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

Chad M. Gerson[1]

I. INTRODUCTION

On July 11, 2003, the African Union[2] adopted a "Protocol on the Rights of Women in Africa," ("Protocol") which established a woman's right to have an abortion in cases of rape or incest or to preserve the health of the mother.[3] Perhaps surprisingly, this Protocol is the first explicit mention of abortion rights in international law.[4] In a previous article I remarked that this was a positive development for the world's women, and considered whether other organizations, particularly the United Nations, might follow suit.[5] In that article I noted that the U.N. has taken the positions that all women should be able to prevent unwanted pregnancies and that all women should receive treatment for abortion-related complications without fear of legal repercussions whether or not abortion

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[1] J.D. 2005, University of Chicago; B.S. 1999, Indiana University. The author is currently a clerk in the chambers of the Honorable Michael J. Reagan in the United States District Court for the Southern District of Illinois. The author would like to thank Prof. Mary Anne Case of the University of Chicago for her invaluable assistance.

[2] The African Union was conceived in 1999, adopted its Constitutive Act at the Lome Summit in 2000, and convened its first assembly of heads of member states at the Durban Summit in 2002. It now has fifty-three member countries. For general information about the AU see < http://www.africa-union.org/home/Welcome.htm> (visited April 25, 2005).

[3] Equality Now press release, *African Union Adopts Protocol on the Rights of African Women: Right to Abortion Articulated for the First Time in International Law*, available online at <http://www.equalitynow.org/English/about/African-protcol_en.html> (visited April 25, 2005). This press release asserts that "States parties shall take appropriate measures to … protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus." The protocol itself is available online at <http://www.africa-union.org/Official_documents/Treaties_%20Conventions_%20Protocols/Protocol%20on%20the%20Rights%20of%20Women.pdf> (visited April 25, 2005). *See id.*, art 14 § 2(c) for the relevant portion of the protocol.

[4] *Id.*

[5] *See* Chad M. Gerson, *Toward an International Standard of Abortion Rights: Two Obstacles*, 5 Chi. J. Int'l L. 753 (2005).

is legal in that country.[6] I went on to note that "[t]hese mandates ring hollow in light of the fact that countries hostile to abortion are also those most likely to be hostile to family planning services (or to be unable to provide them), and be indifferent to the plight of those women who suffer abortion-related complications (or, again, unable to care for women who develop complications)."[7] The purpose of this article is to provide detailed empirical support for those statements in the context of Africa, and to analyze recent developments in abortion rights on that continent.

II. Abortion Rights as a Predictor of Maternal Mortality and Infant Mortality

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

A. Methodology

The following table lists, alphabetically, all the countries in Africa.[8] Next to the name of each country is a numerical ranking of how liberal its abortion policies are (from one to seven), then its rate of contraceptive usage among women fifteen to 49, then its

[6] *See id.* at XXX at n.21.

[7] *See id.* and n.22.

[8] Except the Seychelles and Sao Tome and Principe, for which data were not available.

maternal mortality rate per 100,000 live births, then its infant mortality rate per 1,000 births. There were a few African countries for which the rate of contraceptive usage was unavailable or unreliable.

The ranking of how liberal a country's abortion policies are was determined in the following manner. If a country allows abortions only to save the life of the mother, it was ranked as a one. All African nations allow abortions in this context. If, in addition, a country allows abortions to preserve the mother's physical health, it was ranked as a two. If the country additionally allows abortions to preserve the mother's mental health, it was ranked as a three. Several of the nations in the study have statutes that allow abortions to preserve health but do not specify whether mental health is included in the concept of "health."[9] Such countries were ranked as threes only if abortions to preserve the mother's mental health are openly available in the country or if those nations' Supreme Courts have issued rulings that mandate that mental health must be included. Otherwise, these nations were ranked as twos. If, in addition to life and health, a nation allows abortions in cases of rape or incest, the country was ranked as a four. If the country additionally allows abortions in cases of fetal impairment, it was ranked as a five.[10] If the country additionally allows abortions for economic or social reasons, it was ranked as a six. Finally, if the country allows abortions on demand, it was ranked as a seven. All African

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

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

countries except one fall into one of these categories and do not have abortion rights that are "out of sequence."[11]

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

B. THE DATA

Below is a table listing the countries in Africa alphabetically, with their abortion policy ranking, rate of contraceptive use, rate of maternal mortality, and rate of infant mortality. The calculated correlations are also listed at the bottom.

Level of Freedom to Obtain an Abortion, Contraceptive Use, Maternal Death, and Infant Mortality Rates in African Countries

Country	Level of Freedom[12]	Contraceptive Use[13]	Maternal Death[14]	Infant Mortality[15]

[11] The exception is Zimbabwe, which allows abortion to preserve the mother's life or physical health, in cases of rape or incest, and for fetal impairment, but not to preserve the mother's mental health. I split the difference and ranked Zimbabwe a 4.

[12] Data taken from *Abortion Policies: A Global Review*, available online at <http://www.un.org/esa/population/publications/abortion/profiles.htm> (visited April 25, 2005).

[13] Percentage of women aged between fifteen and 49 using modern contraception. Data taken from *Abortion Policies: A Global Review*, available online at

Algeria	3	52	340	35
Angola	1	N/A	950	170
Benin	1	16	990	101
Botswana	5	32	250	38
Burkina Faso	5	8	930	109
Burundi	2	9	1300	106
Cameroon	3	16	550	94
Cape Verde	7	53	107	54
Central African Republic	1	15	700	113
Chad	1		1500	118
Comoros	2	21	950	67
Congo	1	N/A	950	81
Cote D'Ivoire	1	11	810	90
Dem. Republic of the Congo	1	8	870	128
Djibouti	2	N/A	570	111
Egypt	1	47	170	51
Equatorial Guinea	2	N/A	820	108
Eritrea	2	15	820	70
Ethiopia	2	4	1400	110
Gabon	1	N/A	500	85
Gambia	3	7	1100	64
Ghana	5	10	740	67
Guinea	3	1	1600	124
Guinea-Bissau	1	N/A	910	130
Kenya	3	32	650	75
Lesotho	1	19	610	94
Liberia	5	6	560	157
Libya	1	26	220	20
Madagascar	1	10	490	95
Malawi	1	14	560	134
Mali	1	5	1200	144

<http://www.un.org/esa/population/publications/abortion/profiles.htm> (visited April 25, 2005) (cited in note 12).

[14] Per one hundred thousand live births. Data taken from *Abortion Policies: A Global Review*, available online at <http://www.un.org/esa/population/publications/abortion/profiles.htm> (visited April 25, 2005) (cited in note 12).

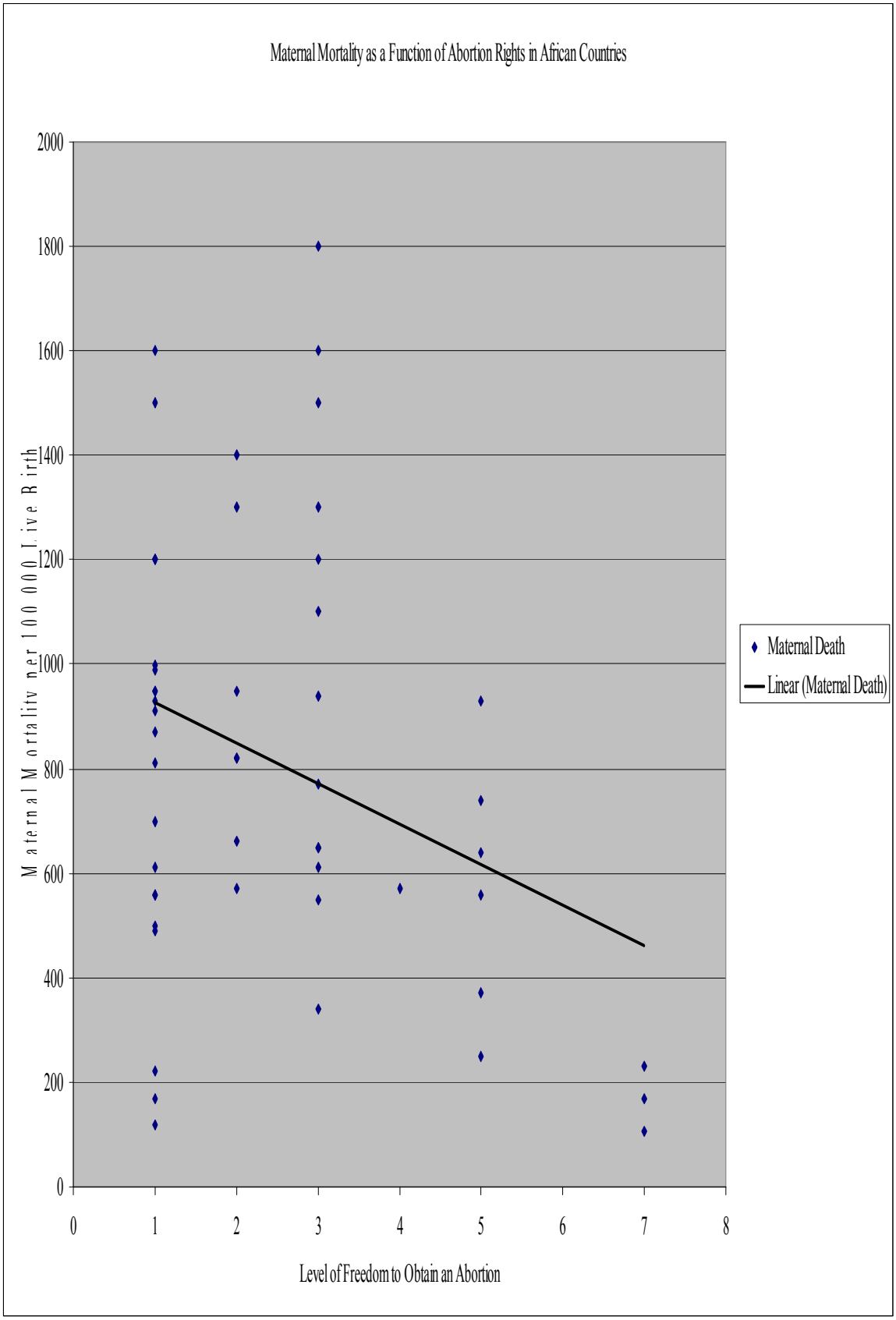
[15] Per one thousand deliveries. Data taken from *UNICEF: The State of the World's Children 2004: Basic Indicators*, available online at < http://www.unicef.org/sowc04/files/Table1.pdf> (visited April 25, 2005).

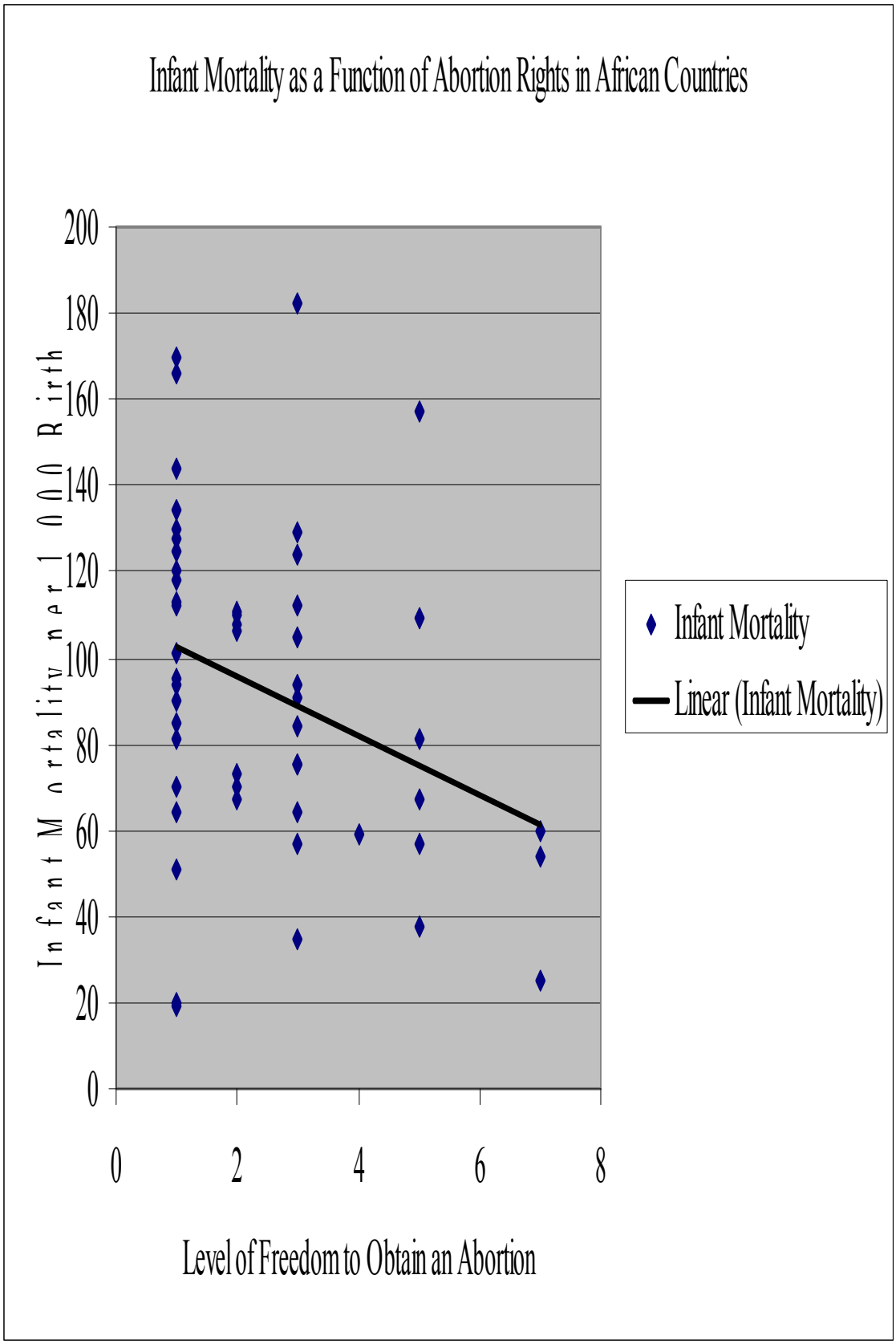
Mauritania	1	1	930	120
Mauritius	1	49	120	19
Morocco	3	42	610	57
Mozambique	3	5	1500	129
Namibia	5	26	370	57
Niger	1	5	1200	166
Nigeria (northern states)[16]	1	4	1000	112
Nigeria (southern states)	3	4	650	75
Rwanda	3	13	1300	105
Senegal	1	8	1200	70
Sierra Leone	3	N/A	1800	182
Somalia	1	N/A	1600	125
South Africa	7	48	230	60
Sudan	2	7	660	73
Swaziland	1	17	560	64
Tanzania	3	13	770	91
Togo	5	7	640	81
Tunisia	7	51	170	25
Uganda	3	8	1200	84
Zambia	3	14	940	112
Zimbabwe	4	42	570	59
Correlation with Abortion Policies			-0.323	-0.318
Correlation with Contraceptive Use			-0.751	-0.723
Correlation between Abortion Policy and Contraceptive Use				0.397

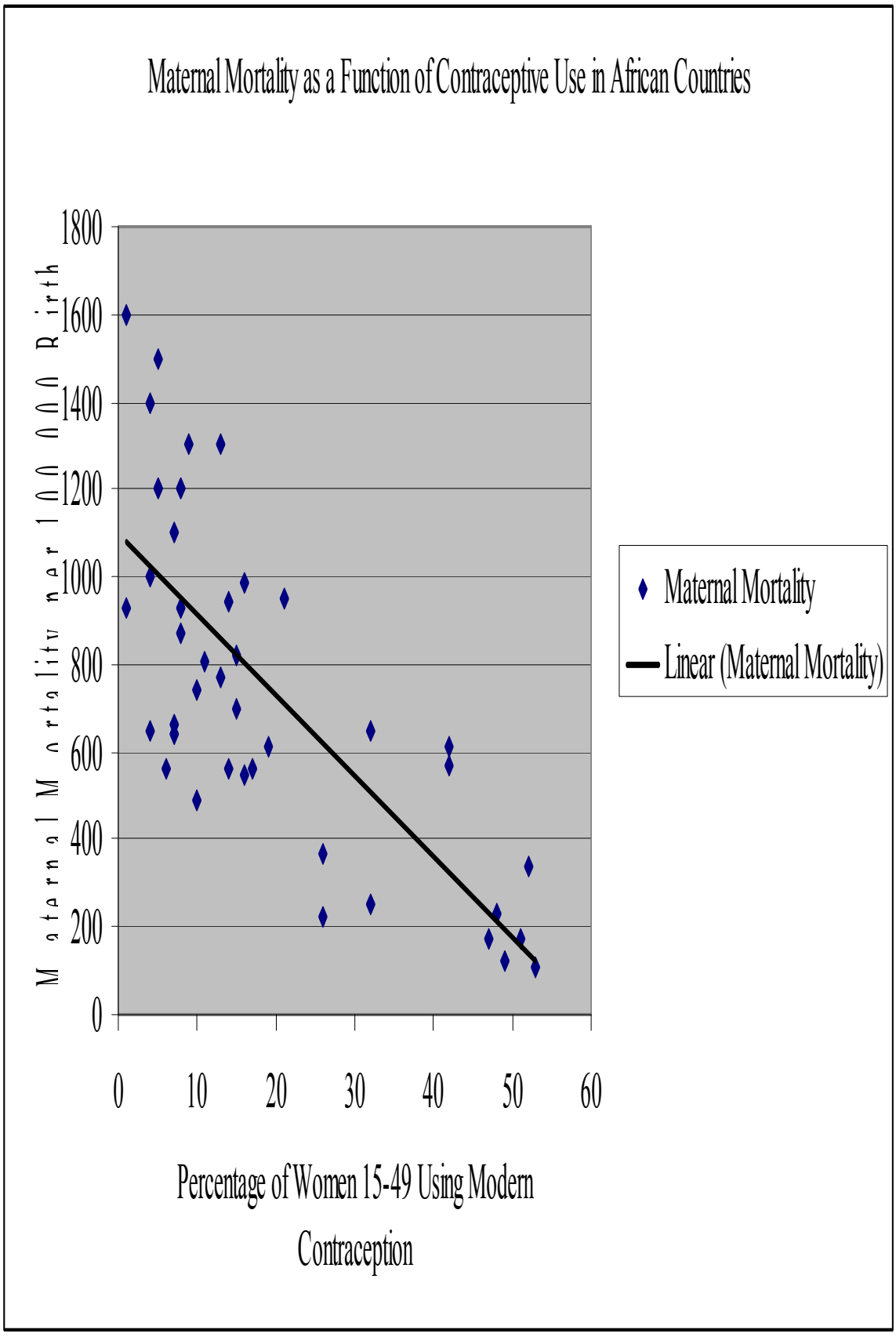
C. DATA ANALYSIS

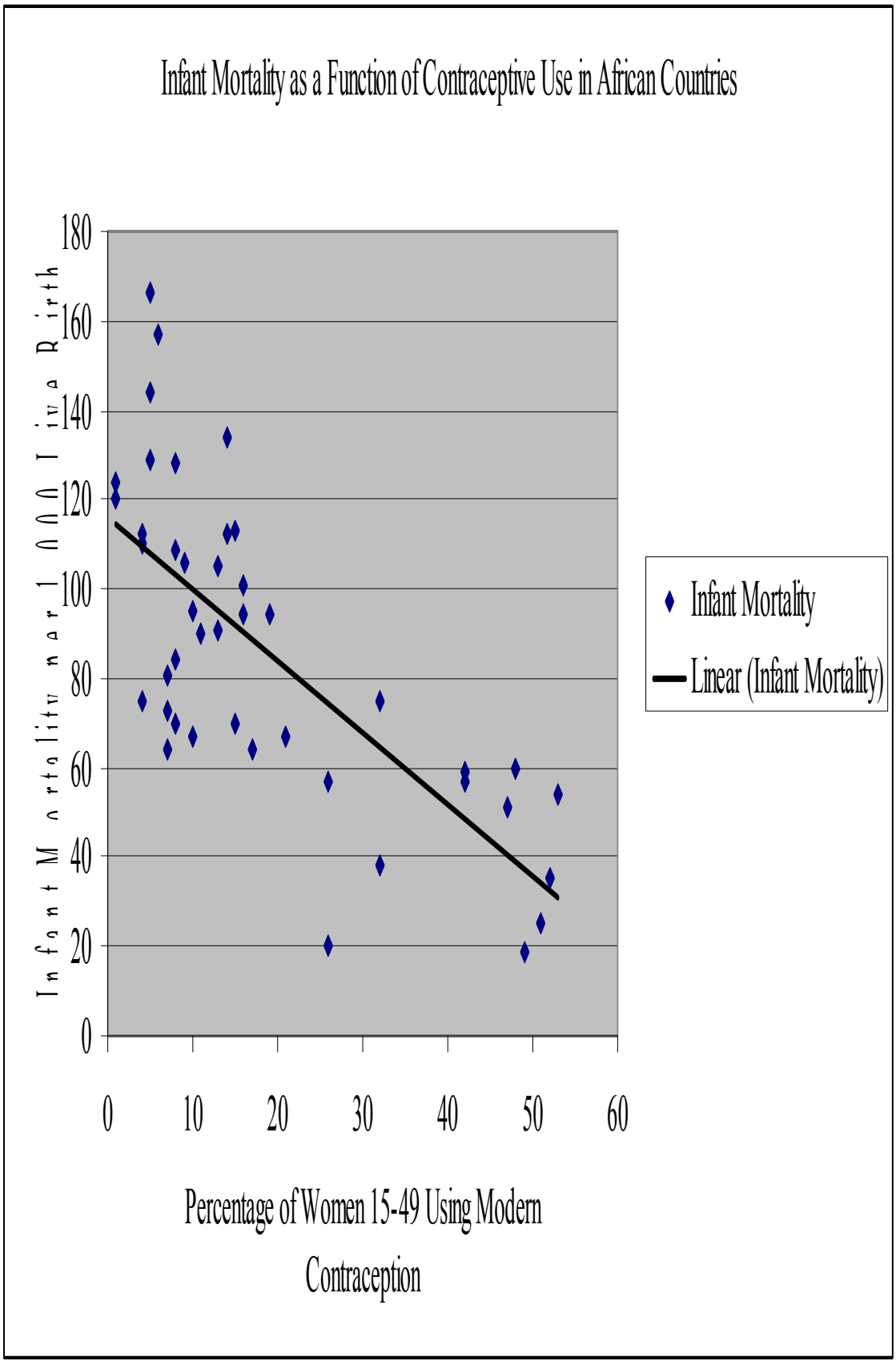
[16] Nigeria has two abortion policies. Its southern states are populated mostly with Christians who have more or less adopted the common law tradition of Nigeria's former British colonial rulers. In these states, abortion is allowed to save the life of the mother or to preserve her physical or mental health. Its northern states, however, follow the Sharia, or traditional Islamic Law, and allow abortions only to save the life of the mother. *See Abortion Policies: A Global Review*, available online at <http://www.un.org/esa/population/publications/abortion/profiles.htm> (visited April 25, 2005) (cited in note 12). See also Richard Dowden, *Death by Stoning*, New York Times Magazine (January 27, 2002) at 26.
Although it is a single data point and therefore not statistically meaningful, the data on Nigeria particularly reinforce the notion that abortion rights, women's health and children's health go hand in hand. Within a single country, a difference in abortion laws between subgroups has made a significant difference in maternal and infant mortality.

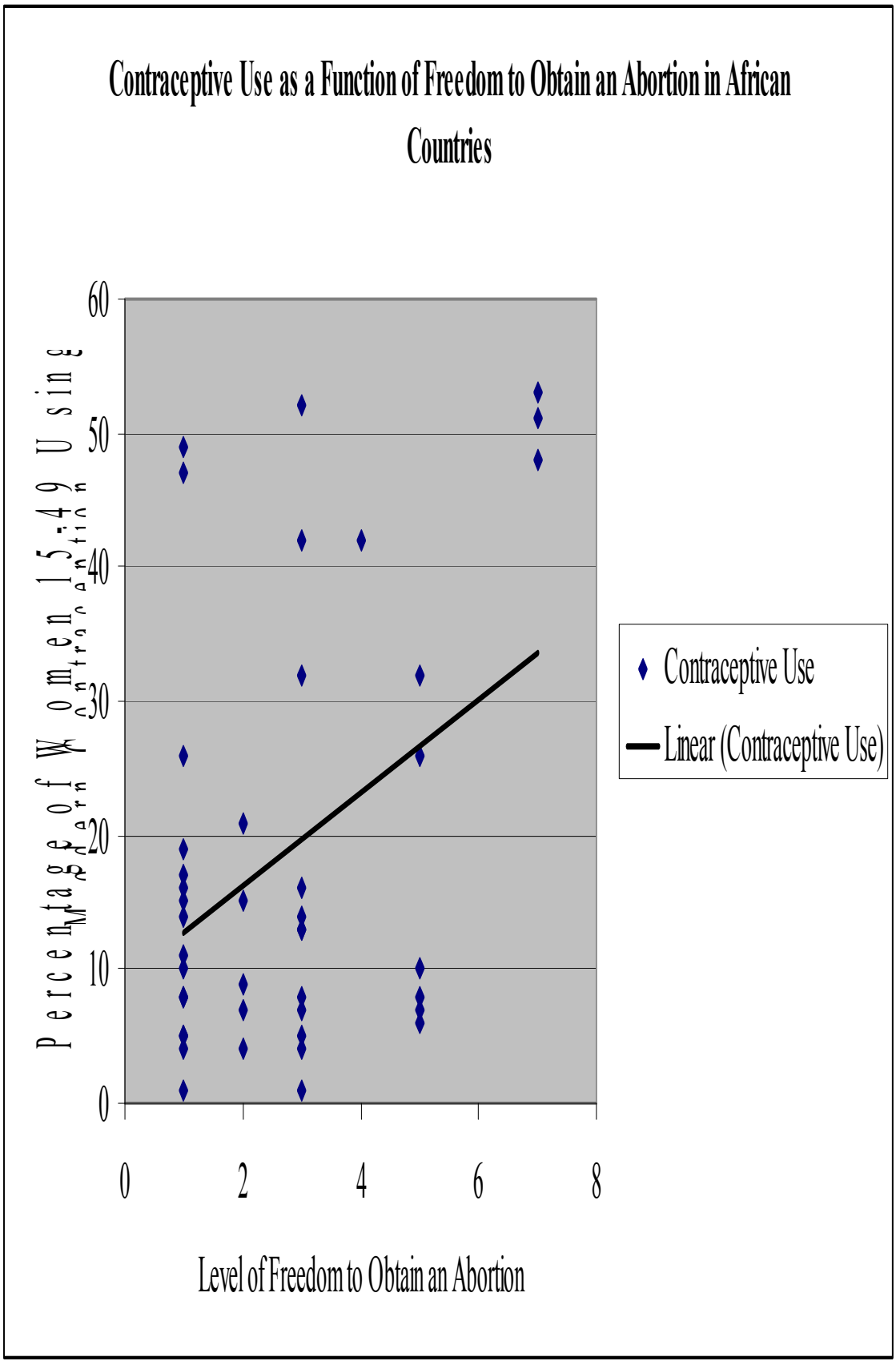
The five scatter plots below represent maternal and infant mortalities as a function of women's access to abortion, maternal and infant mortalities as a function of women's contraceptive usage, and women's contraceptive usage as a function of their freedom to obtain an abortion.


Maternal Mortality as a Function of Abortion Rights in African Countries
Maternal Mortality per 100,000 Live Birth
2000
1800
1600
1400
1200
1000
800
600
400
200
0
0
1
2
3
4
5
6
7
8
Level of Freedom to Obtain an Abortion
Maternal Death
Linear (Maternal Death)


Infant Mortality as a Function of Abortion Rights in African Countries
Infant Mortality per 1,000 Birth
200
180
160
140
120
100
80
60
40
20
0
0
2
4
6
8
Level of Freedom to Obtain an Abortion
Infant Mortality
Linear (Infant Mortality)


Maternal Mortality as a Function of Contraceptive Use in African Countries
Maternal Mortality per 100,000 Birth
1800
1600
1400
1200
1000
800
600
400
200
0
0
10
20
30
40
50
60
Percentage of Women 15-49 Using Modern Contraception
Maternal Mortality
Linear (Maternal Mortality)


Infant Mortality as a Function of Contraceptive Use in African Countries
Infant Mortality per 1000 Live Births
180
160
140
120
100
80
60
40
20
0
0
10
20
30
40
50
60
Percentage of Women 15-49 Using Modern Contraception
Infant Mortality
Linear (Infant Mortality)


Contraceptive Use as a Function of Freedom to Obtain an Abortion in African Countries
Percentage of Women 15-49 Using Contraception
60
50
40
30
20
10
0
0
2
4
6
8
Level of Freedom to Obtain an Abortion
Contraceptive Use
Linear (Contraceptive Use)

Access to abortion is inversely correlated with both maternal (r = -0.323) and infant (r = -0.318) mortality. These correlations are suggestive of a palpable cause and effect relationship between access to abortion and maternal and infant mortalities. The correlations would be much stronger if not for a few outliers. For example, in the maternal mortality graph, there are three data points that represent countries ranked as ones regarding access to abortion but still have very low maternal mortality. These data points represent Egypt, Libya, and Mauritius, which are all wealthy and developed nations compared to most of Africa.[17]

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

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

[17] The per capita Gross National Income of African nations is $460. The per capital Gross National Income of Egypt is $1,470, that of Libya is $5,540, and that of Mauritius is $3,850 (all amounts in U.S. dollars). Similarly, the adult literacy rate of African nations is 50%. The adult literacy rate of Egypt is 55%, that of Libya is 80%, and that of Mauritius is 85%. All data taken from *UNICEF: The State of the World's Children 2004: Basic Indicators*, available online at <http://www.unicef.org/sowc04/files/Table1.pdf> (visited April 25, 2005) (cited in note 15).

contraceptive use when the sexual activity involved is sanctioned by the religion or the prevailing culture.[18]

Usage of contraceptives is even more strongly inversely correlated with both maternal ($r = -0.751$) and infant ($r = -0.723$) mortality. Because the correlations between the usage of contraceptives and the two mortalities is much stronger than those for abortion should not be taken to mean that abortion is necessarily less important than access to and education about contraception. On the contrary, it is further evidence of what is already obvious—that prevention of pregnancy through the use of contraceptives is by far preferable to abortion as a method of family planning. The significant positive correlation between contraceptive usage and the freedom to obtain an abortion ($r = 0.397$) is evidence that countries that are hostile to women obtaining abortions are also likely to be hostile to women controlling their own fertility by contraception (or simply unable to provide effective contraception due to the expense or difficulties in distribution or education).[19] It is also evidence that both abortion and contraception are important to an overall respect for the rights and empowerment of women.

Two dimensions of women's rights regarding access to abortion were not included in this study. The first is whether a woman's husband, or, if she is not married, the father of her baby, must consent to the abortion, or at least has some influence in the decision, even if it is otherwise allowable under that country's law. The other is whether a young woman may independently obtain an otherwise legal abortion before she has reached the age of majority, without the knowledge of her parents and/or regardless of

[18] *See Abortion Policies: A Global Review*, available online at <http://www.un.org/esa/population/publications/abortion/profiles.htm> (visited April 25, 2005) (cited in note 12).

[19] See Section II.B *supra*.

their consent. Countries with otherwise identical laws on their books, but requiring spousal or parental consent or notification could in fact be drastically different regarding the ease with which women can avail themselves of their reproductive rights. But compared with the relative ease of ranking nations with respect to the conditions under which a woman may obtain an abortion, it is difficult to fit notification and/or consent requirements into the same ordinal scheme. For example, is a country that allows abortion on demand, but that requires parental or spousal notification and/or consent, more or less liberal toward abortion rights than a country that allows abortion to save the woman's life, physical or mental health, in cases of rape or incest, and in cases of fetal impairment, but does not require the women to notify or obtain the consent of her spouse or parents? It is not clear which is "worse." The answer is probably not obtainable, because each family lives in different circumstances. Furthermore, the nature of the pregnancy would make a huge difference. Foe example, if the woman came from a strictly Muslim family, or a nation imposing Sharia, and the pregnancy resulted from adultery, spousal notification laws would be tantamount to a death sentence.

Of course, even with correction for other social factors, it is clear that access to abortion is not the only variable contributing to the rates of maternal and infant mortality. Access to abortion is only one facet of a woman's control over her reproduction, which in turn is only one category of a society's general respect (or lack thereof) for women's rights and independence. Access to contraception, prenatal care, education of women, and rules regarding property rights all certainly play a role. Further study would be useful to examine the effects of these factors.

III. How Africa Suffers Under the "Global Gag Rule"

As noted in my previous article, the United States was instrumental in devising and implementing the UN Population Commission in 1946 and the UN Family Planning Association in 1969.[20] I criticized the "Mexico City Policy"[21] (sometimes called the "gag rule"), which denied any U.S. funding to foreign NGOs that promoted or provided abortions, even if American monies were not used for this purpose.[22]

A. The Negative Effects of the Policy on Africa and other developing Countries

The Mexico City Policy is in some sense a de facto abortion policy for those countries that rely on foreign aid for most of their medical and family planning services. Some countries that rely on aid for their family planning services have seen disastrous reduction in services since President Bush reinstated the policy upon taking office. For example, two of Kenya's largest family planning clinics refused to follow the terms of the Policy and subsequently lost their aid funding.[23] Between them, they were forced to close five clinics, lay off nearly one-third of their staff, curtail service hours, and raise their patient fees.[24] Of course, because family planning clinics are often the only local

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[20] *See* Tobey E. Goldfarb, *Abstinence Breeds Contempt: Why the U.S. Policy on Foreign Assistance for Family Planning is Cause for Concern*, 33 Cal. W. L.J. 345, 346–53 (2003).

[21] So named because President Reagan announced it in 1984 during a UN International Conference on Population in Mexico City.

[22] *See* 33 Cal. W. L.J. at 350–53.

[23] These are the Family Planning Association of Kenya and Marie Stopes International Kenya. *See Access Denied: U.S. Restrictions on Global Family Planning: Case Study: Kenya*, available online at <http://www.globalgagrule.org/caseStudy_kenya.htm> (visited May 2, 2005).

[24] *See id.*

sources of information about sexually transmitted diseases, gynecological examinations, and proper prenatal care, these services have also eroded in Kenya, particularly in densely populated and underserved areas.[25]

In Zambia, the rate of unwanted pregnancies has increased since the Policy was reinstated.[26] Only the Planned Parenthood Association of Zambia refused to accept U.S. money under the terms of the Policy. Every other NGO capitulated rather than face the withdrawal of funds.[27] There are only three hospitals in Zambia equipped to perform abortions, and all are government-run; unsafe abortions are rampant and increasing.[28] The rise in the rate of unwanted pregnancies and unsafe abortions suggests that the NGOs had played a crucial role in educating women about the availability of safe abortions in Zambia and that the Policy has undermined Zambia's efforts to rein in its birth rate and protect its women.

Romania, one of the few European countries receiving aid, is a particularly interesting case. During the Cold War its government encouraged a high birth rate, banned abortion, and made contraception almost impossible to obtain.[29] It was not uncommon for women to have multiple illegal abortions.[30] Now, contraception is legal in

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[25] *See id.*

[26] *See Access Denied: U.S. Restrictions on Global Family Planning: Case Study: Zambia, Detailed Report*, available online at <http://www.globalgagrule.org/pdfs/case_studies/GGRcase_zambia.pdf> (visited May 2, 2005).

[27] *See id.*

[28] *See id.*

[29] *See Access Denied: U.S. Restrictions on Global Family Planning: Case Study: Romania, Full Report*, available online at <http://www.globalgagrule.org/pdfs/case_studies/GGRcase_romania.pdf> (visited May 2, 2005).

[30] *See id.*

Romania, but the habit of using abortion as a method of family planning is still disturbingly prevalent.[31] Romanian women often learn about the proper methods of obtaining and using contraceptives only at the time of their first abortion.[32] The Mexico City Policy, however, made this much more difficult because NGOs that mention abortion services now have reduced funding and have reduced their contraceptive services. Meanwhile, NGOs that are better equipped to provide contraceptive services but follow the Mexico City Policy cannot reach women who have had abortions to help them prevent future unwanted pregnancies, because they are barred from associating with the other NGOs. The Policy has driven a wedge between the various groups in Romania and, ironically, has hampered efforts to *reduce* the number of abortions.[33]

B. THE MEXICO CITY POLICY FRUSTRATES HIV PREVENTION PROGRAMS AND GENERATES COGNITIVE DISSONANCE

Interestingly, the George W. Bush administration in some sense partly backed down from the Mexico City Policy on Jan. 28, 2003, during his State of the Union Address. The bulk of that speech has been overshadowed by the now-infamous "sixteen words" about Iraq's alleged attempts to obtain uranium. But in that Address, he announced his plan to help combat the global AIDS epidemic,[34] chiefly by providing aid money to twelve countries in Africa, as well as Haiti and Guyana, which have the world's

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[31] *See id.*

[32] *See id.*

[33] *See id.*

[34] The White House's press release concerning the plan can be found online at <http://www.whitehouse.gov/news/releases/2003/01/20030129-1.html> (visited May 1, 2005).

highest rates of HIV infection.[35] However, many of the groups who are already fighting AIDS in those countries and are well-positioned to continue to do so, and thus would likely receive most of the U.S. monies, also provide abortion counseling or abortions themselves as part of their women's health programs.[36] Thus Bush was caught between a rock and a hard place, because even many social conservatives who support his policies on abortion had been suggesting that he unveil a program to curb AIDS in impoverished nations.[37] Bush chose to slightly relax the Mexico City Policy to facilitate his plan on AIDS.[38] Conservative organizations went into a frenzy, saying that "abortion groups" would now be able to "hijack" U.S. tax dollars,[39] that to vote for Bush would be to vote for the butchering of children,[40] and that Bush was "the biggest baby-killing president in U.S. history."[41]

Bush's compromise, however, did not signal a softening of his administration's general policy regarding abortion in developing countries. On March 3, 2005, the Bush

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[35] *See* Religious Tolerance White Paper, *U.S. "Mexico City Policy": Funding Abortion in Foreign Countries*, available online at <http://www.religioustolerance.org/abo_wrld.htm> (visited May 1, 2005).

[36] *See id.*

[37] *See id.*

[38] *See* Richard W. Stevenson, *Bush Eases Ban on AIDS Money to Pro-Abortion Groups Abroad*, New York Times (Feb. 15, 2003) at A5.

[39] See Austin Ruse (of the Catholic Family & Human Rights Institute), *Abortion Groups Seek to Hijack Bush's AIDS Budget*, Feb. 14, 2003, available online at <http://www.newsmax.com/archives/articles/2003/2/13/170624.shtml> (visited May 1, 2005).

[40] *See* Pro-Life News, *A Vote for Baby Butchering Bloodshed* (Feb. 3, 2004), available online at <http://www.covenantnews.com/abortion/archives/004582.html> (visited May 1, 2005).

[41] This distinction was derived by counting the entire $15 billion in foreign aid for the AIDS epidemic as "abortion funding." *See* the third link on <http://www.covenantnews.com/abortion/archives/004580.html> (Feb. 3, 2004) (visited May 1, 2005). *See also* Chuck Baldwin, *Bush Betrays Pro-Life Cause Again, Backs Federal Aid to Overseas Abortion Providers*, (May 2, 2003) available online at <http://covenantnews.com/baldwin030502.htm> (visited May 1, 2005).

Administration reiterated its belief that the Beijing Declaration did not call for abortion to be viewed as an international human right.[42] The Beijing Declaration,[43] composed at the UN's 1995 Fourth World Conference on Women,[44] stated that "We are convinced that . . . [t]he explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment."[45] The conference's Platform for Action states that "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 from coercion, discrimination and violence."[46] Furthermore, "In most countries, the neglect of women's reproductive rights severely limits their opportunities in public and private life, including opportunities for education and economic and political empowerment. The ability of women to control their own fertility forms an important basis for the enjoyment of other rights."[47] The Platform also recognizes that "Unsafe abortions threaten the lives of a large number of women; . . . it is the poorest and youngest who take the highest risk."[48] The suggested remedy is "improved access to adequate health-care services, including safe

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[42] *See* Catholic Exchange, *United States Presses Ahead with Anti-Abortion Amendment at UN; also, US Amendment to UN Beijing +10 Document Fails to Achieve Consensus* (March 9, 2005), available online at <http://www.catholicexchange.com/vm/index.asp?vm_id=26&art_id=27744> (visited May 1, 2005).

[43] Available online at <http://www.un.org/womenwatch/daw/beijing/platform/declar.htm> (visited May 1, 2005).

[44] The Conference's home page can be found online at <http://www.un.org/womenwatch/daw/beijing/index.html> (visited May 1, 2005).

[45] Beijing Declaration ¶ 17 (cited in note 43).

[46] UN Fourth World Conference on Women Platform for Action, ¶ 96, available online at <http://www.un.org/womenwatch/daw/beijing/platform/health.htm> (visited May 1, 2005).

[47] *Id.* at ¶ 97.

[48] *Id.*

and effective family planning services and emergency obstetric care . . . as well as other methods of their choice for regulation of fertility *which are not against the law* . . . ."[49] Since the adoption of the Beijing Declaration and the Platform for Action, nations have disagreed over whether the two documents implied momentum toward the recognition of abortion rights as universal human rights.[50] Bush's proposed Amendment would explicitly renounce this possibility.[51] The Amendment was defeated because a consensus could not be reached, but most countries are hesitant to accept the responsibilities that would inhere from making abortion an internationally recognized human right.[52] Additionally, "Ms. Kyung-wha Kang of Korea, the Chairperson of the current 49th session of the [U.N.] Commission on the Status of Women, confirmed during the meeting that the Beijing documents created neither new international rights nor the right to abortion."[53]

IV. SUGGESTIONS AND CONCLUSION

The inability to limit family size exacerbates poverty and poor health conditions in developing nations because these families usually cannot afford to properly care for their children. The empirical data from Africa presented here have reinforced this position, and suggest that the world community should attempt to convince African

[49] *Id.* (emphasis supplied).

[50] *See* Catholic Exchange, *United States Presses Ahead with Anti-Abortion Amendment at UN* (cited in note 42). Canada and several European nations, in particular, wanted to interpret the documents as conferring a human right to abortion.

[51] *Id.*

[52] *Id.*

[53] *Id.*

countries to liberalize their abortion laws. Also, the United States should abandon the disastrous “Mexico City Policy” or “gag rule” and instead commit to assisting developing nations implement comprehensive family planning policies.