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Access to basic reproductive rights: Global Challenges

Sheelagh McGuinness and Heather Widdows

I. INTRODUCTION

It has long been recognised that if women are to have true equality with men they must be able to control the number of children they have and the time of childbirth. There are many factors that impact on this ability but key are access to family planning services, particularly safe contraception and abortion. That is the focus of this chapter. The central premise of our analysis is that access to contraception and abortion are properly understood as *basic* reproductive rights. Our claim is that to disallow such access is effectively to bar women from attaining equality with men by denying minimal standards of bodily integrity. We argue for access to contraception and abortion as *basic* reproductive rights because they are necessary to for controlling fertility and childbirth and as such necessary to make women equal to men. *Basic* reproductive rights should not be ‘trumped’ by other rights or sacrificed or compromised to attain other goods.

The chapter is divided into three distinct parts. In the first section we provide the philosophical foundation which grounds our claim that women must be able to access contraception and abortion if they are to be truly equal to men. We move from this to provide a very brief overview of the evolution of how reproductive rights are conceptualised in international human rights norms. The final part of the chapter is focused on current threats to access to abortion and contraception. We provide an overview of one of the biggest impediments to family planning services on a global scale – the Global Gag Rule (GRR). We describe the emergence of this rule and its impact. Looking forward we consider the importance of continued improvements in women’s reproductive rights ‘post 2015’; and we argue that restrictions on development aid funding of particular aspects of family planning services, for instance, safe abortion care, constitute a retrograde step and should be resisted.

Given the basic nature of rights to access contraception it is not enough to protect these rights in a ‘negative’ or ‘non-interference’ form; rather we must ensure an “enabling environment” such that both abortion and contraception are accessible to women (Cohen, 2012). Our approach echoes that of reproductive justice scholars who “simultaneously demand a negative right of freedom from undue government interference and a positive right to

government action in creating conditions of social justice and human flourishing for all.” (Luna & Luker, 2013: 328) Access to contraception and abortion are key to women and girls’ ability to achieve equality because in the words of Sen and Batiwala:

The control of women’s and girls’ sexuality and reproduction is at the heart of unequal gender relations, and is central to the denial of equality and self-determination to women. (as quoted in Baird, 2004, 142)

We argue that these rights are basic on the grounds that such rights are assumed and taken for granted by men; because there is no parallel threat to which men are subject, men cannot be invaded in a similar way. Accordingly, if women are to be equal to men, then such basic rights are required for women to attain the same minimal standard of bodily control that all men automatically have. Moreover, such rights are basic in that they are necessary for the exercise of all other (human) rights, as basic bodily integrity and control is a prerequisite for the exercising of other rights.

II: CONCEPTUALISING BASIC REPRODUCTIVE RIGHTS

(a) What are reproductive rights?

Following Catherine MacKinnon, we ground our arguments about the importance of reproductive control as a basic right (the ability to actually access contraception and abortion and correspondingly the ability to refuse to undergo such procedures) in arguments from sex equality (MacKinnon, 1991).

The nature of reproductive rights is highly contested, in terms of what they are and what they should be. In this chapter we separate ‘basic’ reproductive rights from other possible understandings of reproductive rights and we justify our position on a gendered basis using equality arguments. Reva Siegel summarises some of the key features of a sex equality approach to reproductive rights as follows:

[T]he sex equality approach to reproductive rights views control over the timing of motherhood as crucial to the status and welfare of women, individually and as a class. Arguments from the sex equality standpoint appreciate that there is both practical and dignitary significance to the decisional control that reproductive rights afford women, and that such control matters more to women who are status marked by reason of class, race, age, or marriage. Control over whether and when to give birth is practically important to women for reasons inflected with gender-justice concern: It crucially affects women's health and sexual freedom, their ability to enter and end relationships, their education and job training, their ability to provide for their families, and their ability to negotiate work-family conflicts in institutions organized on the basis of traditional sex-role assumptions that this society no longer believes fair to enforce, yet is unwilling institutionally to redress. (Siegel, 2007, 818-819)

Other arguments could be used and philosophically and legally there is no consensus around what reproductive rights are. Moreover, the topic is highly contested, both in conceptual terms of what reproductive rights could and should amount to, and in practical terms about how such rights should be provided. The global picture is one of complexity and confusion. For instance, the Universal Declaration of Human Rights (UDHR) does not explicitly mention reproductive rights, although they are implied in the right to found a family (article 16), and the importance of bodily integrity which forbids torture and cruel or inhuman treatment and punishment (article 5). Taken together, these rights can be used to claim that no one should be physically prevented from conceiving and bearing children; or conversely that no one should be forced to carry a child. Given there is so little clarity about what reproductive rights are it is not surprising that what is available in practice varies widely both within localities and globally. In section two of this chapter we will track the evolution of human rights discourse on reproductive rights and note some of the key changes in how such rights are conceptualised.

(b)The importance of 'gender' back in the reproductive rights debate

Debates about reproductive rights touch on many controversial and sensitive issues. Perhaps one of the most contested issues relates to the moral status of the embryo/ foetus. It is this

way of framing the debate that is typical of ‘pro-choice’, ‘pro-life’ categories which beset much of the polarised political debate (Widdows, 2013, 201-204). Such arguments ‘against abortion’ are often made on religious grounds or on claims regarding the necessary features for moral personhood (Steinbock, 1992). Those who wish to restrict access to abortion assert the ‘personhood’ or ‘sanctity’ of the embryo at various stages, including conception, quickening, and viability and many who are not religious also share such views (George & Tollefsen, 2008). Fetal centric arguments often assume a complete separation between the pregnant woman and the foetus, elevating the latter to the status of the individual of equal moral worth to the woman. Such arguments are evident in the growing legal trend to afford protection to the foetus through the constitutionalization of fetal rights (DeLondras, 2015). These arguments construct maternal/ fetal conflict and acknowledge the embodied nature of pregnancy only to the extent that the pregnant woman is viewed as a threat to the foetus. The argument posits the woman as an aggressor and the foetus as an innocent bystander rather than a dependent. As Susan Bordo summarises: “as the personhood of the pregnant woman has been drained from her and her function as fetal incubator activated, the subjectivity of the fetus has been elevated” (Bordo, 1993, 85). These arguments have been used to justify restrictions on both abortion and contraception; although ironically they have sometimes had the perverse consequence of increasing the number of abortions rather than decreasing them (Cohen, 2012).

Fetal centric arguments are also often constructed in ways which fail to take account of the gendered nature of reproduction. In this chapter our approach is fundamentally gendered and highlights the gender injustice involved in failure to grant access to contraception and abortion. In adopting a gendered lens our intention is to highlight that not only are women suffering from lack of access to contraception and abortion, but to show that this injustice is partly an injustice which women suffer as women. Failure to protect women from disadvantages and injustices they experience solely because of their gender undermines the universality of ‘rights’ (Cook, 1993). Women’s reproductive rights are not just controversial in the abortion debate, but in other debates about family and social structures, and often these issues share commonality with the abortion debate in that they are essentially about controlling women’s bodies. In the words of Alison Jaggar “because women are typically seen as the symbols or bearers of culture, conflicts among cultural groups are often fought on the terrain of women’s bodies”. (Jaggar, 2005, p46) Attempts to control women’s bodies,

particularly their sexual and reproductive functions, have a long and global history. Ways in which such control has been manifested in the family include practices of female genital mutilation, chastity belts, chaperoning women, restricting freedom by denying movement or employment outside the home (to prevent opportunities for non-approved sexual encounters) (Chavkin & Chesler, 2005). In addition, blame for sexual and reproductive ‘mistakes’ or what is deemed inappropriate behaviour usually, and across cultures, falls disproportionately upon women. Such disparities raise equality questions as such attempts to control reproduction do not apply to men, and rarely to boys. Patriarchal norms have shaped many aspects of the world we inhabit and are mirrored at the policy level in marriage and divorce laws, employment laws and perhaps most obviously in policies of population control. To neglect the gendered aspect of reproductive rights is to neglect key features of the injustices involved and to fail to accord these rights the respect they deserve. Hence in the next section we develop an argument for access to contraception and abortion that is gender sensitive and grounds these basic reproductive rights in an argument from equality.

(c) Basic Reproductive Rights from Equality

In this section we argue that in order for women to achieve equality with men, to be human, basic reproductive rights – including access to contraception and abortion – must be accessible to all women. From this argument follow claims about the importance of basic reproductive rights and the necessity of granting these over and before other rights – including, but not only, other reproductive rights. However, it is not necessary to agree with our argument to agree with our conclusion that these rights are basic for women to function effectively. For instance, one could argue from a perspective of autonomy that women should have access to these rights in order to be able to exercise their autonomy and make choices for their own lives, or that such rights follow from arguments based on negative rights of non-interference.¹ Moreover, some of these arguments complement and supplement our claims. Given this it is possible to accept our conclusion that these basic rights are necessary, and to endorse the claims made in the latter part of the chapter about the global need to grant these basic rights to women, without endorsing the philosophical foundational argument regarding how to ground and construct such rights.

¹ Other arguments could be made on autonomy grounds, our claim is not that such arguments cannot be made we simply wish to focus on the equality argument for this chapter.

We argue that these rights are basic and are necessary for women to be human and equal to men. We argue that these rights are basic not because they are negative rights, nor because they are autonomy rights, but on grounds of equality. This then is a threshold concept. Only by guaranteeing bodily control, by the means of contraception and abortion, can women attain a comparable standard of bodily integrity to men and thus can the requirements of equality be met.²

To make this argument we introduce the debate about whether ‘women’s rights’ amount to ‘human rights’. We endorse the view that where there is a gap between the rights which women hold and the rights which men hold this should be closed if women are to be said to enjoy ‘human rights’. If this gap is not closed then women cannot be considered human, but are effectively subhuman, and treated as inferior to men. This approach draws on the seminal work by Catharine MacKinnon who asks ‘are women human?’ (MacKinnon, 2006).³ Her work considers women’s rights taken as a whole, and not simply reproductive rights, and she is especially concerned with rape and violence in the context of conflict. But the structure, assumptions and implications of her argument can be applied equally to reproductive rights. She states:

If women were human, would we be a cash crop shipped from Thailand in containers into New York's brothels? Would we be sexual and reproductive slaves? Would we be bred, worked without pay our whole lives, burned when our dowry money wasn't enough or when men tired of us, starved as widows when our husbands died (if we survived his funeral pyre), sold for sex because we are not valued for anything else? Would we be sold into marriage to priests to atone for our family's sins or to improve our earthly prospects? Would we, when allowed to work for pay, be made to work at the most menial jobs and exploited at barely starvation level? Would we have our genitals sliced out to “cleanse” us (our body parts are dirt?) to control us, to mark us and define our cultures? Would we be trafficked as things for sexual use and entertainment worldwide in whatever

² Attempts to imagine what a similar bodily invasion would amount to for a man are the subject of many philosophical papers, the most famous being the Judith Jarvis Thompson’s violinist, which is still central to the philosophical debate. (Jarvis Thompson, 1971)

³ This was first published in 1999 in *Reflections on the Universal Declaration of Human Rights*, but is reprinted in MacKinnon’s 2006 collection of the same title.

form current technology makes possible? Would we be kept from learning to read and write? ... Would we be sexually molested in our families? Would we be raped in genocide to terrorize and eject and destroy our ethnic communities, and raped again in that undeclared war that goes on every day in every country in the world in what is called peacetime? If women were human, would our violation be *enjoyed* by our violators? And, if we were human, when these things happened, would virtually nothing be done about it?" (MacKinnon, 2006, p41)

MacKinnon's language is deliberately rhetorical and dramatic and intentionally controversial. Yet her point is simple: that many of the injustices to which women are subjected are gendered. The type of injustices that are often done to women happen only to women, they do not happen to men. That many of the injustices which MacKinnon lists are connected to sex and reproduction is not surprising given the asymmetrical way they are experienced by women and men. Sex and reproduction are sites in which women's experience and men's experience is divergent, and as MacKinnon states, "nowhere is sexuality not central to keeping women down" (MacKinnon, 2006, p13). It is this divergence which MacKinnon focuses on to explain why such gendered injustices are so widely perpetrated and why comparatively little is done to address them, and certainly less than would be done to address them if they were non-gendered injustices. If we reframe MacKinnon's argument slightly so that it directly maps the argument we are making about basic reproductive rights, and why access to contraception and abortion are required if women are to be equal to men, then it would run something like this:

'If women were human would they be denied the right to prevent the invasion of their bodies and involuntary impregnation? Would a foreign body be allowed to feed from them, to grow inside them, and to transform the shape of their body? Would they be required to adapt their lifestyles, eating, drinking and physical activities to accommodate another? Would their wombs be treated as separate from themselves and regarded as the property of others? Would others – husbands, family, religious and cultural leaders, NGOs and policy makers – be able to determine whether or not they put their lives at risk though the risks of childbearing? If women were human would they not be granted the same minimum expectation of bodily integrity as men?

This is just an example of how such an argument could run, and we are not committed to any particular clause. We are merely introducing it as a hypothetical exercise that is useful in highlighting the gendered nature of reproductive rights. Putting the argument this way is, like MacKinnon's, rhetorical and confrontational and designed to be so. The style can be objected to on the grounds that such aggressive language obscures because of its highly political and polemical nature. However, such an approach is useful as a device to show the gender differential which is fundamental to claims about reproductive rights. When one formulates the claims to basic rights in this way, and makes women overtly the focus of the argument, and women as human beings *qua* human being, then the gender injustice emerges clearly. Formulated in this way, focusing on how women are treated when compared to men – or women as compared to 'full humans' – then the extent of what is denied to women when they are denied contraception and abortion is clear. Thinking of reproductive rights in this framework helps us identify why such rights are basic – because they are threshold rights which allow women to be equal to men. It also provides reasons for prioritising such rights over other rights, and for not simply regarding these as 'negative rights' (rights to be left alone, rather than positive rights to actually have access). Such rights are basic, because they are threshold rights, assuring women's equality to men.

MacKinnon's approach highlights that often 'human rights' means 'men's rights' as 'men' are the archetypal 'human': the human rights system is structured and constructed according to male priorities rather than female priorities. For instance, MacKinnon suggests that it is likely that women would prioritise rights differently than men. Thus she states, "lacking effective guarantees of economic and social rights, women have found political and civil rights, however crucial, to be largely inaccessible and superficial" (MacKinnon, 2006, p5-6).⁴ MacKinnon's critique suggests that women's rights initiatives have done little to address the gendered nature of human rights. For instance, she argues that the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) says little about the evils of sexism and the inferiority of women.⁵ However, one does not need to endorse all of MacKinnon's wider claims about the failures of human rights as women's rights to think that there are gendered injustices which must be addressed if women are to be equal to men and to

⁴ Furthermore she continues that "The generational distinctions and their rankings, questionable for men as well, are clearly premised on gendered assumptions, perceptions and priorities". (MacKinnon, 2006, p6).

⁵ Of course this is one view and many feminists welcome CEDAW as a huge advance in women's rights.

think that MacKinnon's style of argumentation is useful for revealing these. With regard to basic reproductive rights, rights which raise women up to the same status and standard as men, her gendered analysis is revealing. Only if these basic reproductive rights are attained can women take for granted certain aspects of bodily integrity which men automatically have. Without the rights to avoid pregnancy or to end pregnancy (using the means of contraception and abortion services) women lack both bodily integrity and basic control of their reproductive functions. These are functions which men do not lack (men cannot suffer similar breaches in bodily integrity) and furthermore these rights are basic in that without them women are unable to exercise agency in other fields, including those of relationships and employment. Such control is a necessary aspect of not only furthering women's emancipation and equality in general, but importantly as threshold rights which allow women to experience the basic bodily integrity and control which men experience. Accordingly if women are to be granted human rights, these basic reproductive rights must be granted not just as formal rights of access. It is not enough for such rights to be formally available – not prohibited – but they must be actually available. Given this, these services are not, we argue, supplementary or mere parts of healthcare packages which can be reasonably sacrificed in order for women to gain other goods.

IV. Beyond Basic Rights

In this chapter we are not denying that there are, or may be, other reproductive rights, for instance, rights to parent. However, we are claiming that there are no other *basic* reproductive rights, at least such rights cannot be constructed from or grounded in equality claims. Further while we argue that access to contraception and abortion is a basic right – and one which is currently conspicuously lacking for a large amount of women globally – the parallel rights not to be coerced into abortion and sterilization are also basic, as these too can be grounded in equality. The debate about basic reproductive rights does not exhaust the reproductive rights debate and there are many other issues that are pertinent to the reproductive rights debate. In particular there questions about whether there is a right to access reproductive technologies. This right is particularly claimed from the 'right to found a family'. However, rights to reproductive technology are not basic rights in the way we have argued the case, as they do not contravene the gender equality criteria and as such are not threshold rights and thus are not our concern in this chapter. Before going on to consider specific case studies on access to

contraception and abortion we will provide a brief overview of how human rights discourses on reproductive rights and how we conceptualise them have evolved.

III: WHERE HUMAN RIGHTS BEGIN - THE SMALL PLACES

In this part of the chapter we consider the emergence and development of reproductive rights within human rights discourse. In doing so we are mindful of the limitations of international human rights documents and wary of the criticisms of scholars like MacKinnon as discussed above. However, consideration of the development of human rights gives us some cause to be hopeful, particularly the way in which human rights have empowered grassroots advocates by providing a rhetorical frame which they can use to ground claims against the State (Cook & Dickens, 2009). International human rights are also being used as a mechanism for improving access to abortion services in countries like Poland and Ireland where such services are highly restricted (Erdman, 2014). As such it is increasingly becoming evident to both scholars and activists who are advocating for improved reproductive futures for women in a variety of contexts that the incorporation of human rights within reproductive justice frameworks can be an important tool of empowerment (Luna, 2009). In the twenty years since International Conference on Population and Development (ICPD) in Cairo we have witnessed some huge improvements to women's health worldwide, so while there is still much to do it is clear that human rights discourses have been a useful political tool for activists worldwide.

In considering the question of where human rights begin Eleanor Roosevelt posited “the small places”. Here Roosevelt is hinting to the fact that human rights are important in all aspects of our lives – for it is only through achieving justice and equality in these spaces is it possible to achieve justice and equality in bigger more public spaces. The full quote is as follows:

Where, after all, do universal human rights begin? In small places, close to home – so close and so small that they cannot be seen on any maps of the world. Yet they are the world of the individual person; the neighbourhood he lives in; the school or college he attends; the factory, farm or office where he works. Such are the places where every man, woman and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have

meaning there, they have little meaning anywhere. Without concerned citizen action to uphold them close to home, we shall look in vain for progress in the larger world.⁶

Roosevelt was speaking in 1958, a decade after the creation of the UDHR. Roosevelt's sentiment holds to this day and is particularly apt in considering the importance and necessity of controlling sexual and reproductive activity if women are to have equality with men, or in MacKinnon's words "truly human". In this section we provide a brief overview of the *women's* human rights paying specific attention to changing discourses around sexual and reproductive health. We do not aim here to be comprehensive in our account but rather to highlight some key shifts in emphasis.

The UDHR explicitly challenges the oppression of women in what was traditionally deemed the 'private sphere'. In so doing, it steps into the small places and transcends the traditional dichotomy of public and private spaces – a dichotomy feminist scholars have long rejected (see for example Pateman, 1983). The UDHR recognises that in order to fully advance women's rights the State must advance not just 'public' rights, for example, employment but also 'private' rights, for example, consent to marriage and education. Reproductive rights have long been recognised at the international level as a sub-set of human rights. At the United Nations (UN) Conference on Human Rights in Tehran in 1968 Resolution XVIII on the Human Rights Aspects of Family Planning was adopted. This resolution states that "couples have a basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect".⁷ This was adopted by a resolution of the UN General Assembly in 1969 and provides the basis upon which current Declarations regarding sexual and reproductive health rights are based.

CEDAW was adopted by the UN General Assembly in 1979. This Convention is important in providing protection for a broad range of rights; those specifically important in the context of our analysis include rights in marriage, health, and family planning. The Convention specifically aims to redress the systemic discrimination against women evident in society and

⁶ <http://www.un.org/en/globalissues/briefingpapers/humanrights/quotes.shtml> (Accessed 31/07/15)

⁷ 'Reproductive Rights' <http://www.un.org/en/development/desa/population/theme/rights/>

with its adoption “UN emphasis turned to moving women to the center of development strategies” (Chesler, 2006, 15). It is beyond the scope of the chapter to map the trajectory of women’s rights from this point forward (on this see for example Bunch 1990, Cook 1993) but it is clear that human rights instruments developed as an important tool in the global enfranchisement of women. Importantly in 1993, in Vienna, the World Conference on Human Rights reaffirmed that the protection of women’s rights was integral to the protection of human rights calling for an end to discrimination against women and women’s enfranchisement in all aspects of political and social life (World Conference on Human Rights, Vienna, 1993). Attention to the importance of protecting sexual and reproductive health rights as part of this has become the focus of increasingly levels of attention since the early 1990s with calls for “maternal and reproductive health policies” to be “understood as a basic obligation of the state’s positive social responsibility to protect women’s right to life, liberty, and security (Chesler, 2006, 17).

The International Conference on Population and Development (ICPD) in Cairo in 1994 was a UN led gathering which focused on the legitimacy and success of global population policies. The Cairo Programme of Action (ICPD 1994) produced a twenty year roadmap (1995 – 2015) for how human rights could be used to protect women’s rights to bodily integrity and in particular their ability to control the timing and number of their children. Importantly this roadmap is concerned not just with the needs of adults but also those of adolescent children. The framing of these protections are not just individual but it is also emphasised that these protections are necessary for the good of society generally. A key feature of the Programme was to increase investment and expenditure on sexual and reproductive health in a broad range of areas including access to healthcare, education, and family planning. It aimed to reduce maternal child mortality rates and incidence of sexually transmitted disease globally. ICPD 1994 was the first time that safe abortion care was recognised as a necessary feature of reducing maternal morbidity and mortality globally. It draws on public health rhetoric and arguments from harm reduction to emphasis the importance in reducing the incidence of unsafe abortions (Hessini, 2005).

Dixon Mueller explains a fundamental tension that exists in the development of family planning policies and the subsequent emergence of sexual and reproductive rights (Dixon Mueller, 1995). The first strand is that of population control. Family planning policies

emerged in order to enable governments to deal with excessive population growth. The second strand to these policies is the protection of individual human rights. Family planning policies have developed to enable individual, and in particular women's, expression of rights of bodily control and bodily integrity. However, it is often the case that population control policies have infringed on individual human rights.

Population control policies include education, the provision of contraception and abortion and sterilization; at times such measures have been forced. A controversial aspect of population control policies, forced sterilization, has a long history in Europe and the US. In the early 20th century it was widely practiced as part of public health measures to improve population health (WHO, 2014). There have also been instances of sterilization being linked with the criminal justice process; women from a variety of groups were forcibly sterilised in order to ensure that they did not pass on their 'deviancy' to the next generation; women who were sterilized include those suffering from mental disabilities, the 'feeble minded', the 'sexually deviant' (which could be interpreted to include promiscuity, lesbianism and adultery) and those from undesirable ethnic groups, particularly 'gypsies'(see for example Trombley, 1998). 'Gypsies' was a general term to include many Roma ethnic groups, usually from central and eastern Europe.⁸ Although campaigners and NGOs acknowledged the importance of these policies in addressing increased global birth rates and the funding they provided to sexual and reproductive health services they called for a shift in emphasis "to reflect a fundamental commitment to reproductive and sexual rights as fundamental human rights" (Chesler, 2006, 19). Such a strategy was in keeping with an approach that acknowledged the importance of the role of women in society rather than being solely concerned with restricting women's reproductive freedom through control of their fertility.

An oft cited example of a population policy that clearly infringes reproductive rights, is China's "Family Planning Policy", often called the 'one child policy'. This policy was established in 1979 as part of a broader programme of population control being instituted by the Chinese Government in the late 1970s with an aim of reducing China's rapidly increasing

⁸ The continuation of forced, or at least coerced, sterilization of Roma in Europe was brought to light in a 2003 report by the Center for Reproductive Rights. The report documents sterilization as a common experience of Roma women. In these instances women go into hospital when in labour, then, when about to be given a caesarean section they are told to sign a consent form. This form gives consent not only to a caesarean section, but also to tubal ligation.

population (Hesketh & Wei Xing, 2005). The main substance of the policy is a restriction on the ability of couples, particularly those from urban areas, from having more than one child. However, there were exemptions from the policy for those whose living in rural areas particular if their first child was a girl, and for ethnic minorities (Hesketh & Wei Xing, 2005). The policy was implemented somewhat unevenly, as much power and discretion lies in the hands of local officials. Broadly the policy has been implemented through a series of monetary fines for those who breach it. More controversially it has been reported that the policy has led to women who have an ‘unapproved’ pregnancy being forced to have an abortion or avoiding antenatal healthcare for fear they would be made undergo an abortion. As recently as 2010 Amnesty International reported that thousands of women in China were at risk of forced sterilization (Amnesty International, 2010). It has also been reported that because women avoid antenatal care and deliver at home, usually without access to appropriate healthcare, they face much higher rates of maternal deaths (Hesketh & Wei Xing, 2005). This highlights a number of ways in which the policy breaches basic reproductive rights. Although extreme this policy is not isolated and there is evidence of similarly coercive population control measures in other countries. Forced sterilization continues in many parts of the world today as does ‘induced consent’, when women are encouraged to undergo sterilization and even given payment or other forms of inducement as part of population control measures. For example, in the USA the linkage in many states between welfare eligibility and contraception usage (Center for Reproductive Rights, 2006, 22).

Cairo was quickly followed in 1995 by the Fourth World Conference in Beijing. The Beijing Platform for Action states:

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences. (Beijing Platform for Action, 1995)

The Platform for Action again reaffirms the importance of women's human rights emphasising the importance of women's emancipation for as part of the development process. However, in addition to the broader aims of development, the platform moves beyond this position and also emphasises the intrinsic importance of women's rights. Women's ability to control their reproductive futures is a necessary feature of their emancipation and a human right deserving of protection.

The move from 'control' to 'freedom', as emphasised in the Cairo Programme, has met with mixed success and as detailed above many human rights violations in this area continuing. However, it is clear from the above that international human rights documents have come to recognise that to respect women's bodily integrity and agency it is necessary to protect a range of sexual and reproductive health rights which aim to facilitate women and girls ability to control the timing and number of their children. These protections are necessary if women are to be able to enter society as equal to men. Specifically family planning and contraception are mentioned as being important to this process. While abortion has proven to be more controversial, since Cairo it is clear that public health ethics arguments, particularly those regarding harm reduction, are becoming increasingly important as a means for advocating for abortion care (Erdman, 2012; Coletti, IPAS, 2013). It has also been recognised across a range of human rights documents that access to safe and legal abortion care is necessary and expected in a number of cases (e.g where the life of the pregnant woman is threatened or where the woman is pregnant as a result of rape). Further the WHO recognises 'safe abortion care' as one of the seven packages necessary to improve maternal morbidity and mortality worldwide (WHO, 2010). This serves to highlight the important and necessary role of safe abortion care within holistic family planning programmes. Although abortion is often subject to moral controversy, it is clear that unsafe abortions have serious negative consequences for maternal health on a global scale (Singh, 2010; WHO 2007). It is also clear that legal restrictions on the availability of abortion does not decrease the incidence of abortion but rather increases the incidence of unsafe abortions – unsafe abortions are defined by the WHO as those that involve “inadequacy of the provider's skills and use of hazardous techniques and unsanitary facilities” (WHO, 2007, 1). No method of contraception is 100% reliable and all are subject to the foibles of human use. Access to safe abortion care is therefore a necessary tool in family planning programmes aimed at reducing maternal morbidity and mortality globally.

In tracing the emergence of reproductive rights on a global scale it becomes clear that a holistic understanding of family planning services is necessary in order to improve maternal morbidity and mortality worldwide. Having argued, therefore, that access to contraception and abortion are basic reproductive rights necessary for all women we spend the final part of this chapter examining what is arguably one of the most controversial aspects of global reproductive health policy; restrictions on development aid which aims to de-couple safe abortion care from family planning services.

IV: ACCESSING BASIC REPRODUCTIVE RIGHTS – RESTRICTIONS ON DEVELOPMENT AID

The most prominent example of a restriction on development aid being used to fund abortion services is the ‘Helms Amendment’ and its subsequent extension through the GRR (Crane and Dusenbury, 2004). Moving on from this example of US restrictions on development aid we consider some emerging examples in other regions, specifically at the European Union (EU) level. Therefore, it is important to note that although the US is the most prominent example of restrictions on development aid of this kind it is not unique. Towards the end of the section we detail similar restrictions in non-governmental organisations (NGOs). Restricting funding for abortion services is often considered as a compromise between opposing views on the permissibility of the procedure (see for example DeGrazia, 2012). In this part of the chapter we consider the legitimacy of such a position. Far from being an example of a compromise it is clear that such restrictions on a global scale often serve to skew domestic policy on abortion. By this we mean that restrictions on development aid often serve to restrict access to contraception and abortion services in countries where they are legal and as such undermine official laws on the issue. The GRR applies to countries where access to abortion and contraception are legal and have the effect of blocking access to these services in ways that contravene international human rights norms (Barot, 2013).

The GRR was introduced by Ronald Reagan, then President of the USA, in 1984. The GRR was an executive order which expanded on the Helms Amendment to the Foreign Assistance Act introduced by Sen. Jesse Helms in 1973. The Helms Amendment prohibited the use of US Foreign Aid for “the performance of abortions as a method of family planning”, and being used to “motivate or coerce any person to practice abortions”. At the time the

amendment was introduced USAID, the government agency responsible for international development, strongly objected stating that it contradicted the core principle of the organization that:

[E]xplicitly acknowledges that every nation is and should be free to determine its own policies and procedures with respect to population growth and family planning. In contradiction of this principle, the amendment would place U.S. restrictions on both developing country governments and individuals in the matter of free choice among the means of fertility control...that are legal in the U.S. (As quoted in Barot, 2013; 9).

Notwithstanding these objections, the amendment was passed. It was then expanded with the introduction of the GRR almost 10 years later. The GRR prohibits any organisations that receive US government funding from facilitating access to abortion services or any advocates for the liberalisation of domestic abortion policy; and importantly applies even if the organisation provides a broad range of sexual and reproductive health services and obtains its funding for abortion services from another source (Center for Reproductive Rights, 2000). As such it amounts to a restriction on both US and non-US funding:

While the Helms amendment limits the use of U.S. foreign aid dollars directly, the gag rule went far beyond that by disqualifying foreign NGOs from eligibility for U.S. family planning aid entirely by virtue of their support for abortion-related activities subsidized by non-U.S. funds. (Barot, 2013; 10)

A version of the GRR has been endorsed by every Republican president since Reagan and rescinded by every Democrat president. The Helms amendment has remained in place since its introduction in 1973. This muddled picture has had a “chilling effect” on a range of sexual and reproductive health services on a global scale (Barot, 2013). It is important to note that the gag applies in countries where abortion is legal; US development aid has never been used to fund access to abortion where the procedure is illegal (Skuster, 2004).

The impact of the GRR has been assessed by several organisations including the Guttmacher Institute (Cohen, 2006), Population Action International (2015), and the Center for

Reproductive Rights (2010). All have highlighted the clear negative impact of this restriction on maternal and reproductive health measures in affected countries. Negative impacts include increased maternal morbidity and mortality, an increased number of unplanned pregnancies, an increased number of unsafe abortions and a subsequent increase in deaths from unsafe abortion. The consequence of the GRR is therefore not a decrease in the number of abortions but rather an interference with family planning services generally with a subsequent increase in the number of unsafe abortions. There are three clear reasons for these negative impacts. Firstly, there is confusion over what exactly is prohibited under Helms and what is prohibited under the GRR (Barot, 2013; Barot, 2011). This is what has led to the ‘chilling effect’ that encourages overly conservative practice as organisations do not want to be found in contravention of either policy. Secondly, the GRR extends the impact on the restrictions so that it applies not just to US Development Aid but to funds received through other avenues (Cohen, 2006). And finally, and in some ways most worrying, results in a situation in which those experts who might otherwise be called upon by governments to provide evidence of the negative impact of unsafe abortion are restricted from speaking to these issues as this would constitute ‘abortion advocacy’ (Skuster, 2004). An example of the impact of the GRR is detailed by Karen Baird: in Nepal family planning services lost \$250,000 as a result of the GRR when they advocated for improved reproductive health care in the face of a maternal health crisis in that country (Baird, 2004). The following quote from the Director of Family Planning Association of Nepal (FPAN) is stark:

This is the challenge: do I listen to my own government that has asked FPAN to save women’s lives or do I listen to the US government? (as quoted in Baird, 2004)

It is important to note that such a restriction would not be permissible were it to impact on US NGOs as detailed by Patty Skuster:

The Global Gag Rule would be unconstitutional if applied to U.S. organizations. The restrictions that make up the order apply only to foreign NGOs—which do not have U.S. constitutional protection over free speech and free association. Federal courts have prohibited restrictions placed on U.S. NGOs similar to those of the GGR. The Constitution does not permit Congress to enact legislation that

restricts a U.S.-based organization's constitutional rights by dictating how a grantee spends funds not provided by U.S. government sources. The U.S. government may not use funding restrictions to impinge upon a U.S.-based NGO's ability to exercise its rights to free speech or to lobby using its own private funds. (Skuster, 2014, 100-101)

Therefore, as argued by USAID, it is clear that GGR has the potential to disrupt the democratic processes of the countries that it impacts on. The GRR has had significant negative impacts on the lives of real women in countries where access to safe abortion is a legal and necessary aspect of family planning services. Like all attempts to impose restrictions on development aid in this way, the impact is on countries where maternal mortality and morbidity are higher than those considered acceptable in the USA, and where access to safe and legal abortion is a basic health need (ICPD, 1994).

Other governments, including Canada, have introduced similar restrictions.⁹ In 2010 the Harper Government pledged increased levels of funding to reduce maternal mortality and morbidity worldwide; however, this policy was not to include increased funding for safe abortion care. At the EU level there was a failed attempt between 2012 and 2014 to use the newly introduced mechanism of a European Citizens' Initiative (ECI) to restrict EU development aid. The Citizenship Initiative is a mechanism introduced by the European Commission allowing citizens to propose legislation for consideration by the European Commission on any issue within its power if they gather one million signatures from at least seven of the 27 EU Member States. An ECI entitled, 'One of Us' aimed to provide human embryos with "dignity and integrity" and as a consequence of this "the EU should establish a ban and end the financing of activities which presuppose the destruction of human embryos, in particular in the areas of research, *development aid* and public health" (One of Us, 2012). The initiative was introduced subsequent to a report by a conservative European think tank, European Dignity Watch, entitled 'The Funding of Abortion through EU Development Aid: An Analysis of EU's Sexual and Reproductive Health Policy' which argued that funding of abortion services was outside EU competence and as such should not be included within the development aid budget (European Dignity Watch, 2012). If successful 'One of Us' would

⁹ http://www.sexualhealthandrights.ca/wp-content/uploads/2015/07/Global-5_Abortion.pdf

have severely restricted EU development aid with a worrying negative health impact on the lives of women in countries in receipt of such aid. It would also have directly challenged fundamental rights of women and been in direct conflict with the aims of UN Millennium Development Goal five: to improve maternal health (UN MDG 2000).

It is not just in the policies of national government that we are witnessing GRR style restrictions. In June 2014, Melinda Gates announced that the Gates Foundation would no longer fund abortions. Gates states that abortion is too controversial and ultimately harmful to helping women worldwide. In her explanation of this decision, Gates highlights the fact that the Foundation will continue to advocate for family planning and the ability of women worldwide to space their children. However, she thinks that abortion should be dealt with separately. Specifically she says:

The question of abortion should be dealt with separately. Both in the United States and around the world the emotional and personal debate about abortion is threatening to get in the way of the lifesaving consensus regarding basic family planning.¹⁰

Gates' rhetoric in justifying the position with regard to funding implies that they have chosen to stop funding abortions in order to promote the greater good overall. One of the global development goals of the Bill & Melinda Gates Foundation is improvement in family planning:

OUR GOAL: to bring access to high-quality contraceptive information, services, and supplies to an additional 120 million women and girls in the poorest countries by 2020 without coercion or discrimination, with the longer-term goal of universal access to voluntary family planning.¹¹

The tension between the above goal and the refusal to fund abortion services contributes to the exceptionalisation of abortion care despite the clear evidence that such services are a

¹⁰ <http://www.breitbart.com/big-government/2014/06/12/bill-and-melinda-gates-foundation-says-it-will-no-longer-fund-abortion/> (accessed 21/02/15)

¹¹ <http://www.gatesfoundation.org/What-We-Do/Global-Development/Family-Planning>

necessary part of global family planning strategies and an important part of any strategy which aims to reduce maternal morbidity and mortality (WHO, 2007). This approach also propagates the idea that contraception is the only tool necessary to combat family planning, this is despite the fact that there is much evidence to suggest that access to abortion and contraception should not be viewed as mutually exclusive but rather both should form part of holistic family planning strategies. In the words of Marge Berer:

[I] feel ... worried about the Gates Foundation's effects on things, because I think theirs is such a retrograde approach. Ideologically, it's supposedly prochoice, but it's very, very antichoice on many levels. (Berer, 2014)

Restrictions on development aid of the sort outlined in this section are worrying for many reasons. They skew democratic processes and create negative health consequences of a sort that would not be acceptable in the country they originate in. Further the attempt to break down family planning policies into component parts ignores the reality of the necessity of both access to contraception and safe abortion care if we are to protect and promote basic reproductive rights. Restrictions that exceptionalise abortion are counter to the accepted principle of most international health bodies that such care is a necessary basic health need. It is for this reason that we suggest that those who are interested to protect basic reproductive rights should challenge the legitimacy of such restrictions.

V. CONCLUSION

In this chapter we have argued on grounds of gender equality that access to contraception and abortion are basic reproductive rights. Consequently we argued that such rights should be prioritised and not sacrificed in order to attain other goods. We have also emphasised the importance of these rights not being sacrificed as part of some effort at compromise for those who wish to restrict access to abortion domestically but have been unsuccessful in this aim.

International human rights norms have increasingly come to reflect and acknowledge the importance of access to abortion and contraception as integral to women's ability to control the number and timing of their children. As such they reflect our view that such rights are basic reproductive rights and should be protected as such.

Globally we found that these rights are often not delivered and the most vulnerable women are too often denied them and we discussed some policies and practices which are eroding these rights. The slogan “Free, Safe and Legal” has long been a mantra of the reproductive rights movement. Restrictions on development aid unfairly impact on women in developing countries and restrict their ability to access the basic reproductive health care that they most need. We have highlighted both the principled objections to such restrictions and also some of the practical negative outcomes of these policies.

Many are now focused on ‘Post 2015’ global reproductive health goals. Given the improvements in maternal health on a worldwide scale since ICPD 1994 it would be a pity that retrograde steps such as restrictions on development aid with regard to family planning services were to become common place. The rhetoric of appeasement such as that evident in the quote from Melinda Gates in this chapter should be challenged. Access to safe abortion cannot be disentangled from access to contraception as part of the protection of women’s basic reproductive rights. Attempting to de-couple access to safe abortion care goes against accepted development policy since 1994 which has “linked abortion with other key public health and women’s health rights issues” (Hessini, 2005). It is important, therefore, that we ensure that access to *both* contraception and safe abortion care occupies a prominent space in the post 2015 ICPD agenda (Barot, 2014).

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