

LOST IN TRANSLATION: THE FAILURE OF THE INTERNATIONAL REPRODUCTIVE RIGHTS NORM

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INTRODUCTION

International relations scholars have hailed the transnational reproductive rights movement as a success.¹ The degree to which nations have embraced reproductive rights language in law and policy seems to bear them out. But contrary to what some advocates on both sides of the abortion debate believe, while “reproductive health” language has been adopted in many nations, an international reproductive rights norm has not.

This came to light during the United States Senate debates on whether the United States should ratify the latest U.N. human rights treaty, the Convention on the Rights of Persons with Disabilities (CRPD).² High-level

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1. JUTTA M. JOACHIM, AGENDA SETTING, THE UN, AND NGOS: GENDER VIOLENCE AND REPRODUCTIVE RIGHTS 158 (2007); MARGARET E. KECK & KATHRYN SIKKINK, ACTIVISTS BEYOND BORDERS: ADVOCACY NETWORKS IN INTERNATIONAL POLITICS 11, 168 (1998); Sakiko Fukuda-Parr & David Hulme, *International Norm Dynamics and “the End of Poverty”*: *Understanding the Millennium Development Goals*, 17 GLOBAL GOVERNANCE 17, 20–21 (2011); Darren Hawkins, *Explaining Costly International Institutions: Persuasion and Enforceable Human Rights Norms*, 48 INT’L STUD. Q. 779, 779, 801 (2004); Bharati Sadasivam, *The Rights Framework in Reproductive Health Advocacy—A Reappraisal*, 8 HASTINGS WOMEN’S L.J. 313, 313 (1997); Susanne Zwingel, *From Intergovernmental Negotiations to (Sub)national Change: A Transnational Perspective on the Impact of CEDAW*, 7 INT’L FEMINIST J. POL. 400, 400–01 (2005).

2. The Senate Foreign Relations Committee debated “sexual and reproductive health” before sending the Disabilities Treaty to the Senate for consideration. Sen. Marco Rubio (R-FL) proposed an amendment that stated: “The United States understands that the phrase ‘sexual and reproductive health’ in Article 25(a) of the Convention does not include abortion, and its use in that Article does not create any abortion rights, cannot be interpreted to constitute support, endorsement, or promotion of abortion, and in no way suggests that abortion should be promoted as a method of family planning.” S. COMM. ON FOREIGN RELATIONS, 112TH CONG., (2011) (statement of Sen. Rubio), <http://www.foreign.senate.gov/imo/media/doc/Rubio%202%20-%20DAV127751.pdf>. The amendment failed when all committee

bipartisan supporters, including Senators John McCain (R-AZ) and John Kerry (D-MA), as well as dozens of veterans and disabilities groups failed to convince enough senators to join the 126 other countries who had bound themselves to the treaty. Among the major concerns was its inclusion, for the first time in a U.N. treaty, the term “sexual and reproductive health.”³ Senator Kerry went to great lengths to assure his colleagues that the nation had nothing to fear from the term. Even if it included abortion, it is only used in the treaty in regard to non-discrimination and not to create any new rights.⁴ Why was such insistence necessary and why was it unpersuasive?

The reason is that the meaning of the term, transparent in its inception as including abortion, evokes controversy in its ubiquity. Proponents have downplayed its meaning in international debates to promote it among traditional nations, while officials in those countries have claimed to purify it before adopting it into domestic usage. Like trench warfare, heated battles over words occupying mere inches of text have gone on for years. The second reason legislators were wary is that U.N. human rights treaty bodies had already pressured more than ninety countries over 120 times to liberalize their abortion laws using far less controversial language in the treaties, such

Democrats opposed it, while all Republicans voted in favor of it. The Committee instead included a version of the amendment, by Sen. John Kerry (D-MA), which stated:

The United States of America understands that the Convention is a non-discrimination instrument. Therefore, nothing in the Convention, including Article 25, addresses the provision of any particular health program or procedure. Rather, the Convention requires that health programs and procedures are provided to individuals with disabilities on a non-discriminatory basis.

S. FOREIGN RELATIONS COMM. 112TH CONG. (2011) (statement of Sen. Kerry), <http://www.foreign.senate.gov/imo/media/doc/Kerry%20-%20DAV128151.pdf>.

3. The Senate Foreign Relations Committee passed the treaty to the Senate for consideration on July 26, 2012. A coordinated lobbying effort by civil society groups against ratification ensued, including a letter to Senate Republicans dated October 24, 2012 expressing concerns about the treaty’s inclusion of the term “sexual and reproductive health.” Letter from Austin Ruse, President, C-FAM, to the U.S. Senate (Oct. 24, 2012), available at <http://www.c-fam.org/docLib/Senate%20Letter%20on%20Disabilities%20Treaty.pdf>.

4. John Kerry, *Objections to Disabilities Treaty Don’t Stand up to Scrutiny*, THE HILL, Dec. 4, 2012, <http://thehill.com/blogs/congress-blog/foreign-policy/270807-objections-to-disabilities-treaty-dont-stand-up-to-scutiny>. Kerry stated:

So let’s be clear: the Disabilities Convention is a non-discrimination treaty. It won’t create any new rights that do not otherwise exist in our domestic law. What are the U.S. obligations under this Treaty? Simple: prevent discrimination on the basis of disability only with respect to rights that are already recognized and implemented under U.S. law. In other words—keep doing what we already have done for the 22 years since we proudly passed the Americans with Disabilities Act.

Id.

as “the right to life.”⁵ The practice of reinterpreting such rights to include abortion was initiated and propelled by the transnational reproductive rights movement.

In addition to human rights, the movement has fought on a second front: international development. The World Health Organization (WHO) established a program on human reproduction in 1972,⁶ promoting abortion as reproductive health. By 1994, the term “reproductive health” was at the center of a major U.N. conference on population in Cairo.⁷ While abortion advocates failed to walk away with the declaration of a new international right to abortion, they gained inclusion of abortion as part of reproductive health care, where it was not against the law.

After the Cairo conference, the major international aid and development organizations established reproductive health programs, including United States Agency for International Development (USAID),⁸ U.N. Population Fund (UNFPA),⁹ Population Council,¹⁰ and Ford and MacArthur Foundations.¹¹ The term now permeates the literature of these agencies. As a result, countries from every region have incorporated the term in policy

5. *Decisions Denied: Women’s Access to Contraceptives and Abortion in Argentina*, 17 HUM. RTS. WATCH 1, 66 (2005). In 2005, Human Rights Watch reported:

Since the mid-1990s the U.N. treaty bodies that monitor the implementation of the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, and the Convention of the Rights of the Child have produced a significant body of jurisprudence regarding abortion in over 122 concluding observations concerning at least ninety-three countries.

Id.

6. Giuseppe Benagiano et al., *The Special Programme of Research in Human Reproduction: Forty Years of Activities to Achieve Reproductive Health for All*, 74 GYNECOLOGIC & OBSTETRIC INVESTIGATION 190, 191 (2012).

7. See JYOTI SHANKAR SINGH, *CREATING A NEW CONSENSUS ON POPULATION* 29–76 (1998).

8. *International Alliance for Reproductive, Maternal, and Newborn Health*, USAID, http://transition.usaid.gov/our_work/global_health/pop/alliance.html (last updated Oct. 9, 2012).

9. *Improving Reproductive Health*, UNFPA, <http://www.unfpa.org/rh/index.htm> (last visited Apr. 21, 2013).

10. *Increase Access to Services; Give People Choices*, POPULATION COUNCIL, <http://www.popcouncil.org/what/rh.asp> (last visited Apr. 21, 2003).

11. *Population & Reproductive Health*, MACARTHUR FOUND., <http://www.macfound.org/programs/population> (last visited Apr. 21, 2013); *Sexuality and Reproductive Health and Rights*, FORD FOUND., <http://www.fordfoundation.org/issues/sexuality-and-reproductive-health-and-rights> (last visited Apr. 21, 2013).

documents, a significant number have adopted some of its programs, but far fewer have adopted its core tenet, legal and accessible abortion.¹²

The case is emblematic of a larger phenomenon in which the language of a norm gains near universal acceptance, but state practice and public attitudes do not evolve accordingly.¹³ This analysis examines the pursuit of a reproductive rights norm using Martha Finnemore and Kathryn Sikkink's articulation of international norm dynamics and political change to identify the reason for this disconnect.¹⁴ The lifecycle of a norm, according to that model, has three stages: norm "emergence," whereby powerful norm entrepreneurs try to convince nations to adopt it; norm "cascade," in which states include it in national laws and policies; and norm "internalization," when domestic debate about the norm stops.¹⁵

As the United States Senate's vote against ratification of the CRPD demonstrates, domestic debate, even in countries with liberal abortion laws, has not stopped. This analysis finds that the transnational reproductive rights movement has been highly successful in the first phase, less so in the second,

12. *The World's Abortion Laws*, CENTER FOR REPROD. RTS., <http://worldabortionlaws.com/map> (last visited Apr. 21, 2013) (The term "reproductive health" is used by the national health ministries in countries of every region of the world, including many with restrictive abortion laws. Some examples include: Chile, El Salvador, Ghana, Kenya, Malta, Nigeria, the Philippines, and Uganda). See also *Acceso Universal a Servicios de Salud Reproductiva: DMP 2012*, MINISTERIO DE SALUD (July 11, 2012), <http://www.salud.gob.sv/index.php/novedades/noticias/noticias-ciudadanosas/188-julio-2012/1409-11-07-2012-acceso-universal-a-servicios-de-salud-reproductiva-dmp-2012> (El Salvador); *Dep't of Family Health*, FED. MINISTRY OF HEALTH, http://www.fmh.gov.ng/index.php?option=com_content&view=article&id=102:department-of-family-health&catid=81&Itemid=501 (last visited Apr. 21, 2013) (Nigeria); *International Tender Notice: Consultancy Services on Social Franchising of Health Services (Component 2) Under the Program Named "Development of Health Sector Reproductive and Sexual Health"*, MINISTRY OF PUB. HEALTH & SANITATION, <http://www.publichealth.go.ke/tenders/151-international-tender-notice-consultancy-services-on-social-franchising-of-health-services-component-2-under-the-program-named-development-of-health-sector-reproductive-and-sexual-health> (last visited Apr. 21, 2013) (Kenya); *Maternal Health*, MINISTRY OF HEALTH OF THE REPUBLIC OF INDON. (Jan. 26, 2013), <http://www.kesehatanibu.depkes.go.id/archives/category/kesehatan-reproduksi> (Indonesia); *Natural Family Planning*, DEPARTMENT OF HEALTH, <http://www.doh.gov.ph/node/1074.html> (last visited Apr. 21, 2013) (Philippines); *Salud Sexual y Reproductiva*, MINISTERIO DE SALUD, http://www.minsal.gob.cl/portal/url/page/minsalcl/g_proteccion/g_salud_sexualyreproductiva/saludinmigrantespresentacion.html (last visited Apr. 21, 2013) (Chile); *Public*, GHANA HEALTH SERVICE, <http://www.ghanahealthservice.org/division.php?dsion=Public Health&dd=29> (last visited Apr. 21, 2013) (Ghana); *Reproductive Health*, MINISTRY OF HEALTH, http://health.go.ug/mohweb/?page_id=779 (last visited Apr. 21, 2013) (Uganda); *Sexual & Reproductive Health*, DEP'T OF INFO. MALTA, <https://gov.mt/en/Life%20Events/Pregnancy%20and%20Birth/Pages/Sexual-and-Reproductive-Health.aspx> (last visited Apr. 21, 2013) (Malta).

13. Fukudu-Parr & Hulme, *supra* note 2, at 18–20 (using Finnemore and Sikkink's model of international norm dynamics to examine the reasons why some of the MDGs have not been implemented despite wide acceptance in national programs and policies).

14. Martha Finnemore & Kathryn Sikkink, *International Norm Dynamics and Political Change*, 52 INT'L ORG. 887, 888 (1998).

15. *Id.* at 898.

and has fallen far short of its goals in the third phase due to strategic overreach and a series of tactical decisions about how to promote its aims.

I. AN UNALIENABLE RIGHT TO FAMILY PLANNING

Two tectonic shifts in the international political agenda converged at the United Nations in the late 1960s: human rights and overpopulation. Coming of age together in the post-war era as they did, it is little wonder that U.N. campaigns to limit human reproduction and to promote human rights remain conjoined fifty years on.

In 2012, the U.N. Population Fund's annual report made headlines for declaring contraception a human right.¹⁶ After the 2012 United States presidential election, UNFPA's executive director sent a congratulatory letter to the U.N. ambassador to the United States calling family planning an "unalienable" right, akin to those enshrined in America's founding documents.¹⁷ Missing from the press coverage about the controversial claim was the fact that it was nothing new.¹⁸

On Human Rights Day, December 10, 1966, twelve heads of state signed and presented to U.N. Secretary General U-Thant a Declaration on Population, saying they believed "the opportunity to decide the number and

16. See, e.g., Associated Press, *Access to Contraception is Supported*, N.Y. TIMES, Nov. 14, 2012, http://www.nytimes.com/2012/11/15/world/united-nations-supports-access-to-contraception.html?_r=1&; *UN Calls Contraception Access a "Universal Human Right"*, CBS NEWS (Nov. 14, 2012, 10:03 AM), http://www.cbsnews.com/8301-204_162-57549577/un-calls-contraception-access-a-universal-human-right.

17. Susan Yoshihara, *UNFPA "Grateful" for Obama's Re-election: Letter to Susan Rice*, LIFESITENEWS.COM (Nov. 15, 2012, 4:50 PM), <http://www.lifesitenews.com/news/unfpa-39grateful39-for-obamas-re-election-letter-to-susan-rice/#>. The UNFPA executive director sent a letter of congratulations upon the re-election of the United States president to the United States permanent representative to the United Nations which stated:

We were grateful to learn that we will have continued support and vision under his leadership in ensuring that all women have access to quality and voluntary family planning and reproductive health care, an unalienable right and an imperative for the fulfillment of the potential of half the population of the world, both as citizens and as human beings. The health and rights of women and young people have proven to be pivotal and winning issues in Tuesday's historic elections.

Id.

18. See, e.g., Margaret Greene et al., *By Choice, Not by Chance: Family Planning, Human Rights and Development*, 2012 UNFPA STATE OF WORLD POPULATION 9 (despite the media's characterization, the report did not declare a new human right to contraception, but rather couched contraception access in terms of UNFPA's rights-based approach: "UNFPA's commitment to the integration of human rights in family planning policies and programmes emphasizes two essential actions. All policies, services, information and communications must meet human rights standards for voluntary use of contraception and quality of care in service delivery.").

spacing of children is a basic human right.”¹⁹ They explicitly connected this assertion to the 1948 Universal Declaration of Human Rights.²⁰ The following year eighteen more heads of state signed on, including Lyndon Johnson, Indira Gandhi, Lee Quan Yew, Ferdinand Marcos, General Suharto, and Marshal Tito.²¹ The declaration was the progeny of John D. Rockefeller, III, chairman of the board of the Population Council and the Rockefeller Foundation, an avid and singularly influential population control advocate. World leaders concretized the notion again in the 1968 Tehran Declaration.²²

The 1966 Declaration on Population preceded by a week the U.N. General Assembly’s adoption of the International Covenant on Economic, Social, and Political Rights (ICESCR),²³ and the treaty would not enter into force until a decade later. Yet, the ICESCR made no mention of family planning, reproduction, population, unwanted pregnancy, unsafe abortion, or maternal mortality. That is not to say that the drafters omitted maternal and child health. To the contrary, the treaty went into detailed requirements such as “[t]he provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child.”²⁴

It was not until the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)²⁵ that “family planning” was mentioned in a binding treaty, and then it was included as a term of non-discrimination and not as a right. As in the case of the ICESCR, CEDAW addressed maternal health, requiring states to ensure women have “appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”²⁶

Government leaders were swift to declare a right to family planning in a non-binding way when population growth seemed to threaten international peace and security. While they agreed in binding treaties not to discriminate

19. Turbay Ayala & Lord Caradon, *Declaration on Population: The World Leaders Statement*, 1 *STUD. FAM. PLAN.* 1, 3 (1968).

20. *Id.* at 2.

21. *Id.* at 1.

22. International Conference on Human Rights, Teheran, Iran, Apr. 22–May 13, 1968, *Final Act of the International Conference on Human Rights*, 3, U.N. Doc. A/CONF.32/41 (1968) [hereinafter *Teheran*].

23. International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3.

24. *Id.* art. 12(2)(a).

25. Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. Doc. A/RES/34/180 (Dec. 18, 1979).

26. Convention on the Elimination of All Forms of Discrimination Against Women, DIVISION FOR THE ADVANCEMENT OF WOMEN, art. 12(2) (June 30–July 25, 2003), <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm> [hereinafter *CEDAW*].

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in matters of family planning, however, they did not recognize it as a right per se.

II. EMERGENCE OF THE REPRODUCTIVE HEALTH NORM

A norm is defined as “a principle of right action binding upon the members of a group and serving to guide, control, or regulate proper and acceptable behavior,” or a “pattern or trait taken to be typical in the behavior of a social group”; or a “widespread or usual practice, procedure, or custom.”²⁷ Examples of successful campaigns to change norms through political action include the fight against human slavery in the 1800s and for women’s citizenship rights in the early 1900s. Finnemore and Sikkink find that the ideas do not evolve internationally unless promoted by “[n]orm entrepreneurs [who] attempt to convince a critical mass of states (norm leaders) to embrace new norms.”²⁸

To be successful, norm entrepreneurs must “frame” the issue, mobilize through various networks, and seize political opportunities such as alliances with influential decision makers.²⁹ Ensuring norm coherence with the original intent spans the first and second stage, “norm cascade.”³⁰ Norm cascade is “characterized more by a dynamic of imitation as the norm leaders attempt to socialize other states to become norm followers.”³¹ Finnemore and Sikkink note that the broader public’s motivation for accepting the norm in this stage may vary, and that “a combination of pressure for conformity, desire to enhance international legitimation, and the desire of state leaders to enhance their self-esteem facilitate norm cascades.”³²

The measure of a successful transnational campaign, “norm internalization,” is marked by a tipping point. Before that point, “little normative change occurs without significant domestic movements supporting such change.”³³ After the tipping point:

- Norms acquire a taken-for-granted quality and are no longer a matter of broad public debate;
- “More countries begin to adopt new norms more rapidly even without domestic pressure for such change”;

27. MERRIAM-WEBSTER DICTIONARY, <http://www.merriam-webster.com/dictionary/norm> (last visited Apr. 21, 2013).

28. Finnemore & Sikkink, *supra* note 14, at 895.

29. *Id.* at 897. See also JOACHIM, *supra* note 2, at 159–60.

30. Finnemore & Sikkink, *supra* note 14, at 895.

31. *Id.*

32. *Id.*

33. *Id.* at 902.

- An international or regional “contagion” may occur “in which international and transnational norm influences become more important than domestic politics for effecting norm change.”³⁴

The reproductive rights movement has, from its inception, enjoyed numerous and powerful norm entrepreneurs. It was born out of the population control movement and made two core additions to its aims: abortion as a legal right and the practice of abortion through international development.³⁵ In the early 1970s, the population establishment was not united in favor of these aims. Former president of the Population Council, Frank Notestein warned in 1973:

If we do not watch out . . . we shall justify the assertion of our enemies that we are basically against life. . . . The world needs some respected group that moves carefully where humanitarian considerations are involved. We can do all that if we constantly and firmly take the anti-abortion stance and use every occasion to point out that the need for abortions is the proof of program failure in the field of family planning and public health education.³⁶

Prominent as he was in the population establishment, Notestein was outmaneuvered by Joan Dunlop, assistant to John D. Rockefeller, III. Dunlop wrote Rockefeller’s speech for the 1974 World Population Conference at Bucharest, in which he shifted sides on the internal debate about abortion, causing opponents like Notestein to leave the Population Council.³⁷ Dunlop went on to found the International Women’s Health Coalition (IWHC), succeeded by Adrienne Germaine, who had assisted Dunlop with the Bucharest speech. Dunlop would later credit the IWHC for putting the term “‘reproductive health’ on the map” in the 1970s.³⁸ United States Secretary of State Hillary Clinton, who popularized the movement’s adage “women’s rights are human rights” as head of the United States delegation to the Beijing conference in 1995, has been central to shaping official United States support for the movement through international development in the Clinton administrations and the first Obama

34. *Id.*

35. Interview by Rebecca Sharpless with Joan Dunlop, Past President, Int’l Women’s Health Coal., in Lime Rock, Conn. (Apr. 14–15, 2004) [hereinafter Dunlop].

36. Martin Morse Wooster, *The Ford Foundation: Founder of Modern Population Control*, 4 INT’L ORG. RES. GRP.: WHITE PAPER SERIES 1, 29 (2004) (second alteration in original) (citation omitted).

37. Douglas Martin, *Joan Dunlop, Advocate for Women’s Health Rights, Dies at 78*, N.Y. TIMES, June 30, 2012, http://www.nytimes.com/2012/07/01/world/joan-dunlop-dies-at-78-fought-for-womens-health-rights.html?_r=0.

38. Dunlop, *supra* note 35; Interview by Rebecca Sharpless with Adrienne Germaine, President, Int’l Women’s Health Coal., in New York, N.Y. (June 19–20, Sept. 25, 2003).

administration.³⁹ Well-connected advocates like these helped the movement seize political opportunities such as international conferences. They also performed an important internal function to the movement—that is keeping the focus on abortion rights despite an ever-expanding network and list of issues the movement encompasses as it seeks to frame its message effectively.

According to Margaret Keck and Kathryn Sikkink, equality and anti-discrimination were the “master frame” that emerged from the documents from the 1960s, such as the Commission on the Status of Women⁴⁰ and the 1967 Declaration on the Elimination of Discrimination Against Women.⁴¹ This was already the frame for the women’s movement in the United States and in Europe, as well as the U.N. system, but not in the developing world.⁴² The Women’s declaration, and its follow-on treaty of 1979, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),⁴³ were silent on abortion. And since they were anti-discrimination documents, they were inadequate for promoting new rights. On the other hand, CEDAW’s definition of discrimination set a lower bar than national courts, which require either evidence of an intention to discriminate or membership in a protected class. For CEDAW: “[D]iscrimination against women’ shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women”⁴⁴ Members of the committee that monitor state compliance with CEDAW thus adopted the position that restrictive abortion laws are always discriminatory because abortion is a procedure only women undergo.⁴⁵

39. Prolifeinformation, *2009 U.S. Policy to Export Abortion (Rep. Chris Smith and Sec. Clinton)*, YOUTUBE (Apr. 22, 2009), <http://www.youtube.com/watch?v=-gEA97EnxE4>; *Hillary Clinton Attempts to Redefine U.N. Agreement by Adding Abortion, Experts Charge*, CATH. NEWS AGENCY, (Jan. 15, 2010, 5:14 AM), http://www.catholicnewsagency.com/news/hillary_clinton_attempts_to_redefine_u.n._agreement_by_adding_abortion_experts_charge.

40. *Commission on the Status of Women*, UNITED NATIONS ENTITY FOR GENDER EQUALITY AND THE EMPOWERMENT OF WOMEN, <http://www.un.org/womenwatch/daw/csw/index.html#about> (last visited Apr. 21, 2013). The Commission on the Status of Women (CSW) is a functional commission of the United Nations Economic and Social Council (ECOSOC), established by ECOSOC in 1946 with the aim of making recommendations to ECOSOC on matters related to women. Member state representatives to CSW meet each year at U.N. headquarters in New York and generally produce an outcome document. Disagreements on controversial topics, however, have prevented agreement on a consensus document at recent meetings.

41. KECK & SIKKINK, *supra* note 2, at 168.

42. *Id.*

43. CEDAW, *supra* note 26.

44. *Id.*

45. See Rebecca J. Cook, *Human Rights Law and Safe Motherhood*, 5 EUR. J. HEALTH L. 357, 366 (1998) (further explaining this approach).

Jutta Joachim has examined the way the reproductive rights movement was persuaded to adopt the litigious approach due to the strong voice of radical feminists in the movement who viewed women's rights as a contest for power. Joachim described the move as a shift toward a "criminal justice" frame which emphasized litigation and away from "therapy and social welfare frames" which emphasized reconciliation of families and social structures.⁴⁶ Joachim argues that justice became a new master frame for the abortion rights movement through a series of international meetings on women's health held in Rome in 1977, Hanover in 1980, Geneva in 1981, and, finally, Amsterdam in 1984, which Joachim says "gave rise to an alliance between Northern and Southern women and the expansion of the reproductive rights frame to include reproductive health."⁴⁷

This meant that in order to make the cause palatable to women in developing countries who largely valued motherhood and family life, the campaign thenceforth included calls for the end of coercive family planning programs in developing nations such as condemnations of forced sterilizations and dumping of defective contraception. The condemnations were added to calls for the legalization of abortion in every country. After the meeting, its organizer, the International Contraception, Abortion, and Sterilization Campaign was renamed the Women's Global Network for Reproductive Rights (WGNRR).⁴⁸

Approaching the 1994 International Conference on Population and Development, commonly called ICPD or the Cairo Conference, abortion advocates had to reconcile two flanks of their movement. Betsy Hartmann was the highest profile proponent of a clean break with the population control movement, arguing from a Marxist perspective.⁴⁹ According to Joachim, pragmatists ultimately won out by arguing that the movement needed to retain the patronage of the powerful population establishment.⁵⁰

46. According to Joachim, it is also the reason why the campaign emerged with strong bias against marriage and family. Moreover, the voice of radical feminism, which emphasizes the structural causes of power inequality, is clearly heard in the ECOSOC Expert Group Meeting proceedings declaring that, "the roots of violence against women within the family are structural," that is, the family is a "cradle of violence" The criminal justice frame proposed by the experts was a radical departure from the therapy and welfare frames that had . . . emphasized mediation between the perpetrator and the victim with the aim of maintaining and restoring the family unit." JOACHIM, *supra* note 2, at 117–18, 120.

47. *Id.* at 137.

48. *Id.* at 134. See also WOMEN'S GLOBAL NETWORK FOR REPROD. RTS., <http://www.wgnrr.org> (last visited Apr. 21, 2013). The WGNRR continues its work, in partnership with such groups as Amnesty International, Catholics for Choice, the Center for Reproductive Rights, and various African and Asian NGOs.

49. JOACHIM, *supra* note 2, at 151–52.

50. *Id.* at 152–53.

While they attempted to re-frame their movement in opposition to population control, they continued to promote its aims in order to maintain the alliance.⁵¹

III. FRAMING ABORTION AS REPRODUCTIVE HEALTH

Whereas the idea of a human right to family planning was inserted definitively in U.N. language by some world leaders in the non-binding Declaration on Population in 1966,⁵² reproductive health language seeped in through routine reports, advanced by advocates among the U.N. staff. From the beginning, reproductive health was a concept aimed at limiting pregnancy and childbirth, and included “fertility regulation,” which in turn included “pregnancy interruption” or abortion.⁵³ The WHO credits José Barzelatto with adopting the term “reproductive health” for international use.⁵⁴ Barzelatto was the first director of the WHO Program on Human Reproduction (HRP) in 1972.⁵⁵

The term’s first appearance in U.N. language was its insertion in the Biennial Report celebrating the twentieth Anniversary of HRP by Barzelatto’s successor, Mahmoud Fathalla. It is a description more than a definition, and its lack of specificity was a sign of the controversial debates over the term’s meaning that would ensue. Nevertheless, the inclusion of abortion was clear. According to Fathalla, reproductive health is not merely

51. MARA HVISTENDAHL, *UNNATURAL SELECTION: CHOOSING BOYS OVER GIRLS, AND THE CONSEQUENCES OF A WORLD FULL OF MEN* 152, 155 (2011). The dichotomy resulted in sporadic U.S. defunding of the U.N. Population Fund due to its ties to the coercive one child per family policy practiced by the Chinese regime. In her interviews with UNFPA personnel, Mara Hvistendahl found that UNFPA staff felt trapped into silence about the practice of sex-selective abortion and infanticide of baby girls due to UNFPA’s aim of promoting reproductive rights and abortion as a “priority issue.” *Id.*

52. Teheran, *supra* note 22, at 3.

53. International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994, *Report of the International Conference on Population and Development*, U.N. Doc. A/CONF.171/13/Rev.1 Annex, (1995) [hereinafter Int’l Conf.]. Several delegations to the 1994 Cairo conference rejected the WHO definition of fertility regulation because it included abortion and made explanations of position and reservations to the Program of Action accordingly. “The inclusion of the term ‘interruption of pregnancy’ as part of the concept of regulation of fertility in the working definition proposed by the World Health Organization, which was used during the course of this Conference, makes this concept totally unacceptable to our country,” stated Paraguay. *Id.* “Accordingly, it accepts the content of the terms ‘reproductive health,’ ‘sexual health,’ ‘safe motherhood,’ ‘reproductive rights,’ ‘sexual rights,’ and ‘regulation of fertility’ but enters an express reservation on the content of these terms and of other terms when their meaning includes the concept of abortion or interruption of pregnancy,” stated the Dominican Republic. *Id.* “[T]he delegation of Ecuador enters a reservation with respect to all terms such as ‘regulation of fertility,’ ‘interruption of pregnancy,’ ‘reproductive health,’ ‘reproductive rights’ and ‘unwanted children,’ which in one way or another, within the context of the Programme of Action, could involve abortion,” stated Ecuador. *Id.*

54. Benagiano et al., *supra* note 6, at 194–95.

55. *Id.* at 191–94.

the absence of disease or disorders of the reproductive process, rather it is a condition in which the reproductive process is accomplished in “a state of complete physical, mental and social well-being.”⁵⁶ This implies “that people have the ability to reproduce . . . that women are able to go through pregnancy and childbirth safely,” and that reproduction is carried to a successful outcome, i.e., infants survive and grow up healthy.⁵⁷ It implies further that people are able to regulate their fertility without risks to their health and that they are safe in having sex.⁵⁸ The various elements of reproductive health are strongly inter-related, and improvement of one can facilitate the improvement of others (as, indeed, can the deterioration of one lead to the deterioration of others).⁵⁹ While all elements of reproductive health are individually important, given the current socioeconomic and environmental conditions in the world, particularly in developing countries, *fertility regulation is central to all other aspects of reproductive health*.⁶⁰ *It has a bearing on*, for example, the prevention of sexually transmitted diseases, *the consequences of unwanted pregnancy*, infertility, sexuality, child survival, and safe motherhood.⁶¹ It was this definition that reproductive rights activists would adopt at the 1994 Cairo conference after a series of internal disputes between the extremes of their movement.⁶² The definition adopted at Cairo had two notable additions to the WHO definition, including emphasis on access to abortion as part of a “constellation” of services that are “methods of their choice for regulation of fertility” where it is not against the law and a new category of “sexual health.”⁶³

56. M.F. Fathalla, *Research Needs in Human Reproduction*, in RESEARCH IN HUMAN REPRODUCTION: BIENNIAL REPORT (1986–1987) 341 (E. Diczfalusy et al. eds., 1988) (internal quotation marks omitted). Fathalla, an Egyptian obstetrician, was director of the UNDP, UNFPA, WHO, World Bank Special Program of Research, Development and Research Training in Human Reproduction, at the WHO from 1989 to 1992.

57. *Id.*

58. *Id.* at 344–45.

59. *Id.* at 342.

60. *Id.* at 342–44.

61. *See id.* at 341–46.

62. JOACHIM, *supra* note 2, at 156.

63. Int’l Conf., *supra* note 53, ¶ 40. The Cairo Programme of Action states:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a *satisfying and safe sex life* and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, *as well as other methods of their choice for regulation of fertility which are not against the law*, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and

In 1995, the Fourth World Conference on Women, held in Beijing, reaffirmed the Cairo definition in its non-binding Platform for Action and added an article on “sexual health”:

The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences.⁶⁴

While Beijing emphasized the context of this definition in terms of human rights, like Cairo it fell short of gaining recognition of a right to abortion.⁶⁵ Both documents contained “sovereignty” clauses allowing nations to apply the language according to national laws, both included language calling for the reduction of abortion, and both evoked strong opposition to abortion in country reservations that accompanied the final outcome document. Countries specifically objected to the inclusion of the terms—and others to any association of abortion with the terms—“reproductive rights,” “reproductive health,” “sexual health,” and “fertility regulation.”⁶⁶ The Holy

provide couples with the best chance of having a healthy infant. *In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.*

Id. (emphasis added).

64. Fourth World Conference on Women, Beijing, China, Sept. 4–15, 1995, *Report of the Fourth World Conference on Women*, ¶ 96, U.N. Doc. A/CONF.177/20/Rev.1 (1996).

65. Remarks of Dana Rosemary Scallon, EUR. PARL. DEB. (H-0670/02) (Oct. 24, 2002) [hereinafter Scallon]. The European Union has referenced Cairo as excluding abortion:

The term “reproductive health” was defined by the United Nations (UN) in 1994 at the Cairo International Conference on Population and Development. All Member States of the Union endorsed the Programme of Action adopted at Cairo. The Union has never adopted an alternative definition of “reproductive health” to that given in the Programme of Action, which makes no reference to abortion.

Id.

66. Int’l Conf., *supra* note 53, at 133–44 (list of reservations to the International Conference on Population and Development). Argentina, Dominican Republic, Ecuador, Honduras, Malta, Nicaragua, Peru, and the Holy See reserved on several terms and definitions of terms such as “reproductive health,” “sexual health,” “safe motherhood,” “reproductive rights,” “sexual rights,” and “regulation of fertility” in the Cairo Programme of Action and a number of Islamic countries reserved on portions of the text perceived to include abortion. *Id.* Likewise, Argentina, Dominican Republic, Honduras, Costa Rica,

See joined consensus only “partially” at both conferences and rejected consensus for the entire paragraph on health at Beijing.⁶⁷ And so, the language and the idea of reproductive health never enjoyed consensus, even from the first time it entered negotiated documents in 1994 and 1995. Moreover, nations rejected them specifically because of the association with abortion. The movement emerged from Cairo and Beijing with two soft law documents that would be very difficult to interpret as including any right to abortion.⁶⁸

Peru, Venezuela, and a number of Islamic countries reserved on portions of the Beijing Platform for Action or terms in it which could be construed as including abortion. *Id.*

67. *Reservations and Interpretative Statements on the Beijing Declaration and Platform for Action*, VROUWEN, <http://www.vrouwen.net/vweb/wcw/reserv.html> (last visited Apr. 22, 2013). The Holy See stated:

The Holy See reaffirms the reservations it expressed at the conclusion of the International Conference on Population and Development, held in Cairo from 5 to 13 September 1994, which are included in the report of that Conference, concerning the interpretation given to the terms “reproductive health,” “sexual health” and “reproductive rights.” In particular, the Holy See reiterates that it does not consider abortion or abortion services to be a dimension of reproductive health or reproductive health services. The Holy See does not endorse any form of legislation which gives legal recognition to abortion.

....

The Holy See maintains that nothing in the Platform for Action or in other documents referenced therein is to be interpreted as requiring any health professional or health facility to perform, cooperate with, refer or arrange for services to which they have objections on the basis of religious belief or moral or ethical conviction.

....

The Holy See does not join the consensus and expresses a reservation on paragraph 232(f), with its reference to a text (para. 96) on a right of women to “control over . . . their sexuality.” This ambiguous term could be understood as endorsing sexual relationships outside heterosexual marriage. It asks that this reservation be noted on the paragraph. On the other hand, however, the Holy See wishes to associate itself with the condemnation of violence against women asserted in paragraph 96, as well as with the importance of mutuality and shared responsibility, respect and free consent in conjugal relations as stated in that paragraph.

Id. (third alteration in original).

68. Int’l Conf., *supra* note 53, ¶ 7.2. In the Cairo Program of Action, the term “reproductive health” in paragraph 7.2—which paragraph 7.4 says is the “comprehensive definition of reproductive health, which includes sexual health”—excludes abortion. *Id.* at ¶ 7.4. *See also* Scallon, *supra* note 65.

The term “reproductive health” was defined by the United Nations (UN) in 1994 at the Cairo International Conference on Population and Development. All Member States of the Union endorsed the Programme of Action adopted at Cairo. *The Union has never adopted an alternative definition of “reproductive health” to that given in the Programme of Action, which makes no reference to abortion.*

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IV. REPRODUCTIVE RIGHTS BY STEALTH

When advocates failed to gain a definitive declaration on reproductive health and abortion akin to the 1966 and 1968 declarations on family planning as a basic human right, they turned to what they called a “stealth” approach.⁶⁹ In 1996, representatives from the U.N. Office of the High Commissioner for Human Rights, U.N. Population Fund, and U.N. Division for the Advancement of Women, along with Adrienne Germaine from IWHC, gathered with other members of the movement to discuss ways they could gain recognition of a right to abortion through re-interpretation of treaties already binding on states with new meanings uttered in non-binding statements of the U.N. committees tasked with monitoring state compliance with the conventions.⁷⁰ Regarding the Cairo and Beijing outcome documents, they asserted:

While these commitments are technically not binding on States, the documents reflect the official consensus of the world community . . . contributing to the evolution of customary international law norms and obligations by clarifying the evolving meaning, or progressive development, of human rights norms as well as . . . widely approved steps or means to further their implementation.⁷¹

It became clear that they may not ever achieve explicit mention of abortion in connection to human rights in a negotiated document; therefore, they had to work to elevate the Cairo and Beijing outcome documents to the status of law:

The international conference and human rights documents . . . do not explicitly assert a woman’s *right* to abortion, nor do they *legally* require

Id. (emphasis added); see generally Mary Ann Glendon, *What Happened at Beijing*, FIRST THINGS, Jan., 1996, <http://www.firstthings.com/article/2007/09/005-what-happened-at-beijing-35> (discussing the reduced interpretive significance of the vague language in the Beijing Platform for Action).

69. 149 CONG. REC. E2534-35 (daily ed. Dec. 8, 2003) (statement of Rep. Christopher Smith). The Center for Reproductive Rights strategic documents were delivered, anonymously, to the New York offices of the Catholic Family & Human Rights Institute (C-FAM) and later introduced in the House of Representatives by the Hon. Christopher H. Smith of New Jersey.

70. Douglas A. Sylva & Susan Yoshihara, *Rights by Stealth: The Role of the UN Human Rights Treaty Bodies in the Campaign for an International Right to Abortion*, 8 INT’L ORG. RES. GRP.: WHITE PAPER SERIES 1, 10 (2d. ed. 2009).

71. *Round Table of Human Rights Treaty Bodies on Human Rights Approaches to Women’s Health, with a Focus on Sexual and Reproductive Health Rights: Summary of Proceedings and Recommendations*, U.N. POPULATION FUND 4 (1996); Comm. on the Elimination of Discrimination against Women, Rep. on its 18th & 19th Sess., U.N. Doc. A/53/38/Rev.1 (May 14, 1998) (welcoming findings in the Roundtable Report); Sylva & Yoshihara, *supra* note 70, at 6.

safe abortion services as an element of reproductive health care. Moreover, the ICPD [Cairo, 1994] and FWCW [Beijing, 1995] agreements recognize the wide diversity of national laws and the sovereignty of governments in determining national laws and policies. Despite these qualifications, however, the conference documents and human rights instruments—if broadly interpreted and skillfully argued—can be very useful tools in efforts to expand access to safe abortion.⁷²

Thus, the movement turned to “strategic litigation” in order to get opinions from national courts that backed their assertions. Other transnational movements, campaigns for the rights to food, water, and health for example, were already attempting to make economic and social rights justiciable. Along with the fact that reproductive rights were more controversial than these aspiring rights, the movement faced the same fundamental problems with social and economic rights jurisprudence.⁷³ Perhaps most importantly, they were an uneasy fit with traditional rights advocacy aimed at preventing harm.

Kenneth Roth, executive director of Human Rights Watch, sparked an internal debate among human rights organizations with a 2004 article questioning whether economic and social rights could achieve the same standards of evidence established for civil and political rights advocacy.⁷⁴ This assumed that “naming and shaming” would mobilize international pressure and enforcement. Human rights organizations had gained credibility by providing proof of violations through investigation and research used to expose violators. This is fairly straightforward when exposing a man jailed without a trial, but not when trying to prove that his standard of health could be higher.

Roth argued for directing economic and social rights work toward proving discriminatory or arbitrary government conduct, and he counseled against a “distributive justice” approach that assessed government behavior by its budgetary allocation.⁷⁵ But anti-discrimination was already proving too limited a framework for achieving the aims of the reproductive rights. Mary Robinson, former U.N. High Commissioner for Human Rights, disagreed with Roth. In her published response, Robinson said rights

72. ADRIENNE GERMAIN & THERESA KIM, EXPANDING ACCESS TO SAFE ABORTION: STRATEGIES FOR ACTION, 6 (Ruth Dixon-Mueller ed., 1998). See also Sylva & Yoshihara, *supra* note 70, at 25.

73. See Malcolm Langford, *The Justiciability of Social Rights: From Practice to Theory*, in SOCIAL RIGHTS JURISPRUDENCE: EMERGING TRENDS IN INTERNATIONAL AND COMPARATIVE LAW 3, 4–5 (Malcolm Langford ed., 2008).

74. PAUL J. NELSON & ELLEN DORSEY, NEW RIGHTS ADVOCACY: CHANGING STRATEGIES OF DEVELOPMENT AND HUMAN RIGHTS NGOS 77–78 (Summer B. Twiss et al. eds., 2008).

75. *Id.* at 78–79.

organizations should cast the net wide, shaming governments, corporations, and international financial institutions.⁷⁶ She emphasized using human rights to rebalance power relations and called for using budgets as “evidence” of discrimination.⁷⁷

By Robinson’s account, there need be no competition between economic and social rights, since non-governmental organizations (NGOs) can call for “progressive realization of rights” through continual increases in the amount and share of national spending on all economic and social rights, in contrast to other spending such as national defense.⁷⁸ This perspective was welcomed in Northern European states that emphasized government-funded social welfare programs. There was more resistance in the United States until the administration of Barack Obama, which was been less reticent to promote social welfare programs as rights than previous administrations. The reproductive rights movement adopted Robinson’s approach.⁷⁹

In 2007, Robinson helped launch a strategic litigation campaign, which sought to re-interpret existing human rights obligations with a new “right to maternal health.” The International Initiative on Maternal Mortality and Human Rights (IIMMHR) was founded and chaired by the Center for Reproductive Rights, along with Amnesty International, Human Rights Watch, CARE, the U.N. Special Rapporteur for Health, and the U.N. Population Fund.⁸⁰ The groups emphasized that the cases would not concern abortion at all, and only seek to establish a right to maternal health, beginning with litigation in Latin America with a left-leaning court favorable toward the justiciability of economic and social rights.⁸¹

76. *Id.* at 80.

77. *Id.* at 82–83.

78. *Id.* at 79–80.

79. Greene et al., *supra* note 18, at 91, 105. The latest annual report from the U.N. Population Fund calls on governments to allocate \$8.1 billion per year to fulfill the “intrinsic” human right to family planning. *Id.* The approach is also evident in the observations of the CEDAW committee, which has argued that governments that restrict abortion are discriminating against women in the area of health care, based upon Article 1 of the treaty on non-discrimination and Article 12 on health care. *Id.* at 58, 91, 105.

80. Susan Yoshihara, *Six Problems with “Women Deliver:” Why the UN Should Not Change MDG5*, at 4 (Int’l Org. Res. Grp., Briefing Paper No. 2, 2007). See also *About Us*, INT’L INITIATIVE ON MATERNAL MORTALITY & HUM. RTS., <http://righttomaternalhealth.org/about-us/about> (last visited Apr. 22, 2013).

81. See COURTING SOCIAL JUSTICE: JUDICIAL ENFORCEMENT OF SOCIAL AND ECONOMIC RIGHTS IN THE DEVELOPING WORLD 279, 358 (Varun Gauri & Daniel M. Brinks eds., 2008); Varun Gauri & Daniel M. Brinks, *Human Rights as Demands for Communicative Action 2–4* (The World Bank, Dev. Res. Grp. Working Paper No. 5951, 2012); Candace Johnson & Surma Das, *The Human Rights Framing of Maternal Health: A Strategy for Politicization or a Path to Genuine Empowerment?* GENDER HEALTH & WELFARE POL’Y PANEL 2 (Sept. 1–4, 2011) (draft) (India case on maternal health right). See generally Langford, *supra* note 73 (willingness of courts in Colombia, India, South Africa, and Indonesia to adopt this approach).

Just two years later, the consortium declared victory, pointing to the Human Rights Council's passing of a non-binding 2009 resolution linking maternal mortality to human rights.⁸² Due to the movement's efforts, the CEDAW committee issued views in 2011, asserting that Brazil was in violation of its obligations under the treaty because a woman of African descent, Alyne da Silva Pimentel, died in childbirth when she did not receive emergency obstetric care in time after a misdiagnosis.⁸³

This appears to be a two-pronged strategy. First, the movement would try to establish a right to maternal health that did not explicitly include abortion but could be reinterpreted later as including such a right. Second, and simultaneously, it would lay the groundwork for that reinterpretation by getting U.N. development and legal experts to make the connection between maternal health and legal, accessible abortion through non-binding reports, statements, and resolutions.

For example, U.N. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover, presented a report to the General Assembly in 2011, asserting that abortion was an integral part of the right to health.⁸⁴ The statement stood out for its boldness, but also for its transparency on abortion. Even the activists in the movement recognized it as a new approach:

82. Susan Yoshihara, *Six More Problems with Women Deliver: Why Attempts to Redefine Maternal Health as Reproductive Health Threaten the World's Women* 2–3 (Int'l Orgs. Research Grp., Briefing Paper No. 6, 2010). In 2009, the United States Senate had passed a non-binding resolution linking maternal health to human rights, although pro-life advocates were able to remove a reference to a "right to 'maternal health'" before it was adopted. *Id.*

83. Judith Bueno de Mesquita & Eszter Kismödi, *Maternal Mortality and Human Rights: Landmark Decision by United Nations Human Rights Body*, 90 BULL. WORLD HEALTH ORG. 79, 79–79A (2012). The Center for Reproductive Rights prepared the communication on behalf of the family of Alyne da Silva Pimentel in 2009. Under the Optional Protocol of the Convention, individuals may communicate directly with the committee if they feel their country has violated their rights under a treaty. The committee is allowed to investigate the story and offer its "views" on the matter. In its account of the Alyne da Silva Pimentel incident, the World Health Organization referred to the CEDAW committee's views as "authoritative interpretation of States' obligations under the CEDAW," displaying WHO's effort to confer the status of high legal authority upon the committee. Likewise, WHO couched the CEDAW committee's comments in terms of a legal case, such as in a court of law, and claimed that the committee could "establish" state obligations.

84. See G.A. Res. 66/254, U.N. Doc. A/66/254 (Aug. 3, 2011). The Report states:

The Special Rapporteur considers the impact of criminal and other legal restrictions on abortion . . . which are often discriminatory in nature, violate the right to health by restricting access to quality goods, services and information. They infringe human dignity by restricting the freedoms to which individuals are entitled under the right to health, particularly in respect of decision-making and bodily integrity.

Id. at Summary ¶ 2.

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At time of writing, only one expert in the UN human rights system has dared to address abortion as an autonomous right, to which access in general ought to be decriminalized as an element of non-discrimination between women and men. This expert's shot-across-the-bow report—which has not yet been debated—stands out in its isolation from the incremental but limited successes on abortion rights over the last twenty years.⁸⁵

The U.N. General Assembly debated the report, which drew sharp criticism from several countries.⁸⁶ Despite the pushback, the Office of the High Commissioner for Human Rights issued a report the following year, reiterating Anand Grover's assertions.⁸⁷ Adding a layer of perceived credibility to the claims was the fact that the Human Rights Council "welcomed" it in a non-binding resolution.⁸⁸

The increased confidence in the movement is, in part, due to strong support from the United States under the Obama administration, which endorsed the right to maternal health as part of the Human Rights Council.⁸⁹ President Obama's reelection may further accelerate these gains. But even with its success in gaining non-binding comments from U.N. committees, recognition of a right to abortion through a new right to maternal health requires establishing abortion as a necessary part of maternal health. The movement has prospects for success in that regard. That is because, while it has failed to gain a human right to abortion, the movement has made marked progress in promoting the practice of abortion through international development programs.

85. Alice M. Miller & Mindy J. Roseman, *Sexual and Reproductive Rights at the United Nations: Frustration or Fulfillment?*, REPROD. HEALTH MATTERS, Nov. 2011, at 102, 103.

86. Timothy Herrmann, *Governments Condemn UN Official's Attempt to Create a Right to Abortion*, 14 FRIDAY FAX (Oct. 27, 2011), <http://www.c-fam.org/fridayfax/volume-14/governments-condemn-un-official%E2%80%99s-attempt-to-create-a-right-to-abortion.html>.

87. See generally U.N. High Comm'r for Hum. Rts., *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality: Rep. of the High Comm'r for Hum. Rts.*, U.N. Doc. A/HRC/21/22 (July 2, 2012).

88. Susan Yoshihara, *Human Rights Council Attempts to Create Abortion Right*, 15 FRIDAY FAX (Oct. 5, 2012), <http://www.c-fam.org/fridayfax/volume-15/human-rights-council-attempts-to-create-abortion-right.html>.

89. Neil MacFarquhar, *U.S. Joins Rights Panel After a Vote at the U.N.*, N.Y. TIMES, May 13, 2009, at A5.

V. ABORTION AND THE RIGHTS-BASED APPROACH TO
MATERNAL HEALTH

Although it has never made it an official position, the WHO asserts a right to abortion as part of an international right to health. This stance was apparent in the organization's 2012 publication *Policy and Technical Guidance for Safe Abortion*,⁹⁰ but it is not new. In 2004, WHO launched a Global Reproductive Health Strategy that included abortion in the need for legal and regulatory reform as "areas for action."⁹¹ The strategy was adopted by U.N. member states at the 57th World Health Assembly and provides the mandate for WHO's RHR department (whose research arm is HRP) to promote abortion worldwide.⁹² In a 2006 report, WHO confirmed that this included conducting thousands of experimental medical abortions on women in the developing world and training abortionists, including one third of the obstetricians in Mongolia.⁹³

While WHO staff may be sympathetic to the movement, they have walked a fine line in public pronouncements about abortion and human rights. This is apparently due to opposing pressure from donor countries with liberal abortion laws desiring that the organization promote "safe" abortion and from recipient nations seeking to protect their traditional norms and restrictive laws.⁹⁴ For this reason, WHO leadership refrains from articulating an official position, and WHO staff who have asserted that abortion is a human right have generally done so with a caveat in fine print that it does not represent the views of the organization.⁹⁵

90. WORLD HEALTH ORG., *SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS* 17 (2d ed. 2012).

91. Benagiano et al., *supra* note 6, at 195. The WHO Special Program in Human Reproduction, HRP, drafted the Global Reproductive Health Strategy (GRHS), which was adopted by the 57th World Health Assembly in 2004, and which defined five elements of sexual and reproductive health: "maternal and newborn health, family planning, unsafe abortion, STIs including HIV and RTIs, and sexual health." *Id.* The strategy claimed human rights as its guiding principle, and highlighted "five main areas for action: strengthening health systems capacity, mobilizing political will, creating supportive legislative and regulatory frameworks, and strengthening monitoring, evaluation, and accountability." *Id.*

92. *Id.*

93. See WORLD HEALTH ORG. DEP'T OF REPROD. HEALTH AND RES., *SEXUAL AND REPRODUCTIVE HEALTH—LAYING THE FOUNDATION FOR A MORE JUST WORLD THROUGH RESEARCH AND ACTION: BIENNIAL REPORT 2004–2005*, at 21–24 (2006); Andrew M. Essig, *The World Health Organization's Abortion Agenda*, 11 INT'L ORG. RES. GRP.: WHITE PAPER SERIES, 2010 at 1, 23 (a World Health Organization report stated "[m]id-level providers in Viet Nam provide first-trimester abortion by MVA as safely as physicians.") (citation omitted).

94. E-mail from former staff member, HPR, to author (July 2010) (on file with author).

95. See, e.g., David A. Grimes et al., *Unsafe Abortion: The Preventable Pandemic*, 368 THE LANCET, Nov. 25, 2006, at 1908 ("Access to safe, legal abortion is a fundamental right of women, irrespective of where they live.").

Likewise, the U.N. Population Fund is officially restrained from promoting abortion as a human right due to its limited mandate from the Cairo Program of Action. Even so, successive executive directors have played a key role in the movement, most notably Nafis Sadik, Thoraya Obaid, and Babatunde Osotimehin. Obaid maintained that UNFPA could promote a right to abortion despite restrictions on the agency regarding abortion by partnering with and funding abortion advocacy groups.⁹⁶ UNFPA also promotes the norm of abortion as reproductive health in its “rights-based” programming.⁹⁷ The Office of the High Commissioner for Human Rights defines the U.N. rights-based approach as a way to “redress discriminatory practices and unjust distributions of power that impede development progress.”⁹⁸

The turn to maternal health addressed a critical vulnerability in the movement: its lack of a compelling symbol. Central to the awareness-raising phase of human rights campaigns is a vivid depiction of the violation of a particular right. In the case of violence against women, victims came forward to tell their stories and personalize the issue. In the case of abortion, women tended to be more reticent, and the unborn child was also perceived as the victim of abortion. Activists needed to shift the focus to the woman as victim of restrictive laws. The image of a woman dying in childbirth and leaving her other children motherless became the symbol of how restrictive abortion laws hurt women and children.

In 1987, the movement launched the Safe Motherhood Initiative in Nairobi, Kenya.⁹⁹ The conference was led by Fred Sai, a Ghanaian physician and Harvard graduate who was co-founder of the Planned Parenthood Association of Ghana in 1967, president of International Planned Parenthood Federation from 1989 to 1995, senior Population Advisor at the World Bank, and chairman of the U.N. conferences on population and development in Mexico City in 1984, and Cairo in 1994.

While the initiative appealed to developing world constituencies and succeeded in establishing Safe Motherhood programs in many countries, the campaign flagged. Government officials accepted international aid but did not implement them as the lobby had hoped. According to one of the

96. United Nations Non-Governmental Liaison Service, *An Update*, 113 GO BETWEEN, Mar.–May 2007, at 1, 9.

97. See U.N. Population Fund, *Human Rights-Based Programming: What It Is* (Dec. 2006), available at http://www.unfpa.org/upload/lib_pub_file/680_filename_hr_book.pdf.

98. High Comm’r for Hum. Rts., *Frequently Asked Questions on a Human Rights-Based Approach to Development Cooperation*, 15 (2006), <http://www.ohchr.org/Documents/Publications/FAQen.pdf>.

99. *Safe Motherhood Initiative*, WOMEN DELIVER, <http://www.womendeliver.org/about/the-initiative/safe-motherhood-initiative> (last visited Apr. 22, 2013).

initiative's founders, Family Care International's president Ann Starrs, a "key component" of the initiative was abortion, another was extending reproductive rights to adolescent girls.¹⁰⁰ There was no government agreement on either, Starrs concluded.

The Safe Motherhood campaign also suffered from a lack of evidence. Starrs lamented "the technical difficulty of estimating maternal mortality, which makes it problematic to measure progress and evaluate programme impact."¹⁰¹ This was especially hampering since the initiative was billed as data-intensive. It was launched precisely because WHO had announced in 1985 that it could count the global number of maternal deaths every year and that number exceeded half a million.¹⁰² In the ensuing decades, however, the number never changed and the methodology to arrive at the 500,000 figure remained controversial. The estimate relied heavily on survey data and "adjustments" of the figures, sometimes doubling deaths and abortion-related mortality figures. Advocates were caught on the horns of a dilemma. They needed the figures to change in order to show programmatic impact, but if it decreased significantly, they would have a more difficult time arguing it was a global health crisis.

A significant setback came from the highest levels. World leaders gathering for the U.N. Millennium Summit in 2000 put maternal mortality on the global development agenda as one of the Millennium Development Goals (MDGs), but they rejected any mention of reproductive health because of its association with abortion. Despite exhaustive efforts by the movement, world leaders rejected it again in 2005. The only way advocates were able to insert the term into the goals was by slipping it secretly into a 2007 Secretary General's end of the year status report.¹⁰³ It appeared in the appendix, a single line mentioning "reproductive health" under the goal on maternal health, MDG5, but with no number or citation attendant to it. The report was accepted as a matter of routine with no discussion of the ostensible target during a session of the General Assembly. The senior United States diplomat responsible for social and economic issues at the U.N. General Assembly later said he had no idea the controversial target was even in the report that he and his colleagues adopted that day.¹⁰⁴ Over the next

100. Ann M. Starrs, Comment, *Safe Motherhood Initiative: 20 Years and Counting*, 368 THE LANCET 1130, 1132 (2006).

101. *Id.* at 1131.

102. *Id.* at 1130.

103. U.N. Secretary-General, *Rep. of the Secretary-General on the Work of the Organization*, ¶ 13, U.N. Doc. A/62/1 (Aug. 31, 2007).

104. Interview with Grover Joseph Rees, U.S. Diplomat to U.N. Gen. Assembly, in San Jose, Costa Rica (Mar. 20, 2011).

several months and without fanfare, the term began appearing as target “MDG5B” on U.N. websites with its own set of indicators which, like the target, were not subjected to debate before adoption.

The fact that a decision made twice by world leaders was reversed by administrative fiat was outrageous to abortion opponents. And while they claimed victory, the situation was far from an ideal outcome for the reproductive rights movement. The way in which reproductive health was “cascading” into international documents did not foster the international consensus required for norm internationalization.¹⁰⁵

Adding to the complication was that the movement chose to broaden the boundaries of their frame even further to include MDG4 on improving child health. Demonstrating that legal abortion was a necessary intervention for improving maternal health was difficult; proving it was central to child health was even more of a challenge. The rationale was simply that fewer children per family resulted in better health for each one and that reducing maternal deaths improved children’s health.¹⁰⁶

At a 2007 conference in London, the movement sought to galvanize support for the expanded agenda, including the right to maternal health. Under the banner “Women Deliver,” the meeting was officially sponsored by the newly-formed U.N. Partnership on Maternal, Newborn, and Child Health (PMNCH) and organized by the International Planned Parenthood Federation, Family Care International, and Catholics for Choice former president Frances Kissling, who dubbed it a “pro-choice conference.”¹⁰⁷ Its organizers, like Joan Dunlop before them, used the conference to rally the base and re-emphasize the movement’s core purpose, legal and accessible abortion. At the opening plenary, UNICEF deputy executive director Francisco Songane, head of the PMNCH, stated the purpose of the U.N. maternal health consortium, even before increasing the number and quality of skilled birth attendants and emergency obstetric care (the primary methods of preventing maternal deaths), must be sexual and reproductive health—abortion—and without taboos!¹⁰⁸ Reinforcing the message, one third of the

105. In 2008, U.N. High Commission for Human Rights (OHCHR) issued a report calling for including abortion in the MDGs under MDG5b. High Comm’r for Hum. Rts., *Claiming the Millennium Development Goals: A Human Rights Approach*, 31, U.N. Doc. HR/PUB/08/3 (2008) [hereinafter OHCHR].

106. This was the rationale UNICEF used when it intervened with the Nicaraguan Legislature in an attempt to keep abortion legal in Nicaragua in 2006. Interview with Nils Kastberg, Reg’l Dir. for Latin Am., UNICEF, in U.N. Headquarters (Jan. 2008).

107. Interview with Frances Kissling, Former President, Catholics for Choice, in London, Eng. (Oct. 20, 2007).

108. Francisco Songane, Remarks at the Opening Plenary Session of the Women Deliver Global Conference (Oct. 18, 2007).

100 sessions at the conference focused on abortion, and only six dealt with skilled care. Another purpose for the re-framing toward maternal and child health was to mobilize networks among mid-level care providers in the developing world, a feat that even the movement's founders found difficult in the earliest stages. Physicians were resistant to the inclusion of abortion as a maternal health intervention, and so several sessions at the Women Deliver conference, and its follow-on meeting in 2010, were devoted to "values clarification" and other methods of overcoming conscience and cultural barriers among mid-wives and other mid-level health providers.¹⁰⁹

The effort also sought to address the perennial problem of evidence. In the developed world, countries such as Ireland and Malta with highly restrictive abortion laws had some of the world's lowest maternal death rates. The same situation was found in developing countries. In some countries where abortion was already widespread, such as in Nepal, maternal death rates were among the highest, while in developing countries such as Chile, where abortion was highly restricted, maternal deaths had been plummeting for decades regardless of changes in abortion laws.¹¹⁰ Sri Lanka, which was the model used to establish MDG5's goal of reducing maternal mortality seventy-five percent by 2015, had the lowest maternal mortality ratio in South Asia in 2010, at thirty-five per 100,000 live births, causing the movement to doubt the efficacy using maternal health as a frame for advancing abortion:

South Asian countries like India and Nepal successfully liberalized their abortion laws by framing reform as a means of population control or to reduce maternal mortality. These reasons are unlikely to be a campaign-turner in Sri Lanka, where impressive achievements in maternal health have been attributed to the provision of free health care, well-developed health infrastructure, free education and other social welfare measures. About 75% of inpatient care is provided free of charge by the public sector.¹¹¹

One reason for this is that in countries where abortion is highly restricted, clandestine abortions are often done by trained medical practitioners in decent conditions and are therefore not a significant contributor to the country's maternal mortality rates.¹¹² Furthermore, the

109. Yoshihara, *supra* note 80, at 3.

110. Elard Koch et al., *Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007*, 7 PLOS ONE, May 2012, at 1, 14, <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0036613>.

111. Ramya Kumar, *Misoprostol and the Politics of Abortion in Sri Lanka*, 20 REPROD. HEALTH MATTERS 166, 167–68 (2012).

112. *See, e.g., id.* at 168. *See also* Koch et al., *supra* note 110, at 7, 9.

global burden of disease from illegal abortion cannot be estimated accurately due to lack of data, and even the estimation used by the movement (thirteen percent of all maternal deaths, or 47,000) remained lower than other causes of death, particularly with the expanded focus to include children's health. According to WHO reports, 8.795 million children died before the age of five every year: 750,000 children died in childbirth, another three million children were stillborn, and one million children died due to premature birth.¹¹³

The biggest challenge to the new frame came from within the research community when, in 2010, an independent group of experts directly challenged the WHO's maternal mortality figure of more than 500,000 per year.¹¹⁴ They further called into question WHO's research methodologies, as well as the very basis of WHO's claim—made since the 1980s—that family planning and “safe abortion” are necessary interventions to reduce maternal deaths.¹¹⁵ The WHO was forced to capitulate, issuing a report that slashed its estimated number of annual maternal deaths nearly in half, an embarrassment to WHO researchers and a setback for the movement. There were even comments from the independent researchers suggesting that WHO should focus on research and not on policy, an observation that alluded to the strong ties between the U.N. and the reproductive rights lobby.

The study could not have come at a worse time for the movement, which was preparing for a string of major policy and funding meetings that year.

113. Robert E. Black et al., *Global, Regional, and National Causes of Child Mortality in 2008: A Systematic Analysis*, 375 THE LANCET 1669, 1669 (2010) (stating that 8.795 million children die before the age of five every year); March of Dimes et al., *Born Too Soon: The Global Action Report on Preterm Birth*, 2012 WORLD HEALTH ORG. 1 (stating that one million children die due to premature birth); Byron Calhoun, *Abortion and Preterm Birth: Why Medical Journals Aren't Giving us the Real Picture 2* (Int'l Org. Res. Grp. Briefing Paper No. 9, 2012), available at <http://www.c-fam.org/docLib/Brief%209%20FINAL.small.pdf> (stating that there are three million still-born deaths, as well as over 120 published studies linking abortion and pre-mature birth).

114. Margaret C. Hogan et al., *Maternal Mortality for 181 Countries, 1980–2008: A Systematic Analysis of Progress Towards Millennium Development Goal 5*, 375 THE LANCET 1609, 1609–10 (2010). The study estimated annual maternal deaths were 342,900 with 60,000 of those from HIV/AIDS, and said the number has been declining since 1980. *Id.* at 1613. At the Women Deliver conference in June 2010, there was sharp disagreement between U.N. staff, who argued for only one set of U.N.-centered “consensus” statistics, and other scientists, such as the Christopher Murray, one of the authors of the independent study and *Lancet* editor Richard Horton, who called for more scholarly independence. Scientists also refuted the claim by U.N. agencies and the movement that family planning improves maternal health. At one of the plenary sessions during the conference, the Guttmacher Institute's president, Sharon Camp, asked Murray whether his study's finding linking declining global fertility rates to better maternal health supports the idea that more family planning will reduce maternal deaths. Murray replied that “there is no scientific way to prove that.” Christopher Murray, Remarks at the Women Deliver 2010 Conference (June 7, 2010). The Karolinska Institute's Hans Rosling linked the global decline in maternal deaths to improved personal income and other infrastructure such as, in the case of Sri Lanka, improved asphalt roads built during the country's colonial period.

115. Hogan et al., *supra* note 114, at 1609–10.

The editor of the journal that published the independent study, *The Lancet's* Richard Horton, told the *New York Times* he was pressured by advocacy groups to delay publication of the report until after the meetings, which included a Group of Eight (G8) Summit in Muskoka, Canada, the movement's Women Deliver Conference in Washington, and a high level summit on maternal mortality at the U.N. General Assembly.¹¹⁶ The report went to press on schedule and contributed to an unusually high profile defeat for the movement when United States Secretary of State Clinton engaged in an ill-fated political showdown with Canadian Prime Minister Stephen Harper on the eve of the G8 summit.¹¹⁷ Despite her public condemnations of his position, Harper won and abortion stayed off the funding agenda.¹¹⁸

Even so, the Clinton-Harper incident shows how well the movement garnered powerful advocates and mobilized them for important political opportunities. This was the result of decades of prior work getting reproductive rights language into international development programming and policy documents.

VI. REPRODUCTIVE HEALTH ENTERS HARD LAW: THE UNTOLD STORY OF THE DISABILITIES TREATY

While the lobby had failed to gain recognition of a right to abortion, in 2006 it was able to get the term "sexual and reproductive health" included in a U.N. "hard" law document for the first time, the Convention on the Rights of Persons with Disabilities.¹¹⁹ Hailed as a victory for the movement, a closer look reinforces the fact that the way it has been able to advance its language has adversely affected its ability to gain acceptance for the norm. Specifically, the Disabilities Treaty debates demonstrate that the movement has not reached the tipping point at which domestic debate ends. In this

116. Denise Grady, *Maternal Deaths Decline Sharply Across the Globe*, N.Y. TIMES, Apr. 13, 2010, http://www.nytimes.com/2010/04/14/health/14births.html?pagewanted=all&_r=0.

117. Addressing the Canadian government in March 2010 regarding its maternal and child health initiative for the G8, Hillary Clinton stated, "You cannot have maternal health without reproductive health. And reproductive health includes contraception and family planning and access to legal, safe abortion." Jessica Arons & Shira Saperstein, *At G8, Obama, Clinton Must Speak with one Voice for Abortion Access*, THE NATION, June 25, 2010, <http://www.thenation.com/article/36667/g8-obama-clinton-must-speak-one-voice-safe-abortion-access#>.

118. *Id.* Harper wanted maternal and child health to be Canada's signature issue at the 2010 G8 summit. The Harper government reversed its original position which opposed both abortion and family planning as part of the maternal health initiative. It consented to include family planning after intense pressure from the United States, U.K., and liberal MPs in the Canadian parliament, but remained steadfast in its opposition to include abortion in any part of the funding for the initiative.

119. Convention on the Rights of Persons with Disabilities and Option Protocol, G.A. 61/106, art. 25(a), U.N. Doc. A/RES/61/106 (Dec. 13, 2006).

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case, norm contestation continued even after the language and the treaty were adopted.

Reproductive health language was inserted during the final meeting of the ad hoc committee drafting the treaty, which was chaired by New Zealand's ambassador to the United Nations, Donald McKay. As soon as the words "sexual and reproductive health services" were projected onto the two large screens above the heads of the U.N. delegations, twenty-three of them called for its immediate deletion. Some objected to the term "services" because in 2001, a U.N. floor debate linked the term to abortion, but most objections were to any formulation of the term.¹²⁰

Nicaragua led the charge against it saying:

The term sexual and reproductive health must be deleted because it is undefined and there is no consensus on what it means nor on the implications of including it in the document. It is a controversial phrase and there have been many debates in various UN bodies for a number of years. We don't have hope it can be resolved at this session: there is little time and it could bog down the whole meeting. If the phrase were to appear, there would be states that could not ratify the document and that would jeopardize the entire project.¹²¹

Next Libya, Qatar, and Egypt objected.¹²² The Egyptian delegate criticized the chairman for continuing to push for negotiation of the phrase despite the very apparent and widespread opposition and asked him to "maintain a degree of objectivity on the matter."¹²³

Honduras said it was "too controversial a term to be included."¹²⁴ The Marshall Islands then called for deletion, followed by Tunisia and Tanzania who said, "'sexual and reproductive health' is open to different interpretations. We will support text that eliminates controversy and does not go against cultures."¹²⁵ Yemen agreed.

120. In a debate at the U.N. Child Summit in 2001, the United States Ambassador to the United Nations Economic and Social Council, Terry Miller, asked what the term "reproductive health services meant," to which the Canadian delegate replied, "Of course it includes, and I hate to say the word, but it includes abortion." Austin Ruse, *Latin American Countries Push for Abortion in Child Document*, 4 FRIDAY FAX (Aug. 31, 2001), <http://www.c-fam.org/fridayfax/volume-4/latin-american-countries-push-for-abortion-in-child-document.html>.

121. Notes from the Ad Hoc Comm. on the Convention on the Rights of Persons with Disabilities (Aug. 14–25, 2006) (on file with author).

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.*

At this point the chairman intervened and said, “When I saw the phrase, I needed to ask what it means! I don’t say that facetiously. We have tried to say that reproductive health is a particular source of discrimination for the disabled. Reference to ‘national legislation’ would not satisfy those who would want to delete the phrase.”¹²⁶ Rather than recognize the lack of consensus and remove the term, in keeping with the custom in U.N. negotiations, he allowed the debate to continue.

Morocco said, “The footnote is clear, but it would be preferable to delete the phrase.”¹²⁷ Iran and Bangladesh called for deletion on the grounds that there were many more pertinent types of health not addressed.¹²⁸

When the Holy See raised its card, delegates turned to listen. The delegate called for deletion, saying “it is legally imprecise,” and “there is no juridical precedence for this phrase. It has never appeared in a binding document.”¹²⁹ When he finished, the room was set in motion again, as Bahrain was the next country to call for striking the language.

The Costa Rican delegate said, “Every time I ask what sexual and reproductive health services means, I get a different answer!”¹³⁰ The Philippines then called for deletion, followed by Kenya.¹³¹ In a surprise comment, Norway said, “We would accept deletion. The term is very flexible and can be interpreted by the committee.”¹³² Lichtenstein had insisted the term already achieved consensus in previous documents, to which the United States delegate countered: “This convention is unlike the documents that Lichtenstein mentioned such as the HIV declaration. They are negotiated in a completely different way. The most straightforward solution is to delete the phrase.”¹³³

Pakistan added, “The term is undefined. We would not like to cherry pick because pre-natal and post-natal care are also important.”¹³⁴ Egypt added, “We should prioritize other things like life threatening illness, like prosthetics. Reproductive health is not a priority. Whether it creates new rights: some say yes, some say no.”¹³⁵

126. *Id.*

127. *Id.*

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.*

134. *Id.*

135. *Id.*

At this point the chairman interjected, “I shudder at the idea of trying to define it! I am not sure we could.”¹³⁶

Mali and Argentina agreed with the move to delete the phrase, followed by El Salvador and finally Saudi Arabia, the last of the twenty-three nations, who summed up the debate saying: “What is in square brackets is not useful and should be deleted.”¹³⁷

There was a time in U.N. negotiations when the dissent of just a few nations could block consensus. But despite the numerous, passionate pleas for deletion of the phrase, the chairman pushed it forward. He sent a member of his staff to intercept the Jamaican delegate, who had suggested just removing “services” at the end of the phrase. While she insisted that Jamaica was not tied to this proposal, the staffer convinced her to submit it in writing and so the “Jamaican language” became the basis of the working text.

To split up the opposition, European Union delegates occupied Muslim countries with a fight over “occupied territories,” a phrase which the Muslim nations sought to keep and the United States wanted removed.¹³⁸ The European Union held simultaneous side negotiations on both issues, physically dividing opponents of reproductive language. The meetings continued all week, and late into the night, with no resolution.

At midnight on the day negotiations were to conclude, the chairman moved the talks from U.N. headquarters to the New Zealand mission, where several delegates who were opponents of the term were turned away. At four in the morning the delegates emerged with three working phrases for the text, all of which included the term “sexual and reproductive health.” With a few hours until the closing bell, the chairman’s staff convened the negotiations in a remote room in the basement of the U.N. Some delegates from dissenting nations arrived in the main conference room, unaware that negotiations had convened elsewhere, and unable to further influence the outcome of the talks.

The final version of the treaty thus obligated states parties to “[p]rovide persons with disabilities with the same range, quality and standard of free or affordable health care and programs as provided to other persons, including in the area of sexual and reproductive health and population-based public health programs.”¹³⁹

The manner of the negotiation was significant because at several points, reproductive rights advocates had to concede that the term “sexual and reproductive health” did not include a right to abortion. At one point, the

136. *Id.*

137. *Id.*

138. *Id.*

139. *Id.*

chairman polled the room and asked if anyone believed that the document created any new rights. No country responded in the affirmative. He stressed on more than one occasion the presence of a footnote in the working text to this effect, and that the rest of the *travaux préparatoires* would provide guidance to interpret the treaty in the future. Footnote (4) to the draft of Article 25(a) as of February 2006 reads:

The Ad Hoc Committee notes that the use of the phrase “sexual and reproductive health services” would not constitute recognition of any new international law obligations or human rights. The Ad Hoc Committee understands draft paragraph (a) to be a non-discrimination provision that does not add to, or alter, the right to health as contained in article 12 of the International Covenant on Economic, Social and Cultural Rights or article 24 of the Convention on the Rights of the Child. Rather, the effect of paragraph (a) would be to require States Parties to ensure that where health services are provided, they are provided without discrimination on the basis of disability.¹⁴⁰

The footnote did not concede on the abortion issue specifically, but it did emphasize that the phrase was included only on the grounds of non-discrimination. Further reinforcing this were statements from U.N. delegations at the time of the treaty’s adoption on December 13, 2006. Of the thirty-six statements made that morning, nearly half affirmed the anti-abortion perspective, twelve affirmed that abortion was not assumed in the controversial term and no statement contradicted this understanding.

The Marshall Islands was the first to inject warning into the celebratory air: “The Marshall Islands accepts the phrase ‘sexual and reproductive health’ with the understanding that it does not include abortion,” the delegate said, reminding the weary delegates of the deal they had struck, “that its use in article 25(a) does not create any abortion rights, cannot be interpreted to constitute support for or endorsement or promotion of abortion and does not create, and would not constitute, recognition of any new international law, obligations or human rights.”¹⁴¹

140. Rep. of the Ad Hoc Comm. on a Comprehensive and Integral Int’l Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, 7th Sess., Jan. 16–Feb. 3, 2006, art. 25(a) n. 4, U.N. Doc. A/AC.265/2006/2 (Feb. 13, 2006). The footnote to the draft of Article 25(a) appeared in this report stating: “Provide persons with disabilities with the same range, quality and standard of free or affordable health services as provided other persons, [including sexual and reproductive health services] and population-based public health programmes.” *Id.* (first alteration in original).

141. U.N. GAOR, 61st Sess., 76th plen. mtg. at 4, U.N. Doc. A/61/PV.76 (Dec. 13, 2006) [hereinafter 76th plen. mtg.].

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Egypt said, “[S]exual and reproductive health services’ in article 25(a) does not by any means entail the authorization of abortion, except in cases where Egyptian national laws permit it.”¹⁴² Peru stated that:

[T]he Peruvian Constitution recognizes the right to life from the moment of conception. Consequently, Peru declares that the programmes and health care, even in the area of sexual and reproductive health mentioned in article 25(a) of the Convention will be implemented in terms of unrestricted respect for life [under the law].¹⁴³

Iran said, “Iran accepts the phrase ‘sexual and reproductive health’ with the understanding that [it] does not include abortion.”¹⁴⁴ Honduras’ Representative stated that “Honduras accepts the phrase ‘sexual and reproductive health’ as used in article 25(a),” emphasizing that “it does not include abortion and does not constitute recognition of any obligation under international law or human rights law.”¹⁴⁵ The representative added that “[t]he internal legal framework . . . is very clear on this point” and asked that the country’s statement be “placed on record and in the final report of . . . the General Assembly.”¹⁴⁶ The Nicaraguan delegate stated, “[M]y delegation, under precise instructions from my Government, wishes to make an interpretive statement concerning subparagraph (a) of article 25 on sexual and reproductive health.”¹⁴⁷ Regarding the interpretation of Article 25(a) the delegate stated “that it does not cover abortion and that its use . . . should not be interpreted as meaning approval, support, or promotion of abortion.”¹⁴⁸

The United States delegate reminded the room that according to the *travaux préparatoires* and the footnote, the term and the article were settled, and went on to say:

In that regard, the United States understands that the phrase “reproductive health” in subparagraph (a) of article 25 of the draft Convention does not include abortion, and that its use in that article does not create any abortion rights and cannot be interpreted to constitute support, endorsement or promotion of abortion. We stated that understanding at the time of adoption

142. *Id.* at 5.

143. *Id.*

144. *Id.*

145. *Id.* at 6.

146. *Id.*

147. *Id.*

148. *Id.*

of the Convention in the Ad Hoc Committee, and note that no other delegation suggested a different understanding of this term.¹⁴⁹

Costa Rica, after calling the treaty a “triumph for humanity,” nonetheless said “sexual and reproductive health does not constitute a new human right or, still less, imply relativization or negation of the right to life, which we regard as the source of all rights.”¹⁵⁰ Uganda affirmed that “‘sexual and reproductive health services’ does not constitute recognition of any new international legal obligations or human rights and that more specifically, it does not include abortion.”¹⁵¹ The Philippines said:

[T]he Philippines is of the belief that the provision of health care and all other services should not in any way undermine the right to life of a person, with or without a disability, in all stages of his or her being. It is in this light that the Philippines understands articles 12 and 25 of the Convention.¹⁵²

In a surprise to some, Canada affirmed that “the Convention does not create any new rights.”¹⁵³ Likewise, the Colombian delegate emphasized that Article 25 was only meant to put the disabled on equal terms with the rest of society.¹⁵⁴ El Salvador’s representative reminded the room that “[i]t is the first legally binding international instrument in this area.”¹⁵⁵ Concerning 25(a) the representative said, “El Salvador understands that the concept of sexual and reproductive health will be applied in accordance with the provisions of national legislation currently in force in that area,” adding a request that the country’s statement be made part of the official record.¹⁵⁶ Libya said that Article 25(a) does not signify action contrary to the “principles of Muslim and national legislation, including abortion, which is prohibited except under very specific circumstances.”¹⁵⁷

In a sobering end to the proceedings and to the years of negotiation, the Holy See said:

[T]he Holy See understands access to reproductive health as being a holistic concept that does not consider abortion or access to abortion as a dimension

149. *Id.* at 7.

150. *Id.* at 11.

151. *Id.* at 14.

152. *Id.* at 15.

153. *Id.* at 19.

154. *Id.* at 18–19.

155. *Id.* at 22.

156. *Id.*

157. *Id.* at 6.

of those terms. Moreover, we agree with the broad consensus that was voiced during negotiations and in the context of the preparatory work done that this article does not create any new international rights and is merely intended to ensure that a person's disability is not used as a basis for denying a health service.

However, even with that understanding, we opposed the inclusion of such a phrase in this article, because in some countries reproductive health services include abortion, thus denying the inherent right to life of every human being, as affirmed by article 10 of the Convention. It is surely tragic that, wherever foetal defect is a precondition for offering or employing abortion, the same Convention created to protect persons with disabilities from all discrimination in the exercise of their rights may be used to deny the very basic right to life of disabled unborn persons.

For that reason, and despite the many helpful articles this Convention contains, the Holy See is unable to sign it.¹⁵⁸

The fact that the prevailing understanding of “sexual and reproductive health” had emerged from the decades of debate in soft law documents to make it into a hard law was a sign of progress for the movement. But the fact that countries insisted that the term did not include a right to abortion—or support, endorsement, or promotion of it—signaled trouble. What is clear from the debate about the term “sexual and reproductive health” during the Disabilities Treaty negotiations is that, for many nations, the language was reluctantly adopted, but the norm was not.

VII. ANALYSIS: A BRIDGE TOO FAR

In the three-stage lifecycle of an international norm, an idea is first promoted by norm entrepreneurs, then “cascades” into law and policy, and reaches a tipping point after which it achieves a taken-for-granted quality and is no longer a matter of broad public debate, when more countries begin to adopt the norm rapidly even without domestic pressure, or when an international or regional “contagion” occurs in which international and transnational norm influences become more important than domestic politics for effecting norm change.”¹⁵⁹ While the transnational reproductive health movement has garnered impressive success in the first phase, it has fallen short of the final stage, internalization. What explains this?

First, activists failed to convince countries to insert the term as a matter of human rights at the Cairo and Beijing conferences. In the sole instance

158. *Id.* at 23.

159. Finnemore & Sikkink, *supra* note 14, at 902.

where it appears in a human rights treaty, the term is included as a matter of non-discrimination and imposes no obligation to create new rights. That is not to say that some international legal experts, along with U.N. human rights special mandate holders and treaty body committee members, have not chosen to interpret the term as imposing new international obligations. But their views are not binding on states, and the sovereignty clause in the Cairo and Beijing documents ultimately left room for state interpretation of its political obligation.¹⁶⁰

Second, activists failed to fully reframe the issue of abortion as a matter of health, choosing to maintain ties to the influential population establishment. The reproductive health movement did not vanquish the supply-side population control advocates so much as get subsumed into them. As a result, the movement did not fully mobilize international alliances with activists and some governments in the developing world, which continue to engender resistance to the term at the international level.

Third, the decision to obscure the abortion component of the phrase during U.N. negotiations gave nations wide latitude to interpret it, diminishing its power to change policy and law. This has resulted in a lack of uniformity in compliance with the movement's original aims, even in the many nations that have adopted reproductive rights as a frame for health care. In the legal realm, the norm has failed to emerge evenly, as evidenced by the need for an ongoing reliance on a strategic litigation campaign in the few countries with favorable judicial and political conditions.

Fourth, there were external limiting factors, chiefly a countervailing attempt by nations to redefine the term "reproductive health" as abortion-neutral, despite the Cairo consensus that it includes abortion where not against the law.

Finally, mutually exclusive norms arising from religious and cultural traditions prevailed in the process of norm contestation. Whereas norms such as the prohibition of slavery, torture, and violence against women are considered consonant with these traditions, a reproductive rights norm remains incompatible with them in many societies who perceive the norm to include abortion. This is evident in the fact that the reproductive rights movement has had to expend capital attempting to change prevailing religious and cultural norms, with mixed results.

One can hardly imagine declaring universal acceptance of the prohibition against slavery where it is against the law, but not where it is still legal. Either a norm has been internalized or it has not. It could be said that it has been internalized in some places and not others, but then it would no longer

160. JOACHIM, *supra* note 2, at 158.

be a universal, nor could it be a human right, which is by definition universal, since it is inherent to all human beings.

The theory of norm dynamics and political change articulated by Finnemore and Sikkink is more or less linear. It assumes that an idea remains coherent through the three step process of emergence, cascade, and internalization. This is much like a toy that emerges the same way from the assembly lines of different factories using the same plan. If a production plant can pick and choose which components it includes, an array of toys emerges, not one that can claim universal appeal. Others have critiqued ideational theory, and models that build upon it, for their need to better account for context and the mechanisms by which a norm is advanced. But so far there has been too little discussion of the effects of deliberately keeping a norm's meaning ambiguous during the process of persuasion.¹⁶¹ In this case, the ostensible aim for political change—legal and accessible abortion—was sometimes deliberately disassociated from the norm through international debate and the process of iterative reframing. This was a direct consequence of the tactics norm entrepreneurs used in its initial international propagation and the way they diluted its meaning by expanding its purview in their strategic choices.

Finnemore and Sikkink argue that “norms that are clear and specific, rather than ambiguous and complex, and those that have been around for awhile . . . are more likely to be effective.”¹⁶² Deliberate ambiguity by norm entrepreneurs led to interminable norm contestation, even after the language of the norm was said to have reached “consensus” and was adopted by U.N. member states in hard law, the U.N. Disabilities Treaty.

In this light, the case of reproductive rights bears out Finnemore and Sikkink's assumptions about the qualities of effective norms. First, effective norms are those which lend “legitimacy,” have “prominence,” and embody “intrinsic qualities.”¹⁶³ It may be true that nations accepted the language of reproductive rights in international documents and national health programs because they perceived it to lend legitimacy to governments desiring to show progress on women's issues. It may be that the language was adopted because of its perceived “prominence” since it was used by powerful,

161. See generally Jennifer P. Ruger, *Normative Foundations of Global Health Law*, 96 GEO. L.J. 423 (2008) (illustrating how other models include theories of global health law which depend upon voluntary norm internalization prior to the promotion of laws and policies of health equity). See also Ole Elgström, *Norm Negotiations: The Construction of new Norms Regarding Gender and Development in EU Foreign Aid Policy*, 7 EUR. PUB. POL'Y 457, 475–76 (2000) (critiquing ideational theory including too little attention to norm resistance).

162. Finnemore & Sikkink, *supra* note 14, at 906–07.

163. *Id.* at 906–08.

Western states, and even that it had “intrinsic qualities” reflecting progressive ideas, such as individualism and autonomy. The fact that reproductive rights were still debated in progressive, powerful nations, however, undermined that prominence, the ability to confer legitimacy, and the “intrinsic quality” of the norm.

Likewise, norms with “adjacency,” which are close to an existing norm or derivable from it, should succeed according to Finnemore and Sikkink.¹⁶⁴ The movement hoped to capitalize on international development and especially international health norms, but failed to produce sufficient evidence that abortion was health care per se, and failed to prove their claim that abortion is a necessary intervention to improve maternal health. Finally, norms which exist in “world time” and respond to a global crisis or shared experience, such as war or economic shock, are likely to be internalized.¹⁶⁵ The family planning norm enjoyed success because it cascaded during a time of widespread fear, substantiated or not, about overpopulation. The reproductive rights movement chose to remain cleaved to the population control movement in 1974, and so reaped some of its benefits.¹⁶⁶ But it also shared in the decline of its prominence and funding when nations began to struggle with the social and strategic effects of fertility decline and rapid population aging, a phenomenon that the U.N. Population Division called “unprecedented,” “pervasive,” “profound,” and “irreversible.”¹⁶⁷

VIII. POLICY IMPLICATIONS: NO NORM, NO RIGHT

Under what conditions could it be said that a movement has succeeded in the propagation of a new norm? One metric is the benchmarks set by the movement for itself.

In an internal strategic memorandum, the Center for Reproductive Rights said one measure, which has been achieved, is the acceptance of their assertions by mainstream treaty bodies, such as the Human Rights Committee.¹⁶⁸ In addition, they say major human rights organizations, such as Human Rights Watch and Amnesty International, promote abortion as a human right. One nation’s high court, Colombia’s, has liberalized its laws,

164. *Id.* at 908.

165. *Id.* at 909.

166. See Robert Whelan, *How Population Control is Violating Reproductive Freedom*, 95 POLITICAL NOTES 1, 1–4 (1994).

167. U.N. Dep’t of Econ. & Soc. Affairs, Population Div., *World Population Ageing 2009*, at viii, ix, U.N. Doc. ESA/P/WP/212 (Dec. 2009).

168. Sylva & Yoshihara, *supra* note 70, at 19–20.

citing the U.N. committees.¹⁶⁹ U.N. agencies have promoted abortion as part of a rights-based approach, regional human rights bodies have begun to adopt the language, if not the norm, including in binding documents such as the Maputo Protocol, and decisions from bodies such as the Inter-American Court on Human Rights.¹⁷⁰ Some within the movement, such as Secretary of State Hillary Clinton, have already attempted to consolidate the perceived victories in policy.¹⁷¹ By its standards, the movement seems to have achieved its goals. Furthermore, in some cases, nations have adopted the language of reproductive rights in legislation. In December 2012, after more than a decade, activists were able to get the Philippine legislature to pass a reproductive health bill that would promote government-funded contraception and mandate reproductive health education for children.¹⁷² But there are reasons to remain skeptical.

Its decision to frame abortion as health care and not just a matter of anti-discrimination presented challenges for the movement. It relied on societies valuing not only fairness but health and life. Success thus depends on overcoming preexisting norms, such as the value of life before, as well as after, birth.¹⁷³ For example, the Philippines still prohibits abortion and protects human life “from conception” in its constitution.¹⁷⁴ In Kenya, which has similar constitutional protection for unborn life, activists were able to exploit pressure from the United States government on the people to adopt a new constitution in 2010, one that kept the conception clause but also added language that can allow for abortion.¹⁷⁵ It is unlikely that this was done as a

169. *Id.* at 32.

170. *See, e.g.,* Murillo et al. v. Costa Rica, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 12.361, ¶ 149 (Nov. 28, 2012) (holding that Costa Rica’s ban on in vitro fertilization violates the right to privacy).

171. Prolifeinformation, *supra* note 39.

172. An Act Providing for a National Policy on Responsible Parenthood and Reproductive Health, Rep. Act No. 10354, § 4 O.G. 1, 6–12 (July 23, 2012) (Phil.).

173. *See* Convention on the Rights of the Child, G.A. Res. 44/25, pmbl., U.N. Doc. A/RES/44/25 (Nov. 20, 1989) (“Bearing in mind that, as indicated in the Declaration of the Rights of the Child, ‘the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.’”).

174. CONST. (1987), art. II, sec. 12 (Phil.).

175. CONSTITUTION, art. 26 (2010) (Kenya). Article 26 states:

- (1) Every person has the right to life.
- (2) The life of a person begins at conception.
- (3) A person shall not be deprived of life intentionally, except to the extent authorised by this Constitution or other written law.

result of any change in public attitudes, since proponents assured voters that the conception clause was intact, but downplayed the abortion clause.

A similar situation occurred in Kosovo in 2008, where a draft constitution including the right to life “from birth”¹⁷⁶ was allowed a year of public debate—but the public was not allowed to see the draft during that period. The words “from birth” were removed after religious leaders discovered the clause.¹⁷⁷ In Colombia, the number of reported abortions increased sharply after it was legalized in 2006, according to some reports.¹⁷⁸ Both sides of the abortion debate recognize that public attitudes may shift toward acceptance, even in traditional societies, once the number of abortions increases. This, however, has not been the experience in the United States.

Even liberal societies, where abortion is common, continue to debate whether abortion is health care. In the United States, many disagreed with the Congressional testimony of Sandra Fluke, a Georgetown University law student who claimed that her right to free birth control trumped the Catholic school’s right to freedom of religion.¹⁷⁹ Still more opposed a mandate in national health care legislation, nicknamed “Obamacare,”¹⁸⁰ which did not allow for conscience protection or religious exceptions in funding abortion. But even with such policies as the law of the land, they are not normative as long as a significant portion of society objects.

What would it take to establish a reproductive health right? If nations were to be held accountable for violating reproductive rights, it is not clear what they are being held accountable for—and who decides. A first, unlikely, way to achieve recognition of an international right would be a binding law document that includes a definition of the term, negotiated and adopted by governing authorities. The second would be the establishment of customary law. Some within the reproductive rights movement claim this

(4) Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.

Id.

176. DRAFT CONSTITUTION, art. 25 (2008) (Kos.).

177. Interview with Lush Gjergji, in Pristina, Kos. (Apr. 2008).

178. Ana Cristina González Vélez, ‘The Health Exception’: A Means of Expanding Access to Legal Abortion, 20 REPROD. HEALTH MATTERS 22, 24, 27–28 (2012).

179. Jim Abrams, *Sandra Fluke, Witness Snubbed by GOP, Speaks to Democrats about Birth Control*, HUFFINGTON POST, Feb. 23, 2012, http://www.huffingtonpost.com/2012/02/23/sandra-fluke-birth-control-democrats_n_1297110.html.

180. See The Patient Protection and Affordable Care Act, 26 U.S.C. § 5000A (2010).

has been achieved, but most countries would not agree, since it is based mostly on non-binding statements from U.N. committees.¹⁸¹

No matter how many statements U.N. committees make, nations can simply ignore them. In 2012, the government of Peru rejected the Human Rights Committee's admonition that the country's restrictive abortion law violated obligations under the International Covenant on Civil and Political Rights.¹⁸² Calling the committee's comments *ultra vires* acts, they rejected both the committee's assertions and its authority to interpret the treaty in that regard.¹⁸³ Further, persistent objectors, chiefly the United States under Republican administrations, undermine the claim to a customary norm. It is infeasible that the movement would be able to get a preponderance of other nations on board before the United States abandoned its role in that regard, since such a development would require persuading a large number of nations to drop their objections to abortion before Democrats leave office, or else it would require pro-life Republicans to change their stance, or the United States Supreme Court to make a definitive statement on the matter. The court has, on rare occasions, used international jurisprudence in its decisions, and there are a handful of countries whose courts favor the justiciability of economic and social rights. But there is a paucity of cases and thus, the movement's lawyers intend to win favorable court decisions by initiating more labor-intensive strategic litigation in select jurisdictions, an effort they say takes three to five years per case.

Contrast today's legal trench warfare with the blithe declaration by some world leaders in 1966, which asserted a human right to family planning by decree. Consider also that in 2000, and again in 2005, world leaders rejected any mention of "reproductive health" in the MDGs. Consider the tactics negotiators resorted to during the Disabilities talks to get mention of the term in the treaty, and the rejection of "reproductive rights" at the high level Rio+20 conference on sustainable development.¹⁸⁴ The latter was a

181. See, e.g., L.S. Johnson, *The Right to Maternal Health Care: Developing International Human Rights Law to Prevent Maternal Mortality*, 11 U. BOTS. L.J. 39, 67 (2010) (illustrating that Philip Alston has argued that while the MDGs are not legally binding, and while many of them have not reached the status of customary international law, maternal health meets the criteria for such a custom).

182. Letter from Rosario Fernández, Peru's Minister of Justice to Jose Antonio Garcia Belaunde, Peru's Minister of Foreign Affairs (July 25, 2011) (on file with author) ("Respuesta del Estado Peruano al Dictamen del Comité de Derechos Humanos recaído en la Comunicación No. 1153/2003, presentada por Karen Noelia Huaman") (giving the "Peruvian Government's response to the Committee's failure on Human Rights Communication No. 1153/2003, submitted by Karen Noelia Huaman") (author's translation).

183. *Id.*

184. UNFPA and a few developed nations attempted to marry "population dynamics" to "reproductive health" in the Rio+20 outcome document. See POPULATION MATTERS FOR SUSTAINABLE DEVELOPMENT, U.N. POPULATION FUND 10 (June 2012), <http://www.unfpa.org/webdav/site/global/>

significant setback according to abortion advocates and a direct result of the movement's decision to maintain its ties to the population establishment.¹⁸⁵

These events raise the question: Has the meaning of reproductive rights come full circle—from transparency, to ambiguity, and back?

CONCLUSION: A CALL TO CONTESTATION

On May 27, 1973 the *New York Times* announced that the city's largest abortion clinic, the Center for Reproductive and Sexual Health, Inc., would be closing its doors.¹⁸⁶ The clinic had relied on "mainly out-of-state clientele" and could no longer compete in the marketplace created by the U.S. Supreme Court's decision in *Roe v. Wade*, which "made abortion as legal elsewhere as in New York."¹⁸⁷ According to Bernard Nathanson—the clinic's director who later became a zealous pro-life activist—the Center for Reproductive and Sexual Health was "the largest abortion clinic in the Western world ([and performed] 60,000 abortions in 18 months)."¹⁸⁸

For those familiar with the early United States debates about abortion, there has been little doubt about the meaning of "reproductive and sexual health" as a euphemism for abortion. Nearly everyone, on both sides of the international abortion debate, has expressed a desire to move on and stop rehashing this term's connotations. With few exceptions, the international pro-life coalition agrees that the terms, unless and until defined in a negotiated U.N. document as excluding abortion, are fraught with danger and should be avoided.¹⁸⁹ As the debate over the Disabilities Treaty in 2006

shared/documents/publications/2012/UNFPA%20Population%20matters%20for%20sustainable%20development.pdf.

185. The Obama administration acknowledged that the defeat of "reproductive rights" language in the Rio+20 outcome document set back plans to promote the controversial term "sexual rights" in the post-2015 funding agenda talks at the U.N. in 2013. Lisa Correnti, *US State Department Laments Losses Last Summer at Rio*, 15 FRIDAY FAX (Jan. 17, 2013), <http://www.c-fam.org/fridayfax/volume-15/us-state-department-lament-losses-last-summer-at-rio.html>. See also Jill Sheffield & Robert Engleman, *The Critical Role of Women in Sustainable Development*, WOMEN DELIVER (Oct. 22, 2012), <http://www.womendeliver.org/updates/entry/the-critical-role-of-women-in-sustainable-development>.

186. Laurie Johnston, *Abortion Clinics Face Crisis Here: Eased Restrictions Reduce Clients from Out of State*, N.Y. TIMES, May 27, 1973, at 48.

187. *Id.*

188. Nick Thimmesch, Editorial, *Doubts About the Abortion Binge*, THE TELEGRAPH HERALD, Dec. 12, 1974, at 4 (internal quotation marks omitted).

189. The European Catholic bishops urged European lawmakers:

[R]efrain from using the terms "sexual and reproductive health" or "sexual and reproductive healthcare" in the official documents of the European Union; to vote against its use or for its deletion whenever its use is included in any draft official document [R]efrain from the use of similar and even more problematic terms such as "reproductive services" or "sexual and reproductive rights" [and] replace these terms, where they are used in draft texts, with the

demonstrates, attempts at purifying the term through negotiation and strident assurances that the terms do not include abortion have not sufficed.

And so, while attempts to sanitize the language of reproductive rights have proved elusive, accounts of its successful adoption are premature. Even though the concept peppers countless U.N. documents, its power to change policy and human behavior and especially attitudes—the evidence of a new norm—has been limited by its ambiguity. In the end, abortion advocates failed to achieve norm internalization, in part due to their strategic overreach and tactical missteps.

While the human rights regime has been essential to propagating international social policy for half a century, it is not the only venue. Even before the articulation of reproductive rights, the population establishment achieved many of the movement's same goals by convincing some like-minded elites to change policies and enforce them heavy-handedly. The transnational reproductive rights movement has been most successful through changing facts on the ground without public debate, by force of institutional momentum in international health and development programs. Lacking U.N. member state consensus on whether abortion is part of reproductive health, U.N. agencies disseminate reports and field manuals that shape policy, asserting such consensus as fact, even in countries that consistently reject it during U.N. debates.¹⁹⁰

Abortion advocates have acknowledged that this is a sort of confidence game.¹⁹¹ They see the need to propagate the perception that abortion is already a human right in order to convince governments to liberalize their laws, believing that the right may eventually be recognized as a result of that state practice. Abortion opponents for their part may draw satisfaction from

expressions “health of the mother and child” or “maternal and child health,” which are more appropriate expressions that are less subject to ideological use.

Commission of the Episcopates of the European Union, *The Term “Sexual and Reproductive Health” and its Meaning at International and European Levels*, 2 SCI. & ETHICS 5, 6–7 (2008). But see Meghan Grizzle, *White Paper: Reproductive Health*, WORLD YOUTH ALLIANCE 19 (2012), available at <http://www.wya.net/advocacy/research/WYA%20Reproductive%20Health%20White%20Paper.pdf>, for a dissenting view from the pro-life perspective which argues that “[t]he term ‘reproductive health’ is firmly rooted in international advocacy efforts, and international negotiations therefore must not reject this term.”

190. See, e.g., INTER-AGENCY FIELD MANUAL ON REPRODUCTIVE HEALTH IN HUMANITARIAN SETTINGS: 2010 REVISION FOR FIELD REVIEW, at forward, 5, 6, 15 (Inter-Agency Working Grp. on Reprod. Health in Crises ed., 2010), available at http://www.who.int/reproductivehealth/publications/emergencies/field_manual_rh_humanitarian_settings.pdf (illustrating that even though many U.N. member states have consistently rejected abortion as part of reproductive health and rights, the WHO promulgates a field manual which asserts, “reproductive health is a human right,” and instructs health care workers how to perform abortion and promote sexual rights to fulfill that right). See generally *Safe Motherhood Initiative*, *supra* note 99; U.N. Secretary-General, *supra* note 103; OHCHR, *supra* note 105, at 31.

191. See GERMAIN & KIM, *supra* note 72, at 7.

this, believing the game will eventually be hoisted on its own petard. But complacency on one extreme, or resignation on the other, is out of place. The reproductive rights movement has already gained ground, as the case of Colombia shows, and will likely make further inroads. The need is for heightened vigilance regarding the way the approach is affecting the nature of human rights and development, regimes that matter to those who care about helping the worlds suffering poor and disenfranchised. Even within the movement, there are inklings of trouble. Jutta Joachim cautioned the reproductive rights movement that, “[b]y using the [human rights] frame in different settings and by linking it to different issues, NGOs may risk diluting its power where rights might be a catchall phrase that means everything and potentially nothing or very little anymore.”¹⁹² The cogency of rights is undermined by their volume. Others have pointed to the apogee of rights. The Holocaust scholar Samuel Moyn noted the relative apathy toward recent political dissidents from China, observing that, “the whole idea of human rights has lost some of its romantic appeal and moral purity . . . once pure ideals are now much harder to separate from the impure world of daily policy making, international power and unfulfilled hopes.”¹⁹³ This is a far cry from Jack Donnelly’s claim that human rights is the new standard of civilization—the line dividing civilization from barbarity.¹⁹⁴ The reproductive rights movement has not concealed the fact that it views human rights as an instrument for achieving its policy objectives.¹⁹⁵ It can be shed, as was the population control frame, when it loses the power to change policy. In the mean time, the tactic of shaming—as barbaric—laws which protect life before birth has promoted a competitive view of rights, particularly pitting mother against child. The rejection of the holistic view of rights, toward satisfaction of particular interests warrants continued debate about the norm.¹⁹⁶

192. JOACHIM, *supra* note 2, at 179.

193. Samuel Moyn, Op-Ed, *Human Rights, Not So Pure Anymore*, N.Y. TIMES, May 12, 2012, http://www.nytimes.com/2012/05/13/opinion/sunday/human-rights-not-so-pure-anymore.html?_r=2&.

194. Jack Donnelly, *Human Rights: A New Standard of Civilization?*, 74 INT’L AFF. 1, 1–2 (1998).

195. See, e.g., *Women Deliver 2013 Conference Registration—Concurrent Sessions*, WOMEN DELIVER, <http://www.cvent.com/events/women-deliver-2013-conference-registration/custom-139-ccfb71484fb4492da451fabcc2679863.aspx> (last visited Apr. 23, 2013) (“One of the most important frames for reproductive health and for women’s rights is the human rights frame.”).

196. Pope Benedict XVI noted in his address to the U.N. General Assembly that such a competitive view of rights represents “a move away from the protection of human dignity towards the satisfaction of simple interests, often particular interests,” and thus, “run[s] the risk of contradicting the unity of the human person and thus the indivisibility of human rights” which underpinned the Universal Declaration of Human Rights. William E. DeMars, *Faith in the UN: Pope Benedict’s Proposal 4* (Int’l Org. Res. Grp., Briefing Paper No. 4, 2008) (emphasis removed) (quoting Pope Benedict XVI, Address at the General

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Reproductive rights has gained ground in the sense of more widespread practice. But norms, as standards of right conduct, ultimately reside in the realm of values. It is people, not states, who entertain ideas. In free societies—and those not yet free—norm internalization will only come if men and women were to decide that the aims of reproductive rights are true, good, and just. After forty years of debate, that is by no means a foregone conclusion.