

## ROE AND ITS GLOBAL IMPACT

Naomi Cahn and Anne T. Goldstein\*

### *World Health Organization Statistics on Maternal Mortality:*<sup>1</sup>

*Estimated number of maternal deaths/year (from all causes):*

World:	529,000
United States:	660
Democratic Republic of Congo:	24,000
Zimbabwe:	5,000

*Estimated percentage of maternal deaths/year attributable to unsafe abortions:*

World:	13%
United States:	~0%

*Lifetime risk of maternal death, 1 in:*

United States:	2,500
Democratic Republic of Congo:	13
Zimbabwe:	16

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<sup>1</sup> All data except that in the second item (maternal deaths attributable to unsafe abortion) is taken from MATERNAL MORTALITY IN 2000: ESTIMATES DEVELOPED BY THE WHO, UNICEF, AND UNFPA, available at [http://www.who.int/reproductive-health/publications/maternal\\_mortality\\_2000/maternal\\_mortality\\_2000.pdf](http://www.who.int/reproductive-health/publications/maternal_mortality_2000/maternal_mortality_2000.pdf).

The 13% of maternal deaths from unsafe abortion figure is from WORLD HEALTH ORG., UNSAFE ABORTION ch. 4 tbl.2 (3d ed. 1997), available at [http://www.who.int/reproductive-health/publications/MSM\\_97\\_16/MSM\\_97\\_16\\_table\\_of\\_contents\\_en.html](http://www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_table_of_contents_en.html). Since abortion is legal in the United States, death from unsafe abortions are rare and thus the percentage of maternal deaths from unsafe abortion is nearly zero. See, e.g., California NOW Action Center, *Abortion Before & After Roe v. Wade* (“During the first half of the century, illegal abortion counted for about 50 percent of all maternal deaths. By 1980, however, the percentage of maternal deaths due to abortions dropped to nearly zero.”), available at <http://www.canow.org/issues/reprobefore.html>.

*Maternal Mortality ratio (number of maternal deaths per 100,000 live births):*

United States:	27
Democratic Republic of Congo:	990
Zimbabwe:	1,100

*Alan Guttmacher Institute's Statistics on Deaths from Illegal Abortions in the United States:*<sup>2</sup>

1930	"Almost" 2,700 women, 18% of maternal deaths.
1940	"Just under" 1,700
1950	"Just over" 300
1965	"Just under" 200, 17% of maternal deaths
1972	39

## I. *ROE* AND ITS IMPACT: RHETORIC AND REALITY

### A. *Is Roe Hanging by a Thread?*

Every American woman of childbearing age has had abortion as a fallback, and millions will not give it up. They want it here for themselves and their daughters and will vote against any politician or party that threatens to take it away.

—2000 Presidential Candidate Patrick Buchanan<sup>3</sup>

*Roe v. Wade* is hanging on by a one-vote majority—with an anti-choice President and Congress eager to install the one justice who could take our freedom away. If *Roe* is overturned, fully half the states would swiftly ban or severely restrict abortion. If *Roe* is overturned, women will return to—and die in—the back alleys. If *Roe* is overturned, women will be forced to bear children against their will—with devastating implications for mother and child alike. If *Roe* is overturned, a woman's right to contraception could be the next right lost.

—NARAL President Kate Michelman<sup>4</sup>

As the above quotes from Patrick Buchanan and Kate Michelman attest, thirty years after *Roe*, the rhetoric of both pro-life and pro-

<sup>2</sup> Rachel Benson Gold, *Lessons from Before Roe: Will Past Be Prologue?*, GUTTMACHER REP., Mar. 2003, at 8, 8–10 (describing the toll illegal abortions took on women's lives and health in the years before *Roe v. Wade*), available at <http://www.guttmacher.org/pubs/journals/gr060108.pdf>.

<sup>3</sup> PATRICK BUCHANAN, *THE DEATH OF THE WEST* 46 (2002).

<sup>4</sup> Press Release, Kate Michelman, President, NARAL Pro-Choice America, 30th Anniversary of *Roe v. Wade* (Jan. 22, 2003) (discussing the various political threats to *Roe v. Wade*), available at [http://www.naral.org/about/newsroom/pressrelease/20030122\\_roverspeech.cfm](http://www.naral.org/about/newsroom/pressrelease/20030122_roverspeech.cfm).

choice advocates in this country suggest that the other side has won (or is about to win) the war. In the political discourse, the opposing sentiments “abortion rights will be protected through the political process, because they are held precious by the voters” and “*Roe* hangs by a thread and contraception is next,” are most often proclaimed by those who least wish what they were saying was true. These apocalyptic warnings rally the troops for the next battle and increase donations. Each side has every incentive to exaggerate the strength of the other.

Yet underneath the rhetoric of “cultural war”<sup>5</sup> on both sides lies a truce. Territory at the margins is still contested and rogue elements use violence against abortion providers. But beneath the constant reminders that abortion is an issue that divides this country like no other lies a broader, deeper consensus than either side acknowledges.

In their analysis of where the votes are on abortion, Buchanan is closer to the mark than Kate Michelman. The Supreme Court’s decision in *Roe v. Wade*<sup>6</sup> enjoys support, as Mr. Buchanan says, from “millions” of women voters and, as he does not say, from millions of male voters as well. (Mr. Buchanan himself, in contrast, enjoyed the support of fewer than 500,000 voters when he ran for president in the 2000 election—or 0.42% of the vote.)<sup>7</sup>

Does *Roe* “hang by a thread”? According to an October 2000 Gallup poll, only 30% of Americans would vote in support of a constitutional amendment that would overturn *Roe* and make all abortions illegal, while 67% would oppose such an amendment.<sup>8</sup> In May 2001, fully 84% of respondents said they believed abortion should be legal in at least some circumstances; three months later an overwhelming proportion of self-described “pro-lifers” (69%) said the same.<sup>9</sup>

The apparent “consensus” on abortion, together with the rhetoric about culture wars, is echoed in other attitudes towards reproductive issues. For example, sex education remains a controversial issue,

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<sup>5</sup> See JOAN WILLIAMS, UNBENDING GENDER: WHY FAMILY AND WORK CONFLICT AND WHAT TO DO ABOUT IT 148 (2000) (“Studies of the abortion debate suggest that, in significant part, it is a gender war between ideal-worker women and women whose lives are framed by caregiving.”).

<sup>6</sup> 410 U.S. 113 (1973) (holding access to abortion to be a fundamental right under the Due Process Clause).

<sup>7</sup> Federal Election Commission, 2000 Official Presidential General Election Results (Dec. 2001), available at <http://www.fec.gov/pubrec/2000presgeresults.htm>.

<sup>8</sup> Lydia Saad, *Public Opinion About Abortion—An In-Depth Review*, GALLUP POLL TUESDAY BRIEFING, Jan. 22, 2002 (analyzing nearly 30 years of polling data on *Roe v. Wade* and abortion from Gallup and other polling organizations), at <http://www.gallup.com/content/login.aspx?ci=9904>.

<sup>9</sup> *Id.*

even though according to a 1998 national poll, 87% of Americans support the provision of such classes in public schools.<sup>10</sup>

*B. Roe and Its Domestic Impact:  
What Our "Mothers Wanted" and Our "Grandmothers Prayed for"*

The opening panel of this Symposium was entitled "What the Court Should Have Said." The Supreme Court's holding in *Roe* has long enjoyed greater support than the reasoning it used to get there. Whether you cherish *Roe* or hold it anathema, you probably do not see it as "really" about privacy. You probably see it as having more to do with what the role of women is or should be.

Kate Michelman may exaggerate the danger that contraception rights are at risk, but she is right to connect the issue of abortion with that of birth control. The people who care most about abortion—from either direction—share in a belief that deep down the fight is about what women should aspire to, and what they should be able to control. When abortion was illegal in the United States, obtaining one was "shameful" not just because it involved a criminal act, but also because it involved sex and "because one was willing to mess with what was defined then as female destiny."<sup>11</sup>

"How you gonna keep 'em down on the farm, after they've seen Paree?" was said of the World War I soldiers who went off to Europe. Well, how you gonna get 'em back in the 'burbs, after they've seen D.C., one might ask of the talented women lawyers, journalists, PR specialists and political aides who have enjoyed the great game in an exciting city.

. . . .

What is going to convert American women to wanting what their mothers wanted and grandmothers prayed for: a good man, a home in the suburbs, and a passel of kids? Sounds almost quaint.<sup>12</sup>

Actually, it is quaint. At least the part about the passel of kids. American women—like European, Latin American, and Asian women—do not want a passel of kids. They want two or three.<sup>13</sup> Only in Africa do women want larger families—and even there, the number of children desired is declining.<sup>14</sup> Once women have access to education, work opportunities, and health care, once they have

<sup>10</sup> JANICE M. IRVINE, TALK ABOUT SEX: THE BATTLES OVER SEX EDUCATION IN THE UNITED STATES 8 (2002).

<sup>11</sup> RICKIE SOLINGER, BEGGARS AND CHOOSERS: HOW THE POLITICS OF CHOICE SHAPES ADOPTION, ABORTION, AND WELFARE IN THE UNITED STATES 40 (2001).

<sup>12</sup> BUCHANAN, *supra* note 3, at 33–34, 47.

<sup>13</sup> FAMILY PLANET, WHY PEOPLE WANT FAMILY PLANNING (stating the "number of children women want has dropped steadily in many poor countries"), at <http://www.familyplanet.org/whywant.htm> (last visited Apr. 17, 2004).

<sup>14</sup> *Id.*

access to contraceptives and abortion,<sup>15</sup> they want and are able to have fewer children. American women are having smaller families than they used to because they want smaller families, and because enough of them have access to reproductive health education and care to translate their desires into reality. Mr. Buchanan is correct—many women are not likely to be converted back to wanting a “passel” any time soon, if they ever did.

Indeed, the right to an abortion and the availability of contraceptives have been linked in the United States to women’s increased ability to make career and marriage choices and to improve their status in the household. The rights to an abortion and to use contraceptives have been identified with two different phenomena: first, and most obviously, they impact fertility because they allow women to have fewer children in a generally reliable manner;<sup>16</sup> second, they have a bargaining effect, allowing women more autonomy within marriage,<sup>17</sup> so they can invest in their careers.<sup>18</sup>

On the other hand, even if the “passel of kids” is an antiquated notion, the home in the suburbs part is not quaint. In her discussion at this symposium, Joan Williams spoke of the “white picket fence” in the mind. She cited a study of sexually active, poor, urban teenage girls in Philadelphia and described the reasons why they were sexually active.<sup>19</sup> They reported that they were having sex with their boyfriends because they perceived having sex as the only way they could access the house in the suburbs with the white picket fence.<sup>20</sup>

<sup>15</sup> See *infra* notes 16–18 and accompanying text for a discussion of how improved access to contraceptives and the legalization of abortion have affected women’s status.

<sup>16</sup> See Claudia Goldin & Lawrence F. Katz, *The Power of the Pill: Oral Contraceptive and Women’s Career and Marriage Decisions*, 110 J. POL. ECON. 730 (2002) (exploring the relationship between the increasing number of young, unmarried, college graduate women and the increasing dissemination of birth control pills); SONIA OREFFICE, ABORTION AND FEMALE POWER IN THE HOUSEHOLD: EVIDENCE FROM LABOR SUPPLY (Univ. of Chi., FEEM, Working Paper No. 41, May 2003) (focusing on how the legalization of abortion positively affected female bargaining power), available at <http://www.ssrn.com>.

<sup>17</sup> See OREFFICE, *supra* note 16, at 3–4. Interestingly, Oreffice finds that women decreased their labor force participation while men increased theirs, as a result of women’s changed fertility bargaining power resulting from abortion legalization. The results for groups for whom abortion legalization might be expected to have minimal impact, such as Catholics and people choosing child-free lifestyles, experienced much smaller bargaining effects. *Id.* at 26–27.

<sup>18</sup> Goldin & Katz, *supra* note 16. Goldin and Katz point out that increases in the age at which women first married and the number of women in professional degree programs coincided with widespread dissemination of the pill. *Id.* at 760 tbl.5. They note that the birth control pill is not necessarily the cause of women’s changing status; nonetheless, a woman’s ability to control contraception with minimal pain and hassles in a relatively inexpensive way does seem to have been “important.” *Id.*

<sup>19</sup> Joan C. Williams, Presentation at the *University of Pennsylvania Journal of Constitutional Law’s* Symposium, *The Legacy of Roe: The Constitution, Reproductive Rights, and Feminism* (Feb. 8, 2003).

<sup>20</sup> *Id.*

The reasons why girls have sex in Philadelphia are comparable to the reasons why girls in Africa are having sex.<sup>21</sup> They are having sex not because of any feminist or liberal ideal of sexual liberation or empowerment, but because they believe that early sexual activity makes the dream of a secure middle-class life (in America) or an escape from the poverty of their own families (in Africa) more likely. Any kind of intervention that ignores this reality is not likely to succeed. What they do not know when they engage in this sexual activity is that education—not marriage—is a more effective means of getting out of poverty.<sup>22</sup>

Recognizing the political reality concerning abortion, pro-life advocates have for years pursued an incrementalist strategy, seeking to limit abortion rights—and score political gains—whenever and wherever they can. Unsurprisingly, some of their greatest successes have been in limiting access to abortion for young women who cannot vote yet in this country, through parental consent requirements, the Hyde Amendment, and other restrictions.<sup>23</sup> In other countries, U.S. pro-life advocates limit the access of women who live in poverty by defunding entities that have any real or apparent relationship to abortion.<sup>24</sup>

Because the legacy of *Roe* reflects issues pursuant to the U.S. Constitution, it should have a minimal legacy internationally. Nonetheless, a small vocal fringe has been able to skew the discussion on abortion rights in a manner that forecloses genuine debate. The challenge for the majority who supports abortion rights, both domestically and internationally, is to take back the debate and reset its terms to focus on the consensus concerning abortion and other reproductive rights that exists in poll after poll. In this paper, we use empirical work from both within and outside of the United States to show what the reproductive health needs of women actually are. We also suggest the importance of building stronger relationships

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<sup>21</sup> See *infra* notes 39–59 and accompanying text for our discussion of adolescents in the Democratic Republic of the Congo.

<sup>22</sup> See Michael Selmi & Naomi Cahn, *Caretaking and the Contradictions of Contemporary Policy*, 55 ME. L. REV. 289, 307–08 (2003) (noting that college-educated women earn more than women with only a high school diploma and that in the developing world, women with more education have fewer children than do women with less education).

<sup>23</sup> In 1976, Congress adopted the Hyde Amendment which prohibited the use of Medicaid funds to pay for abortions for poor women. Representative Henry Hyde explained his focus on poor women: “I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the HEW Medicaid bill.” SOLINGER, *supra* note 11, at 13–14 (quoting Hyde).

<sup>24</sup> See Susan A. Cohen, *Global Gag Rule Revisited: HIV/AIDS Initiative out, Family Planning Still in*, GUTTMACHER REP., Oct. 2003, at 11 (discussing the Bush administration’s efforts to minimize role of abortion in international family planning initiatives), available at <http://www.agi-usa.org/journals/toc/gr0604toc.html>.

between women's advocacy groups and public health groups so that empirical data can guide the abortion debate. As these data show, abstinence-only education does not work, abortion bans increase the number of women dying but do not decrease the number of abortions, and the right to an abortion is a reflection of women's status in society.

### C. *Roe and Its International Impact: Rhetoric and Reality*

Women are still dying in back alleys and are being forced to raise children they do not want. The World Health Organization estimates that more than 80,000 women die each year from medically unsafe abortions in countries where abortion is restricted.<sup>25</sup> In the five years after *Roe v. Wade*, the rate of abortion-related deaths in the United States decreased by 85%.<sup>26</sup> Yet abortion remains illegal, or highly restricted, in many other parts of the world.<sup>27</sup>

To avoid exporting our cultural and constitutional wars over the right to choose, we need to focus on the voices of vulnerable people who risk dying because of their lack of options.<sup>28</sup> What are adolescents in poor countries asking for? What works in countries with astronomical HIV rates? How do we stop the unwanted pregnancies and the dying? Are the issues moral, legal, or health-related? Just like the truce that underlies the abortion divide in the United States,<sup>29</sup> there actually is a deeper consensus on many issues of reproductive health. In their focus on international reproductive policies, conservatives have targeted policies which they link to

<sup>25</sup> See DIV. OF REPROD. HEALTH, WORLD HEALTH ORG., WORLD HEALTH DAY: SAFE MOTHERHOOD, ADDRESS UNSAFE ABORTION (Apr. 7, 1998) (citing World Health Org., *Abortion: A Tabulation of Available Information* (3d ed. 1997)), available at [http://www.who.int/archives/whday/en/pages1998/whd98\\_10.html](http://www.who.int/archives/whday/en/pages1998/whd98_10.html).

<sup>26</sup> CTR. FOR REPROD. RIGHTS, SAFE ABORTION: A PUBLIC HEALTH IMPERATIVE (Mar. 2000) (citation omitted), available at [http://www.crlp.org/pub\\_fac\\_atksafe.html](http://www.crlp.org/pub_fac_atksafe.html). A disproportionate amount of hospital spending is on treating complications resulting from unsafe abortions. See *id.* ("In some low-and-middle-income countries, up to 50% of hospital budgets are used to treat complications of unsafe abortion.") (citation omitted).

<sup>27</sup> See Ctr. for Reprod. Rights, *Abortion*, ("[T]he right to choose abortion remains unavailable or under threat in many parts of the world."), available at [http://crlp.org/ww\\_iss\\_abortion.html](http://crlp.org/ww_iss_abortion.html) (last visited Apr. 17, 2004).

<sup>28</sup> For a trenchant critique of how the U.S. has already exported the abortion debate to other countries, see CTR. FOR REPROD. RIGHTS, BREAKING THE SILENCE: THE GLOBAL GAG RULE'S IMPACT ON UNSAFE ABORTION (Oct. 22, 2003), available at [http://www.reproductiverights.org/pub\\_bo\\_ggr.html](http://www.reproductiverights.org/pub_bo_ggr.html). Pursuant to the "gag rule," foreign non-governmental organizations are precluded from receiving funding from the United States Agency for International Development unless they promise not to use their non-U.S. funds for advocacy of abortion issues, including the provision of information regarding abortion-related services. See Cohen, *supra* note 24, at 1.

<sup>29</sup> See *supra* notes 4-9 and accompanying text.

conservatives have targeted policies which they link to abortion.<sup>30</sup> Outside of abortion-related issues, reproductive health involves decreasing the maternal mortality rate, rehabilitating prostitutes, and providing services to victims of sexual violence. On aspects involving children, mothers' health, and definitive victims, there is broad-based agreement from the left and right, liberals and conservatives, on the need to change existing practices and provide funding for other kinds of international reproductive health activities.<sup>31</sup>

Abortion, because of its link to women's rights and women's control over their own bodies, remains a lightning rod. Conservatives have sought to expand the U.S. abortion debate beyond family planning and a woman's right to control her own body. The Bush administration attempted to extend the existing gag rule, currently applicable only to family planning funds, to include HIV/AIDS funds.<sup>32</sup> The administration justified this extension based on the nature of services provided with HIV/AIDS funds which often overlap with other reproductive health issues. Nonetheless, even though the AIDS groups provide condoms and other family planning services, they do so to promote AIDS prevention, not pregnancy prevention. These groups argued that they could not function with such a gag rule. In response, the administration proposed a "gag rule lite," under which AIDS groups could use U.S. funding with the condition that they not use it for abortions. If the subject of abortion arose, they were to refer clients to un-gagged providers (if such providers still existed). The AIDS groups rejected this proposal as well. Ultimately, both the administration and Congress acceded. Thus, HIV funds can be used without complying with the gag rule but family planning funds can only be used if they comply with those rules—even if the funds are used for the same purpose.

The lesson of *Roe* for work overseas is that the debate has to be grounded—hard—in the empirical public health data, not in the constitutional and public conflicts occurring in the U.S. One of the most significant problems with the way the debate has played out in the U.S. is that it is largely phony, on both sides. The tactic of the pro-choicers at every turn is that if this battle (whatever this battle is)

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<sup>30</sup> For a catalogue of these actions, see Gregg Sangillo, *Abortion: Going Global*, 35 NAT'L J., Jan. 11, 2003.

<sup>31</sup> See Stephen W. Sinding, *Family Planning and the Religious Right's Overseas Reach*, CHRISTIAN SCI. MONITOR, Feb. 7, 2002, at 11; see also Symposium, *Should the United Nations Support More Family-Planning Services for Poor Countries?*, INSIGHT ON THE NEWS, Dec. 10, 2001, at 40, 41. We do not mean to minimize the impact of current restrictions on funding for international family planning activities, which have been eloquently documented by the Center for Reproductive Rights. Instead, we are focusing on different aspects of international family planning.

<sup>32</sup> See Cohen, *supra* note 24, at 1. The following discussion of the gag rule and AIDS advocacy groups draws on the events described by Cohen.



is lost, we will be back to where we were in 1972. But we won't. Abortions of the kind that upper-middle-class American women need will still be available to upper-middle-class American women, period. The pro-life side has been much shrewder tactically—the “partial-birth” advocacy has been a tremendous victory for them domestically, while the gag rule has been a victory internationally.

While constitutional/legal debates are useful, and can result in changing the law, the primary focus should be on the consequences that result when women in other countries do not have access to family planning and abortion counseling. For this reason, the focus should shift from theory and law to empiricism and documentation of the needs for family planning and other reproductive health activities.<sup>33</sup>

The statistics at the beginning of the article are a graphic example of how costly it is to export the debate over *Roe*. In the U.S., virtually no maternal deaths are attributable each year to unsafe abortions, while 13% of maternal deaths in the rest of the world are. In the U.S., there are 470 maternal deaths per year; there are 515,000 such deaths worldwide. Restricting the expenditure of U.S. family planning funds based on an abortion screen prevents organizations from helping women plan their births and space their children, and dooms women to countless unwanted pregnancies. The statistics speak for themselves on the need for family planning services and the right to an abortion.

To provide additional empirical perspectives<sup>34</sup> on how, notwithstanding its status as an internal U.S. constitutional decision, *Roe* affects women outside of the United States, this Paper focuses on studies of adolescents in the Democratic Republic of the Congo, regarding their sexual activity and knowledge of contraception. These studies, and others which document adolescent sexual activity and knowledge worldwide, illustrate the importance of adequate sex education for pre-adolescents and adolescents to ensure that they act responsibly. Yet as these studies and other research in this area show, reproductive issues cannot be isolated from their social and political context; as girls and women are able to exercise more of their human

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<sup>33</sup> For an example of other attempts to use the real voices of women affected by various abortion-related laws, see Brief of Amici Curiae, Women Who Have Had Abortions, at 19, *Webster v. Reprod. Health Servs.*, 492 U.S. 490 (1989) (No. 88-605). This brief, referred to as the “Voices Brief,” is a compilation of personal experiences based on 2,887 letters from women who had abortions. See also Linda McClain, “Irresponsible” *Reproduction*, 47 *HASTINGS L.J.* 339, 442 (1996) (discussing efforts to use women’s voices in abortion litigation).

<sup>34</sup> See Cohen, *supra* note 24, at 1–3; *supra* text accompanying notes 23–24 (discussing the global gag rule).

capabilities,<sup>35</sup> they are generally also able to exercise more authority with respect to reproductive issues.

## II. REAL VOICES, REAL PROBLEMS

The right to abortion varies in sub-Saharan African countries. For example, in Zimbabwe, abortion is allowed only in situations where there is a serious threat to the woman's health, a high risk of fetal impairment, or in cases of "unlawful intercourse."<sup>36</sup> In Mali, the fetus's right to life is protected under their constitution.<sup>37</sup> In the Democratic Republic of the Congo, abortion is completely illegal. Thus, in some ways, the post-*Roe* debates are irrelevant to these countries because of their restrictive abortion laws (although the events culminating in the *Roe* decision may be somewhat useful in helping to craft a strategy to challenge existing abortion laws). Nonetheless, access to abortion remains a critically important issue, given the high rate of unwanted pregnancies, illegal pregnancy terminations, and resulting

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<sup>35</sup> For further discussion of the capabilities approach, see AMARTYA SEN, *DEVELOPMENT AS FREEDOM* (2000), and *WOMEN, CULTURE AND DEVELOPMENT: A STUDY OF HUMAN CAPABILITIES* (Martha C. Nussbaum & Jonathan Glover eds., 1995). The capabilities approach emphasizes the freedom of individuals to achieve, rather than measuring development as gross national product. See, e.g., Martha C. Nussbaum, *Introductory Essay*, in *WOMEN, CULTURE, AND DEVELOPMENT*, *supra*, at 5.

The human capabilities approach, which is used by the United Nations Development Programme to measure people's abilities to perform certain basic functions in their countries, includes:

*Bodily Health.* Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.

*Bodily Integrity.* Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction.

Martha C. Nussbaum, *Human Rights Theory: Capabilities and Human Rights*, 66 *FORDHAM L. REV.* 273, 287 (1997).

Bodily health and bodily integrity are two aspects of adolescent lives that are endangered through ignorance of reproductive issues and lack of access to reproductive products. As Amartya Sen points out:

[T]he "solution" to the population problem that seems to deserve the most attention involves a close connection between public policies that enhance social development and gender equity (particularly education, health care, and job opportunities for women), and individual responsibility of the family (through the decisional power of potential parents, particularly mothers). The effectiveness of this route lies in the close link between the well-being and agency of young women. As a result, the solution to the population problem calls for more responsibility and freedom, not less.

Amartya Sen, *Fertility and Coercion*, 63 *U. CHI. L. REV.* 1035, 1061 (1996).

<sup>36</sup> CHILD & LAW FOUND., *CTR. FOR REPROD. LAW & POLICY, STATE OF DENIAL: ADOLESCENT REPRODUCTIVE RIGHTS IN ZIMBABWE* 25 (Apr. 2002) [hereinafter *STATE OF DENIAL*], available at [http://www.crlp.org/pdf/zimbabwe\\_report.pdf](http://www.crlp.org/pdf/zimbabwe_report.pdf).

<sup>37</sup> *CTR. FOR REPROD. RIGHTS, WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES: FRANCOPHONE AFRICA* (2000), available at [http://www.crlp.org/pub\\_bo\\_wowfr.html](http://www.crlp.org/pub_bo_wowfr.html). In Burkina Faso, Cameroon, and Senegal, a woman can obtain an abortion if it is necessary for her health. *Id.*

deaths. And, if we place the right to abortion at one end of a continuum that concerns women's reproductive health and rights issues with no right to an abortion at the other, or use abortion as an indication of women's status in society, then its importance to assuring women's bodily integrity and health is even more critical.

The types of reproductive issues faced by adolescents are staggering. They range from a need for sex education to the accessibility of contraceptives to cultural and legal attitudes towards gender and motherhood. In the Congo, as in many other countries, girls do not have the legal right to obtain contraceptives; they feel unable to control their own reproductive lives. These statements are supported by a number of surveys of the attitudes and information of adolescents.<sup>38</sup> This section first catalogues adolescents' surveys on reproductive issues prior to examining the barriers to improving reproductive health.

#### A. Adolescent's Reproductive Lives in the Congo

One recent study of 120 students between the ages of twelve and twenty-two conducted by a Congolese nonprofit group showed that adolescent girls' decision making was dictated by fear and intimidation either from their parents or their sexual partners. The study also showed a general ignorance of sexuality and contraception and a lack of access to information or materials.<sup>39</sup> Indeed, what is striking about the survey is the number of children who regretted their sexual activity and the number who used no protection at all. Of the 120 participants, twenty-six admitted to having had sexual intercourse, sixty denied having sexual intercourse and thirty-four did not answer the question; the survey administrators suspect that many respondents were not entirely honest in their responses and felt reluctant to discuss their sexual experiences.<sup>40</sup> In explaining why they had not yet had sexual intercourse, respondents' reasons included fears of pregnancy, having a child too young, and fear of God or parents.<sup>41</sup> By contrast, the respondents who acknowledged a sexual relationship were overwhelmingly influenced by friends, their environment, or the media (four by envy, six by environment, two by the influence of

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<sup>38</sup> Many of these studies are discussed *infra* notes 39–58.

<sup>39</sup> Republique Democratique du Congo Reveil & Dynamisme des Femmes a La Base, Enquete Sur Les Droits Humains en Matiere de la Sante Sexuelle et de la Reproduction Effectuee en milieu Scolaire des Quartiers Peripheriques de Kinshasa-Ouest 67 (2002) [hereinafter RDF-Base].

<sup>40</sup> *Id.* at 45.

<sup>41</sup> *Id.* at 48 (showing that six said fear of pregnancy, seven said fear of God, and eight said fear of early parenthood). The highest number of respondents (nineteen) were worried about the effect on their studies. *Id.*

friends or the media).<sup>42</sup> Of the twenty-six respondents who had been involved in a sexual relationship, twenty-four of them regretted their actions, for reasons ranging from having committed a sin (three female, two male) to having abused their bodies before marriage (seven female, zero male).<sup>43</sup> Of the fifteen females who admitted to engaging in sexual activity, seven had already been pregnant<sup>44</sup> and four who had obtained abortions had not informed their parents of either their pregnancies or their abortions.<sup>45</sup> Of those who had given birth, one explained that it was a sin to obtain an abortion, another was frightened that she would die from an abortion, and the third wanted to experience the joy of children.<sup>46</sup>

In their last sexual encounters, sixteen respondents claimed to have used a condom but no one mentioned any other form of birth control.<sup>47</sup> Given the general ignorance about how a woman becomes pregnant<sup>48</sup>—lack of knowledge about calculating a menstrual cycle as well as the (im)possibility of becoming pregnant through one sexual encounter—the failure to discuss any other forms of contraception is not surprising. Almost one-third of the respondents who used a condom could not remember how they had acquired it,<sup>49</sup> thereby casting doubt on their account of having used one at all. The primary reason cited for using a condom was not a fear of pregnancy but a fear of AIDS.<sup>50</sup>

For those women who did not use contraceptives, some claimed they did not use contraception because they felt that the Lord would protect them or they believed contraceptives would cause illness.<sup>51</sup> Other surveys have shown similar misconceptions about the use of contraceptives.<sup>52</sup> Nonetheless, the most common explanation cited for why they did not use contraceptives was that they did not want to diminish their pleasure. This further emphasizes the single-minded

<sup>42</sup> *Id.* at 49.

<sup>43</sup> *Id.* at 51. The gender breakdown is astounding—only the female respondents felt remorse about having sex prior to marriage.

<sup>44</sup> *Id.* at 56. Only two of the eleven males knew of pregnancies that had resulted from their actions.

<sup>45</sup> *Id.* at 60.

<sup>46</sup> *Id.* at 57.

<sup>47</sup> *Id.* at 52.

<sup>48</sup> See *infra* notes 51–52 and accompanying text for further discussion of general knowledge about contraceptives in the Congo.

<sup>49</sup> RDF-Base, *supra* note 39, at 55.

<sup>50</sup> *Id.* at 54. Eight females and two males explained that they had used condoms for fear of AIDS, while only three males explained that they had used condoms to avoid a pregnancy.

<sup>51</sup> *Id.* at 53 (citing a “hunched back” as one feared illness).

<sup>52</sup> Interview with Tenley Mogk, Population Fellow, United States Agency for International Development in Kinshasa, Democratic Republic of the Congo, in Kinshasa, Dem. Rep. of Congo (Sept. 1, 2003); see also LINA M. PRIPIRI & MBADU MUANDA, *ANALYSE DE LA SITUATION* (Jan. 2000) (report on file with authors).

focus on condoms and indicates the lack of knowledge about, or access to, alternative forms of contraceptive.

This study, conducted by the RDF-Base, is arguably of limited significance taken on its own. The RDF-Base sample is small and respondents are limited to only one part of the capital city of the country. As such, this study is not statistically valid for the rest of the country, and broad generalizations should not be drawn from it. Moreover, the researchers were not paid professionals and lacked training in survey methods. Nonetheless, the study does record the actual voices and experiences of a group of adolescents. Moreover, its conclusions regarding lack of knowledge and lack of access to contraceptives are supported by larger studies of reproductive knowledge and contraception use in the Congo and in other parts of Africa. Thus, if we do not give credence to the data and anecdotal information reported because of the study's limitations, the real needs of these adolescents are ignored.<sup>53</sup>

In other studies of Kinshasa teenagers, researchers believe that as many as 30% of all female adolescents had attempted to have an abortion.<sup>54</sup> The most common form of contraception appears to be the calendar method, although few adolescents know how to accurately calculate their time of maximum fertility.<sup>55</sup> While approximately one-third of sexually active adolescents in Kinshasa have been pregnant, the actual birth rate is much lower.

This leads to a tentative conclusion that there are a significant number of unreported, illegal abortions.<sup>56</sup> In Kinshasa, more than 80% of adolescent pregnancies are unwanted.<sup>57</sup> National studies have found that about two-thirds of women do not use any form of contraception. Of those that do, no more than 3–5% use condoms or the pill.<sup>58</sup> In its interviews of 1500 people in the capital city of Kinshasa, one nongovernmental organization found only four who used a birth

<sup>53</sup> See Michael Selmi, *Sex Discrimination in the Nineties, Seventies Style: Case Studies in the Preservation of Male Workplace Norms* 27 (2003) (unpublished paper on file with Naomi Cahn) (discussing representative nature of class action sex discrimination cases).

<sup>54</sup> JSI RESEARCH AND TRAINING INSTITUTE FOR THE REPRODUCTIVE HEALTH FOR REFUGEES CONSORTIUM, *ASSESSMENT OF REPRODUCTIVE HEALTH IN THE DEMOCRATIC REPUBLIC OF CONGO* 10 (July 2002) [hereinafter JSI ASSESSMENT].

<sup>55</sup> Lina M. Piripiri, *Cultural and Socioeconomic Correlates of Premarital Adolescent Pregnancy in Lemba, Kinshasa, DRC: A Public Health Approach*, 89–90 & tbl.11.b (2000) (unpublished DrPH dissertation, Tulane University) (on file with authors). Although almost 30% of the girls claimed to have used the calendar method in their first sexual encounter, less than half that number was able to identify the appropriate time to abstain from intercourse.

<sup>56</sup> *Id.* at 158–59.

<sup>57</sup> *Id.* at 160. The rate Piripiri found in Kinshasa is somewhat higher than a 1996 study of developing countries which observed that 60% of such pregnancies were unwanted. *Id.*

<sup>58</sup> See JSI ASSESSMENT, *supra* note 54, at 8 (“Only 3% of Congolese women use a modern method of contraception.”); International Planned Parenthood Federation, *Country Profiles: Congo*, at [http://ippfnet.ippf.org/pub/IPPF\\_Regions/IPPF\\_CountryProfile.asp?ISOCode=CD](http://ippfnet.ippf.org/pub/IPPF_Regions/IPPF_CountryProfile.asp?ISOCode=CD).

control pill.<sup>59</sup> Almost 75% of all women become sexually active by the age of seventeen; in rural areas (where approximately two-thirds of the population lives), more than 25% of girls are sexually active by the age of fourteen.

### B. Why Isn't There Better Access to Reproductive Health?

Even if women wanted access to family planning materials, there are many barriers to overcome. When women do go to clinics, those that exist are inadequately stocked with supplies, providers are ill-informed as to the various methods of family planning, and the cost—generally less than one dollar—is prohibitive for the average Congolese woman,<sup>60</sup> considering the GDP per capita is approximately \$99.<sup>61</sup> While contraceptives are available on the street, their quality is highly questionable.<sup>62</sup> Less than 1% of government spending is devoted to health programs.<sup>63</sup> The government's Ministry of Health admits that fewer than 30% of the country's health zones are "functional."<sup>64</sup> And even if a woman is able to find and purchase contraceptives, she still needs her husband's permission to receive them.<sup>65</sup>

Overall, there are three barriers to the use of contraceptives in the Congo. First, there is both misinformation and a lack of information about contraceptives. Studies repeatedly show widespread fears that use of family planning techniques will result in sterility or diseases, such as cancer.<sup>66</sup> At the same time, there is little accurate information available about different methods of contraception.<sup>67</sup> Second, contraceptive supply is limited and many areas of the country have no family planning materials or clinics.<sup>68</sup> Third, and perhaps most significantly, cultural norms interfere with contraceptive use.<sup>69</sup> In its focus group surveys, Population Services International ("PSI") found that almost all women defer to their partners on the decision as to whether to use contraceptives at all, and then as to what kind to

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<sup>59</sup> Interview with Sean Mayberry, Country Director Population Services International ("PSI"), Democratic Republic of the Congo, in Kinshasa, Dem. Rep. of Congo (Feb. 23, 2004).

<sup>60</sup> JSI ASSESSMENT, *supra* note 54, at 3–4.

<sup>61</sup> United Nations Development Programme, *Human Development Report 2002: Democratic Republic of Congo* [hereinafter *UNDP Human Development Report*], at [http://www.undp.org/hdr2003/indicator/cty\\_f\\_COD.html](http://www.undp.org/hdr2003/indicator/cty_f_COD.html).

<sup>62</sup> JSI ASSESSMENT, *supra* note 54, at 6.

<sup>63</sup> *Id.* at 3.

<sup>64</sup> *Id.* at 4.

<sup>65</sup> *Id.* at 6.

<sup>66</sup> Piripiri, *supra* note 55, at 94 tbl.15 (listing fear of infertility as a professed reason to avoid condom use); Interview with Sean Mayberry, *supra* note 59 (describing fears of cancer and other diseases from condom use).

<sup>67</sup> JSI ASSESSMENT, *supra* note 54, at 5.

<sup>68</sup> *Id.* at 6–7.

<sup>69</sup> *Id.*

choose.<sup>70</sup> Women fear that, if they use contraceptives, including refraining from intercourse during their fertile periods (the rhythm method), their husbands or boyfriends will find other sexual partners.<sup>71</sup> Also, both men and women subscribe to very strong pro-natalist values. For youth, the problems are especially severe, since during the past decade of civil war in the Congo<sup>72</sup> there has been little dissemination of information regarding family planning because the country and its institutions, including the public health system, have been disrupted.<sup>73</sup> While 92% of children were enrolled in primary school in 1980, that number dropped to 47% in the late 1990s.<sup>74</sup> In focus groups, adolescents have explained that they do not seek out family planning clinics because they do not understand why they need the services.<sup>75</sup>

### III. CHANGING THE CONTEXT FOR ADOLESCENTS' REPRODUCTIVE LIVES

There are a series of levels on which to respond to the situation in the Congo and countries with similar problems. The proposals and recommendations of various groups attempting to develop programs on reproductive health issues range from modest to monumental and they are quite illuminating with respect to the problems concerning reproductive rights.

Within these reproductive health proposals, the emphasis is on both practical access to contraceptives and education, and political issues involving legal change and education. The law can make a difference. For example, the United Nations Population Fund draft

<sup>70</sup> See Interview with Sean Mayberry, *supra* note 59.

<sup>71</sup> These barriers to contraceptive use are not, of course, unique to the Congo. The Center for Reproductive Rights reports that "Ethiopian women fear that their husbands will divorce them" if they use contraceptives because the men believe that use of contraceptives indicates adultery or a sexually transmitted disease. Also, in Ghana, almost half of those surveyed by the government's Ministry of Health believed that it was "appropriate" for a husband to beat his wife if he discovered that she had been using contraceptives without his knowledge. CTR. FOR REPROD. RIGHTS, COMMON REPRODUCTIVE HEALTH CONCERNS IN ANGLOPHONE AFRICA (May 2002), available at [http://www.crlp.org/pub\\_fac\\_wowaa.html](http://www.crlp.org/pub_fac_wowaa.html).

<sup>72</sup> See MIKAELA WRONG, IN THE FOOTSTEPS OF MR. KURTZ: LIVING ON THE BRINK OF DISASTER IN MOBUTU'S CONGO (2001); Keith Somerville, *DR Congo Awash with Rebels*, BBC NEWS ONLINE, July 23, 2002 (describing the groups involved in conflict in the Congo), at <http://news.bbc.co.uk/1/hi/world/africa/2146537.stm>; ELISABETH REHN & ELLEN JOHNSON SIRLEAF, UNITED NATIONS DEVELOPMENT FUND FOR WOMEN, WOMEN, WAR AND PEACE: THE INDEPENDENT EXPERTS' ASSESSMENT OF ARMED CONFLICT ON WOMEN AND WOMEN'S ROLE IN PEACE-BUILDING 128 (2002) (discussing the breakdown of the health system due to the civil war), available at [http://www.unifem.org/index.php?f\\_page\\_pid=149](http://www.unifem.org/index.php?f_page_pid=149).

<sup>73</sup> JSI ASSESSMENT, *supra* note 54, at 3.

<sup>74</sup> WORLD BANK, AFRICAN DEVELOPMENT INDICATORS 2003, at 5 (2003), available at <http://www4.worldbank.org/afr/stats/adi2003/ch1.pdf>.

<sup>75</sup> Interview with Sean Mayberry, *supra* note 59.

project focuses on four different types of programs: first, making reproductive health services, including contraceptives, more accessible and targeting youth; second, providing reproductive health services targeting youth in the eastern, previously war-torn zones of the Congo; third, ensuring that issues involving population are integrated into any development policies and plans; and finally, "advocacy," which includes fostering support for the empowerment of women.<sup>76</sup>

We will discuss four different contexts in which to address reproductive health issues: education, culture, access to contraceptives, and law. Changing the reproductive lives of adolescents requires focusing on their health, rather than their morality; this, in turn, suggests approaches that deal with the practical issues underlying adolescent reproductive health rather than approaches that try to impose a particular moral framework.

### A. Education

RDF-Base, which conducted the survey of adolescents in the Congo discussed in detail above, recommends fostering more discussion of reproductive issues in the home, at school, and in churches. Almost 90% of the adolescent respondents indicated that they wanted such discussions at home, although only 20% had actually done so.<sup>77</sup> The largest number of respondents who had previously heard discussions of reproductive issues indicated that they had occurred among their friends, rather than at school, in the media, in their family, or in their community.<sup>78</sup> In addition to their homes, they wanted to discuss reproductive issues in their schools and churches, although many of the younger children between the ages of eleven and thirteen believed that it was inappropriate to discuss them at their age.<sup>79</sup> Of the 1200 Congolese girls she interviewed, Dr. Lina Piripiri found that fewer than half had taken a course in school that included sex education.<sup>80</sup> When RDF-Base asked various questions concerning Congolese law and sexuality rights, it found a lack

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<sup>76</sup> United Nations Population Fund Proposed Projects and Programmes: Recommendation by the Executive Director: Assistance to the Government of the Democratic Republic of the Congo, U.N. Population Fund, 1st Sess., Provisional Agenda Item 10, at 6–10, U.N. Doc. DP/FPA/COD/2 (2001) [hereinafter UNDP Proposal].

<sup>77</sup> RDF-Base, *supra* note 39, at 25–26. Of the twenty-three children who had spoken about reproductive issues in the house, seven girls had spoken to their mothers, eight girls had spoken to an aunt or other close female relative, and eight boys had spoken with their fathers. *Id.* at 25. There was no cross-gender discussion. *Id.*

<sup>78</sup> *Id.* at 24. Twenty-four had heard about reproductive issues at school, twenty-one through the media, fourteen at home, thirty-four among friends, fifteen from older members of their community, nine "in the street," and three had never discussed it before.

<sup>79</sup> *Id.* at 27.

<sup>80</sup> Piripiri, *supra* note 55, at 83, 85 tbl.10.



of basic knowledge. For example, almost 60% of the respondents indicated that sexuality was not a right; of those who believed it was a right, almost half believed it was reserved for those who were married or were adults.<sup>81</sup> Nonetheless, the right to reproductive autonomy is guaranteed by international agreements that establish the rights of privacy and of planning a family, to which the Congo is a signatory.<sup>82</sup>

Encouraging more discussion can be accomplished through various public education campaigns, as well as through courses on sex education offered in schools. Such a course, however, cannot simply be a recitation of technical details; it must also educate youth as to the right to say no and other "life skills."<sup>83</sup> There are various small sex education projects funded by international donors in the Congo, but they are inadequate given the widespread need.

At the practical level, adolescents clearly need more and better education on reproductive health—a task which should be undertaken by schools, churches, and nongovernmental organizations. Again, lest U.S. residents pat themselves on the back, American adolescents are not particularly well informed either:

A recent study of teenagers between ages twelve and sixteen found a striking lack of knowledge about sexuality. (For example, almost three-quarters of them believed that letting semen drip out of the vagina after intercourse prevents pregnancy. Almost one-quarter believed that a girl does not need birth control if she only has occasional intercourse. Seventy percent did not know that douching is not a contraceptive method.)<sup>84</sup>

In addition, during the past decade, there has been increasing support for abstinence-only sexual education programs in U.S. schools.<sup>85</sup>

<sup>81</sup> RDF-Base, *supra* note at 39, 42–43.

<sup>82</sup> See STATE OF DENIAL, *supra* note 36, at 43–47. The exact contours of these rights are debatable. Congo ratified the Convention on the Elimination of All Forms of Discrimination Against Women on October 6, 1985, Law No. 85-040 and the Convention on the Rights of the Child. See RDF-Base, *supra* note 39, at 4.

<sup>83</sup> See Piripiri, *supra* note 55, at 178.

<sup>84</sup> IRVINE, *supra* note 10, at 5 (footnotes omitted).

<sup>85</sup> *Id.* at 190. For example, the Adolescent Family Life Act, enacted in 1996, provided \$50 million per year for five years to states for abstinence-only educational programs. *Id.* On the other hand, as is typical with public attitudes towards issues involved in the reproduction cultural wars, a large majority would like to expand the content of sex education programs beyond abstinence-only. *Id.* at 193.

Once again, a strong minority (less than 20% of the population) have been able to promote its perspective—in this case, abstinence-only education. See Heather Boonstra, *Issues & Implications: Legislators Craft Alternative Vision of Sex Education to Counter Abstinence-Only Drive*, GUTTMACHER REP., May 2002, at 1, available at <http://www.guttmacher.org/journals/toc/gr0502toc.html>.

Nonetheless, American adolescents are more likely to have access to, and to use, modern birth control methods. In 2001, almost 60% of sexually active teenagers claimed they used a condom in their most recent sexual encounter. See HENRY J. KAISER FAMILY FOUND., NATIONAL

Reproductive health education in schools has been shown to be effective in increasing knowledge and, in the short term, in affecting behaviors. The educators offering the courses must, however, be sensitive to adolescents' needs without letting their own judgments influence the information they provide.<sup>86</sup> The program content must also respond to adolescents' actual situations. In Zimbabwe, for example, the government mandates that schools and health care professionals teach abstinence, rather than teaching adolescents about safe-sex practices.<sup>87</sup> Consequently, adolescents surveyed indicated that they did not know much about contraception or sexually transmitted diseases<sup>88</sup> even though 40% of adolescents have had at least one child by the age of nineteen.<sup>89</sup>

In Africa, however, there are additional problems beyond the failure of sex education in schools. Access to education itself is critical; higher educational achievement is linked with lower fertility levels. Indeed, internationally, a higher literacy rate and higher levels of education correlate with lower fertility rates; throughout the world, women who are better educated have fewer children than women with less education, marry at an older age, and are better informed about contraception.<sup>90</sup>

Studies of fertility in the Congo have found that women with only a primary school education have a higher fertility rate than women with a secondary school education.<sup>91</sup> In her study of 1200 Congolese girls, Piripiri concluded that girls who were no longer in school, overwhelmingly because their families could no longer afford school fees, were almost four times more likely to become pregnant than

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SURVEY OF ADOLESCENTS AND YOUNG ADULTS: SEXUAL HEALTH KNOWLEDGE, ATTITUDES AND EXPERIENCES 29 (May 2003), available at <http://www.kff.org/youth/hivstds/3218-index.cfm>.

<sup>86</sup> Piripiri points out that educators may have judgmental attitudes that would impede their effectiveness. Piripiri, *supra* note 55, at 182.

<sup>87</sup> STATE OF DENIAL, *supra* note 36, at 56.

<sup>88</sup> *Id.*

<sup>89</sup> *Id.* at 19. In a fascinating indication of the underreporting of sexual experiences, only 30% of female adolescents between the ages of 15–19 admitted in a national survey to having had sexual intercourse at least once. *Id.* (the report itself does not comment on the disparity). Among adolescents interviewed for the *State of Denial* report, 85% of both boys and girls reported that they had had sexual intercourse by the age of sixteen. *Id.* at 74 n.28.

<sup>90</sup> Engendering Development Through Gender Equality in Rights, Resources, and Voice, WORLD BANK POLICY RESEARCH REPORT (World Bank), 2001, at 82–83. Increasing the education level of the average woman by one year results in a decrease in the fertility rate of between 0.23–0.32 births per woman. *Id.* at 83. Lower fertility rates are also correlated with women's status within a marriage. *Id.*

<sup>91</sup> DAVID SHAPIRO & B. OLEKO TAMBASHE, FERTILITY IN THE DEMOCRATIC REPUBLIC OF THE CONGO (July 2001) (working paper on file with authors).

girls who stayed in school.<sup>92</sup> In the Congo, however, education is expensive and not universal. Fewer than one-fifth of all children are enrolled in secondary school.<sup>93</sup> When families are unable to afford to send all of their children to school, they choose to send boys rather than girls, as reflected in the differential school enrollment rate between boys and girls and the almost double dropout rate for girls. The adult illiteracy rate is approximately 44% for women, but only 19% for men.<sup>94</sup>

Simply offering sex education in the schools will not reach the requisite population. Reproductive health is intertwined with literacy, so it is important to develop an approach that focuses on increasing literacy and providing information regardless of educational level. Promoting universal access to education at the primary school level, using churches to disseminate materials, making reproductive health information available in birthing centers, using older women in the community and peer-to-peer counseling,<sup>95</sup> and providing literacy programs to adults illustrate the types of creative programs necessary to teach about better reproductive health.<sup>96</sup>

### B. Culture

As discussed above, most of the barriers to using contraceptives are cultural and educational: women and men fear sterility as a result of contraceptive use, they do not know about the different kinds of contraceptives, they are worried that their partners will desert them if they use contraceptives, and they live in a strongly pro-natalist society where the worth of both men and women is measured by the number of children they have. Virtually all Congolese women defer to their husbands on decisions as to whether to use contraceptives at all, and then as to what type to choose. Given that many clinics require that women obtain their husbands' or boyfriends' permission before being allowed to purchase contraceptives, not only must the laws be changed so that women can make their own reproductive decisions, but so too must cultural norms that support women's obedience to their partner's choices.

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<sup>92</sup> Piripiri, *supra* note 55, at 84, 85 tbl.10 (describing lack of money as a central reason for abandoning schooling); *id.* at 165 ("The girls who were not in school were almost four times as likely to become pregnant.").

<sup>93</sup> *UNDP Human Development Report*, *supra* note 61.

<sup>94</sup> *Enquete Nationale Sur la Situation des Enfants et Des Femmes, MICS2/2001*, Vol. II, (July 2002) at 83 [hereinafter Congo Report].

<sup>95</sup> As another example of the type of innovative publicity that is needed, see IRVINE, *supra* note 10, at 187-97, which suggests the utility of the 1960s consciousness-raising groups.

<sup>96</sup> Naomi Cahn visited a center for street children that had little artwork except for a poster on avoiding pregnancy.

Culturally, women are second-class citizens in the Congo.<sup>97</sup> A girl is not considered a woman until she has become a mother; Congolese refer to each other as “Mama Karinne” rather than using titles based on marriage or other status. In the Congo, as in many other African cultures, norms dictate that women satisfy men’s desires.<sup>98</sup> The median number of children for each woman between the ages of 45–49 is 7.3.<sup>99</sup> Informal and formal polygamy are common, and conservative estimates are that 80% of husbands are not faithful to their wives.<sup>100</sup>

In the interim, men must be educated as to the need for birth spacing. One of the concerns expressed by women about the use of CycleBeads, which are necklaces that allow women to determine when their most fertile days are so as to avoid intercourse on those days,<sup>101</sup> is that their men will find other women willing to have intercourse at a time when they are also most fertile.

Governmental entities and nongovernmental organizations can change Congolese culture through different mechanisms. First, contraceptives need to be cheap (or free) and available. Second, church groups—for this is an extremely religious country—could provide contraceptives and information, so there need to be adolescent centers associated with these churches. Many of the churches are amenable to providing family planning information. For example, one of the large Protestant churches in Kinshasa has a youth center that already provides limited information. Third, popular culture, including music and street theater, is extremely persuasive in influencing attitudes. For example, the Congo is one of the major epicenters in sub-Saharan Africa’s popular music,<sup>102</sup> where various pop stars have already used their voices for other issues. Moreover, street theater is an innovative method for reaching into different communities.

The possibility of effecting change in reproductive behavior through the use of popular culture is illustrated in neighboring Uganda, where HIV prevalence has decreased dramatically, from approximately 15% in 1986 to 5% in 2000. This decrease is due to a series of factors unrelated to the law that has resulted in a significant

<sup>97</sup> HUMAN RIGHTS WATCH, *THE WAR WITHIN THE WAR: SEXUAL VIOLENCE AGAINST WOMEN AND GIRLS IN EASTERN CONGO* (June 2002), available at <http://www.hrw.org/reports/2002/drc/Congo0602-03.htm>.

<sup>98</sup> See PIRIPIRI & MUANDA, *supra* note 52.

<sup>99</sup> Congo Report, *supra* note 94, at 55.

<sup>100</sup> The Human Rights Watch report summarizes the situation as follows: “extramarital sex for husbands (but not wives) is tolerated.” See HUMAN RIGHTS WATCH, *supra* note 97.

<sup>101</sup> For discussion of the CycleBead method, see Marcos Arevelo et al., *Efficacy of a New Family Planning Method: The Standard Days Method*, 65 *CONTRACEPTION* 333 (2002). The Arevelo study reports that when couples can change their sexual behavior, the method is highly effective.

<sup>102</sup> Cf. *Rumba in the Jungle*, *ECONOMIST*, Dec. 20, 2003 (describing the importance of Congolese music to the war-ravaged citizens of the DRC).

change in sexual behavior. While the story of Uganda's HIV-AIDS success cannot be translated directly into the Congo, Uganda's experience does provide some suggestions and guidelines for effective campaigns.

Studies of Uganda have identified several different elements as contributing to the overall success. First, the president personally led strong efforts to reduce the HIV infection rate by providing high levels of political support throughout the government. Second, Uganda used grassroots activities to promote AIDS awareness, including training teachers on how to incorporate HIV education into their curricula and organizing religious leaders on how to handle HIV-related issues in education and counseling. The activities also emphasized the inclusion of women and youths in anti-AIDS efforts.<sup>103</sup> In addition, Uganda developed the first confidential voluntary counseling and testing program in Africa.<sup>104</sup> Third, health programs such as condom promotion and projects that focus on preventing sexually transmitted diseases have also been important.<sup>105</sup> Overall, Uganda's success appears to rest on the personalization of the risk of HIV and the aim to make people understand that their behaviors put them at risk for acquiring AIDS.<sup>106</sup> The programs emphasized the "ABC" approach: abstinence, be faithful, and condom use. This AIDS prevention strategy resulted in a decrease in the number of sexual partnerships.<sup>107</sup>

Understanding that behavior may result in pregnancy, as is the case in the Congo, is obviously different from understanding that the same behavior will result in a fatal disease, as was the case in Uganda. Nonetheless, using small, personal networks to provide education as to the risks and implications of pregnancy, as well as to prevent it, will provide a basis for informed decision making and behavioral change. Cultural tolerance of multiple sexual partners appears to have been radically affected in Uganda; similarly, cultural taboos on the use of contraceptives have also been transformed. This same change must occur in the Congo as well.

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<sup>103</sup> U.S. AGENCY FOR INT'L DEV., WHAT HAPPENED IN UGANDA?: DECLINING HIV PREVALENCE, BEHAVIOR CHANGE, AND THE NATIONAL RESPONSE 5 (Janice A. Hogle, ed.) (2002), available at [http://www.usaid.gov/our\\_work/global\\_health/aids/Countries/africa/uganda\\_report.pdf](http://www.usaid.gov/our_work/global_health/aids/Countries/africa/uganda_report.pdf). In fact, a statute requires that women constitute one-third of the Parliament. Moreover, youth are able to elect representatives.

<sup>104</sup> *Id.* at 7.

<sup>105</sup> *Id.* at 8. Condom use for men who reported a nonregular sexual partner was 59%, and for women it was 38% in 2000.

<sup>106</sup> *Id.* at 10.

<sup>107</sup> *Id.* at 9, 10; see Edward C. Green & Wilfred Mlay, Editorial, *Let Africans Decide How To Fight AIDS*, WASH. POST., Nov. 29, 2003, at A23. As they point out, condom use is most effective among high-risk populations; in Uganda, the focus was on "zero grazing" (abstinence or be faithful) because the majority of the population that did not fall into the high-risk category.

### C. Access to Contraceptives

The supply of contraceptives in the Congo is limited. For example, PSI is the only licensed importer of Depo-Provera and a few other contraceptives.<sup>108</sup> The U.N. Family Planning Fund distributes contraceptives through state-run hospitals and maternity centers, but they have experienced problems with its products being diverted and sold on the black market. Indeed, the general problems of corruption that characterize other aspects of the country appear in reproductive health issues as well. Condoms sold on the street, for example, have often been imported illegally and have not been tested for effectiveness.<sup>109</sup>

In the Congo, much of the focus is on the social marketing of contraceptives. Social marketing involves donor-funded programs with social goals, like reducing teenage pregnancy, that make products affordable and available to specific populations.<sup>110</sup> The sale of reproductive materials through social marketing may be even more effective than providing such materials for free.<sup>111</sup> In the Congo, PSI, the largest family planning nongovernmental organization in the country, popularized "Prudence," a brand of condoms.<sup>112</sup> It is now undertaking a program to popularize Confiance-branded oral and injectable contraceptives for women. Although it has used the name in other countries, PSI is developing a marketing plan for "Confiance" that is targeted to the Congolese population. In focus groups established to test the Confiance brand, PSI found that the concept of *confiance* ("confidence" in English) has positive connotations because it is connected with the idea of confidence in oneself, one's partner, and in the future. Because of the many fears associated with contraceptives, such as sterility, use of the term *confiance* is designed to promote confidence both in the product and any associated services by the provider. The contraceptives are packaged in attractive blue containers and include instructions in five of the most common lan-

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<sup>108</sup> Interview with Sean Mayberry, *supra* note 59.

<sup>109</sup> *Id.* The clinics that do sell contraceptives often experience stock depletion, so women cannot expect consistent supplies. *Id.*

<sup>110</sup> See FRANCOISE ARMAND, COMMERCIAL MARKET STRATEGIES, USAID, SOCIAL MARKETING MODELS FOR PRODUCT-BASED REPRODUCTIVE HEALTH PROGRAMS: A COMPARATIVE ANALYSIS 9 (2003), available at [http://www.cmsproject.com/resources/PDF/CMS\\_SocMktgModels.pdf](http://www.cmsproject.com/resources/PDF/CMS_SocMktgModels.pdf).

<sup>111</sup> One study in Cameroon found that 90% of youth who had purchased socially marketed condoms used them, while only 50% of those who had received free condoms used them. *Id.*

<sup>112</sup> See Population Servs. Int'l, *Congo-Kinshasa*, available at [http://www.psi.org/where\\_we\\_work/congo\\_kinshasa.html](http://www.psi.org/where_we_work/congo_kinshasa.html). In Uganda, "Protector" is the name of the socially marketed condom brand. In order to increase sales, the nonprofit community used the same techniques of commercial marketers, using consumer opinions as the basis for its marketing campaigns. Ugandans believed that Protectors were used by happy, responsible people, so advertisements used that image.

guages in the country. To market Confiance, PSI has trained pharmacists and clinic workers at selected sites. Because there are so few health care providers in the Congo, and because health care is virtually unaffordable, those women who do receive contraceptives do so through a pharmacy. Pharmacy employees are thus critical to the successful distribution of contraceptives. PSI has also provided training to clinicians at both the local university and art school. Furthermore, they have provided training to one of the largest religious youth centers, in an effort to target teenagers.<sup>113</sup> In the past, PSI has used a variety of mechanisms to publicize its contraceptives, ranging from radio and television programs to puppetry, peer education, and information dissemination at work and in communities.

Yet even this ambitious program for social marketing of contraceptives presents some problems that reflect the surrounding social and economic context. First, as discussed earlier, the illiteracy rate among women is approximately 50%, and the instructions for contraceptive use are written. In other countries, PSI has used pamphlets with pictures to illustrate how to take contraceptive pills on the right days. Thus, should this become necessary in the Congo, PSI is prepared to do so.

Second, while the injectable contraceptives can be purchased through a pharmacy, they must be administered either at a clinic or by a community health worker. This requires women to undertake an additional step and expend additional money. Third, clinics continue to interpret the Family Code as requiring a husband's consent in order for his wife to receive contraceptives.<sup>114</sup> Additionally, while large trainings reach more people, they have not proven to be as effective as on-site training.<sup>115</sup> Nonetheless, on-site training proceeds more slowly because fewer people can be trained at once. Finally, social marketing depends on effective distribution. There are few centers outside of Kinshasa that offer reproductive health services to youth, and less than five in Kinshasa itself.<sup>116</sup> The country needs more centers that are youth friendly.<sup>117</sup>

#### D. Law

While education, changes in culture, and improved access to contraceptives will improve reproductive health, advocates must change the laws and culture that sustain both women's second-class status in

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<sup>113</sup> Interview with Sean Mayberry, *supra* note 59.

<sup>114</sup> See *infra* note 129 and accompanying text.

<sup>115</sup> See UNDP Proposal, *supra* note 76, at 5 (describing the need for on-site experts).

<sup>116</sup> JSI ASSESSMENT, *supra* note 54, at 11.

<sup>117</sup> *Id.* at 17 (suggesting more centers and other youth-friendly services that can be offered in a confidential and unbiased manner).

Congolese society and the importance of large families. Women's inequality in the Congo is enshrined in various laws. Girls can get married at age fifteen without parental permission, although boys must wait until eighteen.<sup>118</sup> A man and his family are required to pay a dowry for his bride.<sup>119</sup> The Family Code explicitly designates the husband as the head of the Congolese family, and requires the wife to defer to her husband's decisions (unless she sues him).<sup>120</sup> The Family Code requires that a woman obtain her husband's permission before undertaking any legal act,<sup>121</sup> and warns, in the same provision establishing the incapacity of minors and those who are mentally incompetent, that wives' capacities may be limited in accordance with the law.<sup>122</sup> Only in 2002 was the Labor Code changed to allow a wife to work without her husband's permission. A woman must live with her husband and follow him where he thinks it appropriate to reside.<sup>123</sup> If there is a disagreement between the mother and the father concerning child rearing, the father's decision controls.<sup>124</sup> These laws on women's status provide the basis for the requirement that a woman obtain her husband's permission prior to acquiring contraceptives.<sup>125</sup>

In addition to codifying inequality in the family, the law is also quite punitive concerning the use of contraceptives. The penal code punishes anyone who exposes or distributes contraceptives with the object of selling them; punishment can be imprisonment for a time period between eight days and one year, coupled with a monetary fine.<sup>126</sup> Interestingly, there is no punishment for use or distribution of contraceptives without charge. Although there is no statute or regulation that explicitly prevents a woman from acquiring contraceptives, the patchwork of laws that literally enshrine male power, together with deference to custom, have been interpreted as requiring spousal permission before health clinics or pharmacies can dispense contraceptives.<sup>127</sup> One clinic is embroiled in a dispute with a man

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<sup>118</sup> See C.FAM. art. 352 (Dem. Rep. of Congo).

<sup>119</sup> See C.FAM. art. 361. The dowry can be symbolic, but at least something must be exchanged before the marriage can be celebrated. *Id.*

<sup>120</sup> See C.FAM. art. 444 ("Le mari est le chef du ménage. Il doit protection a sa femme; la femme doit obeissance a son mari.").

<sup>121</sup> See C.FAM. art. 448. The Labor Code was recently amended to allow women to work without their husbands' written authorization.

<sup>122</sup> See C.FAM. art. 215.

<sup>123</sup> See C.FAM. art. 454. If he fixes the residence in an abusive manner or contrary to what has been agreed upon, then she can sue him in court. *Id.* art. 455.

<sup>124</sup> See C.FAM. art. 317.

<sup>125</sup> See JSI ASSESSMENT, *supra* note 54, at 6 ("Women need a husband's permission to receive contraceptives."). Notwithstanding repeated conversations on the topic, we have seen nothing in writing.

<sup>126</sup> See CODE PÉNAL [C. PÉN] art. 178 (1933) (Congo).

<sup>127</sup> See *infra* note 129 and accompanying text.



whose wife was given Depo-Provera without his permission, even though the clinic retained the permission slip on which she indicated that she was unmarried.

For those under the age of eighteen, there are no provisions directly regulating their right to information or counseling, although the Family Code does recognize their general incapacity.<sup>128</sup> As a practical matter, children need their parents' consent in order to obtain contraceptives. The national reproductive health program requires that young women be accompanied by a "responsible" person, such as a fiancé or parent, before they can receive contraceptives, although, even then, many nurses are reluctant to distribute contraceptives to women who have never been pregnant.<sup>129</sup> Many of these laws and practices violate the international human rights documents that the Congo has signed.<sup>130</sup>

An approach to legal change of emphasizing a "right to choose," which focuses on a right to pregnancy termination rather than the ability—in all of its meanings—to say "no" to sex,<sup>131</sup> will not result in a meaningful transformation of the law. The single-minded focus on abortion access, significant as the right to an abortion remains to women's status, frames the issues too narrowly.<sup>132</sup> In her much larger survey of Kinshasan adolescents, Piripiri found that girls reported that 10.8% of their sexual encounters were coerced.<sup>133</sup> Almost 75% of the girls in her study who became pregnant reported feeling fear, panic, and/or embarrassment, while 13% felt happy, and 12% felt confused.<sup>134</sup> In 1999, PSI conducted a survey which found that 35% of teenagers between the ages of fifteen and nineteen had accepted gifts or money in exchange for sex.<sup>135</sup> Defining adolescent reproductive issues more generally as a health issue, rather than a moral prob-

<sup>128</sup> See C.FAM. art. 215. In the U.S., for many purposes, minors are similarly incapable. See, e.g., RESTATEMENT (SECOND) OF CONTRACTS § 14 (2003).

<sup>129</sup> See JSI ASSESSMENT, *supra* note 54, at 10.

<sup>130</sup> For a discussion of the appropriate international human rights framework, including applicable treaties and conventions, such as the Convention on the Elimination of All Forms of Discrimination Against Women ("CEDAW"), see STATE OF DENIAL, *supra* note 36; FAMILY LAW IN THE WORLD COMMUNITY: CASES, MATERIALS, AND PROBLEMS IN COMPARATIVE AND INTERNATIONAL FAMILY LAW (D. Marianne Blair & Merle H. Weiner eds., 2003).

<sup>131</sup> The right to say "no" implies that girls will not be punished for saying "yes." Regarding adolescents in the United States, Deborah Tolman suggests, "[u]ntil girls can say 'yes' and not be punished or suffer negative consequences . . . girls will continue to have their 'no' mistaken for 'token resistance.'" DEBORAH L. TOLMAN, DILEMMAS OF DESIRE: TEENAGE GIRLS TALK ABOUT SEXUALITY 204 (2002).

<sup>132</sup> Given the Bush administration's punitive actions towards international family planning that has any mention of abortion, a focus on abortion risks forgoing funds for other, perhaps even more necessary, family planning needs.

<sup>133</sup> Piripiri, *supra* note 55, at 157.

<sup>134</sup> *Id.* at 82 tbl.9.

<sup>135</sup> See Interview with Sean Mayberry, *supra* note 59.

lem, provides a potentially effective strategy<sup>136</sup> because it defuses the “us v. them” mentality and focuses instead on why these issues are so critical for adolescents.<sup>137</sup> For example, one of the existing frameworks for reproductive advocacy efforts in the Congo focuses on the high maternal mortality rate, which is one of the worst in the world, at 1,837 per 100,000 live births. Providing information about contraception in order to decrease the number of life-threatening pregnancies places the emphasis on maternal health, rather than birth control per se.

## CONCLUSION

In recent years, through their efforts to focus attention on the partial birth abortion strategy, pro-lifers have placed pro-choicers on the defensive. To turn the tables, putting pro-lifers on the defensive, we need to listen to the real (not idealized) needs and goals of women and girls in places like the Congo (as well as in the United States).<sup>138</sup> They tell stories of not being able to attend school, not receiving information about contraceptives, not having access to health care facilities for prenatal care or safe abortions, and being raped by former combatants.<sup>139</sup>

A focus on the rhetoric of reproductive rights in the United States obscures issues that are important both at home and internationally. In the United States, our focus on abortion rights fundamentally relates to women’s rights and we can assume that decent health care is available.<sup>140</sup> Indeed, Rickie Solinger argues that using “choice rhetoric” for abortion undercuts women’s rights because it transforms a basic human right into a consumer privilege.<sup>141</sup> That is, the right to

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<sup>136</sup> See Piripiri, *supra* note 55, at 179.

<sup>137</sup> The popular approach to an issue can influence its acceptance. For example, PSI recently conducted training in the Congo on adult reproductive issues and, instead of emphasizing the use of birth control to prevent having additional children, emphasized how spacing the births of children improves both infant and maternal survival rates. Joan Williams has written of the need to find common ground in the abortion wars and health needs can provide a basis for agreement.

<sup>138</sup> NARAL Pro-Choice Am. Found. Proactive Pol’y Inst., *Fact Sheets and Publications on Proactive Issues* (July 30, 2003), available at <http://www.naral.org/ppi/pubs/index.cfm>.

<sup>139</sup> See, e.g., SAVE THE CHILDREN, CONFLICT PROTECTION SCORECARD: A POWERFUL TOOL TO PREVENT HUMAN SUFFERING (2003), at 18–19, available at <http://www.savethechildren.org/publications/Scorecard.pdf>; HUMAN RIGHTS WATCH, *supra* note 97; JSI ASSESSMENT, *supra* note 54, at 9–10.

<sup>140</sup> In 1950, even in the alleged era of “back alley butchers,” the actual abortion mortality rate was estimated to be 316 women for every million abortions performed because of the availability of antibiotics. See SOLINGER, *supra* note 11, at 51. Solinger believes that a focus on the rhetoric of the back alley butcher and the abortion mortality rate obscures the real issue: women’s rights. *Id.* at 62–63.

<sup>141</sup> *Id.* at 223.

choose becomes something akin to selecting a new pair of shoes, rather than the basic fundamental right for a woman to control her own body and to make important health decisions. The vocal minority that has been successful in restricting abortion rights, albeit only for those outside of the mainstream of electoral politics, has also succeeded in shaping policy in a way that forecloses genuine debate over critical reproductive health issues. The empirical data, often gathered by public health groups, showing a connection between women's status, literacy, and abortion rights, showing the number of deaths from unsafe abortions in countries with highly restrictive laws, or showing the high maternal mortality rates in countries where contraceptives are virtually unavailable, also show the means to reframe the abortion debate.

In countries like the Congo, the right to an abortion must be framed as both a woman's right in the context of her capability to achieve and function,<sup>142</sup> as a health care issue that is critical to women's lives, and as an educational issue that concerns not just knowledge about contraceptives but about the impact of having babies too early and too often. Even if we are unsuccessful in reframing reproductive health issues, we can still focus on developing concrete strategies to deal with the health risks and actual needs of adolescents, thereby shifting the focus from the morality of sexual activity to solve the problem. Adolescent girls have already internalized their own feelings of immorality and need help deciding how to have sex on their own terms, while adolescent boys have already learned the importance of being a man. Their practical problems include lack of basic knowledge about contraceptives, access to contraceptives, and pregnancy risk, in addition to the larger cultural issues involving the responsibilities of sexuality, and responsible sex.

The reproductive health needs certainly include access to safe abortion, and education about and access to contraceptives, but they extend across a broad spectrum of other issues, including care for rape survivors and their children, rehabilitation of prostitutes, and safe motherhood. *Roe v. Wade*, which protects abortion rights, also protects a woman's privacy and reproductive autonomy.<sup>143</sup> Placing *Roe* in its larger contexts, of reproductive health nationally and internationally, illustrates the promise and limits of focusing on the right

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<sup>142</sup> As Cass Sunstein explains, restrictions on abortion place women's sexuality and reproductive capacities outside of their control, under the control of others. See Cass R. Sunstein, *Gender, Caste, and Law*, in *WOMEN, CULTURE, AND DEVELOPMENT*, *supra* note 35, at 332, 358.

<sup>143</sup> See *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) (stating that the issues present in *Roe* are "choices central to personal dignity and autonomy"). These rights are attenuated for adolescents, but even they have the right to seek abortions against their parents' wishes through judicial bypass procedures.

to abortion. When women have literacy, voice, and resources, they protect the right to abortion.<sup>144</sup>

How we talk about reproductive issues profoundly affects reproductive politics.<sup>145</sup> Framing the issues in legal, educational, and health terms allows policy makers to focus not just on changing discriminatory laws, but on developing practices that respond to the health care and educational needs of girls and women. The rhetoric must shift from a morality-based discourse to a health care focus that uses empirical data to frame the issues. Finding the consensus on reproductive health issues, looking at attitudes towards abortion and at issues beyond abortion, protects the lives of women and girls. The pro-reproductive rights majority can take control over the terms of the abortion debate if it uses the actual data on the significance of the right to an abortion and places this in the larger context of women's and girls' reproductive health. With this control and this power, we can provide the help that girls and women so desperately need to realize their human potential. Ultimately, we export our internal debates over *Roe* at the unbearable expense of limiting women's and girls' control over their reproductive lives and high maternal mortality rates.

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<sup>144</sup> Cf. SEN, *supra* note 35 (pointing out that democracies do not have famines; when the political process works, countries are unlikely to experience massive starvation).

<sup>145</sup> See, e.g., IRVINE, *supra* note 10, at 10 ("It matters how a social movement talks. In part, words, phrases, narratives and symbols comprise the expressive elements of discursive politics."); SOLINGER, *supra* note 11.