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Toward an International Standard of Abortion Rights: Empirical Data from Africa

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ARTICLES

TOWARD AN INTERNATIONAL STANDARD
OF ABORTION RIGHTS: EMPIRICAL
DATA FROM AFRICA

Chad M. Gerson†

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I. INTRODUCTION

On July 11, 2003, the African Union¹ adopted a "Protocol on the Rights of Women in Africa," ("Protocol") which established a woman's right to have an abortion in cases of rape or incest or to preserve the health of the mother.² Perhaps surprisingly, this Protocol is the first explicit mention of abortion rights in international law.³ In a previous article, I remarked that this was a positive development for the world's women and considered whether other organizations, particularly the United Nations, might follow suit.⁴ In that article, I noted that the U.N. has taken the position that all women should be able to prevent unwanted pregnancies, and that all women should receive treatment for abortion-related complications without fear of legal repercussions whether or not abortion is legal in that country.⁵ I went on to note that "[t]hese mandates ring hollow in light of the fact that countries hostile to abortion are also those most likely to be hostile to family planning services (or to be unable to provide them), and be indifferent to the plight of those women who suffer abortion-related complications (or, again, unable to care for women who develop complications)."⁶ The purpose of this article is to provide detailed empirical support for those statements in the context of Africa and to

¹ The African Union was conceived in 1999, adopted its Constitutive Act at the Lome Summit in 2000, and convened its first assembly of heads of member states at the Durban Summit in 2002. It now has fifty-three member countries. For general information about the AU, see <http://www.africa-union.org/root/au/index/index.htm> (last visited Jan. 3, 2007).

² Press Release, Equality Now, African Union Adopts Protocol on the Rights of African Women: Right to Abortion Articulated for the First Time in International Law (July 14, 2003), available at http://www.equalitynow.org/reports/annualreport_2003.pdf. This press release asserts that "States parties shall take appropriate measures to . . . protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus." *Id.* The protocol itself is available online at http://www.africa-union.org/Official_documents/Treaties_%20Conventions_%20Protocols/Protocol%20on%20the%20Rights%20of%20Women.pdf. See *id.*, art 14 § 2(c) for the relevant portion of the protocol.

³ *Id.*

⁴ See Chad M. Gerson, *Toward an International Standard of Abortion Rights: Two Obstacles*, 5 CHI. J. INT'L L. 753 (2005).

⁵ See *id.* at n.21

⁶ *Id.* at n.22.

analyze recent developments in abortion rights on that continent.

II. ABORTION RIGHTS AS A PREDICTOR OF MATERNAL MORTALITY AND INFANT MORTALITY

Using data on the ability of African women to obtain abortion, as well as the maternal mortality and infant mortality of various countries, it will be observed that both maternal and infant mortality statistics improve as access to abortion is liberalized. Africa is by far the poorest and least healthy continent, where respect for women's rights, including access to abortion, would probably have the greatest positive effect on health conditions and the general standard of living.

A. *Methodology*

The following table lists, alphabetically, all the countries in Africa.⁷ Next to the name of each country is a numerical ranking of how liberal its abortion policies are (from one to seven), then its rate of contraceptive usage among women aged fifteen to 49, then its maternal mortality rate per 100,000 live births, and its infant mortality rate per 1,000 births. There were a few African countries for which the rate of contraceptive usage was unavailable or unreliable.

The ranking of how liberal a country's abortion policies are was determined in the following manner. If a country allows abortions only to save the life of the mother, it was ranked as a one. All African nations allow abortions in this context. If, in addition, a country allows abortions to preserve the mother's physical health, it was ranked as a two. If the country additionally allows abortions to preserve the mother's mental health, it was ranked as a three. Several of the nations in the study have statutes that allow abortions to preserve health but do not specify whether mental health is included in the concept of "health."⁸ Such countries were ranked as threes only if abortions to preserve the mother's mental health are openly availa-

⁷ The exceptions are Seychelles, Sao Tome and Principe, for which data was not available.

⁸ In most African countries, the woman must be examined by a mental health professional, or a team of mental health professionals (often three), usually including a psychiatrist, to determine whether carrying the fetus to term would be

ble in the country or if those nations' Supreme Courts have issued rulings that mandate that mental health must be included. Otherwise, these nations were ranked as twos. If, in addition to life and health, a nation allows abortions in cases of rape or incest, the country was ranked as a four. If the country additionally allows abortions in cases of fetal impairment, it was ranked as a five.⁹ If the country additionally allows abortions for economic or social reasons, it was ranked as a six. Finally, if the country allows abortions on demand, it was ranked as a seven. All African countries, except one, fall into one of these categories and do not have abortion rights that are "out of sequence."¹⁰

After these data were obtained, both maternal mortality and infant mortality were plotted against freedom to obtain an abortion. Both mortalities were also plotted against contraceptive use. Finally, contraceptive use was plotted against freedom to obtain an abortion. Using the trend line feature in Microsoft Excel, a linear representation of the effect of abortion policies (or contraceptive use) on maternal and infant mortalities was added to each plot. Also using Microsoft Excel, the correlation between abortion policies (or contraceptive use) and the mortalities was calculated, and the correlation between abortion policies and contraceptive use was calculated.

B. *The Data*

Table one lists the countries in Africa alphabetically, with their abortion policy ranking, rate of contraceptive use, rate of

a serious danger to her mental health. See, e.g., <http://www.un.org/esa/population/publications/abortion/doc/zambia.doc> (last visited Jan. 3, 2007).

⁹ There is significant variation in what level of fetal impairment is required to make an abortion available. There is also significant variation in the procedure for determining the level of fetal impairment and how many doctors or officials must agree that an abortion is in the best interest of both mother and fetus. In most African countries, an identifiably impaired fetus must be inspected as effectively as possible by a specialist in the area where the deformity or impairment occurs. That specialist must confer with the OB/GYN, or in some cases, the family doctor or attending physician. Usually, all the participating doctors must agree. *Id.*

¹⁰ The exception is Zimbabwe, which allows abortion to preserve the mother's life or physical health, in cases of rape or incest, and for fetal impairment, but not to preserve the mother's mental health. See <http://www.un.org/esa/population/publications/abortion/doc/zimbabwe.doc> (last visited Jan. 3, 2007). I split the difference and ranked Zimbabwe a 4.

maternal mortality, and rate of infant mortality. The calculated correlations are also listed at the bottom.

LEVEL OF FREEDOM TO OBTAIN AN ABORTION, CONTRACEPTIVE USE, MATERNAL DEATH, AND INFANT MORTALITY RATES IN AFRICAN COUNTRIES

Country	Level of Freedom ¹¹	Contraceptive Use ¹²	Maternal Death ¹³	Infant Mortality ¹⁴
Algeria	3	52	340	39
Angola	1	N/A	950	154
Benin	1	16	990	93
Botswana	5	32	250	80
Burkina Faso	5	8	930	107
Burundi	2	9	1300	114
Cameroon	3	16	550	95
Cape Verde	7	53	107	29
Central African Republic	1	15	700	115
Chad	1	N/A	1500	117
Comoros	2	21	950	59
Congo	1	N/A	950	81
Cote D'Ivoire	1	11	810	102
Dem. Republic of the Congo	1	8	870	129
Djibouti	2	N/A	570	100
Egypt	1	47	170	35
Equatorial Guinea	2	N/A	820	101
Eritrea	2	15	820	47
Ethiopia	2	4	1400	114
Gabon	1	N/A	500	60
Gambia	3	7	1100	91
Ghana	5	10	740	57
Guinea	3	1	1600	109
Guinea-Bissau	1	N/A	910	130
Kenya	3	32	650	78
Lesotho	1	19	610	64
Liberia	5	6	560	157
Libya	1	26	220	16
Madagascar	1	10	490	84
Malawi	1	14	560	114
Mali	1	5	1200	122
Mauritania	1	1	930	120
Mauritius	1	49	120	17

¹¹ *Abortion Policies: A Global Review*, <http://www.un.org/esa/population/publications/abortion/profiles.htm> (last visited Jan. 3, 2007).

¹² *Id.* This column provides the percentage of women aged fifteen through 49 using modern contraception.

¹³ *Id.* This data is per one hundred thousand live births.

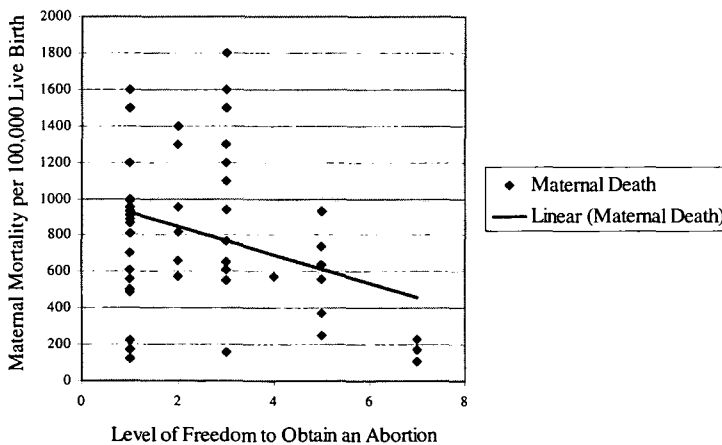
¹⁴ UNICEF: *The State of the World's Children 2004: Basic Indicators*, <http://www.unicef.org/sowc04/files/table1.pdf> (last visited Jan.3, 2007). This data is per one thousand deliveries.

Morocco	3	42	610	39
Mozambique	3	5	1500	125
Namibia	5	26	370	55
Niger	1	5	1200	156
Nigeria (northern states)	1	4	1000	110
Nigeria (southern states)	3	4	650	75
Rwanda	3	13	1300	96
Senegal	1	8	1200	79
Sierra Leone	3	N/A	1800	165
Somalia	1	N/A	1600	133
South Africa	7	48	230	52
Sudan	2	7	660	64
Swaziland	1	17	560	106
Tanzania	3	13	770	104
Togo	5	7	640	79
Tunisia	7	51	170	21
Uganda	3	8	1200	82
Zambia	3	14	940	108
Zimbabwe	4	42	570	76
Correlation with Abortion Policies			-0.322557682	-0.302221391
Correlation with Contraceptive Use			-0.751067251	-0.72334568
Correlation between Abortion Policy and Contraceptive Use				0.397070665

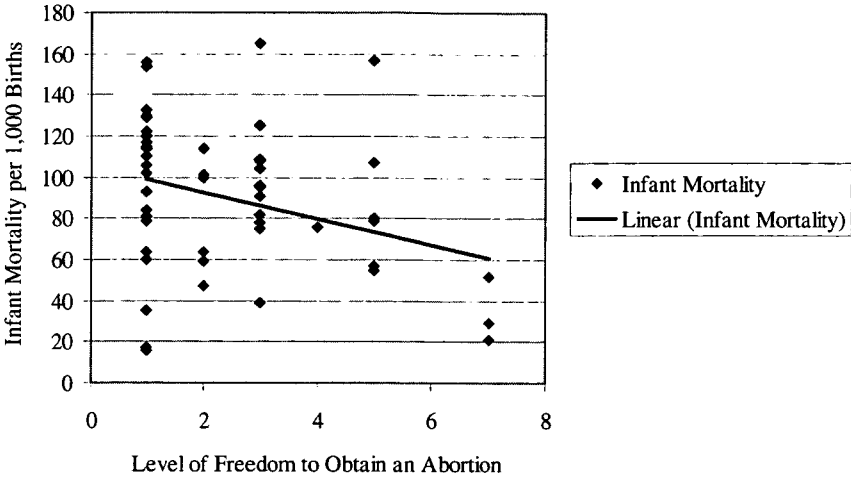
C. Data Analysis

The five scatter plots represent maternal and infant mortalities as a function of women's access to abortion, maternal and infant mortalities as a function of women's contraceptive usage, and women's contraceptive usage as a function of their freedom to obtain an abortion.

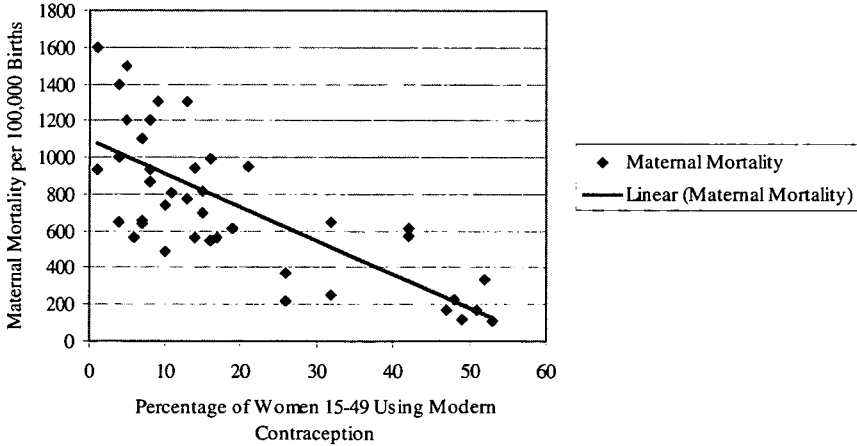
MATERNAL MORTALITY AS A FUNCTION OF ABORTION RIGHTS IN AFRICAN COUNTRIES



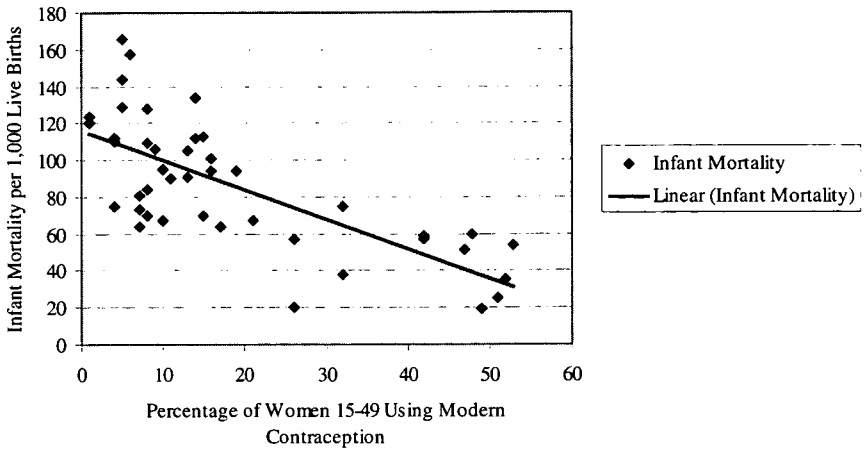
INFANT MORTALITY AS A FUNCTION OF ABORTION RIGHTS IN AFRICAN COUNTRIES



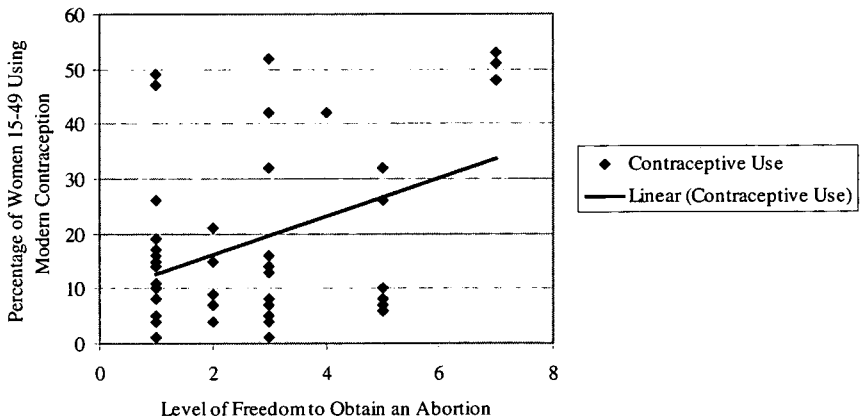
MATERNAL MORTALITY AS A FUNCTION OF CONTRACEPTIVE USE IN AFRICAN COUNTRIES



INFANT MORTALITY AS A FUNCTION OF CONTRACEPTIVE USE IN AFRICAN COUNTRIES



CONTRACEPTIVE USE AS A FUNCTION OF FREEDOM TO OBTAIN AN ABORTION IN AFRICAN COUNTRIES



Access to abortion is inversely correlated with both maternal ($r = -0.319$) and infant ($r = -0.302$) mortality. These correlations are suggestive of a palpable cause and effect relationship between access to abortion and maternal and infant mortalities. The correlations would be much stronger, however, if not for a few outliers. For example, in the maternal mortality graph, there are three data points that represent countries ranked as “ones” regarding access to abortion, yet still have very low maternal mortality. These data points represent Egypt, Libya, and

Mauritius, which are all wealthy and developed nations compared to most of Africa.¹⁵

There was no correction in the data for regional differences or individual circumstances. For example, some regions of Africa have much higher rates of HIV infection, malaria, and sickle-cell anemia, which contribute to both maternal and infant mortalities. Also, countries with recent major political upheavals, such as Guinea, Liberia, Rwanda, Sierra Leone, and Somalia, tend to have even higher rates of maternal and infant mortality than other similarly situated nations with comparable access to abortion. If the data were controlled for these factors, the correlation and inverse relationship would be even stronger.

There was also no correction in the data on contraceptive usage. For example, some African countries actually provide contraceptives for free (usually in urban areas) or encourage their use through education and campaigns in an effort to lower the birth rate. The data also refer to married or ever-married women only, because it is easier to ask about contraceptive use when the sexual activity involved is sanctioned by the religion or the prevailing culture.¹⁶

Usage of contraceptives shows an even stronger inverse correlation with both maternal ($r = -0.751$) and infant ($r = -0.723$) mortality. Although the correlations between the usage of contraceptives and the two mortalities are much stronger than those for abortion, this should not be taken to mean that abortion is necessarily less important than access to and education about contraception. On the contrary, it is further evidence of what is already obvious—that prevention of pregnancy through the use of contraceptives is by far preferable to abortion as a method of family planning. The significant positive correlation between contraceptive usage and the freedom to obtain an abortion ($r = 0.397$) is evidence that countries that are hostile to women obtaining abortions are also likely to be hostile

¹⁵ See *supra* note 14. The per capita Gross National Income of African nations is \$460. *Id.* The per capital Gross National Income of Egypt is \$1,470, that of Libya is \$5,540, and that of Mauritius is \$3,850 (all amounts in U.S. dollars). *Id.* Similarly, the adult literacy rate of African nations is 50%. *Id.* The adult literacy rate of Egypt is 55%, that of Libya is 80%, and that of Mauritius is 85%. *Id.*

¹⁶ See *supra* note 11.

to women controlling their own fertility by contraception (or simply unable to provide effective contraception due to the expense or difficulties in distribution or education).¹⁷ It is also evidence that both abortion and contraception are important to an overall respect for the rights and empowerment of women.

Two dimensions of women's rights regarding access to abortion were not included in this study. The first is whether a woman's husband, or, if she is not married, the father of her baby, must consent to the abortion or have some influence in the decision, even if it is otherwise allowable under that country's law. The other is whether a young woman may independently obtain an otherwise legal abortion before she has reached the age of majority, without the knowledge of her parents and/or regardless of their consent. Even if their laws are otherwise identical, those countries requiring spousal or parental consent or notification could, in fact, be drastically different in regard to the ease with which women can avail themselves of their reproductive rights. Compared with the relative ease of ranking nations with respect to the conditions under which a woman may obtain an abortion, it is difficult to fit notification and/or consent requirements into the same ordinal scheme. For example, is a country that allows abortion on demand, but that requires parental or spousal notification and/or consent, more or less liberal toward abortion rights than a country that allows abortion to save the woman's life, physical or mental health, in cases of rape or incest, and in cases of fetal impairment, but does not require the woman to notify or obtain the consent of her spouse or parents? It is not clear which is "worse." The answer is probably not obtainable, because each family lives in different circumstances. Furthermore, the nature of the pregnancy would make a huge difference. For example, if the woman came from a strictly Muslim family or a nation imposing Sharia and the pregnancy resulted from adultery, spousal notification laws would be tantamount to a death sentence.¹⁸

Of course, even with correction for other social factors, it is clear that access to abortion is not the only variable contributing to the rates of maternal and infant mortality. Access to

¹⁷ See *supra* Part II.B.

¹⁸ See, e.g., http://www.religioustolerance.org/isl_adul1.htm (last visited Jan. 3, 2007).

abortion is only one facet of a woman's control over her reproduction, which in turn is only one category of a society's general respect (or lack thereof) for women's rights and independence. Access to contraception, prenatal care, education of women, and rules regarding property rights all certainly play a role. Further study would be useful to examine the effects of these factors.

III. HOW AFRICA SUFFERS UNDER THE "GLOBAL GAG RULE"

As noted in my previous article, the United States was instrumental in devising and implementing the U.N. Population Commission in 1946 and the U.N. Family Planning Association in 1969.¹⁹ I criticized the "Mexico City Policy"²⁰ (sometimes called the "gag rule"), which denied any U.S. funding to foreign NGOs that promoted or provided abortions, even if American funding was not used for this purpose.²¹ This law had the strange effect of denying to impoverished foreign women a basic medical service that the United States, itself, cannot constitutionally deny its own female citizens.²²

A. *The Negative Effects of the Policy on Africa and Other Developing Countries*

The Mexico City Policy appears to be a de facto abortion policy for those countries that rely on foreign aid for most of their medical and family planning services. Some countries that rely on aid for their family planning services have seen disastrous reduction in services since President Bush reinstated the policy upon taking office.²³ For example, two of Kenya's

¹⁹ See Tobey E. Goldfarb, *Abstinence Breeds Contempt: Why the U.S. Policy on Foreign Assistance for Family Planning is Cause for Concern*, 33 CAL. W. INT'L L.J. 345, 346-53 (2003).

²⁰ So named because President Reagan announced it in 1984 during a UN International Conference on Population in Mexico City. See Memorandum: Restoration of the Mexico City Policy, January 22, 2001, available at <http://www.whitehouse.gov/news/releases/20010123-5.html>.

²¹ See *supra* note 5, at 350-53.

²² See *Roe v. Wade*, 410 U.S. 113, 162-64 (1973). At a minimum, no jurisdiction of the United States may deny or restrict abortions sought by adult women in the first trimester of pregnancy. *Id.*

²³ See ACCESS DENIED: U.S. RESTRICTIONS ON GLOBAL FAMILY PLANNING: IMPACTS ON AFFECTED COUNTRIES, <http://www.globalgagrule.org/impacts.htm> (last visited Dec. 13, 2006).

largest family planning clinics refused to follow the terms of the Policy and subsequently lost their aid funding.²⁴ Between them, they were forced to close five clinics, lay off nearly one-third of their staff, curtail service hours, and raise their patient fees.²⁵ Since family planning clinics are often the only local sources of information about sexually transmitted diseases, gynecological examinations, and proper prenatal care, these services have also eroded in Kenya, particularly in densely populated and already underserved areas.²⁶

In Zambia, the rate of unwanted pregnancies has increased since the Policy was reinstated.²⁷ Only the Planned Parenthood Association of Zambia refused to accept U.S. money under the terms of the Policy. Every other NGO chose to capitulate rather than face the withdrawal of funds.²⁸ There are only three hospitals in Zambia equipped to perform abortions, and all are government-run; unsafe abortions are rampant and increasing.²⁹ The rise in the rate of unwanted pregnancies and unsafe abortions suggests that the NGOs had played a crucial role in educating women about the availability of safe abortions in Zambia and that the Policy has undermined Zambia's efforts to rein in its birth rate and protect its women.

Romania, one of the few European countries receiving aid, is a particularly interesting case. During the Cold War its government encouraged a high birth rate, banned abortion, and made contraception almost impossible to obtain.³⁰ It was not uncommon for women to have multiple illegal abortions.³¹ Now, contraception is legal in Romania, but the habit of using abortion as a method of family planning is still disturbingly

²⁴ See ACCESS DENIED: U.S. RESTRICTIONS ON GLOBAL FAMILY PLANNING: CASE STUDY: KENYA, http://www.globalgagrule.org/caseStudy_kenya.htm (last visited Dec. 13, 2006). These are the Family Planning Associations of Kenya and Marie Stopes International Kenya. *Id.*

²⁵ See *id.*

²⁶ See *id.*

²⁷ See ACCESS DENIED: U.S. RESTRICTIONS ON GLOBAL FAMILY PLANNING: CASE STUDY: ZAMBIA, DETAILED REPORT, http://www.globalgagrule.org/pdfs/case_studies/GGRcase_zambia.pdf (last visited Dec. 13, 2006).

²⁸ See *id.*

²⁹ See *id.*

³⁰ See ACCESS DENIED: U.S. RESTRICTIONS ON GLOBAL FAMILY PLANNING: CASE STUDY: ROMANIA, FULL REPORT, http://www.globalgagrule.org/pdfs/case_studies/GGRcase_romania.pdf (last visited Jan. 3, 2007).

³¹ See *id.*

prevalent.³² Romanian women often learn about the proper methods of obtaining and using contraceptives only at the time of their first abortion.³³ The Mexico City Policy, however, made this much more difficult because NGOs that mention abortion services have now reduced funding and have reduced their contraceptive services. Meanwhile, NGOs that are better equipped to provide contraceptive services but follow the Mexico City Policy cannot reach women who have had abortions to help them prevent future unwanted pregnancies, because they are barred from associating with the other NGOs. The Policy has driven a wedge between the various groups in Romania and, ironically, has hampered efforts to *reduce* the number of abortions.³⁴

B. *The Mexico City Policy Frustrates HIV Prevention Programs and Generates Cognitive Dissonance*

Interestingly, the George W. Bush administration seemingly backed down from the Mexico City Policy on Jan. 28, 2003, during his State of the Union Address.³⁵ In that Address, he announced his plan to help combat the global AIDS epidemic,³⁶ chiefly by providing aid money to twelve countries in Africa, as well as Haiti and Guyana, which have the world's highest rates of HIV infection.³⁷ However, many of the groups who are already fighting AIDS in those countries and are well-positioned to continue to do so, and thus would likely receive most of the U.S. monies, also provide abortion counseling or abortions themselves as part of their women's health programs.³⁸ Thus, Bush was caught between a rock and a hard place, because many social conservatives who support his policies on abortion

³² *See id.*

³³ *See id.*

³⁴ *See id.*

³⁵ The text of the address is available online at <http://www.whitehouse.gov/news/releases/2003/01/20030128-19.html> (last visited Dec. 9, 2006). The bulk of that speech has been overshadowed by the now-infamous "sixteen words" about Iraq's alleged attempts to obtain uranium. *Id.*

³⁶ Press Release, The White House, Fact Sheet: The President's Emergency Plan for AIDS Relief (Jan. 29, 2003), available at <http://www.whitehouse.gov/news/releases/2003/01/20030129-1.html>.

³⁷ *See* B.A. Robinson, *U.S. "Mexico City Policy": Funding Abortion in Foreign Countries*, (Oct. 27, 2000), available at http://www.religioustolerance.org/abo_wrlld.htm.

³⁸ *See id.*

had been suggesting that he unveil a program to curb AIDS in impoverished nations.³⁹ Bush chose to slightly relax the Mexico City Policy to facilitate his plan on AIDS.⁴⁰ Conservative organizations went into a frenzy, saying that “abortion groups” would now be able to “hijack” U.S. tax dollars,⁴¹ that to vote for Bush would be to vote for the butchering of children,⁴² and that Bush was “the biggest baby-killing president in U.S. history.”⁴³

Bush’s compromise, however, did not signal a softening of his administration’s general policy regarding abortion in developing countries. On March 3, 2005, the Bush Administration reiterated its belief that the Beijing Declaration did not call for abortion to be viewed as an international human right.⁴⁴ The Beijing Declaration,⁴⁵ composed at the U.N.’s 1995 Fourth World Conference on Women,⁴⁶ stated, “[w]e are convinced that . . . [t]he explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.”⁴⁷ The Conference’s Platform for Action states, “[t]he 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 from coercion, discrimination

³⁹ See *id.*

⁴⁰ See Richard W. Stevenson, *Bush Eases Ban on AIDS Money to Pro-Abortion Groups Abroad*, N.Y. TIMES, Feb. 15, 2003, at A5.

⁴¹ See Austin Ruse, *Abortion Groups Seek to Hijack Bush’s AIDS Budget* (Feb. 14, 2003) <http://www.newsmax.com/archives/articles/2003/2/13/170624.html>. Mr. Ruse is a member of the Catholic Family & Human Rights Institute.

⁴² See Pro-Life News, *A Vote for Baby Butchering Bloodshed* (Feb. 3, 2004), <http://www.covenantnews.com/abortion/archives/004582.html>.

⁴³ See <http://www.covenantnews.com/abortion/archives/004580.html> (follow third hyperlink (last visited Jan. 3, 2007)). This distinction was derived by counting the entire \$15 billion in foreign aid for the AIDS epidemic as “abortion funding.” See also, Chuck Baldwin, *Bush Betrays Pro-Life Cause Again, Backs Federal Aid to Overseas Abortion Providers* (May 2, 2003), available at <http://covenantnews.com/baldwin030502.htm>.

⁴⁴ See Catholic Exchange, *United States Presses Ahead with Anti-Abortion Amendment at UN*, http://www.catholicexchange.com/vm/index.asp?vm_id=26&art_id=27744 (last visited Jan. 3, 2007); See also, *US Amendment to UN Beijing +10 Document Fails to Achieve Consensus* (March 9, 2005), available at http://www.catholicexchange.com/vm/index.asp?vm_id=26&art_id=27744.

⁴⁵ See <http://www.un.org/womenwatch/daw/beijing/platform/declar.htm> (last visited Jan. 3, 2007).

⁴⁶ Additional information about the Conference is available online. See <http://www.un.org/womenwatch/daw/beijing/index.html> (last visited Jan. 3, 2007).

⁴⁷ See *supra* note 45, at para. 17.

and violence.”⁴⁸ Furthermore, “[i]n most countries, the neglect of women’s reproductive rights severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment. The ability of women to control their own fertility forms an important basis for the enjoyment of other rights.”⁴⁹ The Platform also recognizes that “[u]nsafe abortions threaten the lives of a large number of women; . . . it is the poorest and youngest who take the highest risk.”⁵⁰ The suggested remedy is an “improved access to adequate health-care services, including safe and effective family planning services and emergency obstetric care . . . as well as other methods of their choice for regulation of fertility *which are not against the law*. . . .”⁵¹ Since the adoption of the Beijing Declaration and the Platform for Action, nations have disagreed over whether the two documents implied momentum toward the recognition of abortion rights as universal human rights.⁵² Bush’s proposed Amendment would explicitly renounce this possibility.⁵³ This Amendment was defeated because a consensus could not be reached, but most countries are hesitant to accept the responsibilities that would inhere from making abortion an internationally recognized human right.⁵⁴ Additionally, “Ms. Kyung-wha Kang of Korea, the Chairperson of the current 49th session of the [U.N.] Commission on the Status of Women, confirmed during the meeting that the Beijing documents created neither new international rights nor the right to abortion.”⁵⁵

IV. SUGGESTIONS AND CONCLUSION

The inability to limit family size exacerbates poverty and poor health conditions in developing nations because these fam-

⁴⁸ See *supra* note 45 at para. 96.

⁴⁹ *Id.* at para. 97.

⁵⁰ *Id.*

⁵¹ *Id.* (emphasis added).

⁵² See *supra* note 45. Canada and several European nations, in particular, wanted to interpret the documents as conferring a human right to abortion. See *Full Implementation of 1995 Beijing Action Plan for Women Essential to Achieving Global Anti-Poverty Goals, Women’s Commission Declares*, <http://www.un.org/News/Press/docs/2005/wom1496.doc.htm> (last visited Dec. 10, 2006).

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

ilies usually cannot afford proper care for their children. The empirical data from Africa presented above has reinforced this position, and suggests that the world community should attempt to convince African countries to liberalize their abortion laws. Furthermore, the United States should abandon the disastrous "Mexico City Policy" and instead commit to assisting developing nations implement comprehensive family planning policies.