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THE "MEXICO CITY POLICY" AND ITS EFFECTS ON HIV/AIDS SERVICES IN SUB-SAHARAN AFRICA

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Abstract: The United States recently joined the global effort to combat the HIV/AIDS pandemic in sub-Saharan Africa and other developing regions when it committed more than $15 billion to international HIV/AIDS initiatives. In the spirit of strengthening U.S. participation in this effort, this Note encourages U.S. leaders to reevaluate the Mexico City Policy, a foreign policy that indirectly affects numerous people living with HIV/AIDS. Commonly known as the global gag rule, the Mexico City Policy prohibits most foreign non-governmental organizations that receive U.S. family planning funding from providing or promoting abortion services. This Note analyzes the Mexico City Policy's impact on HIV/AIDS services provided by family planning clinics in sub-Saharan Africa, as well as the potential implications of an executive branch proposal that would expand the policy beyond family planning to HIV/AIDS assistance. This Note concludes that congressional repeal of the Mexico City Policy is the most plausible remedy.

INTRODUCTION

Recognizing that uncontrolled population growth and poor public health undermines economic stability and living standards in developing countries, the United States has contributed to international family planning and voluntary population control programs since the 1960s.1 In general, family planning clinics provide prenatal care, con-

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1 See Foreign Assistance Act, 22 U.S.C. § 2151b(b) (2000) (authorizing the president to provide assistance for voluntary population planning). The U.S. government also recognizes that investing public funds in these programs benefits Americans for several reasons. U.S. AGENCY FOR INT’L. DEV. (USAID) POPULATION BRIEFS, USAID’S POPULATION ASSISTANCE PROGRAM: OVERVIEW AND ACCOMPLISHMENTS 2 (2001) [hereinafter PopBriefs]. Investing in family planning strengthens the economies of our trading partners by decreasing the “long-term consequences of poverty, environmental degradation and resource scarcity.” Id. It also boosts our trade relations with “strategically important” partners such as Egypt and Indonesia. Id. Further, Americans benefit from U.S.-supported contraceptive research and new technologies, including the female condom and low-dose oral contraceptives. Id.
traception, counseling, medical services, and information about birth spacing, fertility, and sexually transmitted infections (STIs). These clinics are crucial for ensuring individuals’ and couples’ access to sexual and reproductive health care, particularly in developing countries where high maternal and child mortality rates continue to diminish the quality of life. Politically, however, international family planning has been controversial in the United States because it often includes abortion counseling, referrals, and related medical care.

On January 22, 2001, President George W. Bush issued an executive memorandum blocking U.S. family planning funding to any foreign nongovernmental organization (NGO) that supports abortion, even with its own non-U.S. funds. Under this policy, in order to receive U.S. funding, NGOs that provide family planning services must cease to

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2 See **Family Health Int'l, From Rhetoric to Reality: Delivering Reproductive Health Promises Through Integrated Services** fig. 1 (2002) [hereinafter Delivering Reproductive Health] (listing the reproductive health services that international organizations recommend for family planning); **PopBriefs, supra note 1, at 1–2.** Methods of family planning range from “traditional” or “natural” methods such as breast-feeding, the use of herbs, rhythm, and withdrawal, to “modern” methods such as the pill, condom, intra-uterine device, sterilization, and hormonal implants. **The Right to Know: Human Rights and Access to Reproductive Health Information** at xi (Sandra Coliver ed., 1995); see also **Maja Kirilova Eriksson, Reproductive Freedom: In the Context of International Human Rights and Humanitarian Law** 182–83, 185 (2000) (discussing the concept of “family planning” as a human right and analyzing the substantive content of that right as defined by the group Third World Women, the World Health Organization, and the United Nations (UN) Convention on the Elimination of All Forms of Discrimination Against Women).


4 **Larry Nowels, Cong. Research Service, Population Assistance and Family Planning Programs: Issues for Congress 3–4 (2001);** see **Eriksson, supra note 2, at 181** (arguing that family planning and abortion are connected); **Michael S. Greco, Global Gag Rule Recommendation and Report, 2002 A.B.A. SEC. INDIVIDUAL RTS. & RESP. 1, 2** (A U.S. Congressional Research Service report observes that this issue “essentially stem[s] from the contentious domestic debate over U.S. abortion policy that has continued since the Supreme Court’s 1973 Roe v. Wade decision holding that the Constitution protects a woman’s decision whether to terminate her pregnancy.” Nowels, supra, at 4. A Population Studies professor comments that the original instatement of the Mexico City Policy in the 1980s marked a dramatic policy turnaround that “reflected the success of the anti-abortion lobby.” **Andrzej Kulczycki, The Abortion Debate in the World Arena** 26 (1999).

perform and "actively promote" abortion-related services. Specifically, NGOs must not participate in public education campaigns about reproductive choice, provide patient referrals to facilities where abortion may be obtained, counsel on abortion as a medical option, or lobby for government reform regarding the liberalization of abortion laws.

Officially called the "Mexico City Policy," this condition on foreign assistance was first announced by Reagan administration officials at the United Nations (UN) International Conference on Population in Mexico City in 1984. The Policy is also commonly called the "global gag rule" because it limits the advice medical professionals abroad may give their patients, should their organization accept U.S. funding.

In developing countries with poor health conditions and insufficient resources, family planning clinics are often the best, if not the only, places where individuals can obtain medical advice and resources for protecting themselves against STIs such as human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). In 2002, more than 90% of the 42 million people living with

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6 Jan. 22 Memorandum, supra note 5, at 216; Memorandum: Restoration of the Mexico City Policy, 3 C.F.R. § 873 (Mar. 28, 2001) [hereinafter Mar. 28 Memorandum] (expanding on the Jan. 22 Memorandum regarding Mexico City Policy implementation, enforcement, and exceptions); Greco, supra note 4, at 2.

7 Mar. 28 Memorandum, supra note 6, at 877-78; CTR. FOR REPROD. LAW AND POLICY (CRLP), THE BUSH GLOBAL GAG RULE: A VIOLATION OF INTERNATIONAL HUMAN RIGHTS AND THE U.S. CONSTITUTION 2 (2001) [hereinafter BUSH GLOBAL GAG RULE]. There are very limited exceptions to this general rule. See Mar. 28 Memorandum, supra note 6, at 878.

8 Jan. 22 Memorandum, supra note 5, at 216; Greco, supra note 4, at 3 n.13 (citing the Policy Statement of the United States at the United Nations International Conference on Population Planning).

9 See, e.g., BUSH GLOBAL GAG RULE, supra note 7, at 1; Deborah L. Rhode, Gagging on a Bad Rule, NAT'L. L.J., Sept. 3, 2001, at A21. The terms "Mexico City Policy" and "global gag rule" will be used interchangeably in this Note. Although major newspapers and other periodicals commonly refer to the Policy as the "global gag rule," this term is considered pejorative. See Mexico City Policy: Effects of Restrictions on International Family Planning Funding: Hearing Before the S. Comm. on Foreign Relations, 107th Cong. 57 (2001) [hereinafter Hearing] (statement of Kathy Cleaver, Director of Planning and Information for the Secretariat for Pro-Life Activities, U.S. Conference of Catholic Bishops) (pointing out that opponents of the Mexico City Policy use the term "global gag rule"). The phrase "gag rule" is also used in the domestic context, referring to U.S. Department of Health and Human Services regulations which restrict Title X family planning money from being dispersed to U.S. clinics that support abortion-related services. See generally Carole I. Chervin, The Title X Family Planning Gag Rule: Can the Government Buy Up Constitutional Rights?, 41 STAN. L. REV. 401 (1989).

10 Press Release, Nat'l. Family Planning & Reprod. Health Ass'n, Swift Congressional Action Urged on "Global Democracy Protection Act" (Feb. 15, 2001) (on file with author);
HIV/AIDS globally lived in developing nations. This proportion is expected to increase because the AIDS virus spreads rapidly in developing countries that have inadequate resources for prevention and treatment, as well as poor health-care systems. Worldwide, the region most affected by AIDS is sub-Saharan Africa, where AIDS is the leading cause of death and has killed more than 19.4 million people. A news editor of *The Namibian*, a leading newspaper in Namibia, writes, "when it comes to implementation of [AIDS prevention] in the Third World, family planning centers literally offer a lifeline . . . . The challenge is nowhere greater than in sub-Saharan Africa—the epicenter of the AIDS pandemic."

In the fight against HIV/AIDS, family planning centers are particularly vital for women, who are at greater risk for contracting HIV or AIDS than men. In sub-Saharan Africa, 58% of those living with HIV/AIDS are women. Women and girls are particularly susceptible because HIV transmission to women is biologically more "efficient" than transmission to men and, in many circumstances, women lack power to negotiate safer sexual practices due to gender inequality. Through education, counseling, and condom distribution, family


13 *Id.* at 2; JOINT U.N. PROGRAMME ON HIV/AIDS (UNAIDS), *AIDS EPIDEMIC UPDATE* 16 (2002).

14 Sutherland, *supra* note 10.

15 *Id.*; see H.R. REP. No. 108–60, at 2 (stating that women are four times more vulnerable to infection than men and are becoming infected at increasingly high rates); David Brown, *Women Make Up Half of HIV Cases: Milestone Explains Effects of Epidemic*, WASH. POST, Nov. 27, 2002, at Al (discussing the biological and social reasons why women, and specifically African girls between the ages of 15 and 24, are at a high risk of becoming infected).


planning centers can help women respond to high-risk situations and avoid contracting HIV.\textsuperscript{18}

As it stands, the Mexico City Policy forces the recipients of U.S. family planning funding to make value judgments about the services they provide.\textsuperscript{19} Family planning organizations must decide whether to accept U.S. funding and cease their abortion-related services, or to reject U.S. funding and thus limit their potential services due to constrained budgets.\textsuperscript{20} Moreover, regardless of whether these groups decide to assist individuals with abortion-related services, the global gag rule forces organizations to prioritize which communities they want to serve: women seeking abortions or all other women, children, and families.\textsuperscript{21}

Further, the rule does not allow pregnant women living with HIV/AIDS, for whom abortion may be a legal option domestically, full access to information regarding their medical options.\textsuperscript{22} Women in Cameroon, Ghana, Liberia, Mali, Rwanda, Zambia, and Zimbabwe are permitted to have abortions under certain limited circumstances, such as to protect their mental or physical health, or on socio-economic grounds.\textsuperscript{23} A report by Ipas, a non-profit agency focusing on women’s reproductive health, states that “2.5 million of the 200 mil-

\textsuperscript{18} See USAID Population Briefs, USAID’s Family Planning Services 1, 2 (2001) (highlighting USAID’s contraceptive marketing programs and HIV prevention efforts in the family planning context); Sutherland, supra note 10 (explaining that family planning centers can teach women “how to recognize situations that put them at risk of contracting the disease”); see also Int’l Planned Parenthood Fed’n (IPPF), Learning from the Field 20 (2002) [hereinafter Learning from the Field] (stating that the condom is the best method for preventing HIV transmission, and observing that condom promotion provides the main link between the work of family planning associations and HIV/AIDS efforts).

\textsuperscript{19} Bush Global Gag Rule, supra note 7, at 3 (describing the choice that health care organizations must make as immoral); see, e.g., IPPF, 2001 Annual Report 15 (2001) [hereinafter IPPF Annual Report].

\textsuperscript{20} See Bush Global Gag Rule, supra note 7, at 3.

\textsuperscript{21} See id.

\textsuperscript{22} See Maria de Bruyn, Ipas, Reproductive Choice and Women Living with HIV/AIDS 26 (2002); Bush Global Gag Rule, supra note 7, at 11.

\textsuperscript{23} Ctr. for Reprod. Rts., The Global Gag Rule’s Effects on NGOs in 56 Countries (2003) [hereinafter NGOs in 56 Countries], available at http://www.crlp.org/pub_fac_ggreffects.html (last visited Oct. 16, 2003). These countries all receive U.S. family planning funds. Id. The sub-Saharan countries where abortion is generally prohibited, and which receive U.S. funding, are Cote d’Ivoire, Kenya, Malawi, Nigeria, Senegal, Tanzania, Togo, and Uganda. Id. With regard to these countries, this Note argues solely that U.S.-funded NGOs should be permitted to lobby their governments or speak about abortion within the boundaries of their national laws. See id.
lion women who become pregnant each year are HIV-positive."24 In sub-Saharan Africa, a growing number of women are testing positive for HIV at prenatal clinics, which indicates that their babies may become infected.25 Yet, because of the Mexico City Policy, women who visit many U.S.-funded clinics will not be made aware of their legal rights.26 Thus, the Mexico City Policy is not only an abortion issue, but is also an HIV/AIDS issue.27

This Note examines the Mexico City Policy and explores its effect on HIV/AIDS services in sub-Saharan Africa. Part I describes the Policy's political background in the United States and its current status. Part II sets forth legal arguments against the Policy, as well as responses to arguments by its proponents. Part III examines the existing Policy's negative implications for HIV/AIDS treatment in the family planning context in sub-Saharan Africa and discusses the potential impact of an executive proposal to apply the Policy to HIV/AIDS funding. Part IV presents legal suggestions for preventing the negative consequences of the Policy on HIV/AIDS services. This Note concludes that the Mexico City Policy must be abolished in order to end the Policy's damaging effects on family planning centers that provide HIV/AIDS services and the individuals who rely on them for survival.

I. BACKGROUND OF THE MEXICO CITY POLICY

In 1961, Congress passed and President John F. Kennedy signed into law the Foreign Assistance Act, which authorized the president to provide funding for voluntary population planning programs on the terms and conditions determined by the president.28 The president's constitutional authority to conduct foreign affairs provided the foundation for Congress's conferral of such broad discretion to the presi-

24 Bruyn, supra note 22, at 2 (citing a 2002 UNAIDS study).
26 See NGOs IN 56 COUNTRIES, supra note 23, at Countries where Abortion is Legal.
27 See Sutherland, supra note 10 (quoting Nancy Padian, director of International Programs at the University of California-San Francisco AIDS Research Institute).
dent.\textsuperscript{29} The United States Agency for International Development (USAID), an independent federal government agency, was created by executive order that same year, and has since remained the main U.S. agency through which foreign assistance is granted for international economic growth and global health.\textsuperscript{30}

Congress typically appropriates funding to USAID every fiscal year.\textsuperscript{31} USAID then disperses the funds through cooperative agreements and grants to private agencies, foreign governments, domestic and foreign NGOs, and multilateral agencies such as the World Health Organization.\textsuperscript{32} The vast majority of USAID's assistance for family planning and HIV/AIDS goes to NGOs in the field because

\textsuperscript{29}See U.S. Const, art. II, § 2 (providing that "[t]he President shall be Commander in Chief of the Army and Navy of the United States . . . ; he may require the Opinion, in writing, of the principal Officer in each of the executive Departments, upon any Subject relating to the Duties of their respective Offices . . . ."); 22 U.S.C. § 2151b(b); Rebecca J. Cook, \textit{U.S. Population Policy, Sex Discrimination, and Principles of Equality Under International Law}, 20 N.Y.U. J. Int'l L. & Pol. 93, 101 (1987). The Reagan administration later referenced these sources of authority when implementing the Mexico City Policy. See Cook, supra, at 101 n.27 (citing Letter from Howard M. Fry, to Robert H. Hunter 3-7 (June 13, 1985)).

\textsuperscript{30}Exec. Order No. 10,973, 3 C.F.R. 493 (1959-1963); PopBriefs, supra note 1, at 1.

\textsuperscript{31}See Craig Lasher, \textit{U.S. Population Assistance}, \textit{Population Action Int'l} (listing annual population assistance funding levels for USAID from 1965 to 2000), available at http://www.planetwire.org/\textbackslash upload/files.fcgi/2112_USpopassist.htm (last visited Sept. 18, 2003). The amount of population assistance funding is a highly contentious issue. Nowels, supra note 4, at 12. Supporters of increased funding argue that population growth must decelerate in order for economic, social, and environmental development to occur. Id. at 12. In contrast, those who support freezing funding levels stress that, even without an increase, the United States will remain the largest bilateral donor for population programs worldwide. Id. Overall, USAID reports that less than 1% of the total federal budget each year goes to international assistance. USAID, \textit{Global Health: Frequently Asked Questions About Population and Reproductive Health Activities}, at http://www.usaid.gov/pop_health/pop/popfaq.html (last visited Sept. 18, 2003). International family planning programs are awarded 1/50th of 1% of this budget, or the equivalent of $1.70 per year for each American. Id.

\textsuperscript{32}PopBriefs, supra note 1, at 2; see also Tara A. Gellman, \textit{The Blurred Line Between Aiding Progress and Sanctioning Abuse: United States Appropriations, the UNFPA and Family Planning in the P.R.C.}, 17 N.Y.L. Sch. J. Hum. Rts. 1068, 1063–1064 (2001); Roberta J. Sharp, \textit{Holding Abortion Speech Hostage: Conditions on Federal Funding of Private Population Planning Activities}, 59 Geo. Wash. L. Rev. 1218, 1221 (1991). Additionally, the State Department provides aid for family planning programs to the UN Fund for Population Activities (UNFPA). PopBriefs, supra note 1, at 2; Gellman, supra, at 1063–64. This funding has provoked controversy over the years because leaders including President Bush have claimed that the UNFPA's program in China supports coercive abortion or involuntary sterilization. Nowels, supra note 4, at 8–11 (describing the details of UNFPA deliberations in Congress, as well as the Bush administration's investigation into this matter).
they have direct connections to those in need of the services.\textsuperscript{33} NGOs use the money for contraceptive supplies, service delivery, public education and marketing, and training for medical and health care providers.\textsuperscript{34}

Since 1973, when a provision known as the Helms Amendment was enacted, the use of U.S. funds "for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions" has been prohibited.\textsuperscript{35} The Helms Amendment also prohibits the use of U.S. funds for biomedical research that relates to the "methods" or "performance" of abortions.\textsuperscript{36} Thus, since 1973, no U.S. taxpayer dollars have directly supported abortion-related services.\textsuperscript{37}

President Reagan further extended these restrictions in 1984 by implementing the Mexico City Policy.\textsuperscript{38} This policy prohibited organizations receiving U.S. funds from using their own money to perform abortions, to lobby foreign governments for abortion legalization, or to conduct public education campaigns regarding the benefits or availability of abortion.\textsuperscript{39} Although USAID has traditionally funded some foreign governments to help them initiate voluntary family planning programs, the Reagan administration decided not to apply the Policy directly to foreign governments in order to respect their national sovereignty.\textsuperscript{40} Instead, the Policy applies to foreign NGOs, as


\textsuperscript{34} See PopBriefs, supra note 1, at 2.

\textsuperscript{35} See Foreign Assistance Act, 22 U.S.C. § 2151b(f)(1) (2000); Nowels, supra note 4, at 4; Greco, supra note 4, at 3. Because abortion opponents in Congress have not been successful in their post-Roe v. Wade attempts to prohibit abortion altogether, they have used strategies such as the Helms Amendment as an alternative for restricting abortion. Nowels, supra note 4, at 4.

\textsuperscript{36} 22 U.S.C. § 2151b(f)(1).

\textsuperscript{37} See id.; Nowels, supra note 4, at 4 (distinguishing the Helms Amendment from legislative attempts to ban indirect support for abortion-related activities). Thus, from 1973 to 1984, when President Reagan implemented the Mexico City Policy, U.S.-funded NGOs could use their own independent funds to perform abortion-related services abroad. See Nowels, supra note 4, at 4.

\textsuperscript{38} Family Planning and Population Assistance Activities, 48 C.F.R. § 752.7016(b) (1986); see Memorandum on the Mexico City Policy, 29 Weekly Comp. Pres. Doc. 10 (Jan. 22, 1993) [hereinafter Clinton] (noting that the Mexico City Policy expands the limitations originally enacted by Congress); Jan. 22 Memorandum, supra note 5, at 216.

\textsuperscript{39} Clinton, supra note 38, at 10; Bush Global Gag Rule, supra note 7, at 3.

\textsuperscript{40} Cook, supra note 29, at 97–99. The draft originally circulated by the White House applied the rule to foreign governments, but the Policy was changed before it was officially announced at the UN Conference due to criticism of the draft and concerns about violat-
well as domestic and international groups that provide U.S. population assistance to foreign NGOs.41

The Policy remained in place until President William J. Clinton rescinded it on January 22, 1993.42 During Clinton’s presidency, several congressional representatives sought repeatedly to attach provisions reinstating the Mexico City restrictions to foreign operations appropriations bills and State Department reauthorization bills.43 As an executive branch policy, however, the rule was not fully restored until President Bush reinstated it in 2001.44

A. Current Status of the Policy

The current version of the Mexico City Policy resembles the original Reagan policy, except that it does not withhold funds from organizations that provide post-abortion medical treatment to women with injuries or illnesses caused by abortions.45 USAID first authorized the use of population funds for post-abortion treatment and counseling in 1994, when the Mexico City Policy was not in place.46 At the urging of leaders from NGOs that provided post-abortion care (PAC), USAID began funding PAC programs in order to address the issue of unsafe abortion, a major cause of maternal illness and mortality worldwide.47

Id. at 99 n.16. Similarly, the current version of the Mexico City Policy does not apply to foreign governments. Mar. 28 Memorandum, supra note 6, at 879, 885 (conditioning U.S. funding to foreign governments on the placement of U.S. funds in a “segregated account to ensure that such funds may not be used to support the abortion activity of the government”); see also Hearing, supra note 9, at 35 (statement of Dr. Nicholas N. Eberstadt, Scholar, American Enterprise Institute) (pointing out that the U.S. will “continue to support either directly or through a grantee to foreign governments even in cases where the governments include abortion in their family planning programs”).

41 Mar. 28 Memorandum, supra note 6, at 874, 879; see, e.g., Hearing, supra note 9, at 51–52 (statement of Dr. Daniel E. Pellegrom, President, Pathfinder International) (discussing U.S.-based organizations’ dissemination of USAID grants).

42 Clinton, supra note 38, at 11. In his executive memorandum to the Acting Administrator of USAID, President Clinton reasoned that the anti-abortion conditions on funding were “excessively broad” and “undermined efforts to promote safe and efficacious family planning programs in foreign nations.” Id. at 10–11.

43 BUSH GLOBAL GAG RULE, supra note 7, at 2 (providing a detailed account of the congressional action on this policy from 1995 through 2001).

44 Id.

45 See Hearing, supra note 9, at 21 (testimony of Alan J. Kreczko, Acting Assistant Secretary, Bureau of Population, Refugees and Migration, U.S. Department of State); Mar. 28 Memorandum, supra note 6, at 877, 878, 883, 884.


47 See id. at 1, 2, 4. The World Health Organization (WHO) estimates that between the years 1995 and 2000, 78,000 women worldwide died from complications from unsafe abor-
When it re-implemented the Policy in 2001, the Bush administration added an exception for organizations that provide PAC.48

As with the earlier version of the Policy, the current Policy permits referrals for abortions or abortion services that are performed with NGOs' own funds in order to save the life (but not health) of the mother.49 These services are also allowed if the mother is pregnant from rape or incest "because abortion under these circumstances is not a family planning act."50 Additionally, health care providers may offer "passive responses" about abortion.51 The Policy's language imposes strict circumstantial requirements on what constitutes a "passive response":

[When] the question is specifically asked by a woman who is already pregnant, the woman clearly states that she has already decided to have a legal abortion, and the family planning counselor reasonably believes that the ethics of the medical profession in the country requires a response regarding where [the abortion] may be obtained safely.52

Because the conditions satisfying this scenario are so limited, USAID-funded clinics fear risking their budgets by providing any responses whatsoever and are often forced to turn women away.53 USAID repre-
sentatives strictly enforce the Policy, and organizations such as International Planned Parenthood Federation have lost up to $12 million in USAID grants for noncompliance.\textsuperscript{54}

These exceptions are virtually meaningless in practice: the Policy has a chilling effect that deters USAID-funded clinics from treating women even in emergency situations for fear of losing funding.\textsuperscript{55} At a congressional hearing in 2001, New York Congresswoman Nita Lowey recounted the story of a nurse in Egypt who was afraid to treat or refer a woman bleeding from a botched abortion due to the possible negative consequences from the Mexico City Policy.\textsuperscript{56} As the accessibility of a family planning clinic can mean the difference between life and death for a woman suffering from an unsafe abortion, it is important to evaluate the practical effects of U.S. policy on family planning clinics and their services.\textsuperscript{57}

B. Practical Implications of the Policy

The Mexico City Policy has caused devastating consequences worldwide for organizations that provide both abortion-related care and other health care.\textsuperscript{58} Regardless of whether foreign NGOs decide to accept or reject U.S. funds, the Policy reduces organizations' abilities to provide women and families with medical attention and information.\textsuperscript{59}

\textsuperscript{54} See Mar. 28 Memorandum, supra note 6, at 875, 881; Cook, supra note 29, at 100. USAID representatives employ a variety of techniques for policy enforcement, ranging from document inspection to worker consultation to observation of family planning activities. See Mar. 28 Memorandum, supra note 6, at 875, 881.

\textsuperscript{55} See Hearing, supra note 9, at 12 (statement of Hon. Lowey); Cook, supra note 29, at 99–100.


\textsuperscript{57} See Cobb, supra note 46, at 1, 3–4 (providing statistics about maternal mortality from unsafe abortions worldwide and describing the global response regarding providing post-abortion care); Alan Guttmacher Inst., supra note 47, at 35, 38 (discussing the severe medical trauma that women experience when suffering from unsafe abortion, contrasting the availability of emergency care services in rural and urban areas, and mentioning the abortion-inducing methods most likely to be life-threatening).


\textsuperscript{59} See Hearing, supra note 9, at 51, 52 (statement of Dr. Pellegrom). Pathfinder International was the first organization to negotiate a cooperative agreement with USAID when
Bolivia has the highest maternal mortality rate in Latin America.\textsuperscript{60} Complications from unsafe abortions kill one woman every day.\textsuperscript{61} In response to this horrific trend, fifteen NGOs joined together to lobby the government and promote public awareness of the situation.\textsuperscript{62} The imposition of the global gag rule, however, forced four of the NGOs to resign from the information campaign because communicating with the government about the negative effects of Bolivia’s abortion laws would have threatened their budgets.\textsuperscript{63} This resignation also cost them the ability to inform the public about their experiences and the need for reform.\textsuperscript{64} Had these four NGOs advocated anti-abortion reform, they would have been able to continue lobbying while receiving USAID funding.\textsuperscript{65} Yet they chose to comply with the Mexico City Policy, unlike another NGO in the Bolivia campaign that refused to compromise and lost a quarter of its budget due to non-compliance with the global gag rule.\textsuperscript{66} This drastic budget cut limited the latter group’s outreach potential for providing health services.\textsuperscript{67}

Nepal’s maternal mortality rate is among the highest in South Asia, in part due to the numerous deaths caused by unsafe abortion.\textsuperscript{68} Recognizing that the criminalization of abortion was greatly contributing to Nepal’s high maternal morbidity and mortality rates, the Mexico City Policy was first implemented. \textit{Id.} At a congressional hearing in 2001, Pathfinder’s President testified that the rule puts innumerable organizations in jeopardy because they are:

trapped between reliance on American foreign assistance and their own nation’s laws and medical practices . . . . [W]hichever choice is made, there is harm . . . to organizations and finally to the patients the organizations serve. Usually the patients are women. Mostly they are poor, young and anything but independent. They are people who rely on our good will.

\textit{Id.} at 52.

\textsc{Country by Country Snapshot, supra note 58, at Bolivia.}\textsuperscript{60}

\textit{Id.} In Bolivia, abortion is illegal except when the life of the mother is at stake or when the pregnancy results from rape or incest. \textit{Id.} One report indicates, “Despite the fact that for the past 26 years the Penal Code has made some exceptions to the restrictive abortion law, under which it is possible to receive judicial authorization to obtain access to abortion services, as of 1999, only one legal abortion had ever been performed in Bolivia.” CRLP, \textsc{Women’s Reproductive Rights in Bolivia: A Shadow Report 4} (2001).\textsuperscript{62}

See \textsc{Country by Country Snapshot, supra note 58, at Bolivia.}\textsuperscript{60}

\textsc{Id.}\textsuperscript{61}

\textit{Id.} at 52.

See Hearing, supra note 9, at 11 (statement of Hon. Lowey); Greco, supra note 4, at 2; Country by Country Snapshot, supra note 58, at Bolivia.\textsuperscript{66}

\textit{See Hearing, supra note 9, at 11 (statement of Hon. Lowey); Country by Country Snapshot, supra note 58, at Bolivia.}\textsuperscript{66}

\textit{See id.} at Nepal.\textsuperscript{68}
Nepalese Ministry of Health developed a plan to decriminalize abortion; however, the plan involved forming a coalition of NGOs to create advocacy strategies. A number of these NGOs received U.S. funds and were thus unable to participate in the Ministry's plan without losing their funding. Even though Nepal eventually legalized abortion in a historic move in 2002, the Mexico City Policy will continue to reduce the ability of Nepalese NGOs to provide safe and legal abortion services, since U.S. funding is the largest source of foreign family planning assistance in Nepal. As a result, organizations will likely choose to continue receiving USAID funds rather than risking bankruptcy.

Another practical effect of the Mexico City Policy has been the closure of family planning clinics due to USAID's withdrawal of funding, notably in sub-Saharan Africa. Seventeen centers in Uganda, five centers in Kenya, one outreach program serving poor communities in Ethiopia, and several clinics in Tanzania have closed for this reason. In Kenya alone, the five clinics that closed served tens of

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69 Id.
70 See id.
72 See id.
73 See Telephone Interview with Wendy Turnbull, Legislative Policy Analyst, Population Action International (Apr. 1, 2003) [hereinafter Turnbull Interview] (discussing recent fact-finding trip to collect data on the effects of the global gag rule on family planning centers, staff, and clients in Africa); see also Salih Booker, Pandering to Abortion Foes Cripples Global AIDS Effort, L.A. TIMES, Feb. 9, 2001, at 9 (linking groups' loss of funding and contraceptives to an increase in unsafe abortions, as well as an increase in HIV/AIDS infections); Nancy Dunne, Condom Shortage 'Contributing to Spread of AIDS in East Europe and Third World,' FIN. TIMES (London), Oct. 2, 2002, at 7 (reporting that the U.S. is the largest international donor of condoms worldwide, and that the global gag rule has "cut supplies to many local organisations").
74 GGRIP, ACCESS DENIED: THE IMPACT OF THE GLOBAL GAG RULE IN KENYA 1, 4 (2003) [hereinafter KENYA IMPACT REPORT], at http://www.globalgagrule.org (last visited Oct. 9, 2003); Joan Ryan, Bush vs. Women of the World, S.F. CHRON., May 26, 2002, at D3; Current Global Campaigns (Marie Stopes Int'l) [hereinafter MSI CAMPAIGNS], at http://www.mariestopes.org.uk/ww/avcacy-cur-glob-camp.htm (last visited Sept. 18, 2003). Even local clinics run by anti-abortion groups in Africa suffer from this rule, since they are often supported by larger organizations that refuse to certify compliance with the rule. E.g., Marie Cocco, U.S. 'Gag Rule' Could Impair AIDS Programs, NEWSDAY, Mar. 11, 2003, at A29. President Bush's reinstatement of the rule two years ago has forced the faith-based group Family Life Movement of Zambia to close three of its nine family planning clinics. Id. The clinics were jointly-run with Planned Parenthood, which does not comply with the Mexico City Policy. Id. Hilary Mulenga Fyfe, the group's chair, describes the damage caused by the rule with a proverb from Zambia: "Where the giants are fighting, what suffers is the grass." Id.
thousands of women. They provided basic services that many poor women could not otherwise afford or access, including well-baby care, pre- and post-natal obstetric care, HIV testing and counseling, and contraception. In order to avoid closing seven more health posts and one maternal nursing home when President Bush imposed the global gag rule, health care provider Marie Stopes International of Kenya laid off one-fifth of its staff, cut the remaining employees' salaries, reorganized its clinic structure, and increased client fees. The country's other leading reproductive health provider, the Family Planning Association of Kenya, laid off nearly one-third of its staff, raised patient fees, and cut salaries in order to keep its remaining clinics open and running without U.S. funding.

Similarly, the global gag rule has cost the Family Guidance Association of Ethiopia—which runs 671 community-based reproductive health care sites, 24 youth centers, and 18 clinics—more than a half-million dollars. The Association does not provide abortion services because abortion is illegal in Ethiopia. Nevertheless, by communicating the fact that unsafe abortion was claiming the lives of Ethiopian mothers to local policymakers, the group forfeited its U.S. funding, which resulted in a loss of services to 301,054 women and 229,947 men living in urban areas. Clearly, the women and families who lost access to these resources and clinics were the true victims of the Mexico City Policy.

In addition, the Mexico City Policy has forced abortion politics into NGOs' partnering selections by shifting the criteria that organizations receiving USAID grants rely upon to select foreign partners. Specifically, the Policy has forced groups that receive USAID grants and disperse this funding to foreign programs to judge the abortion stance of their potential grantees, rather than allowing them to select programs that could provide increased access to quality family plan-

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75 *Kenya Impact Report, supra* note 74, at 4.
76 *Id.*
77 *Id.* at 4, 5.
78 *Id.* at 5. As a result, the health care personnel at the remaining facilities are overworked and underpaid. *Id.* In September of 2003, clinic staff of the Family Planning Association of Kenya reported that morale had never been lower. *Id.*
80 *Id.*
81 *Id.*
82 See *Cocco, supra* note 74, at A29; Matluck, *supra* note 79, at B; Ryan, *supra* note 74, at D3; *MSI Campaigns, supra* note 74.
83 See *Hearing, supra* note 9, at 53, 55 (statement of Dr. Pellegrom).
ning services. For example, Pathfinder International has conducted reproductive health work abroad for more than forty-five years. Without the rule, Pathfinder would create local partnerships based on a program's cost effectiveness, its capacity to reach the "poorest of the poor," its commitment to helping clients, and the quality of care it provides. Because of the global gag rule, however, Pathfinder's overriding question has become, "How against abortion is this organization?" This consequence of the Mexico City Policy clearly conflicts with USAID's stated goals of "maximizing access to and improving the quality of family planning."

Accordingly, the Mexico City Policy is harmful not only because it leads to clinic closures and a reduction in available services, but also because it allows abortion politics to impede the provision of health care to needy populations. Because the Policy's true victims are "people who can't vote [President Bush] out of office," it is relevant to examine non-legislative methods for challenging the Policy, such as through the judicial system.

II. THE MEXICO CITY POLICY'S VIOLATION OF LEGAL RIGHTS

Lawmakers, advocacy organizations, and litigants have set forth legal arguments both for and against the Mexico City Policy. Support-
ers in Congress have argued that it is the only means of preventing U.S. funds from indirectly supporting abortion. 92 Under this view, U.S. funding to groups that support abortion might "free up" other, non-USAID funds for abortion-related services. 93 Federal courts, however, have rejected the view that money is "fungible" when it pertains to abortion service providers in the United States. 94 The U.S. Court of Appeals for the Ninth Circuit found that "the freeing-up theory cannot justify withdrawing all state funds from otherwise eligible entities merely because they engage in abortion-related activities disfavored by the state." 95 No court, however, has extended this holding to foreign NGOs. 96

Several legal scholars and advocates have developed arguments opposing the Mexico City Policy based on domestic and international guarantees of free speech and expression. 97 Although these groups have been largely unsuccessful in litigating their claims, the merits of their arguments are compelling and deserve attention in the legislative arena. 98
A. Violation of U.S. Law

The Policy's provisions prohibiting advocacy that "actively promotes abortion" are inconsistent with the First and Fourteenth Amendments of the U.S. Constitution because they restrict U.S.-based organizations' communication activities, discriminate on the basis of viewpoint, and unfairly place U.S.-based NGOs that advocate anti-abortion views abroad at an advantage over pro-choice NGOs trying to do the same work. The Policy restricts U.S.-funded foreign NGOs that support legalizing, decriminalizing, or liberalizing abortion laws from communication activities, such as organizing or distributing information during public debates or media events, participating in public fora including internet discussions, testifying before or providing briefings to the U.S. Congress, or attending or speaking publicly at UN conferences. Hence, when asked to testify before the U.S. Congress in 2001 at a hearing on the Mexico City Policy's effects on international family planning funding, the President of a Peruvian NGO had to appear in a U.S. federal court to receive legal permission to testify without threatening her group's funding.

The Center for Reproductive Rights, formerly known as the Center for Law and Reproductive Policy (CRLP), is a U.S.-based organization that advocates for reproductive health law reform in the United

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99 See U.S. CONST. amends. I, XIV; Jan. 22 Memorandum, supra note 5, at 216; Greco, supra note 4, at 5.
100 Mar. 28 Memorandum, supra note 6, at 878, 883; BUSH GLOBAL GAG RULE, supra note 7, at 13.
101 Hearing, supra note 9, at 1–2, 27 (statement by Sen. Boxer). The press reported that, in this situation, the Bush administration "backed away" from the "embarrassing possibility that its abortion gag would censor the testimony of a witness before Congress." Id. at 27 (Sen. Boxer quoting and discussing a New York Times article at hearing). When the NGO's President returned to her country after the hearing, however, the Mexico City Policy continued to apply to her organization and she could no longer advocate for the liberalization of abortion laws without jeopardizing U.S. funding. See id.
States and abroad. It brought an unprecedented lawsuit against President Bush in 2002, claiming, in part, that the gag rule violated its First Amendment rights by impeding its ability to lobby for abortion reform in foreign countries. Because it regularly works with "gagged" NGOs, the organization claimed that the implementation of President Bush's restrictions violated its First Amendment rights to freedom of speech, freedom of peaceable assembly and association, and freedom to petition the government for redress of grievances. In dismissing \textit{CRLP v. Bush}, the U.S. Court of Appeals for the Second Circuit relied on \textit{Planned Parenthood Federation of America (PPFA) v. Agency for International Development (AID)}, which held that any impairment of PPFA's freedom of speech, association, or privacy by the Mexico City Policy was permissible because it rationally furthered a legitimate governmental interest using the least restrictive means. Reasoning that the plaintiffs in \textit{CRLP} were not legally distinguishable from those in \textit{PPFA}, the \textit{CRLP} court implicitly determined that the Policy rationally furthered the legitimate governmental objective of refraining from funding abortion overseas, and the Policy also accomplished the government's objective by using the least restrictive means.

Opponents of the global gag rule are also concerned about the rule's viewpoint-based discrimination of speech. The rule permits

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  \item See \textit{CRLP}, 304 F.3d at 187. Although CRLP changed its name in late January 2003 to the Center for Reproductive Rights, this Note refers to the organization by its former name because the lawsuit was filed under that name, and most reports cited in this Note were developed under that name.
  \item \textit{Id.} at 186; see \textit{Bush Global Gag Rule, supra} note 7, at 13; see also U.S. Const. amend. I.
  \item \textit{CRLP}, 304 F.3d at 186, 189; see \textit{Bush Global Gag Rule, supra} note 7, at 12.
  \item \textit{CRLP}, 304 F.3d at 190–91, 195; \textit{PPFA}, 915 F.2d at 63–65. In \textit{PPFA}, Planned Parenthood claimed that the Mexico City Policy placed obstacles in the path of its exercise of First Amendment rights and should, therefore, receive strict scrutiny. 915 F.2d at 63. The court rejected this reasoning and used the rational basis test because the alleged infringement of free speech was the "result of choices made by foreign NGOs." \textit{Id.} at 64, 65. Thus, the court found that the executive branch's restrictions on the class of U.S. funding recipients was rationally related to its objective of withholding federal funds from foreign NGOs that perform or actively promote abortion. \textit{Id.} at 65. Although the court agreed with Planned Parenthood that allowing foreign NGOs to use separate accounts for abortion-related activities would be less restrictive than the Mexico City Policy, it found that such means would be inconsistent with the government's objective. \textit{Id.}
  \item See \textit{CRLP}, 304 F.3d at 190–91; \textit{PPFA}, 915 F.2d at 65 (the \textit{PPFA} court upheld the government's interest as legitimate); see also Anne Marie Gillette, United States Restrictions Funding to Foreign Nongovernmental Organizations Performing or Promoting Abortions, \textit{PPFA v. AID}, 15 Suffolk Transnat'l L. Rev 768, 769 (1992).
  \item \textit{Hearing, supra} note 9, at 11 (statement of Hon. Lowey); \textit{Bush Global Gag Rule, supra} note 7, at 5; see also \textit{CRLP}, 304 F.3d at 197.
\end{itemize}
anti-abortion communications but prohibits pro-choice communications by foreign NGOs.\footnote{Hearing, supra note 9, at 11 (statement of Hon. Lowey); Bush Global Gag Rule, supra note 7, at 5; see also CRLP, 304 F.3d at 197.} This particular restriction does not apply to domestic NGOs because it would violate their First Amendment rights to free speech, but foreign groups cannot invoke the First Amendment, as they do not receive protection under the U.S. Constitution.\footnote{Bush Global Gag Rule, supra note 7, at 5, 16 n.35; see U.S. Const. amend. I.} CRLP challenged this aspect of the Policy by claiming that it violated the organization’s Fourteenth Amendment right to equal protection of the laws.\footnote{U.S. Const. amend. XIV (stating “[Nor shall any State] deny to any person within its jurisdiction the equal protection of the laws”); CRLP, 304 F.3d at 196–97.} Specifically, the group maintained that the Policy put anti-abortion groups at an unfair advantage over CRLP when communicating with foreign NGOs and advocating for abortion law reform.\footnote{CRLP, 304 F.3d at 197.} Although the court acknowledged that the Policy “bestowed a benefit on [CRLP’s] competitive adversaries” engaged in advocacy, it dismissed this claim, finding that the government’s preference for the anti-abortion position was rational.\footnote{Id. at 197–98.}

\section*{B. Violation of International Human Rights Law}

The Mexico City Policy undoubtedly violates the free speech guarantees of international human rights instruments to which the United States is a party.\footnote{Bush Global Gag Rule, supra note 7, at 8–9; Greco, supra note 4, at 5, 6; see also International Covenant on Civil and Political Rights, opened for signature Mar. 23, 1976, art. 19, 999 U.N.T.S. 171, 178 [hereinafter ICCPR]; Universal Declaration of Human Rights, Dec. 10, 1948, art. 19, U.N. G.A. Res. 217A (III), U.N. Doc. A/810, 71 [hereinafter UDHR].} The Universal Declaration of Human Rights (UDHR) was adopted without dissent by the UN General Assembly in 1948.\footnote{See UDHR, supra note 113, at art. 19.} The principles expressed in the UDHR include that all men and women are entitled to the right to freedom of opinion and expression.\footnote{Id.} These principles are legally binding on the U.S. through the International Covenant on Civil and Political Rights, which states: “Everyone shall have the right to hold opinions without interference . . . . 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 . . . “116 The global gag rule expressly violates the spirit of this agreement, as well as the explicit rights it seeks to protect.117 As such, the rule not only impairs the freedom of expression of U.S.-funded foreign NGOs that wish to pursue expressive communications with their own, separate funds, it also violates the rights of patients and citizens seeking medical advice to be fully informed.118

International human rights law, however, does not provide a particularly powerful means for attacking the Policy because many international treaties lack enforcement mechanisms and offer limited fora for challenging violations.119 One human rights law scholar points out that the effectiveness of a challenge to the Mexico City Policy “need not be based upon a final decision of [an] adjudicatory body.”120 Rather the “mobilization of public opinion” is more likely to reverse it.121

Furthermore, abortion arguments based on human rights law tend to be unpersuasive because they are malleable, depending on one’s political perspective on abortion.122 They may be used to support either a fetus’s right to life or a woman’s right to privacy, liberty,

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116 ICCPR, supra note 113, at art. 19; see Hearing, supra note 9, at 62–63 (prepared statement of Aryeh Neier, President, Open Society Institute); UDHR, supra note 113.

117 See ICCPR, supra note 113, at art. 19; Hearing, supra note 9, at 62–63 (statement of Neier); Greco, supra note 4, at 6.

118 See Greco, supra note 4, at 6–7. This violation is troubling from an ethical standpoint, as well. See Julia A. Martin & Lisa K. Bjerknes, The Legal and Ethical Implications of Gag Clauses in Physician Contracts, 22 Am. J.L. & Med. 433, 465–68, 476 (1996). As two scholars point out, “Regardless of the reason behind gag clauses, restrictions on doctor-patient discussions are harmful. Not only are gag clauses undesirable, they violate tort law and recognized standards of physicians’ professional ethics, leave patients uninformed and erode physicians’ professional and personal autonomy.” Id. at 476. In the health care setting, preserving physician and patient autonomy is central to maintaining professionalism and fully informed patient consent. See id. These basic health care standards should not be diminished in the family planning setting, where individuals’ sexual and reproductive health care is at stake. See id.

119 See Cohen, supra note 97, at 242, 252, 266.

120 Id. at 252. Professor Cohen astutely acknowledges, “Even if an international forum were to hold that the policy violates one or more human rights, the United States may remain unwilling to alter its family planning funding restrictions.” Id. at 265.

121 Id. at 266.

122 See James Kingston, Human Rights: The Solution to the Abortion Question?, in UNDERSTANDING HUMAN RIGHTS 455, 458–66, 468 (Conor Gearty & Adam Tomkins eds., 1996) (discussing the applicability of general international law and specific treaty interpretations to both anti-abortion and pro-choice perspectives of the abortion debate); see also Cook, supra note 29, at 101 (explaining that President Reagan based the Mexico City Policy, in part, on an international human rights obligation to protect and care for children before and after birth, pursuant to the U.N. Declaration on the Rights of the Child).
or self-determination.\textsuperscript{123} As a researcher of international and comparative law observes, human rights arguments regarding abortion frequently oversimplify matters because they pit the "'rights' of the unborn against the 'rights' of the mother, rather than looking at the actual relationship between them."\textsuperscript{124} Viewing abortion as a phenomenon within a social context rather than a question of competing rights is a more useful approach.\textsuperscript{125} Thus, it is appropriate to examine the Mexico City Policy and its practical implications for women, families, and abortion in a very specific context: the AIDS crisis in sub-Saharan Africa.\textsuperscript{126}

### III. HIV/AIDS Services in Sub-Saharan Africa\textsuperscript{127}

In his State of the Union address in January of 2003, President Bush announced his administration's $15 billion initiative to combat the AIDS pandemic over the next five years.\textsuperscript{128} This initiative includes U.S. participation in the Global Fund to Fight AIDS, Tuberculosis, and Malaria, which is an independent partnership between governments of

\textsuperscript{123} Kingston, supra note 122, at 467, 468; see also Laura R. Woliver, Rhetoric and Symbols in American Abortion Politics, in Abortion Politics: Public Policy in Cross-Cultural Perspective 5, 11 (Marianne Githens & Dorothy McBride Stetson eds., 1996) (analyzing abortion-related rhetoric and arguments of 78 American amicus briefs, and noting that "[p]ro-life advocates are adamant about the citizenship of the fetus at the moment of conception").

\textsuperscript{124} See Kingston, supra note 122, at viii, 476.

\textsuperscript{125} See id. at 476.

\textsuperscript{126} See id.

\textsuperscript{127} The phrase "HIV/AIDS services" as used in this Note refers to direct outreach to local populations, as well as training and education of local providers, in the areas of HIV/AIDS prevention, care, and treatment. See Turnbull Interview, supra note 73 (discussing the community-based distribution of family planning services, including HIV/AIDS prevention and care); cf. Scott Foster et al., Henry J. Kaiser Family Found., 2001 Federal HIV/AIDS Spending: A Budget Chartbook 9 (4th ed. 2002) (discussing U.S. spending for research in addition to prevention, care, training, and education). Depending on the clinic, these services may include public outreach for youth intervention, education and counseling on behavior modification to reduce the risk of HIV/AIDS transmission, improving blood safety, voluntary counseling and testing, contraceptive distribution, and treatment regimes for preventing mother-to-child transmission. Learning from the Field, supra note 18, at 1–32; Jennifer Kates, Henry J. Kaiser Family Found., A Three Part Series: Spending on the HIV/AIDS Epidemic 27 (2002).

\textsuperscript{128} President George W. Bush, State of the Union Address (Jan. 28, 2003) ("I ask the Congress to commit $15 billion over the next five years, including nearly $10 billion in new money, to turn the tide against AIDS in the most afflicted nations of Africa and the Caribbean."), available at http://www.whitehouse.gov/news/releases/2003/01/20030128-19.html (last visited Oct. 27, 2003); see also H.R. Rep. No. 108–60, at 6, 10–11, 23 ("H.R. 1298 is consistent with and endorses President Bush's $15 billion, 5-year strategy to arrest the spread of AIDS.").
industrialized and developing countries, private corporations, foundations, and individuals. The administration proudly requested from Congress $500 million for the Global Fund, $540 million for USAID's HIV/AIDS budget, and $500 million for a new International Mother and Child HIV Prevention Initiative, which seeks to prevent mother-to-child transmission of HIV/AIDS in Africa and the Caribbean.

Undoubtedly, this assistance is desperately needed, particularly in sub-Saharan Africa, where one-quarter of the region's population is expected to die from AIDS in the next ten years. Nevertheless, even as the Bush administration and Congress increase efforts to help those infected and affected by this pandemic, the 2001 re-imposition of the Mexico City Policy on family planning funding continues to undermine U.S. efforts to fight HIV/AIDS.

A. Current Effects on HIV/AIDS Services and Pregnant Women Living with HIV/AIDS

The Mexico City Policy currently applies to “family planning” funding, but not to U.S. funds designated for HIV/AIDS. As this Note has indicated, however, family planning clinics in sub-Saharan Africa are essential for providing HIV prevention and care, since many family planning clients have HIV/AIDS, and health care facilities, particularly in rural areas, may be scarce. According to one prominent commentator, “there is no distinction anymore between what’s family planning and what’s HIV” because many “women who

130 See U.S. Government HIV/AIDS Support, supra note 33. The $540 million request represents a 24% increase over the $435 million USAID budget for HIV/AIDS in 2002. Id.
132 See Turnbull Interview, supra note 73.
133 The effects of the Policy on specific clinics in general, as well as in the sub-Saharan Africa region, are difficult to measure due to the lack of U.S. monitoring of family planning programs once funding has ceased. See id. Public policy groups and advocacy organizations, such as Population Action International (PAI), have worked to document the global gag rule's effects on the community-based distribution of HIV/AIDS services by visiting and collecting data from field sites in Zambia, Kenya, Ethiopia, and Romania. See, e.g., KENYA IMPACT REPORT, supra note 74; ZAMBIA IMPACT REPORT, supra note 56.
135 See IPPF ANNUAL REPORT, supra note 19, at 8 (pointing out that family planning programs are important for HIV/AIDS prevention because of their experience with STI prevention, condom distribution, and dealing with very personal aspects of clients' lives).
are accessing contraception are at risk of HIV infection, and women who are HIV-infected may still be sexually active and in need of pregnancy prevention." The integration of sexual health and HIV/AIDS programs increases the quality and effectiveness of clinics by allowing providers to share their expertise and learn from each other about effective ways to work with clients. Service integration also prevents the duplication of local services in certain areas, thereby allowing more efficient resource allocation among populations in need of family planning. Because family planning assistance serves people with HIV/AIDS or others seeking HIV/AIDS services, the Mexico City Policy’s negative impact on this population must be exposed in the policy and lawmaking arenas.

The Mexico City Policy fails to address the complexities that HIV/AIDS raises for pregnant women in the reproductive health decision-making process by effectively foreclosing the option of voluntary, safe, legal abortion for many women suffering from HIV or AIDS in sub-Saharan Africa. Ensuring individuals’ access to uncensored information regarding their full range of reproductive rights is essen-

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136 All Things Considered: Expected Announcement by Bush Administration on Extending the Mexico City Policy to AIDS Funding (National Public Radio Broadcast, Feb. 28, 2003) (interview of the Executive Director of the U.S.-based Center for Health and Gender Equity). For instance, approximately 30–40% of women visiting family planning centers in Zimbabwe are thought to be HIV-infected. Sutherland, supra note 10.

137 See Turnbull Interview, supra note 73.

138 See id.

139 See id.

140 See Naomi Rutenberg et al., Reproductive Decision-Making in the Context of HIV and AIDS: A Qualitative Study in Ndola, Zambia, INTERNATIONAL FAMILY PLANNING PERSPECTIVES, Sept. 2000, at 124–30 (stating that all women should have the right to bear or not to bear children); Anna Vrska, HIV and Pregnancy: A Growing List of Options, but No Easy Choices, 1997 BERKELEY MED. J. (discussing the "immensely complex and overwhelming" nature of "dealing with the emotional and physical consequences of HIV" and abortion), at http://www.ocf.berkeley.edu/~issues/fall97/Pregnant.html (last visited Oct. 17, 2003). "For pregnant women with HIV there are many options to consider and difficult decisions to make. It is impossible to say which is correct or to judge the decisions made because each case is unique." Vrska, supra. The term “voluntary” is used to distinguish a woman’s independent, affirmative decision to terminate her pregnancy, from “coerced” abortion, where a government or other entity forces a woman to undergo an abortion against her will. See, e.g., Mar. 28 Memorandum, supra note 6, at 874 (using the term “voluntary”); NOWELS, supra note 4, at 8–11 (discussing the issue of coerced abortion in China in the context of UNFPA funding). The sub-Saharan African countries where abortion is legal under certain circumstances and which receive U.S. population assistance funds are Cameroon, Ghana, Liberia, Mali, Rwanda, Zambia and Zimbabwe. See NGOs IN 56 COUNTRIES, supra note 23.
tial in the HIV/AIDS context.\textsuperscript{141} In sub-Saharan Africa, women are frequently prevented from exercising full control over their sexual and reproductive lives due to gender inequalities, societal or spousal pressures, lack of information, or lack of financial means to implement their decisions.\textsuperscript{142} HIV-positive or AIDS status adds to women’s vulnerability by creating pressure to conduct their reproductive lives in certain ways based on the stigma and discrimination they perceive from others, including even health professionals.\textsuperscript{143} Not only is full access to information and resources necessary for HIV/AIDS prevention, it is also crucial for pregnant women who have HIV or AIDS because they customarily face complex decisions regarding whether and how to proceed with their pregnancies.\textsuperscript{144}


\textsuperscript{142} See United Nations, HIV/AIDS and Human Rights International Guidelines: Second International Consultation on HIV/AIDS and Human Rights, HR/PUB/98/1, at 26–28 (1998) (recognizing women’s vulnerability to HIV/AIDS, as well as the discrimination and stigmatization that women with HIV/AIDS face); Bruyn, supra note 22, at 16; PATH Dialogue, supra note 17, at 37. Ipas reports several examples of women with HIV/AIDS who have wanted to terminate their pregnancies but did not due to the costs of abortion, negative attitudes and discrimination, and a lack of information about abortion safety and availability. Bruyn, supra note 22, at 17–20.


\textsuperscript{144} See Rutenberg, supra note 140, at 124. A study of pregnant women who are HIV-positive in Zambia concludes, “Family planning programs could help clients ascertain their own risk of infection and thus reduce perinatal transmission of HIV by frankly discussing risk factors, offering HIV testing and assisting couples affected by HIV make better choices about contraceptive methods.” \textit{Id.}
Women living with HIV/AIDS may wish to terminate their pregnancies for a number of HIV/AIDS-related reasons. Some women fear transmission of HIV to their fetuses or newborns. Worldwide, more than 2,000 children are infected with HIV every day. Compared with industrialized nations, developing countries experience proportionately higher rates of mother-to-child transmission due to inadequate resources and the prevalence of breast-feeding. In sub-Saharan Africa, up to 30% of pregnant women are infected with HIV and 25–35% of their children will be born infected. Mother-to-child transmission in this region is of particular concern due to the region’s high birth rates, high prevalence of HIV, high rates of HIV among women of reproductive age, and the sizeable population of women capable of bearing children.

A fetus may contract HIV from his or her mother at any time during pregnancy, delivery, or after the baby is born through breast-milk. Based on the work of scientists and health professionals, methods for reducing the chances of mother-to-child transmission of HIV and methods for prolonging the disease’s progression in children are being developed, thereby creating hope for the lives of women and children living with HIV/AIDS. Voluntary HIV/AIDS testing, counseling,
medical treatment plans, safe infant feeding methods, and elective cesarean delivery can reduce the likelihood of mother-to-child transmission; however, these services and drugs are only effective if they are available, accessible, and affordable for mothers.¹⁵³

There are also moral and ethical dimensions to the risk of mother-to-child transmission.¹⁵⁴ One HIV-positive mother from South Africa whose baby died of AIDS writes, “To have a baby die of AIDS is the most horrible thing because the child experiences a kind of pain that nobody can explain—not even a doctor. But a mother can feel it in her gut.”¹⁵⁵ Another HIV-positive woman described her thoughts when facing the possibility of being pregnant, “It’s profoundly, deeply selfish to put a baby at risk.”¹⁵⁶

Other pregnant women with HIV/AIDS in sub-Saharan Africa may seek abortions or information about abortion because they realize that even if their fetus escapes infection, the mother will likely die before the child becomes self-sufficient.¹⁵⁷ UN statistics show that of the more than 13.2 million children who have been orphaned by the AIDS epidemic, 95% are from sub-Saharan Africa.¹⁵⁸ The psychological and emotional trauma on both a mother who is dying and her child is immeasurable.¹⁵⁹ A woman from South Africa wrote:

Apart from the pain, anxiety and the feeling of death being so near during the time of my HIV diagnosis, another hurdle and indescribable pain was when I had to disclose [my status] to my eldest child. I had never cried in front of anyone to whom I had told my status. On this particular day,

¹⁵³ See USAID EFFORTS TO PREVENT MTCT, supra note 25, at 3, 7.
¹⁵⁴ PATH DIALOGUE, supra note 17, at 37. “Faced with the prospect of protecting and caring for another life yet to begin, pregnant women may find the potential consequences of being HIV+ to be worse than death.” Id.
¹⁵⁶ Denison, supra note 143. Denison recounted a conversation with an HIV-positive friend whose daughter died of AIDS at age 3. Id. Her friend said that her daughter “suffered every day of her life . . . . If your child gets AIDS, it’s not you who suffers, it’s your child.” Id.
¹⁵⁷ See Rutenberg, supra note 140, at 124.
¹⁵⁹ See id. at 10–11 (quoting a personal account by Maria Ndlovu entitled Living Positively with HIV: A Mother’s Perspective).
when I tried to explain everything about my HIV status to
my daughter, the tears kept flowing down.\textsuperscript{160}

Children orphaned by AIDS experience trauma that can manifest itself in the form of depression, aggression, drug abuse, malnutrition, anxiety about the future, or developmental problems caused by the loss of consistent nurturing and guidance.\textsuperscript{161}

In addition to the emotional and psychological toll, the economic burden on children affected by AIDS is significant.\textsuperscript{162} The presence of AIDS in a household often causes children to assume responsibility for generating income and providing food for their families, as well as caring for their ill family members.\textsuperscript{163} A case study by the Joint United Nations Programme on HIV/AIDS (UNAIDS) points out that “[t]he death of a mother or father\textsuperscript{164} can leave unsettled debts which impact negatively on the future care and resources left for the remaining children.”\textsuperscript{164} In Zimbabwe, when a family’s breadwinner is ill or its income is spent on medical treatment for HIV/AIDS, children are often forced to drop out of school and work.\textsuperscript{165} In Uganda, 25\% of children whose parents have HIV/AIDS drop out of school.\textsuperscript{166} Children orphaned by AIDS often leave school to care for parents or younger siblings because they cannot pay school fees, or because of discrimination or emotional distress.\textsuperscript{167} These children are also at greater risk of illness, abuse, and sexual exploitation compared to children orphaned by other causes.\textsuperscript{168} Further, these factors increase orphaned children’s own chances of contracting HIV.\textsuperscript{169}

Another consideration for pregnant women is that HIV/AIDS may significantly weaken their immune systems and jeopardize their health, as well as the health of their fetuses.\textsuperscript{170} A report published by Ipas explains:

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\textsuperscript{160} Id.
\textsuperscript{161} Id. at 20.
\textsuperscript{162} See id.; USAID ET AL., CHILDREN ON THE BRINK 2002: A JOINT REPORT ON ORPHAN ESTIMATES AND PROGRAM STRATEGIES 9 [hereinafter CHILDREN ON THE BRINK].
\textsuperscript{163} CHILDREN ON THE BRINK, supra note 162, at 9; USAID, USAID PROJECT PROFILES: CHILDREN AFFECTED BY HIV/AIDS 1 (2d ed., 2002) (providing detailed information about USAID initiatives to help children affected by AIDS in specific countries).
\textsuperscript{164} PSYCHOSOCIAL SUPPORT, supra note 158, at 22.
\textsuperscript{165} Id. at 21.
\textsuperscript{166} UNITED NATIONS CHILDREN’S FUND (UNICEF) ET AL., YOUNG PEOPLE AND HIV/AIDS: OPPORTUNITY IN CRISIS 23 (2002).
\textsuperscript{167} Id.
\textsuperscript{168} Id.; CHILDREN ON THE BRINK, supra note 162, at 9.
\textsuperscript{169} CHILDREN ON THE BRINK, supra note 162, at 9; see UNICEF, supra note 166, at 23.
\textsuperscript{170} See BRUYN, supra note 22, at 6–7.
\end{flushleft}
Pregnancy in itself does not accelerate HIV progression in women who are in the earlier and asymptomatic stages of infection; the situation may be different for women with high viral loads and diagnoses of AIDS. Pregnancy complications that have been observed more frequently among pregnant [women living with HIV/AIDS] than HIV-negative women include genital and urinary tract infections, more frequent and severe blood loss, anemia, bacterial pneumonia, intrauterine growth retardation, preterm labor and premature rupture of membranes, premature delivery and low birth weights.\textsuperscript{171}

The Mexico City Policy undermines the legal rights of women with HIV/AIDS and their partners to be respected and supported when seeking to learn about and exercise their full range of reproductive options.\textsuperscript{172} In Zimbabwe, for example, the 1977 Termination of Pregnancy Act provides that abortion may be legally performed when the pregnancy represents a serious threat to the woman’s physical health.\textsuperscript{173} This language would perhaps permit abortion based on the probable health risks that a woman with HIV/AIDS would experience with pregnancy.\textsuperscript{174} Yet the application of the Mexico City Policy to clinics that would otherwise provide these services deprives women of the ability to exercise their rights under the 1977 Act and control their reproductive health decisions.\textsuperscript{175}

The Mexico City Policy admittedly does not interfere with a woman’s affirmative decision to bear children.\textsuperscript{176} HIV-positive women in countries including Kenya and South Africa have cited various rea-

\textsuperscript{171} Id. at 6.

\textsuperscript{172} See id.; Rutenberg, supra note 140, at 124; see also Pregnancy and HIV Transmission, WISE WORDS, no. 4 (June 1999) (recommending that a pregnant woman with HIV/AIDS who wants to proceed with her pregnancy should be supported in her decision), available at http://www.thebody.com/pinf/wise_words/jun99/pregnancy.html.

\textsuperscript{173} CRLP, WOMEN’S REPRODUCTIVE RIGHTS IN ZIMBABWE: A SHADOW REPORT 8, 21 n.87 (1997) [hereinafter ZIMBABWE REPORT] (citing Termination of Pregnancy Act, ch. 15:10, § 2(1) (1977)). The Termination of Pregnancy Act prohibits abortion generally but includes an expanded scope of exceptions compared to the Mexico City Policy. See Mar. 28 Memorandum, supra note 6, at 877, 878, 883, 884; ZIMBABWE REPORT, supra, at 21 n.87. The 1977 Act also permits abortion when there is a severe risk that the child would suffer from a permanent and serious physical or mental handicap, or when the pregnancy was the probable result of intercourse by a mentally handicapped woman or girl. See ZIMBABWE REPORT, supra, at 8, 21 n.87 (noting that “[i]ntercourse with a mentally handicapped woman or girl is a criminal offense” pursuant to the Criminal Law Amendment Act, ch. 9:05 § 3(d)).

\textsuperscript{174} See ZIMBABWE REPORT, supra note 173, at 8, 21 n.87.

\textsuperscript{175} See id. See generally Mar. 28 Memorandum, supra note 6.

\textsuperscript{176} See generally Mar. 28 Memorandum, supra note 6
sons for deciding to bear children, such as wanting to experience motherhood, wanting to be considered truly "adult" in society, wanting to leave something of themselves behind, and knowing that their children will find care once they die.177 In addition to supporting these decisions and helping such mothers prevent transmission to their children, however, protecting a woman’s legal right not to bear children is pivotal for preventing the spread of HIV/AIDS and contributing to HIV/AIDS development in sub-Saharan Africa.178

B. The Harm of Extending the Mexico City Policy to HIV/AIDS Funding

A proposal that would extend the Mexico City Policy to U.S. funding of international HIV/AIDS programs further undermines the Bush administration’s global AIDS efforts.179 In February of 2003, a proposal that would require all foreign NGOs receiving U.S. funds for “reproductive health” to certify compliance with the Mexico City Policy was publicized by an unclassified briefing memorandum from a senior population official to Secretary of State Colin Powell.180 In addition to family planning, "reproductive health" would include pro-

177 See Bruyn, supra note 22, at 15.
180 Dewey Memo, supra note 134 (providing the text of the memorandum). Additionally, statements by Secretary Powell at a subsequent congressional hearing intimated that the White House was considering expanding the Mexico City Policy. See Abercrombie, supra note 179 (responding to suggestions made by Powell at committee hearing). See generally Hon. Colin Powell, S. Budget Comm., 108th Cong., Statement on President’s International Affairs Budget (Comm. Print 2003).
grams to prevent and treat HIV/AIDS, sexually transmitted diseases, gender-based violence, maternal illness and mortality, and reproductive health education programs. 181

Despite indications that the White House was considering either issuing an executive order or lobbying Congress to include the expanded Mexico City Policy in the global AIDS bill, the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, the Bush administration appears to have backed down from its initial stance due to pressure from congressional leaders who feared that the issue would hold up passage of the global AIDS bill. 182 Reportedly, Republican Congressman Henry Hyde, an adamant opponent of abortion and chairman of the House of Representatives Committee of International Relations, insisted that policymakers refrain from attaching any amendments regarding the Mexico City Policy to the global AIDS bill. 183 Congress passed the bill without extending the Mexico City Policy and President Bush signed it into law on May 27, 2003. 184 This substantial new commitment of U.S. HIV/AIDS funding

181 See Dewey Memo, supra note 134. Although it may be argued that the Policy’s extension would harm these other reproductive health programs, this Note focuses on the Policy’s extension to HIV/AIDS funding because the latter has generated the most controversy. See Kati Marton, The New AIDS Fight; Protect Women, Stop a Disease, N.Y. TIMES, Mar. 1, 2003, at A19; Press Release, IPPF, 130 NGOs Sign Letter to Bush Denouncing Use of Global Gag Rule for AIDS Money (Mar. 5, 2003) (on file with author).

182 Associated Press, Lawmakers Agree on AIDS Package, CHI. TRIBUNE, Mar. 18, 2003, at 9; Cusack, supra note 179, at 37; Edward Epstein, House Set to OK AIDS Funding; Abortion Gag Rule Has Barred Some Programs Overseas, S.F. CHRON., Mar. 17, 2003, at A1; see Dewey Memo, supra note 134. Reflecting a compromise between the White House and congressional leaders, the House Committee on International Relations reported in favor of the AIDS bill without a proposed extension in April of 2003. Associated Press, supra, at 9; Cusack, supra note 179, at 37; Epstein, supra, at A1; see also Dewey Memo, supra note 139 (advising Powell that this issue would cause controversy and delay in the passage of the FY2003 Omnibus Appropriations Bill or the FY2004 Foreign Operations Bill); see generally H.R. REP. No. 108-60.

183 Corine Hegland, Hyde-Bound It Isn’t, NAT’L J., June 28, 2003, at 2106–07. The Hill newspaper reported, “Congressional aides contend that Hyde . . . was well aware that any Mexico City provision would scuttle the legislation.” Cusack, supra note 179, at 37. Although President Bush acknowledged Senators Joe Biden, Bill Frist, and Richard Lugar for playing a major role in developing and passing the bill, the House of Representatives passed the bill out of committee first, and the Senate adopted the House version of the bill rather than passing its own version. Hegland, supra. Claiming credit for the House bill, Hyde was quoted saying that the President praised the senators, “but by God, it was our bill that he signed.” Id.

is historic and certainly deserves praise, but the White House’s lack of an express statement that it will refrain from extending the Policy to HIV/AIDS funding in the future continues to undermine the sincerity of the Bush administration’s initiative.185

Supporters of expanding the Mexico City Policy want to ensure that new federal assistance for HIV/AIDS does not promote abortion services.186 As this Note has demonstrated, however, U.S. funds have not directly supported abortion activities since the passage of the Helms Amendment in 1973.187 Moreover, the unconvincing argument that U.S. assistance might be “fungible” simply does not justify withholding funds and resources from desperately needy populations in sub-Saharan Africa.188

In recommending this policy expansion to the White House, the Assistant Secretary of the Bureau of Population, Refugees and Migration proposed limited exceptions.189 The exception that generated controversy in the NGO community provided that otherwise non-compliant foreign NGOs that implemented discrete HIV/AIDS projects could receive U.S. funding and continue providing abortion-related services with their own funds, so long as they kept the funding and services separate.190 As more than 130 NGOs pointed out in a letter to the White House, encouraging the segregation of HIV/AIDS services from family planning clinics that provide abortion-related services would impede the efforts of already overburdened HIV/AIDS services.

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185 See Cusack, supra note 179, at 37; Epstein, supra note 182, at A1; Lee Press Release, supra note 179; Telephone Interview with Molly Diachok, Policy Associate, Center for Reproductive Rights (Mar. 10, 2003) [hereinafter Diachok Interview].

186 See AIDS Funding: White House Hopes to Restrict AIDS Money for Foreign Family Planning Groups, AIDS WEEKLY, Mar. 10, 2003, at 8 [hereinafter AIDS WEEKLY]; see also Dewey Memo, supra note 134 (predicting that conservatives on Capitol Hill “will not support a policy that provides [a] carve out for HIV/AIDS projects,” while moderates and liberals “of both sides of the aisle will support such a carve out”). National “pro-life” groups also support the policy extension because they do not want U.S. aid to support groups that encourage HIV-infected pregnant women to seek abortion. AIDS WEEKLY, supra, at 8.


188 See Hearing, supra note 9, at 8 (statement of Hon. Smith); BUSH GLOBAL GAG RULE, supra note 7, at 12; AIDS WEEKLY, supra note 186, at 8.

189 See Dewey Memo, supra note 134. Under one exception, foreign NGOs not otherwise compliant with the Mexico City Policy would be eligible for funding if they merely serve as a “pass-through to a subcontractor that is compliant.” Id.

190 See id. (stating, “Foreign NGOs that either perform or counsel abortions that also implement discrete HIV/AIDS projects would be eligible for funding these projects).
programs.\textsuperscript{191} Separating the resources available to people with HIV/AIDS would cause an unnecessary and inefficient duplication of services, thus limiting the total range of services accessible to this population.\textsuperscript{192}

An expansion of the Mexico City Policy to HIV/AIDS funding would force the abortion debate into the HIV/AIDS context through its effects on organizations unrelated to abortion.\textsuperscript{193} For example, an extended Policy could potentially apply to the $100 million grant USAID is providing to the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) over the next five years.\textsuperscript{194} EGPAF is a U.S.-based NGO that funds and conducts pediatric research on the treatment and prevention of HIV transmission to infants and children.\textsuperscript{195} Under the Policy, EGPAF could be obligated to sign binding compliance contracts stating that the foundation will not "promote or perform abortion-related services," and its subgrantees would have to do the same.\textsuperscript{196} Thus, this HIV/AIDS foundation, whose health-based focus is completely outside the realm of abortion politics, could be forced to base its funding allocations on the abortion-related involvement of its subgrantees.\textsuperscript{197} The Policy could force the organization either to cease its partnerships with, or separate the services provided by, some of its program sites in sub-Saharan countries, which include Cameroon, Kenya, Uganda, Rwanda, Tanzania, Malawi, Zambia, and Zimbabwe.\textsuperscript{198}


\textsuperscript{192} Letter to Bush, \textit{supra} note 191.

\textsuperscript{193} See Telephone Interview with Natasha Bilimoria, Senior Public Policy Officer, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) (Mar. 12, 2003) [hereinafter Bilimoria Interview] (stating that EGPAF has never looked into the abortion-related activities of its grantees because its focus is "getting services to the ground" to prevent mother-to-child transmission of HIV infection).


\textsuperscript{195} Bilimoria Interview, \textit{supra} note 193.

\textsuperscript{196} See Jan. 22 Memorandum, \textit{supra} note 5, at 216; Bilimoria Interview, \textit{supra} note 193; EGPAF Press Release, \textit{supra} note 198.

\textsuperscript{197} See Jan. 22 Memorandum, \textit{supra} note 5, at 216; EGPAF Press Release, \textit{supra} note 194. EGPAF has never before taken a political stance on abortion and has never looked into the abortion-related activities of its subgrantees. See Bilimoria Interview, \textit{supra} note 193.

\textsuperscript{198} See EGPAF \textit{ANNUAL REPORT}, \textit{supra} note 146, at 29–31.
Extending the Policy to HIV/AIDS funding would prioritize the exportation of anti-abortion political interests over the actual demand or need for field programs, which is considerable in sub-Saharan African countries. If preventing the spread of HIV/AIDS were truly the intention of U.S. foreign assistance, more relevant factors, such as location, strength, potential success, and local or regional need for a program, would dominate the allocation decisions of organizations receiving HIV/AIDS funding.

In his State of the Union address, President Bush reported that only 50 thousand of the 30 million AIDS victims in Africa were receiving the medicine they need. The United States' priority should be to help people with AIDS by, for example, providing them with HIV/AIDS pharmaceuticals, antiviral therapies, and other medicines. Withholding funds from programs that are “already well positioned to provide women with the full range of services they need” would not only be economically inefficient, but would also victimize the very people the funding aims to help.

IV. REMEDYING THE NEGATIVE IMPACT OF THE MEXICO CITY POLICY ON HIV/AIDS SERVICES AND PEOPLE LIVING WITH HIV/AIDS

An executive memorandum rescinding the entire Mexico City Policy would be the most effective strategy for allowing family planning clinics to serve their HIV/AIDS clients in accordance with local, regional, and national health standards. Yet such an order is unlikely under the current administration; each post-Reagan Republican president has implemented the Policy and the current administration has consistently advanced policies opposing abortion. Moreover,

199 See Hearing, supra note 9, at 55 (statement of Dr. Pellegrom); PopBriefs, supra note 1, at 1; Maximizing Access, supra note 86.
200 See Hearing, supra note 9, at 55 (statement of Dr. Pellegrom); PopBriefs, supra note 1, at 1; Maximizing Access, supra note 86.
203 See Marion, supra note 181, at A19; see also Ctr. for Reprod. Rights, Expanded Global Gag Rule Limits Women’s Rights and Endangers their Well-Being (2003) (on file with author) (examining the impact of the proposed extension on fourteen countries that have been named as recipients of the Bush global AIDS initiative).
204 See, e.g., Clinton, supra note 38, at 10 (rescinding U.S.-imposed anti-abortion restrictions, and thereby implicitly allowing existing legal standards to govern).
205 See Mar. 28 Memorandum, supra note 6, at 873 (noting that the Policy remained in effect until President Clinton rescinded it); The War Against Women, N.Y. Times, Jan. 12, 2003, at 114 (highlighting several anti-abortion acts by the Bush administration, which include withdrawing information about abortion and contraception from federal govern-
President Bush expanded the Mexico City Policy in August of 2003 by extending it to State Department grants to foreign NGOs for family planning programs. Thus, lawmakers have explored more probable and pragmatic remedies.

In response to President Bush's re-imposition of the Policy in 2001, moderate and liberal lawmakers introduced the Global Democracy Promotion Act in both the 107th Congress and the current 108th Congress. With the goal of respecting the sovereignty of foreign governments and their laws, the bill allows NGOs receiving U.S. assistance to use their own funds for abortion-related services, so long as their actions do not violate the laws of the country in which the services were provided. Although the 107th Congress did not pass this legislation, the House International Relations Committee passed an amendment that would have included the bill's language in an authorization bill in 2001, and the subsequent 218–210 vote on the amendment in the House of Representatives was close.

Momentum to pass the Global Democracy Promotion Act may be building again, since the Bush administration sparked a vigorous debate with its proposed extension of the Mexico City Policy to funding web sites, banning federal funds for new embryonic stem cell research, redesignating the Children's Health Insurance Program to cover "unborn children" rather than pregnant women, supporting a ban on so-called partial-birth abortions, and appointing an "anti-choice" Attorney General, John Ashcroft).

Memorandum: Assistance for Voluntary Population Planning, 68 Fed. Reg. 52,323 (Aug. 29, 2003) [hereinafter Aug. 29 Memorandum]; see infra note 32. President Bush reportedly issued this order because the State Department wanted to withdraw funding from Marie Stopes International, a large and active organization that provides reproductive health and HIV/AIDS services worldwide. Darlene Superville, Bush Broadens Global Gag Rule on Abortion, ASSOCIATED PRESS, Aug. 30, 2003; see Aug. 29 Memorandum, supra at 52,323. Even though administration officials admitted to having no evidence that the group supported involuntary or coerced abortion, the Bush administration expressed discontent with the group's abortion-related activities. Superville, supra; see infra note 32.


See H.R. 2952; H.R. 755; see also BUSH GLOBAL GAG RULE, supra note 7, at 14; Newels, supra note 4, at 1, 16; Greco, supra note 4, at 10. Congress may override the president's executive action through bicameral passage and presidential enactment of legislation. See U.S. CONST. art. I, § 7 (providing that "[e]very Order, Resolution, or Vote to which the Concurrence of the Senate and House of Representatives may be necessary ... shall be presented to the President of the United States . . .; shall be approved by him, or being disapproved by him, shall be repassed by two thirds of the Senate and House of Representatives . . ..").

See H.R. 2952; H.R. 755.

for HIV/AIDS.211 In July of 2003, the Senate approved an amendment to the State Department Authorization bill, which would overturn the Mexico City Policy.212 If the Global Democracy Promotion Act were to pass without any modifications, its language would be broad enough to overturn such a proposed extension to HIV/AIDS funding.213 In fact, the bill's application to the proposed extension may be the key for mobilizing congressional support in favor passing the Global Democracy Promotion Act in the 108th Congress.214

Fortunately, the Bush administration and congressional leaders have thus far refrained from extending the Mexico City Policy to HIV/AIDS funding.215 Even though the new global AIDS law did not extend the Policy, there has been no indication that the Bush administration intends to scale the Policy back or rescind it altogether.216 Maintaining public pressure on President Bush, as well as on future presidents, to limit the current scope of the Mexico City Policy will be crucial for implementing Bush's $15 billion AIDS initiative and other U.S. efforts to combat the HIV/AIDS pandemic in sub-Saharan Africa.217

CONCLUSION

The current Mexico City Policy presents a significant threat to the health of women and others living with HIV/AIDS in sub-Saharan Africa and elsewhere. Although the symbolic value of court challenges to this policy is powerful, any legal change will most likely be brought about through the political process rather than the court system. Consequently, policy debates between the public, Congress, and the White House must fully expose the Mexico City Policy's damaging impact on HIV/AIDS services for women in developing countries. When con-

211 See H.R. 2952 (introduced in the House of Representatives on July 25, 2003).
212 NOWELS, supra note 4, at 1.
213 See Diachok Interview, supra note 185.
214 See id.
215 See Epstein, supra note 182, at A1. Part of the administration’s willingness to compromise may have derived from the considerable public outcry about the possible extension. See, e.g., Letter to Bush, supra note 191.
216 See NOWELS, supra note 4, at 1 (noting the White House’s statement that President Bush would veto any legislation that includes an amendment to overturn the Mexico City Policy); see, e.g., Aug. 29 Memorandum, supra note 206, at 52,323. The recent order extending the Policy to State Department funding explicitly exempts foreign aid furnished pursuant to the global AIDS law, but the narrow nature of this exemption could fail to prevent lawmakers from applying the Policy to HIV/AIDS funding. See id.
217 See id.; Cusack, supra note 179, at 37; Epstein, supra note 182, at A1; Letter to Bush, supra note 191.
tributing to the international effort to combat the HIV/AIDS pandemic, the United States must not allow abortion politics to victimize people with HIV and AIDS.