



## POLICY FORUM: PUBLIC HEALTH

# The Mexico City Policy and U.S. Family Planning Assistance

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On 22 January 2001, George W. Bush revived what Bill Clinton had put to rest 8 years before. With a short memorandum to the director of the U.S. Agency for International Development (USAID), the President reimposed a set of restrictions on overseas family planning programs known as the Mexico City policy (1), named for the United Nations (UN) conference at which the Reagan administration announced the policy.

The policy contains three basic restrictions. First, it withholds USAID family planning grants and technical assistance from foreign nongovernmental organizations (NGOs)—including reproductive health organizations, women's groups, private hospitals and clinics, and health research centers—that, using non-U.S. funds, “perform or actively promote” abortions or conduct research to improve abortion methods. The policy specifically targets foreign NGOs that provide what the memorandum calls “abortion as a method of family planning,” defined as any abortion other than those induced in response to rape, incest, or conditions threatening the life of the woman (2). None of the Mexico City policy restrictions, however, apply to grants to foreign governments.

Second, the Mexico City policy forbids foreign recipient NGOs from lobbying, with non-U.S. funds, for liberalization or decriminalization of abortion or conducting a public information campaign “regarding the benefits and/or availability of abortion as a method of family planning” (2). And third, in countries where abortion is permitted in circumstances other than rape, incest, or life-threatening conditions (3), the Mexico City policy prohibits health workers in USAID-funded NGOs from “actively promoting” abortion as an option or referring women to an abortion provider. Thus, health workers in NGOs accepting U.S. family planning funds are forbidden to take the initiative to counsel women with HIV or other health problems on all legal pregnancy options.

These same health workers may, however, “passively respond” to clients’ specific questions about where to obtain a safe abortion, but only after the counselor has ascertained that the client is pregnant, that she has already decided to have a legal abortion, and the counselor “reasonably believes that the ethics of the medical profession in the country require a response regarding where it may be obtained safely” (2).

If the United States were a minor donor to international reproductive health efforts, its actions might be of little consequence.



**The immediate closing of two reproductive health centers, including the pictured clinic in Mathare Valley, a Nairobi slum, was announced by the organization Marie Stopes Kenya (M.S.K.). According to M.S.K., these closures are the result of a funding shortfall experienced when M.S.K. was dropped from a family planning project, sponsored by USAID, for declining to agree to Mexico City policy restrictions.**

However, it remains the largest single donor to what the UN categorizes as international population assistance, accounting for about 43% of all primary funds in that category (4), which includes aid to programs in family planning, maternal and child care, and sexually transmitted diseases including HIV/AIDS (5).

## Point and Counterpoint

The language of the President’s memorandum implies that the policy is being restored as a means of keeping U.S. family planning aid from paying for abortions and activities that promote abortions. Opponents of the policy, however, point out that since 1973, an amendment to the Foreign Assistance Act (referred to as the Helms amendment) has prohibited the use of U.S. family planning

funds for abortion overseas. A later amendment prohibits the use of these funds for biomedical research on abortion methods; a current provision of federal appropriations legislation for foreign operations prohibits direct funding of lobbying to alter abortion laws in foreign countries (6). The Mexico City policy, opponents say, tramples on the rights of local NGOs by imposing restrictions not only on the NGOs’ use of U.S. funds, but also on the activities that they carry out with their own funds. In reply, proponents contend that, because grants are fungible, the restrictions are needed to end indirect U.S. support of abortion services and lobbying activities seeking to overturn abortion laws of foreign governments (7).

Opponents of the policy assert that, in USAID-program countries where abortion is permitted under a wider range of circumstances than the policy permits (including India, Bangladesh, South Africa, Ghana, Jordan, Russia, and other former Soviet states), the Mexico City policy forces the most competent and affordable private family planning providers to close their abortion services or become ineligible for USAID funding. In these situations, opponents argue, the policy compels women seeking an induced abortion to use government services that often offer lower quality of care, or to use private providers not supported by USAID, who, after inducing abortion, are often unable to follow up with family planning counseling and an adequate choice of contraceptives. Opponents allege that where trained abortion providers are unavailable, women may resort to employing unsafe providers or to self-induced abortion. Opponents also contend that, in all USAID-program countries, the policy creates an atmosphere of fear and overcautiousness that discourages NGOs from providing post-abortion care (treating botched and septic abortions), and stifles research, discussion, and dissemination of data concerned with unsafe abortion.

The policy’s opponents also charge that the Mexico City policy guidelines on counseling and referrals are ambiguous and unworkable in the countries where abortion is permitted under a wide range of circumstances and therefore put women’s lives at risk. According to the American College of Obstetricians and Gynecologists, these restrictions “violate basic medical ethics by jeopardizing a health care provider’s ability

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to recommend appropriate medical care" (8). Other opponents point out that the policy's prohibitions on NGOs' participation in abortion debates would be an unconstitutional infringement on freedom of speech if applied to organizations in the United States (7).

Proponents argue that there is no evidence that the policy significantly affects USAID-funded family planning services or the health of their clients. They point out that more than 350 foreign family planning NGOs agreed to comply with the Reagan-Bush-era Mexico City policy. And, they state, when a similar U.S. policy was applied in fiscal year 2000 (9), only 9 out of more than 450 international and foreign NGOs receiving USAID money for family planning or related reproductive health services refused to comply or indicated their inability to comply (7). Proponents also point out that the current U.S. administration has made clear its intention that the policy's restrictions not restrain foreign organizations from providing post-abortion care (10).

Although passionate arguments (going beyond the scope of this essay) are made on both sides, neither position is well informed by systematic research on the consequences of the policy, including its health consequences for the clients of U.S.-funded family planning NGOs. When the former Mexico City policy (instituted by President Reagan) was in effect, only two empirical studies looked at these consequences. Both surveys collected qualitative data, gathered by interviewing family planning providers, focusing narrowly on the direct effects on NGOs that had agreed to the restrictions. In the first study, a two-person nongovernmental team (11) visited foreign NGOs and governmental officials in 10 countries in 1987 and 1988 (12–14). Then in 1990, a two-person team (15), employed by the USAID-funded Population Technical Assistance Project, visited 49 subproject sites in six developing countries, and published the most carefully documented evaluation of the Mexico City policy to date [hereafter, the Blane-Friedman report (16)].

### Reviewing the Former Policy

Although the Blane-Friedman report found that most of the subprojects visited were not significantly affected by the Mexico City policy, the authors encountered several subprojects in which personnel had, mostly out of overcautiousness motivated by a fear of losing funding, engaged in actions not mandated by the policy. Among these subprojects, staff members reported cases where: clients in medical need were turned away or left uninformed of the health consequences of their conditions; efforts to treat septic abortion were left out of projects or discontinued; physicians who worked at NGOs

were told they could not perform legal abortions at their independent private practices; staff were prohibited from conducting research on the local incidence of abortion, or from discussing abortion in the workplace or at conferences (16).

In their report, Blane and Friedman relayed family planning providers' concerns that "this situation may be having an impact on women's health issues in some cases" [(16), p. 29]. Still, we conclude that the studies as designed were not adequate to fully assess the policy's broad consequences for access to contraceptive or abortion services, much less for women's health. Moreover, neither study looked at the degree to which the previous Mexico City policy did or did not reduce the incidence of induced abortion.

### The Way Forward

Research studies should be undertaken in countries where USAID's family planning program is a major donor to local nongovernmental health providers. Such studies would investigate widely (not just current USAID recipients) to determine the extent of the health and social consequences of the policy.

To help reduce confusion and overcautiousness associated with the policy, U.S. NGOs have developed a short written guide, published in several languages, with examples of what is and is not permitted under the Mexico City policy. But such a minor remedy scarcely mitigates the formidable policy barriers that prevent USAID from addressing unsafe abortion as the serious public health issue that it is. The World Health Organization estimates that there are some 20 million unsafe abortions each year, resulting in more than 70,000 women dying annually, more than 99% of them in the developing world (17, 18).

Although U.S. policy-makers undoubtedly will continue to be deeply divided over policies that affect women's access to safe abortion, there is significant room, and need, for bipartisan agreement on family planning, post-abortion care, HIV/AIDS prevention, and programs for adolescents. Demand for more and broader reproductive health care, not just contraception, is growing. More than 1 billion young people worldwide are entering their childbearing years, many not fully aware of the risks of sex and reproduction. We hope that President Bush, in pursuing his goal to "find common ground to reduce the number of abortions" (19), is serious about continuing to support what public health experts conclude are the only strategies proven effective in reducing the demand for abortion: improving couples' access to family planning services, and expanding educational and

communications efforts that inform adults and adolescents about reproductive risks, responsibilities, and contraceptive choice.

### References and Notes

1. G. W. Bush, "Memorandum for the administrator of the United States Agency for International Development" (The White House, Washington, DC, 22 January 2001); available at [www.whitehouse.gov/news/releases/2001/01/23-5.html](http://www.whitehouse.gov/news/releases/2001/01/23-5.html).
2. "Contract Information Bulletin (CIB) 01-03: Voluntary population activities: Restoration of the Mexico City Policy" (USAID, Washington, DC, 16 February 2001); available at [www.usaid.gov/procurement\\_bus\\_opp/procurement/cib/1010216-95052.27658.shtml](http://www.usaid.gov/procurement_bus_opp/procurement/cib/1010216-95052.27658.shtml).
3. This includes physical health, mental health, or socioeconomic grounds, in cases of fetal impairment, without restriction as to the reason, or under the title of menstrual regulation. Menstrual regulation is the aspiration evacuation of the uterus, legally permitted in some countries within 8 to 12 weeks of the last menstrual period [see A. Rahman, L. Katzive, S. K. Henshaw, *Int. Fam. Plann. Perspect.* **24**(2), 56 (1998)].
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6. *Legislation on Foreign Relations Through 1999*, Section 104 (f) (1, 3, and notes) of the Foreign Assistance Act of 1961, as amended (P.L. 87-195), (U.S. Senate, U.S. House of Representatives, Washington, DC, March 2000), pp. 36–37.
7. *Congressional Record: House of Representatives* **147**(67), H2189 (16 May 2001).
8. R. W. Hale, letter to U.S. congressional representatives on behalf of the American College of Obstetricians and Gynecologists, 4 May 2001.
9. As part of compromise legislation paying a portion of UN arrears, in 1999 President W. J. Clinton signed appropriations legislation for fiscal year 2000 that included restrictions similar to the Mexico City policy, but without the policy's counseling restrictions.
10. "The Mexico City Policy" (Office of the Press Secretary, The White House, Washington, DC, 22 January 2001); available at [www.whitehouse.gov/news/releases/2001/01/23.html](http://www.whitehouse.gov/news/releases/2001/01/23.html).
11. S. Camp (Population Crisis Committee) and J. M. Paxman (Pathfinder International), both from U.S.-based NGOs, conducted interviews in Kenya, Turkey, India, Bangladesh, Thailand, Indonesia, Nigeria, Mexico, Brazil, and Colombia.
12. S. Camp, *N.Y.U. J. Int. Law Politics* **20**, 35 (1987).
13. "Impact of the Mexico City Policy on Family Planning Programs and Reproductive Health Care in Developing Countries," (Population Crisis Committee, Washington, DC, 1988).
14. J. M. Paxman, unpublished reports and synopses of interviews.
15. J. Blane, a diplomat, and M. Friedman, a public health analyst, conducted their survey in Turkey, Bangladesh, Kenya, Egypt, Pakistan, and Brazil.
16. J. Blane, M. Friedman, "Mexico City policy implementation study" (Occasional paper 5, Population Technical Assistance Project, Washington, DC, 1990).
17. J. Sioncke, F. Donnay, *Maternal Mortality Update 1998–1999* (U.N. Population Fund, Geneva, 2001).
18. Division of Reproductive Health, "Unsafe abortion: Global and regional estimates of incidence of and mortality due to unsafe abortion with a listing of available country data" (WHO/RHT/MSM/97.16, World Health Organization, Geneva, 1998).
19. "The first 2000 Gore-Bush presidential debate: 3 October 2000" (Commission on Presidential Debates, Washington, DC, 2000), comment by G.W. Bush, [www.debates.org/pages/trans2000a.html](http://www.debates.org/pages/trans2000a.html).
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