

Unit 6

Reproductive Choices: Make the Global Connection

The number of women and adolescents worldwide lacking access to information about family planning and reproductive health services is probably in the hundreds of millions – much higher than official United Nations estimates. According to 1997 United Nations Population Fund (UNFPA) estimates, this number is around 150 million women. Population Action International reports this number is more than 350 million women. In the year 2000, nearly 3.5 million deaths in the world stemmed from poor or nonexistent reproductive health services (UNFPA). In addition, the Alan Guttmacher Institute estimates that of 210 million pregnancies each year, at least 62-80 million are unintended and 46 million result in abortion. Out of 514,000 childbirth or pregnancy-related deaths each year, some 80,000 result from complications of unsafe, mostly illegal abortion (PAI, “A World of Difference” 2001). Some experts place the number of deaths due to botched illegal abortions much higher, at 200,000 per year.

Much of the data collected on family planning and reproductive health services in poor countries applies to married women and ignores adolescents and unmarried women. Many poor countries have inadequate health information reporting systems. Where abortion is illegal, the level of injury and death from unsafe abortion is often grossly underreported.

At the 1994 United Nations Conference on Population and Development, 179 countries agreed that \$17 billion per year would be required to provide universal comprehensive reproductive health care services for women around the world, including family planning. By the year 2015, \$22 billion per year would be required. Up to 2/3 of this money was expected to come from developing countries. While developing countries are providing most of their share of needed resources, support from international donors is less than half of the \$5.7 billion called for in 2000. In addition, the 1994 estimates only included modest resources needed for HIV/AIDS prevention, leaving a significant gap in funding for the treatment of people living with AIDS because of the rapidly advancing epidemic in developing countries (UNFPA, “State of the World Population” 2000).

This unit gives an overview of women’s access to contraception, safe and legal abortion, and a range of reproductive health services in different countries. The Action section provides suggestions on how you can help women around the world gain access to contraception, safe and legal abortion, and other reproductive health care services.

Women in Industrialized Countries Have High Access to Reproductive Health Services

Reproductive choice includes: the right of sexually active persons to choose with whom, when, and how often to engage in sexual activity; how many children to have, when to have them, and the freedom from

diseases associated with sexual activity as well as freedom from sexual violence. Generally, women in industrialized countries face the lowest risk from voluntary sexual activity and childbearing. In the richer countries of the world, women have:

- relatively high access to, and usage of, modern contraception

- a variety of contraceptive methods available
- the right to have an abortion.

ACCESSIBILITY AND USE OF CONTRACEPTION

An estimated 228 million women – 1 in 6 – who want to delay or cease childbearing do not have access to contraceptive methods (UNFPA, “Safe Motherhood” 2002). Most women in industrialized countries have access to and use a wide range of contraception. **Access to a range of contraceptive options is an important determinant of women’s use of contraception and, ultimately, to women’s exercise of reproductive choice.** A high percentage of women use contraception in industrialized countries. Germany, New Zealand, Spain, Sweden, Switzerland, and the United States rank among the highest of industrialized countries in the range of methods available to women.

Though contraceptive use is high in many industrialized countries, the available methods or access may be limited. In Japan, sex education in schools is minimal as is the choice of contraceptive methods. Until recently, oral contraceptives (“the pill”) were banned. They are now only permitted to be prescribed for therapeutic purposes, but in actuality are used as birth control. The law for “The Protection of Mothers’ Bodies” strictly regulates family planning workers who supply contraceptives. In Greece, injectable contraceptives such as Depo Provera are not available. Also, though sterilization is widely available in the richer countries, its access is limited in the Czech Republic, Finland, France and Italy. And, the IUD is no longer widely available in the United States. In Estonia, modern contraceptives are widely available, but use remains low as access to quality contraceptives is very expensive

(International Planned Parenthood Federation, “Country Profiles” 1999).

Furthermore, some industrialized countries have poor access to contraception. For example, Albania and Romania had extreme restrictions on access to contraception until the early 1990s. As a result, **women in Eastern Europe, the former Soviet Union and Southern European countries such as Greece and Hungary have used abortion as their primary form of contraception.**

Suspicion toward modern methods of contraception, as well as lack of high-quality, low-cost contraceptives, contribute to persistently low rates of contraceptive use in the former Soviet Union and many Eastern European countries. In the 1970s and 1980s, negative Soviet government sentiment toward hormonal contraceptives such as the Pill made women suspicious of this and other modern contraceptives. To this day, some women in the former Soviet Union feel that abortion is preferable to modern contraception. A survey of contraceptive use found that only 22 percent of women ages 15-49 in the Russian Federation used contraception on a regular basis (United Nations, “Abortion Policies” 56). Because of the Japanese government’s restrictions concerning the pill, many Japanese women are skeptical about its safety (International Planned Parenthood Federation, “Country Profiles” 1999).

Access to contraception is not enough; education is necessary as well. Unfortunately, the United States lags far behind other countries in sex education, and its teen pregnancy rates illustrate the cost of this gap. In France, where national campaigns promote contraceptive use – including among teenagers – abortion rates among adolescents are only 10.2 per 1000 compared to 29.2 in the U.S.; adolescent pregnancy rates in France are 20.2 per

1000 compared to 83.6 in the U.S. (Alan Guttmacher Institute, 2001).

FEW INDUSTRIALIZED COUNTRY GOVERNMENTS SUBSIDIZE CONTRACEPTIVE COSTS

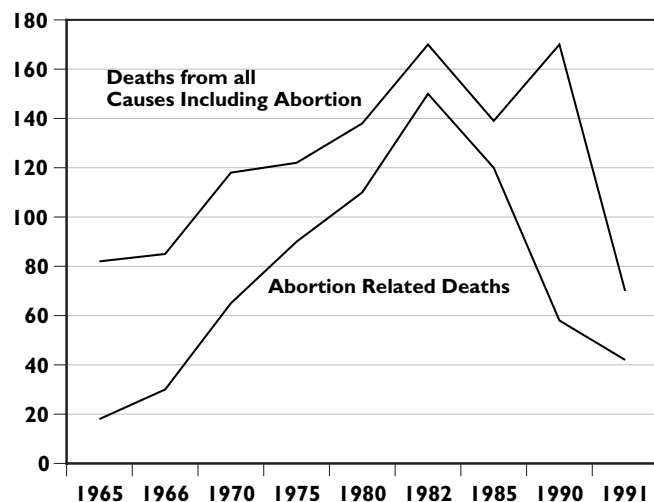
Some industrialized country governments partially subsidize contraceptives. Until recently, Sweden (Persson et al 12) and the Netherlands (Doppenberg 8) subsidized oral contraceptives. For Czech women, oral contraceptives manufactured in the Czech Republic are completely reimbursed by health insurance, as is IUD insertion. Imported oral contraceptives are only partially covered, and imported IUDs must be purchased by the woman from a pharmacy and are not covered at all by insurance (Uzel et al). In Bulgaria, most contraceptives are imported and in irregular supply, and therefore expensive; abortion is free for teenagers, students and poor women. As a result, Bulgarian women often choose abortion over modern contraceptives (Chernev et al 13). The French national health insurance system reimburses women for certain contraceptives and not others. The cheapest brands of oral contraceptives are reimbursed; IUDs and diaphragms are partially reimbursed, and condoms and spermicides are not reimbursed (Coulet 15).

SAFE AND LEGAL ABORTION SAVES LIVES

Study after study has shown that providing safe abortion is a key factor in reducing maternal mortality (Cohen 4). Thirteen percent of maternal deaths can be attributed to unsafe abortions coupled with lack of skilled follow up (UNFPA, "State of the World Population" 1997). Abortion is legal and available in most industrialized countries (See Chart 2). This, combined with the fact that contraception and gynecological services are accessible, contributes to the much lower maternal mortality rates compared to

countries where abortion is restricted. A few industrialized countries still restrict a woman's right to abortion. In Turkey, abortion upon request is legal in the first ten weeks. Turkey is the only European

Chart 1 ■ Maternal Mortality in Romania 1965-1991
Deaths per 100,000 live births



Source: Adapted from Stephenson et. al. using Romanian Ministry of Health data in *The 1993 World Development Report: Investing in Health*. Washington, DC: The World Bank, 1993.

country where married women must obtain their husband's consent to have an abortion (Unalan et al 33). Poland, Portugal, Spain, Switzerland, the Republic of Ireland, Northern Ireland, Cyprus, and Israel still have considerable restrictions on abortion (International Planned Parenthood Federation, "Choices" 2000). In Germany, a woman must undergo counseling provided by the Catholic church before having an abortion (International Planned Parenthood Federation, "Choices" 2000).

Countries that greatly restrict abortion and contraception have high numbers of maternal deaths. In 1966, the government of Romania banned abortion and contraception. By 1989 Romania's maternal

mortality rate was ten times that of most other European countries. On average, Romanian women had undergone five illegal abortions by age 40 (UN, “Abortion Policies” 52). When a new Romanian government legalized abortion and contraception in 1990, the percentage of maternal deaths from unsafe abortion

went from 90% to 60% within that year (World Bank 86).

Strong restrictions on abortion and contraception in Albania until 1991 translated into over 50% of maternal deaths due to self-induced abortions. Within one year of liberalizing the law, the number of deaths from illegal abortions in Albania

dropped from 3,130 to about 300. Though abortion is now legal in Albania, contraception is still scarce or too costly, and therefore only used by 10% of women (Population Action International, “A World of Difference” 2001). Most women use abortion as their primary method of family planning (Sahatchi 20).

Parental consent laws exist in much of Europe but the age limit varies: Austria (14); Czech Republic, Greece, Norway (16); Denmark, Italy, Moldova, Norway, Romania, Portugal, Sweden, Turkey (18). Only Denmark, Italy and Norway offer minors a bypass procedure through a court or hospital (International Planned Parenthood Federation, “Choices” 2000).

The costs of obtaining abortions vary in the industrialized world. Though countries such as Netherlands (Ketting) and Turkey (Unalan et al 35) offer free and low-cost abortions, women in most of the industrialized world pay the partial or full cost of the abortion.

In countries where abortions were once provided free through a national health

Chart 2 ■ Contraceptive Use, Abortion Policies and Maternal Deaths in Industrialized Countries

Country	Women Receiving Prenatal Care	Percentage of Women Using Contraceptives	Abortion Policy	Maternal Deaths per 100,000 Births
Italy	100%	91%	Available on request	12
Denmark	100%	78%	Available on request	9
Norway	99%	74%	Available on request	6
Sweden	100%	78%	Available on request	7
Belgium	90%	79%	Available on request	10
Netherlands	95%	79%	Available on request	12
France	99%	75%	Available on request	15
Australia	100%	76%	Permitted on broad social & health grounds	9
Singapore	100%	74%	Available on request	10
Canada	100%	75%	Available on request	6
Finland	100%	78%	Permitted on broad social & health grounds	11
Austria	100%	51%	Available on request	10
United Kingdom	99%	82%	Permitted on broad social & health grounds	9
Japan	99%	59%	Permitted on broad social & health grounds	18
Singapore	100%	74%	Available on request	10
Hong Kong	N/A	86%	Permitted on limited health grounds	4
United States	96%	76%	Available on request	12
Spain	96%	80%	Permitted on limited health grounds	7
Germany	98%	75%	Available on request	22
Switzerland	99%	71%	Permitted on limited health grounds	6
Portugal	95%	66%	Permitted on limited health grounds	15

Source: *Reproductive Risk: A World-wide Assessment of Women's Maternal and Reproductive Health*, Washington, DC: Population Action International, 1995.



system, women are increasingly footing the bill for abortion as health systems become privatized (Ketting 5). In the Baltic republics of Estonia, Latvia and Lithuania, where abortion was once provided free of charge, women have had to pay part of the costs since 1994 for abortions performed on nonmedical grounds. In the Czech Republic, abortions that were once provided free during the first eight weeks of pregnancy now cost K1,200 to K2,800 (the average monthly salary is K5,700). In Estonia, money collected from women having abortions goes to making contraception accessible to specific groups of women (Karro et al 14-16).

Countries such as Austria and Lithuania only cover abortion for medical reasons; Bulgaria only after sexual assault; and Israel only when the woman is a minor (International Planned Parenthood Federation, "Choices" 2000).

Refusal by medical personnel to provide abortions also creates financial barriers for women. Though abortion in the first trimester is legal in Austria, many clinics and hospitals refuse to perform them, so most women are forced to seek abortions from private practitioners. Austrian women pay the equivalent of 29% of their monthly salary for abortions, which are not covered by the National Health Service (Pracht 10).

The French Ministry of Health sets the prices of abortions at \$170-\$230 plus any required medical tests and reimburses 80% of the cost. Unfortunately, many women, particularly in large cities,

have difficulty finding clinics or hospitals that charge these low rates. Therefore they must turn to private organizations such as the Movement Francais pour le Planning Familial which offer abortion services and contraceptives at the government rates and free of charge to women under 18 (Coulet 15).

Where abortion is restricted, the costs of the procedure escalate. A woman from Northern Ireland spends \$900-\$1200 to travel to England to procure an abortion, making abortion financially inaccessible to many (Simpson 7). **And though legalizing abortion is an important step toward**

Chart 3 ■ Contraceptive Use, Abortion Policies and Maternal Deaths in Eastern Europe and Former Soviet Republics

Country	Percentage of Women Using Contraception	Abortion Policy	Maternal Deaths per 100,000 Births
Czech Republic	45% (1990-1996)	Available on Request	15 (1990-1996)
Slovakia	67% (1995)	Available on Request	10 (1995)
Bulgaria	8% (1990-1996)	Available on Request	27 (1990-1996)
Hungary	64% (1990-1996)	Permitted on broad social & health grounds	30 (1990-1996)
Poland	26% (1990-1996)	To save the life of the woman, preserve physical health, fetal impairment and in cases of rape and incest	19 (1990)
Slovenia	66% (1990)	Available on Request	13 (1990-1996)
Romania	57% (1990-1996)	Available on Request	83 (1990)
Russian Federation	22% (1994)	Available on Request	51 (1994)
Republic of Moldova	16% (1994)	Available on Request	44 (1994)
Tajikistan	15% (1994)	Available on Request	120 (1994)
Turkmenistan	12% (1994)	Available on Request	134 (1994)
Kazakhstan	22% (1994)	Available on Request	67 (1994)

Data obtained from: *The State of World Population 1997*, New York, NY: United Nations Population Fund, 1997; *UNICEF State of the World's Children, 1997*, New York, NY: UNICEF, 1997; *Abortion Policies: A Global Review Volume III, 1995*, New York, NY: United Nations, 1995; *Reproductive Risk: A World-wide Assessment of Women's Maternal and Reproductive Health*, Washington, DC, Population Action International, 1995.

Chart 4 ■ Chance of a Woman Dying from Complications of Pregnancy, Childbirth or Unsafe Abortion During Her Lifetime

Country	Likelihood of Dying
Italy	1 in 17,361
Norway	1 in 15,432
Australia	1 in 8,772
United States	1 in 5,669
Poland	1 in 3,608
Cuba	1 in 1,286
China	1 in 439
Zimbabwe	1 in 217
Mexico	1 in 131
India	1 in 59
Kenya	1 in 31
Mali	1 in 7

Source: Population Action International, *Reproductive Risk Report Card*, 1995.

getting women access to abortion, physical and financial access are critical to ensuring that women obtain abortions under safe and sanitary conditions. For example, in Belgium, where abortion was legalized only in 1990, some women still travel to the Netherlands because the closest clinic is there or because their doctor is unwilling to carry out the procedure (Vrancken 23).

Between 1985 and today, several industrialized countries have liberalized their abortion policies including: Taiwan (1985), Greece (1986), Canada (1988), Malaysia (1989), Belgium (1990), Romania (1990), Albania (1991), Hungary (1992), and Nepal (2002). In addition, the past 5 years have seen a few developing countries legalize abortion for limited health reasons (PAI, “A World of Difference” 2001). Meanwhile

attempts have been made to restrict legal abortion in countries with previously liberal policies, such as the Czech Republic, El Salvador, Poland, and the United States. (Henshaw, “Factors Hindering Access” 5).

WOMEN IN DEVELOPING COUNTRIES HAVE FEW REPRODUCTIVE CHOICES

For women in the poor countries, low access to reproductive health services is the

Chart 5 ■ Women’s Unmet Need for Contraception in Selected Developing Countries*

Country	Number of Married Women with Unmet Need for Contraception
ASIA	
India (1992)	31.0 million
Pakistan (1990-1991)	5.7 million
Bangladesh (1994)	4.4 million
Phillipines (1993)	2.5 million
AFRICA	
Kenya	1.1 million
Tanzania	1.06 million
Nigeria	3.9 million
NORTH AFRICA/MIDDLE EAST	
Egypt	1.8 million
Turkey	1.0 million
LATIN AMERICA	
Brazil (1986)	3.0 million
Mexico (1987)	3.1 million

Source: “Meeting Unmet Need: New Strategies.” *Population Reports Series J*, No. 43, Baltimore: Johns Hopkins School of Public Health, Population Information program, 1996.

*In many developing countries, researchers are restricted to collecting data on contraceptive use by married women because of government policies or cultural conservatism.

norm and a high risk of illness and death from pregnancy and childbearing is a fact of life. One in every 16 African women will die from a pregnancy-related cause. A woman in Mali, West Africa, has a 1 in 7 chance of dying in childbirth compared to a woman in the United States whose probability is 1 in 5,669. In Zaire, Angola and Somalia, for example, less than 10 percent of women use any method of contraception. Abortion is illegal or permitted only to save a woman's life, and more than one-fifth of 15-19 year olds give birth each year. Moreover, women have an average of six to seven children, and a woman has a greater than 1 in 20 lifetime chance of dying in childbirth. Additionally, 10-21% of women in poor countries are infertile in large part due to the high rate of untreated sexually transmitted infections (STIs) in these populations (Population Action International, "Contraceptive Choice").

THE UNMET NEED FOR CONTRACEPTIVES IS LARGE IN POOR COUNTRIES

In developing countries, hundreds of millions of women have an unmet need for contraception, which means they would like to be using contraception, but for some reason, are not. Family planning programs established in the last 35 years have helped women access contraceptives, and have increased contraceptive use ten-fold, from less than 10% to more than half among women in some poor countries, who now have half as many children. Many of these programs offer contraceptives free or subsidized. Still, lack of information and physical access to services, limited contraceptive choices, resistance from male sexual partners, fear of contraceptive side effects, and poor quality of care at family planning clinics, have deterred women from ultimately using contraceptives (Population Action International, "A World of Difference" 2001).

Additionally, conservative attitudes have meant that **most family planning services have been made available only to married women**, leaving unmarried women and adolescents largely ignored (Johns Hopkins University, "Meeting Unmet Need" 5). And countries restrict contraceptive access in other ways. Fourteen countries require spousal consent for impermanent methods of contraception and 60 countries require spousal authorization for sterilization. Fifty-six countries restrict sterilization based on age and 50 countries restrict sterilization in families below a specific size (UNFPA, "The State of the World Population" 34).

While responsibility for family planning continues to be thrust upon women, their low status prevents them from exercising reproductive choice. Women often cannot ask their partners to use condoms. Since most women in poor countries do not have access to antibiotics and modern health care facilities, STIs are the second highest burden of disease for these women of reproductive age (15-44) after maternal mortality and morbidity (illness) (UNFPA, "The State of the World Population" 20).

Women worldwide are biologically more susceptible to contracting STIs than are men because women's genital tissues are more sensitive. Seventeen to 40 percent of gynecological admissions to hospitals are due to pelvic inflammatory disease (PID). Two hundred-fifty thousand new cases of cervical cancer are diagnosed worldwide each year, and are caused by human papillomavirus (HPV), a sexually transmitted virus. Women constitute 19.2 million of the 42 million HIV-infected adults worldwide, the majority of whom live in poor countries (World Health Organization, 2002). According to Kofi Annan, Secretary General of the United Nations, women make up 58% of those living with HIV in Africa. Today, AIDS has a woman's face.

Chart 6 ■ Reproductive Health Data for Selected Developing Countries

Country	Percent of Women Using Contraception	Abortion Policy	Number of Maternal Deaths per 100,000	Average Births per Woman
Zaire	8%	Illegal or permitted only to save a woman's life	800	6.7
Angola	2%	Illegal or permitted only to save a woman's life	650	6.6
Somalia	5%	Illegal or permitted only to save a woman's life	1100	7.0
Mali	5%	Illegal or permitted only to save a woman's life	1750	7.1
Tanzania	10%	Illegal or permitted only to save a woman's life	342	6.3
Kenya	33%	Illegal or permitted only to save a woman's life	500	5.4
Nigeria	6%	Illegal or permitted only to save a woman's life	800	6.5
South Africa	50%	Permitted on limited health grounds	84	3.8
Haiti	10%	Illegal or permitted only to save a woman's life	500	5.8
Cuba	70%	Available on request	36	1.8
Argentina	66%	Permitted on limited health grounds	140	2.9
Nicaragua	49%	Illegal or permitted only to save a woman's life	300	4.6
Honduras	47%	Illegal or permitted only to save a woman's life	221	5.2
Venezuela	49%	Illegal or permitted only to save a woman's life	200	3.6
India	41%	Permitted on broad social & health grounds	420	3.4
China	83%	Available on request	95	2.0
Pakistan	12%	Permitted on limited health grounds	600	6.1
Bangladesh	40%	Permitted on broad social & health grounds	640	4.4
Afghanistan	2%	Illegal or permitted only to save a woman's life	640	6.9
Jordan	40%	Permitted on limited health grounds	40	5.6
Lebanon	55%	Illegal or permitted only to save a woman's life	128	2.9
Israel	65%	Permitted on limited health grounds	3	2.9
Iraq	14%	Permitted on limited health grounds	117	5.7

Source: *Reproductive Risk: A Worldwide Assessment of Sexual and Reproductive Health*, Washington, DC: Population Action International, 1997.

MOST DEATHS FROM UNSAFE ABORTION OCCUR IN POOR COUNTRIES

When pregnancy results from contraceptive failure or not using contraception, safe abortion is largely unavailable as a backup method. In Africa, one in every 150 abortions leads to death while only 1 in every 85,000 abortions does so in the developed world. An estimated 36 million abortions take place in the developing world. Twenty million of these abortions are carried out in illegal and unsafe conditions, dramatically increasing the risk of infection, illness or death (PAI, “A World of Difference” 2001). **Abortion is illegal in most poor countries.** Of the estimated 80,000 deaths from unsafe illegal abortions worldwide, over three-fourths occur in developing countries. However, experts agree that this figure is a great underestimate (Johns Hopkins University, “Saving Women’s Lives” 1). Studies of women treated in hospitals for abortion complications in Nigeria and Bolivia show that only 7-10% of these women had ever used contraception, though 45-77% would have preferred to (UNFPA, “The State of the World Population” 23). Some poor countries such as Ethiopia, Kenya, Nigeria, and South Africa have recently liberalized their abortion laws (IPPF, “Country Profiles” 1999).

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For women to exercise reproductive choice, legalizing abortion alone is insufficient – abortion services must also be physically accessible and affordable. Even in countries such as India and Bangladesh, where abortion is legal, there are a high number of illegal, unsafe abortions because many women live too far from abortion services or cannot afford the cost (World Bank 93).

NATIONAL FAMILY PLANNING PROGRAMS SHOW MIXED RESULTS

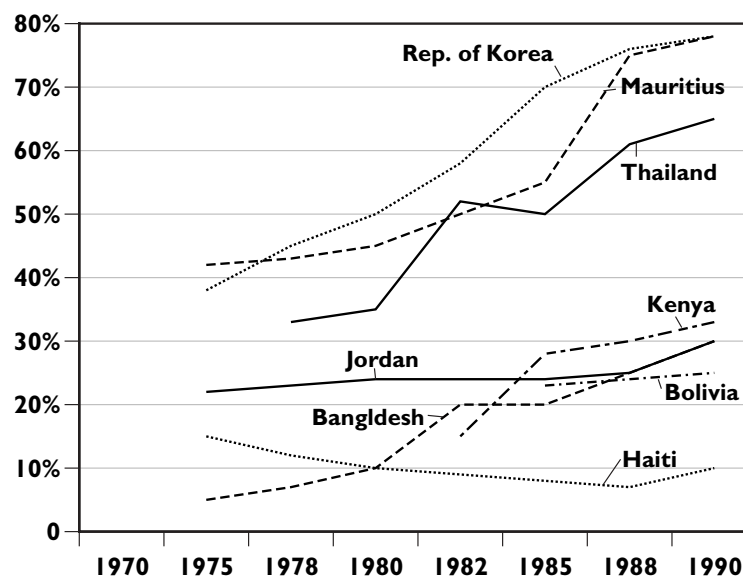
Strong political leadership coupled with adequate access to family planning services, including an array of contraceptive choices and access to safe abortion have led to higher contraceptive use, lower birth rates, and improved reproductive health for women in Thailand, Indonesia, Singapore and Malaysia. Countries such as India (Conly and Camp, “India’s Family Planning Challenge” 28) and Pakistan (Conly and Rosen, “Pakistan’s Population Program” 10-11) that used heavy-handed, coercive approaches to increasing women’s use of contraception, paid a large price in terms of women’s health and confidence in public policy. Financial incentives and punitive measures used to enforce China’s 1979 one-child population policy have long been criticized (Conly and Camp, “China’s Family Planning” 25-26). The family planning programs in India, Pakistan and China described above were primarily concerned with reducing population growth rates, rather than promoting health and

reproductive choice for women. Only since the 1994 International Conference on Population and Development have family planning programs been designed with women’s rights and the exercise of reproductive choice in mind, an approach that will perhaps herald more success stories from poor countries in the future.

FUNDING FOR FAMILY PLANNING AND REPRODUCTIVE HEALTH FOR DEVELOPING NATIONS HAS INCREASED, BUT STILL FALLS FAR SHORT OF NEED

Although developing countries pay for at least two-thirds of their own family planning costs, they greatly benefit from outside funding from richer countries, multilateral organizations (such as the World Bank) and foundations to carry out programs that increase women’s access to contraception and reproductive health. This type of family planning assistance over the last 30 years has increased use of

Chart 7 ■ Percentage of Women Using Modern Contraceptives in Selected Countries



Source: The World Development Report, 1993.

modern contraceptives in developing countries from 10% to 50% (World Bank).

At the 1994 International Conference on Population and Development (ICPD), women's human rights were put at the center of population programs, and over 180 nations agreed that \$17 billion was required annually to provide contraceptives and comprehensive reproductive health care for women and men worldwide. Two-thirds of the money, or \$11.3 billion, would come from developing countries and one-third (\$5.7 billion) would come from donor countries (UN, "International Conference").

In 1995, several industrialized donor countries, including Australia, Denmark, Germany, the United Kingdom, and the Netherlands, increased their funding for population programs. A total of \$2 billion was raised – \$3.7 billion short of the \$5.7 billion goal. And since 1995, the trend has been for donors to decrease their contributions (UNFPA, "Coming Up Short" 2).

Conservatives in U.S. Congress Limit Population Assistance

The United States government contributes to funding family planning services in developing countries in Asia, Africa, Latin America and the Newly Independent States (of the former Soviet Bloc) through the United States Agency for International Development. The United States also contributed directly to the United Nations Population Fund until the White House blocked the U.S.'s annual \$34 million contribution to the UNFPA in 2002. The United States began funding overseas family planning programs in the late 1960s with a contribution of \$10.5 million between 1965-1967. By 1995, the United States contribution had reached \$582 million (3.42% of the \$17 billion requirement) (PAI, "Contraceptive Choice").

The tide turned in 1994 when a Republican-dominated Congress attempted

unsuccessfully to reduce population assistance by as much as 65% and to impose restrictions on population aid recipients who were using their own funding to provide abortion counseling and services. Between 1995 and 1996, Congress slashed family planning funding for USAID by 35%, from \$582 million to \$378.8 million. **This may sound like a lot of money, but in fact is just 0.02% of the total U.S. budget.** This reduction in funding meant that seven million couples worldwide would be left without access to modern contraception and four million women would have unwanted pregnancies, resulting in 1.6 million abortions, 8,000 women dying in pregnancy and childbirth, and 134,000 infant deaths (Alan Guttmacher Institute).

In 1973, the same year that abortion was legalized in the United States, conservative Congress members, led by long-standing Senate Foreign Relations Committee Chair Jesse Helms (R-NC), joined forces to pass the anti-choice Helms Amendment. This legislation prevents any U.S. international family planning money from funding the provision of abortions, ensuring that the United States Agency for International Development (USAID) does not provide assistance to women seeking abortions. This amendment also set the stage for the passage of the Hyde Amendment in 1977, prohibiting federal funding for abortions in the United States.

In 1984, in an unprecedented move, Ronald Reagan issued the Mexico City Policy, also known as the Global Gag Rule, which prohibited international family planning programs receiving money from the U.S. to provide counseling, information, or referrals about abortion, **even if the funds for those programs were their own or were provided by other countries.** Shortly after taking office, Bill Clinton reversed the Global Gag Rule, allowing family planning



Chart 8 ■ Comparison of Population Assistance By Industrialized Donor Countries

Donor	Total Family Planning Assistance in 1994	Cost per Capita of Donor's Population (1994)
Australia	\$18.0 million	\$1.01
Belgium	\$2.9 million	\$0.28
Canada	\$22.8 million	\$0.78
Denmark	\$32.6 million	\$6.27
Finland	\$7.8 million	\$1.52
France	\$13.4 million	\$0.23
Germany	\$114.8 million	\$1.41
Italy	\$17.5 million	\$0.31
Japan	\$82.7 million	\$0.66
Netherlands	\$43.8 million	\$2.85
Switzerland	\$8.2 million	\$1.18
Norway	\$40.7 million	\$9.47
United States	\$462.9 million	\$1.78
United Kingdom	\$58.0 million	\$0.99

Source: Conly and Rosen, *International Population Assistance Update: Recent Trend in Donor Contributions, 1996*.

programs to provide counseling on a full range of reproductive options.

However, on January 22, 2001, the anniversary of *Roe v. Wade*, George W. Bush reinstated the Global Gag Rule as his first executive order. In public statements, George W. Bush **deceptively** defended this move by claiming that taxpayer funds should not be used to pay for or advocate abortions. In reality, **this funding has been prohibited since 1973**, in accordance with the Helms Amendment. In a strong bipartisan response to President Bush's restoration of the Global Gag Rule, Senator Barbara Boxer (D-CA), Senator Olympia Snowe (R-ME), Representative Nita Lowey (D-NY), and Representative Nancy Johnson (R-CT) denounced Bush's

action and introduced new legislation that would reverse the Global Gag Rule.

With the Global Gag Rule again in place, family planning programs in developing nations receiving U.S. funds that provide a wide range of services, including gynecological exams, AIDS prevention and treatment, and contraception, will be forced to lose U.S. funds or to discontinue providing vital services, such as counseling, referrals, or information about abortion, formerly paid for by other sources. With no other option, young women in developing nations will turn to illegal, unsafe abortions, too many of them dying as a result of punctured wombs or serious infections.

The Global Gag Rule not only poses a threat to women's lives, but also restricts freedom of speech. Organizations that receive USAID funding are prohibited from speaking publicly in favor of abortion counseling, abortion referrals, or from lobbying their elected officials for abortion reform. In fact, at a Senate Foreign Relations Committee hearing chaired by Senator Barbara Boxer on July 19, 2001, the head of a non-governmental organization in Peru, Susana Galdos, was forced to seek a temporary restraining order in a New York Federal Court in order to gain the freedom to speak before the committee.

According to the United Nations, an estimated 20 million unsafe, illegal abortions occur annually worldwide, resulting in more than 80,000 young women dying. The Global Gag Rule endangers the health, futures, and lives of millions of women and girls around the world who rely on reproductive health treatment that includes abortion counseling.

MULTILATERAL ORGANIZATIONS AND PRIVATE FOUNDATIONS CANNOT REPLACE GOVERNMENT FUNDING

Multilateral organizations such as the World Bank are becoming a more important

funding source for international family planning. Consider, for instance, that World Bank lending for population and reproductive health to developing countries doubled between 1992 and 1996 to \$600 million (Conly and Rosen, “International Population Assistance” 11). In addition, the UN Population Fund continues to provide substantial financial and technical assistance to developing countries as well as industrialized countries such as Albania and the former Soviet Republics. Private philanthropic funding for population and family planning has increased dramatically in recent years. Foundations such as Rockefeller, Ford, MacArthur, Mellon and Hewlett collectively gave \$117 million to family planning in 1994. However, this \$117 million is just 0.68% of the \$17 billion needed per year to fund comprehensive reproductive health care.

CONSERVATIVE FORCES BLOCK WOMEN’S ACCESS TO REPRODUCTIVE HEALTH CARE

Organized opposition to women’s reproductive rights exists worldwide and enjoys strong support from conservative religious movements and extremist groups. In the 1970s the Catholic Church organized groups in Poland to create and distribute information attacking contraception and abortion (Kozakiewicz 18). Abortion in Poland had been legal since 1956, but in 1990 the Catholic Church asserted its anti-abortion stance publicly. Doctors followed suit in 1992. By 1993, it was virtually impossible to get a legal abortion in Poland. That year, Poland passed a law making abortion illegal except to save the mother’s life or in a case of rape or incest or severe fetal malformation (CRLP 1999). Pope John Paul II has consistently lobbied to keep abortion illegal in Poland, and a 1996 law legalizing abortion – beyond circumstances of rape or incest or when the life of the pregnant women was in danger – was recently overturned by a Polish Court

(International Planned Parenthood Federation). Since that time, Poland has reverted to its restrictive abortion policy. Anti-choice advocates in Russia and the Russian Orthodox Church are calling for restricting abortion in Russia (Borisov et al 24).

Strong ties exist among anti-choice extremists in different countries. Ireland’s anti-abortion movement, which has been active since 1973 when its Supreme Court gave married couples the right to use contraceptives, has strong ties to American anti-abortion groups, which are alleged to have had significant involvement in countering the national referendum to decriminalize abortion in 1991. Nevertheless, Irish pro-choice advocates have managed to make contraception accessible nationwide by establishing family planning centers, and Irish university students helped win a victory in the European Court of Human Rights – the right of Irish women to travel within the European Union to obtain a legal abortion (Riddick 4,5).

Similarly, feminist activists in France have uncovered close ties between French anti-abortion groups such as Treve de Dieu (God’s Truce) and American anti-choice groups which provide strategic and technical assistance. Anti-choice activists in France are also closely linked to the French extreme right wing. Subsequently, France has seen an increase in violent anti-abortion tactics similar to those used in the United States, such as clinic invasions and blockades aimed at closing clinics and doctors offices. Consequently, French activists mobilized to help pass a law in 1993 banning anti-choice activists from physically preventing women’s access to abortion services (similar to the 1994 Freedom of Access to Clinic Entrances Act in the United States). To date, it has not been consistently enforced (Gallard and Gabison 19).

Anti-choice activities from industrialized countries have directly attempted to politi-

cize the abortion issue in some developing countries such as Namibia. This was most apparent at recent United Nations conferences. The Vatican has been one of the strongest and most vocal opponents of women's reproductive rights. Though not a voting member of the United Nations, the Vatican has "permanent observer" status at the United Nations – the only religion with such status – and can participate and vote at United Nations conferences.

At the 1994 United Nations Conference on Population and Development, the Vatican repeatedly tried to block agreement among the over 100 countries present on policy recommendations related to reproductive rights, adolescent sexual health, condom distribution, and abortion. To achieve this, the Vatican attempted to form a strategic alliance with predominantly Catholic and Muslim countries. In addition, the Vatican tried to discourage poor countries from joining other countries in adopting a progressive stance on reproductive health and choice by accusing industrialized country representatives and activists of "cultural imperialism." However, the Vatican failed, and the final Platform for Action emphasized women's equality and reproductive freedom.

The Vatican again disputed the reproductive health sections at the United Nations Fourth World Conference on Women (held in Beijing, China in 1995), but once again failed. The final Platform for Action recognized unsafe abortion as a public health concern and declared that women have the right to control their own sexual and reproductive health. Many activists have since used the victories at Cairo and Beijing to mobilize for improving women's reproductive rights by advocating change in national laws and policies in their individual countries.

WOMEN GAIN LAST MINUTE VICTORY AT GLOBAL EARTH SUMMIT

As the World Summit on Sustainable Development (Earth Summit) in Johannesburg, South Africa drew to a close in September 2002, delegates agreed to add language to the final plan that guarantees access to comprehensive healthcare and reproductive services for women. The issue had become a road block during the last days of the international environmental meeting. Even though negotiations on the final plan were completed, Canadian and European delegates were able to reopen the document to add the 10 words, "and in conformity with all human rights and fundamental freedoms," to a paragraph that promotes the strengthening of women's healthcare.

Canada originally proposed the inclusion of a specific statement on human rights tied to women's healthcare in an effort to prevent such atrocities as female genital mutilation and to safeguard abortion rights. Without this language, countries would be permitted to hide behind traditional customs and laws to vindicate the denial of reproductive services and other healthcare to women – as the Taliban did in Afghanistan, where women were not allowed to go to the hospital, to be treated by male doctors or to work as doctors themselves. Although the wording matches other international declarations on the topic, the addition of the human rights language was opposed by a coalition that includes the United States, the Vatican and conservative Islamic countries.

Executive Director of Women's Environment and Development Organization (WEDO) June Zeitlin exclaimed that after hours of "intense negotiations.... We won, we won," as reported in the Los Angeles Times. "Never underestimate the women of the world."

International Women's Day Celebration

INTRODUCTION

International Women's Day began March 8, 1857 as a day of action among U. S. women who demonstrated against poor working conditions and low wages in the textile industry. During their protest, many women were arrested, and others trampled by the crowds. In 1908, thousands of people in the U.S. marched to honor the 1857 demonstration and once again rallied against unacceptable working conditions and child labor. Following the 1908 march, activists dedicated the last Sunday in February as "National Women's Day." While celebrated in the U.S., the day was not internationally celebrated until 1911, when the theme of the day was "Universal Female Suffrage." That year, people across the globe in the U.S., Germany, Austria, Denmark, and Switzerland all held rallies demanding equal rights and the end of sex discrimination. France, Sweden and the Netherlands joined in the celebration the following year. Finally, in 1977, the United Nations asked all countries to set aside a day to commemorate women's achievements. March 8th was officially designated "International Women's Day," and is celebrated by women and men throughout the world.

As we begin a new century, women around the world still face many challenges. Among the most pressing is a widespread lack of safe and accessible abortion and other reproductive healthcare services. Therefore, this International Women's Day, feminist women and men on campus must rally to protect *Reproductive Choices*.

Hosting an International Women's Day celebration is an excellent way for the Leadership Alliance to share a global pro-choice feminist perspective with your campus and raise awareness about the women's reproductive rights conditions worldwide. One suggestion for the celebration is to host an International Women's Day Fair. A variety of organizations representing women in various parts of the world can sponsor tables at the fair. These groups can feature food, dance, music, and literature about women in their region. Another idea would be to hold an International Women's Day performance. The show would feature musical, theatrical, and dance acts by international groups, which highlight women's contributions and tribulations in various regions of the globe.

PEOPLE POWER AND COMMITTEES

This action calls for participation by members of multicultural, feminist, and pro-choice groups on campus. The idea is to create an International Women's Day celebration committee consisting of a diverse collection of student activists, who can each add a unique international perspective. This coalition should be chaired by 2-4 Leadership Alliance members, and should consist of 6-10 people total.

MATERIALS AND EQUIPMENT

- P.A. system (mic, speakers, stereo system) and other technical equipment needed to broadcast music, announcements, stories, statements, etc. Know in advance what technical or other equipment each participating group needs.
- A Stage (if outdoors) or podium for speakers.
- Tables to set up information about the various groups co-sponsoring the event.
- Movable chairs (both for indoors and out, if possible.)

- Although each group participating will be responsible for buying/preparing its region's food for the event, you will need adequate equipment to display the food. You will need additional tables and banquet trays to hold food and to keep it heated. Check with your cafeteria and food services office to obtain information on reserving or borrowing the necessary equipment.
- Plates, utensils, napkins, paper cups, etc., if you decide to provide international food tasting as part of the celebration.
- Flyers and posters advertising the event and listing all of the groups hosting the event.
- A lot of garbage pails, especially if the event is held outdoors.

TIMELINE

Seek out other groups to participate well in advance (one to two months) of International Women's Day. Depending on the scope of the event, begin meeting with the steering committee at least a month in advance of the event. Make sure to delineate responsibilities among members of the steering committee so that no group is overwhelmed with work, and all feel equally involved.

BUDGET

While this event can be quite costly, this cost can be divided among the many groups co-sponsoring the event. Decide as a group how much each club will donate, and make sure the funds are transferred to the Leadership Alliance account before the event. You do not want to be stuck with all of the bills and no money! Because other groups' funds are involved, the Leadership Alliance treasurer must keep very close track of all expenditures and receipts. If needed, you could seek out additional funding from international centers on campus (see appendices for more fundraising tips). Also, keep in mind that if you have food and refreshments, you could raise money by charging per plate or selling tickets to the event.

PUBLICITY

As usual, the more time you put into publicizing your event, the larger your crowd will be. You will also greatly increase campus awareness on the issues by doing a thorough job. Allow each group co-sponsoring the event to advertise to their own constituency, while also participating in a more general advertising campaign. Try to get local press and campus press to cover the event. Perhaps this is the first time your campus has done anything for International Women's Day? If so, capitalize on this. Call local news stations and inform them that your university is doing its first ever International Women's Day celebration.

HELPFUL HINTS

Building a Coalition of Student Activists

- At least five weeks before your designated date, contact women's groups on your campus (especially international feminist groups). Ask them if they have plans/ideas for International Women's Day. If they do, offer to co-sponsor or participate in the activities. If they have not yet organized any activities, offer to organize and oversee an International Women's Day steering committee of which they would be a part.

- Begin to build your steering committee through well-placed phone calls, personal invitations, and faculty input. Contact feminist faculty in the language departments, African-American Studies, Women's Studies, Ethnic Studies, and International Policy Studies.
- Make sure that your steering committee represents the diversity of women on your campus.

Other Tips

- Depending on the weather, consider setting up portions of the activities outdoors to help draw a larger crowd. Make sure to also reserve space indoors in case of rain.
- Include food, music, storytelling, dance, etc., to make the event exciting and well attended.
- Invite faculty and staff who have had international feminist experiences to participate or speak. A great place to start is with your Global Education Center and the Study Abroad Office.
- Do maintenance, kitchen or cleaning crew workers come from other countries? This could be a great opportunity to get to know these workers and foster positive student/staff relations. (Remember that International Women's Day has its roots in the labor movement, which fights for better working conditions.)
- Also, take advantage of this opportunity to educate participants on the issues of choice that the Leadership Alliance is working on.

Additional Actions

INTERNATIONAL REPRODUCTIVE RIGHTS SPEAKER

Once you have familiarized yourselves with the global reproductive rights perspective included in this unit, take the opportunity to help educate your campus on this issue. By using the same resources listed at the end of this section, you can identify an international pro-choice organization based out of the U.S. Call the organization, inform them about the Leadership Alliance program and your group's pro-choice work, and ask if a representative can come to campus and speak on the subject. Also consider a professor or community member who has done work with such an organization as a potential speaker. (See appendices for more information on getting a speaker to your campus.)

SHOW "ABORTION FOR SURVIVAL"

Produced by the Feminist Majority Foundation, this video examines abortion through an international perspective. A discussion can follow the viewing of this video. Call your Campus Organizer to obtain a copy of the film and the accompanying literature.

INTERNATIONAL PRO-CHOICE EDUCATIONAL CAMPAIGN

Find statistics indicating the number of women who are still dying from illegal abortions overseas. A good place to start is with organizations like the Alan Guttmacher

Institute (which specializes in U.S. and domestic reproductive issues) or International Planned Parenthood.

- Flyer the campus with information on the statistics you have found. Make sure to highlight the fact that abortion is still illegal, inaccessible, and unsafe in most developing countries, and hundreds of thousands of women are dying *each year* from illegal abortions.
- Consider incorporating some important facts from the *Abortion for Survival* video. For example, include statistics that illuminate low teenage pregnancy and abortion rates in countries which have better abortion accessibility, contraceptive availability, and sex education than the U.S..

FIND AN INTERNATIONAL SISTER ORGANIZATION

Take the opportunity to learn about an international women's group that your Leadership Alliance finds particularly interesting or important. One way to initiate the search is to pick a country that your group is interested in learning more about. Once you have chosen a region, begin researching your sister organization. Here are some helpful hints:

- Get onto the Feminist Majority Foundation's web site (<http://www.feminist.org>), and click onto "global feminism." Under this heading you will see a bar for organizational links, and one of the first links is called **Aviva**. This will link you by country to women's organizations and will give you their contact information. (Some headquarters work out of the United States.)
- Once you have found an organization you are interested in learning more about, email, call, or write to them. Introduce yourselves as members of the Feminist Majority Leadership Alliance on your respective campus. Explain the work you are doing on issues of global feminism, and ask for information on the work that they are doing. See if they have projects you can participate in, as well as literature or information to share with you.
- Since some of these organizations have headquarters in the U.S., and others make frequent business trips to the U.S., investigate the possibility of having a representative come to your campus and do a presentation on the work they do and the conditions of women in their respective country.

TAKE ON UNITED STATES INTERNATIONAL FAMILY PLANNING FUNDING

- **Find out and monitor** your elected representatives' positions on international family planning and on restricting organizations receiving U.S. funding from performing abortions with their own funds.
- **Develop a Speakers Bureau** of persons knowledgeable on international family planning and reproductive rights issues, and coordinate speaking events featuring these individuals both on your campus and in the surrounding community. See the "Pro-choice Speakers Bureau" action component of Unit 2 for further help forming a speakers bureau.

SUPPORT POLICY AND LEGAL CHANGES IN OTHER COUNTRIES

- The 1995 Fourth World Conference on Women challenged over 180 governments to

make commitments to promote women's rights in their respective countries. Some governments are receiving funding from the U.S. government to carry out some of these commitments. Other governments are using their own resources to do so. Non-governmental Organizations (NGOs) have had a pivotal role in holding their governments accountable for keeping these promises.

- **Research** various NGOs working on legal and policy reform to improve women's reproductive rights in poorer countries. **Publicize** the efforts and successes of these organizations in your newsletters and web pages. **"Adopt"** a struggling family planning clinic (one whose funding has been cut due to the restrictive policy of not allowing clinics to perform abortions using its own funds, perhaps). Raise funds to help such a clinic afford supplies and health personnel.

List of Organizations for Further Research

- Alan Guttmacher Institute, New York, NY
- International Planned Parenthood Federation, London, England
- International Women's Health Coalition, New York, NY
- Population Action International, Washington, DC
- Population Reference Bureau, Washington, DC
- United Nations Population Fund (UNFPA)
- Women's Environment and Development Organization, New York, NY

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