CENTER FOR REPRODUCTIVE RIGHTS

BRIEFING PAPER

Cairo +5: Assessing U.S. Support for Reproductive Health at Home and Abroad

ICPD Paragraph 7.6. All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals.

ICPD Paragraph 14.1. International cooperation has been proved to be essential for the implementation of population and development programmes during the past two decades.

At the 1994 International Conference on Population and Development held in Cairo (ICPD or Cairo), the United States (U.S.) was a key leader in reorienting international population assistance toward a broader approach that emphasizes meeting individual reproductive health needs. In 1994, just prior to ICPD, then Under Secretary of State for Global Affairs Timothy Wirth stated:

> [A] determined cooperative effort must be launched to make good quality voluntary family planning and the full range of reproductive health services universally available early in the next century. . . . Everywhere we must have and we must generate the political will at the highest levels of government to live up to these responsibilities.[1]

Today, these statements ring hollow. The U.S has fallen short in its efforts to live up to ICPD's goals, both as a major donor to reproductive health programs in low- and middle-income countries and in providing for the reproductive health needs of women in the U.S.

In both the domestic and foreign policy arenas, the fact is that the Congress of the United States (Congress)—not the President—must pass legislation and appropriate funding for programs. The anti-choice/anti-family planning ideology of religious conservatives in Congress has made it extremely difficult to achieve the goals set forth in the ICPD Programme of Action. These conservatives have obstructed the fulfillment of this country's international financial commitments as well as the realization of Cairo's goals for American women. Moreover, since Cairo in 1994, the Clinton Administration has not aggressively incorporated the principles of the Programme of Action even in those policies and programs over which it has control.

Maximizing women's ability to make individual choices regarding their reproductive lives continues to elude U.S. programs at home and abroad. U.S. policymakers have not yet internalized the principle that ensuring women's reproductive rights is an end in itself. Not only does Congress refuse to view the decision to terminate a pregnancy as an aspect of women's reproductive autonomy, but it uses

abortion to interfere with law and policymaking related to all other aspects of reproductive health and rights affecting American women and women in countries that receive U.S. aid. Funding for publicly funded family planning and other reproductive health services in the U.S. remains inadequate, as does funding for U.S. international population and family planning assistance. Women's reproductive rights in the U.S. and in U.S. aid recipient countries continue to be limited by U.S. laws and policies that contravene the spirit of ICPD.

ICPD Provisions Concerning Donor Assistance

ICPD Paragraph 13.15. It has been estimated that, in the developing countries and countries with economies in transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analysing population data, will cost: $17.0 billion in 2000, $18.5 billion in 2005, $20.5 billion in 2010 and $21.7 billion in 2015.

ICPD Paragraph 14.11. Given the magnitude of the financial resource needs for national population and development programmes . . . and assuming that recipient countries will be able to generate sufficient increases in domestically generated resources, the need for complementary resource flows from donor countries would be in the order of (in 1993 U.S. dollars): $5.7 billion in 2000; $6.1 billion in 2005; $6.8 billion in 2010; and $7.2 billion in 2015.

I. U.S. Support for ICPD Goals Abroad

As United Nations Population Fund (UNFPA) Executive Director Nafis Sadik stated at ICPD in 1994, "Without resources. . . the Programme of Action will remain a paper promise." The ambitious agenda set by the Programme of Action—including quality and affordable reproductive health services for all—led to an unprecedented agreement among participants that spending on population assistance, reproductive health care, and related social sector initiatives needed to increase. But donor contributions have stagnated at around $2 billion per year, significantly below the donor target of $5.7 billion needed to provide sufficient resources to low- and middle-income countries in the year 2000.[2]

The U.S., a leader in population assistance since the 1960s, is failing to provide its share of needed funding. Congress' appropriation for population and family planning assistance plummeted 35% from a high of $547 million in 1995 to $356 million in 1996, increasing slightly to $385 million for the succeeding three years. Because of its size and wealth, the U.S. remains the largest bilateral donor to international population programs.[3] However, the U.S. ranks eighth out of 20 major donors in its contribution relative to gross national product.[4] As stated by Under Secretary of State for Global Affairs Frank E. Loy in December 1998, the U.S. "risks becoming the biggest Cairo deadbeat."[5] The Clinton Administration needs to redouble its efforts to secure increased funding and end restrictions to make up for the U.S. shortfall to date.

However, ICPD's legacy demands more than just U.S. financial resources. The Programme of Action was revolutionary in its repudiation of the traditional "family planning" assistance model, which is focused on the provision of inexpensive contraception, and its embrace of a "reproductive health" model centered on the provision of comprehensive reproductive health care to all and the empowerment of women to ensure their basic human right to reproductive self-determination. However, the U.S. Agency for International Development (USAID) has not provided sufficient leadership in operationalizing the shift from the family planning to the reproductive health model, as envisaged by Cairo. While 1994 was marked by the occurrence of Cairo, it was also the year in which the conservative Republican party won control of both houses of Congress. While attacking development assistance generally, Republicans also have conducted an ideologically motivated campaign that has successfully singled out population assistance for extreme cuts and restrictions. The Republican Congress' efforts to hobble U.S. population assistance programs are partly responsible for USAID's reluctance to shift gears. However, the agency must not permit an ultraconservative Congress to impede its efforts to expand certain promising initiatives that further a reproductive health paradigm and to develop other innovative approaches to implementing Cairo's provisions related to reproductive health and rights, women's empowerment, and gender equality.

A. THE CONGRESSIONAL ASSAULT ON U.S. POPULATION AND FAMILY PLANNING ASSISTANCE

Although in 1995 the U.S. Congress approved a record $547 million for U.S. population assistance programs, the Clinton Administration has since then been stymied in its effort to provide adequate funding levels for USAID's population assistance programs.

USAID and Family Planning Assistance (in US$ millions)

Fiscal Year	USAID Obligations
1993	$448
1994	$480
1995	$542
1996	$356*
1997	$385
1998	$385
1999	$385

* For FY96, Congress appropriated only US$356 million towards USAID population program funds. However, USAID's obligations that year totalled US$432 million, representing US$356 million in appropriations, plus US$76 million in additional prior year funds. *Source: USAID*

The agency's funding difficulties are clearly attributable to the conservative Republican majority gaining control of both congressional houses. While the 1973 Helms Amendment[6] is interpreted by the U.S. government as a restriction on U.S. funding of most legal abortion services overseas, ultraconservative ideologues in Congress use abortion to push through harmful cuts and restrictions in U.S. population assistance. These religious conservatives have largely succeeded in suppressing the improvements in women's health and lives that U.S. assistance promotes.

Congress slashed funding for population programs by 35% to $356 million in 1996. Five leading U.S. research organizations conservatively estimated that the impact of the 1996 funding reduction alone resulted in 4 million unplanned pregnancies, 1.6 million abortions, 8,000 maternal deaths, and 134,000 infant deaths due to increased high-risk births.[7] Funding levels for U.S. population assistance increased very slightly to $385 million in 1997. Funding has stagnated ever since.

The Republican Congress also has threatened to impose other debilitating restrictions on U.S. population assistance with the purported aim of discouraging overseas abortions.[8] In each of the last four appropriations cycles (from fiscal year (FY) 1995 to FY 1999), conservative religious politicians have fought to reinstitute a harsher version of the Reagan-era anti-abortion "Mexico City Policy."[9] The Clinton Administration repudiated this policy in early 1993. The latest reincarnation of the Mexico City Policy, termed the "Global Gag Rule" by women's advocates, including Secretary of State Madeleine Albright, would go far beyond the current legal prohibitions on abortion.[10] It also would bar organizations in U.S. aid recipient countries from receiving population assistance if they use their own non-U.S. funds to provide legal abortion services. The proposed restriction would also deny funding if such non-U.S. organizations participated—consistent with their own laws—in efforts to alter laws or governmental policies with any connection to abortion. This proposed limitation would include not only overt lobbying, but also sponsoring conferences, distributing materials and disseminating public statements.[11] Thus, the Global Gag Rule would prohibit policy discussions that address high maternal mortality caused by unsafe abortion and those that question whether abortion should be more or less restricted in a particular country. It is a congressional ban on the core democratic right of free speech overseas.

During recent FY 1999 budget negotiations, anti-choice conservatives dropped their demand for the Global Gag Rule. However, President Clinton was forced to veto a bill containing crucial provisions for payment of U.S. arrears to the United Nations (U.N.) because Republican ideologues had appended the unrelated Global Gag Rule to the bill.[12]

The political price of defeating the Global Gag Rule each year has been other onerous restrictions. In 1996, the release of appropriated funds was delayed for nine months, and the funds were then available only on a month-to-month basis at a rate of 6.7%. The latter restriction is known as metering. The deal cut to break the legislative deadlock in 1997 delayed the release of funds for five months pend-

ing a required presidential finding that delays were causing "serious, irreversible, and avoidable" harm to the U.S. population program. The president's report stated that the lives and well-being of thousands of women and their families were being compromised by the delays.[13] In 1998 and 1999, months-long delays were avoided, although metering was continued.

Tragically, in 1999, Congress has also eliminated the U.S.'s annual contribution to UNFPA, purportedly because of a new UNFPA program in several areas of China. In FY 1998, the U.S. contribution to UNFPA amounted to $20 million, or about 7% of UNFPA's budget. UNFPA is beginning a four-year reproductive health program whose purpose is to "contribute to making comprehensive quality reproductive health services available to Chinese men and women on a voluntary basis and in line with the principles, approaches, and recommendations of the ICPD Programme of Action."[14] Because UNFPA programs reach many low-income countries that USAID does not, the U.S. cuts effectively penalize women and their families in those countries. Indeed, the anti-choice zealots leading the charge against UNFPA fail to consider the 870,000 women left without effective contraception and the resulting 500,000 unwanted pregnancies and 12,000 maternal deaths that will result from U.S. cuts in funding.[15]

To support the goals set for donor contributions to population and reproductive health assistance at ICPD, the U.S. needs to triple its assistance by the year 2000.[16] Extremists in Congress must be prevented from impairing U.S. efforts to meet its obligations under ICPD.

B. U.S. POPULATION ASSISTANCE: TENTATIVE STEPS TOWARD COMPLYING WTIH ICPD AIMS

1. Inconsistency in U.S. Support for ICPD's Reproductive Rights Paradigm

ICPD's greatest legacy is in heeding the call of women's organizations worldwide that population concerns could not and should not be addressed merely through the provision of inexpensive family planning and by focusing on demographic targets. Rather, they should be addressed within the framework of women's human rights. Women should be empowered to make and effectuate free and informed decisions concerning their reproductive lives.

The United States deserves considerable credit for its role in framing this new agenda. Prior to Cairo, numerous U.S.-based non-governmental organizations (NGOs) lobbied the Clinton Administration to ensure decreased emphasis at ICPD on population growth rates and increased emphasis on women's reproductive health, quality of care, and the conditions of women's lives. The Clinton Administration's Cairo team, led by Under Secretary of State for Global Affairs Timothy Wirth, was a strong advocate of the reproductive health model incorporated into the Programme of Action. Indeed, in the months leading up to ICPD, in high-profile diplomatic sparring, the Administration stood firm against the Vatican, insisting on the inclusion in preliminary drafts of the Programme of

Action language supporting access to safe and legal abortion.[17]

Emphasizing the U.S. government's support for the shift to a women's rights and empowerment focus, Vice President Al Gore, who attended the conference, announced, "here at Cairo, there is a new and very widely shared consensus.... The education and empowerment of women, high levels of literacy, the availability of contraception and quality health care—these factors are all crucial."[18] In terms of the U.S.'s own assistance programs, the Clinton Administration's position at Cairo suggested that USAID would adopt a reproductive health approach, thereby broadening its long-standing commitment to a narrow family planning model. Official U.S. documents issued in preparation for the conference contained language largely consistent with ICPD's emphasis on reproductive health. A State Department statement referred to an "emerging consensus" responding to "concerns voiced by women's groups and the citizens of developing countries" and described improving the status of women as "a core objective of the Cairo conference."[19]

At the same time, the United States stopped considerably short of explicitly repudiating a narrow family planning model. Indeed, the U.S. National Report to ICPD acknowledged that 75% of the agency's expenditures went directly to the provision of family planning information and services, including contraceptives.[20] While noting many objectives consistent with a reproductive health approach, the report emphasized that family planning would continue to be the "centerpiece" of USAID's new strategy for "stabilizing world population and growth and protecting human lives." Funding for family planning, the report further stated, would "at a minimum" remain constant proportionate to the U.S.'s overall development budget.[21] Moreover, USAID stops short of ensuring women reproductive autonomy in its policies and programs because it interprets the Helms Amendment as preventing USAID from providing support for the performance of almost all abortions.

2. Assessing USAID Population Assistance Post-Cairo

U.S. law gives USAID great flexibility in implementing U.S. population and family planning assistance programs as well as other goals advocated by ICPD. The Foreign Assistance Act (FAA) sets out a broad mandate for the provision of voluntary family planning assistance and related funding for maternal and child health as well as related development funding aimed at improving economic and social conditions such as education, poverty reduction, nutrition, disease control, and improvement in women's status.[22] For historical and political reasons as much as for legislative ones, USAID continues to view its population assistance programs as driven solely by the need to "reduce the rate of population growth," as articulated in the FAA.[23] However, the FAA does not mandate the means by which USAID must carry out this objective. The international community's consensus, as reflected in the Programme of Action, to rely on the provision of comprehensive reproductive health care and the empowerment of women, is a legitimate means of fulfilling the FAA's mandate regarding population assistance. Moreover, other provisions of the FAA broadly authorize funding to address women's socioeconomic rights and human rights more broadly.[24]

The FAA does not hamper USAID's efforts to update the focus of its population assistance programs to better integrate women's health and rights. But lack of a specific legislative mandate to promote women's health and well-being may have quelled more comprehensive reform of USAID's long-standing internal policies and practices. To some extent, the agency has adapted its internal policies and programs in an effort to integrate ICPD's goals, but it remains fundamentally tied to a family planning approach to population assistance in many respects. USAID continues to be results-driven in its approach, which tends to maintain the program's bias toward a family planning model, emphasizing the delivery of product and lowering of fertility rates rather than meeting women's reproductive health needs. For example, many women lack adequate maternal health care and access to safe abortion services even where abortion is legal. USAID provides far less funding for maternal services than it does for family planning services,[25] despite continued high rates of maternal mortality and morbidity in many low- and middle-income countries. Although the 1973 Helms Amendment[26] continues to prohibit USAID from funding most legal abortion services, USAID does not fund those abortions it can—such as when a woman's life is in danger, or in cases of rape or incest.[27]

Even as some officials in the Clinton Administration and USAID have worked to refine U.S. population assistance programs to incorporate Cairo's legacy more effectively, long-standing demographic rationales for U.S. population assistance continue to be embraced.[28] Policy documents usually articulate the need to address population stabilization through the provision of family planning services alongside the incorporation of reproductive rights, other components of reproductive health, and women's socioeconomic and educational status.[29] At the same time, however, high-level officials, including President Clinton and Secretary of State Albright, continue to advance the more traditional demographic and national-interest related arguments.[30] Clinton Administration and agency leaders have concluded that emphasizing population stabilization rationales with their implicit appeal to U.S. security interests is a politically neutral strategy for shoring up congressional support for the agency. Promoting comprehensive reproductive health programs remains at best a secondary goal dependent on such programs' ability to generate declines in population growth.

It is difficult to discern the extent to which USAID has embraced Cairo's progressive stand on putting women's empowerment and the provision of comprehensive reproductive health care at the forefront of population policy. On the one hand, official agency statements point to an impressive array of programs demonstrating the agency's commitment to the reproductive health paradigm. On the other hand, the extent of the agency's investment in these new programs as well as the degree to which reform has touched its core activities are difficult to assess five years after Cairo.

Unquestionably, USAID has undertaken a number of important initiatives in the spirit of the Programme of Action. The most important of these include a $25 million, five-year commitment to ReproSalud, which funds a Peruvian women's

organization providing comprehensive reproductive health care at the grass-roots level;[31] participation, together with U.S.- based voluntary organizations, in a $60 million, five-year initiative aimed at curbing maternal and infant mortality; a 33-country, multimillion-dollar effort to address complications from incomplete abortion; and substantial efforts (about $128 million in FY 1997) to combat the spread of HIV/AIDS and other STIs.[32] In addition, USAID, together with its cooperating agencies, has launched a multimillion-dollar, multi-year initiative called "Maximizing Access and Quality" (MAQ), whose aim is to improve the delivery and use of family planning and reproductive health services primarily through training personnel to adopt a more client-oriented approach.[33] Efforts to fund comprehensive, client-centered reproductive health care services, such as ReproSalud, remain the exceptional project example rather than the norm.

Little quantifiable data is readily available concerning USAID's efforts to broaden its programs to embrace a more comprehensive reproductive health care approach. It is extremely difficult to assess the extent to which the broad contours of USAID programs related to "Service Delivery,"[34] as broken out by USAID from other population assistance, measure up to the Programme of Action's mandate of funding comprehensive reproductive health care programs rather than family planning services. USAID does not distinguish between narrow family planning services and more comprehensive reproductive health services.[35] From data provided by USAID, UNFPA estimated that the U.S. devoted 53% of its population assistance resources to family planning services in 1996, higher than any other donor country, as compared with just 33% for basic reproductive health services and 7% for STDs and HIV/AIDS activities.[36] In the same year, many other major bilateral donors, such as Germany, Japan, the Netherlands, Norway, and Sweden, gave more assistance for reproductive health services than for family planning services.[37] Because of USAID's longstanding leadership role in the population assistance field and the relatively large amounts USAID spends each year, its reluctance to reorient its programs to embrace a reproductive health paradigm skews the population assistance provided to low- and middle-income countries away from that paradigm.

Other official documents suggest that USAID's transition to the reproductive health model has not been as rapid or as complete as women's health advocates have fought to ensure. USAID literature continues to set forth achievements incompatible with the Cairo approach. USAID's 1996 progress report on its post-Cairo efforts to implement reproductive health programs emphasizes USAID's provision of 3 million doses of DepoProvera.[38] The same report continues to use terminology that harkens back to a narrow family planning model. Thus, the agency's achievements for 1995 are summarized in terms of $48.3 million worth of contraceptives shipped, the equivalent of 17.9 million "couples-years of protection."[39] USAID continues to use such "objective indicators" to measure the breadth and depth of its programs and has thus far failed to adopt more progressive qualitative indicators on a wide scale.[40] Indeed, the preference for measuring success through reductions in fertility rates can result in serious lapses in protecting

women's reproductive autonomy.[41] USAID should use such situations to aggressively push for full informed consent and widespread availability of all contraceptive methods.

The Clinton Administration, led by Secretary of State Madeleine Albright, has been outspoken in its support for women's rights worldwide, another important legacy of ICPD. USAID has supported women's rights initiatives as part of its development assistance since the 1970s and has maintained an Office on Women in Development since 1974. USAID funds projects related to women's equality through the various organizational arms embodying the agency's core objectives, including Democracy and Governance, Economic Growth, and Human Capacity Development, in addition to Population, Health, and Nutrition. These projects seek to further gender equity and equality related to education, political participation and the building of women's organizations, legal reform, and economic empowerment. However, funding for these efforts remains a relatively small component of USAID's overall development assistance. From 1994 to 1998, USAID committed a total of roughly $2.5 billion to women's rights initiatives,[42] of a total development assistance budget of $32.6 billion during that period, or 7.67%.[43] USAID has undertaken certain important initiatives since Cairo, including projects aimed at addressing violence against women and eradicating the practice of female circumcision/female genital mutilation in African countries where the practice is prevalent.[44] However, USAID could still do more to build projects

Recommendations Related to Reproductive Health in the U.S.:

- **Increase funding for reproductive health and population programs in FY 2000.**
- **Resist efforts to impose additional funding cuts and restrictions, including the Global Gag Rule, on U.S. reproductive health and population programs. Ensure an end to destructive efforts to append the Global Gag Rule to unrelated, vital legislation, such as payment of U.N. arrears.**
- **Repeal the Helms Amendment, which is interpreted by the U.S. government as a restriction on funding for most legal abortion services in its population assistance programs. Pending repeal, fund those abortions permitted under the Helms Amendment — at least to protect the woman's life, and in cases of rape and incest — as part of encouraging comprehensive reproductive health.**
- **Redouble efforts of the U.S. government to fund innovative, high-quality, comprehensive reproductive health care programs that promote and protect individuals' rights to reproductive health and reproductive self-determination.**
- **Ensure that there are no irregularities or coercive practices in reproductive health programs — both private and governmental — in U.S. aid recipient countries. Cease measuring program successes primarily by reductions in fertility rates and other "objective indicators" such as "couples years of protection," and instead rely increasingly on qualitative measures.**
- **Increase U.S. funding for development assistance that directly promotes and protects women's social, economic, and political rights, and expand efforts to fund innovative programs that empower women and enable them to better exercise their reproductive rights.**

aimed at improving women's rights, both through projects directly related to reproductive health and in all others aspects of women's lives.

> **ICPD Paragraph 7.6.** All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible. . . . Reproductive health care in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25 [of ICPD], including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancers and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required.
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> **ICPD Paragraph 7.46.** Countries. . . should protect and promote the rights of adolescents to reproductive health education, information and care….

Greater U.S. leadership is needed both to ensure that Cairo is viewed as firm policy and to go beyond Cairo and take leadership on those issues in the document that are weak, equivocal, or harmful. For example, the U.S. should champion legal abortion as a human rights issue. The long history of U.S. development assistance in championing health and human rights, building democracy and civil society, and empowering women demands that USAID population assistance programs take the lead in fulfilling the Cairo agenda. USAID is uniquely suited to ensure more aggressively that family planning services are a component of a broader integrated set of comprehensive reproductive health care services. U.S. leadership is also urgently needed to ensure that the protection of individual rights and voluntarism in family planning programs remain paramount in population programs worldwide. USAID should promote a reproductive health model and a firmer commitment to empowering women among its own staff as well as with other executive branch agencies, with Congress, and with the American public.

II. U.S. Progress Towards ICPD Goals At Home

The United States' progress on implementation of the Programme of Action is measured not just in terms of its support for programs outside of the country, but also in terms of whether the reproductive health and rights goals of Cairo are furthered in domestic policy. Here, also, the U.S. falls short. The U.S. has taken few proactive steps to implement the reproductive health paradigm of the Programme of Action within its own borders, and policymakers have not been applying Cairo's rights-based principles to initiatives within the U.S. In fact, the same anti-abortion and anti-family planning forces in Congress that have obstructed the fulfillment of this country's financial commitment abroad have put forward proposals that undermine the goals of Cairo in this country. While the Administration supports the Cairo consensus, it has not relied on the Programme of Action to support its internal policy proposals, nor aggressively advocated programs that would implement ICPD principles.

Congressional actions since 1994 reveal inconsistencies that demonstrate not merely a lack of commitment to the goals of Cairo, but antagonism to comprehensive reproductive health care for American women. These inadequacies in policy not only undermine the position of the U.S. as a leader in the implementation of Cairo, but have a significant adverse impact on U.S. women.

Under the American system of government, the individual states develop policies and laws in addition to those enacted by the federal government. These policies can have a significant impact on the ability of women to exercise their rights and obtain reproductive health care. Even more so than the federal government, the states are neither acknowledging nor applying the principles of Cairo. As a result, the ability of women to access reproductive health care varies widely based on where they live. The impact of regressive policies at the state level falls most harshly on adolescents, low-income women, and people who live in rural areas. By applying the principles of the Programme of Action to its domestic policies, the federal government could provide much-needed leadership in this area. Until these principles become part of state as well as federal policy, this country will never meet the goals of Cairo.

A. REPRODUCTIVE HEALTH INDICATORS IN THE U.S.

Compared with other industrialized nations, the U.S. lags behind in many important indices of reproductive health.[45] One measure of access to reproductive health care and the ability of women to control their reproductive decisionmaking is the rate of unintended pregnancy. According to a recent study on unintended pregnancy in the United States, "[e]xcluding miscarriages, 49% of the pregnancies concluding in 1994 were unintended; 54% of these ended in abortion. Forty-eight percent of women aged 15 to 44 in 1994 had had at least one unplanned pregnancy sometime in their lives . . . ."[46] The unintended pregnancy rate for adolescents is also higher than that experienced in other industrialized democracies.[47] The pregnancy rate among adolescents, while falling, is still 52.9 births per 1,000 females aged 15 to 19.[48] For U.S. adolescents under the age of 18, it is estimated that more than 80% of such pregnancies are unintended.[49]

Lack of coverage for contraceptive services and supplies in private insurance and other health benefits plans has been identified as a contributing factor to the unintended pregnancy rate in this country.[50] A recent study on private insurance found that 49% of large-group plans do not routinely cover any contraceptive method.[51] Oral contraceptives, the reversible birth control method used by the greatest number of women in the United States, are routinely covered by only 33% of large-group plans, even though 97% of those plans generally provide prescription coverage for other drugs.[52] Due in part to this discriminatory practice, women ages 15 to 44 pay 68% more in out-of-pocket medical costs than men, and make up 69% of those in this age category forced to spend 10% or more of their income on out-of-pocket health expenses.[53]

According to the U.S. government, "[d]ifferences in the infant mortality rates among industrialized nations reflect differences in the health status of women before and during pregnancy and the quality of primary health care accessible to pregnant women and their infants."[54] In 1994, the infant mortality rate in the United States ranked 25th among industrialized countries.[55] Although the U.S. has reduced its infant mortality rate (from 8.02 per 1,000 births in 1994 to 7.3 per 1,000 births in 1996), the rate for black infants remains 2.4 times the rate for white infants.[56] Similar discrepancies exist between blacks and whites for low birth-weight babies.[57]

This data belies any argument that the U.S. has nothing to gain by incorporating the principles of the Cairo consensus into internal policies. The United States has much work to do to meet the critical goals of ensuring that reproductive health services are universally accessible and that the U.S. population has the necessary information and opportunity to take advantage of these services.

B. LEGISLATION AFFECTING REPRODUCTIVE HEALTH

Existing government health programs as well as programs developed since 1994 provide the infrastructure to meet the Cairo goal of universal access to reproductive health services. However, congressional action with respect to these programs illustrates that lawmakers are not considering the reproductive health and rights paradigm of the Programme of Action in the formulation of policies and are still relying on demographic factors to guide policy.

1. Changes in the Welfare Program

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the Act),[58] one of the most significant pieces of social policy legislation adopted since 1994, provides perhaps the clearest illustration that the U.S. government is not applying the principles of Cairo to internal policies. In fact, several provisions of the Act run counter to the goals of the Programme of Action. The law enacted major changes to the welfare program that provides public support, including medical care and other services, to eligible low-income families. The majority of recipients have traditionally been women with children in single-parent households.

Instead of looking holistically at the underlying causes of welfare reliance, the Act focuses on "out-of-wedlock" births.[59] As a result of its focus on a single characteristic of some welfare recipients, the Act is unlikely to provide systemic solutions to the complex socioeconomic factors that force women to seek public assistance. Just as USAID programs continue to be "results driven," the success of the Personal Responsibility Act is tied to a reduction in out-of-wedlock births that may or may not result in a reduction in welfare dependency.

One troubling provision of the Act establishes a "bonus to reward decreases in illegitimacy" by making available up to $20 million for the five states that demonstrate the greatest decrease in the number of out-of-wedlock births.[60] Only those states that demonstrate that their rate of abortion is less than the previous year are eligible for the "reward." Although it is too soon to document the actions of states seeking the bonus, concerns have been raised that the provision may result in pressure on welfare recipients to marry or to travel out of state to obtain abortions.[61]

The Act also permits states to deny benefits for additional children born into families receiving assistance,[62] even if the pregnancy results from contraceptive failure or rape. This policy may drive some families deeper into poverty or financially coerce women into having abortions. While nearly half of the states have approved child exclusion provisions, there have been only limited studies on their impact.

Another provision of the Act provides new funding of $50 million per year for state programs that focus on those most likely to bear children out-of-wedlock. The provision and scope of sexuality education in the schools is determined largely at the state level, but the availability of federal funding influences the content of the programs. The funding made available under the Act can only be used for "abstinence education," narrowly defined as a program which "has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity."[63] This provision will encourage a trend in many states to adopt abstinence-only programs.[64] Even within the Act's narrow focus on out-of-wedlock births, funding for abstinence education to the exclusion of comprehensive sexuality education fails to recognize the complex factors that contribute to adolescent and out-of-wedlock pregnancy.

2. Government Health Programs

Publicly funded health programs, such as Title X, Medicaid, and the newly established State Child Health Insurance Program, provide a framework through which the United States could go far toward achieving the Programme of Action goal of universal access to comprehensive reproductive health care. These programs serve millions of primarily low-income Americans who do not have private health insurance. For many, they provide the only means of obtaining health care, particularly preventative services such as family planning. Government action in this area reflects not only a lack of commitment to reproductive health, but also a measure of animosity towards the full realization of reproductive rights by women.

Title X of the Public Health Service Act[65] is one of the most important public

programs providing family planning services. The goal of the program is "to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services."[66] The program funds public and private entities for the provision of family planning services and general pre-pregnancy reproductive health care.[67] Any person can obtain services through Title X services, with individuals below the federal poverty level eligible for free services and those above paying on a sliding fee scale.[68] It is estimated that almost one out of every four of the 21 million women in the United States who use some form of reversible birth control rely on public funds for their contraceptive care.[69] According to one study, an estimated 1.3 million women a year are able to avoid unintended pregnancy due to publicly funded family planning services.[70]

In spite of this dependence on publicly funded family planning services, and the high rate of unintended pregnancy in the U.S., funding for the Title X program is inadequate to meet current need. According to the Alan Guttmacher Institute, "In constant dollars—that is, dollars adjusted for inflation—Title X expenditures for contraceptive services decreased by 65% between 1980 and 1994."[71] In spite of funding increases since 1994 ($215 million for fiscal year 1999[72]), "[h]ad the program's 1980 funding level . . . simply kept up with the rate of inflation . . . funding for the program would now [fiscal year 1998] be at $515.16 million."[73] Thus, in spite of rhetoric from both Congress and the Clinton Administration regarding the need to reduce unintended pregnancy, Title X funding remains woefully inadequate.

Title X places "a special emphasis on preventing pregnancies among sexually active adolescents."[74] Since 1996, however, family planning opponents in Congress have attempted to restrict adolescents' access to Title X services by proposing mandatory parental involvement requirements. So far these efforts have failed, but the attacks on the ability of adolescents to obtain confidential reproductive health care will continue.

The largest government health program, Medicaid, is a joint federal-state program through which eligible individuals receive an array of services, including assistance with family planning.[75] According to the Committee on Unintended Pregnancy, "Medicaid has become the principal source of public funding for contraceptive services, accounting for 58 percent of all federal family planning expenditures (and 43 percent of all public family planning expenditures) . . ."[76] Policies within the Medicaid program illustrate the wavering commitment of Congress to ensuring access to reproductive health care. For example, since 1976, Medicaid coverage for abortion has become severely limited; currently the program pays for abortions only if the pregnancy is the result of rape or incest or if the woman faces a life-endangering physical condition.[77]

Medicaid coverage was provided originally under a fee-for-service model, whereby participants obtained services from the physician of their choice, who was then reimbursed by the government. The private health care market in the U.S. has shifted dramatically away from the fee-for-service model in recent years, with many health benefit plans adopting a managed care model under which partici-

pants' choice of health care provider is limited. As a result, Congress has granted the states discretion to provide Medicaid services through managed care systems.[78]

In recognition of the importance of access to family planning services, Congress in 1987 enacted a provision that permits Medicaid recipients who get benefits through a managed care program to obtain family planning services from any provider, even one that is not part of their managed care plan.[79] Congress has since undermined this protection, however, by granting broad exemptions for plans that have religious objections to the provision of these services.[80] As a result of this so-called "conscience clause," sectarian organizations providing managed care services to Medicaid recipients are not only exempt from providing family planning services, they need not inform recipients that they may receive these services from the provider of their choice, nor make a referral. These changes to the Medicaid program tip the scales against, rather than in favor of, access to family planning services.

In 1997 Congress created an important new public health program: the State Children's Health Insurance Program (CHIPS). The purpose of CHIPS "is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner . . ."[81] Under the law, states are given significant discretion to determine the structure and scope of their programs. Coverage may include inpatient and medical services provided by physicians, prescription drugs, and "[p]re-natal care and pre-pregnancy family planning services and supplies."[82]

While the CHIPS program is a significant policy initiative that should advance the health of low-income children in this country, unfortunately it does not mandate comprehensive reproductive health care for teens,[83] leaving it to the discretion of each state as to whether these vital services will be provided. Moreover, because the services are not mandated, states may impose barriers to this care, such as parental consent or notification, before teens may receive contraception. In addition, the CHIPS statute expressly prohibits insurance coverage for abortion, except "if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest."[84]

It is only in regard to reproductive health that the federal government appears so willing to compromise the provision of comprehensive services within government health programs. The inconsistency of policy in this area can perhaps best be explained by the conflicting desires of Congress to reduce adolescent and out-of-wedlock births while at the same time limiting and restricting women's reproductive rights. The failure to acknowledge the connection between the two illustrates once again that Congress has failed to internalize the most significant aspect of the Programme of Action.

3. Insurance Coverage for Contraceptives

The federal government is in a position to improve access to contraception dramatically through the private insurance market. One means of doing so would be passage of the Equity in Prescription Coverage of Contraceptives Act,[85] which would require equi-

table contraceptive coverage in private insurance. The bill would prohibit health benefit plans that provide benefits for outpatient services and prescription drugs from excluding benefits for contraceptive drugs or devices approved by the federal government.[86] Although it was first introduced in 1997, Congress has not taken action on the measure.

As the largest employer in the country, policies adopted by the U.S. government affecting federal employees' health benefits can have a significant impact, both in the number of people directly affected, and by influencing the private insurance market. Through the Federal Employees Health Benefits Act (FEHBA), the government contracts with private insurance companies to provide health care for its employees.[87] Government employees then choose from among the offered plans.

As a result of the contracting process, government workers and their dependents have faced the same shortcomings in insurance coverage for reproductive health care as other individuals covered through private insurance. For fiscal year 1999, Congress has required, for the first time, that future Federal Employees Health Benefits Program (FEHBP) contracts that include prescription drug coverage must include contraceptive coverage.[88] The measure also provides, however, an exemption for "any . . . existing or future plan, if the plan objects to such coverage on the basis of religious beliefs."[89] Moreover, the bill makes explicit that the provision does not require coverage of abortion or abortion-related services, which are already excluded from FEHBP coverage, unless the abortion is necessary to preserve the woman's life or when the pregnancy is the result of rape or incest.[90] Although this provision was part of an appropriations measure and therefore must be renewed by Congress each fiscal year, adoption of this policy represents a significant step towards eliminating current inequities in contraceptive coverage in private insurance.

C. LEGISLATION REGARDING FEMALE CIRCUMCISION / FEMALE GENITAL MUTILATION

In one area, female circumcision/female genital mutilation (FC/FGM), the United States has taken steps toward implementing the Programme of Action. [91] The legislative measures enacted by Congress should help to ensure that girls and adolescents from countries where FC/FGM is prevalent will not be subjected to the procedure in the U.S. A provision prohibiting the performance of FC/FGM was enacted by Congress as part of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996.[92] To date, there have been no criminal prosecutions for FC/FGM.

Congress has passed two other legislative measures relating to the practice within the U.S. One law required the Secretary of Health and Human Services (HHS) to carry out educational outreach to affected communities, and to undertake a study on FC/FGM in the U.S.[93] The other measure requires the Immigration and Naturalization Service to provide information to those entering the U.S. from countries where FC/FGM is practiced about the harmful effects of FC/FGM and the potential legal consequences of its performance in the U.S.[94]

The issue of FC/FGM also has arisen in the U.S. in the context of political asylum. In 1996, the Board of Immigration Appeals granted asylum to a Togolese woman on the basis of a well-founded fear of persecution of FC/FGM should she return to her country.[95] However, the Board declined to establish standards for granting asylum in future cases.[96] A bill introduced in Congress requiring the attorney general to promulgate regulations relating to gender-related persecution, including FC/FGM, for use in determining eligibility for asylum [97] has not been acted upon.

D. RATIFICATION OF THE WOMEN'S CONVENTION

Another shortcoming in congressional policy is the failure of the Senate to ratify the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention). The Programme of Action emphasizes the importance of eliminating discriminatory barriers to women's full participation in society and the development of policy;[98] ratification of the Women's Convention is one of the specific actions listed in this regard.[99] As of 1998, 161 countries had ratified the Women's Convention.[100] The United States signed the convention in 1980. In spite of the fact that the Clinton Administration listed ratification of the Women's Convention as one of its top priorities during the 105th Congress,[101] and a nationwide grassroots effort, the Senate refuses to act on the convention.

Recommendations Related to Reproductive Health in the U.S.:

- **Review existing and proposed programs with the goals of Cairo in mind to ensure that they promote women's health and well-being, and facilitate access to comprehensive reproductive health care using a rights-based, rather than a family planning approach.**
- **Increase funding for Title X to ensure that all those desiring services have access to comprehensive reproductive health care. Reject efforts to impose parental involvement requirements for adolescents seeking Title X services.**
- **Remove restrictions on abortion funding within government health care programs such as Medicaid and CHIPS, and remove broad conscience clauses for organizations posing religious objections to the provision of reproductive health services through the Medicaid program.**
- **Ratify the Convention on the Elimination of All Forms of Discrimination Against Women.**
- **Support comprehensive sexuality education; redirect funds currently dedicated to the illegitimacy bonus and abstinence only education toward comprehensive programs.**
- **Enact the Equity in Prescription Coverage of Contraceptives Act, and improve access for federal employees by removing the religious objection provision in the FEHBP contraceptive mandate.**
- **At the state level, repeal restrictions on abortion, support comprehensive sexuality education, and improve access to reproductive health care for adolescents through school-based clinics and other programs.**

E. GOVERNMENT ACTION ON ABORTION

The government's failure to adopt the goals of Cairo into internal U.S. policies is particularly striking in light of the attention that is focused on one relatively small aspect of comprehensive reproductive health care and reproductive rights: abortion.[102] In 1998 alone, Congress took action on nearly a dozen abortion-related issues.[103] Even the debate over whether to provide contraceptive coverage for federal employees was tied to abortion when opponents attempted to exclude from coverage any contraceptive method, including the birth control pill, that may work to block implantation of a fertilized egg, arguing that these methods were abortifacients.[104] Other abortion-related measures include the following: a ban on so-called "partial-birth abortions" (failed); further narrowing of restrictions on abortion in publicly funded programs to exclude mental health from determinations of whether an abortion is necessary to preserve a woman's life (adopted); and a prohibition on government approval of mifepristone or other drugs for use as abortifacients (failed).

As active as Congress has been on the issue of abortion, it is primarily the states that regulate the procedure. A majority of states have restricted access to abortion by enacting laws, such as mandatory waiting periods and parental consent requirements.[105] Whereas Congress has been unable to enact a ban on so-called "partial-birth abortions," more than half the states have adopted such measures.[106]

ENDNOTES

1 Statement of the Honorable Timothy E. Wirth on behalf of the United States of America, International Conference on Population and Development, Third Preparatory Meeting, Press Release USUN # 39-(94), at 3-4 (April 4, 1994).

2 United Nations Population Fund (UNFPA), Global Population Assistance Report 1996, E/3000/1998, at 1 (1998).

3 *Id*., at 14.

4 *Id*., at 16.

5 David Briscoe, *Official, Citing Changes in China, Urges Restoration of U.S. Population Aid*, Associated Press Wire, Dec. 1, 1998. *See also* U.S. NGOs in Support of the Cairo Consensus, Keeping America's Promises: U.S. Funding for Reproductive Health Care at Home and Abroad (Dec. 1998).

6 In 1973, the Foreign Assistance Act was amended by a provision, known as the Helms Amendment, that prohibited the use of federal money "for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions." 22 U.S.C.A. § 2151b(f)(1). In 1974, USAID established its own policy, later codified, that prohibits U.S. funding for "information, education, training, or communication programs that seek to promote abortion as a method of family planning." 48 C.F.R. 752.7016(b) (1996). In 1987, the Reagan Administration interpreted "abortion as a method of family planning" to include "abortions performed for the physical or mental health of the mother but does not include abortions performed if the life of the mother would be endangered if the fetus were carried to term or abortions performed following rape or incest." *See* John Blane & Matthew Friedman, Mexico City Policy Implementation Study Appendix A, AID Mexico City Policy Procedures (Population Technical Assistance Project, Occasional Paper No. 5, 1990), *citing* AID Handbook #13. Trans. Memo No. 13:43, at 4C-47, 4C-53 (effective date June 19, 1987). The Bush Administration indicated that foreign NGOs could engage in "counseling and referrals when the life of the mother is threatened or in cases of rape or incest; abortion research; training and equipment to deal with incomplete or septic abortions… [and] post-abortion counseling for women who have an obvious need for contraceptive family planning services." Supplemental Declaration of Duff. G. Gillespie (June 15, 1990), at ¶ 5, in Pathfinder Fund v. A.I.D., 746 F. Supp. 192 (D.D.C. 1990). In 1994, the Clinton Administration affirmed that "abortion as a method of family planning" does not include "cases of rape, incest, or if the life of the woman is in danger…." USAID Policy on Abortion, April 1994 (on file with the Center for Reproductive Rights).

7 The Rockefeller Foundation, High Stakes: The United States, Global Population and Our Future 25 (1997).

8 *See, e.g.*, Christopher H. Smith, *The Unborn Must Be Protected*, *in* Global Issues: Population at the Millenium: The U.S. Perspective 26 (Sept. 1998).

9 The Mexico City Policy prohibited overseas NGOs from receiving U.S. funds, either through USAID or indirectly through U.S.-based NGOs that received U.S. funds, if, with their own funds and in accordance with their own laws, they "performe[d]" or "actively promote[d]" "abortion as a method of family planning." The name is derived from the fact that the U.S. announced the policy at the 1984 U.N. International Conference on Population in Mexico City. *See* Policy Statement of the United States of America at the United Nations International Conference on Population, 2nd Sess., Mexico City (Aug. 6-13, 1984).

10 *See, e.g.*, H.R. 4569, the Foreign Operations, Export Financing, and Related Programs Appropriations Bill, FY 1999, 105th Cong., 2d Sess., § 518A(h)(1) (1998).

11 *Id*., at Sec. 518A (h)(2),(4).

12 *See* Tom Raum, *Clinton Vetoes U.N. Backpayments*, Associated Press Wire, Oct. 22, 1998.

13 United States Agency for International Development (USAID), The Impact of Delaying USAID Population Funding from March to July 1997 (1997). USAID also provided evidence that metering cost taxpayers $1.5 million to administer and involved 143 employees on a part-time basis.

See General Accounting Office, Foreign Assistance: Impact of Funding Restriction on USAID's Voluntary Family Planning Program 9 (April 1997).

14 Executive Board of the United Nations Development Programme and of the United Nations Population Fund, United Nations Population Fund Proposed Projects and Programmes, Recommendation by the Executive Director, Assistance to the Government of China, DP/FPA/CP/196, at para. 21 (July 8, 1997).

15 Judy Mann, *An Ill-Conceived Way to Fight Abortion*, in Washington Post, E3 (Dec. 11, 1998).

16 David Briscoe, *supra* note 5 (quoting Under Secretary of State Frank E. Loy).

17 C. Alison McIntosh and Jason L. Finkle, *The Cairo Conference on Population and Development*, 21 Population and Development Review 223, 243-249. Language supporting safe access to abortion was retained in the Programme of Action, ¶ 8.25.

18 Remarks Prepared for Delivery by Vice President Albert Gore, International Conference on Population and Development (September 5, 1994) (on file with the Center for Reproductive Rights).

19 United States Department of State, The United States and the International Conference on Population and Development (June 1994).

20 United States Department of State, U.S. National Report to The International Conference on Population and Development 55 (April 1994)

21 *Id*., at 61.

22 22 U.S.C.A. § 2151b.

23 *Id*. at § 2151b(b).

24 *Id*. at §§ 2151b(d), 2151k & 2304(a) & (b).

25 According to USAID, the agency spent approximately $55 million on maternal health and breastfeeding programs, when compared with about $366 million on family planning services and programs in FY 1997.

26 *See supra* note 6.

27 Abortion is legal in cases of threat to the woman's life, rape and/or incest in every country that receives significant levels of USAID funding, with the exception of El Salvador. *See* Anika Rahman, Laura Katzive and Stanley Henshaw, *A Global Review of Laws on Induced Abortion, 1985-1997*, in 24(2) Intl. Fam. Plan. Persp. 58 (June 1998).

28 Craig Lasher, *U.S. Population Policy Since the Cairo Conference*, 4 Enviro. Change and Security Project Rep. 16, 18-19 (Spring 1998); Amy Higer, Transnational Movements and World Politics: The International Women's Health Movement and Population Policy 282 (May 1997) (unpublished Ph.D. dissertation).

29 Lasher, *supra* note 28, at 19, *citing* U.S. Dept. of State, U.S. Department of State Strategic Plan 70-71 (Sept. 1997).

30 Lasher, *supra* note 28, at 19, *citing* Alex de Sherbinin, World Population and U.S. National Security, 1 Envir. Change and Security Project Rep. 24-39 (Spring 1995); Sec. of State Madeleine Albright, *Stable Population Important for Progress*, *in* Global Issues: Population at the Millenium 6-7 (USIA, Sept. 1998).

31 The Working Group on Reproductive Health and Family Planning, Report from the Meeting on Women's Health, Human Rights and Family Planning in Mexico and Peru 51-69 (The Health and Development Policy Project and the Population Council, May 13, 1996).

32 Elizabeth Maguire, *Meeting the Challenge of Cairo*, *in* Global Issues: Population at the Millenium: The U.S. Perspective 22 (Sept. 1998).

33 MAQ: From Guidelines to Action (Report of a USAID-Sponsored Conference May 12-13, 1998) (1998).

34 USAID, Overview of USAID Population Assistance FY 1997, at 4. "Service Delivery" is USAID's leading expenditure at 42% of the FY 1997 total, and "Contraceptives/Logistics" follows with 12% of funds, down 2% from FY 1996.

35 It is inherently problematic to disaggregate expenditures on a family planning and reproductive health service provision that is, in fact, increasingly integrated. However, USAID's methodologies for track-

ing expenditures complicate an evaluation of whether its funds are being shifted toward comprehensive reproductive health programs.

36 Global Population Assistance Report 1996, *supra* note 2, at 28. Preliminary figures for 1997 compiled by USAID for UNFPA show 60% of 1997 expenditures for family planning, 12% for reproductive health and 21% for HIV/AIDS.

37 *Id*., at 28.

38 USAID, Reproductive Health Programs Supported by USAID: A Progress Report on Implementing The Cairo Program of Action 8 (May, 1996)

39 *Id*.

40 For a discussion of some alternative indicators, *see* the Working Group on Reproductive Health and Family Planning, Measuring the Achievements and Costs of Reproductive Health Programs (The Health and Development Policy Project and the Population Council, June 24-25, 1996)

41 Recently in Peru, where USAID historically has been active in family planning programs, allegations of coercive practices and serious quality of care issues in government family planning services, particularly with respect to sterilization, have surfaced. *See* Calvin Sims, *Using Gifts as Bait, Peru Sterilizes Poor Women*, *in* N.Y. Times, Feb. 15, 1998, at A1. USAID-funded programs have not been linked to the government programs where violations have occurred.

42 USAID, From Commitment to Action: Meeting the Challenge of ICPD 3-4 (1999).

43 According to figures from the Office of Management and Budget, in 1994, international development and humanitarian assistance spending was US$7.049 billion. In 1995, it was US$7.599 billion; in 1996, US$6.160 billion; in 1997, US$6.054 billion. The amount estimated for 1998 is US$5.750 billion. *See* Historical Table 3.2 on the website of the Office of Management and Budget, Executive Office of the President of the United States of America (visited Jan. 12, 1999) <http://www.gpo.gov/OMB/index.html>.

44 *See* USAID Office of Women in Development, Information Bulletin on FGM (March 1997); USAID Office of Women in Development, *Violence against Women: An Issue of Human Rights*, *in* 1 Gender Action: A Newsletter of the USAID Office of Women in Development (No. 4, Summer 1997).

45 Jones E, Forrest JD, Henshaw, Silverman & Torres, Pregnancy, Contraception and Family Planning in Industrialized Countries, the Alan Guttmacher Institute 217-224 (1989).

46Stanley K. Henshaw, *Unintended Pregnancy in the United States*, in 30:1 Fam. Plan. Persp. at 24 (Jan./Feb. 1998).

47 Committee on Unintended Pregnancy, Institute of Medicine, National Academy of Sciences, The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families [hereinafter The Best Intentions] 43 (Sarah S. Brown and Leon Eisenberg, eds., National Academy Press 1995), *citing*, Jones E, Forrest JD, Henshaw, Silverman & Torres, Pregnancy, Contraception and Family Planning in Industrialized Countries, Alan Guttmacher Institute , *supra* note 45.

48 Stephanie J. Ventura, T.J. Mathews, and Sally C. Curtin, *Declines in Birth Rates: 1991-98: National and State Patterns* in 47 Nat'l. Vital Stat. Rep. from the Centers for Disease Control and Prevention 2, 17 (Vol. 12, December 17, 1998).

49 Stanley K. Henshaw, *Unintended Pregnancy in the United States*, *supra* note 46, at 27.

50 The Best Intentions, *supra* note 47, at 153.

51 The Alan Guttmacher Institute, Uneven and Unequal, Insurance Coverage and Reproductive health Services 12 (1995).

52 *Id.* at 17.

53 Women's Research and Education Institute, Women's Health Insurance Costs and Experiences 2 (1994).

54 United States Department of Health and Human Services, Maternal & Child Health Bureau, Child Health USA 1998, 20 (Sept. 1998).

55 *Id.*

56 *Id.*, at 20-21.
57 *Id.*, at 18-19.
58 P.L. 104 –193 (1996); 110 Stat. 2105, et seq. (1996).
59 The legislative findings in the bill conclude: "in light of this demonstration of the crisis in our Nation, it is the sense of the Congress that prevention of out-of-wedlock pregnancy and the reduction in out-of-wedlock birth are very important Government interests. . ." *Id.* at §101(10); 110 Stat. 2112.
60 42 U.S.C.A. § 603 (2).
61 Institute for Women's Policy Research, Reproductive Issues and Welfare Reform Network News, 2-3 (Oct./Nov. 1997, revised Aug. 1998).
62 *Id.*, at 2.
63 42 U.S.C.A. § 710.
64 *See* Advocates for Youth, 1 Measuring Up: Assessing State Policies to Promote Adolescent Sexual and Reproductive Health, nos. 1 & 2 (1998). Out of a sampling of 26 states, 18 states require the inclusion of abstinence as a topic in their sexual education curriculum.
65 42 U.S.C.A. §§ 300.
66 State of New York v. Heckler, 719 F.2d 1191, 1193 (2d Cir. 1983), *quoting* Pub. L. No. 91-572 at § 2(1).
67 As with funding for foreign assistance, family planning services do not include pregnancy care or abortion services 42 C.F.R. 59.2 (1982).
68 The Alan Guttmacher Institute, *Title X and the U.S. Family Planning Effort, in* Issues in Brief 4 (1997).
69 Jacqueline D. Forrest and Rene Smara, *Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures*, 28:5 Fam. Plan. Persp. 188, 193 (Sept./Oct. 1996).
70 *Id.*, at 192-93.
71 *Title X and the U.S. Family Planning Effort*, *supra* note 66, at 5.
72 144 Cong. Rec. 11, 4 2 3 (1998).
73 Testimony of the Family Planning Coalition on Funding for the Title X (Ten) Family Planning Program for Fiscal Year 1998, House App. Subcomm. On Labor, HHS, Education, and Related Agencies (April 29, 1997) (Judith DeSarno, National Family Planning and Reproductive Health Association).
74 Planned Parenthood Federation of America v. Heckler, 712 F. 2d. 650, 652 (D.C. Cir 1983), *citing* S. Rep. No. 822 95th Cong., 2d. Sess. 24 (1978).
75 42 U.S.C.A. §§ 1396, *et. seq.*; 42 U.S.C.A. § 1396d(a)(4)(C).
76 The Best Intentions, *supra* note 47, at 28.
77 P.L. No. 105-78 §509 (1997); 144 Cong. Rec. 11, 406 (1998).
78 *See, e.g.*, 42 U.S.C. § 1396n (1998).
79 42 U.S.C.A. § 1396a(a)23(B); 42 C.F.R. §431.51(a)(4).
80 42 U.S.C.A. § 1396(u)-2(b)(3)(B).
81 42 U.S.C.S. § 1397aa(a).
82 42 U.S.C.S. §§ 1397cc and 1397jj(a).
83 For purposes of the statute, "'child' means an individual under 19 years of age." 42 U.S.C. § 1397jj(c)(1).
84 42 U.S.C.S. § 1397ee(c)(1) and (7).
85 S. 766 105th Cong., 1st Sess. (1997).
86 *Id.*
87 5 U.S.C. §§ 8901, *et.seq.*; § 8902(d).
88 144 Cong. Rec. 11, 187 (1998).
89 *Id.*
90 *Id.*
91 *See Programme of Action of the International Conference on Population and Development, Cairo, Egypt*, 5-13 Sept. 1994, at ¶4.22, in Report of the International Conference on Population and Development, U.N. Doc. A/CONF.171/13/Rev.1 (1995) [hereinafter *Cairo Programme of Action*].
92 Codified as 18 U.S.C.A. § 116.
93 Pub. L. 104-134, Title I, § 101(d)[Title V § 520] Apr. 26, 1996, 110 Stat. 1321-250; renumbered Title I Pub.L. 104-140, § 1(a), May 2, 1996, 110 Stat. 1327 (*see* 42 U.S.C.A. § 241, Historical and Statutory notes (1998 Supp.)). The study estimated that, in 1990, there were approximately 168,000 girls and women in the U.S."with or at risk for FC/FGM."

Wanda K. Jones et al., *Female Genital Mutilation/ Female Circumcision: Who Is at Risk in the U.S.?* 112 Pub. Health Rep. 368, 372 (1997).

94 8 U.S.C.A. § 1374 (to be recodified as 8 U.S.C.A. § 904, pursuant to H.R. 2716, 105th Cong.)

95 *See* Fauziya Kassindja and Layli Miller Bashir, Do They Hear You When You Cry (1998).

96 *See* In re Fauziya Kasinga, Bd. of Immig. Appeals No. A73 476 695, 1996 BIA LEXIS 15 (Jun. 13, 1996).

97 H.R. 825, 105th Cong. (1997).

98 *See, e.g., Cairo Programme of Action*, Chapter IV, on Gender Equality, Equity and Empowerment of Women.

99 *Cairo Programme of Action*, ¶ 4.5.

100 The Working Group on the Women's Human Rights Treaty, Convention on the Elimination of All Forms of Discrimination Against Women 1 (April 1998).

101 Working Group on the Women's Human Rights Treaty, Convention on the Elimination of All Forms of Discrimination Against Women (April 1998).

102 *Cairo Programme of Action*, at ¶8.25 regarding abortion provides in part: "All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion."

103 National Abortion and Reproductive Rights Action League Federation, Choice Wins and Losses, 105th Congress—Second Session (August 19, 1998).

104 Mary Agnes Carey and Juliana Gruenwold, *Treasury-Postal Fight Erupts on Birth Control Issues*, *in* Cong. Quart, Sept. 24, 1998.

105 National Abortion and Reproductive Rights Action League Federation, Who Decides? A State-by-State Review of Abortion and Reproductive Rights (1998).

106 Out of the 28 state laws that have been enacted, 19 have been limited or prohibited from going into effect as a result of court challenges (information on file with the Center for Reproductive Rights).

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