gender norms is the strength, or potential strength, that civil society has in advocating for change within one or all of these dimensions. Civil society can provide the means to transform SRHS and poverty reduction. This is summarized graphically in Figure 1.

In what follows, we begin by providing a broad overview of the interrelationship between SRHS and poverty reduction. This is followed by sections on institutions, rights and gender norms, in which we draw on our case studies to highlight how variations across these dimensions impact SRHS and poverty reduction. We then discuss the role of civil society in terms of social movements, advocacy and agency as central to influencing institutions, rights and gender norms across countries. Finally, we discuss the broader implications of our conceptual framework.
Figure 1: Conceptual Framework

Civil Society
- Advocacy
- Agency

Institutions (political, economic and social structures, including family)
- Policies
- Implementation
- Leadership

Rights
- Sexual and reproductive, including
  - Safe sex
  - Safe motherhood
  - Family planning
  - Right to health
  - Political and civil rights

Gender Norms
- Masculinity/femininity
- Gender division of labour
- Sexuality
- Value of girls

Sexual and Reproductive Health Status
- Total Fertility Rate
- Mortality
- Nutrition
- Fistula
- HIV/AIDS

Poverty Reduction
- Income
- Intra-household (re)distribution
II. Overview

A. Poverty as a determinant of sexual and reproductive health status

SRHS and poverty are deeply interconnected. Literature in the fields of development, economics, health, health economics and epidemiology documents a strongly negative relationship between general health and poverty (Mwabu, 2007; Strauss and Thomas, 2007). This phenomenon, known as the income gradient, shows that health indicators improve with increased income. The same is true of sexual and reproductive health, and the channels through which this mechanism applies are similar (Greene and Merrick, 2005).

Poverty can render health investments unaffordable, and the absence of public health systems heightens the lack of access to health care in many countries. Poverty and lack of access to health care mean that medicines and treatment cannot be readily acquired; preventive health measures such as pre-natal care do not take place; and, especially important for SRHS, family planning solutions are not readily available. In the spirit of Sen’s (1999) capability approach, poverty creates strict limits to individuals’ ability to live long, healthy and productive lives.\(^2\)

Poverty is also interconnected with low educational attainment, which is associated with worse health outcomes. Education can lead to higher incomes and thus better health outcomes. Education can also lead to a higher ability to process health-related information. More education is also believed to influence an individual’s

\(^2\) Sen argues that well-being depends not only on income but on capability to realize different states of being such as a long and healthy life, being educated, and so on. Poverty, therefore, is not only the lack of income but also the limitation of an individual’s capability (Sen, 1999).
preference for future, which in turn improves his/her health behaviours and health outcomes. For instance, Rao et al. (2003) found that female sex workers in Calcutta who were exposed to basic information on HIV transmission were more likely to require clients to practice safe sex. Similarly, de Walque (2007) showed that AIDS/HIV awareness campaigns in Ugandan schools were effective at postponing the age of first sexual activity, especially among girls.

With respect to SRHS, poverty operates through one additionally important channel: decision making within the household. This channel is particularly acute where a woman’s income is low relative to her spouse’s, and extremely acute when combined with gender norms or institutions that give her few de jure or de facto rights. In a randomized experiment on contraceptive use in Zambia, it was found that women were more likely to use contraceptive vouchers if they were available without their husband’s knowledge (Ashraf, Field and Lee, 2010). A counter-example in China suggests that in households with shared household division of labour, indicating greater spousal communication, women more likely to receive proper antenatal care (Li, 2004).

1. Case studies

The three country case studies underscore the relationship between poor SRHS and poverty. For example, in Ghana fertility declines with income, with a fertility rate of 3.0 in Greater Accra compared to 6.8 in the poor Northern Region (Darkwah, 2011). In Brazil, using education as a proxy for poverty, a study found

---

3 Key relevant findings from the case studies are summarised illustrate the discussion. See the detailed studies, available in this CD, on Brazil (Heringer, 2011), Ghana (Darkwah, 2011) and Lebanon (DeJong and Meyerson-Knox, 2011) for more-in-depth discussion.
that women with up to seven years of schooling had 3.9 children compared to 1.68 for women with eight or more years of schooling (Heringer, 2011). In terms of health-seeking behaviour, the Ghanaian case study suggests that education and income are also major factors in determining the likelihood of seeking treatment for sexually transmitted infections. Income also plays a role in breastfeeding and diarrhoea treatment, as was found in a study of the impact of micro-credit on income and reproductive health.

The opening up of options with education is reflected in Brazil and Ghana, with higher levels of “modern” contraceptive use by women with secondary or higher education compared to women with less education. The limits of the transformative power of education, in a context of rigid gender norms, are evident in Lebanon. Despite high levels of education, Lebanese women do not actively participate in the labour force. The social barriers women face in working after marriage may lead them to have more children than otherwise (DeJong and Meyerson-Knox, 2011).

B. The influence of sexual and reproductive health status on poverty

The association between poverty and ill health reflects causality running in both directions. Ill health is often associated with substantial health costs as well as reduced capacity to work, potentially impacting household income. Therefore, SRHS itself is an important determinant of poverty. High fertility rates can be detrimental to a woman’s participation in the labour market, and hence her ability to generate income and
improve her bargaining power within the household. This exacerbates the unequal intra-household power relationship that is detrimental to her health. Ill health events, such as maternal morbidity and HIV/AIDS, have triple negative effects on poverty: in addition to reducing her ability to participate in income-generating activities, these illnesses can cause households to incur exorbitant healthcare expenses and large funeral expenses in the case of death (direct costs), and require other household members to withdraw from income-generating activities to care for their sick loved one (indirect costs).

The effects of low SRHS on poverty are also intergenerational, since mothers can suffer specific disability or reduced capacity as a result of poor sexual and reproductive health. There are multiple channels through which the effects of low SRHS are felt on children. The first, and perhaps most obvious, is the effect of sexual and reproductive health on the number, timing and spacing of children born to a mother. Large numbers of children, spaced closely together, can affect the quality of children’s health and the quality of care given to any particular child, an effect closely linked to Becker’s quantity-quality relationship. A high dependency ratio, coupled with low income, can bindingly constrain the household from investing in their children’s human capital. To the extent that household well-being (income, wealth, health) is negatively affected by poor SRHS, the resources available to children may not be adequate to provide sufficient nutrition and education, thereby setting the odds against them as they grow into adulthood.

---

4 Becker posits that couples increase investment in children and reduce the number of children as income rises (see Becker and Lewis, 1973).
Furthermore, recent evidence from multiple disciplines (economics, medicine, epidemiology and sociology, to name a few) has shown the importance of the foetal and early infant environment in programming the long-term life trajectory of the child (Barker, 1998). Indeed, nutritional and psychological shocks to pregnant mothers can cause irreparable physiological damage to a developing foetus, which lasts until adulthood (Maccini and Yang, 2009). Adequate pre-natal care, maternal nutrition and anti-poverty policies can therefore be seen as instrumental in preparing future generations to live long, healthy and productive lives.

1. Case studies

The Ghanaian case study, thanks to the availability of longitudinal datasets on the reproductive health of individuals, has allowed researchers to look at issues such as the impact of the presence of children on the participation of women in the labour force. The data suggest that more children tend to induce women, particularly younger women, into spending most of their available time on childcare rather than looking for work in the informal sector, impacting household income. On the other hand, where women have formal sector employment, the number of children has no impact on labour force participation. The study, however, cautions that the link is not unique and that more analysis is needed in order to be able to assess the various strengths of the causality relationship between SRHS and poverty.
The Brazilian case study suggests that young men and women in low-income families tend to view marriage and children as a way to gain social recognition. They are inclined to start families earlier and have more children at reduced intervals, which might then bring health complications and impair the income-raising abilities of women.

C. The relationship between poverty and sexual and reproductive health status in a cultural and institutional context

So far, we have explored two direct ways in which SRHS and poverty are interconnected. Poverty is a determinant of SRHS and SRHS is also a determinant of poverty, illustrating a vicious circle: poor individuals have lower SRHS, which in turn can cause, perpetuate or deepen poverty. However, this is not a process that operates in a vacuum. Indeed, underlying this process are the cultural and institutional environments dictating social norms, legal systems and other dimensions of social institutions that influence and are influenced by SRHS. In the same way that poverty is affected by, and in turn affects, social norms and political or judiciary institutions, so it is the case for SRHS.

Equitable and gender-sensitive institutions and norms can mitigate the negative effects of poverty on poor SRHS and vice versa, much as weak institutions and discriminatory norms can make the circle even more vicious. However, norms and institutions are notoriously slow to change. For instance, Ashraf et al. (2010) document a practice of requiring spousal consent for birth control, even well after the Zambian laws were reformed to abandon this practice. This example illustrates that even by
changing laws and regulations in favour of sexual and reproductive health rights, de jure, it can take time for cultural practices to adjust, de facto. This is where civil society can play an important role, as an agent of change for both the formal and informal institutions and cultural norms, which heavily influence the complex relationship between SRHS and poverty.

III. Institutions, rights and gender norms

Institutions, rights and gender norms are interrelated and contribute to the sexual and reproductive health status of individuals. Institutions, whether formal or informal, shape the understanding of rights, which in turn helps to shape gender norms. Similarly, gender norms form understandings of existing rights and engagement with institutions. Although institutions, rights and gender norms are explained separately below, they are equally interconnected. What is central for each component is that they determine access to and control over resources, which ultimately impacts women’s autonomy over sexual and reproductive health decisions.

A. Institutions

Institutions are both formal and informal and are related to the economy, religion, politics and state structures. The structure of the economy determines whether women have access to employment within the formal or informal sector. Within the informal sector, women may participate in micro-finance schemes to improve access to resources, which may or may not be successful (Hadi, 2001; Rankin, 2001). Religion
similarly contributes to women’s sexual and reproductive health status, depending on the extent to which laws and policies endorse specific religious tenets (Tabbush, 2010; United Nations Research Institute for Social Development, 2011). Political structures influence women’s access to political representation. Particularly important is the implementation of policies that increase women’s sexual and reproductive health status (Afifi, 2009; Gitter and Barham, 2008). Health and educational institutions also play a large role (Sundaram and Venneman, 2008); health centres and schools may not be readily available to girls and women, and educational instruction may further enforce gender norms (Subrahmanian, 2005). Therefore, the nature of institutions – and the extent to which they are gender responsive – is central to understanding women’s sexual and reproductive health status.

1. Case studies

Ghana and Brazil have some of the most progressive laws in terms of sexual and reproductive health rights. However, the approaches to sexual and reproductive health lead to varying outcomes. In Ghana, the state supports the improvement of sexual and reproductive health status legally, but it does not do well in disseminating legal information or in funding programmes. For example, the safe motherhood initiative has been supported primarily by international donor agencies. In Brazil, however, the government implemented a national health policy that provided health services for everyone. These different approaches may help to explain why the maternal mortality rate in Ghana remains very high.
(despite some decrease) while in Brazil it has decreased significantly. Common to three case study countries, though, is that women are still placed in submission to a man’s will, and this is particularly strong in Lebanon. Despite this limitation to women’s autonomy, the maternal mortality rate in Lebanon is lower than Ghana and Brazil, and one reason for this may be that Lebanon is more economically developed. Interestingly, in all three countries, women’s legislative representation is relatively low, indicating women’s limited political participation.

B. Rights

The right to health, and therefore to reproductive health, is established at the international, state and community/family levels. Although the international community encourages women’s sexual and reproductive health rights, it does not necessarily follow that states adhere to these recommendations (Cook and Fathalla, 1996; Eager, 2004). For example, if a state has signed the Convention on the Elimination of All Forms of Discrimination Against Women, aimed at achieving equality between men and women along with women’s right to control over their bodies, the national legislation may not comply and may in fact restrict women. Similarly, even if the state legally supports women’s sexual and reproductive health rights, these laws still may not be enforced with consistency. Women’s sexual and reproductive health rights are further expanded or restricted by the extent to which states fulfil their obligations to non-discrimination in other areas such as access to education, politics, economic participation and health centres. Women’s ability to exercise their right to health, and
specifically sexual and reproductive health, is therefore influenced by a combination of legal rights and gender norms that are largely controlled through institutions.

1. Case studies

As indicated above, by law, women’s sexual and reproductive health rights are protected in Ghana and Brazil. However, within Ghana knowledge of rights and access to health institutions remains limited. In Lebanon, laws are more lenient for men than for women and in some instances violence against women is condoned. Legally, women experience less autonomy than men in the three countries. Nonetheless, their rate of access to either private or public health facilities is high. Regardless of country, rights determined by knowledge of and access to sexual and reproductive health are further conditioned by rural or urban location, race, ethnicity, immigrant status and class.

C. Gender norms

Gender norms are values that define gender role expectations for women and men within societies. Norms include standards on attributes, responsibilities and privileges of men and women that are reflected in constructs of masculinity and femininity. These norms operate through institutions at multiple levels including the family and community and are embodied in laws and policies. More importantly, gender norms result in harmful and discriminatory practices such as early marriage, son preference and gender-based violence, all of which have clear and direct effects on sexual and
reproductive health status. Due to gender norms women face tradeoffs that can impact their sexual and reproductive health; for example, increased fertility may mean greater community status. Central to women improving their sexual and reproductive health status is their decision-making authority (Ashraf, Field and Lee, 2010; Blanc, 2001). In many traditional contexts gender norms may restrict women’s mobility. In such situations women have to negotiate with husbands and family members to access education, to participate in the informal or formal economy, or to seek health care (Ashraf, Field and Lee 2010; Contreras and Gonzalo, 2010; Mumtaz and Salway, 2005). The precise outcome for individual women depends on the negotiation at family and community level as well as legal rights and access to institutions.

1. Case studies

Despite lenient laws in Ghana and Brazil, women still face gender norm obstacles. In Ghana, women are less likely to seek care when their labour in childbirth is long, as this is an indication of infidelity. This gender norm may help to explain the high rate of maternal mortality. In addition, women gain more social status through fertility, and are therefore less likely to use contraception. In Brazil, one in two women experiences domestic violence, which restricts women’s autonomy, affecting their sexual and reproductive health status. This is further exacerbated by racial discrimination and inequalities that have been embedded within society throughout history. In Lebanon, women are expected to submit to men within the household, limiting their sexual and reproductive health status.
Institutions, rights, and gender norms all contribute to and shape women’s sexual and reproductive health status. As seen in the case studies, women’s sexual and reproductive health status varies according to the interaction of institutions, rights and gender norms. Context determines outcomes. Importantly, though, institutions, rights and gender norms are not stagnant. Change in one component may influence change in the other two. The best means to bring about transformation is through civil society and advocacy. Opportunities created at local, national or international level allow citizens to engage with and challenge existing institutions, rights and gender norms. Civil society and advocacy then become central to improving women’s sexual and reproductive health status.

IV. Civil society and community-based organizations

A. The need for agency and advocacy

As the case studies all underscore, the relationship between SRHS, economic growth and poverty reduction is a complex one that reflects political dynamics, cultural norms and intra-family relations. But even when “good” policies are enacted, their potential positive impact can be lost because people do not know they exist. Even when people are aware of them, the resources required to make such policies effective are often lacking because the potential beneficiary is too poor to make use of them and/or because governments fail to provide sufficient state resources. At the same time, such
policies are often rejected in practice due to countervailing norms, including patriarchy in its various guises.

At its core, the challenge is twofold: On the one hand, women lack the agency that would allow them to better safeguard their SRHS and take advantage of various opportunities - including access to education, micro-finance, contraceptives, and so on - that improved policy regimes have created. On the other hand, there is a lack of advocacy for SRHS that can apply sustained pressure on recalcitrant policy makers to both enact more appropriate policies and ensure that once enacted, adequate state resources are provided so that they can achieve their explicit goals. At the same time, the empirical evidence from around the world - including the now developed global North - demonstrates the essential role that such advocacy must play in challenging the cultural norms and structural obstacles to the advancement of women and achievement of SRHS.

Although women’s movements have been active and have made important advances in a number of southern countries, women still confront obstacles grounded in entrenched patriarchal values. These patterns reflect a general weakness of civil society, which historically has played a crucial role in terms of the agency and advocacy of disadvantaged groups (Oxhorn, 2011). This weakness is reflected in the limited capacity of civil society organizations (CSOs), including social movements, for mobilizing people to find collective solutions to shared problems. There is also a need for CSOs to pressure authorities to meet their human rights obligations and respond to societal needs and expectations, ensuring a certain level of accountability when they are not met.
This perspective focuses on the nature of civil rights, which are understood in terms of their breadth (what rights are included or not) and depth (the extent to which such rights are realized in practice). More inclusive civil rights are the result of the emergence of pressures for their expansion, whereas less inclusive rights reflect the inability of such pressures to emerge and effect genuine change. In this way, differing attitudes and beliefs about civic responsibility reflect which groups participate in their social construction and how, and the strength of civil society is mirrored in the scope and depth of civil rights. Similarly, civil society’s active involvement in such processes of social construction of rights helps ensure that the successful adaption of more-or-less universal rights and external practices in specific contexts reflect local histories, experiences and priorities.

Civil society is not monolithic and different groups will compete for resources and influence. This is particularly relevant for understanding SRHS. Historically, women’s rights organizations have been the most disadvantaged in this competition, confronting a range of other (often male-dominated) groups that in a variety of ways advocate for women’s continued oppression. Competition may also be with organizations of men working for gender equality that may not be working with women’s rights organizations, diverting resources away from such women’s organizations. Indeed, it was the exclusion of women from the definition and defence of civil rights that frequently gave rise to women’s organizations demanding such inclusion. When discussing “civil society” it is important to emphasize that it can have positive and negative effects on SRHS, depending on the interests particular groups represent, and that even when groups
share similar mandates, the competition for resources can still undermine the specific agendas of a number groups.

It is also important to emphasize that CSOs work at the level of both the state and civil society; the dichotomy between civil society and the state is a false one, although individual CSOs may emphasize activities exclusively at either level. Social movements are a good example of how this functions in practice. Typically, members of social movements seek to live their lives in accordance with the values and objectives that define the movement. Their political activities reflect the ultimate goal of social, economic and political change so that whole societies come to reflect the movement’s values and objectives. Women’s movements are a particularly important illustration of this, as women seek to experience gender equality in their own lives and strive to achieve greater levels of gender equality in their respective societies. Other groups that often advocate for gender equality include human rights groups. Given the central role of women in family social structures, a variety of organizations are increasingly focusing on poverty reduction, the need to improve educational and healthcare systems, and advocating for greater gender equality to achieve their mandates.

1. Case studies

In both Ghana and Brazil, a coalition of women’s groups formed to place pressure on their respective governments to institute a law that criminalized domestic violence. Because of their continued pressure, both governments passed domestic violence laws. In Brazil the law was passed in 2006 and in
Ghana in 2007. Though the passage of the laws helps to protect women who choose to address domestic violence within the legal system, the practice nonetheless continues. Women who suffer the most tend to be women from more disadvantaged backgrounds. In Lebanon, women’s groups are only now attempting to address domestic violence.

CSOs that advocate for greater gender equality are most effective when working to simultaneously address gender norms and relations, state institutions, and rights. In this way, CSOs become agents of change through their direct activities, affecting both men and women, and through advocating for more appropriate laws and state institutions. In terms of rights, CSOs not only advocate for their recognition; their activities can help make such rights more effective through demands for state accountability and pressuring for the kinds of societal changes required for the effective realization of rights in practice. This is what CSOs working to undermine gender inequality do in a variety of ways and it is imperative that CSOs working to improve SRHS be able to do the same.

V. Implications

It is possible that policies towards improving the SRHS of individuals will lead to an alleviation of poverty for the women and other household members who are affected by sexual and reproductive decisions. This brief, however, points out that some particular conditions must also be present. Indeed, we have reviewed the ways in which
SRHS and poverty are interconnected and emphasized that the relationship between the two is influenced by social norms and political or judiciary institutions. Weak institutions and discriminatory norms will affect the relationship between SRHS and poverty and will adversely influence the poverty-alleviation potential of policies aimed at improving SRHS.

In contemplating SRHS policies, analysts must then take into consideration the role played by norms and institutions, and understand that while norms and institutions are notoriously slow to change it may be possible to create conditions that will facilitate change. In this respect, civil society can be an important agent of change for both the formal and informal institutions and cultural norms, which heavily influence the complex relationship between SRHS and poverty. However, civil society does not operate in a vacuum as it is a function of the norms and institutions in which it operates.

Consequently, one cannot just create CSOs that will quickly modify norms and institutions, that will then in turn enable SRHS policies to lead to an increase in economic growth and alleviation of poverty. Getting CSOs to properly channel their agency and advocacy roles to allow individuals to make SRHS decisions that will lead to poverty alleviation in the right context of norms and institutions is something that results-oriented analysts should pay attention to in order to maximize the impact of the programmes they consider. As this brief has discussed, this is neither easy nor immediate and suitable to a “cookie-cutter” approach of imposing the same type of policies regardless of the conditions. There are, nevertheless, some important implications to consider both in terms of policy and research, for agencies such as the
United Nations who would like to maximize the impact of SRHS policies on long-term poverty alleviation.

A. Policy implications

- Besides conventional SRHS policies, governments and development partners should also consider in their portfolio of options more general policies aimed at making resources available to women and increasing their autonomy (e.g. policies favouring access to education, to political representation, to health centres, to micro-finance, etc.). In fact the Quick Wins identified for realizing the Millenium Development Goals (such as eliminating uniform and school fees as well as user fees for basic health services, training large numbers of village health workers, expanding access to sexual and reproductive health information and services, and launching national campaigns to reduce violence against women) are immediate measures that would address some of the key determinants of poor SRHS.

- Law reforms and law implementation are necessary to accelerate the realization of women’s rights. Mobilization of communities, including men, through innovative approaches (such as the proven successful case of the social convention change strategy to accelerate the abandonment of female genital mutilation, e.g. the Tostan approach) is also critical to enforce implementation.

- Gender-responsive budgeting can help to track the way budgets respond to women’s priorities and the way governments use funds to reduce poverty,
promote gender equality, reverse the spread of HIV, and lower the rates of maternal and child mortality. It helps ensure government accountability to the commitments made to women in the Cairo Programme of Action on Population and Development and the Beijing Platform for Action for Gender Equality and Women’s Empowerment, and to achieving the Millennium Development Goals.

- For gender-equitable policy decisions and budget allocation, the availability of quality gender-related statistics is critical, including data disaggregated by sex as well as data on issues important from a gender perspective (such as gender-based violence, maternal mortality, and women’s decision-making and negotiation power). Data on time use, in particular, are often lacking or out of date. This prevents quantitative measurements and arguments about the impact of government policies and related budgets on unpaid care work done by women and men.

- Support for CSOs should be a cornerstone in any efforts to link SRHS, like gender equality more generally, with economic growth and poverty alleviation. This support should be allocated to CSOs that are already established with a track record and whose operations can be scaled up.

- In addition to an emphasis on sexual and reproductive health programmes, agencies should also consider - as a component of support for civil society - support for state policies that would facilitate their ability to fulfil their role, such as:
State reforms designed to bring civil society perspectives into policy making processes.

Educational reforms designed to promote not only gender equality but the importance of citizen engagement.

B. Research implications

• More research needs to focus on how CSOs can contribute directly to improved SRSH and poverty reduction in terms of:
  
  o Determining the characteristics of the rights, norms and institutions enabling CSOs to be more effective in terms of SRHS policies.
  
  o Appropriate policies for supporting the growth of CSOs focusing on SRHS.
  
  o Setting appropriate criteria for determining which CSOs should be considered for funding (e.g. assessing their representativeness, social legitimacy, accountability, and so on) so that they, given the norms and institutions they operate in, can fulfil both roles of agency and advocacy.
  
  o How to avoid or at least minimize the dominance of professional NGOs within civil society.

C. Methodological implications

• The linkage between SRHS, economic growth and poverty reduction is a complex, multi-level one, which requires:
o Recognizing the role that both civil society and state institutions play in mediating their relationship.

o Developing a holistic approach that captures the ways in which societal and state-level change can either reinforce one another or create unanticipated consequences that undermine the contribution specific policies can make to improved SRHS, economic growth and poverty reduction.

o Addressing difficult issues relating to societal norms in a culturally sensitive way that recognizes the importance of greater levels of gender equality for meeting basic development goals.

• Existing macro-level studies and data need to be supplemented with more qualitative research including:
  o In-depth case studies.
  o Focus groups.
  o Opinion surveys.

• There is a need to develop formal models of the relationship between SRHS, economic growth and poverty reduction that can:
  o Integrate multiple research methodologies.
  o Capture the interrelationships between rights, institutions and social norms.
  o Measure the role of civil society through agency and advocacy.
References

Afifi, Mustafa (2009). Wealth index association with gender issues and the reproductive health of Egyptian women. *Nursing and Health Sciences*, vol. 11, pp. 29-36.


