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Issues of Abortion and Reproductive Health in the United States and Abroad: The Mexico City Policy

Christina C. Lombardo

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Issues of Abortion and Reproductive Health in the United States and Abroad:
The Mexico City Policy

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Issues of Abortion and Reproductive Health in the United States and Abroad:  
The Mexico City Policy

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Issues of Abortion and Reproductive Health in the United States and Abroad: The Mexico City Policy

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I. Introduction

Abortion has been open to public debate for over two centuries. In the last three decades, it has been a more prominent concern of national public policy. Arguments are not limited to abortion policy and the extent of such policies, but also include moral differences. Through governmental systems, the public debate should ideally be concerned only with policy based on research and scientific study. However throughout history, political figures have influenced policy to reflect their personal moral views.

There are many motivations for abortion. Women may access abortion services to protect their health or in an attempt to limit childrearing. Women may choose to access abortion in order to terminate a gender specific fetus in countries where culture indicates male children are more desired. Women may also seek abortion procedures because they lack the financial means to care for additional children. The cultural and socio economic reasons may be strong motivators in limiting children and consequently accessing abortion procedures.

Arguments against abortion are rooted in the moral belief that life begins at conception. To these individuals, if one has an abortion in the first trimester of pregnancy then one is destroying life. Other individuals oppose abortion because they believe it is used as a birth control method and it should not be used as such.
In the United States (US), medical professionals determine the viability of the fetus or its ability to survive outside the womb. This is based on a legal case, *Roe v. Wade* (see page 15) that indicates a woman can have an abortion until viability of the fetus. Therefore, in US law viability is the scientific measure to determine when life begins rather than conception as a determinant of when life begins.

The number of people who believe that abortion is necessary to protect a woman’s right to choose and the number of people who believe abortion procedures should not be used, are almost equal in the US. The public debate is reflected in the intense political debate. Consequently, the political party in power in the US will attempt to influence abortion policy. For example, the Republican party in the US has recently fought to ban partial birth abortions, or abortions during the last trimester of pregnancy in an effort to control abortion policy and limit a woman’s access to the procedure. The political party in power sometimes extends their reach to international policies as a method to control abortion procedures worldwide.

Closely related to abortion is the use of contraception. If women have education and easy access to contraception, they will be less likely to seek an abortion. There are several methods of contraception. One is the use of a condom by the man or the use of the internal condom by the woman. Other birth control methods include the diaphragm, rhythm method, withdrawal method, and intrauterine devices. Hormonal contraceptives are offered through internal use, such as the nuva ring, external use, such as the patch, and several varieties of oral contraceptives, such as birth control pills. Surgical methods of contraception are available such as a vasectomy for the male and tying of the tubes for a woman. Lastly, RU486, a pill taken after the egg and sperm may have joined is
considered by some groups a form of abortion because it interferes with pregnancy. Other groups view it as emergency contraception. There exists a strong belief by some groups that any form of contraception is an interference with life. Contraception, like abortion, is a politically sensitive issue.

Embedded in the history of abortion is the establishment of the Mexico City Policy, which limits a woman’s ability to access abortion services overseas. This thesis reviews the history of abortion in the United States (US), the history of the Mexico City Policy and the current status of the policy. Issues of reproductive health worldwide will follow. These issues include the impact of foreign abortion legislation. While Part V explains human rights and the various covenants related to women’s health, Part VI discusses the human rights articles as they relate to the Mexico City Policy. In the latter section of this thesis, there will be a discussion of the implications of the Mexico City policy on women’s health throughout the world.

The Mexico City Policy restricts reproductive services that an international, non-governmental agency is allowed to provide to its citizens with US funds. The Mexico City Policy was originally imposed in 1984 by the Reagan administration. The policy limits the ways in which United States Agency for International Development (USAID) funds are used in foreign nongovernmental organizations and specifically addresses issues of abortion overseas. According to the policy, receiving agencies cannot provide abortions, counseling and referrals for abortions, and are prohibited from lobbying for abortion law. The Mexico City Policy would not be constitutional in the US because of the restriction on counseling and referrals and on providing information pertaining to
abortion procedures. The US does not pay for abortions with federal dollars, however according to the Constitution it can not limit or deny the amount of information that is given to a woman regarding the procedure. Also, abortions are still available to women through private, non governmental organizations, such as Planned Parenthood of America. The restrictions of the Mexico City Policy prevent the provision of information and counseling that might well be necessary for positive reproductive health outcomes.

II. Issues of Reproductive Health: Worldwide

The Mexico City Policy places restrictions on a woman’s access to reproductive health services outside of the US. This section defines reproductive health and health services and provides a history of women’s health to demonstrate trends in thinking. Finally, family planning and abortion in the US is discussed.

A. Definition of Reproductive Health

Reproductive health has been an important component of international human rights. In an attempt to directly address this issue, there was a conference devoted to women’s health. The International Conference on Population and Development was held in Cairo in 1994 and focused on women’s health issues. As a result, there were many changes in the conceptualization of population and reproductive health problems. The Programme of Action, a result of the International Conference on Population and Development, was signed by 179 governments and established a framework for providing reproductive health services. The comprehensive framework rejected the
“demographically driven, top down approach that has been the hallmark of many family planning programs for the past four decades” (Haberland, 2002).

In 1994, the Convention on Elimination of Discrimination Against Women (CEDAW), which guarantees equal and gender specific rights of women, in conjunction with the International Conference on Population and Development, provided a much needed concise definition of reproductive health. The definition indicates that included in reproductive rights are: contraception, diagnosis and treatment of sexually transmitted diseases, infertility, abortion and other dysfunctions of reproduction.

In 1995, the United Nations Fourth Conference on Women focused on ensuring “equal access and equal treatment of women and men in education and health care”. The conference goal, specific to women, was “to enhance women’s sexual and reproductive health as well as education” (United Nations Department for Policy Coordination and Sustainable Development, 1995). The United Nations Fourth World Conference on Women concluded that reproductive health;

“implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. …” (Platform for Action of the 1995 Fourth World Conference on Women, Paragraph 95)

Reproductive rights are not limited to abortion. Using the World Health Organization (WHO) definition of health, reproductive health includes “all matters
Based on this definition, reproductive health can be obtained by providing reproductive services. For example services include, but are not limited to: appropriate sex education, counseling, prevention of sexually transmitted diseases, family planning, contraception, treatment of reproductive dysfunctions and birth spacing in addition to induced abortion and post-abortion care (Peters, 1995).

**B. Family Planning**

The goal of public health initiatives is to ensure healthy populations through the reduction of potential risks and consequent mortality. This goal, in terms of women’s health can be better achieved through various avenues of family planning, such as birth spacing, education and offering access to counseling and referral services. As many as 14 million children die each year in developing countries (Rosenfield, 1986), many of these deaths could be prevented through birth spacing alone. Empirical data shows increased birth intervals can decrease infant mortality by 10-20 percent (Rosenfield, 1986). However, without adequate resources offered through family planning initiatives, women are unaware of the benefits of birth spacing, contraceptive methods and options regarding pregnancy.

Family planning strives to decrease the rates of maternal mortality. Access to abortion information, counseling and medical procedures are viable aspects of reproductive health. Without such access, women may delay an abortion or search for alternative options to terminate a pregnancy. Non-medical procedures pose health risks and potentially dangerous complications. Research shows that procedures that are
undertaken later in gestation increase health risks. Maternal mortality and morbidity increase with gestational age at the time the pregnancy is terminated (Coliver, 1995).

National and international family planning initiatives do not promote induced abortion as a method of family planning yet their goal is to provide appropriate services to promote reproductive health. By providing counseling and referrals, this goal is achievable by providing women information, counseling and referrals in order to meet this goal. For example, small birth intervals have negative consequences and are directly correlated to maternal, infant and child mortality (Coliver, 1995). Should a woman conceive shortly after giving birth, it may be in her best interest to abort the fetus. In doing so, the outcome is the preservation of the woman’s reproductive health as well as positive benefits to the birth infant’s health (Wulf, 1998).

Poor prenatal and postnatal consequences are preventable. Rates of maternal and infant mortality can be reduced through comprehensive family planning initiatives. Helping women to space births at healthy intervals and preventing unwanted pregnancies through providing education and providing prenatal care, positively impacts the health of the woman and infant. Restricting family planning narrows the scope of services offered, such as education, counseling and referrals, that might otherwise be instrumental to improving women’s and infants’ health.

C. Abortion

According to WHO, there are an estimated 500,000 pregnancy-related deaths each year. It is estimated that at least 60,000 women die from complications of unsafe abortion procedures (Coliver, 1995). This section will look at the statistics and scope of
abortion, maternal mortality and the impact of foreign abortion legislation on the frequency of unsafe abortion worldwide.

1. Statistics and Scope of Abortion

In 1995, there were an estimated 180 million pregnancies, a quarter of which were terminated (Henshaw, 1999). In some countries, namely China and India, women terminate pregnancies based on the sex of the fetus. Frequent occurrences of unwanted pregnancies may be a causal factor in the high rates of induced abortion (Henshaw, 1999).

In developing countries, many women raise their children in impoverished, unsanitary homes (Cook, 1994) and are often unable to get the nutrition required to promote a safe and healthy pregnancy. Further, a lack of education and available contraception may lead to successive births. Successive and high-risk births may be unplanned, timed at poor birth intervals (Uygur, 2001), or the woman may be infected with a transmittable disease. These characteristics can result in multiple consequences, including death to the mother and/or child. The number of births and the spacing of births affect a woman’s ability to carry a child safely to term (Henshaw, 1999). A pregnancy that results in maternal mortality increases the risk of infant mortality (Wulf, 1998).

Twenty-five to fifty percent of the approximate 500,000 pregnancy related deaths are associated with unplanned pregnancy and subsequent unsafe procedures to abort the fetus (Peters, 1995). The rate of mortality from abortion is .5 per 100,000 procedures (Frederick, 1981). However, it is also noted that the rate of mortality increases 40-60% for each week of delay after the eighth week of gestation (Frederick, 1981). Decreasing
maternal mortality, defined as deaths among pregnant women or women who have been pregnant in the previous forty-two days (Peters, 1995), is a specific indicator of reproductive health. Higher risk of maternal mortality and morbidity is epidemiologically associated with access to medical care (Peters, 1995).

Figure 1 (on page 11) shows rates of maternal mortality related to abortions in United Nations selected regions. For example, the graph demonstrates that close to 25% of all maternal deaths are related to unsafe abortion in Eastern Europe, and the rate of deaths from unsafe abortion is 1/1000. In South-central Asia, the estimated rate of abortion deaths is approximately 29/1000 and approximately 13% of all maternal deaths. The percentage of maternal deaths related to unsafe abortion ranges from 3% - 24% in various countries.

2. Impact of Foreign Abortion Legislation

Restrictive legislation also plays an important role in unsafe abortion. Legislation ensures access to safe, sanitary procedures and impacts maternal mortality. US legislation is less restrictive and allows women access to safe, sanitary abortion procedures. Figure 1 (on page 11) shows the correlation between the rates of maternal and infant mortality with abortion law.

Mortality and morbidity rates are significantly higher in countries that have more restrictive legislation regarding the procedure (Peters, 1995). These restrictions can result in unsanitary and unsafe termination of unwanted pregnancies which are usually performed by the woman herself or by non-medical persons. The fetus may be aborted by insertion of a solid object into the uterus, an improperly performed dilatation and curettage procedure, ingestion of harmful substances or exertion of external force. Each
of these abortion methods has a great potential for post-abortion complications. Secondary complications may therefore lead to maternal death. Therefore, rates of maternal mortality and morbidity can be impacted by legislation (WHO, 1998; Benagiano, 2000).

Figure 2 (on page 11) shows the rates of maternal deaths across the globe. In countries such as the US, there are few restrictions on abortion and a maternal death ratio among the lowest in the world. In comparison, Africa has extremely high rates of maternal mortality and the most restrictive abortion law (refer to graph). It is evident from these examples that there is a strong association between maternal mortality and abortion law (Singh, 1998). Thus, legislation permitting abortion and ensuring its safety is crucial to protecting women’s health.

A comprehensive report published by the Institute of Medicine found that women will terminate a pregnancy regardless of its legal status. Legislation allowing access to abortion procedures results in fewer medical complications and deaths than restrictive legislation and practices (Frederick, 1981). If there are less restrictive policies on abortion and family planning, one could safely assume the rates of hospital admissions due to secondary complications of unsafe abortions, septic and incomplete abortions would decrease.
Figure 1: Estimated annual mortality due to unsafe abortion, United Nations regions, 1995-2000

Deaths due to unsafe abortion as a % of all maternal deaths

Deaths due to abortion as a % of maternal deaths

Estimated number of abortion deaths (1000)

For regions where incidence is negligible no estimates are shown


Figure 2: Maternal Deaths per 100,000 Live Births

Maternal Death Ratios

No data | 0-29 | 30-99 | 100-199 | 200-499 | 500-999 | >1000

III. Background and History of Abortion

This section discusses the legal history of abortion in the US, focusing on landmark cases and the resulting impact on current US law. US abortion laws are important to understanding the Mexico City Policy because the policy is imposed by the US as an international policy, restricts abortion overseas and differs greatly from the laws in the US.

US laws place minimal restrictions on abortion nationally. US law demonstrates that if the same restrictions for counseling, referrals and information were applied in the US, they would be unconstitutional based on the history of abortion law. One would believe US international policy would be aligned with US domestic policies, however that does not seem to be the case.

Abortion laws in the US give a woman the right to terminate a pregnancy before viability with certain provisions. Further, women have the inherent right to information on abortion procedures and potential complications, counseling and referrals to locations where the procedures are performed. Although abortions cannot be paid for using federal dollars, a woman has the legal right to obtain information, counseling, and referrals prior to the abortion procedure.

Title X of the Family Planning Services and Population Act of 1970 is the only federal program in the US that funds both public and private family planning clinics, including those that provide abortion procedures with private funding. Abortions can be provided in private clinics so long as they are not paid for with Title X funds. Funding guidelines indicate clinics are required to provide pregnancy testing. If the result is
positive, clinics are required to provide “non-directive counseling” on options, including abortion. Currently, these guidelines remain in effect and clinics are allowed to provide “non-directive counseling” including information and referrals (Coliver, 1995).

Legal rights promote women’s health. They promote public health measures that prevent unwanted pregnancy, and reduce the rates of poor maternal health and mortality. Women are informed, prior to the abortion, of possible health consequences, and have access to safe and sanitary procedures. This is possible because of US laws which promote the health of women by allowing contraception to prevent unwanted pregnancy and the need for abortions.

A. The Legal History of Abortion in the United States

Before 1820, abortion was legal in the US with little government regulation. Although common, it remained a very dangerous procedure (Hull, 2001). Government regulation began in 1821 with Connecticut as the first state to outlaw “post-quickening” abortions. Quickening is the first motion of the fetus felt by the mother, which usually occurs between the sixteenth and eighteenth week of pregnancy. Following Connecticut state law, many states adopted statutes prohibiting abortion. Further restrictions on abortion required a procedure be medically necessary intended to save the life of the woman. By the early 1900’s, most states did not permit abortion and adopted laws that made abortion a criminal offense (Hull, 2001). Although abortion was illegal, many practitioners still performed abortions for several years in secrecy. For those women who could not locate an illegal abortion provider, many women would attempt to destroy the fetus through the ingestion of chemicals. This was an attempt to force the organs into
convulsions. Some women also used a sharp object to puncture the walls of the uterus (Hull, 2001) to terminate the pregnancy.

Many women had several health complications from these unsanitary methods to abort a fetus, including death during or after an abortion. An estimate from 1937 indicates there were over 500,000 illegal abortions each year (Hull, 2001). The health complications were due to the lack of appropriate regulation on abortion yet it gained little attention. The rise of feminist movement in the mid-1970’s fostered the attention of the government, and at that time legal cases brought before the courts heightened legal regulation on abortion. The legal cases are discussed below.

In 1965, Griswold v. Connecticut (1965) clarified contraception use in marriage. The case held that the right to privacy includes marital privacy. This right is implied in the Bill of Rights of the US Constitution. As a result of this case, there is a constitutionally recognized zone of privacy in marriage, which merits special protection. In 1972, a similar case was brought against the state of Massachusetts. Eisenstadt v. Baird (1972) challenged Massachusetts state law regulating marital contraception. This case extended the right to privacy to the individual, married or single, stating that “If the right to privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child” (Eisenstadt v. Baird, 1972).

These two cases established that contraceptive use was the decision of both the married couple and the individual and limited acceptable legal regulation.

Until this point, statutes indicated that abortion was illegal with few exceptions. Exceptions included saving the life or preserving the health of the woman, rape, incest or
a serious congenital deformity. Elective abortion remained illegal until 1973 with the
decision in *Roe v. Wade* (1973), which challenged a Texas law and argued that denying
abortion is a violation to an individual’s right to privacy.

1. *Roe v. Wade*

   In 1973, a Texas law prohibited abortion. The law was challenged and the court
found that law to be unconstitutional, violating the right to privacy. The Supreme Court
stated the right to privacy is fundamental and extends to abortion. As a fundamental
right, privacy may only be regulated by the government when the state has a
“compelling” interest (*Roe v. Wade*, 1973). As the most instrumental case in the history
of abortion, *Roe* seriously altered abortion law in the US by establishing a trimester
approach. The trimester approach indicated that the interest of the state is to protect both
the life of the woman and the fetus. The state interest must be compelling and it is based
roughly on the trimesters of pregnancy. In the first trimester of pregnancy, little
regulation was permitted. The interest in protecting the life of the woman becomes
compelling in the second trimester. Therefore, abortions are permitted so long as the
health of the woman is protected. In the last trimester of pregnancy, the compelling
interest expands to include the life of the fetus. As noted in the Supreme Court case, the
compelling interest of the state changed during the third trimester of pregnancy once the
fetus is viable. After viability the fetus can be sustained outside of the womb. The state
can therefore prohibit abortion, unless it is medically necessary to save the life of the
In summary, *Roe* established several new legal concepts:

- a) the right to privacy extends to abortion,
- b) a compelling state interest is required to restrict abortion,
- c) a state’s interest in fetal life is not compelling prior to viability,
- d) if the pregnancy is viable, the state’s interest is in fetal life. However, the state must allow abortion to protect the life or health of the woman,
- e) at the end of the first trimester, the state’s interest in maternal health becomes compelling,
- f) under the fourteenth Amendment, a fetus is not a “person”, and the state can not justify abortion restrictions based on theory of when life begins (*Roe v. Wade*, 1973).

The *Roe* decision provided the legal framework for abortion services in the US. Although *Roe v. Wade* (1973) legalized abortion procedures, many states attempted to limit abortion through other avenues. States adopted laws that prohibited the use of public funding, required parental consent and enforced specific restrictions including reporting requirements, a 24 hour wait period, and limited access to abortion providers. These statutes made abortion procedures more difficult for a woman to obtain safely and confidentially.

Despite *Roe*, the legal battles regarding abortion continued with additional attempts to limit access to abortion procedures and state restrictions.

2. *Other Landmark Cases*

In the same year as the historic *Roe* decision, a woman was denied an abortion after eight weeks of gestation because it was a viable pregnancy and the woman’s health and life were not in danger. According to *Roe*, abortions must be allowed to protect the life or health of the woman. In *Doe v. Bolton* (1973), abortion could not be proven medically necessary to preserve the life and health of the woman and therefore could not
meet the conditions of *Roe*. *Doe* challenged this decision, stating that it was unconstitutional. As a result of *Doe*, the court provided a clear definition of health. *Doe* defined health as “physical, emotional, psychological, familial and the woman's age -- relevant to the well being of the patient” (*Doe v. Bolton*, 1973). As a consequence of *Doe*, the companion case eliminated potential loopholes, such as limiting the definition of health to physical or medical health, as in the *Roe* decision. As stated, *Roe* allowed abortions at any stage of pregnancy to preserve the life or health of the mother yet neglected to define “health”. *Doe* legally defined the health of a woman to include emotional and psychological health.

In 1977, the Hyde Amendment was passed to restrict the use of US federal funds for abortions that are not medically necessary to preserve the life of the woman. The Hyde Amendment was challenged in a Supreme Court case, *Harris v. McRae* (1980) but was upheld. This narrowed a woman’s right to abortion in the US. At the same time as the Hyde Amendment became law, a Supreme Court case, *Maher v. Roe* (1977), established that a state could make its own decision whether or not to fund non-therapeutic abortions. Many states banned the use of state facilities and employees from performing abortions and providing counseling (*Webster v. Reproductive Health Services*, 1989).

As stated, there were many state restrictions following *Roe*. *Webster v. Reproductive Health Services* (1989) challenged a state restriction on abortion. The holding upheld a ban on the use of public employees and facilities to perform abortions. Therefore, federal money cannot be used to perform abortions. Public hospitals are funded with federal dollars and consequently cannot perform abortions except to save the
life of the woman. The court held that the interest in fetal life is compelling and questioned the applicability of the trimester approach. Although federal dollars cannot be used to perform non-therapeutic abortions in the US, women can still access abortion procedures, counseling and referrals through clinic funded through Title X funds. In foreign countries, the Mexico City Policy significantly diminishes options for safe abortion, education or counseling to women.

In 1992, Planned Parenthood v. Casey (1992) challenged the trimester standard established by Roe. With advanced technology, fetuses could be viable and sustained earlier in the pregnancy. For that reason, abortions were becoming more difficult to attain. As a result, Casey established an “undue burden” test as a basis for the pre-viability restriction. Casey defined an “undue burden” as laws with the purpose or effect of placing a substantial obstacle in the way of obtaining an abortion (Center for Reproductive Law and Policy, 2001). Restrictions, such as mandatory counseling, a 24 hour wait period and parental notification, can only be implemented after a physician has determined the viability of the fetus. Casey established the state limitations on imposed restrictions. For example, a state restriction that requires notifying the husband of an abortion procedure would be considered unduly burdensome for the woman. More importantly, Casey reaffirmed Roe’s standard to evaluate allowable state restrictions after viability. It also eliminated the trimester framework. Thus, a woman could decide to terminate a pregnancy until viability. After viability the state’s interest in fetal life becomes compelling and elective abortion can no longer take place.
3. Overall Impact of Abortion Cases

*Roe* was clearly a significant case in establishing the legal right to abortion and the trimester approach. By establishing a legal framework, many state abortion statutes were invalidated, allowing women to take more control of their reproductive functions, including termination of pregnancy. States were required to change or adopt new laws that adhered to the precedent set by *Roe*. In doing so, many states attempted to limit access to abortion through additional restrictions. Regulating abortion through funding, access to safe procedures, requirements for parental consent and reporting requirements were restrictions implemented by several states following the *Roe* decision. These restrictions were attempts to deter a woman from terminating a pregnancy.

Although abortion remains legal in the US with restrictions that are not considered unduly burdensome, foreign policy differs greatly. The foreign policy of the US has placed specific restrictions on agencies receiving US funds. These restrictions hinder a woman’s ability to control reproductive functions by restricting counseling and information, and consequently compromise reproductive health as discussed in section II.

The US maintains a strong stance on abortion; allowing women to access safe abortion procedures prior to viability in US based clinics. This stance in the US is opposite of the Mexico City Policy which will not fund any reproductive health services if abortions are performed at the receiving agency. Historic cases have aided in streamlining and narrowing the scope of legal restrictions placed on a woman’s choice to terminate a pregnancy. The “undue burden” test and the compelling interest in maintaining the health of the women attempts a legal safeguard for the reproductive health of the woman.
IV. The Mexico City Policy

Abortion policy extends from domestic to foreign efforts. Although Roe was a victory for many Americans, it was a great loss for others. In an effort to continue the political fight regarding abortion, the political figures who viewed the domestic Supreme Court ruling as a loss, created an opposite foreign policy. Following Roe, foreign policy was delineated to ensure the denial of, or extremely limited access to, abortion overseas. The effort to push abortion policy beyond the limits of the US, was successful in the introduction of the Mexico City Policy.

A. History

The United States has given financial assistance to foreign healthcare agencies since 1961, with the establishment of the Foreign Assistance Act. The aim of this Act was to provide financial assistance to international entities which focused on specific problems such as agriculture, family planning, education, among others. In 197 following Roe v. Wade, the Helms Amendment was added to the Foreign Assistance Act. The Helms Amendment strictly prohibited the use of US funds for abortions overseas. The Hyde Amendment in 197 part of the Foreign Assistance Act, work in conjunction with the Helms Amendment. The Hyde Amendment, as mentioned before, restricted the use of federal dollars for abortion procedures within the US. International policies extend domestic restrictions, such as the Helms and Hyde Amendments, to include the prohibition of lobbying local governments regarding abortion, counseling, information and referrals once the Mexico City Policy was introduced in 1984.
In 1984, the Reagan administration introduced the Mexico City Policy at the United Nations International Conference on Population in Mexico City. The conference emphasized an integrated approach to population, resources, environment and development (http://www.unfpa.org/intercenter/agenda21/intro.htm, accessed 7/29/03). The Mexico City Policy restricted foreign agencies from providing abortions, except in cases of maternal danger, incest or rape. In addition, agencies could not provide counseling or referrals for abortions. These activities were strictly prohibited under the Mexico City Policy even if non-US funds were available. Under the conditions of the policy, a woman does not have access to abortion procedures, related information, referrals and counseling.

In 1991, an attempt was made to reverse the Mexico City Policy (H.R. 2508- H. Rept. 102-225), however the House of Representatives of the US rejected it. At the same time as the attempt to reverse the policy was taking place, Rust v. Sullivan (1991) upheld US federal regulation that restricted programs from providing non-therapeutic abortions if they received federal funds. Under Title X funding, agencies are allowed to provide information, referrals and “non directive” counseling on all options, including abortion. As stated, US federal dollars can not be used to provide abortion procedures overseas, yet in the US women have access to information, counseling and referral services (Coliver, 1995, Hull, 2001).

Another attempt to reverse the policy was made in 1992 (H. Rept. 102-101), however it was dropped under threat of a presidential veto by George H.W. Bush. Once in office in 1993, Bill Clinton repealed major portions of the Mexico City Policy by allowing counseling, referrals and lobbying for abortion. According to Clinton, the
The Helms Amendment was still valid so organizations were required to maintain segregated accounts so US federal dollars were not used for abortions. Having two accounts gave both the US and the funded agencies a way to prove that US dollars were not used for abortions overseas. In other words, agencies could provide abortions with their own monies, but not with US dollars. US dollars could, however, be used for related activities, such as information, counseling and referrals. The changes imposed by Clinton remained until George W. Bush became President in 2000.

On January 22, 2001, an announcement was made stating the Mexico City Policy was reinstated and a presidential memorandum would follow. The policy states “foreign nongovernmental organizations (NGO) [are] to agree as a condition of their receipt of [US] federal funds for family planning activities that such organizations would neither perform nor actively promote abortion as a method of family planning in other nations” except for cases of rape, incest and maternal danger (Federal Register, 2001). International agencies that perform, even with non-US funds, or actively promote abortion as a method of family planning are ineligible for funding.

The presidential memorandum, entitled “Restoration of the Mexico City Policy”, provided clear guidelines for the Mexico City Policy. It was issued on March 28, 2001. Mexico City Policy guidelines prohibit NGO’s from the following activities:

1. Counseling or providing advice and information regarding the benefits and availability of abortion as a method of family planning;
2. Providing advice or referrals for abortion;
3. Lobbying a foreign government to include abortion as a method of family planning;
4. Conducting a public information campaign regarding the benefits or availability of abortion (Federal Register, 2001).
The memorandum clearly states that under no circumstances are agencies allowed to perform abortions except in cases of rape, incest or maternal danger. The policy also allows for post abortion care following abortion procedures so long as the abortion is not performed in the funded agency. Although there are exclusions for providing abortions and post abortion care is permitted, according to the memorandum NGO’s cannot purchase the necessary medical equipment with US funds (Federal Register, 2001). For example, under the conditions of the Mexico City Policy, post-abortion care is allowed. The need for funding is great and many agencies lack the financial resources to purchase the medical equipment. Therefore, it is extremely difficult or impossible for agencies to provide post abortion care.

B. Current Status of the Mexico City Policy

The US Senate approved language taken from the Global Democracy Promotion Act which states US funds may not be denied to overseas groups based on the medical services they provide and US funds may not be used to impose restrictions on free speech that would be illegal if applied in the US. This language would essentially overturn the Mexico City Policy in the fiscal year 2002 Foreign Operations Appropriations Act (Center for Reproductive Law and Policy, www.crlp.org). The language states that the President is prohibited from refusing to fund NGO’s solely because they provide medical services related to abortion, including counseling and referrals, which are legal in both the US and the receiving country. Further, the President is prohibited from imposing free speech restrictions on foreign NGO’s (that is, lobbying governments regarding abortion), which are not imposed on US organizations receiving assistance under the foreign aid
program. In other words, the US cannot impose restrictions on foreign NGO’s that would not be applied to US based organizations receiving funds. Accordingly, the policy restrictions would not be constitutional in the US and by virtue of US law, could not be imposed internationally (CRLP, www.crlp.org).

In an effort to circumvent the Senate approved language, which essentially overturned the Policy, the Bush administration froze the US contribution to international organizations in January of 2002. This contribution was previously approved in December of 2001.

During the fiscal year 2003 budget process, Congressional supporters of international family planning focused extensively on restoring funding. Funding remained unresolved until the State Department made an official announcement indicating that the United States was revoking funding. As of July 2004, the funding has not been restored (Marquis, 2004).

The Senate version of the fiscal year 2003 Foreign Operations Bill included language to overturn the Policy (CRLP, www.crlp.org). The focus on the restoration of funding to international organizations has resulted in a lack of attention to overturning the policy and the policy remains fully intact.

C. Legal Challenges to the Mexico City Policy: A Historical Progression

The first of several legal challenges against the Mexico City Policy occurred in 1985. The plaintiff argued that the Policy violated freedom of speech because it limited access to information about abortion and democratic participation in foreign countries. The case was overturned when the D.C. Court of Appeals found that the Policy was not
in violation of freedom of speech (DKT Memorial Fund v US Agency for International Development, 1989). The court stated that agencies were free to accept US dollars and therefore knowingly decided to agree to the conditions.

Planned Parenthood Federation of America (PPFA) brought a case against USAID which challenged USAID, and specifically the policy, as a violation of freedom of speech. The Supreme Court dismissed the case in 1990, stating that the attempt to reverse the policy based on freedom of speech was unwarranted and without merit (Planned Parenthood Federation of America v. USAID, 1988). In other words, the argument brought forth by PPFA was based on unproven relationships between foreign NGO’s and US based organizations. In 1990, the Pathfinder Fund, Population Council, and the Association for Voluntary Surgical Contraception sued USAID. Pathfinder et al. (1961) claiming that the clause for funding eligibility violated the constitutional rights of US based organizations to support abortion-related activities abroad. The District Court dismissed the case stating that the plaintiffs did not substantiate their claim.

Since the recent reinstatement of the policy, lawsuits have followed. The Center for Reproductive Law and Policy (CRLP) launched a lawsuit in 2001 in New York against President Bush claiming that the Policy is “global censorship that violates fairness, freedom and democracy” (CRLP v. Bush, 2001). In addition, CRLP argued the policy denies the First Amendment rights of American lawyers working with foreign partners (CRLP v. Bush, 2001). The suit was dismissed stating that the CRLP lacked the standing to challenge the President. In addition, the court stated that accepting US funding is a voluntary process, therefore making any censorship voluntary, as stated in earlier cases regarding the policy. In other words, receiving the funds is voluntary so the
US can place any restrictions they want on the money. The CRLP advocacy group appealed to the US Court of Appeals for the Second Circuit. This appeal was dismissed on September 13, 2002 (CRLP v. Bush, 2001).

US Courts have found legal arguments against the Policy unwarranted, unsubstantiated and unfounded. The arguments brought against the Policy have not been legally sound arguments and have failed in changing the policy. Generally, the Courts have stated that the policy is not in violation of the US Constitution because acceptance of funds is voluntary. By voluntarily accepting funds, the receiving agency must therefore comply with the restrictions.

D. Implications for Foreign Agencies

There are specific implications to the implementation of the Mexico City Policy. Agencies receiving funding must adhere to the conditions set forth and many of the implications hinder the positive reproductive health of women.

An implementation study published by the Population Technical Assistance Project for USAID found the major result of the implementation of the Mexico City Policy was “over cautiousness” on the part of the employees working for agencies who received US funding (Blane, 1990; Coliver, 1995). Employees did not answer questions posed by pregnant women, even if they were questions regarding the accessibility of abortion procedures or if abortion was legal in the country where the agency is located. Although the Mexico City Policy allows for “passive” or non-specific referrals, agencies feared jeopardizing their funding and therefore opted to avoid all possible interactions regarding abortion. Study findings demonstrated that overcautious employees were
unwilling to provide any educational information about abortion. The conclusions of the study indicate that “this situation may be having an impact on women’s health issues in some cases” (Coliver, 1995).

Perhaps the most detrimental restriction is monetary. Agencies and/or governments providing funding place conditional restrictions on the services that the receiving agency is permitted to provide, as well as ways in which the agency can use their own funds (CRLP v. Bush, 2001). This conditional funding serves as a major source of financial support in the developing world, and therefore it is very difficult for NGO’s to refuse these funds. Because NGO’s need money, they feel great pressure to accept funds offered and therefore comply with the restrictions.

Financial restrictions placed on receiving agencies, namely the US imposed Mexico City Policy, potentially hinder the reproductive rights of women by limiting family planning services, education and access to information. If these family planning services existed, they would protect women’s health by reducing rates of maternal mortality and morbidity associated with reproductive functions.

The policy does not directly deny a woman’s right to health care and information, nevertheless its implementation and stringent restrictions have placed an undue burden on receiving agencies. The need for funding is great and the loss of funding would be detrimental to the services provided. In an attempt to continue providing services, the agencies accept conditional funding, but this hinders reproductive health by denying women the right to accurate information.

The Mexico City Policy obstructs access to safe abortion by placing restrictions on foreign agencies, even if abortion is permitted by law in that country. In accepting
funds, the agency is not respecting the laws established in their respective country. For example, the International Planned Parenthood Federation (IPPF) is based in England where abortion is legal. After the Mexico City Policy was introduced, the London-based IPPF was unable to comply with the restrictions because English law indicated that abortion was legal. Without accepting these funds, IPPF lost roughly 90% of their funding (Coliver, 1995).

V. International Human Rights

_The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..._
- Preamble to the WHO Constitution

_“And repressed people around the world must know this about the United States...We will always be the world’s leader in support of human rights.”_
President George W. Bush (May 18, 2001)

Human rights documents set out guidelines for basic human rights for individuals. These guidelines serve in developing international policy. These documents include the United Nations, Universal Declaration of Human Rights, International Covenant on Civil and Political Rights (The Political Covenant), the International Covenant on Economic, Social and Cultural Rights (The Economic Covenant), among others. These documents are potentially an additional means to challenge the Mexico City Policy. However, human rights documents are not able to enforce moral or legal rights. They are a broad set of guidelines intended to streamline the development of international policies.
Although they are not enforceable, they lay out a framework to help countries to reach for the highest attainable stand of health and to plan a good life for their populations.

In this section, human rights will be defined followed by an explanation of the United Nations and the International Bill of Rights. The legally binding human rights treaties, such as: the International Covenant on Civil and Political Rights (The Political Covenant), the International Covenant on Economic, Social and Cultural Rights (The Economic Covenant), and the more recent Convention on the Elimination of Discrimination Against Women (Women’s Convention) will be explored.

Human rights are considered a fundamental freedom. They are the basic rights an individual has by nature of being human. Human rights are universal and ensure that all people are treated equally. Human rights include: 1) civil, 2) political, 3) economic, 4) social, 5) cultural and 6) the rights of individuals, groups of people (Cook, 1994; Mann, 1999). On many levels of government systems, these freedoms are accepted, understood and many countries are in compliance with the international declarations and covenants set forth to protect human rights.

International human rights protect and promote fundamental rights, including the right to health (Mann, 1999). The most widely accepted definition of health was developed by the World Health Organization (WHO) in 1994. According to this definition, health is a “state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.” Health as defined by WHO, includes social determinants to health and therefore expands the avenue for providing health services. A definition of this caliber necessitates health promotion and a level of control to improve
health (Mann, 1999). To do so, one must be aware of their choices, have accurate information available and make informed decisions pertaining to their health.

Given the definition of health, human rights include much more than medical and health related services. Achievement and maintenance of health as defined by WHO, requires attention to the promotion and protection of women’s health. The promotion and protection of women’s rights can be addressed through four key components. These components are necessary to ensure the rights of women are not violated, but are protected under International Human Rights law (Cook, 1994; WHO, 1998). Thus, the promotion and protection of women’s rights can be addressed through the following rights:

- The right of women to be free from all forms of discrimination;
- Rights relating to individual freedom and autonomy, including rights regarding survival, liberty and security, rights regarding, family and private life, and rights to information and education;
- Rights to health care and the benefits of scientific progress;
- Rights regarding women’s empowerment, including the rights to freedom of thought and assembly and the right to political participation (Cook, 1994; WHO, 1998).

Women are entitled to rights that are specific to their gender. Many countries, however fail to recognize the rights of women. Throughout the world, women are not afforded rights specific to their gender, namely reproductive rights (Cook, 1994). As seen in various international treaties, human rights are intended to protect and promote the reproductive health of women. Various treaties address health, maternity and information. Although basic human rights should protect reproductive health, those protections are limited by the Mexico City Policy.
A. United Nations Universal Declaration of Human Rights

The United Nations Charter was established in October of 1945, creating an international collaboration among the people worldwide. The founding of the United Nations followed the United Nations Conference on International Organization in San Francisco, California and identifies fundamental human rights “in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small” (UN Charter, 1945).

The United Nations ensures that there are fundamental freedoms and rights of humans. The UN strives to guarantee international peace and security, “friendly relations among nations,” and to achieve “international cooperation in solving international problems of an economic, social, cultural, or humanitarian character.” Ultimately, the UN serves as a central force in “harmonizing the actions of nations in the attainment of these common ends” and is responsible for preparing the ground for the Universal Declaration of Human Rights.

B. International Bill of Human Rights

In 1945, the United Nations reached a consensus stating that all people are “born free and equal in dignity and rights” therefore making their mission the promotion of human rights (Mann et al, 1999). As a result, the Universal Declaration of Human Rights (UDHR) was established in 1948, following the ill treatment of people during World War II (Mann et al, 1999, Detels, forthcoming) and the aforementioned consensus. This serves as the universal standard for all nations; the preamble clearly states human rights and dignity are self-evident (UDHR).
The UDHR states that all people are entitled to basic rights, simply because they are human. Along with this feature of human rights, there are five others identified by Mann et al. (1999). Others include:

- human rights are universal,
- people are treated as equal,
- human rights are the rights of individuals, which address the relationship between individuals and the government,
- the fundamental principles of humanity are addressed through human rights, and
- national states can not limit the promotion and protection of human rights.

(Mann et al, 1999)

Although the UDHR was not created as a legally binding instrument, the foundation it provides has become legally binding through the subsequent development of two international treaties, namely the International Covenant on Civil and Political Rights (CCPR) and the International Covenant on Economic, Social and Cultural Rights (CESCR). These human rights treaties, along with the UDHR, constitute the International Bill of Human Rights (Mann, 1999).

Nations that have voluntarily endorsed these human rights documents were legally bound to ensure that government actions did not violate human rights. As of December of 2002, 146 and 149 states became parties to the CESCR and CCPR respectively (UN High Commissioner for Human Rights, 2002), including the United States.

Monitoring bodies were established and required states to submit reports periodically indicating that actions have been taken to ensure that human rights have not been violated. Nongovernmental organizations are required by the monitoring bodies to submit periodic reports and as a result, NGO’s have the opportunity to report the promotion and protection of human rights. The reports that are submitted are scrutinized.
and aid the monitoring bodies to develop general recommendations to assist countries in the interpretation of the content of treaty articles. Further, they aid in the application and determination of measures, indicators and criteria used to evaluate their implementation.

Treaty articles create the basis to advancing safe motherhood, both individually and collectively. Both the CESCR and the CCPR contain articles that are pertinent to reproductive health and the rights of women. Those treaties and the specific articles related to women’s health are discussed below.

C. International Covenant on Civil and Political Rights (The Political Covenant)

The International Covenant on Civil and Political Rights, hereon in referred to as the Political Covenant, was adopted by the UN General Assembly in 1966 and entered into force on March 23, 1976. As stated, there are 144 states including the US, party to the covenant, which ensured the right to life and survival, liberty and security of person, the right to marry and have a family, the right to receive and to impart information, and the right to be free from inhuman and degrading treatment (Columbia University, 2001).

The Political Covenant, Article 23: The right to marry and found a family
"The family is the natural and fundamental group unit of society and is entitled to protection by society and the state."

The Political Covenant, Article 17 (1): The right to private and family life
"No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home…"

The Political Covenant, Article 19: The right to receive and to impart information
"…Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice…" established by law."

Continued on page 34.
The Political Covenant, Article 6 (1): The right to life and survival
“Every human being has the right to life. This shall be protected by law. No one shall be arbitrarily deprived of his life.”

The Political Covenant, Article 9 (1): The right to liberty and the security of the person
“Everyone has the right to liberty and security of the person…no one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.”

The Political Covenant, Article 7: The right to be free from inhuman and degrading treatment
“No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment…”


D. International Covenant on Economic, Social and Cultural Rights (The Economic Covenant)

Similar to the International Covenant on Civil and Political Rights, the
International Covenant on Economic, Social and Cultural Rights, hereon is referred to as the Economic Covenant, was adopted in December of 1966. It was entered into force on January 3, 1976 and includes the right to the highest attainable standard of health and the right to education (Columbia University, 2001).

The Economic Covenant, Article 10 (2): “Special protection should be accorded to mothers during a reasonable period before and after childbirth.”

The Economic Covenant, Article 12: The right to the highest attainable standard of health
“1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   (a) The provision for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child…”

E. Convention on the Elimination of Discrimination against Women (Women’s Convention)

In 1979, the Convention on the Elimination of All Forms of Discrimination Against Women (Women’s Convention) was adopted by the UN General Assembly and entered into force as an international treaty in 1981. As a culmination of thirty years of work by the UN Commission on the Status of Women, the Women’s Convention is the central and most comprehensive document establishing an agenda for action to guarantee equal and gender specific rights of women. Major attention is devoted to the reproductive rights of women; stating in the preamble “the role of women in procreation should not be a basis for discrimination” (Columbia University, 2001).

The right to reproductive choice is a recurring theme in the Women’s Convention as it is the only human rights treaty that addresses family planning. According to the Women’s Convention, states who are party to the treaty are obliged to provide advice on family planning in the education process. This document is responsible for the establishment of the international bill of women’s rights and has brought humanity on behalf of women into the focus of human rights.

Women’s Convention, Article 16(1): The right to free choice of maternity
“States parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure... (e) the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”

Women’s Convention, Article 10 (1): The right to information on family planning
“States parties shall take all appropriate measures to eliminate discrimination against women in order to ensure ...(h) Access to specific educational information to help ensure the health and well-being of families, including information and advice on family planning.”

VI. Applying International Human Rights to Reproductive Health

To date, the Mexico City Policy has been challenged in the US yet not in the international arena on the grounds of a violation of human rights. Human rights, as set forth in the Political and Economic Covenant, are legally binding rights. As international documents, they are applicable to the Mexico City Policy and the policy goals should foster the goals of human rights doctrines. However, the human rights doctrines are broad legal guidelines that are extremely difficult to enforce. In this section, the Mexico City Policy will be examined using legally binding international covenants to determine if the policy violates human rights as set forth in 1948 in the Universal Declaration of Human Rights.

Human rights covenants pertaining to women’s reproductive health can be categorized as they contribute to overall health (WHO, 1998). The categories are listed below:

- Rights of life, liberty and security of person;
- Rights of family, maternity and health;
- Right to information (WHO, 1998).

These are legal rights as stated in various human rights covenants. Moral rights are embedded in many of the legal rights. For example, exercising reproductive functions is a moral right. The right to the highest attainable standard of health is a legal right but this is very broad and it is not possible to enforce it because the highest attainable standard of health can not be easily defined. The two rights, moral and legal, must be in accordance for positive reproductive health. Moral rights are not enforceable by law yet they contribute to the overall health of a woman.
A. Rights of Life, Survival and Security of Person

Perhaps the most obvious right applied to women’s health is the right to life (Political Covenant, Article 6 (1)). Applied to women, this right protects a woman from the risk of death in childbirth due to a lack of access to care or sanitary procedures. In order to protect this right, States that are party to the covenant must adopt positive measures, such as those necessary to reduce maternal and infant mortality. It is estimated that there are 1,400 maternal deaths worldwide each day (WHO, 1998), which could be prevented through governmental measures that ensure and promote safe childbirth and pregnancy. A lack of services may jeopardize liberty and the security of person through health (Political Covenant, Article 9 (1)). Medical and health systems can adversely affect a woman by placing her at an increased risk of mortality or morbidity and therefore denying her right to security of person. For example, by improving the conditions in which a woman can obtain an abortion, a woman’s right to security of person is guaranteed. It has been argued that this right protects a women’s “freedom to decide if, when and how often to bear children” (WHO, 1998). Thus, security of the person ensures that women have access to care which would prevent mortality and morbidity. If appropriate health care and treatment is not made available to women, it may be a violation of human rights in that she is subjected to inhuman treatment (Political Covenant, Article 7). Healthcare for women may include the treatment of a high risk pregnancy and preservation life or health through termination of a pregnancy.

As the human rights articles are applied to women, it is clear that many of the concerns surround reproductive health. Abortion is not universally legal, however if
there is a medical necessity, the best possible care must be provided in accordance with
the articles set forth.

B. Rights of Family, Maternity and Health

According to human rights doctrines, the family is highly respected and therefore
afforded certain protections. As seen in the Political Covenant (Article 23), the family is
“entitled to protection by society and the state.” The right to found a family implies that
there is a possibility to procreate and this therefore includes planning, timing and spacing
births (Hull, 2001). Birth spacing is addressed in the Women’s Convention (Article 16
(1) (e)) clearly stating that the family has the right to “decide freely and responsibly on
the number and spacing of their children.” Planned pregnancies allow women to
maximize the health of her offspring as well as her own and according to Article 10(2) of
the Economic Covenant, the woman is entitled to specific protections before and after
childbirth. Implicit in these articles are protections to preserve reproductive health if the
decision to bear children is made. It is important to recognize that in the Women’s
Convention the decision to bear children is the right of the family unit. Ultimately it is
the women’s moral right to exercise reproductive functions and it must not be limited. If
the needs of a woman are neglected and women are at risk for maternal death or
disability, the rights to family are jeopardized.

As the woman’s right to decide reproductive functions should not be limited, the
right to a private and family life (Political Covenant, Article 17 (1)) should not be
subjected to interference. Private decision between consenting partners concerning
maternity are protected against governmental intrusions (Political Covenant, Article
Private decisions include choices regarding maternity. Private and family life is protected against government intrusions and the right to a private life respects choices of women regarding maternity. Therefore, women can not be subjected to bear children against their will (WHO, 1998).

Respecting a woman’s private life also ensures that women can aspire to the highest attainable standard of health by ensuring that a woman decides reproductive functions. If a woman is able to make decisions regarding reproductive functions with the advice from a medical provider, the choices would be aligned with her life. Therefore, women are able to take a greater responsibility for their health. This is related to the highest attainable standard of health by examining the scientific technology that is available to women. In other words, if there are medical procedures that are available, then a woman should have the moral right to obtain those services. Without those services available, women may be forced to take undesirable measures.

The right to the highest attainable standard of health is an inalienable right (Economic Covenant, Article 12). Indirectly, Article 12 addresses reproductive health services in view of the fact that birth intervals and multiple births jeopardize infant survival and health (Wulf, 1998). To implement the right to the highest attainable standard of health (Economic Covenant, Article 12), there are essential features that are interrelated. Availability of health services is crucial to the implementation of the highest attainable standard of health. The second feature, accessibility, has four components. The first two components state that healthcare must be physically accessible and accessible to all populations without discrimination. Third, economic accessibility guarantees that healthcare is affordable for all populations. Lastly, there is a right to
information accessibility, defined as the “right to seek, receive and impart information concerning health issues” (WHO, 1998). The third feature of the right to the highest attainable standard of health is acceptability, which indicates respect for medical ethics and culturally appropriate practices. Quality, as a feature of the standard of health, requires scientifically and medically appropriate procedures of good quality.

This article (Economic Covenant, Article 12, section a) directly addresses the reduction of infant mortality and still-birth rates. High risk pregnancies and maternal mortality increase the likelihood of infant mortality. Accordingly, the Women’s Convention directly addresses reproductive health and family planning. Article 16(1) states that a woman is free to decide the number and spacing of her children. In doing so, a woman can control and maximize reproductive health as well as the health and survival of her unborn and existing children. Therefore, to comply with these articles, it is crucial that a woman has the right to determine reproductive functions, including induced abortion. Compliance also requires medically appropriate procedures of good quality. In countries where abortion is legal, healthcare facilities should act in accordance with the four components of the accessibility feature of the standard of health.

C. Right to Information

Under the Political Covenant, Article 19, the right to information is understood as the freedom to seek, receive and impart information. Traditionally the right is to be free of government intrusion, yet some now argue the right has evolved to include obligations of governments to provide information (WHO/RHT/MSM/97.16, 1998). This suggests governments have a duty to provide information to protect and promote reproductive health, including choice. Encompassed in this obligation is the necessity to guarantee
access to information. Violations of access to information could be seen in instances where maternal death or disability could have been prevented through appropriate information. Information regarding pregnancy or abortion complications, primary or secondary, prevention and care for complications could decrease the number of poor maternal health outcomes.

The Women’s Convention is the first international treaty to address family planning specifically. Article 10(1) of the Women’s Convention delineates information specific to reproductive health and family planning to “ensure the health and well being of families.” Women must be able to receive information and education regarding family planning methods and have safe access to reproductive health services in order to make informed choices.

The right to information may be the most vital of reproductive rights. In order to make informed choices regarding their reproductive health, women must have comprehensive information. Without information, women may seek abortions when the gestational age suggests a greater likelihood of complications. The increased risks of later abortions may be unknown to the woman and symptoms of post-abortion complications may not be recognizable to the woman. Therefore, information regarding family planning and reproductive choice is vital to ensuring the long-term health of the woman.
VII. Discussion

“The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.” (Platform for Action, Paragraph 97)

The Mexico City Policy has been challenged under US law on various occasions. To date, it has not been challenged under international law. The Universal Declaration of Human Rights is not a legally binding document, however the articles set forth are considered to be fundamental freedoms. Article 21 states “Everyone has the right to take part in the government of his country, directly or through freely chosen representatives.” The Mexico City Policy forbids lobbying a government to legalize or make abortion available as a method of family planning. Based on the legal status of the UDHR, the policy is not a legal violation yet its conditions are not aligned with the mission of the doctrine. Legally binding human rights, such as the Political Covenant, Economic Covenant and the Women’s Convention, that pertain to women strive to promote and protect reproductive health. On the other hand, NGO’s must comply with conditions that hinder the promotion of reproductive health and cause women to suffer poor health consequences of reproduction because of the Mexico City Policy.

Pertinent human rights articles address numerous areas that can be applied to reproductive health. Incorporated in the right to start a family is the right to maximize the prospects for survival for the conceived or existing child (Mankiller, 1998). This can be accomplished through birth spacing, induced abortion or contraception.
Complementary to this right is the right of the woman to ensure her survival, through delaying pregnancy or successful birth spacing. The right to life entitles a woman to have access to reproductive health services without legislative obstruction. Certainly obstructing access to education and family planning violates international human rights and increases a woman’s risk for complications, disability and death. The Mexico City Policy does just this by forbidding access to counseling, referrals and information about abortion procedures.

Women cannot preserve their health or the health of their children without accurate information. The right to information guarantees a woman access to comprehensive information regarding matters of reproduction. By limiting access to counseling, referrals and advice, the Mexico City Policy is not upholding this right, nor is it protecting or promoting the health of women. Although the policy allows for “passive” or non-specific referrals the implementation study conducted by USAID found women were being turned away if they asked for information regarding pregnancy options, including abortion. For fear of losing funding, agencies receiving US AID funds violate a woman’s right to information and hinder her ability to decide freely matters relating to reproductive functions.

There are many consequences to uninformed decisions regarding pregnancy and childbirth. As a result of childbirth, a woman may be faced with post partum depression and the child may be at an increased risk for neglect. In many countries, there are stigmas associated with abortion procedures and a woman may be shunned for having chosen to terminate a pregnancy. Information and education surrounding reproductive health will aid in increasing the level of awareness within society.
It is also important to recognize that many women will terminate an unwanted pregnancy regardless of the legal status of abortion. Women may resort to unsafe procedures to abort a fetus. Puncturing the walls of the uterus or ingesting chemicals as means to abort a fetus, can lead to severe complications. In order to decide if abortion is a feasible option for a woman, she must also know the risks and potential complications of such a procedure. Limiting access to abortion procedures and information on pregnancy options has a negative effect on a woman’s physical, mental and social well being. Lack of information is perhaps the most detrimental aspect of reproductive health. Women need accurate, appropriate and timely information to make choices regarding their reproductive options. Without information, women are unable to make informed decisions that benefit their emotional and physical well being. Therefore, safe procedures and options should be made available to decrease the number of unsafe abortions performed each year.

At minimum, women should be fully aware of the functions of their reproductive systems and the medical procedures available to control reproduction. The ability to carry a child is uniquely a woman’s and discrimination should not be embedded in this role.

A. The Future of Policy Surrounding Reproduction

By calling for special attention to empowering women, women’s rights have become the forefront of the international agenda. International conferences have encouraged “subtle and overt changes” in respect to population and health policy (Haberland, 2002). Raising awareness of the injustices women are faced with empower
them to take control of their health. Access to education and information, contraception and counseling will aid women in making informed, healthy choices that are in their best interest, both physically and emotionally. Human rights are basic to empowerment and it is imperative that the Mexico City Policy be reexamined in the context of these doctrines. The driving force behind the debate surrounding reproductive health is human rights and the human rights framework entitles women to the “highest attainable standard of health.”

Issues surrounding reproductive health, specifically abortion, have many focal points. The focus lies within the community, family, the pregnant woman and the fetus. For these reasons, it is a complicated issue. In the US, Roe established that the right to privacy extends to abortion and US policy states that abortion restrictions can not be based on a theory of when life begins. Abortion can be denied if the fetus is viable or if the restrictions are not unduly burdensome, but generally in the US a woman has the right to have an abortion before viability. The US laws are founded on scientific evidence, as seen in the legal concepts established in Roe. Roe established that states can not justify abortion restrictions based on a theory of when life begins. Current US law allows for abortion and reproductive choice in the US. Presently, foreign policy, specifically the Mexico City Policy, differs greatly from US policy. US foreign policy sets international restrictions that hinder reproductive health. Without the ability to access information, counseling, referrals and safe abortion procedures, women are faced with serious medical conditions from unsafe, unsanitary methods to abort a fetus. If foreign policy matched US policy, fewer women would die from secondary complications from abortion procedures.
VIII. Conclusion

The recent reinstatement of the Mexico City Policy has many implications. As a result of the policy, women in foreign countries have limited options regarding their reproductive functions. Considering the maternal mortality rates and the rates of secondary complications due to unsafe abortion procedures, it would benefit this population immensely to have access to safe abortion procedures as well as adequate information and counseling about reproductive health. Without the much needed access, women will continue to face avoidable health consequences, including death.

In addition, the US laws regarding abortion are opposite to the US imposed foreign policy on abortion. US foreign policy should reflect the majority view of the US. At the present time, that includes access to safe abortion procedures, information, counseling, referrals as well as the freedom of speech to lobby one’s government and express their views. As seen, the Mexico City Policy does not allow the same freedoms as a condition of the receipt of US funds.

The Mexico City Policy has not been examined in the international courts, under international human rights law. However, this avenue would be important to pursue in order to ensure that women have the fundamental freedoms guaranteed by human rights doctrines. Although it may not be in direct violation of legally binding doctrines, the policy is not aligned with the goals of human rights. Promoting and protecting the health of women could be attained through the examination of the policy and ensuring that the conditions are not indirectly violating human rights. In other words, as international
human rights were examined in this paper, it became increasingly clear that the Mexico City Policy does not strive to attain the same goals as human rights.

Human rights are considered fundamental freedoms and doctrines were established to create legal guidelines for international policies. The guidelines however, are too broad to be enforceable. As a result, the Mexico City Policy has a detrimental effect on women’s health and limits ones ability to control reproductive functions. As these functions are specific to women, there is a level of gender discrimination, marginalized health care based solely on gender, that hinders international reproductive rights and the rights of women. International doctrines, such as the Convention on the Elimination of Discrimination Against Women, focus on the gender specific rights of women. The Mexico City Policy hinders the goals and intent of such doctrines.
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