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Worth More Than Her Womb

A Cross-Country Analysis of Reproductive Rights

By

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of the requirements for
Honors in the Department of Sociology

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Abstract

A woman's empowerment derives from education, economic independence and political and social autonomy. Reproductive health is an extremely relevant and important concept for many reasons. Reproductive rights include basic elements; the ability to reproduce and to regulate fertility; proper prenatal care and safe childbirth; and ultimately optimal maternal and infant health outcomes. Gender inequality has become manifested in societies throughout the world as result of the lack of control over a woman's respective fertility. While a woman's unique biological ability to reproduce should be privileged and respected, it instead entails both additional responsibilities and even negative consequences for her progression in society. Procreation should be treated and upheld as a basic human right. Through the quantitative analysis of 215 countries and relevant indicators and the case-study comparison of reproductive health and rights in Uganda, Afghanistan, the United States and Sweden, I will argue that upholding reproductive rights is critical to a woman's empowerment. I will also argue that a woman's access to both proper education and healthcare is essential to her ability to maintain control over her life and develop to her full potential as an individual and as a participating member of society. Clear trends concerning the effects of reproductive control are identified which offers insight to the importance and relation between control of one's body and women's progression and status in society.

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Introduction

Reproductive health is an extremely relevant and important concept for many reasons. Gender inequality has become manifested in societies throughout the world as result of the lack of control over a woman's respective fertility. A woman's biological ability to reproduce entails both additional responsibilities and even negative consequences for her progression in society. While the introduction of birth control devices has eased the biological and social restrictions that effect women, these contraceptive methods are not attainable for most women throughout the world. A woman's ability to reproduce permeates each sector of her life, threatens her autonomy and her opportunity in both private and public spheres.

With the recent news of the world's population reaching seven billion, there has been a surge of attention to the risks that women face throughout the world because of childbirth. CNN's recent article "In giving life, women face deadly risks" (Park 2011) addresses this very pertinent worldwide issue. "There's a clear connection between countries that have a high fertility rate, where women are having six to seven children, and the maternal mortality rates," said Dr. Dorothy Shaw, a clinical professor in obstetrics and gynecology at the University of British Columbia in Canada. Pregnancy and childbirth complications are among the leading causes of death among women living in developing countries, according to the World Health Organization. Park discusses how one out of seven women will face a complication. She asserts that these figures are true across the globe (Park 2011). Each pregnancy that a woman carries intensifies her health risks, especially when she lacks access to healthcare. This article addresses the issues that arise from childbirth, including access and inability to pay for healthcare, the

physical harm to a woman's body and women's lack of access to contraception. This article, one of many recent ones, has finally given the issue of reproductive rights the public recognition that it needs.

In 1968, reproductive rights began to develop as a subset of human rights at the United Nations International Conference on Human Rights. The Proclamation of Tehran was produced as the first international document to recognize reproductive rights. "The protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and the spacing of their children" (United Nations, 1968). This entails that individuals and couples have the right to decide freely and responsibly the number, spacing and timing of their children. It also means that they will be provided with the appropriate information and means to do so in an effort to fulfill their rights of sexual and reproductive health (WHO, 2011). Reproductive rights have the capacity to include access to education, quality reproductive healthcare and the right to a safe or legal abortion, in order for a woman to be able to make informed and autonomous decisions about her reproductive health. Unfortunately, this proclamation still remains legally non-binding.

With the rapid population growth of our world, reproductive rights has become an increasingly urgent issue. This can be seen both domestically and abroad. In the United States, the education system, environment and economy are all struggling, and in developing countries, these issues are even more drastic. The UN has set Millennium Development goals targeted towards the fields of food security, environment, health, education and the empowerment of women. The aim is to achieve these goals by 2015,

yet Jane Dreaper, a health correspondent for BBC News, wrote in September of 2011 about how the millennium development goals will not be met. “Researchers say just nine of 137 developing countries will achieve ambitious targets to improve the health of women and children” (Dreaper 2011:1). The researchers say that “many aspects of health systems limit the scale-up of child and maternal interventions” and also mention several intervention strategies, including “vaccination, distributing insecticide-treated bed nets, vitamin A supplementation and de-worming” (Dreaper 2011:1). These are seemingly simple solutions that could really go a long way in terms of saving lives.

Collins, Chafetz, Blumberg, Coltrane and Turner (1993) collaborated to produce an integrated theory on gender stratification. Their work shows that gender stratification is determined on the basis of every sociological level of analysis and through every institutional sphere. Their integrated theory shows the causal factors and outcomes of gender stratification. Collins *et al.*, (1993) identify four fundamental causal conditions, which include gender organization of production, gender organization of reproduction, sexual politics and structure of political economy. Gender organization of production stresses the economic position of men and women, while gender organization of reproduction focuses specifically on childbirth, mothering, and the effects on both gender psychodynamics and culture and on women’s economic activities. Theories of sexual politics address erotic relationships and their connection to social power, and how sexual property and exchange enter into political alliances and how sexual violence affects other modes of gender stratification. The fourth condition is the structure of political economy which explains how these conditions flow into the gender theory blocks. Their theory also addresses gender resource mobilization which are the levels of gender control of

strategic resources, including economic, coercive and organizational advantages and disadvantages (Collins *et al.*, 1993: 187). Their research addresses how each of these factors play an important role in gender stratification.

Historically, women have held a subordinate position in our society due to their inability to have control over the capacity to reproduce. Women's status had been established in the home based on ideas, which took hold in the early 19th century. These ideas entailed that men and women were innately different, thus should assume positions in separate spheres.

Women never manage the outward concerns of the family, or conduct a business, or take a part in political life; nor are they, on the other hand, ever compelled to perform the rough labor of the field, or to make any of those laborious exertions, which demand the exertion of physical strength. No families are so poor, as to form an exception to this rule (Tocqueville in DuBois and Dumenil, 2009: 187).

This mentality represents the widespread concept of “true womanhood” which was sustained because of family and childrearing. “They did not consider housewifery and childrearing as work but as an effortless expression of women's feminine natures” (DuBois and Dumenil, 2009: 188). Motherhood is at the very core of this idea of the woman's sphere, which emphasizes “wholly selfless activity built around service to others” (DuBois and Dumenil, 2009: 188). This emphasis on women being mothers threatened their autonomy and opportunity in the workforce. The emergence of the birth control movement in America in the early 1900s stressed a woman's right to have access to contraceptive information and methods so that she could avoid unwanted pregnancy and still enjoy sexual intercourse. The latter indicates a step towards equality among men and women since earlier movements had “regarded sexuality as fundamentally male, and they did not think it was important—or desirable—for women to have greater amounts of

sexual intercourse freed of the threat of pregnancy” (DuBois and Dumenil, 2009: 480).

The US Agency for International Development promoted the use of condoms in developing countries in the mid 1960s. In 1971, the US Agency for International Development also helped to establish an international Planned Parenthood program. Within 15 years, the International Planned Parenthood Federation (IPPF) became the largest U.S. non-governmental provider of family planning services. The organization works to reach out to millions of women and men in developing countries to address sexual and reproductive health issues. Planned Parenthood Global is a more recent organization launched by Planned Parenthood Federation of America. Their recent campaign “Health Has No Borders” (2011) works to empower young leaders to become champions for health and rights in their societies. The introduction of birth control technology to developing countries has not only challenged traditional ideas about women’s sexuality and reproduction, but has become a catalyst for much more progressive action to come. This paper will delve into the impact that women’s reproductive rights have had on women around the world. Particularly, it will focus on how a woman’s access to healthcare is related to her health and the effect this has on her empowerment and progress in society.

Chapter One: Literature Review

Reproductive health is a very broad and complex matter. There are many facets that affect one's reproductive health, including sexually transmitted diseases, sexual violence and circumcision, abortion, pregnancy care, delivery care, marital age, maternal age, access to healthcare, quality of healthcare and education. Representatives from nearly 180 countries convened at the International Conference on Population and Development in 1995 and adopted a Programme of Action which includes a definition of reproductive health.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that when they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law, and the right of access to appropriate health-care services that enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant...it also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases (United Nations, 1995).

The Programme of Action includes both expansion and reform of health services and calls upon non-healthcare related sectors to create a supportive environment for improvements in reproductive health. "Maternal sickness and death may be triggered by pregnancy, but frequently result from cultural, medical, and socioeconomic factors that devalue the status and health of women and girls" (Cook, 1993: 73). While there are indeed many factors that play a role, this thesis will be focusing specifically on maternal education, socioeconomic status, norms, values and laws, and access to healthcare.

Maternal Education

Maternal education is shown to have a direct connection with the survival rate of pregnant women. Approximately one-third of a million women die each year from pregnancy-related conditions. Three-quarters of these deaths are considered avoidable (Karlsen *et al*, 2011). Education is the most basic way to instill a sense of social and behavioral change into individuals and society. Teaching males and females about their bodies, their choices, the consequences of sex, family planning and contraception would really make an important contribution to women's health. Instilling this knowledge at a young age would be even more beneficial for preventing unwanted pregnancy and promoting health and empowerment. Bongaarts and Bruce (1995) conducted a study about the effects of education and contraception on women. They argue that most unmet need is associated with women's lack of knowledge, concerns about health, side effects, the behavior required to use contraception and objections from their husbands. If early education and family planning were promoted throughout the world, women and men would be able to decide if and when to have children, and a woman would be less at risk for an unsafe pregnancy and delivery. There is also evidence for long-term impacts of education, which include, "families that are not burdened by excess fertility can and do invest more in nutrition, schooling, and health care of their wanted children. This investment, in turn, can be expected to improve the reproductive health of the next generation, among other benefits" (Tsui, Wasserheit and Haaga, 1997: 85). The impact of education is truly priceless; educating a woman instills empowerment and can literally save her life.

Karlsen *et al.*, (2011) collected data from hospitals in Africa, Asia and Latin America to determine the relationship between maternal education and mortality. They determined that

there is a positive relationship between levels of maternal education and health service use, even in adverse family or socioeconomic situations. Women with no education had over two and a half times the risk and those with between one and six years of education had twice the risk of maternal mortality compared with women with more than 12 years of education, after adjusting for the effects of marital status, maternal age, parity, institutional capacity and levels of state investment in health care (Karlsen *et al.*, 2011)

This study shows just how vital education is for a woman and her future. “Educate a woman, you educate a nation,” said Deputy President, Phumzile Mlambo-Ngcuka at the 4th annual Women’s Parliament Conference in Cape Town, Africa in August 2007, as she spoke out about the importance for girls’ education. The possibilities of education are endless, but first and foremost, women need to know that they are worth more than their womb.

Socioeconomic Factors

By possessing autonomy, an individual is in control over most other factors in her life, and in turn has a sense of opportunity and hope for a positive future. Germaine Greer summarizes the importance of control in her book *The Whole Woman* (1999), “to be pregnant against your will is to see your life swerve out of control. To become a mother without wanting to is to live like a slave or a domestic animal. Like any other adult, a woman would wish to be infertile and fertile when appropriate” (Greer, 1999: 15). Greer is specifically talking about control of one’s biological freedom attained through birth control, but her statement can be related to all realms of a woman’s life. A

woman's ability to make her own living and lead an independent lifestyle depends greatly on her ability to control her own body. Her sexual health, general education, control over her body and a strong sense of herself are also important factors that relate to a woman's autonomy and progress in her society. Gender equity and economic structures are closely linked. Gender equity has been promoted by international development organizations because it is positively associated with lower fertility and better health for women and children as well as with economic development (Barrett, 1995:221). Receiving an education and working to support oneself creates a balance of power and fairness in gender relationships.

Socioeconomic factors, including education, poverty, income, income equality, and occupation are some of the strongest and most consistent predictors of health and mortality. Gender (in)equity, combined with socioeconomic inequality, together form a powerful explanatory framework for variations in women's health (Moss, 2002: 656).

It is clear that a woman's ability to receive an education and gain employment is linked with better maternal health because she is more equipped to seek out the help she needs.

Collins *et al.*, (1993) address how economics plays an important role in gender stratification. The gender organization of production explains the factors that structure gendered work. "It is well known that relative economic power affects many other dimensions of gender stratification. In modern households, the relative income of husbands and wives affects decision power making" (Collins *et al.*, 1993: 189). They specify between different types of labor and how a woman's labor is more likely to be unpaid domestic labor while a man's labor may be paid, thus putting him in a position of power relative to the woman. They also refer to hunter and gathering societies specifying that if women partake in the work, then these societies are "among the most gender

egalitarian societies known” and if men did most of the subsistence work, then these societies are examples of male dominated. “A key condition is the gender segregation of productive labor, as this is what identifies particular kinds of work as ‘men’s’ or ‘women’s’” (Collins *et al.*, 1993:187). Several conditions are identified as affecting productive and reproductive organization. For example, the demographic and technical factors of pregnancy, the time a woman spends child bearing or child rearing and the resulting ramifications. “Even when women take part in the labor market, their careers are disadvantaged if they are more committed to childcare and domestic responsibilities than are men” (Collins *et al.*, 1993: 191). The demographic and environmental conditions are important factors of reproductive labor.

Collins *et al.*, (1993) also notes that higher levels of female income result in greater freedom of movement for women. “Higher female income levels result in greater freedom of movement for women; greater control by women over their own sexuality, fertility, and choices for marriage and divorce; and higher self-esteem and educational and career ambitions” (Collins *et al.*, 1993:208). They observe that this is true cross-culturally. Women who are in control of their income are more likely than men to invest money into their children’s well-being and education, which absolutely allows for social development.

Norms, Values and Laws

Laws and policies indeed have the power to shape the level of reproductive healthcare that is made available throughout the world. Laws have the ability to create and change social structures within a society.

Paternalistic control of women's sexual and reproductive behavior manifests itself in laws and policies. For example, access to voluntary sterilization services in some country is contingent on the number of cesarean sections that a woman has undergone. Laws and policies stereotype and punish women because of their role in reproduction, denying them equal opportunities with men (Cook, 1993: 74).

If laws were to take on a more holistic approach to women's reproductive health, then women would be healthier and much more autonomous. Protective laws are especially lacking in certain countries where there is no legal age of marriage. Girls who are married off at a young age are at a much higher risk of maternal mortality because their bodies are not yet ready to handle the stresses of carrying out a pregnancy. This topic will be discussed further in the results section. Epidemiological data demonstrate life and health risks from pregnancies that come too early, too late, too often, or too close together in a woman's reproductive years (Royston and Armstrong, 1989). Pre-natal and delivery care are also important factors in one's reproductive health. These factors are made available depending on the level of government spending on healthcare and the availability of health-care providers per person. Providing women with a supportive social structure would indeed enable them to make informed decisions about their lives and futures.

Gender ideologies about production and reproduction vary across cultures. In modern America, an increase in paternal childcare and domestic labor can be attributed to material and ideological factors. Higher earnings for a mother entails that the father is more involved in the household. A very important factor is an individual's personal beliefs about what to expect from oneself and his or her significant other.

Women's enhanced bargaining position and willingness to initiate change appear to be precursors to change in the domestic division of labor, but men's motivation to be involved parents can be an independent causal force. Perhaps the most important predictor of shared responsibility for domestic tasks is the willingness

of married couples to accept wives as economic co-providers (Collins *et al.*, 1993: 196).

This makes it clear just how important it is to have a positive impression of oneself and of women in general. It also further proves the importance of early childhood experiences and in instilling positive models of gender social roles, which will indeed shape interactions and future action. In more patriarchal cultures, these positive ideologies about women would be harder to come by, which creates a cycle of un-empowered women, who are made to believe that they are incapable of work outside the home, thus they do not become economic co-providers. Researchers attribute global conceptions of gender interactions and roles to

the socialization into currently prevailing customs, and by learning gender roles in childhood, or the negotiation of gendered spheres and interactions during adulthood. The social roles of the mother and father also provide models for social learning with different degrees and kinds of involvement are thereby shaping the rest of their life world of interactions in a gendered pattern as well (Collins *et al.*, 1993: 197).

Without having the feelings of empowerment, self-efficacy and worth, and ability for the consequent social behaviors, societal change is not foreseeable. Collins *et al.*, (1993) also touch upon the global issue of sexual politics. Women who are pregnant or caring for their children are particularly more vulnerable to violence (Collins *et al.*, 1993:200). The effects of sexual politics depend on a woman's culture. Societies with an exceptionally high birthrate or a distinct segregation of gender spheres and where women specialize in reproductive and domestic labor, tend to be the societies in which men regard women as objects to be protected and controlled. "Within tribal societies, fixed marriage and residence rules determine whether a woman will stay in her home, or move to her husband's village. In the former case, the woman has a better power position because she

is surrounded by her kin; in the latter, her position is especially weak because she is isolated among her husband's relatives" (Collins *et al.*, 1993:200). Sexual alliance politics is the use of sexuality as an item of exchange to make social ties. In a place where there is a strong emphasis on sexual politics, men gain status through controlling and protecting women while women gain status by maintaining her sexual purity. "Since status is acquired as a member of the family rather than as an individual, women (especially the older women with more family authority), as well as men, take an active role in enforcing sexual restrictions on other women (Collins *et al.*, 1993:200). This contributes to the separation of men and women and to the overall degradation of women as capable individuals. Also, in some cultures, arranged marriages determine the social equality of women. This exemplifies how sexual politics impacts different cultures and also, demonstrates the idea of "sexually oriented status ideology" (Collins *et al.*, 1993: 200). This type of ideology creates a divide between men and women and restricts women from partaking in economic productivity. If women were treated with more respect and seen as men's equivalents, their status in the home and in society would be greatly improved.

Access to Healthcare

Too often, a woman's greatest obstacle is her literal distance from a healthcare facility. If she is able to access the facility, she may however, face other barriers. "Lack of facilities with skilled personnel and equipment and supplies to support essential obstetric care, poor attitudes of providers, unavailability and cost of transportation, and the high costs of services are referred to repeatedly as the major obstacles to using services" (Tsui, *et al.*, 1997: 137). Without proper education, financial independence, or

the enforcement of effective laws and policies, a woman very often does not have the resources she needs to obtain the healthcare that she needs. Health services in rural areas have to be improved in order to allow for women's access to proper healthcare. In 1993, the World Health Organization (WHO) estimated that only 37% of births in developing countries take place in a health facility. This means that more than 60% of births—or 55-60 million infants annually—took place either with the help of traditional birth attendants, family members or with no assistance at all (World Health Organization, 1993). A woman's access to proper healthcare depends on different factors, which include, "their geographic location, insurance status or ability to pay, their ease in handling the bureaucratic and authoritarian structure of health care delivery, the presence of traditional or non- bureaucratic providers of care and the extent to which families support women's access to and use of services" (Moss, 2002: 43).

A more nuanced assessment would take into account country variations. Huber and Spitze (1988) developed a basic dynamic to determine the relationship between the demographic conditions and reproductive labor. They emphasize the importance of health technology and environmental factors which contribute to the likeliness of survival. Where these factors result in a high mortality rate, "there is a social demand for a high birth rate, women spend much of their lives pregnant or lactating. Under these conditions there is an additional vicious cycle, since high rates of birth result in high rates of death of women in childbirth, driving up further the overall death rate" (Collins *et al.*, 1993: 191). Birth control technology and other such social arrangements (like baby feeding technology) help to free women of these additional domestic responsibilities, but a woman's ability to take advantage of these options is dependent on her culture and

economic status. If she lives in a family-centered or economically disadvantaged society, she is less apt to use birth control methods. “A high birth rate perpetuates other aspects of the cycle of poverty” (Blumberg 1984: 91).

Another important condition of social organization includes childcare. Historically, the stratification of women by class has meant that wealthier women have been able to free themselves from the burden of childcare by means of a servant, wet nurse, or a nanny. Women who are of lower or middle social classes are not afforded the same luxury and typically end up taking on the role of caretaker. “Comparisons among pre-state societies give evidence that where paternal childcare is relatively higher, the position of women in the society is also higher. Male participation frees women for greater labor force participation, with political and ideological consequences, while relatively higher female position in the society makes men take more responsibility for childcare” (Collins *et al.*, 1993: 196). Their research shows that if men’s involvement in childcare were increased, women would be able to more fully participate in the workforce and achieve a higher position in society and could “affect virtually all subsequent conditions in the model” (Collins *et al.*, 1993:195). An additional important variable is early childhood experiences. If a child grows up with his or her father as the caretaker, he or she will have a more open-minded outlook about gender roles and responsibilities. The fact that male’s potential increase in domestic participation has such a far-reaching impact is very telling of just how unequal gender organization of reproduction is.

Sexual Violence

As discussed in the Norms, Values and Laws section, in some countries, there is a

gendered divide that prevents women from contributing and progressing in society. This divide is often enforced through means of violence and sexual politics. “Male sexual aggressiveness and the tendency to stereotype women as sexual objects is one of the results of a highly competitive structure of sexual politics” (Collins *et al.*, 1993:201). These acts of violence take place throughout the world and in times of peace and war. “In agrarian states dominated by military aristocracies, women of the lower classes or of the enemy are typically regarded as sexual plunder” (Collins *et al.*, 1993:201). Rape and sexual abuse have long been used as a war tactic and a threat to international security. It is referred to as the silent war because these women suffer this physical and psychological devastation on their own and often are fearful to report the abuse because of the political situation in their country. “Violence against women has reached unspeakable proportions. Sexual violence is used as a tactic of war to humiliate, dominate, instill fear in, disperse and/or forcibly relocate civilian members of a community or ethnic group” (UN Security Council, 2008). Gender based violence has a direct impact on a female’s sexual health, autonomy, control over her body and life. It is important to note that there are severe psychological effects, such as “depression, anxiety, and sexual dysfunction” (Tsui *et al.*, 1997: 31). Such gender-based violence is connected to aggression and male dominance over women, who are perceived to be weak. This cultural understanding of men as strong and women as weak, as discussed in the socioeconomic section clearly has a detrimental effect on women’s health, as well as their “full participation in many activities of their daily life” (Tsui *et al.* 1997: 31). This gendered culture of violence is responsible for breeding an environment of fear and tension, which is unhealthy for any woman’s sexual health and life in general.

It is important to note that sexual violence is not only used as a tactic in wartime, but also in relationships and marriages. Domestic violence has extreme social and psychological effects since the perpetrator is not a stranger, but rather someone known or loved by the woman. “Rape can change a woman’s relationship with her partner and her family or have serious consequences for her social or economic status” (Koss, Heise and Russo, 1994: 296). Another issue of domestic violence is that the police and courts in many countries often neglect the reported cases. “In some Islamic countries, there are stringent requirements for corroboration from eyewitnesses to prove sexual violence against women, and women who fail to prove their complaints leave themselves open to accusations of adultery and fornication” (Tsui *et al.*, 1997:31). This represents how certain laws and practices reflect social and cultural norms that condone violence against women, both within and outside the home.

Conclusion

In their research on healthcare policies, Tobin and Whiteford (2002) discuss how it is important to gain a context of global politics, flows of power, wealth and history when dealing with issues of gender. The U.S. government’s role in global reproductive health programs has receded in recent years. In 1984, President Reagan presented the Mexico City policy, better known as the “global gag rule” (Center for Health and Gender Equity, 2010). This rule withdrew funding for nongovernmental organization programs that addressed abortion. “The effect was to effectively undermine international reproductive health policies” (Tobin and Whiteford, 2002:229). In 2001, George W. Bush extended the Mexico City policy to remove funds for NGOs that even discussed

abortion as a reproductive health issue. This policy only further contributes to the dangerous health risks that women face. In February 2011, the House of Representatives passed a measure to end funding for Planned Parenthood. Taxpayers' money is going towards family planning, cancer screening and other reproductive health programs, but under longstanding federal law, none of this money goes towards abortions. Though this legislation passed through the house, it did not pass through the Senate. House Minority Leader Nancy Pelosi (D-California) remarked about the legislation, saying it "is just part of the Republican agenda that is the most comprehensive and radical assault on women's health and reproductive freedom in our lifetime, and that's saying something" (Pelosi, 2011). The fact that the funding for life saving reproductive healthcare is at risk certainly speaks volumes about the societal value placed on reproductive healthcare and the fundamental worth of women throughout the world.

Reproductive health is important at every level of society, in every country, for every individual, no matter his or her gender. There are so many contributing factors and effects of reproductive health. We have gotten to a point where there really is no choice but to start to pay attention and act upon these issues because they truly permeate society and human life at every level. In order to improve the economic, political and social systems in our world, we need to start at the beginning, where human rights first come into existence. This thesis will continue to explore women's reproductive right and health. I will engage in the quantitative analysis of 215 countries and the comparative study of four countries to gain a better understanding of the best determinants of women's reproductive health.

Chapter Two: Methods

In order to gain an understanding of the best measures of reproductive rights and women's health, I performed quantitative analysis of 215 countries and relevant indicators. I obtained the data from World Bank, which is an international financial institution that provides loans to developing countries. They also collect and provide financial, economic, health and human development data from 215 countries (World Bank, 2012). The indicators I chose include adolescent fertility rate, births attended by skilled health-staff contraceptive prevalence, labor participation rate among men and women, life expectancy, literacy rate among female and male youths, maternal mortality ratio, prevalence of HIV among men and women (ages 15-24), pregnant women receiving prenatal care, proportion of seats held by women in parliament, ratio of female to male in primary, secondary and tertiary enrollment and teenage mothers.

The following descriptions of the different indicators of health and female empowerment were drawn from the World Bank (2012). In order to gain an understanding of maternal education, I analyzed several measures. These include "literacy rate" which is the percentage of people ages 15-24 who can understand how to read and write a short, simple statement about their everyday life. "Ratio of female to male primary enrollment" is the ratio of female to male gross enrollment rates in primary school. "Ratio of female to male secondary enrollment" and "ratio of female to male tertiary enrollment" is the ratio of female to male gross enrollment in secondary and tertiary school respectively. Contraceptive prevalence and adolescent fertility rate are also relevant maternal education variables. These two factors will be discussed below.

Several variables were included in order to examine the impact of socioeconomic factors on women and their health outcomes. They include “labor participation rate” which is the percentage of the population over the age of 15 that is economically active. “Contraceptive prevalence” is the percentage of women who are practicing or whose sexual partners are practicing any form of contraception. “Prevalence of HIV” is categorized as men and women ages 15-24 who are infected with HIV. “Teenage mothers” is the percentage of women ages 15-19 who have had children or are currently pregnant. I thought it was important to include contraception in the socioeconomic category, because often times, women do not use contraceptives because they cannot afford them. HIV and pregnancy are dependent on the use of contraception. Literacy rate and the ratio of male to female enrollment are relevant to women’s socioeconomic status as well.

In order to understand women’s access to healthcare, I analyzed several variables. These include “births attended by skilled health-staff” which is the percentage of birth deliveries attended by personnel trained to give the proper supervision, care and advice to women during pregnancy, labor and the postpartum period. “Pregnant women receiving prenatal care” is the percentage of women attended at least once during their pregnancy by a skilled health staff for reasons related to pregnancy. “Adolescent fertility rate” is shown by the number of births per 1,000 women ages 15-19. “Life expectancy at birth” is defined as the number of years a newborn infant would live if prevailing patterns of mortality at time of its birth were to stay the same throughout its life. “Maternal mortality ratio” is the number of women who die during pregnancy and childbirth, per

100,000 live births. I also included contraceptive prevalence and adolescent fertility rate in order to better understand women's access to healthcare.

In order to gain an understanding of norms, values and laws, I analyzed the "proportion of seats held by women in national parliament" which is the percentage of women in parliamentary seats in a single or lower chamber. Contraception, school enrollment and adolescent fertility rate could also help to explain norms, values and laws of a given society.

Overall, this data informs us about the most important measures of female empowerment throughout the world. By running regressions and correlations of the specific indicators, I was able to conclude that education and literacy are the best indicators of a positive health outcome and of female empowerment. I determined that maternal mortality rate, life expectancy and adolescent fertility rate were the dependent variables based on correlations and regressions with the other indicators. The quantitative analysis ensures that these factors are important across all countries. After performing the quantitative analysis, I engaged in a comparative analysis of Uganda, Afghanistan, the United States and Sweden. The comparative analysis ensures that these indicators occur within the countries, thus proving that the quantitative results are important and worthwhile.

I chose these four countries because they represent healthcare and gender equality in both developed and developing countries. I chose Uganda because it has interesting cultural and social implications that impact fertility and gender roles. Also, Uganda is apart of sub-Saharan Africa, which is a region known in particular for its poverty and

limited healthcare and education access. Therefore, I thought that Uganda would be a good representation of the sub-Saharan region of Africa.

I chose Afghanistan because it is a developing country whose healthcare and gender inequality are among the worst in the world. Afghanistan has among the highest maternal mortality rate in the world. I thought that including Afghanistan would provide for a very interesting comparison with the other countries chosen.

I chose the United States because I live here and the information is familiar and relevant to me and to my readers. The United States represents a developed, democratic country. The Declaration of Independence states that “all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness” (US Declaration of Independence 1776). This seemingly entails that human liberties are fundamental inherent rights to each individual, no matter their gender, race or class. Therefore, I was interested in gaining a better understanding of how and if the United States upholds their declaration of equal rights among all (wo)men.

I chose Sweden because it is known to have among the best healthcare in the world, and to be among the most gender-egalitarian societies. I thought that it would be interesting to compare the progressive healthcare and social aspects of Sweden with the other countries chosen. I was interested in learning whether the universal healthcare and education systems do indeed have a positive impact on women’s empowerment and progress in society.

Both the quantitative and comparative analysis were extremely important and relevant to my research. The quantitative analysis provided me with important indicators

of health and female empowerment that occur across all countries, and the comparative analysis proved that these factors are indeed important since they occur within these selected countries. In the subsequent chapters, I will report my quantitative and comparative analysis.

Chapter Three: Quantitative Results

Correlation I: Literacy rate and adolescent fertility rate

		Adolescent fertility rate (births per 1,000 women ages 15-19)	Literacy rate, youth female (% of females ages 15-24)	Literacy rate, youth male (% of males ages 15-24)	Ratio of female to male primary enrollment (%)	Ratio of female to male secondary enrollment (%)	Ratio of female to male tertiary enrollment (%)	Labor participation rate, female (% of female population ages 15+)	Labor participation rate, male (% of male population ages 15+)
Adolescent fertility rate	Pearson Correlation	1	-.729**	-.724**	-.062	-.181*	-.342**	.346**	.405**

	N	205	99	99	167	157	122	204	204
Literacy rate, youth female	Pearson Correlation	-.729**	1	.937**	.041	.327**	.369**	-.333**	-.337**
	N	99	99	99	83	78	60	99	99
Literacy rate, youth male	Pearson Correlation	-.724**	.937**	1	.022	.240*	.343**	-.437**	-.341**
	N	99	99	99	83	78	60	99	99
Ratio of female to male primary enrollment	Pearson Correlation	-.062	.041	.022	1	.725**	.199*	.042	-.023
	N	167	83	83	167	157	122	167	167
Ratio of female to male secondary enrollment	Pearson Correlation	-.181*	.327**	.240*	.725**	1	.372**	-.082	-.129
	N	157	78	78	157	157	122	157	157
Ratio of female to male tertiary enrollment	Pearson Correlation	-.342**	.369**	.343**	.199*	.372**	1	-.141	-.175
	N	122	60	60	122	122	122	122	122
Labor participation rate, female	Pearson Correlation	.346**	-.333**	-.437**	.042	-.082	-.141	1	.791**
	N	204	99	99	167	157	122	204	204
Labor participation rate, male	Pearson Correlation	.405**	-.337**	-.341**	-.023	-.129	-.175	.791**	1
	N	204	99	99	167	157	122	204	204

This matrix shows that there is a high correlation between both male and female literacy rate and female adolescent fertility rate. The female literacy rate tells us that a strong inverse relation ($r=-.729$) between female literacy rate and adolescent fertility rate. This entails that the more educated a female is, the less likely she is to have a child in her adolescent years. The value of ($r=-.729$) tells us that literacy rate accounts for 53% of adolescent fertility rate, which is very significant. The data informs us that male and female enrollment is similar, which is interesting, but shows that the correlation between the ratio of female to male primary enrollment and adolescent fertility rate does not have much significance ($r=-.62$). The ratio of female to male secondary enrollment has a more significant inverse relationship ($r=-.181$) and tertiary enrollment ($r=-.342$) has the most significant

inverse relationship with adolescent fertility rate. This means that primary, secondary and tertiary enrollment accounts for respectively .4%, 3.2% and 12% of the prevention of adolescent female fertility rate. These numbers tell us that as more males and females are enrolled in school (particularly higher levels of education), female adolescents are less likely to have a child. The female labor participation rate ($r=.346$) tells us that there is a significantly positive relationship between female labor participation and female adolescence fertility. This means that female labor participation accounts for 12% of female adolescent fertility. There is an even more significant positive relationship between male labor participation ($r=.405$) and female adolescence fertility. This means that male labor participation accounts for 16% of female adolescent fertility. This tells us that as labor participation is increased, so does the female adolescent fertility rate.

Regressions

Model Summary

Model	R	R Square	Adjusted Square	R	Std. Error of the Estimate
1	.965 ^a	.931	.889		8.75711

a. Predictors: (Constant), Literacy rate, youth female (% of females ages 15-24), Labor participation rate, female (% of female population ages 15+), Contraceptive prevalence (% of women ages 15-49)

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	368.071	63.080		5.835	.002
	Contraceptive prevalence	.332	.190	.217	1.746	.141
	Labor participation rate, female	.991	.196	.626	5.058	.004
	Literacy rate, youth female	-3.870	.640	-.722	-6.051	.002

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	368.071	63.080		5.835	.002
	Contraceptive prevalence	.332	.190	.217	1.746	.141
	Labor participation rate, female	.991	.196	.626	5.058	.004
	Literacy rate, youth female	-3.870	.640	-.722	-6.051	.002

a. Dependent Variable: Adolescent fertility rate (births per 1,000 women ages 15-19)

The regression tells us that these three indicators account for 93.1% of adolescent fertility rate. (R square=.931 and Adjusted R square=.889). This tells us that contraceptive prevalence, female labor participation rate and literacy rate among females are all very pertinent and impactful to an adolescent female's fertility rate. Both labor force participation and female literacy have statistically significant effects on literacy rates, with labor force participation increasing and literacy decreasing adolescent fertility.

Correlation II: Education and Literacy and Births attended by skilled health staff

	Ratio of female to male tertiary enrollment (%)	Literacy rate, youth female (% of females ages 15-24)	Contraceptive prevalence (% of women ages 15-49)	Prevalence of HIV, female (% ages 15-24)	Prevalence of HIV, male (% ages 15-24)	Teenage mothers (% of women ages 15-19 who have had children or are currently pregnant)	Births attended by skilled health staff (% of total)
Ratio of female to male tertiary enrollment (%)	1	.369**	.400	-.244*	-.211*	-.440	.730*

male tertiary enrollment	N	122	60	10	95	95	6	9
Literacy rate, female	Pearson Correlation N	.369**	1	.153	-.112	-.086	-.332	.647*
Contraceptive prevalence	Pearson Correlation N	.400	.153	1	-.277	-.274	-.229	.364
Prevalence of HIV, female	Pearson Correlation N	10	9	17	13	13	4	12
Prevalence of HIV, male	Pearson Correlation N	95	78	13	144	144	6	13
Teenage mothers	Pearson Correlation N	95	78	13	144	144	6	13
Births attended by skilled health staff	Pearson Correlation N	6	4	4	6	6	8	4
		9	10	12	13	13	4	15

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

This matrix informs us of the significance of literacy and education. These two factors enable awareness for the need for certain precautions, including the use of contraception, the prevention of HIV and unwanted pregnancy and the ability to provide a safer birth experience. Literacy rate of female youths has a strong correlation ($r=.369$) with the ratio of female to male tertiary enrollment. This means that the literacy of female youths accounts for 14% of females in tertiary education. Tertiary enrollment of males and females also has a strong correlation with contraceptive prevalence ($r=.400$) meaning that the more educated males and females are, the more likely they are to use contraception. Tertiary enrollment accounts for 16% of contraceptive prevalence among women ages 15-49. Contraception prevalence has a strong inverse relationship with female HIV prevalence ($r=-.277$) meaning that the more readily available contraception is, the less

likely it is for HIV to be prevalent among females ages 15-24. Contraception prevalence accounts for 8% of HIV prevention among females. Tertiary enrollment is a stronger indicator for the prevention of HIV in females than it is for males. The relationship between tertiary enrollment and HIV prevalence is ($r=-.211$) among males and ($r=-.244$) among females. This shows that education is that much more important for females in regards to the prevention of HIV. Tertiary enrollment also has a strong inverse relationship with teenage mothers who have had children, or are pregnant ($r=-.440$). These numbers tell us that as more males and females are enrolled in school (particularly higher levels of education), the less likely a female is to have a child in her teenage years. Tertiary enrollment accounts for 19% of teenage pregnancy prevention. Finally, tertiary enrollment also has a strong correlation with births attended by a skilled health staff ($r=.730$). This means that tertiary enrollment accounts for 53% of births attended by a skilled health staff, thus meaning that these births will be safer for both the mother and the child. Overall, this data shows that literacy and education allow for more contraceptive prevalence, less HIV prevalence, less teenage pregnancy and more births that are attended by skilled health staff.

Regressions

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.986 ^a	.973	.946	76.71489

a. Predictors: (Constant), Pregnant women receiving prenatal care (%), Literacy rate, youth female (% of females ages 15-24), Births attended by skilled health staff (% of total)

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-3852.403	1992.738		-1.933	.149
	Births attended by skilled health staff	-13.203	2.994	-.899	-4.410	.022
	Literacy rate, youth female	78.843	15.536	.572	5.075	.015
	Pregnant women receiving prenatal care	-26.578	18.092	-.295	-1.469	.238

a. Dependent Variable: Maternal mortality ratio (modeled estimate, per 100,000 live births)

The regression shows that these three indicators account for 97% of maternal mortalities. (R square=97% and Adjusted R square=95%). This informs us that literacy rate among female youths, pregnant women receiving prenatal care and births attended by skilled health staff are extremely relevant to the health and well-being of the mother and nearly completely determine whether or not she will live through childbirth or causes related to childbirth. The coefficients in the regression show that the more pregnant women receive prenatal care and the more births attended by skilled health staff, the lower the maternal mortality rate.

Correlation III: Labor participation and female life expectancy

Correlations

		Labor participation rate, male (% of male population ages 15+)	Labor participation rate, female (% of female population ages 15+)	Births attended by skilled health staff (% of total)	Ratio of female to male tertiary enrollment (%)	Literacy rate, youth female (% of females ages 15-24)	Life expectancy at birth, female (years)
Labor participation rate, male	Pearson Correlation N	1 204	.791** 204	-.785** 15	-.175 122	-.337** 99	.388** 204
Labor participation rate, female	Pearson Correlation N	.791** 204	1 204	-.684** 15	-.141 122	-.333** 99	.251** 204
Births attended by skilled health staff	Pearson Correlation N	-.785** 15	-.684** 15	1 15	.730* 9	.647* 10	.613* 15
Ratio of female to male tertiary enrollment	Pearson Correlation N	-.175 122	-.141 122	.730* 9	1 122	.369** 60	.257** 122
Literacy rate, youth female	Pearson Correlation N	-.337** 99	-.333** 99	.647* 10	.369** 60	1 99	.694** 99
Life expectancy at birth, female	Pearson Correlation N	.388** 204	.251** 204	.613* 15	.257** 122	.694** 99	1 204

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

This matrix shows that there is an inverse relationship between births attended by skilled health staff and labor participation of females and males. Labor participation among males, $r = -.785$ and among females, $r = -.684$. This means that employment among males and females accounts for 62% and 47% of births unattended by skilled health staff. One might think that employed individuals would be more apt to hire a skilled health staff, but according to this data, that is not the case. Tertiary enrollment and literacy also have an

inverse relationship with labor participation. For tertiary enrollment ($r=-.175$) for males and ($r=-.141$) for females. This means that tertiary enrollment accounts for .031% of male labor participants and .019% of female labor participants. According to these statistics, the more men and women in tertiary enrollment, the less of them are in the labor force. For literacy rate among females, ($r=-.333$) meaning literacy rate accounts for 11% of labor force participants. Tertiary enrollment has a strong correlation with births attended by a skilled health staff ($r=.730$). This means that tertiary enrollment accounts for 53% of births attended by a skilled health staff, thus meaning that these births will be safer for both the mother and the child. Literacy rate among females accounts for ($r=.647$) 42% of births attended by a health staff. This means that in countries with more literacy, more births are attended by skilled health-staff. Births attended by a health staff have a positive relationship with life expectancy of females. Births attended by a health staff accounts for 38% of life expectancies of females ($r=.613$).

Regressions

Model Summary

Model	R	R Square	Adjusted Square	R	Std. Error of the Estimate
1	.996 ^a	.991	.947		2.78294

a. Predictors: (Constant), Labor participation rate, male (% of male population ages 15+), Literacy rate, youth female (% of females ages 15-24), Labor participation rate, female (% of female population ages 15+), Ratio of female to male tertiary enrollment (%), Births attended by skilled health staff (% of total)

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	148.900	25.732		5.787	.109
	Births attended by skilled health staff	-.343	.093	-.900	-3.692	.168
	Literacy rate, youth female	.211	.115	.277	1.831	.318
	Ratio of female to male tertiary enrollment	.113	.054	.398	2.071	.286
	Labor participation rate, female	-.337	.119	-.513	-2.840	.215
	Labor participation rate, male	-.904	.286	-.794	-3.165	.195

a. Dependent Variable: Life expectancy at birth, female (years)

The regression tells us that these five indicators account for 99.1% of life expectancy among females (R-square=99.1% and r=94.7%). This tells us that male and female labor participation rate, ratio of female to male tertiary enrollment, literacy rate and births attended by a skilled health staff are extremely significant and relevant to a female's life expectancy.

Correlations IV: Maternal Mortality and Women in Parliament

Correlations

		Maternal mortality ratio (modeled estimate, per 100,000 live births)	Pregnant women receiving prenatal care (%)	Prevalence of HIV, female (% ages 15-24)	Proportion of seats held by women in parliament (%)
Maternal mortality ratio	Pearson Correlation	1	-.580**	.372**	.055
	N	198	23	144	198
Pregnant women receiving prenatal care	Pearson Correlation	-.580**	1	-.022	.229
	N	23	23	17	23
Prevalence of HIV, female	Pearson Correlation	.372**	-.022	1	.062
	N	144	17	144	144
Proportion of seats held by women in parliament	Pearson Correlation	.055	.229	.062	1
	N	198	23	144	198

** . Correlation is significant at the 0.01 level (2-tailed).

This matrix shows the relationship between proportion of seats held by women in parliament, prevalence of HIV (female), pregnant women receiving prenatal care and maternal mortality ratio. It is evident that there is a significant inverse relation between pregnant women receiving prenatal care and maternal mortality rate ($r=-.580$). This means that if a woman receives prenatal care, she is less likely to die. Maternal mortality is defined by the World Health Organization (WHO) as “the death of a woman while pregnant or within 43 days of termination of pregnancy, irrespective of the duration and site of pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (WHO, 2004). The value of ($r=-.580$) tells us that prenatal care accounts for 34% of prevented maternal mortality cases. The prevalence of HIV among females ages 15-24 also has a statistically and substantively significant relationship with maternal mortality ($r=.372$). This means that HIV prevalence among women accounts for 14% of maternal mortalities. Surprisingly, the proportion of seats held by women in parliament does not have that significant of a relationship with maternal mortality ratio ($r=.055$) meaning that this accounts for only

.0035% of maternal mortality cases. One might think that having women in parliament would in fact decrease maternal mortality rate, however it does not seem to be the case.

Regressions

Model Summary

Model	R	R Square	Adjusted Square	R	Std. Error of the Estimate
1	.762 ^a	.580	.483		164.46937

a. Predictors: (Constant), Proportion of seats held by women in parliament (%), Prevalence of HIV, female (% ages 15-24), Pregnant women receiving prenatal care (%)

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	1795.188	616.098		2.914	.012
	Pregnant women receiving prenatal care	-17.543	6.724	-.491	-2.609	.022
	Prevalence of HIV, female	36.417	11.370	.578	3.203	.007
	Proportion of seats held by women in parliament	1.263	4.051	.059	.312	.760

a. Dependent Variable: Maternal mortality ratio (modeled estimate, per 100,000 live births)

The regression tells us that these three indicators account for 76% of maternal mortalities. (R square=58% and r=48%). This tells us that pregnant women receiving prenatal care, the prevalence of HIV among females and the proportion of seats held by women in parliament are significant and relevant to maternal mortality ratio. In this case, more women receiving prenatal care reduces mortality while women with HIV increases it. Having more women in Parliament apparently has very little effect on maternal mortality rates.

Correlation V: Education, Prenatal Care and Maternal Mortality Prevention

Correlations

		Ratio of female to male primary enrollment (%)	Ratio of female to male secondary enrollment (%)	Ratio of female to male tertiary enrollment (%)	Literacy rate, youth female (% of females ages 15-24)	Literacy rate, youth male (% of males ages 15-24)	Pregnant women receiving prenatal care (%)	Births attended by skilled health staff (% of total)	Maternal mortality ratio (modeled estimate, per 100,000 live births)
Ratio of female to male primary enrollment	Pearson Correlation N	1	.725**	.199*	.041	.022	.697**	.236	-.079
		167	157	122	83	83	22	13	167
Ratio of female to male secondary enrollment	Pearson Correlation N	.725**	1	.372**	.327**	.240*	.549**	.167	-.238**
		157	157	122	78	78	21	12	157
Ratio of female to male tertiary enrollment	Pearson Correlation N	.199*	.372**	1	.369**	.343**	.603*	.730*	-.434**
		122	122	122	60	60	15	9	122
Literacy rate, youth female	Pearson Correlation N	.041	.327**	.369**	1	.937**	.279	.647*	-.767**
		83	78	60	99	99	10	10	98
Literacy rate, youth male	Pearson Correlation N	.022	.240*	.343**	.937**	1	.466	.812**	-.805**
		83	78	60	99	99	10	10	98
Pregnant women receiving prenatal care	Pearson Correlation N	.697**	.549**	.603*	.279	.466	1	.819**	-.580**
		22	21	15	10	10	23	12	23
Births attended by skilled health staff	Pearson Correlation N	.236	.167	.730*	.647*	.812**	.819**	1	-.692**
		13	12	9	10	10	12	15	15
Maternal mortality ratio	Pearson Correlation N	-.079	-.238**	-.434**	-.767**	-.805**	-.580**	-.692**	1
		167	157	122	98	98	23	15	198

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

This matrix informs us of the significance of literacy and education to a woman's optimal health outcome. First of all, primary enrollment has a strong correlation with secondary enrollment ($r=.725$). This means that the enrollment of students in primary education accounts for 53% of secondary enrollment. This suggests that in those countries in which girls and boys attend primary school at similar rates, they are enrolled in more equal numbers in secondary education as well, suggesting a general pattern of educational

egalitarianism. However, that the correlation is not 100% means that gender equity in primary education is not determinative of equality further on in the educational system. Literacy rate of female youths has a strong correlation ($r=.369$) with the ratio of female to male tertiary enrollment accounting for 14% of females in tertiary education. Tertiary enrollment also has a significant relationship with pregnant women receiving prenatal care ($r=.603$), meaning that tertiary enrollment accounts for 36% of prenatal care. Tertiary enrollment also has a strong correlation with births attended by a skilled health staff ($r=.730$). This means that tertiary enrollment accounts for 53% of births attended by a skilled health staff, thus meaning that these births will be safer for both the mother and the child. Tertiary enrollment has a significant inverse relationship with maternal mortality rate ($r=-.434$). This means that tertiary enrollment accounts for 19% of prevented maternal mortalities.

Literacy rate of female youths has a strong correlation with pregnant women receiving prenatal care ($r=.279$), meaning that female literacy rate accounts for 8% of prenatal care. Literacy rate of male youths has an even stronger correlation with pregnant women receiving prenatal care ($r=.466$), meaning that male literacy rate accounts for 22% of prenatal care. Literacy rate of females also has a significant relationship with births attended by skilled health-staff ($r=.647$), meaning that female literacy accounts for 42% of births attended by skilled health-staff. Male literacy rate has an even higher correlation with births attended by skilled health-staff ($r=.812$), meaning that male literacy accounts for 66% of births attended by skilled health-staff. Female literacy also has a significant inverse correlation with maternal mortality rates ($r=-.767$), meaning that female literacy

accounts for 62% of prevented maternal mortalities. Male literacy accounts for (r=-.805) 65% of prevented maternal mortalities.

Prenatal care has a significant correlation with births attended by skilled health staff (r=.819), meaning that prenatal care accounts for 67% of births attended by skilled health-staff. Pregnant women receiving prenatal care has a significant inverse relationship with maternal mortality (r=-.580). This tells us that if a pregnant woman has prenatal care, she is less likely to die from pregnancy or childbearing. Prenatal care accounts for 34% of prevented maternal mortalities. Births attended by skilled health-staff also has a significant inverse relationship with maternal mortality rate (r=-.692), meaning that a woman is less likely to die if her birth is attended by skilled health-staff. The presence of skilled health-staff accounts for 48% of prevented maternal mortalities.

This information tells us that education is a key element to women's optimal reproductive health outcomes. A woman is more likely to seek out and obtain prenatal care and a skilled health-staff to attend and assist the birth. These two factors are significantly correlated with the reduction of maternal mortalities. This emphasizes how crucial education and literacy are to a woman's life, health and empowerment. It is important to note that societies with more literate men also have better reproductive health outcomes.

Regression

Model Summary

Model	R	R Square	Adjusted Square	R	Std. Error of the Estimate
1	.986 ^a	.973	.946		76.71489

a. Predictors: (Constant), Pregnant women receiving prenatal care (%), Literacy rate, youth female (% of females ages 15-24), Births attended by skilled health staff (% of total)

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-3852.403	1992.738		-1.933	.149
	Births attended by skilled health staff (% of total)	-13.203	2.994	-.899	-4.410	.022
	Literacy rate, youth female (% of females ages 15-24)	78.843	15.536	.572	5.075	.015
	Pregnant women receiving prenatal care (%)	-26.578	18.092	-.295	-1.469	.238

a. Dependent Variable: Maternal mortality ratio (modeled estimate, per 100,000 live births)

This regression informs us that these three indicators account for 97.3% of maternal mortalities (R square=97.3% and Adjusted R Square=.946). This tells us that literacy rate, births attended by skilled health-staff and pregnant women receiving prenatal care are extremely significant to the prevention of maternal mortalities.

Conclusion

Through the quantitative analysis of 215 countries and relevant indicators of maternal health and reproductive rights, I have ascertained that maternal education, socioeconomic factors, norms, values and laws, and access to healthcare are important measures of reproductive rights. In order to reach those results, I performed correlations and regressions among different indicators relating to gender. These indicators include adolescent fertility rate (among women ages 15-19), literacy rate among female and male youths, ratio of females to males in primary, secondary and tertiary enrollment, labor participation rate among men and women (ages 15 and above), prevalence of HIV among men and women (ages 15-24), births attended by skilled health-staff, life expectancy, contraceptive prevalence, pregnant women receiving prenatal care, proportion of seats held by women in parliament and maternal mortality ratio.

The results inform us that education and literacy are the best predictors for a positive health outcome. Education enables awareness about the need for certain health precautions, including the use of contraception, the prevention of HIV and unwanted pregnancies. Education also enables the ability to provide a safer birth experience, and thus a better life expectancy. Education has a significantly positive relationship with women receiving prenatal care, obtaining skilled health-staff during birth and thus, is largely responsible for a safe and healthy life outcome for the mother and her children. There is a significant inverse relationship between literacy rate and adolescent fertility rate. Overall, this information is indicative that education and literacy are vital to the empowerment of women and their progression in society. Educating a woman about her body and the risks that she faces encourages her to be autonomous, and take proper health

precautions. These results show that a woman is empowered through education, because educated and/or literate women are significantly more likely to seek out contraception, which means they are less prone to HIV or other sexually transmitted infections. Educated and literate women are also more likely to seek out prenatal care and birth assistance from skilled health-staff, which each are hugely significant factors in the prevention of maternal mortalities.

Women's empowerment and the promotion of gender equality are key to achieving sustainable development. Greater gender equality can enhance economic efficiency and improve other development outcomes by removing barriers that prevent women from having the same access as men to human resource endowments, rights, and economic opportunities. Giving women access to equal opportunities allows them to emerge as social and economic actors, influencing and shaping more inclusive policies. Improving women's status also leads to more investment in their children's education, health, and overall wellbeing (World Bank, 2012).

This data supports my thesis that promoting women's reproductive rights, supporting women's education and personal development yields positive health outcomes and improves women's status in society. Based on the information obtained through the analysis of the World Bank data, I was able to determine specific measures of female empowerment and optimal healthcare outcomes.

Chapter Four: Comparative Analysis

In order to ensure the validity of the quantitative analysis, I have performed comparative studies of the healthcare, economic, political and social systems (and the quantitative determined measures of health and empowerment) in Uganda, Afghanistan, the United States and Sweden. I will review these four cases in order to determine the level of variation of maternal healthcare across different countries. I anticipate that these four case studies will prove to be a useful lens into the patterns of gender inequality across countries. This information will give me a better understanding of the healthcare in both developed and developing countries, and determine how reproductive rights contribute to female's empowerment and progression in society.

The quantitative analysis provided me with important indicators of health and female empowerment that occur across all countries. I have ascertained that maternal education, access to healthcare, socioeconomic factors, norms, values and laws are important indicators of female empowerment. I will analyze these four indicators across Uganda, Afghanistan, the United States and Sweden. I anticipate that the comparative analysis will show that these factors are indeed important to the lives and development of women in each respective country.

Uganda

Uganda is a presidential republic, meaning the President of Uganda is both the head of state and of the government. The President is elected by a popular vote for a five-year term. The government is based on a democratic parliamentary system with a multi-party system. Executive power is exercised by the government and legislative power by the government and the Parliament of Uganda. The Parliament is comprised of 225 Constituency representatives, 79 District Women Representatives, 10 Uganda People's Defense Force Representatives, 5 Representatives of Persons with Disabilities, 5 Representatives of Workers and 13 Ex-officio members. (Parliament of the Republic of Uganda, 2011). The Parliament is the national legislative body where elected and appointed members from all over the country meet to draft, debate and pass laws and legislation through which the institutions of government endeavor to guide the country's progress (Parliament of the Republic of Uganda, 2011). The Parliament also works to protect and uphold the Constitution in order to promote the democratic governance of Uganda.

Uganda suffers from great poverty, a serious HIV/AIDS epidemic and shockingly high maternal and infant mortality rates. "Just one out of four households in Uganda have safe drinking water, and 5% have electricity for lighting. The gross domestic product per capita is \$1,390 per year, and life expectancy at birth is only 46.2 years" (UNDP, 2004). On top of these factors, Uganda has one of the highest fertility rates in the world. The average woman has 7 children (UBOS, 2001: 41) although nearly half of all births are mistimed or unwanted (Prada, *et al.*, 2005: 5). Abortion is illegal in Uganda, unless a woman's pregnancy endangers her life. The country's major religions, Christianity and

Islam also outlaw the practice. Therefore, this procedure is very often performed in dangerous and secretive conditions. “This explains why complications from unsafe abortion are a leading cause of maternal morbidity and mortality” (Prada *et al.*, 2005: 6). Contraception is not extremely prevalent in Uganda, due to a strong cultural emphasis on fertility, ignorance or lack of understanding about contraception or women’s inability to negotiate contraceptive use with her partner. This explains why fertility rates are high throughout the country, but especially among the poorest individuals. The median age at first marriage is 17.7 years for women and 21.9 for men. Nearly half of all 18-19 year old women have had a baby and another 16% are pregnant at any given time (Alan Guttmacher Institute, 2005: 2).

Uganda’s economy has great potential due to wide range of natural resources, but due to political and economic instability, is very unstable.

The country is self-sufficient in food, although the distribution is uneven over all areas. Coffee accounts for most of Uganda’s export revenues. During the period immediately following independence, from 1962 to 1970, Uganda had a flourishing economy with a gross domestic product (GDP) growth rate of 5 percent per year. However, in the 1970s through the early 1980s, Uganda faced a period of civil and military unrest, resulting in the destruction of the economic and social infrastructure. This seriously affected the growth of the economy and the provision of social services such as education and health care (UBOS, 2007: 1).

Yoweri Museveni, the current Ugandan President has worked to improve the country’s economic system by working to rebuild roadways and reaching out for external support. New economic policies have been implemented to restore price stability, rehabilitate the infrastructure and improve resource mobilization and allocation in the public sector (World Bank 2003). Uganda has an abundance of natural resources which account for nearly all of the country’s foreign exchange earnings.

The Ugandan education system is structured with seven years of primary education and six years of secondary education. In order to go on to secondary education, one must pass the Primary Leaving Examination. In 1997, the government introduced universal primary education and ten years later, universal secondary school. This initiative certainly helped to improve enrollment, particularly among girls and poor students. This transition also helped create jobs for teachers. However, the quality of education has not necessarily improved. Ugandan teachers note that, “academic performance standards are deteriorating, and the education being universal, students are just pushed through” (Kavuma, 2011: 2). Examination results give a hint of this decline. In 2006, nearly 95% of Primary Leaving Examination-level candidates achieved at least the minimum pass rate to qualify for a national certificate. Last year, with a 54% increase in candidates, 80% qualified for the certificate (Kavuma, 2011). The loss of quality is somewhat inevitable in the broad expansion of access to education. Sexual education is not part of a typical schools curriculum.

Life expectancy is 53.1 years and the infant mortality rate is 63 per thousand (World Bank, 2011). In 2008, Uganda attempted to launch a compulsory public health insurance plan, which would have been a step towards universal health coverage. However, the plan did not pass through the “parliament due to resistance from employers, trade unions and worker representatives. Employers, who already contribute 10% of employees' gross income to the national pension plan, questioned how the 4% figure was determined and wondered whether the government could guarantee efficient service delivery, considering the poor state of public health facilities” (Kagumire, 2009: 1). The lack of health insurance hinders Ugandans from being able to afford the health care that

they need. Another major issue is access to healthcare due to the literal distance from the healthcare facility.

Socioeconomic Factors

In Uganda, 46% of the population lives below the absolute line of poverty. “The Uganda Participatory Poverty Assessment Project (UPPAP) found ill health to be the most frequent cause of poverty” (Ministry of Health, 1999). 88% of Uganda’s population the country’s 24.4 million inhabitants live in rural areas, where healthcare is least accessible. Accessibility to healthcare services is made especially challenging because of the “general lack of transportation and communication infrastructure across the country. Uganda’s road system, particularly in the countryside is extremely limited” (Knudsen, 2003: 254). Socioeconomic factors place women at a greater risk than men. If a woman becomes sick, she is less apt to receive medical care because her health tends to be less of a priority than that of male family members. “This inequality persists despite the fact that pregnant and lactating women are most in need of balanced diets; they are also more likely to develop anemia—an especially dangerous condition for pregnant women” (Knudsen, 2003: 47). Since women often do not have independent economic earnings, they do not make the decision about whether or not they should seek healthcare. “Women account for 70-80% of Uganda’s agricultural work force, yet only 7% of them own land and 30% have access to the proceeds of their labor” (Republic of Uganda, 2001: 51). Women work an average of 15-18 hours each day, while men work 8-10 hours. Due to their demanding work schedules, women often cannot afford to leave their domestic responsibilities to seek health care. (Neema, 1999: 102). “Even where public health care is free, transportation to the health center and sometimes the need for additional drugs

can cost women money they do not have, requiring the notification and consent of the husband.” (Knudsen, 2003: 257). The lack of financial autonomy becomes especially important in regards to family planning tactics. This shows how important financial independence is to empowerment and thus the ability to take ownership over her health and that of her unborn child(ren).

Available family planning services are often less than ideal. In a 2001 study on contraceptive use, only 23% of married Ugandan women reported use of contraception. This is very low by regional standards, as Kenya has a contraceptive prevalence rate of 38% and Zimbabwe with 54% (Knudsen, 2003: 257). Surveys show that women in Kenya wanted fewer children than those in Uganda, but that in Uganda there was also a greater unmet need for contraception” (Blacker *et al.*, 2005: 355). However, the tendency for Ugandans to not use contraception can be attributed to a lack of sexual education and therefore a misunderstanding of the benefits of contraceptive use. Between 1980 and 2000, total fertility in Kenya fell by about 40%, from some eight births per woman to about five. During this same time period, total fertility in Uganda fell by less than 10%. The difference in contraception use among women in Kenya and Uganda may also be attributed to political and economic factors in each country. For instance, the Kenyan government had long promoted family planning through health services, while the Ugandan government did not promote such services until 1995. Other factors, like education, age at marriage, age at first sexual intercourse and other aspects of sexual behavior are thought to be associated with fertility (Zaba *et al.*, 2004: 80). If a woman has the resources of education and money, she is more likely to have children later in her life.

The population in Uganda has increased from 5 million in 1984 to nearly 25 million in 2002 (UBOS 2002). The United Nations have projected that at this rate, Uganda will have a population of over 100 million by the year 2050 (United Nations 2003). “The apparent stagnation in Ugandan fertility levels actually masks increasing unequal birth rates between rich and poor. When fertility rates were analyzed according to socioeconomic status, it was shown that fertility levels increased by nearly one child per women for the poorest two quintiles over the past five years, and decreased by around one child for the richest 40%” (Chavkin and Chesler, 2005: 103). A recent study shows that childbearing has actually increased among the youngest cohort of women, ages 15-19 (Chavkin and Chesler, 2005: 103). Also, the number of women who delivered their child with the assistance of a skilled healthcare provider has remained at 39% since 1995 (Chavkin and Chesler, 2005: 103). These are indicators that we need more change. Health equity is critical to reach the 1994 International Conference on Population and Development Program of Action goals.

There are also important differences by the wealth index of the household. “The percentage of teenagers who have begun childbearing in the poorest households is 41% compared with only 16% in the wealthiest households” (UBOS, 2007: 61). It is clear that wealthier 15-19 year old Ugandans are more equipped to make informed decisions about reproduction. Since they are more likely to have access to education, they have a better understanding of contraception and the ramifications of pregnancy. Poorer Ugandans, who might lack access to education, would be more likely to follow the traditional, strong cultural beliefs, which promote fertility and reproduction because they don’t know any different. These individuals who lack education and socioeconomic status are more apt to

experience a negative health outcome because they are unable to attain the healthcare they need. They might also lack the ability to send their children to school, which in turn inhibits their children's ability and creates a cycle of poverty.

Norms, Values and Laws

Fertility has a particularly strong value and cultural emphasis in Uganda. In many Ugandan cultures, it is considered a bad omen if an adult dies without having children. (Knudsen, 2003: 41). The value of fertility is consistent throughout the country and among the diverse population of nine major ethnic groups and many other smaller groups (UBOS, 2002:12). These cultural views of fertility are also influenced by a lack of education about sex and its ramifications. Females in Uganda start reproducing at a young age. The age at which childbearing commences is an important indicator of the overall level of fertility as well as the health and welfare of the mother and the child. "In some societies, postponement of first births due to an increase in age at marriage has contributed to overall fertility decline. However, in Uganda, it is not uncommon for women to have children before getting married" (UBOS, 2007: 60). The median age at first birth in Uganda is 19.1 years (UBOS, 2007: 62). Research from the Uganda Bureau of Statistics (2007) shows that 49.5% of 19-year old females in Uganda have had a live birth. 42.7% of those who have had a live birth have had no education and 29.8% of these females fall in the lowest wealth quintile (UBOS, 2007: 62). These statistics illustrate how strong the correlation between education and socioeconomic status is with fertility rates. Ugandan woman have an average of 3.5 children by their late twenties and more than six children by their late thirties (UBOS, 2007: 2). Teenage pregnancy is an especially critical factor to women's health because of its association with higher

morbidity and mortality for both the mother and the child. “In addition to the physiological risks, under the current school practice, pregnant girls have to terminate their education, which may indirectly affect the health of the mother and the child through loss of socio-economic opportunities” (UBOS, 2007: 62). This demonstrates how easy it is to perpetuate poverty when a woman has limited access to education and the inability to make choices for herself. It also touches upon how important contraception and sexual education are to a woman’s ability to prevent pregnancy, stay in school and be able to make informed decisions about her sexuality and body.

The vast majority of Ugandan youth do not learn much about reproduction and sexual health in school or at home. Sexual education is made exceptionally more difficult since the literacy rate is low and only 43% of 15 year olds have completed primary school and even fewer continue on to primary school. Only 61% of women are literate and 76% of men are (Knudsen, 2003: 61).

Family planning has been in Uganda since 1957, but birth control has always been a contentious issue because of religious and ethnic tensions. “The politics of population growth has therefore been played out in terms of the power-sharing potentials of regional, ethnic, religious, and interest groups rather in terms of the over-all impact of population growth on national development” (Kirumira, 1998: 186). Due to years of civil strife, it was not until 1990 that the Ugandan government finally eliminated some of the restrictive policies that inhibited women from using family planning. Prior to that point, women had needed their husband’s permission to use family planning. In 1993, the Ugandan government recognized access to family planning as a basic human right (Kirumira, 1997: 192). The decision to allow women to make decisions about their

bodies and their reproduction as individuals, without the governance of their husbands or the government, was certainly a positive step towards upholding reproductive rights.

Uganda has recently had much success in the fight against HIV/AIDS, but much less with women's reproductive health issues. Uganda has "experienced no decline in fertility rates, infant mortality rates have risen, and access to reproductive health services is limited" (Richey, 2004: 96). In comparing the policy responses in these two health areas, there is clear leadership in HIV/AIDS policy, but not with reproductive health services. In the early 1990s, Uganda reported the highest HIV infection rates in the world, with an estimated 15% among all adults, and over 30% among pregnant women in urban areas living with HIV/AIDS (Stoneburner and Low-beer, 2004: 714). The country managed to decrease the prevalence of HIV/AIDS to 5% by 2001 (Hogle 2002). "Figures from Uganda's National AIDS Control Program suggest that the prevalence and incidence of HIV/AIDS are declining across all age groups and socioeconomic levels" (Chavkin and Chesler, 2005: 99). So far, the HIV/AIDS policies have achieved much more success than any part of the reproductive health policies. The Ugandan government promoted a dynamic strategy to combat AIDS, including "public information campaigns, research, voluntary testing and counseling, safe blood transfusions, school health programs, home-based care for people living with AIDS, and a broad campaign to treat STDs" (Richey, 2004: 100). It is now time for the Ugandan government to instate the same informative and preventative policies for maternal healthcare so that women can have more control over their fertility.

Access to Healthcare

Since 88% of Uganda's population the country's 24.4 million inhabitants live in rural areas, accessing healthcare is certainly a challenge. Communication lines are key in transmitting crucial health related information about the value and use of available health services to the community. Rural women are the most disadvantaged in this regard, since they often have no access to newspapers, radio or television and they are more likely than men to be illiterate (Knudsen, 2003: 255). The Uganda Demographic and Health Survey (UDHS) did a study on problems in accessing health care (2006). Overall, 86% of the women interviewed said they encounter at least one serious issue when accessing health care. 65% of women said that having the money to be able to afford healthcare is a serious problem, while 55% said that distance to the health facility is the second most commonly reported issue, followed by having to take transport (49%) and concern over unavailability of medications (46%) (UBOS, 2007: 131). This shows the crucial correlation between socioeconomic status and access to healthcare. If indeed reproductive rights are a basic human right, as stated in the Proclamation of Teharan (1968) then one's socioeconomic status should not impede on their ability to seek proper reproductive healthcare.

If a patient is able to reach a healthcare facility, they are likely to be met with limited healthcare services. Four in ten births occur in a health facility. This proportion has increased from 37% in the 2000-2001 UDHS study. "Overall, 42 percent of births were delivered with the assistance of a trained health professional—that is, a doctor, nurse, midwife, medical assistant, or clinical officer—while 23 percent were delivered by a traditional birth attendant" (UBOS, 2007: 131). These statistics are likely due to the fact

that a healthcare facility may be too expensive or too far. The “doctor to population ratio in Uganda is 1: 28,000. Over 50% of hospitals are located in urban areas, where only 12% of the population lives” (Ministry of Health, 2001: 7). As a result, many rural women give birth in their homes with the assistance of a relative or with a local trained birth attendant.

There is an extremely low amount of postpartum care in Uganda. Three-quarters of women who had a live birth in the five years preceding the UDHS survey “received no postnatal care at all, and only 23% of mothers received postnatal care within the critical first two days of delivery” (UBOS, 2007: 131). Postnatal care issues typically include recovery from childbirth, concerns about newborn care, nutrition, breastfeeding and family planning. However, 34% of maternal deaths in the developing world are caused by postpartum hemorrhaging, making it that much more dire to have proper postnatal care in order to prevent death. Postnatal care is important for the recovery of the mother and for the well-being of the newborn. Most importantly, it helps to reduce maternal and infant morbidity and mortality. According to Tamar Manuelyan Atinc, the Vice President for Human Development at the World Bank, “Maternal deaths are both caused by poverty and are a cause of it. The costs of childbirth can quickly exhaust a family’s income, bringing with it even more financial hardship” (World Bank, 2010: 2). This shows the interrelationship between socioeconomic status and access to healthcare.

Considering that nearly half of all births in Uganda are unwanted or mistimed (Prada *et al.*, 2005: 5), it is important to note that abortion is a leading cause of maternal deaths. “22% of all maternal deaths are caused by unsafe illegal abortions. This societal tragedy could be addressed by either legalizing abortion or improving the post-abortion

care” (Republic of Uganda, 2000: 20). Considering these factors, it is no surprise that there are such high mortality rates among mothers and infants in Uganda.

The infant mortality rate is 63 deaths per 1,000 live births, as compared to 6.9 deaths per 1,000 live births in the United States (World Bank, 2011). Maternal mortality also remains high in Uganda at 550 per 100,000 live births, as compared to 13.3 deaths per 100,000 live births in the United States (UNICEF, 2010). While it is good that more births are occurring in a healthcare facility, it is evident that there are still not enough healthcare resources that would yield positive health outcomes for more women and their children. It is clear that education and socioeconomic levels have an especially strong association with the ability to access healthcare and thus, a positive health outcome.

Maternal Education

Women in Uganda are generally less educated than men. Although the gender gap has recently narrowed, “19% of women ages 15-49 have never been to school, compared with only 5% of men in the same age group. Only 56% of women are literate, compared to 83% of men.” (UBOS, 2007: 131). Also, although employment among Ugandan women is reported as 86% compared to 95% of men in 2006, a significant proportion of women are not reimbursed for their work. 30% of employed women, compared to 13% of men are not paid for their work (UBOS, 2007: 131). This means that women are not able to be economically independent, even though they work nearly as much as men, if not more.

Education has a marked effect on fertility, with uneducated mothers having about three more children on average than women with at least some secondary education and women in the lowest wealth quintile having almost twice as many children as women in

the highest wealth quintile (UBOS, 2007: 1). This could be due to the fact that women who go to school become empowered by education and want more for themselves and their future, or perhaps it is because they have access to contraception and wisely decide to have only as many children as they can afford.

Nuwagaba (1997) suggests that ignorance about modern contraception, such as the belief that contraceptives lead to sterility is the reason for low levels of use in Uganda (Nuwagaba, 1997:75). This is exactly why sexual education is so important to a woman's life. Educating men and women about the function of contraceptives to prevent disease and unwanted pregnancy would likely lead to a decreased population rate. It is important to educate women to understand their bodies and capabilities and also to encourage them to "demand their rights of bodily self-determination and create institutional contexts in which these rights are respected" (Richey, 2004: 119). Reproductive rights are necessary for both women's fertility choice and sexual decision-making. Education is key to a woman's socioeconomic status and ability to provide for herself and her children. Education also allows a woman to understand the importance of contraception and maternal healthcare as important facets to her health and future.

The 2006 Uganda Demographic and Health Survey (UDHS) shows that teenage pregnancy varies with level of education. Their survey shows that "only 15 percent of girls with secondary education have begun their reproductive life, the corresponding proportion of those with no education is 50 percent" (UBOS, 2007: 63). This shows that education discourages early childbearing and has a positive influence on a young woman's life. Women in the highest wealth quintile, living in an urban region tend to have children later than other women. "Women with secondary education started having

children two years later than those with less education (20.6 and 18.5 years, respectively)” (UBOS, 2007: 63). This study illustrates the importance of education as a way to empower women and help them to make informed decisions about their lives.

Interestingly, knowledge of family planning has “remained consistently high in Uganda over the past five years, with 97% of all women and 98% of all men ages 15-49 having heard of at least one method of contraception” (UBOS, 2007: 131). Yet, acceptance and ability to attain contraception is another challenge. “Twenty-four percent of currently married women ages 15-49 are currently using a method of contraception, up from 19% in the 2000-2001 UDHS” (UBOS, 2007: 131). “Just over half of currently married women obtain methods of contraception from private medical sources, while 35% obtain their method from government facilities. 13% obtain their method from other private sources” (UBOS, 2007, 131). While this seems positive, it is important to note that 41% of currently married women have an unmet need for family planning services. Currently, only 37% of the demand for family planning is being met (UBOS, 2007: 131). It is also important to note that married women in urban areas (43%) are twice as likely to use contraception as women in rural areas (21%). This could be attributed to the fact that they have easier access to healthcare facilities.

Women with less education are more likely to experience difficulty in attaining healthcare compared to other women. In a 2006 UDHS study on problems in accessing health care, it is apparent that educational attainment has an especially strong association with reporting specific challenges, like having the money for treatment, having trouble finding transportation and significant distance from healthcare facility (UDHS, 2006). It

is clear that sexual education has a positive influence on a woman's life and gives her the ability to make informed, responsible decisions and thus, take ownership over her life.

Afghanistan

Afghanistan is a land locked country in Central West Asia. The country's diverse landscape, "dotted with high mountains and deep and narrow valleys, separates regions and people of different cultures and lifestyles. Geography has contributed to the perpetuation of the deeply rooted tribalism, localism and regionalism" (Emadi, 2005: 2). Just like the climate and geography, the people of Afghanistan are also diverse in their ethnicity and languages. "Each ethnic community has its own history, culture and speaks its own language. Some 49 languages are spoken throughout the country" (Emadi, 2005: 7).

Afghanistan became an independent country on August 8, 1919 after winning the Anglo-Afghan war against the British. Afghanistan has experienced years of unstable governance and the rise and fall of countless dynasties. More recently, Afghanistan has been under the control of the Taliban. Their rule lasted from 1996 until 2001, when the United States, aided by Canada, the United Kingdom and other countries initiated military action in Afghanistan, as a response to the September 11th attack which was perpetrated by the Al-Qaeda network which is based in and allied to the Taliban. "To most of the dispossessed and suffering Afghans, September 11 heralded a new era that liberated them from a tyrannical rule unprecedented in the country's history. People who had endured years of oppression and brutality at the hands of various Islamic fundamentalist groups and the Taliban welcomed the new era, believing it would bring significant changes in the years to come" (Emadi, 2005: 50). The current President Karzai took office in 2004 and has a lot of work ahead of him.

The Karzai government remains weak and relies on the International Force to maintain peace and stability in Afghanistan. The small-scale economic and

educational progress Afghanistan had achieved has been completely destroyed during the two decades of war. The country remains dependent on foreign aid and technology, and the poor and dispossessed will continue to endure years of suffering with no immediate remedy to help them rebuild their lives (Emadi, 2005, 50).

In the 18th century, Afghanistan was divided into four semi-autonomous regions including Heart, Qandahar, Turkistan and Qataghan-Badakhshan, with Kabul as the capital city. However, as different leaders have come into power, the division of these provinces has changed. By 2004, Afghanistan had 34 different provinces. Each province is divided into several districts or sub-districts depending on the population size. A governor, who is appointed by the central government, rules over each respective province.

The cultivation of agriculture and animals are the main sources of income for Afghans. The two decades of war in the 1980s and 1990s has hindered the development and progression of Afghan economic and social infrastructure. The times of destruction and instability forced people to flee their homeland and seek refuge in Pakistan and Iran. Afghanistan used to export timber, but has since nearly depleted their timber resources. Oil was exported to Russia for a number of years after its discovery in 1950. After the withdrawal of Soviet troops in 1989, Afghanistan's natural gas fields were capped to prevent sabotage by the Mujahideen, Islamic fundamentalists, in the Afghan Civil War. Since the formation of the new Karzai Administration in 2004, the production of natural gas has been restored. (Tamkin, 2010). Afghanistan's main exports also include textiles, opium for medicinal purposes, fruit, nuts and gemstones. In 2006, a United States Geological Survey estimated that there are as much as 36 trillion cubic feet of natural gas (EurasiaNet, 2006). Geologists also discovered abundant deposits of

minerals and gemstones. In 2010, American Pentagon officials and American geologists revealed the discovery of nearly \$1 trillion in untapped mineral deposits in Afghanistan that would likely transform Afghanistan into one of the most important mining centers in the world (Risen, 2010). Plans are being made to extract these minerals which would surely bring Afghanistan economic success. The economic disparity of the country helps to explain some of the social and political turmoil.

Ethnicity, tribalism and regionalism have created rifts in the country's social, political and economic infrastructure. "Tribal and regional conflict on one hand and the widening gap between rich and poor on the other hand stalled the modernization process and paved the road to a bloody civil war in the 1990s that destroyed much of the country's infrastructure" (Emadi, 2005: 21). Afghanistan is a multi-tiered society, including the elite, landowner, peasantry and the dispossessed classes. Members of the elite class are typically the ones that govern the country. They have access to formal education and professional training in Afghanistan and the ability to study and travel abroad (Emadi, 2005: 21). There are elite classes among urban and rural environments. These two types of elite classes differ due to their difference in access to education and other societies. Landowners tend to influence rural politics, through their economic position as landowners and through their connections with the rural elite class (Emadi, 2005: 22). Large landowners tend to be tribal chiefs in their communities. Peasants make up the largest part of Afghanistan's population. They tend to be the least educated and have limited contact with other classes. They are able to influence politics due to the large size of their social class. The dispossessed social stratum is comprised of people in socially undesirable occupations. They are "beneath the notice of the leadership and are

invisible as people. This group of people remains the most vulnerable to exploitation and abuse because they have no access to support services of any kind” (Emadi, 2005: 26).

Religion also plays an important role in Afghan history and culture. The official religion in Afghanistan is Islam, which is practiced by over 99% of the population. “Their practice of and belief in their view of Islam plays a fundamental role in providing daily moral, ethical and social guidance” (Emadi, 2005: 53). Muhammed, the founder of Islam, made it his life’s mission to rid Arab tribal society of all forms of injustice.

Maternal Education

Prior to Afghanistan’s independence from the British in 1919, the educational institutions were controlled by the clerics and ulamas, who taught subjects related to Islamic philosophy, arts, and sciences. The curriculum gave priority to subjects that dealt with ethical and moral codes of conduct compatible with the philosophy of Islam. Religious subjects constituted the bulk of the curriculum at existing public schools. “There was no school for girls because conservative clerics and ulamas viewed education for women as a waste of time. There were a few exceptions among the upper and middle class families, including enlightened clerics and religious leaders who supported education for women, but only a few women received an education, which was no more than a rudimentary education delivered at home” (Emadi, 2005: 66). Afghan society attaches greater importance to boys for their ability to provide physical labor and to carry on the family’s name and property, so males have priority over females when it comes to receiving education. Men are seen as the dominant figures in the family, clan and tribe. The father has “absolute authority in supervising and controlling the lives of male and

female members of the household within and outside the home. He decides what kind of education his children will receive, if any, and what type of profession they will undertake” (Emadi, 2005: 168). Lacking education often means that women are confined to their homes, which is stifling to their potential and independence. Islam upholds the importance of maintaining as much difference as possible between the sexes. Women are secluded in society, based on the belief that women are property. While the Taliban were in power, they instated a temporary halt to formal female education and banned women from working. The ban on the employment of women meant that many schools had to close since women were no longer allowed to work as teachers (Marsden, 2002: 88). Since women often lack education, they lack the empowerment and ability to fight for their rights.

“Patriarchal tradition deems women to be creatures who lack the wisdom and judgment to decide their own future and whom to marry” (Emadi, 2005: 172). This further proves how education is a crucial tool that would enable women to make autonomous decisions, and how Afghan women are deprived of education for that exact reason. Conservative families do not support education for women because they do not see any immediate or relevant impact of education on the lives of women and they view education as a disruption to their traditional way of life. More progressive, liberal families believe that educated women can and should play a significant role in the development of society (Emadi, 2005: 181). Religion plays an important role in the general opposition towards education for females. “Conservative religious leaders and clerics both in the Sunni and Shia communities oppose education for women, viewing their expansion of modern schooling as a threat that diminishes their own authority as the

sole dispensers of Islamic vales and possessors of religious knowledge” (Emadi, 2005: 181). This shows that the potential of women is understood and therefore a woman’s potential ability in society is seen as a threat to the traditional Afghan culture. Families and Islamic religion attach great honor to virginity. Women are meant to stay virgins until marriage or else they face severe punishment. Though there is little to no sexual education, abstinence is indeed an important cultural value.

There has been a recent shift in ideas about gender equality and the ability for women to receive education. The spiritual leader of an Afghan community spoke in favor of women’s education, saying, “providing the means to educate a man, one educates just one person and by educating a woman, one educates a family” (Emadi, 2005: 182). He also spoke highly of how education and providing professional training for women is a major step in improving their lives and allowing them to be independent. A profession “empowers women and improves their status in their communities. It provides positive role models for other women, strengthens their decision-making and problem-solving capabilities in the eyes of other, and promotes their personal, professional and financial autonomy” (Kahn, 1999). The ability and empowerment that comes with education is undeniable and Afghan women would undoubtedly flourish with the independence autonomy that coincides with education. Education for all females would bring about gender equality and more economic independence and likely, social, political and healthcare reforms. Women would learn about sexual health, how to be safe, stay healthy, prevent unwanted pregnancy and ultimately how to have a safe childbirth experience and healthy outcome for both the mother and her child.

Socioeconomic Factors

Historically, per capita yearly income in Afghanistan is estimated to be between \$200 and \$800 USD, which makes Afghanistan one of the poorest and least developed countries in the world (Sharp *et al.*, 2002: 216). The economic disparity of the country helps to explain why the country is developmentally lacking in many ways. Traditionally, gender roles and women's status have been tied to property relations. "Women and children tend to be assimilated into the concept of property and to belong to a male" (Nyrop and Seekins, 1986: 126). The subordination of women in Afghan society, culture and traditions confines women to the domestic realm. Even if a woman does work outside of the home, out of necessity to help provide for her family, the man is still regarded as the guardian of the family.

Arranged marriages are very common in Afghanistan. It is typical for a young girl to be married off to a wealthier, older man. An important factor of arranged marriages are the economic considerations. "Profit is the main motive for arranged marriages when two families try to combine their landholdings. Another reason for arranged marriages is to reciprocate a favor a man receives during a time of need" (Emadi, 2005: 172). This shows how women are seen and treated as commodities. Since women are often married off at a young age, they become immediately economically and socially dependent on their new, older husband. During the reign of the Taliban, women were forbidden from leaving their homes without the accompaniment of a male relative. They were also forbidden from working or from receiving any formal education. This type of social structure exemplifies just how cut off Afghan women are from the rest of

society, let alone the world. It is easy to see how debilitating it would be to be so isolated and to be forced to be utterly dependent on male relatives.

Norms, Values and Laws

Afghan culture is very traditional and patriarchal. “A major characteristic of every ethnic community is the shared concept of inviolability of the family. An individual’s honor, social status and personal code of conduct are largely determined by the institution of the family. Islamic law and social customs govern family-related business, such as marriage and inheritance” (Emadi, 2005: 166). The very conservative Afghan culture promotes the seclusion and restriction of women and the primacy of males. One of the major aspects of social formation in tribal Afghanistan is that of gender inequality and treatment of women as second-class citizens. Women are subordinated to men and are deprived of their basic rights. Afghan women have long been oppressed both socially and politically. Writers and intellectuals who support the patriarchal system often perpetuate these cultural norms. Respected Persian poet Muslihuddin Sa’adi wrote poems which enforced the poor treatment of women by their husbands. He wrote:

Shut the doors of joy to a house
In which women’s voices are being heard
You beat the woman if she visits the market,
Otherwise you ought to stay home as a woman (Sadi, 1362/1983: 327).

Women are treated as a man’s personal property and often are given less respect than an animal. Nomadic tribes often refer to women as camels and value their wives less than their precious animals. To them, “a good woman is like a transport camel. She is sturdily

built, has big, strong legs, a steady gait and is clean” (Stucki, 1978: 140). A girl who is socialized to believe that she is less worthy than an animal and that her only social function should be to please her husband would certainly not have a positive self concept.

The Taliban, who were in power from 1996 until 2001, were extremely harsh towards women. They demanded that women wear burqas, which are full-body garments, in observance of seclusion. They also created strict guidelines about how men and women should behave both publicly and privately. One Taliban describes the appropriate behavior of women; “women are duty-bound to behave with dignity, to walk calmly and refrain from hitting their shoes on the ground which makes noises” (Rashid, 1997: 52). This exemplifies the complete degradation of women by the Taliban. If a woman should refrain from letting her feet hit the ground, she is restricted in every possible way. This implies that a woman should not be a part of public life. In an effort to maintain strong cultural traditions, the Taliban encouraged severe punishment of women who violated the established social and cultural traditions. Violence was and is very often used against women to enforce these cultural norms and expectations. Since women have no rights, a man’s word is very typically taken over a woman’s. A woman who might stand up for herself and attempt to expose her husband’s violent brutality would be socially looked down upon. “Women can be victimized not only by the husband but also by men of power and authority who have no recourse to fight back. Men who assault women will even kill them without a second thought in order to cover up the crime” (Emadi, 2005: 171). Women who can no longer bear this physical and verbal abuse often feel hopeless about ever getting help and may look to commit suicide as her only option to end her suffering. “The entrenched cultural values of such a system stress greater respect for age,

marriage at a young age and a great impetus on the part of young women to become mothers” (Emadi, 2005: 165). Most families prefer their children to marry within their extended family. This is in an effort to maintain close family ties and similar beliefs and values. The married son’s wife and children submit to the authority of the husband’s parents. “Maintaining family discipline is a cherished ideal, as it gives a man a good name and enhances his prestige in the community. Individuals are encouraged to avoid committing actions that negatively affect the name and status of their families or bring disgrace” (Emadi, 2005: 166). Polygamy is a common practice among all ethnic groups. Islam allows men to marry up to four wives. A man would typically take on an additional wife if his previous wife were unable to bear him a son, or when she were to become old. This shows how women are seen as commodities in Afghan culture and solely valued for their capacity to reproduce and bring their husbands prestige and possibly economic gains for the family. Since Afghan women are regarded solely for their ability to reproduce, one would think that there would be safe and accessible healthcare options, however, this is not the case.

Access to Healthcare

The geographic features of Afghanistan have had a great impact on the cultural development of its people. An insufficient transportation system has impeded internal communications and, because of this, economic, social and political integration has been very slow. Of the 27 million total population of Afghanistan, 20% live in urban areas and 80% in rural areas (World Food Programme, 2011). There are significantly less healthcare facilities in rural areas than in urban areas. In 1981, about 80% of the

country's physicians practiced in Kabul where the physician to patient ratio was 1 to 1,000. The estimated ratio for the country as a whole was 1:13,000, and some isolated northern districts reported a ratio of 1:200,000 (Nyrop and Seekins, 1986:129). This helps to explain why the healthcare system in Afghanistan is still severely lacking. Women traditionally give birth at home with the assistance of a midwife. If there is a complication, a woman may be taken to a nearby hospital if possible. "Child mortality is high in rural areas because most families cannot afford to take their women to a hospital, even if there is one in the center of the provincial town" (Emadi, 2005: 178). A woman usually gives birth to six or seven children during her prime fertility years. Conservative families do not believe in abortion and rather, see it as an act against the will of God. Abortion was not even an option in Afghanistan until the 1970s. Currently, abortion is only permitted when there is medical indication that a woman's life is endangered (Afghan Family Guidance Association, 2006). Almost no women use or have access to any form of contraception (Sharp, *et al.*, 2002: 216).

During the rule of the Taliban, women were much less likely to attend health facilities for fear of being attacked by the Taliban in the streets. The Taliban created a particular dress code for men and women. Women were required to wear burqas in public and would be severely beaten if they were seen without them. Since not all women could afford burqas, they might attempt to borrow the garment from another woman, further inhibiting their movement in society. "The periodic practice by some elements within the Taliban, particularly the religious police, of beating women with sticks in the street if they do not comply has had an enormous impact on the mobility of

the female population” (Marsden, 1998: 89). This climate of fear that the Taliban created led to the inhibition of women to leave their homes.

Overall, in 2000, the Afghanistan health system ranked 173 out of 191 nations. Every indicator of health status reveals a healthcare system in crisis. The average life expectancy is estimated to be 45 years for men and 46 years for women. Only 35% of the population has access to any health care. Virtually all medical care is supplied by international relief agencies, yet women in rural areas are still particularly underserved (Sharp *et al.*, 2002: 218). Afghanistan has an infant mortality rate of 149 deaths per 1,000 live births and a maternal mortality rate of 1,400 deaths per 100,000 live births (CIA World Factbook, 2012). These healthcare indicators show that women’s reproductive health is given little regard in Afghanistan. Afghan women’s identities are nearly completely stripped. Without education, economic independence or access to adequate healthcare, a woman in this society is completely un-empowered. She is virtually confined to her home, discouraged or forbidden from partaking in public activities or self-enriching opportunities. These factors contribute to the degradation of women in Afghan society and their inability to become independent, autonomous, empowered individuals in society.

The United States

The United States is a federal constitutional republic, comprised of fifty states and a federal district. The federal government is made up of three branches, including a legislative, a judicial and an executive. These branches were created under the premise of “checks and balances” in an effort to keep balance and cooperation among the branches. Checks and balances allows for one branch to limit another. The federalist government entails that power is shared among the federal government and the individual state governments.

According to the U.S. Census Bureau, the United States of America has a population of nearly 313 million people. It is often referred to as the “melting pot” in reference to the assimilation of immigrants to the United States. The large-scale immigration to the United States is responsible in part for population growth and cultural changes throughout the country’s history. Nearly 14 million immigrants came to the United States from 2000-2010 (U.S. Census Bureau 2011).

The United States has a capitalist mixed economy, in which both the state and private sector lead the economy. The US is “fueled by abundant resources, a well-developed infrastructure and high productivity” (Wright, 2007: 288). The unemployment rate is currently 8.5% and the nation’s poverty rate is 15.1% (U.S. Census Bureau 2010).

The United States’ public education system is regulated by the United States Department of Education, but in most states, children are required to attend school from kindergarten until the age of 18. The basic literacy rate in America is 99% (The World Factbook 2009).

Life expectancy is 78.4 years and the infant mortality rate is 6.06 per thousand (The World Factbook 2009). Healthcare coverage is not universal, which means the United States is among the few industrialized countries without universal health insurance (Vladeck, 2003: 16). Instead, the U.S. depends on private and public forms of healthcare coverage. The obesity rate in the U.S. is the highest in the industrialized world and “has more than doubled in the last quarter century” (Schlosser, 2002: 240). “Approximately one-third of the population is obese and an additional third is overweight” (CDC, 2007).

The quality of maternal healthcare in the United States has recently been a source of criticism. Statistics released in 2010 by the United Nations show that the United States is ranked as 50th out of 215 countries in the world for maternal mortality, with “maternal mortality ratios higher than almost all European countries, as well as several countries in Asia and the Middle East” (WHO 2010). The United Nations data also show that between 1990 and 2008, while the “vast majority of countries worked to decrease their maternal mortality ratios for a global reduction of 34%, maternal mortality in the United States nearly doubled” (WHO 2010). In 2007, the maternal mortality rate was 12.7 deaths per 100,000 live births, as compared to a low of 6.6 per 100,000 in 1987 (Xu, Kochanek and Tejada-Vera, 2010: 39). Considering that the U.S. spends more on healthcare than any other country and that at least half of maternal mortalities are preventable, “this is not just a matter of public health, but a human rights failure” (Coeytaux, Bingham and Strauss, 2011: 189). These inordinately high maternal mortality rates that exist in the United States are indicative of the severity of the healthcare issues that exist in the United States. The Universal Declaration of Human Rights states that “everyone has the right to a

standard of living adequate for the health and well-being of himself and his family, including medical care and necessary social services. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.” (United Nations, 1948: Article 25). If this were the case, then the United States would offer proper maternal healthcare that would help to save women and children’s lives.

Rickie Solinger addresses many reproductive rights issues that women in the United States face. In her book *Pregnancy and Power* (2005), she emphasizes the prevalence of reproductive rights issues in relation to American women’s full citizenship, safety and privileges. She encourages her readers to seek change and strive for reproductive justice. Solinger’s conclusions encapsulate the arguments of many different feminists who both support and expand her views. Solinger emphasizes how crucial it is for a woman to be in control of her own sexual and reproductive body in order to be considered full citizens. She discusses how this autonomy is a necessary condition for gender equality. Lacking reproductive autonomy is to be lacking control over virtually every aspect of an individual’s life. “Women’s rights activists began in the 1960s to define reproductive autonomy as a core requirement of full citizenship status for women” (Solinger, 2005: 165). She delves into all the different losses women suffer due to the lack of reproductive control, which includes economic independence, and a certain level of comfort and ability loss throughout pregnancy and childbearing. She claims that a woman’s inability to control her fertility is evidence of inequality among men and women.

Solinger echoes Crystal Eastman's assertions about autonomy being a key element to a woman's sexual and reproductive power. Eastman, a socialist and feminist of the early 1900s discusses how

life is a big battle for the complete feminist even when she can regulate the size of her family. If we add to this handicap complete uncertainty as to when children may come, how often they come or how many there shall be, the thing becomes impossible. I would almost say that the whole structure of the feminist's dream of society rests upon the rapid extension of scientific knowledge about birth control (Eastman in DuBois and Dumenil, 2009: 507).

Socioeconomic Factors

Maternal healthcare is very much a socioeconomic issue. "In the country many consider to be the most powerful in the world, American citizens experience the highest poverty levels and largest gaps between rich and poor of any other industrial country. The educational and job opportunities, living standards, and health status of Americans are all heavily influenced by race, class, gender and geographical location" (Knudsen, 2006:109). Among different races, 11.6% of whites live in poverty, 33.3% of blacks live in poverty and 29.3% of Latinos live in poverty (Forte and Judd, 1998: 263). Access to healthcare is dependent on one's geographic location and socioeconomic status (National Women's Law Center, 2004: 9). A woman's access to healthcare is highly correlated with a positive pregnancy outcome.

Unintended pregnancy is prevalent in the United States; more common than in Western Europe. Unintended pregnancy is highest among teenagers and low-income women. "Women living below the federal poverty level report that three out of four of their pregnancies and over a third of their births are unintended. Both teens and poor women have high abortion rates; 40% of their pregnancies end in abortion" (Institute of

Medicine 1995). “If contraceptive methods are cheap and easy to use, birth control will be practiced. By lowering the price of contraceptives or supporting research on methods that are easier to use, public family planning programs are likely to have an impact. In other words, the lower the price of contraceptives, the more they will be used” (McFarlane and Meier, 2001: 7). The demand for contraception and the demand for abortion are related. If contraceptives are very expensive or otherwise unavailable, but abortion is legal and accessible (as in Japan), then abortion will become a common method of fertility control. If contraceptives are readily available, then the incidence of abortion drops. Studies on fertility control show that there is an inelastic demand for abortion. The Haas-Wilson (1997) study of Medicaid funding for abortions demonstrates this inelastic demand. Haas-Wilson concluded that abortion rates are no higher in states that fund abortions for Medicaid eligible women than in states that do not offer such funding. Her findings present the argument that even eliminating all monetary costs of abortion will not affect the number of abortions. Though fertility control methods have at times been discouraged or made illegal, contraception and abortion have always been practiced. “The inelastic demand for abortion entails that any attempts by policymakers to change abortion practices within the United States will likely have little success. Many individuals will do what they have to do or pay what they have to pay to obtain this service” (McFarlane and Meier, 2001: 9). This inelastic demand for fertility control methods entails the significance that these abilities mean for a woman’s life, her autonomy and thus, ability to contribute and progress in society.

Unintended or unwanted pregnancies are associated with adverse health outcomes for both the mother and the child. John Santelli and other members of the Unintended

Pregnancy Working Group (2003) performed a study on the measure and meaning of unintended pregnancy. Their findings show that the United States has a high-unintended pregnancy rate and that the prevalence of unintended pregnancies was the highest among those living below the federal poverty line. “Excluding miscarriages, but including pregnancies ending in abortion, 49% of pregnancies in 1994 were unintended. Among unintended pregnancies ending in a live birth, 71% were mis-timed and 29% were unwanted” (Santelli *et al.*, 2003: 94). The fact that the majority of these unintended pregnancies are to women who live below the poverty line is telling that this group of individuals is in the most dire, susceptible position. They often lack the financial ability to take preventative pregnancy measures and also lack the ability to properly take care of themselves and their child during and after their pregnancy.

Women with unintended pregnancies are less likely than those with intended pregnancies to seek prenatal care during the first trimester, and more likely to use alcohol and tobacco during pregnancy. Unintended pregnancy that results in a live birth is associated with physical abuse and violence during pregnancy and the 12 months before conception, and with household dysfunction and exposure to psychological, physical or sexual abuse during the woman’s childhood. Findings from U.S. studies suggest that the impact of unintendedness on infant health is related more to the mother's preexisting physical and socioeconomic status than to her pregnancy intentions (Santelli *et al.*, 2003: 95).

It is important to take note of the diversity among social contexts within which pregnancies occur and are carried to term. This is especially true in the United States, where there are considerably large gaps between the “haves” and the “have-nots” and also because of the growing diversity due to immigration to the U.S. This means that “social and cultural factors will continue to influence contraceptive use and pregnancy termination” (Santelli *et al.*, 2003: 96). Santelli *et al.* emphasizes how millions of American women, and women around the world, are not always in control of when they

engage in sexual intercourse, let alone the decision to have a child. Santelli *et al.* (2003) argues that these limits are created and restricted because of gender inequality, limited access to resources or health services and limited control over women's own bodies. "Although some studies challenge the disenfranchisement among minority women in the United States and suggest that women often play a powerful role in controlling barrier contraceptive use, unfortunately many women frequently continue to make decisions under circumstances that limit their choices" (Santelli *et al.*, 2003: 97). "The attitudes and behaviors of a male partner can influence a woman's intentions, sexual behavior, contraceptive use and parenting" (Santelli *et al.*, 2003:97). The demeanor and attitude of a male partner can influence the couple's contraceptive use and therefore, sexual health and tendency towards pregnancy. Poor, young and single women are the least likely to intentionally conceive, carry through with the pregnancy and know the father's intentions.

An important facet of a woman's independence is her ability to enjoy sexual activity without the constant fear of becoming pregnant. Birth control gave women the ability to have some form of control in their lives, which in turn gave them the opportunity to fulfill other prospects and have more economic freedom. The prevention of pregnancy allowed a woman to pursue employment without the incessant threat of being laid off because of an unexpected pregnancy. Both Eastman (1920) and Solinger (2005) believe that in order for women to maintain control over their lives, it is necessary that they have the ability to control their own bodies.

Solinger (2005) places emphasis on reproductive rights and their relation to a woman's economic independence, another important element of full citizenship for

women. She says, “In countries where women do not have reproductive rights—where the state, through the law, forces women to have children—women are degraded by a number of aspects of this reproductive coercion” (Solinger, 2005: 250). She discusses the uncompensated labor of pregnancy, childbearing and motherhood “whether they want to or not, whether they have the resources to take on these tasks or not. In millions of cases, women are forced into positions of economic dependency because taking care of newborns and small children is often incompatible with earning money” (Solinger, 2005: 250). Eastman also discusses the relevance of birth control to one’s economic independence. She sees birth control as a means to

choose one’s way of making a living as men now enjoy, and definite economic rewards for one’s work. Until women learn to want economic independence, and until they work out a way to get this independence without denying themselves the joys of love and motherhood, it seems to me feminism has no roots (Eastman in DuBois and Dumenil, 2009: 507).

A woman’s ability to make her own living and lead an independent lifestyle depends greatly on her ability to control her own body.

Norms, Values and Laws

Maternal healthcare has always been a controversial issue in American society. The pro-choice movement emerged from the broader reproductive rights movement, which entailed family planning, birth control and population control. While ideas of the separation of sex from procreation predated the nineteenth century, there had been no social movement to justify or promote contraception until this point. Beginning in the 1830s in the United States, a small group of freethinkers argued that family limitation would “help the poor by limiting the labor supply, or that it would strengthen the family

by easing the burdens of overtaxed parents” (Wells, 1971: 75). Therefore, these ideas about a woman’s ability to control her fertility had long been in existence, but it was some time before the movement actually emerged.

The modern family planning movement materialized within three different waves. The first wave took place in the early twentieth century. In 1912, Margaret Sanger invented the term “birth control” to finally give a name to a practice that had long existed, but hadn’t been openly discussed or advocated. She believed birth control was a “means to women’s autonomy” and said, “it is none of society’s business what a woman shall do with her body” (Sanger in DuBois and Dumenil, 2009: 480). Sanger opened the first American birth control clinic in 1916 and fought hard to promote birth control methods. Gradually, people became more aware of the importance of birth control to females, their independence and the feminist movement as a whole. The second wave of reproductive rights occurred during the Progressive Era, a period of social activism and political reform from the late 1800s until the 1920s. A common theme throughout this time period was achieving complete efficiency, by identifying and reforming any and all social issues. Population control was one of these issues and one solution was eugenics, limiting “deviant” populations and the social burdens of crime, prostitution, and illegitimacy—through birth control, sterilization, and immigration restriction (Critchlow, 1996: 2). The third wave was the population-control movement that occurred after World War II. This movement emerged in an attempt to address issues of social stability, war, poverty and economic development both domestically and abroad.

The birth control movement initially emerged as part of a radical feminist movement to empower and liberate women. Similar to the family planning movement, the birth control movement also passed through three waves. The first, “voluntary motherhood” is the idea that women should be able to choose when and how often to become pregnant. Voluntary motherhood influenced women to maintain control over their sexual activity and the possibility of pregnancy to be able to live autonomously. In 1891, Harriot Stanton Blatch spoke about “voluntary motherhood” saying that as long as motherhood is welcomed and desired, it is sacred, but if unwelcomed, then women are not helping themselves or humanity (Stanton Blatch in Kraditor, 1968: 167). These socialist ideas gave way to a cultural shift, the second wave, where women yearned for more autonomy and found organizational expression and growth in birth-control leagues. These organizations were mainly made up of women in the working class. “Between 1850 and 1890, the average number of live births for white, native born women fell from 5.42 to 3.87” (DuBois and Dumenil, 2009: 346). Volunteer motherhood seemed to have influenced women to maintain control over their sexual activity and the possibility of pregnancy. The third wave, from 1920 and beyond, represents a more liberal movement for civil rights and population control and attempts to use liberal democracy to create legal reform. “Women’s decisions to limit their pregnancies reflected a growing desire for personal satisfaction and social contribution beyond motherhood” (DuBois and Dumenil, 2009: 348). Women began to see their sexuality as an important aspect of personal identity and fulfillment and gained a renewed freedom to pursue further education or a higher position in the workforce, without the threat of pregnancy.

Margaret Sanger viewed birth control as basic to freedom: “no woman can call herself free until she can choose consciously whether she will or will not be a mother” (Sanger in Rossi, 1973: 533). She saw birth control as the catalyst of women’s full rights and independence and saw reproduction as a key element to many social issues that existed during the late 19th and early 20th centuries. Sanger worked to establish the principle that “a woman’s right to control her fertility is a fundamental human right” (Kundsen, 2006: 111). In her article, “The Civilizing Force of Birth Control” (1939), Sanger says,

The mothers who are liberated—and liberated through the exercise of their own intelligence and foresight—from the relentless pressure of involuntary motherhood—almost automatically become more interested in life, in the future, in the upbringing of their children, in the affairs of the community at large. In a word, they have become more civilized. And this has been made possible not through the much-vaunted agencies of popular education, but because she has been given simple, sanitary instruction which assures her mastery of her own body and procreative functions (Sanger, 1939: 530).

In Sanger’s opinion, the victory of biological freedom, attained through birth control will allow “women and men and children to enter triumphantly into an era that will be in every sense of the word civilized” (Sanger, 1939: 530). She saw birth control as the catalyst of women’s full rights and independence. Sanger worked to establish the principle that “a woman’s right to control her fertility is a fundamental human right” (Kundsen, 2006:111) and that “it is none of society’s business what a woman shall do with her body” (Sanger, 1938: 170).

Betty Freidan, an activist of the second wave of feminism “condemned the media, educators, professionals and the culture as a whole for defining domesticity and motherhood as the only appropriate goals for women” in her book *The Feminine Mystique*. She addresses “the problem with no name”, which is “that voice within

mothers that says: “I want something more than my husband and my children and my home” (Friedan, 1963: 224). By interviewing mothers and housewives in different suburbs, Friedan concluded that “these women were alike mainly in one regard: they had uncommon gifts of intelligence nourished by at least the beginnings of higher education—and the life they were leading as suburban housewives denied them the full use of their gifts” (Friedan, 1963: 224). Friedan’s findings on wife and mother fulfillment and her challenge of conventional expectations about a woman’s role in society emphasize the growing change in consciousness that was going on at this time. The activists at this time helped to create a social consciousness about women’s reproductive rights in a more general sense, which led to the emergence of the pro-choice movement.

Simultaneously, there were many vocal proponents who promoted contraception in an effort to “purify” the American race. Angela Davis (1983) wrote about a form of birth control that existed in the early 1900s; “what was demanded as a ‘right’ for the privileged came to be interpreted as a ‘duty’ for the poor” (Davis in Knudsen, 2006: 110). This introduces the issue of eugenics, which was prevalent in the United States especially during the early 1900s. “High ranking politicians, including President Theodore Roosevelt, embraced the idea of eugenics and sought to implement their views through large scale sterilization campaigns targeting “undesirables” (Forte and Judd, 1998: 263). Forte and Judd note, “The USA became the first nation in the world to permit mass sterilization as part of an effort to ‘purify the race.’ By the mid 1930s, about 20,000 people had been sterilized against their will and twenty-one states had passed eugenic laws” (Forte and Judd, 1998: 264). From 1929 until 1941, the American government

carried out over 70,000 involuntary sterilizations for eugenic purposes, particularly on epileptics, alcoholics, criminals and the “feeble minded” (Forte and Judd, 1998: 267). Some women who were deemed “promiscuous” were institutionalized and sterilized during this time period (Roberts, 1997: 89). In addition to poor women, minority women were also targeted for compulsory sterilization programs because public health officials wanted to control childbearing of women who they deemed unfit to be mothers. This practice of forced sterilization took place until even the early 1980s. Joan Kelly (1984) writes about the inequality that exists among women of different races.

There is no mistaking the race and class bias in the government’s recent denial of equal access to abortion...the public funds are now denied only for abortion but continue to be provided for sterilization. Many women have their tubes “tied” believing they can be “untied” in the future. They are clearly not informed that tubal sterilization is an irreversible procedure (Kelly, 1984: 148).

In Ronald Reagan’s 1983 essay entitled “Abortion and the Conscience of the Nation”, he writes, “We cannot survive as a free nation when some men decide that others are not fit to live and should be abandoned to abortion and infanticide.” (Reagan in Solinger, 2005: 229). The discrimination against women who lack certain resources or privileges encapsulates the importance of reproductive politics.

There is still much discrepancy between public declaration and private behavior of Americans. Many Americans believe that sexual intercourse should take place solely between heterosexual married individuals. Yet, most Americans first sexual experience takes place around the age of 17, which is seven years before the average age of marriage (Upchurch *et al.*, 1998). Also, only 32% of Americans believe that abortion should be legal in all circumstances (O’Connor, 1996), yet an estimated 50% of American women will have an abortion in her reproductive years (Gold, 1990). The discrepancy between

Americans' sexual beliefs and sexual behavior has serious implications for fertility control practices. It becomes difficult to allow for the forethought that most contraception requires when one believes that either sexual activity or birth control is inherently wrong, or even when one is just ambivalent about them. Such beliefs and their deterrent effect on contraceptive use may be a consequence of conservative religious or societal values and contributes to the high rates of fertility and abortion among American teenagers. Adolescents in the United States are not more sexually active than those in Western Europe; they are simply less effective users of contraception (Institute of Medicine, 1995).

Contraception, no matter the form, gives a woman control over her body and thus, she has the capability to control other aspects of her life. "If a woman has the fundamental right to control her own body, then unlimited access to contraception logically follows. A fundamental right would not recognize economic limitations and thus would require the government to provide for those unable to afford contraception" (McFarlane and Meier, 2001: 10). If indeed a woman has the right to control her body, then she should have access to a medically safe abortion should she need it. "Adding conditions or restrictions on choice essentially denies the fundamental right of all women by limiting it to only some women" (McFarlane and Meier, 2001: 10). Margaret Sanger would agree. Sanger placed such emphasis on reproduction being a key element to many social issues that existed in the late 19th to early 20th century. She summarized the ideals of most pro-choice feminists who believe that birth control was a "means to a woman's autonomy" (Sanger in DuBois and Dumenil, 2009: 480). She expressed her view of birth control as a means to a woman's freedom, "no woman can call herself free until she can

choose consciously whether she will or will not be a mother” (Sanger in Rossi, 1973: 533).

Many factors led to the legalization of abortion in the Roe v. Wade landmark case in 1973. Planned Parenthood played a key role in the movement, by providing direct organizational strength and the promotion of family planning tactics. The Association for the Study of Abortion (ASA) was formed by a member of Planned Parenthood to serve as an educational institution consisting of doctors, lawyers and other like professionals. ASA played an important role in bringing prestige and authority to the abortion reform and also was crucial in bringing together crucial activists who went on to found the National Association for Repeal of Abortion Laws. ASA funded research, which was used in an article on the history of abortion and cited in the 1973 Roe v. Wade decision. ASA provided the lawyers who filed the Roe v. Wade case and the leaders who coordinated the briefs for the case, “mobilizing professional groups and others to submit a total of forty-two briefs in favor of legal abortion” (Staggenborg, 1991: 16). ASA also aided in the distribution of educational materials, which promoted research projects on abortion. This social movement was truly transformative in the lives of all women, allowing them to reclaim their rights and control over their bodies.

Access to Healthcare

Sanger asserted that a woman should be in control of her ability to have children. The 1960s introduction of the birth control pill demonstrates a preventative method that women themselves have control over, unlike previous methods of birth control like

condoms or volunteer motherhood which require the willingness of a partner. A woman's ability to make decisions for herself translates into other realms of empowerment, which ensure her full citizenship.

Solinger (2005) discusses the relation between reproductive rights and a woman's safety. She speaks specifically about the slavery system in America and the type of institutionalized control that the masters had over their female slaves' fertility. Inez Milholland (1913) wrote about how women have historically used their sexuality, "legally or illegally, for a guarantee of food, shelter and clothing" (Milholland in Dubois and Dumenil, 2009: 506). It is interesting to see this kind of contrast in regards to the power that lies within sexuality. Solinger also discusses how the law, technology and education shape women's reproductive lives and safety. For example, the invention of the sonogram made it possible to see images of the fetus, which made the fetus seem to be a more real person than the mother. "The enlargement of the fetus allows this emblem of life to incorporate both civic and theological meaning while draining away the personhood—the rights and needs—of the pregnant woman, leaving her at the mercy of the "super-subject" inside of her body" (Solinger, 2005: 233). Solinger's book emphasizes how women's lives can be affected by societal understandings and knowledge about fertility and the fetus. Societal opinions and the law have a great impact on women's safety in regards to abortion rights and other forms of birth control.

Sanger emphasized how "every child should be a wanted child" in order to improve societal and individual life. The separation of sexual and reproductive lives was made possible through the legalization of birth control. Solinger refers to Sanger's efforts to legalize contraception for overpopulation and emancipation reasons.

Do you, a woman, realize that true emancipation and acknowledgment of an equal status for women can never be realized until motherhood is by choice and not by chance? This is the first time in the world's history that an organized drive at race betterment, through conscious, intelligent, forward looking parenthood, is being launched and women must lead the way since women are the Mothers of the race (Solinger, 2005: 104).

Sanger's emphasis on a female's autonomy over her reproductive rights shows the relation between a woman's independence and her safety, thus reproductive justice. Eastman also believes in a woman's ability to control when she gets pregnant, so that she can properly take care of both herself and her child(ren).

We want our children to be deliberately, eagerly called into being, when we are at our best, not crowded upon us in times of poverty and weakness. We want this precious sex knowledge not just for ourselves, the conscious feminists; we want it for all the millions of unconscious feminists that swarm the earth, --we want it for all women (Eastman in Dubois and Dumenil, 2009: 507).

A woman's control over the conception of her children would enable her to live a more safe and healthy life and be able to more adequately provide for her children. The arguments of Sanger, Eastman and Milholland support and expand Solinger's conclusions about reproductive politics in the United States.

It is hard to believe that after all of the positive and far-reaching impacts that Planned Parenthood has had on the lives of both American and non-American women that governmental funding towards the organization is now being threatened. Cecile Richards, the president of Planned Parenthood, told HuffPost that the funding cut would be a threat to women's health. "We have three million come to us every year and two million come through some kind of federal program either for an annual pap or for birth control or for a breast exam or even prenatal care," she noted, adding that the cuts would disproportionately impact rural areas with relatively few medical options. "More than 70 percent of our health centers, more than 800 centers in the country, are located in rural

America or communities that are medically underserved communities. That's what's getting lost here” (Richards in the Huffington Post, 2011). These funding cuts would directly impact the healthcare and education that Planned Parenthood provides to three million women throughout the United States.

Maternal Education

While more than half of students in higher education today are women, this was not always the case. “As women delayed marriage and childbirth, increased their attendance in higher education and joined the labor force in greater numbers, the pressure to be able to control the timing of childbearing grew” (Knudsen, 2006: 119). The birth control and pro-choice social movements had truly opened the eyes of many women to the opportunities they could seek out if they were not burdened by an untimely pregnancy. Women's progress in recent decades — in education, in the workplace, in political and economic power — can be directly linked to Sanger's crusade and women's ability to control their own fertility (Planned Parenthood, 2012). This has a cyclic effect, since higher education often leads to involvement and contribution in the workforce. Yet, it seems that despite the strides that women have made in education and in the workforce, the United States still has a ways to go. Since the “American government promotes abstinence only sexual education, the majority of the country’s sexual education lacks comprehension concerning contraception, homosexuality, abortion and sexually transmitted infections (STIs)” (Knudsen, 2006: 110). Abstinence only sexual education denies children access to comprehensive information about sexual behavior and the consequences. Sexual education is a form of individual empowerment. Teaching and informing individuals about sex allows them to make an informed decision about

whether or not they want to have sex. “Twenty-five studies have reported strong evidence that comprehensive sex education programs do not hasten the initiation of sex nor increase a teenager’s average number of sexual partners. Furthermore, teens who have received comprehensive sex education are significantly less likely to experience an STI or unwanted pregnancy” (Cloninger and Pagliaro, 2002: 35). It is clear that sexual education plays a large role in the prevention of unwanted pregnancies and also in the promotion of female empowerment by enabling females to make informed decisions about their bodies and lives.

Sweden

Sweden is a Nordic country on the Scandinavian Peninsula in Northern Europe. Sweden is the third largest country in the European Union, but is sparsely populated with a total population of about 9.4 million (Befolkningsstatistik, 2010). The country is characterized by its long coastline, extensive forests and many lakes. The country has not been at war since 1814.

Sweden is a constitutional monarchy with a parliamentary democracy of government and a highly developed economy. The Swedish head of state since 1973 is King Carl XVI Gustaf. He represents the country as a whole and performs many ceremonial duties and functions. He does not participate in political life or exercise any political power. The next in line to the throne is Princess Crown Victoria who is currently one of Sweden's most important ambassadors.

General elections take place every four years to give the eligible voters a chance to influence which political party will represent them in the county councils and municipalities (Sweden.SE, 2011). The Swedish Constitution defines how Sweden is governed. It regulates the relationships between decision-making and the executive power. The Constitution is made up of the four fundamental laws, including the Instrument of Government, the Act of Succession, the Freedom of the Press Act and the Fundamental Law on Freedom of Expression. This Instrument of Government allows citizens the ability to obtain information freely and to freely express themselves politically, socially and through expressive actions. The Act of Succession regulates the right of members. The Freedom of Press Act enables public access of official, legal documents for all. The Law on Freedom of Expression allows the freedom to

communicate information and the right to anonymity (Sweden.SE, 2011). The Riksdag, the Parliament is made up of 349 members who are selected by Swedish citizens every four years in general elections. The Riksdag appoints a Prime Minister who helps to form the government. The Government governs the country but is accountable to the Riksdag (Sweden.SE, 2012). In the 2010 election, populist right-wing parties entered the parliament. Populist politics appeals to the “common man” rather than the elites.

The Swedish healthcare system is based on the funds of taxpayers and provides equal access to everyone in Sweden. Life expectancy in Sweden is high and is on the rise. In 2008, the life expectancy was 79 years for men and 83 for women (UNICEF, 2008). The Swedish healthcare system is decentralized and therefore, is dealt with by the combination of the central government, county councils and the municipalities. Sweden is divided into 290 different municipalities, 18 county councils and two regions. The different county councils work toward promoting good health and medical care for the residents in their respective sector. 90 percent of what the county councils deal with is healthcare, but they are also involved in culture and infrastructure areas (Sweden.SE, 2012). Health and medical care accounts for about 9% of the country’s gross domestic product. The county council and municipal taxes pay for the bulk of the health and medical costs. The national government contributes to costs, and patient fees cover a small percentage of the costs (Sweden.SE, 2012). People in Sweden have free choice in health care, meaning they can choose to obtain treatment anywhere in the country. They can also choose their own healthcare provider, whether it is a nurse, doctor, midwife, specialist or any other.

Sweden was a largely impoverished society until the 19th and 20th centuries when it became an important center of industrial development. Sweden's natural resources include iron ore, timber and hydroelectric power. Some of the main industrial sectors include forestry, information technology, automotive and pharmaceutical industries. The industry has evolved throughout the years, from traditional sectors, such as wood and iron ore processing, to more modern industries. This industrial shift was especially prominent in the 1990s with the emergence of new research-intensive industries including information technology and pharmaceuticals. The economy continues to develop due to high levels of education, a skilled workforce and technological advances. "Sweden remains one of the most egalitarian countries in terms of income distribution, and has one of the world's lowest levels of poverty. While Swedes pay high taxes to maintain their prized social welfare system, they are no longer the highest-taxed people in the world" (Sweden.SE, 2012). The economy is organized in a way that it benefits the people and country as a whole.

Education is highly valued in Sweden. Swedish law states that all children should have equal access to education, despite gender or socioeconomic factors. Therefore, primary and secondary education (and school lunches) are free. Law requires school attendance for children ages 7-16. Compulsory school also allows for children with learning disabilities or impairments. 80% of funding for Sweden's universities is from Sweden's government. Another 7% of funding comes from public sources, meaning that almost 88% of financing is in the form of public funding. In 2006, women's percentage in undergraduate programs was 57%, up from 20% in the mid-1940s (Sweden.SE, 2012).

The emphasis on education is clearly very beneficial to the development of the Swedes and to the country in general.

Socioeconomic Factors

Maternal healthcare is very interrelated with socioeconomic factors. Those who can afford better healthcare options tend to have a better health outcome. Since healthcare in Sweden is made available to all, it is clear that this greatly impacts the health and well-being of mothers and their offspring. However, the healthcare and economic systems were not always this way. In the mid 1800s, more than one million Swedes immigrated to the United States in search of a better life. Sweden relied almost entirely on agriculture for their economy, at a time when most other European countries were beginning to industrialize (Kolbik, 1975:8). The move towards a democracy occurred in the early 1900s after a series of grassroots movements for social democracy. The social democratic policies took hold in the mid 1900s and pursued efforts for reform, full employment, child benefits and single-track education, universal health insurance and more progressive taxes. The initial goals for social democracy included preventive social policy, aimed to “hinder or eliminate the occurrence of poverty, unemployment and illness” (Tilton, 1992: 164). The goal of preventive social policy was to be productive and form a collective unity which would create a multitude of benefits. “Women can enjoy new freedoms, economic production can be rationally directed, children need no longer suffer from their parents’ profligacy or neglect, many social ills can be prevented and the capabilities of the workforce greatly enhanced” (Tilton, 1992: 165). The aim was to create a collective responsibility among Swedes for the benefit of generations to come

and the implementation of socialization of consumption in their favor. Social planning and working collectively is ultimately how Sweden was able to reform its economy and social policies. These social changes allow Swedes to take comfort and seek freedom through means of the public sector and a socially controlled market. The Swedish socialist and economic policies encourage individual freedom, gender equality and access to education and healthcare.

Women are more active participants in Sweden's workforce than anywhere else in the world. In 2009, 70.2% of women are a part of the workforce, thus, allowing them to be economically independent and capable (Eurostat, 2010). These ideals promote gender equality. All women have access to day care facilities and fathers have the right to stay home from work and take care of their children on paternity leave. Parents on leave typically receive 90% of their original earnings and are assured that their job will be available to them upon their return to work (Haas, 1992:60). The Swedish ideal of the welfare state consists of several distinct features, including full employment, universal social policy, parental leave insurance, the availability of birth control, abortion and education. These features of the Swedish welfare state are essential to gender equality, maternal health, the empowerment of women and consequently, women's ability to succeed and progress in society. Full employment entails that virtually all who are able and willing to work are employed. Employment is deemed "critical to a person's welfare and sense of belonging" (Tilton, 1992: 277). Aside from benefiting the welfare of the individual, full employment also benefits the collective good of the country because it generates tax revenues and productivity. Full employment is an important objective for Sweden, though they are currently not at that point. In the year 1990, the unemployment

rate in Sweden was about 1.4% for women and 1.5% for men (Bjornberg and Dahlgren, 2003:11). An increase in unemployment is attributed to a large drop in industry and in the public service sector. The success of Sweden to become a welfare state required high taxation and a reasonably efficient public sector to deliver services that citizens want. Sweden also created a workfare benefits system, in which only employed individuals received the benefits, including childcare, paternal leave among others.

In an effort to eradicate poverty, Sweden engaged in an egalitarian income redistribution. This involved the compression of wages, high employment, “supported by high taxes that redistributed income to such an extent that low-decile Swedes are considerably better off in purchasing-power-parity-terms than low-decile Americans” (Bjorklund and Freeman, 1995: 21). The compressed wage structure allows an employed individual to be a part of normal society. The welfare state of Sweden allows for the maintenance of high employment and wage compression that offset disincentives from welfare benefits and high taxes, and that ultimately helped eliminate poverty (Bjorklund and Freeman, 1995: 18). It is clear that Sweden’s transition to a welfare state has created more equality among the socioeconomic status of Swedes, which allows them equal opportunity and access to healthcare and the ability to succeed in society.

Norms, Values and Laws

In every known society, women assume the role of the primary caretaker of their children. There are of course instances where men take on the role of the primary caretaker if the mother is absent, but there is no society in which men and women generally share the responsibilities for child care (Haas, 1992:1). Linda Haas (1992)

introduces the idea that the idea that women should be the primary caretakers for the child has become so culturally universal that it is often assumed that the reason must lie in biology. However, scientists have long rejected the notion that mothers have an innate, unique capacity to care more for their child than the father does.

There is no evidence to show that female hormones or chromosomes make a difference in human maternalness, and there is substantial evidence that non-biological mothers, children and men can parent just as adequately as biological mothers and can feel just as nurturant (Chodorow, 1999: 29).

Since mothers took on the role of the caretaker, they were set back economically, while their husbands were freed to pursue employment opportunities. “Masculinity became defined in terms of men’s levels of ambition and achievement outside the home. The ‘father as breadwinner’ ideal had emerged” (Haas, 1992: 6). The economic dependence of mothers and children on fathers became taken for granted, just as a man’s ability to work and produce economic gains because their wives were taking care of the children and the home became taken for granted. Stereotypes about the roles of men and women in regards to participation in early child care work to encourage women to be the primary caretakers and to depress men’s participation in early childhood care.

Sweden was the first country to institute paid parental leave for both mothers and fathers. This was a big step in the eyes of advocates of equal parenthood. Not only were the issues of gender equality and childrearing responsibilities finally being addressed, but they were being approached as a public issue, not merely as one resolvable within the context of individual families (Haas, 1995:11). According to the Swedish government, equal parenthood is part of the Swedish ideology of equality. This equality entails that men and women have the “same rights, obligations and opportunities to have a job which gives them economic independence, to care for home and children, and to participate in

political, union, and other activities in society” (Statistika Centralbyran, 1990). One key reform of equal parenthood is parental leave. This entitles a Swedish father to fifteen months of paid leave, with a guaranteed return to his work. Pregnant women get fifty days of paid pregnancy leave, in addition to parental leave taken after the baby is born. The benefits are paid directly from social insurance offices. This initiative was a radical attempt to allow women to engage in employment outside of the home and to get men to become more involved in childcare.

These social, political and economic changes to the infrastructure of Sweden were brought on in an effort to improve the lives of individuals and also the collective good of the country. Theorist Gunnar Myrdal spoke about how the investment in human capital was the most worthwhile investment. “Preventive social policy, far from being a drain upon social resources, would be productive; ‘a large part of the state’s expenditures for the health and education of the young and the working generation, and for the welfare of families generally, increased not only the population’s enjoyment of life but also its quality and productivity’” (Myrdal, 1982: 176). Preventive social policy was a productive investment in human capital. “Our riches lie above all in our natural resources and moreover in our population, in its moral health, its intellectual acuity and its physical endurance. We cannot become poorer by taking better care of our human capital (Myrdal, 1982: 332). He emphasized how social policy was extremely worthwhile because equality meant efficiency. Instituting policies like parental-leave programs, public childcare, school-lunch provision has allowed for a more compatible relationship between female employment and motherhood.

These social reforms benefit the lives of both men and women. They have allowed for important changes in gender equality in policies, home, work life, and society. A study on fertility levels of Swedish women by Hoem, Neyer and Andersson (2006) shows that levels of childbearing are positively correlated with levels of earned income. They demonstrate that women with a higher income also have a higher instance of first birth risks than women with low earned income. This can be attributed to the fact that women who are economically independent and comfortable are more likely to have children because they feel more equipped to support the child. Access to education, housing, employment provides a sense of security which can attribute to the higher levels of childbearing. A decent level of income for a woman has become a prerequisite for childbearing rather than a hindrance to it (Hoem, Neyer and Andersson, 2006: 383). These policies have allowed for an increased level of father's engagement in active parenting, equal division of household labor and provided some equal ground in employment and economic gains among men and women.

Maternal Education

The Swedish government strongly encourages and promotes the importance of education. Primary and secondary education are supported by the government and about 88% of tertiary education is funded by the government. The availability of education is very important to the development of the Swedes. A study conducted by Bjornberg and Dahlgren (2003) demonstrates how education is an important factor in determining whether mothers work full-time or part-time. Their findings show that the higher the education level, the more likely it is that the mother

works full-time. Among mothers who have long post-secondary education, 72% work full-time whereas of mothers with 2-year upper secondary education, 52% work full-time. This shows that education is truly instrumental to other important elements of a woman's life (Bjornberg and Dahlgren, 2003: 9).

A separate study (2002) by Bjornberg and Dahlgren shows that the educational level of parents is also an important factor in determining who takes parental leave and who does not. This study shows that fathers with higher levels of education are more likely to take more days of paternal leave than those with lower education. Fathers who have primary and some secondary education or less are more likely to take no parental leave at all. At the same time, those with post-secondary education are more likely to be found among those who take 30 days or more (Bjornberg and Dahlgren, 2002: 23). Education is also positively correlated with wages. Swedish women generally have a higher level of education than men across all age groups. 40% of women ages 25-29 have a post-secondary education, compared with 33% of men in the same age group (Bjornberg and Dahlgren, 2002: 27).

In the mid 1970s, the Swedish government increased the number of study grants for higher education and made student loans separate from spousal income. These two factors greatly contributed to the increase of women, married or not, to higher education (Haas, 2005: 27). This shows that when education is accessible, as is the intent in Sweden, women will take advantage of it in order to better themselves. Women are more likely to have a higher education level than men. "When Swedish parents have different levels of education, it is slightly more common that the mother has the highest level" (Bjornberg and Dahlgren, 2003: 38). In the last decade, it has been common for

young men and women to remain in education longer. This means that women may enter the workforce at a later age, and push off having children until they have a stable position in the workforce.

Sweden's solution to extending human freedom was to promote education and organized workers to assume political and economic power. This could be done through the socialization of workers into the economic life of society. This form of empowerment requires equality and promotes efficiency. It is incredible that education and employment are promoted because this gives women the time and ability to choose when to have a child. It entails that "if children are to be desired, born, and reared to be productive adults, society must invest in their welfare and that of their families" (Tilton, 1992: 260). Sweden's expenditures on Swedes' health and education are seen as important investments in human capital.

Sweden has had a national curriculum for sexual education since the early 1960s. Sweden has among the lowest teenage pregnancy rate (7 births per 1,000) but also among the highest abortion rate (69 per 100 pregnancies were resolved by abortion) (Darroch, Singh and Frost, 2001:3). This shows that sexual education, contraception and abortion are accessible, acceptable and used in Sweden. It also informs us that there is more motivation to delay motherhood in Sweden, perhaps because of positive attitudes towards educational and job aspirations and expectations.

Access to Healthcare

Economic resources are an integral aspect of access to maternal healthcare. Since Sweden provides universal healthcare, no one is left behind. Everyone has equal access to proper healthcare, no matter his or her socioeconomic background. The Swedish healthcare system was founded on the principle of equity and aims to guarantee health resources on a need basis, rather than on socioeconomic terms (Beckman *et al.*, 2004). The Swedish healthcare system is taxpayer-funded and largely decentralized to the county councils. Different sectors of the government work together on initiatives of healthcare to ensure the promotion of good healthcare for the entire population. “Sweden is actively involved in cooperation across the European Union to improve access to health and medical services. This includes collaborating on specialized care, improving patient safety and enhancing patient influence” (Sweden.SE, 2010: 27). The successes of the healthcare system can be seen with the rise of life expectancy among both men and women and the dramatic decrease in mortality of mothers and infants.

There are special clinics for children and expecting mothers, as well as youth clinics that offer advice on a range of issues, including family planning. In an effort to increase access to healthcare, more health-care regions have been set up to provide advanced care (Sweden.SE, 2012). These initiatives have proved to be successful. Sweden has long used trained professional midwives to assist mothers with childbirth. This has contributed to an incredible decrease in the maternal mortality rate. “Between 1860 and 1900, mortality fell 75% as more parishes employed midwives. Today, there are on average, 3 deaths per 100,000 births” (Sweden.SE, 2010). This means that Sweden

has among the lowest maternal mortality rates in the world. Organizations like UNFPA and WHO use Sweden's healthcare system and use of midwives as a model for having achieved the target of halving maternal mortality among mothers by 2015.

A study on oral contraceptive use in Sweden (1993) shows that contraception is widely accepted and utilized by women in Sweden. Of the 2,573 female participants in the study, 2,245 (88%) reported having used oral contraceptives at some time. 77% of these women had started using contraception in their teenage years (Ranstam and Olsson, 1993:32). The availability of contraception is essential to women maintaining control over their fertility, and thus, the well-being of the mother (and her child).

Another study (1993) explores abortion as a form of birth control in Sweden. In 1975, Swedish legislation gave women the right to make a decision about abortion before the end of the 18th week of pregnancy. Abortion services are provided to those women who want it for free. This study aimed to understand high school students' attitudes about abortion. Two-thirds of the participants believed that the decision to have an abortion should be made jointly by male and female partners (Lindell and Olsson, 1993: 281). This type of belief makes sense in a gender egalitarian country such as Sweden, since men often partake in childrearing as much as women do. The majority of the students felt that abortion should not be used as a form of birth control, but rather, as a solution to an unplanned pregnancy. It is clear that access to maternal healthcare and forms of contraception has a positive impact on Swedish women's development because they are able to make informed and conscientious decisions about their bodies, fertility and future.

Conclusion to Comparative Analysis

The comparative analysis of Uganda, Afghanistan, the United States and Sweden ensures the validity of the quantitative analysis. Through these four case studies, I have ascertained that maternal education, access to healthcare, socioeconomic factors, and a society's respective norms, values and laws are very important indicators of female empowerment and gender equality. I found that looking into the healthcare, economic, political and social systems in both developing and developed countries was crucial to gaining an understanding of reproductive rights on a global level.

Through my research, I have learned that gender equality and maternal healthcare are critically important issues throughout the world. I have concluded that gender equity is positively associated with lower fertility and better health for women and children as well as with economic development. While it is clear that maternal healthcare impacts women in each respective country, only some countries make these fundamental rights a priority. The value of women in a given society is an important determinant of a woman's access to proper healthcare.

Through my research, it is clear that in countries where women are not given the chance to participate in society, they are further subordinated and un-empowered. This perpetuates the negative impact on their health and status in society. On the other hand, in countries where gender equality is promoted, women have much better access to the healthcare they need. By granting women equal opportunity within society and creating

policies that accommodate women's reproductive rights, women are empowered and thus, seen and treated as equals. By upholding women's fundamental human rights and allowing women to maintain control over their bodies, this allows women to maintain control over their life and develop as individuals and as participating members of society.

Chapter Five: Conclusion

Reproductive rights are crucial to the lives of women and their progression within society. Through extensive quantitative and comparative analysis of maternal healthcare throughout the world, I have ascertained that socioeconomic status, maternal education, access to healthcare and a society's respective norms, values and laws are extremely critical to understanding female health and empowerment. Reproductive rights impact every facet of society. These rights include basic elements; the ability to reproduce and to regulate fertility; proper prenatal care and safe childbirth; and ultimately optimal

maternal and infant health outcomes. Procreation should be treated and upheld as a basic human right.

Collins *et al.*, (1993) theory on gender stratification provides a useful lens into the patterns of gender inequality across countries. They introduce the importance of economic power and how it translates to decision power making both privately and publicly. Their theory exemplifies the importance of socioeconomic standing for the empowerment and progression of women within their respective society. Unfortunately, the implications of gender inequality result in an unending spiral, a cycle that can be very difficult to escape. If a woman has no access to education, she is less apt to use contraception and becomes increasingly more prone to pregnancy during adolescence. Thus, educational constraints and the burden of un-timely pregnancies most often results in women who are ill equipped to obtain an independent income. A lower socioeconomic status translates to a disadvantaged status within society. Interestingly, this cycle could be broken if women were not burdened with childcare responsibilities and thus, better equipped to make independent economic earnings. Collins *et al.*, (1993) points out that when women are in control their own income they are more likely than men to invest in their children's well-being and education, thus diminishing the cyclical effect of gender inequality.

My quantitative analysis of 215 countries and relevant variables has enabled me to establish the important indicators of maternal health and female empowerment. I have concluded that education and literacy are the best indicators of a positive health outcome and of female empowerment. My analysis indicates the presence of clear trends of gender inequality throughout the world. I have determined that my dependent variables

are maternal mortality rate, life expectancy, adolescent fertility rate based on correlations and regressions with the other indicators. I have ascertained that maternal education, socioeconomic factors, norms, values and laws, and access to healthcare are important measures of reproductive rights.

My comparative case studies identify the degree of variation and similarities of reproductive rights in relation to female empowerment across four different countries. I chose Uganda, Afghanistan, the United States and Sweden in an effort to encapsulate healthcare and gender equality in both developed and developing countries. The quantitative analysis provided me with broad, generalized patterns that exist throughout the world, and the comparative analysis helped to confirm these patterns across specific studies. These case studies proved that a woman's personal development is a direct result of her ability to prevent unwanted pregnancies which is directly correlated to her access to proper healthcare. Thus, regardless of a society's norms or the status of a country's development, the fundamental human rights of women must be upheld. Women must have access to both proper education and healthcare in order for them to maintain control over their lives and develop to their full potential as individuals and as participating members of society.

In order to combat gender inequality, it is important that we work to empower and respect a woman's unique biological ability to reproduce. In order to uphold women's rights as human beings, it is crucial that there is policy in place to promote social change which allows women to maintain control over their reproductive life. Contraception, no matter the form, gives a woman control over her body and as a direct result, the capability to control other aspects of her life. Legislating restrictions or conditions on reproductive

choice essentially denies the fundamental right of all women by limiting it to the privileged.

The complex and varying political, economic and social environments of different countries have made combating gender inequality challenging. It is difficult to create universal development goals because of the degree of political and social variation that exists throughout the world. Therefore, in order to gain an understanding of global reproductive health, it is important to take on an intersectional approach. This method aims to explain the varying types and degrees of oppression by studying gender, race and class. It is critically important that policies allow for appropriate variation among different cultures and countries. Subsequent research should be conducted to determine and systematically address the impact that sexual violence and religion have on women's reproductive rights cross-culturally.

There is no need for reproductive rights to be seen as controversial or taboo issues. Reproductive can simply be defined as upholding the rights of all women and allowing them each the fundamental right of maintaining control of their own bodies and thus, their lives. A woman's unique ability to reproduce should be accommodated and respected, *not* diminished, degraded or subordinated. Women are indeed worth more than their wombs. Globally supporting and promoting women's reproductive rights through social policies that provide universal education and healthcare will empower generations of women to become autonomous, fully participating members of society.

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