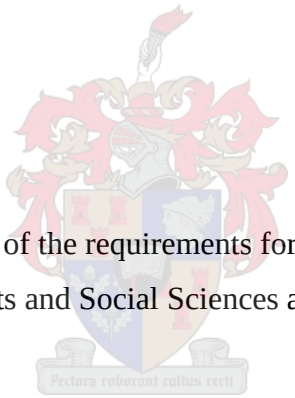
Whose morality, Whose burden: Abortion, International Development and Grandstanding

By

Dr RCH Thetard



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Supervisor Prof. A.A. Van Niekerk

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Declaration

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Abstract

The Roe v. Wade decision (1973) by the American Supreme Court is a pivotal moment in American history when the onus of choice about abortion shifted to pregnant women. While this signified victory for one segment of the American population (the pro-choice group), it awoke strong resistance from others (the pro-life group) resulting in long-standing acrimonious conflict. Pro-choice groups affiliated themselves with like-minded groups, including the Democratic Party, who stood for the rights of women to exercise reproductive choices including abortion. Pro-life groups aligned themselves with conservative religious groupings from which emerged the Christian Right. The Christian Right coined the term '*right-to-life*' which, as part of their anti-abortion ideology, became a rallying cry in pursuit of the establishment of fetal personhood from the moment of conception, a core anti-abortion strategy. They created strong networks with conservative Republicans and subsequently, as a movement, became influential in the national political process and the election of Republican Presidents including Reagan, the two Bush's and Trump. The Christian Right, in addition, pursued a global effort to strengthen their anti-abortion cause.

The combination of domestic and international agendas stimulated the development of a strong American anti-abortion push exemplified by the enactment of the Mexico City Policy (MCP) in 1984. Subsequently, this policy has been typically re-enacted by Republican administrations and rescinded by Democratic administrations. The MCP restricts American Government funding to international NGOs who commit not to provide or promote abortion as a method of family planning, even if funded through alternative sources. Funding to non-compliant institutions is cut. MCP enactment has a severe impact since the American Government is a major funder of development aid, including family planning, globally. Much of this aid in support of family planning service delivery is processed through international NGOs who are active in low resource settings. MCP restrictions on non-compliant NGOs leads to family planning service gaps associated with an increase in maternal morbidity and mortality following a greater burden of unintended pregnancies and unsafe abortions. In addition, service providers are restricted in the provision of information and services related to reproductive choices that they can provide to pregnant women while pregnant women are denied the option of autonomously exercising their choice about pregnancy options including abortion.

The imposition that follows MCP enactment together with the associated injustice and harms calls for the evaluation of the policy to determine whether it is just toward those at the receiving end of the policy. The ethical evaluation assesses the internal consistency of the policy and turns to global health ethics to assess the global impact of the policy. The evaluation concludes that the MCP is internally incoherent which weakens the moral foundation for its global application while global health ethics confirms that the policy is unjust and deepens global inequality and inequity. Recommendations are formulated to address the impact of the MCP when enacted. Recommendations aim to mitigate injustice by encouraging compromise between opposing groups as a key mechanism for reducing the impact of the MCP.

Opsomming

Die beslissing van die Amerikaanse Hooggeregshof oor die opspraakwekkende Roe v. Wade saak (1973) het besluitneming oor aborsie in die hande van swanger vrouens geplaas. Die oorwinning vir een groep van die bevolking (die pro-aborsie groep) laat ‘n ander groep hoogs geaffronteer (die anti-aborsie groep). Die besluit lei tot ‘n lang staande konflik. Die pro-aborsie groep, in assosiasie met enersdenkende groeperings insluitend die Demokratiese Party, het vroue se reg om voortplantings keuses (insluitend aborsie) sonder inmenging van andere aangemoedig. Die teen-aborsie groep, in alliansie met konserwatiewe Christelike groepe, het as ‘n teenvoeter ontstaan wat later ontwikkel het as die ‘*Christian Right*’. Die ‘*Christian Right*’ het die idee van die ‘*right-to-life*’ bevorder met as kerngedagte dat die persoon by bevrugting tot stand kom; hierdie idee word uiteindelik deel van ‘n belangrike anti-aborsie strategie. Die ‘*Christian Right*’ het hulle invloed uitgebrei na die Republikeinse Party en het gehelp om verskeie Amerikaanse Presidente te verkies, insluitend Reagan, die twee Bush presidente en Trump. Die ‘*Christian Right*’ beywer hulle sedertdien om die anti-aborsie boodskap wêreldwyd uit te brei.

Die binnelandse en buitelandse agendas van die ‘*Christian Right*’ het bygedra tot die formulering van die ‘*Mexico City Policy*’ (MCP) in 1984. Sedertdien is die MCP tydens periodes van Demokratiese beheer teruggetrek terwyl dit afgedwing was tydens periodes van Republikeinse beheer. Die doel van die MCP was om Amerikaanse befondsing aan nie-regerings organisasies wat gesinsbeplanning dienste lewer te beperk, tensy die organisasies hulle verbind het om geen aborsie-verwante aktiwiteite te onderneem nie. Die verbod het ook die gebruik van befondsing vanaf nie-Amerikaanse regerings bronne om aborsie aktiwiteite te doen, verbied. Omdat die Amerikaanse regering in belangrike bydra tot internasionale gesinsbeplanning in derde wêreldse lande maak, lei die afdwinging van die MCP tot omvattende en uitgebreide gevolge. Dienslewering deur internasionale nie-regerings instellings in ontwikkelde lande word tipies ingekort met ‘n gevolglike toename in onbeplande swangerskappe asook ‘n toename in onveilige aborsies met ‘n gepaardgaande styging in moederlike morbiditeit en mortaliteit. Die MCP lê ook beperkinge op die inligting wat gesondheidswerkers oor aborsie aan pasiënte kan oordra en die besluite wat swanger vrouens oor hulle eie swangerskap kan neem. Die beperkings wat die MCP bring, lei tot onreg en skade aan mense wat daaraan blootgestel is.

In ag genome die globale impak van die MCP, ondersoek hierdie tesis die etiese basis van die beleid om te bepaal of die onreg wat geassosieer word met die MCP, regverdigbaar is. Die evaluering bepaal, eerstens of die samestelling van die beleid intern konsekwent is en tweedens, tot watter mate die beleid se globale gevolge regverdig kan word. Die gevolgtrekking word gemaak dat die interne struktuur van die MCP etiese teenstrydighede toon wat die morele fondasie daarvan belemmer. Die evaluering van die MCP as ‘n beleid binne ‘n raamwerk van ‘*global health ethics*’ lei tot die gevolgtrekking dat die beleid wêreldwye onreg veroorsaak vir die persone wat daaraan blootgestel is. Aanbevelings word gemaak wat poog om die onreg wat volg uit die beleidsimplementering te bemiddel waarvan kompromie tussen strydende partye belangrik is.

Acknowledgements

In December 2016 I moved back to Malawi after an absence of 5 years to start up a large integrated health project across approximately half of Malawi. This was shortly after Trump's election as President and one of the topics of conversation was whether the Global Gag Rule (Mexico City Policy) would be enacted again. A colleague made a comment about certain organizations who were likely to refuse American funding to support service delivery activities based on the principled opposition to the Global Gag Rule. I found this observation intriguing – why should an institution make a principled stand by refusing funding to support service delivery in settings with multiple health needs? What is the basis for justifying such a decision? This subsequently provided the idea for my thesis topic.

My subsequent research led to much amazement – much of which is shared in this thesis. At a certain point I became stuck as I tried to determine how I would assess this topic ethically since there were no clear pathways to do this. The thesis expresses some of my ideas in this regard. One of the areas I began to explore was global health ethics and its associated concepts. The more I came to understand, the more my eyes began to open about the context within which I still work in Malawi. What were general expressions of unease or discomfort could now be put into words together with the chain of thinking that enables one to reach conclusions. This was a helpful insight in the world I inhabit here which includes many of the institutions I refer to in this thesis such as government, NGO and donors. I have also seen some of the issues I describe such as conditionality, the need for duty of care, injustice, poverty, etc.

I have been incredibly blessed to have been given so many opportunities to make some contribution toward those who are much less fortunate than I am. All the employers, colleagues, friends, and organizations that I have been involved with need to be thanked. It makes for a rich life. This experience provides a necessary backdrop to the topic I have chosen to pursue.

Anton and his team gave me the opportunity to put some concrete words to '*n warboel van deurmekaar gedagtes*[1] ' and to understand in a much more insightful manner what is going on around me in a complex environment that exhibits so many issues described by Anton, Benatar and others.

David who looks after my house must have wondered why I spend so much time behind my desk working on a computer. He always ensured that the food was ready and the garden peaceful and quiet, allowing me to enter a comforting and secure space to retreat to and work.

To my family and friends who have carried this thesis burden with me for almost two years. Balancing a busy work life with a thesis is challenging and something has to give and often it was them who had to watch me working. I am glad to say this work is now complete. I do appreciate the remarkable tolerance displayed by all.

Finally, it was always great to travel to Stellenbosch for coursework which provided moments to either run or walk on the 'bergpad' or even watch a little 'koshuis' rugby at Coetzenburg. This experience is exclusive to Stellenbosch.

[1] For the English readers the closest interpretation is probably a 'confusion of mixed up ideas.'

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List of acronyms

IPPF	International Planned Parenthood Federation
PPF	Planned Parenthood Federation
MCP	Mexico City Policy
MSI	Marie Stopes International
NGO	Non-Government Organization
PLGHA	Protecting Life in Global Health Assistance
RDE	Rule of Double Effect
UN	United Nations
UNFPA	United Nations Population Fund
US	United States
USA	United Stated of America
USAID	United Stated Agency for International Development
USG	United States Government
WMA	World Medical Association
WHO	World Health Organization

Chapter 1. Introduction

This thesis aims to evaluate the morality of the Mexico City Policy (MCP) through the conditions it imposes on international non-governmental organizations (NGO) through United States Government (USG) foreign assistance. In particular, the MCP largely targets support provided for the delivery of family planning and other reproductive health services. The MCP evolved in response to the domestic debate around abortion in the USA. It was drafted during the Reagan presidential era and was subsequently reenacted by the Bush and Trump presidencies. Clinton and Obama rescinded the policy during their presidencies and relied on the less intrusive Helms Amendment to guide US policy on the application of foreign assistance for family planning service provision.

The focus of the MCP is to reduce the incidence of abortions and is justified by the explanation that US funds should not support any abortion activities with very limited exceptions such as pregnancy following rape, incest or where the life of the pregnant woman is endangered by the pregnancy. The MCP is characterised by a deep intrusiveness that dictates how organizations spend their funds. The policy stipulates the condition that recipients of USG funds pledge not to support any abortion-related activities, even when sourced from non-USG sources. It prohibits the scope of health worker service delivery activities as it relates to abortions. Pregnant women and their families are prohibited from making reproductive health choices about pregnancies even if the continuation of a pregnancy has long term consequences for the health of the unborn child or negatively impacts the social and economic status of the pregnant woman as individual or the larger family unit she nurtures. The MCP focuses on the prevention of abortions while neglecting the consequences of an unintended pregnancy and the burdens that may accrue to women and families.

Since the original enactment of the MCP, there has been increased attention by a variety of institutions to document the impact of the MCP. It increasingly becomes apparent that several harmful consequences accrue. For instance, one evidence-based finding is the growing body of evidence that the policy is ineffective in reducing abortions but rather drives abortions underground. As a public health problem, unsafe abortions bring a significant burden of morbidity and mortality and impacts, in many instances, women who are highly vulnerable due to their socio-

economic status, age or gender status. The negative consequences that accrue to the MCP do not result only from the conditionalities imposed through the policy but also from decisions made by organizations such as NGOs that provide family planning service delivery. Certain institutions feel strongly about providing a full package of reproductive health services including abortion; during periods of MCP enactment they subsequently reject USG support as a result of the intrusive MCP impositions. This has in many well-documented instances led to the reduction of family planning service delivery activities. The problem is that often it is difficult for resource-constrained governments to replace the gap left by service delivery institutions who do not accept the MCP conditions.

The MCP follows a domestic debate on abortion in the United States (US) which is controversial and intense. This debate has spilled over into USG foreign assistance. The MCP thus reflects a view that is typical of conservative Americans and is heavily influenced by conservative religious groupings, particularly Christians, in the United States. The abortion debate in the US is, in addition, vested in a form of gender competition whereby distinct groups of women emerge through the expression of their ideologies and worldviews on education, family, work and religion. The typically more liberal group of women are interested in pursuing an education, a career and a stable and secure family life. Women in this group tend to be well educated and earn higher incomes. Conservative-minded women tend to be less well educated and earn lower incomes and by emphasizing motherhood and family they validate their self-worth and dignity as women. It is the conservative group of women who have efficiently organized themselves in close association with religious groups to advocate and promote a pro-life message throughout America which extends to the political process and ultimately impacts the election of presidents.

While the intent of the MCP is to reduce abortions, the reality is that the need for abortion is unlikely to be eliminated soon. This is especially so, since globally, there remains a gap in the availability and delivery of family planning services and women are constantly faced with the dilemma of managing an unintended pregnancy which includes the option to end such pregnancies through an abortion. It is likely that communities will continue to need to deal with the consequences of unintended pregnancies for many years to come. This situation can only change when human sexuality can be addressed in an open and uncontroversial manner together while making family planning methods readily accessible and available and indeed highly efficacious in preventing pregnancies. Hence, the issue of abortion needs to be managed in a pragmatic fashion

that acknowledges the difficulty of abortion as an intervention while also ensuring that women and families do not bear the brunt of the long term consequences of unintended pregnancies, especially in nations that are socio-economically under-resourced and where social safety nets may be either non-existent or limited in scope.

This thesis will examine the content, consequences and historical origins of the MCP, the abortion debate in the US, the stakeholders with their particular perspectives on abortion, explore and discuss ethical frameworks and issues that arise from MCP enactment and propose recommendations to manage the consequences of MCP enactment.

Chapter 2. Problem statement

The Centers for Disease Control and Prevention views family planning as one of the top ten achievements of public health in the twentieth century. The introduction of family planning has assisted individuals to time and space their children thereby improving their health and socio-economic status (Institute of Medicine (U.S.), 2009: 29).

The capacity for fertility control has expanded globally throughout the developed and developing world. Despite much progress there remains an ongoing challenge to satisfy the need for family planning services (UNFPA, 2012). The United Nations Population Fund (UNFPA) and the Guttmacher Institute reported in 2012, that 222 million women in the developing world had an unmet need for contraception (UNFPA, 2012). Women with an unmet need for modern family planning methods account for over 80 per cent of unintended pregnancies. About 22 million women are exposed to unsafe abortions each year with an estimated 8.5 million who suffer complications. Only about 5.5 million out of the 8.5 million who experience complications are able to access post abortion care (UNFPA, 2012). Complications include maternal deaths which largely occur in countries where women are least likely to access skilled attendance during delivery. Maternal deaths are associated with an increased likelihood of the newborn child dying; this death toll reduces economic growth with global productivity losses of some $15 billion annually (UNFPA, 2012).

The United States of America (USA) is the world's largest contributor to global family planning assistance (USAID, no date a). Funding for family planning service delivery is channeled through several US-based and international NGO's and large multilateral institutions such as UNFPA. The USA's stated intent in support of family planning development assistance is to assist countries to meet their reproductive health needs, including family planning. (USAID, no date a). USAID, an important provider of family planning assistance to the developing world, reported that its assistance contributed to a decrease in average family size from more than six (1965) to 4.4 in 2018 (USAID, no date a).

However, family planning and abortion in the USA is a highly politicized and heavily debated subject as conservatives tend to view '*family planning as code for abortion*' despite enacting the Helms Amendment in 1973 that prohibits United States (US) foreign assistance to fund

abortions (Coleman, 2011). Conservatives strongly hold the conviction that no US taxpayer dollars should pay for abortion or abortion-related services (Bendavid, Avila and Miller, 2011: 873).

Republican and Democratic administrations view the issue of family planning in relation to abortion differently. Republicans maintain a conservative approach which attempts to restrict funding for family planning and abortion activities both nationally and internationally while, by contrast, Democrats maintain a more liberal approach by placing less prohibitive restrictions on abortion and family planning (Turnbull and Kaeser, 1998: 3-4). This internal American debate impacts the family planning development assistance provided by USAID to developing countries.

Two important policies have addressed abortion in US international health assistance. The Helms Amendment to the Foreign Assistance Act passed in 1973 prohibits the use of US funding '*to pay for the performance of abortions as a method of family planning*'(Fox, 1986: 609). Senator Helms' intent was to ensure that USAID-sponsored abortions would be halted (Fox, 1986: 609). He emphasizes that '*It would not put any restrictions whatsoever upon the programs of foreign governments and international organizations which fund abortion programs from other sources*' (Fox, 1986: 643). The second policy, known as the MCP and first implemented in 1984 by the Reagan administration, restricts funding to international NGOs who commit to '*not perform or actively promote abortion as a method of family planning*.' This restriction applies even to funds originating from privately sourced, non-United States Government (USG) sources (Kates and Moss, 2017). The MCP thus broadens the extent of the Helms amendment that was aimed at simply limiting the use of US monies to fund abortions to actively prohibiting organizations from providing any abortion related services including services provided with non-USG monies. The MCP, alternatively referred to as the '*Global Gag Rule*' by opponents of the MCP, therefore becomes an important means through which Republican administrations by policy enactment and Democratic administrations by policy rescission manifest their ideologies globally on family planning and abortion through their foreign assistance efforts.

Since the first enactment by the Reagan administration in 1984, the MCP has been rescinded by the Clinton (1993) and Obama (2009) administrations and reenacted by the Bush (2000) and Trump (2017) administrations (Kaiser Family Foundation, 2019). Traditionally, the MCP is one of the first Executive Orders to be either rescinded or re-enacted following the inauguration of a

new president. Most recently on January 23, 2017, the first business day of his administration, Trump signed an executive order re-enacting the MCP ('Presidential Documents', 2017). Trump expanded his executive order to encompass all forms of foreign health assistance instead of family planning funding streams only. Secretary Tillerson in 2017 developed a plan known as *Protecting Life in Global Health Assistance* that applies the provisions of the MCP to foreign non-governmental organizations (NGOs) that receive U.S. funding for global health assistance (USAID, 2018: 85).

At the re-enactment of the MCP in 2017, the USG was providing global health assistance to 64 countries. In 37 countries abortion was legally allowed for at least one criterion not allowable under the MCP, including 35 countries where abortion is legally available to preserve the life of a woman endangered by her pregnancy and in 28 where abortion is indicated for fetal abnormalities. In 27 countries supported through US Global Health Assistance, abortion is not legally available (Kates and Moss, 2017). The impact of the MCP is different in countries where abortion is legally allowed compared to countries where it is illegal. In countries where abortion is legally allowed, foreign NGOs are prohibited from providing a full package of abortion services with non-USG sourced funds. In countries where abortion is not legally allowed, the MCP does not limit abortion activities although it does prohibit activities such as the provision of counseling for abortion as a method of birth control (Kates and Moss, 2017).

It is important to contextualize what '*perform or actively promote abortion'* means (USAID, 2018).

Protecting life in global health assistance provisions (revised terminology for the MCP adopted by the Trump Administration)

(I) Operating a service-delivery site that provides, as part of its regular program, counseling, including advice and information, regarding the benefits and/or availability of abortion as a method of family planning;

(II) Providing advice that abortion as a method of family planning is an available option or encouraging women to consider abortion;

(III) Lobbying a foreign government to legalize or make available abortion as a method of family planning or lobbying such a government to continue the legality of abortion as a method of family planning; and

(IV) Conducting a public information campaign in foreign countries regarding the benefits and/or availability of abortion as a method of family planning.

Source: *PLGHA (Standard provisions https://www.usaid.gov/sites/default/files/documents/1868/303mab.pdf*

Abortion in relation to family planning is defined as follows: '*Abortion is a method of family planning when it is for the purpose of spacing births.*'[2] The MCP expands the concept of '*spacing births*' to additionally prohibit abortions indicated for the physical and mental health of the mother and fetal abnormalities. The application of MCP requirements in this context limits the choice of women and parents to '*determine freely the number and spacing of their children' (*American definition for family planning; US Department of Health and Human Services*).* [3] It also restricts the mother's choice in those instances where the pregnancy may harm the mother's health or fetal abnormalities suggesting consideration of abortion as an option to prevent the harmful consequences of carrying a pregnancy to term. Organizations are prohibited from actively providing and promoting abortion services even though this may be a core mandate of an organization. Lobbying governments to legalize and expand abortion services is prohibited.

The 2017 reenactment of the MCP therefore has important implications for organizations that support the delivery of FP in development settings. Certain organizations, following their refusal to sign the MCP requirements, lost their USG funding and were forced to cease or scale back service delivery activities. Marie Stopes International (MSI), a global provider of family planning services defended their refusal to sign the MCP as follows:

> '*…. agreeing to the conditions of the Global Gag Rule would restrict us from providing abortion services using other funding, in countries where they are permitted. It would even restrict us from talking to women about abortion. This goes against our core principles as an organization…'*(Marie Stopes International, 2017a).

Following MCP enactment, in many countries, family planning service provision is reduced or withdrawn from areas already constrained by a dearth of reproductive health services (the two links below provide insight into the impact of the re-instatement of the MCP in 2017)[4],[5]. The implementation of the MCP has been shown to lead to increased numbers of unplanned and

[2] Abortion is a method of family planning when it is for the purpose of spacing births. This includes, but is not limited to, abortions performed for the physical or mental health of the mother and abortions performed for fetal abnormalities, but does not include abortions performed if the life of the mother would be endangered if the fetus were carried to term or abortions performed following rape or incest (USAID, 2018, p. 89).
[3] 'Educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved' (US Department of Health and Human Services [DHHS], 2000, Family Planning Services definition).
[4]The video link provides a visual overview of the MCP and its impact in developing and under-resourced nations. https://wapo.st/2oHhQe1
[5] https://www.washingtonpost.com/opinions/2019/02/08/ive-witnessed-devastating-effects-trumps-global-gag-rule-congress-must-act/?utm_term=.8c8ffdb61d20

unwanted pregnancies and potentially, an increase in the number of unsafe abortions which increases the risk of maternal mortality and morbidity (Brooks, Bendavid and Miller, 2019: 7).

The application of abortion related restrictions contained in the MCP provisions raises question of a moral nature that apply to both the agent that provides the funds (USG) and providers of family planning and abortion services. The following moral issues worthy of analysis emerge:

1. To what extent may the MCP be viewed as being morally justifiable? Can the USG justify the restrictions imposed by the MCP?
2. The MCP has direct implications for service delivery to vulnerable communities. What moral justification exists for imposing service delivery restrictions on health workers and on the choices to be made by patients? The MCP restrictions impact health worker autonomy (to provide a comprehensive and complete service), and patient autonomy (to make individual decisions about continuing or terminating a pregnancy).
3. How should recipients of US funds (international NGOs and institutions such as the UNFPA) respond to the demands of the MCP? Is a principled stand as espoused by MSI acceptable or should there be consideration of the consequences of service withdrawal with the potential of increased levels of unwanted pregnancies and even the number of abortions – both safe and unsafe.

Prima facie, the MCP breaches at least three principles of biomedical ethics; respect for autonomy, non-maleficence and justice. The provisions of the MCP inhibit decisions by pregnant women or parental couples about the spacing of pregnancies and even the decision-making involved in instances where the pregnancy constitutes a physical or mental risk to the mother or when a decision is required about carrying a fetus with birth defects to term. The principle of non-maleficence is violated by the consequences of service withdrawal with increased numbers of unintended pregnancies most likely leading to an increase in maternal morbidity and mortality. Additionally, restrictions that '*gag'* the range of services that health workers may provide is likely to decrease the quality of care that health workers are able to provide. Justice becomes compromised as we begin to explore how decisions made by distant structures such as the US Presidency, Congress and Senate and large global institutions such as MSI or IPPF impact the most vulnerable in society. It raises the question whether the vulnerable hold certain rights, and should they be involved in a conversation that intimately involves their personal lives, the children they bear and their families?

Since the impact of the MCP unfolds in the domain of global health it is important to consider moral issues that manifest themselves in this sphere. Several authors comment that the biomedical principles till fairly recently have mostly applied to individual health issues that focus on the level of the doctor/patient relationship; these biomedical principles are less directly applicable to the sphere of global health ethics or global bioethics (Ten Have, 2016: 39; Benatar, 2005: 77).[6] The principle of autonomy is often cited in this context as it tends to emphasize individual freedom of choice which, by its very nature, is restrictive since issues such as resource allocation, the aims of healthcare and justice cannot be ethically assessed (Ten Have, 2016: 39). Critical issues that emerge, rather than being individually focused, are population-based and emphasize social inequality, injustice, violence and poverty (Ten Have, 2016: 9). Where inequality exists, the application of the MCP can be further assessed in terms of its impact on harm and justice and whether its enactment contributes toward or reduces global health inequality.

The moral analysis of the MCP therefore requires consideration of both aspects of biomedical ethics and global health ethics.

[6] Global bioethics refers to injustices that emerges due to the inequalities of wealth and resources between the developing and developed world (Van Niekerk, 2005: 85)

Chapter 3. The Mexico City Policy

The MCP has generated much controversy since its initial enactment in 1984. In order to proceed with a succinct and clear discussion about the policy it is necessary to firstly, explore the content of the policy and secondly, to the greatest extent possible, objectively assess the impact of the MCP. Subsequently, the historical influences that led to the development of the MCP will be presented. This will enable the distinction of those important issues that have contributed to the development of the MCP.

It is important to note the interplay and complementarity between the two major policies that guide US foreign assistance in relation to abortion service provision abroad[7]. The Helms Amendment restricts the flow of tax dollars to support abortion through US foreign aid (Barot, 2013: 9; Fox, 1986: 609). The MCP extends the restrictions put in place through the Helms Amendment by targeting and prohibiting foreign NGOs in receipt of U.S. family planning assistance from using non-U.S. funding to provide abortion services (Barot, 2013: 10). The MCP thus represents a complementary second prong of attack to the Helms Amendment in preventing abortions by selectively cutting off funding to those organizations who are unwilling to relinquish privately sourced funds to provide abortion services.

Under the Helms Amendment arrangement, typical of periods of Democratic ascendency in the White House, groups such as International Planned Parenthood Federation (IPPF) and MSI have accepted US Federal funds to provide family planning services although always cognizant of not contravening prescribed legal abortion requirements stipulated through the Helms Amendment. This is not the case for the MCP, and it will be important to discern what offends organizations to such an extent that they refuse US foreign assistance funds during those periods when Republican Presidents occupy the White House.

[7] Other US foreign assistance legislation on abortion includes the following amendments (excluding Helms and the MCP): the 'Helms amendment' prohibits the use of U.S. funds to perform abortions or to coerce individuals to practice abortions; the 'Biden amendment' prohibits the use of U.S. funds to conduct biomedical research related to abortion or involuntary sterilization; the 'Siljander amendment' prohibits U.S. funds from being used to lobby for or against abortion; the 'Kemp-Kasten amendment' prohibits the provision of funding to any organization or program that supports or participates in the management of a program of coercive abortion or involuntary sterilization; and the 'Tiahrt amendment' which places requirements on voluntary family planning projects receiving assistance from USAID. https://fas.org/sgp/crs/row/R41360.pdf

Official text of the MCP

On January 23, 2017, President Trump through a Presidential Memorandum reinstated the 2001 Presidential Memorandum on the "Mexico City Policy," and directed the Secretary of State to develop a plan that would extend the Mexico City Policy to '*global health assistance furnished by all departments or agencies*.' In May 2017, Secretary Tillerson approved the '*Protecting Life in Global Health Assistance*' policy instructing U.S. Government Departments and Agencies how to apply of the provisions of the Mexico City Policy to foreign non-governmental organizations (NGOs) that receive U.S. funding for global health assistance. In terms of this policy, *'global health assistance'* applies to funding for international health programs, including HIV/AIDS, maternal and child health, malaria, global health security, and family planning and reproductive health. This policy applies to global health assistance to, or implemented by, foreign NGOs, including those to which a U.S. NGO makes a sub-award with such funds. The policy does not apply to national or local governments, public international organizations, and other similar multilateral entities. Also excluded is humanitarian assistance, including State Department migration and refugee-assistance activities, USAID disaster and humanitarian-relief activities, and U.S. Department of Defense (DoD) disaster and humanitarian relief.

Provisions of the MCP

Italicized sections identify language revisions made to the Mexico City Policy following the introduction of the PLGHA

The Mexico City Policy requires foreign NGOs to certify, as a condition of receiving U.S. global health assistance, that they will not "*perform or actively promote abortion as a method of family planning*" with any funds, including non-U.S. funds. The following definitions apply:

Abortion is a method of family planning when used for the purpose of spacing births (including, for example, abortion to preserve a woman's physical or mental health and *abortions performed for fetal abnormalities).*

To perform abortion means to operate a facility where abortions are performed as a method of family planning.

To actively promote abortions means for an organization to commit resources, *financial or other, in a substantial or continuing effort* to increase the availability or use of abortion as a method of family planning by:

- operating a family planning counseling service (*service delivery site*) that provides, *as part of its regular program, counseling including* advice and information regarding the benefits and/*or* availability of abortion as a method of family planning;
- providing advice that abortion is an available option *or encouraging women to consider abortion* in the event that other methods of family planning are not used or are not successful or encouraging women to consider abortion;

- lobbying a foreign government to legalize (continue legality of) or make available abortion as a method of family planning; and *lobbying such a government to continue the legality of abortion as a method of family planning; and*
- conducting a public information campaign regarding the benefits and/or availability of abortion as a method of family planning.

Excluded from *the definition* of active promotion of abortion *as a method of family planning* are the following exceptions (allowable activities):

- *Referrals for* abortion in cases where the pregnancy either poses a risk to a woman's life *if she carries the fetus to term* or is the result of incest or rape;
- treatment of injuries or illnesses caused by legal or illegal abortions (e.g., post-abortion care); and
- *passively* responding to a question regarding where a safe, legal abortion may be obtained if the question is specifically asked by a woman who is already pregnant, she clearly states that she has already decided to have a legal abortion, and the family planning counselor (*healthcare provider*) reasonably believes that the ethics of the medical profession in the country requires a response regarding where it may be obtained safely *and legally*.

Source: USAID (2018) *Protecting Life in Global Health Assistance*. Available at: https://www.usaid.gov/sites/default/files/documents/1864/Interagency_PLGHA_FAQs_September_2018_USAID_FINAL-508-v2.pdf (Accessed 6 October 2019).

Further comments on the official text of the MCP. One of the strongest prohibitions placed on NGOs is the restriction that dictates how they may not promote abortion with funds sourced through non-USG sources. The issue at stake is the fungibility issue[8] and the attempt of the MCP to prevent indirect funding of organizations and NGOs that provide or promote abortions.

Abortions are not absolutely forbidden by the MCP. Referrals are allowed in those instances where the life of the mother may be endangered by the pregnancy or following rape or incest. Also allowed is the provision of treatment and care for women with post-abortion sequelae following safe or unsafe abortions. Abortion is forbidden when utilized for family planning purposes or birth spacing. Birth spacing includes abortions that may be indicated for pregnancies that cause mental or physical health problems for the pregnant woman or for fetal abnormalities. Counseling that abortion is an option when a woman is subject to an unintended pregnancy is disallowed. This includes advice that abortion as an option if family planning methods were not used or not

[8] Being something (such as money or a commodity) of such a nature that one part or quantity may be replaced by another equal part or quantity in paying a debt or settling an account. https://www.merriam-webster.com/dictionary/fungible. In the instance of the MCP the fungibility issue may be viewed as a means of US funds to indirectly support and cross-subsidize abortion-related activities actioned through other funding sources.

successful or by encouraging women to consider abortion. Health workers may provide a passive response to a question where a safe, legal abortion may be accessed; this is not considered as active promotion of abortions. The passive response is further qualified; she has already made the decision to have a legal abortion, she inquires specifically about the location and availability of abortion services, and safe abortion is legally available per national guidance and policy. Counselling exceptions to this ruling were subsequently made in those instances where an affirmative duty rests on health workers to provide this information in countries such as South Africa where health workers are obliged to provide a full range of available options including abortion (Center for Health and Gender Equity, 2018: 27).[9]

Recipients of USG funding are prohibited from operating service-delivery sites that provide counseling advice about abortion. Lobbying of foreign governments on the introduction or continuation of legal abortion is not allowed while public information campaigns in foreign countries about the benefits and/or availability of abortion is prohibited.

As the understanding of the content of the MCP emerges we should link this understanding to the global scope of its implementation and the consequences that have been documented from its implementation.

What is the importance of the MCP (PLGHA)[10] and why is it relevant to global health?

At the heart of this question lies a decision that foreign NGOs need to make when needing to choose between receiving US funding or the continuation of abortion related work (Center for Health and Gender Equity, 2018: 6). Either choice has an impact in terms of cuts to service

[9] The *affirmative defense*' applies where health care providers have an "*affirmative duty*" based on local legislation to provide counseling and referral for abortion as a method of family planning. In these instances, compliance with local legislation do not trigger a violation of the MCP. The affirmative defense is likely to apply in about a dozen countries effected by the MCP. South African legislation allows abortion far beyond the scope of the three MCP indications exceptions, including abortion for any reason during the first 12 weeks of pregnancy, and for a variety of indications to 20 weeks. The problem emerges however, when providers do not fully understand the provisions of the MCP and how local legislation provides the ultimate legislative guidance for managing patients who require information on abortion and the options that exist. This has the potential to lead to much confusion and inappropriate decision-making by health providers that may not be in the best interests of the pregnant woman. (Center for Health and Gender Equity, 2018: 27).

[10] While introducing the term PLGHA since this is now the MCP's official title I will largely refer to the MCP throughout this thesis since this is how the abortion restrictions are famously known.

provision and the provision of information about reproductive health choices, including abortion, which is often felt by communities served by the NGO.

A subsequent question is why abortion is so pivotal for effective service delivery? The answer is provided by the relationship between abortion and comprehensive reproductive health care and its relationships with other health programs. In the original MCP, initially enacted by Reagan in 1984, abortion was prohibited as a method of family planning and affected donor supported health programs only in the area of family planning. The expansion of the restrictions of the MCP through the PLGHA to the majority of foreign assistance support provided by the USG extends the tentacles of the policy to multiple areas of health programming such as maternal and child health, HIV/AIDS, malaria, infectious diseases and nutrition programming and non-health activities in the area of education and agriculture. The impact is severe since reproductive health services are often integrated into and constitute a core element of programs such as maternal and child health and HIV/AIDS. Family planning has been shown to be pivotal in reducing maternal mortality thereby ensuring healthier lives for children and families (Maternal Health Task Force, no date). Similarly, the control of HIV/AIDS, among other interventions, requires the provision of effective family planning services as a mechanism to prevent transmission between partners as well as preventing unintended pregnancies with the risk of transmitting HIV from the pregnant woman to her unborn child. PLGHA restrictions, through the focus on family planning, impacts comprehensive service delivery which in turn impacts important health outcomes such as maternal mortality.

The financial contribution from the USA and its geographic reach assists in understanding the global impact of the MCP. Annually, as the largest donor for global health activities in the world, the United States provides about $8.8 billion in foreign assistance; the expanded MCP or PLGHA is projected to impact about $2.2 billion of that funding (Rowthorn, 2018). As an example of the US's massive contribution; the United States Government contributed 38.4 percent of the global health budget of $21.3 billion dollars in 1916 (Kaiser Family Foundation, 2013). This portfolio covers health-related activities in about 60 low- and middle-income countries, including programs on HIV/AIDS, zika, maternal and child health, malaria, nutrition and others (Barot, 2017: 73). During the Federal Fiscal Year 2019, Congress appropriated $607.5 million dollars toward family planning activities enabling 24.3 million women and couples to receive contraceptive services. This assistance is anticipated to prevent 7.2 million unintended pregnancies and avert 3.2

million unplanned births and 3.1 million induced abortions including 2 million abortions deemed '*unsafe*' (Guttmacher Institute, 2019a).

The re-enactment of the MCP creates funding gaps where international NGOs choose not to receive US Federal Funds; the International Planned Parenthood Foundation (IPPF) and Marie Stopes International (MSI) estimate funding gaps of $100 million and $80 million, respectively (Rowthorn, 2018). Despite measures by alternative donors (Canada and the Netherlands) to close the gap, it is not clear whether this will be sufficient to fully compensate for the contribution made through USG foreign assistance funds (Starrs, 2017: 485). MSI reported in January 2019 that they continue to face a funding gap of $50 million; MSI Madagascar requires $3.5 million while MSI Uganda lost funding to the value of $20 million in 2017 following the re-enactment of the MCP which they have largely succeeded in replacing (Marie Stopes International, 2019). The $50 million gap amounts to an estimated 1.8 million unintended pregnancies, 600,000 unsafe abortions, and 4,600 preventable maternal deaths (Marie Stopes International, 2019).

The geographic and demographic reach of the MCP is substantial. Half of 1.65 billion women between 15-44 years of age globally live in countries affected by the MCP. In 37 countries where abortion is legal beyond the restrictions of the MCP, 880 million women are affected; in 27 countries where abortion restrictions are not legal beyond the restrictions of the MCP, 298 million women are affected (Guttmacher Institute, 2018).

It thus becomes very clear why the MCP (and now the PLGHA) has such a dramatic impact on global health service provision. The US provides large sums of money for global health with a very broad reach and any reductions of USA funding is bound to have significant consequences.

Consequences following the MCP enactment

It is challenging to discern clear facts that describe the impact of the MCP. The conversation is characterized by claims and counter claims as is illustrated by an extract from a Congressional Hearing conducted in 2008. For example, pro-choice congressional members claim, that by implementing the MCP, the President is hoping to reduce abortion rates; however, all that is being achieved is to make abortion more unsafe. The MCP therefore assumes a harmful nature that hurts women across the globe (Committee on Foreign Affairs, 2008: 1). By contrast, pro-life congressional members claim that abortion rates have declined during periods when the MCP has

been enacted. They deny that the enactment of the MCP has endangered the lives of women by providing no exceptions to MCP guidance about abortions and forcing women to seek unsafe abortions. The MCP does allow abortions in instances of rape, incest or if the life of the pregnant woman is endangered by the pregnancy. The MCP also allows women to receive compassionate care when post-abortion care services are required and does not block '*passive*' referrals when a woman who has decided to abort a child, directly requests information from a health worker about abortion (Committee on Foreign Affairs, 2008: 3). It becomes important to extract valid scientific data to the extent possible together with accurate anecdotal reports in trying to make sense of the impact of the MCP. Other data that emerges includes ethical challenges experienced by health workers and constraints on patient choice and autonomy in relation to the implementation of the MCP.

Peer-reviewed scientific data on the impact of the MCP is emerging. Studies done by Bendavid and Brooks demonstrate the impact clearly in terms of the rise in induced abortions. In a paper published in 2011, Bendavid, Avila and Miller were able to demonstrate by comparing two periods where the MCP had been enacted (2001 -2008) and rescinded (1994 - 2000) that induced abortions increased by an adjusted odds ratio of 2.55 for countries highly exposed[11] compared to countries less highly exposed to the policy (2011: 873). In a paper published by Brooks in 2019, the comparison period was extended from 1995 to 2014 – a period which included two episodes of rescission (1995-2000 and 2009-2014) and one episode of enactment (2001-2008). The study found that when the MCP was enacted (2001–08), abortion rates rose in countries highly exposed to the policy by 4·8 abortions per 10 000 woman-years compared to low-exposure countries (Brooks, Bendavid and Miller, 2019: 1). Both authors conclude that the MCP is associated with increases in abortion rates in sub-Saharan African countries (Bendavid, Avila and Miller, 2011: 873; Brooks, Bendavid and Miller, 2019: 1).

Jones examined reductions in contraceptive availability during periods of MCP enactment to examine women's behavioral responses with regards to fertility decisions and pregnancy outcomes in Ghana (2015: 33). One measure she analyzed was whether a given women in rural Ghana is less likely to abort a pregnancy when the MCP was enacted (Jones, 2015: 33). She tracked the incidence

[11] Measures of exposure to the MCP were based on a continuous measure of United States assistance per capita for family planning and reproductive health and a comparable measure of exposure based on data obtained from USAID (Brooks, Bendavid and Miller, 2019: 873).

of abortion over two time periods when the MCP was enacted and two periods when it had been rescinded. The evidence suggest that women do not decrease their reliance on the use of abortion as a result of MCP enactment; rather the incidence of abortion significantly increases (by 50 %) among rural women due to increased rates (10 %) of conception (Jones, 2015: 56-57). The author suggests that policy-induced budget shortfalls force NGOs to cut rural outreach services with a resultant reduction in contraceptive availability causing the increase in pregnancies. Similar effects were observed in urban settings although statistical significance was not achieved (Jones, 2015: 56-57).

Several anecdotal reports describe the impact of the MCP enactment. Following the re-enactment of the MCP by George W. Bush in 2001, a study by a consortium of NGOs assessed the impact of the policy in affected countries. In Kenya, the MCP impacted services run by the Family Planning Association of Kenya and MSI Kenya, targeting especially rural and impoverished communities. Services that were disrupted included community-based outreach activities and the distribution of contraceptive supplies. MSI Kenya was forced to reorganize its clinical service delivery, raise service fees, terminate about 20 percent of its staff, reduce the salaries of remaining staff, and cut back on the services in order to maintain service delivery at seven clinics and a nursing home (Center for Health and Gender Equity, 2018: 17). The diminished service delivery impacted more than 300,000 clients and left one of the poorest urban communities without a clinic to provide health services (Center for Health and Gender Equity, 2018: 17). Government clinics were never able to fill the vacuum created by the reduction of services provided by the Family Planning Association or MSI Kenya (Cohen, 2011: 3). USAID stopped shipments of contraceptives to 16 countries in Sub-Saharan Africa, Asia and the Middle East. In Lesotho, the Planned Parenthood Association had previously received 426,000 condoms from USAID during the Clinton administration (Global Gag Rule Impact Project, 2003: 4). Once the MCP was re-enacted, USAID ceased condom shipments to Lesotho entirely since no alternative distribution mechanism existed for condom provision to the country (Global Gag Rule Impact Project, 2003: 4). The consequences associated with MCP enactment indicate that many thousands of women have lost access to family planning and reproductive health services thereby increasing the risk of unintended pregnancy and unsafe abortion or delivering children into under-resourced societies with limited social security nets.

Less tangible forms of impact of the MCP include reduced quality of service delivery, inhibition of the professional ethics of providers and restrictions of free speech. The global trend toward the integration of services brings together in a facility a variety of complementary services such as family planning, HIV prevention or treatment, ANC and obstetric care, immunizations, child health and information or referrals for safe abortion care (Barot, 2017: 74). NGOs under Trumps' expanded MCP regime are denied any global health funding from the United States because they provide integrated care that incorporates information about or referral to services related to abortion with non-US funding. Removing U.S. Government funding has important implications in terms of facilities being able to provide a comprehensive range of good quality services in under-resourced settings. The MCP is likely to contributed to increased suffering by patients reliant on those services and the provision of care that is likely to be more expensive, less effective and less efficient (Barot, 2017: 75).

The MCP restrictions violate fundamental principles of medical ethics (Barot, 2017: 75). Health care professionals need to comply with professional codes of ethics that govern the care they deliver to their patients and are obliged to act in the best interest of the patient and her welfare (Barot, 2017: 75). This includes the provision of adequate, accurate and unbiased information that presents available options for care and enables the patient to actively and autonomously participate in decisions about treatment options including referral (Barot, 2017: 75). The World Health Organization emphasizes the need for compliance with ethical standards in the provision of information and counseling for patients for safe abortion care. With respect to abortion, WHO prescribes: '*Information must be complete, accurate and easy to understand, and be given in a way that facilitates a woman being able to freely give her fully informed consent'* (Barot, 2017: 75). Similarly, the World Medical Association (WMA) insists that patients are entitled to receive the information they need to provide informed consent and that continuity is provided even when providers do not provide abortion services. The WMA clearly states how conscientious objection by providers needs to managed: '*If the physician's convictions do not allow him or her to advise or perform an abortion, he or she may withdraw while ensuring the continuity of medical care by a qualified colleague'* (Barot, 2017: 75).

Despite clear ethical guidance, the MCP restricts the information that providers may provide to clients about their reproductive health options including referrals. In countries where abortion is legal, providers are obliged to provide to the patient all the legal options and referral to abortion

services where appropriate (Barot, 2017: 76). Even in countries with restricted access to abortion, providers remain obliged to act in their patient's best interests and ensure access to abortion in those circumstances where valid indications for abortion exist (Barot, 2017: 76).

The MCP has been charged with the undermining of democratic values (Barot, 2017: 76). **I**t gags advocacy for abortion by local actors in their own countries. It prevents organizations from using their own funds to lobby government for change to existing abortion laws and prohibits them from promoting changes to abortion laws through public information campaigns and other forms of advocacy (Barot, 2017: 76). No such restrictions apply to antiabortion advocates who engage in public debate on matters of abortion. The United States is characterized by its emphasis of free speech as a core democratic principle at home and abroad and provides foreign assistance for the promotion of the rule of law and good governance and democracy programs. The MCP '*subverts the very goals of overall U.S. foreign policy*' (Barot, 2017: 76).

Concluding remarks

The MCP is not a neutral policy and evokes much controversy. It adds a level of restriction to US foreign assistance that many find difficult to accept while its global impact is huge due to the extensive funding reach of the USG and the multiple health program areas that are involved. The body of available evidence suggests that the impact of the policy is often harmful as is well evidenced by an increasing reliance on induced abortions during periods when the policy is enacted. This harm especially accrues to many of the world's poorest and most vulnerable persons – especially women.

It is important to look at the historical development of the MCP and to identify those conditions and factors that led to its enactment by President Ronald Reagan in 1994. The historical overview will also serve to identify the ideological influences and political trends following the Roe v Wade decision in 1973 thereby enabling the MCP to become an important instrument for the global dissemination of American values on sexual and reproductive health.

Chapter 4. History, origins and partisan expression of the MCP

Historical origins of the MCP

The MCP was presented to the UN Population Conference in Mexico City in August 1994 (Fox, 1986: 609). The policy stated that the USA would not provide funding to international family planning organizations who used non-USG sourced funds to provide abortion activities and services (Fox, 1986: 609). The MCP dictated that if recipients wanted to continue to receive US funds, then all abortion activities should cease irrespective of the funding source (Fox, 1986: 609).

The MCP evolved from a longstanding US engagement in global population control efforts that had started during the sixties. Prior to Reagan, Congress as the responsible institution for formulating US population control policies, and USAID as the responsible institution for implementation of policies, shared a common consensus that developing nations would remain economically and socially constrained unless women in these countries were supported to increase their access to modern methods of contraception (Fox, 1986: 611). Population control had become a popular political issue following President Lyndon B Johnsons Great Society initiatives and the legalization of the sale of contraceptives to married couples following Grisworld v. Conneticut (Fox, 1986: 613). During the mid-sixties, the Title X Amendment to the 1961 Foreign Assistance Act was promulgated specifying that US population assistance could be provided to developing country government, NGOs and multilateral organizations such as UNFPA (Fox, 1986: 614). Title X maintained that '*every nation is and should be free to determine its own policies and procedures with respect to the problem of population growth'* while stating that '*voluntary family planning programs …… can make a substantial contribution to improve health, family stability, greater individual opportunity, economic development, a sufficiency of food, and a high standard of living*' (Fox, 1986: 614).

In 1973 US development assistance was transformed from an emphasis on large scale projects to an emphasis on small scale projects with the aim to ensure that US development aid would reach intended beneficiaries – especially the poor (Fox, 1986: 618). This shift was launched as the '*New Directions Strategy'*, the essence of which was to bring a focus to community-based projects in preference over larger construction and development projects with little immediate direct impact

on the majority of the population (Fox, 1986: 618). Family planning played a key role in this new initiative since it was perceived that traditional approaches that relied on trickle down aid to stimulate economic growth were not effective where rapidly growing populations were '*depleting'* available resources (Fox, 1986: 619).

During the Reagan era new ideas about developmental approaches emerged. Particularly, the MCP represented a shift in thinking about the New Directions Strategy and the role of population control in the economic development in developing countries (Fox, 1986: 620). The US position advanced through the MCP was aimed at achieving the objectives of the Reagan administration in the areas of population, development, and family planning (Fox, 1986: 621). Ideas about population control shifted toward an economic response, in particular an emphasis on the private sector, as the instrument to achieve population control, rather than through an emphasis on family planning programming (Fox, 1986: 621).

This was accompanied by the idea that population growth did not impact economic growth as had been thought earlier (Fox, 1986: 629-630). The reasons provided for this perspective included excessive government control of economies with resulting inhibition of agricultural growth, over taxation of newly growing industries and the growth of the environmental movement in developed countries described as '*anti-intellectualism which attacked science, technology and the very concept of material progress'*(Fox, 1986: 630). Only through a re-orientation of free market economics would population growth be slowed (Fox, 1986: 630).

The emphasis on strong government intervention in managing population was altered to cast population growth as a '*neutral phenomenon*' (Finkle and Crane, 1985: 3). The US position was buttressed by an assumption that the global population crisis was not real and did not require drastic intervention by governments (Finkle and Crane, 1985: 11). By referring to a '*demographic overreaction in the 1960's and 1970's,'* policy makers implicitly rejected the strong previous emphasis to support population programming that had characterized the efforts of the US Agency for International Development (Finkle and Crane, 1985: 11).

The MCP further affirmed the American position on the voluntary nature of participation in family planning programs:

> *'U. S. support for family planning programs is based on respect for human life, enhancement of human dignity, and strengthening of the family. Attempts to use coercive measures in family*

> *planning must be shunned, whether exercised against families within a society or against nations within the family of man'* (Finkle and Crane, 1985: 12).

The statement indicated that the United States would not provide assistance through any international or nongovernmental organization that supported abortion or coercive family planning programs, or to any nation which forcibly coerced its population to achieve population growth objectives (Finkle and Crane, 1985: 12). Ethical concerns were stressed by the United States including the introduction of statement calling for population policies to '*respect human rights, the religious beliefs, philosophical convictions, cultural values and fundamental rights of each individual and couple, to determine the size of its own family'* (Finkle and Crane, 1985: 12).

While the Reagan Administration and USAID were split about the most effective developmental approaches in managing population growth there was uniformity in the opposition to abortion (Fox, 1986: 621). Prior to the introduction of the MCP, USAID had withdrawn funding from organizations '*tainted by abortion activities*' and demonstrated the intent of the US Administration to break any association between US development programs and organizations supporting abortion activities (Fox, 1986: 621).

The MCP was formulated in preparation for the 1984 Mexico City Population Conference (Fox, 1986: 628). The Conference was scheduled to review progress of the World Population Plan of Action adopted in 1974 (Fox, 1986: 628). During January 1984, the right-to-life movement had met with White House staff to push for a '*pro-life delegation*' to participate in the Mexico City conference (Finkle and Crane, 1985: 17). Agreement was reached that former Senator James L Buckley would lead the delegation. Buckley had collaborated with the right-to-life movement previously to introduce a constitutional amendment aimed at banning abortion. He agreed to take on the role of head of delegation after insisting, through discussions with the White House, that the official policy position should be consistent with his personal views on abortion (Finkle and Crane, 1985: 17). The paper was developed in the Office of Policy Development by an erstwhile aide to Senator Jesse Helms with the '*intellectual underpinnings*' provided by Professor Julian L Simon of the University of Maryland (Fox, 1986: 17). This contrasted with the normal approach of the allowing the State Department to take the customary lead in developing the US position and coordinating US participation (Finkle and Crane, 1985: 17).

The first draft of the MCP was shared by May 1984 and attracted opposition from the Department of State and USAID. They raised concern about '*economic stagnation in Least Developed*

Countries ' while emphasizing the need to intervene and address '*demographic realities*' that perpetuate poverty with resulting '*human degradation*' that undermines the fabric of families and society (Fox, 1986: 630). USAID acknowledged that abortion would not be recommended as a method of '*family planning*' and planned to propose language that family planning assistance would focus on preventing unwanted pregnancies and avoiding abortions (Fox, 1986: 630). The White House faced with criticisms from the institutions that would implement the policy, began to re-draft the statement[12]. During the revision process of the initial MCP draft the White House was approached by the American Life Lobby – a pro-life group[13] (Fox, 1986: 631). The American Life Lobby provided evidence that US funds were used to support groups engaged in abortion activities abroad (Fox, 1986: 632). The subsequent version of the draft MCP maintained the economic focus while further clarifying the abortion components. The proposed statement allowed direct bilateral aid to nations practicing abortion through segregated accounts while the prohibition against funding NGOs would be absolute (Fox, 1986: 632). UNFPA was requested to provide guarantees that it would not engage in abortion activities (Fox, 1986: 632). The American Life Lobby commented that they had achieved 90 percent of their initial request (Fox, 1986: 632). This version, following the inputs from American Life Lobby, subsequently became the official policy statement that would be used by the US delegation attending the Mexico City Conference (Finkle and Crane, 1985: 17).

Why conservatives captured the MCP for political purposes?

The policy statement on abortion, in respect of the status of women, created tension between conservative groups and the Reagan administration. (Finkle and Crane, 1985: 14). The final version of the policy was linked both politically and ideologically to its position on the status of women. Initial policy statements had included language on women which were not referred to when the American delegation made its policy statement at the conference (Finkle and Crane,

[12] The manifesto drew sharp distinctions between the White House and the 'foreign policy establishment' at the State Department. The manifesto …. Fuses two hot wires of social conservatism – particularly the Presidents solid pro-life philosophy - and supply side economics into an explosive combination that projects a very dynamic philosophy of what we should be bringing abroad'(Fox, 1986: 631).

[13] The American Life Lobby actively campaigned against Planned Parenthood. Pamphlets produced through the American Life Lobby charged Planned Parenthood with 'perversion, homosexuality, pornography, abortion, family destruction [and] population control'. Another pamphlet states '*there is a widely held conviction that unmarried teenage sex is immoral and that widespread sexual immorality tends to weaken the moral fibre of the nation. A case can be built on the history of nations that moral decay leads to the fall of nations. In the face of such history, it is hardly appropriate for a nation to use its own tax monies to increase the spread of immorality*' (Fox, 1986: 631).

1985: 14). This silence aligned with expectations of members of the right-to-life movement and the New Right[14] who discouraged attempts to enhance the status of women (Finkle and Crane, 1985: 14). They opposed the principle that women should have equal rights with men including control over fertility with access to abortion counseling and services. This was a consequence of a traditional view of the family and the role of women in society including the perspective that abortion is immoral (Finkle and Crane, 1985: 14). The Reagan administration, in contrast, was reluctant to be perceived as opposing efforts to enhance the status of women, as this perspective may have impacted the upcoming Presidential elections. Ultimately, the American delegation agreed to strengthen language about women's concerns that was incorporated into the official conference recommendations. This is thought to have followed pressure by the Reagan Administration and American women who represented NGOs at the conference (Finkle and Crane, 1985: 14).

Since the previous population conference in Bucharest in 1974, new political forces had emerged in the USA who expressed a '*high degree of religious and ideological commitment*' (Finkle and Crane, 1985: 15). Furthermore, these groups felt it to be morally and politically acceptable to expand concerns about domestic policies for population and family planning to the international arena. The spread of domestic population policies on population into the international arena is not unique. However, when they influence the behavior of a leading power and actor, the impact tends to be greatly amplified (Finkle and Crane, 1985: 16). This necessitates a deeper understanding of the impact of domestic politics in the preparation of the US position for the Mexico City conference.

The newly appointed Reagan administration raised concern among members of the population community about the introduction of changes to international population policy (Finkle and Crane, 1985: 16). Prior to Reagan's re-election bid in 1984, the Reagan Administration had continued

[14] The '*New Right*' was a grassroots coalition of American conservatives that collectively led to Republican ascendancy of the late 20th century. The '*New Right*' coalesced conservative activists around the issues of abortion, homosexuality, the Equal Rights Amendment, the Panama Canal Treaty, affirmative action, and most forms of taxation. The '*newness*' referred to both to the reinvigoration and redefinition of conservative political activity and to the mobilization of a previously disorganized youthful, suburban, middle class. The movement grew rapidly during the 1960s and 1970s. As a group, the movement was characterised by being white, middle-class, Protestant and suburban and strove to counteract the perceived decline in morality during the 1960s and 1970s. https://www.britannica.com/topic/New-Right

broad and bipartisan support for family planning foreign assistance (Finkle and Crane, 1985: 16). This assistance aimed to secure and promote the long term economic and security interests of the United States in a '*stable global order*' (Finkle and Crane, 1985: 6-17). Cost-effectiveness of population programming compared to other forms of aid together with the health and humanitarian arguments provided additional justification for assistance (Finkle and Crane, 1985: 17). The '*opposition'* coalition, formed before the 1980 Presidential election, included right-to-life groups and informal networks of institutions and organizations comprised of appointees of the Reagan administration, Congressmen and their staffs and representatives of lobbying organizations and '*think tanks*'(Finkle and Crane, 1985: 17). The coalition represented several different movements that had been gathering strength since the seventies and included the right-to-life movement, Protestant fundamentalism, and importantly, the New Right wing of the Republican Party (Finkle and Crane, 1985: 18). Despite the differences between these groups they shared some common values and themes, including perspectives on personal morality, women's rights and opposition to abortion:

> *'a desire to see religious institutions and practices receive more overt support from the government; fervent anti-Communism and nationalism; devotion to an ideal of free enterprise and opposition to social welfare programs regarded as "social engineering"; antipathy toward the "Eastern establishment"; and a strong desire for American political leaders to project more confidence and optimism about the future*' (Finkle and Crane, 1985: 18).

The New Right coalition took an interest in the Mexico City conference and international population issues for the following reasons. Firstly, concerns were raised about perceived trends in national and international population programs such as the liberalization of abortion policies and the role of international agencies in supporting abortion-related activities, increased availability of sterilization and, increased use of incentives and disincentives to promote family planning (Finkle and Crane, 1985: 18). Reports about forced abortions in China from 1983 reinforced concerns (Finkle and Crane, 1985: 18). Secondly, the conference provided an opportunity to achieve domestic objectives (Finkle and Crane, 1985: 18). Acknowledgement and incorporation of antiabortion recommendations by the United Nations would serve to validate the efforts of the coalition; failure to do so would enable the coalition to highlight the inadequacies of the UN (Finkle and Crane, 1985: 19). Participation of the right-to-life movement in the conference would enable global networking with likeminded groups while assisting with the establishment of a multinational movement and raising the credibility of the right-to-life movement at the national

level (Finkle and Crane, 1985: 19). The New Right coalition could regain credibility after failing at previous attempts with its broader social agenda to ban abortion after the effort two years earlier to amend the US Constitution (Finkle and Crane, 1985: 19). Arguing for the incorporation of antiabortion comments in Mexico on the international level would serve to partially regain their losses and boost the future of the movement (Finkle and Crane, 1985: 19). Finally, a successful outcome at the conference would serve to motivate grassroots supporters and wealthy contributors to strongly support the 1984 Presidential elections since the coalition could demonstrate that it had the ear of the White House (Finkle and Crane, 1985, p. 19). Challenging the foreign policy establishment including moderate Republicans who supported US leadership in international population assistance, demonstrated the political influence of the New Right coalition (Finkle and Crane, 1985: 19). The Reagan administration in turn gained from a strong position at Mexico City by fulfilling earlier promises made to the New Right coalition that had only partially fulfilled during the first four years of the Reagan administration; this visibly demonstrated the commitment of the Reagan administration to try to fulfill earlier promises (Finkle and Crane, 1985: 19).

Abortion and the conscience of a nation – President Reagan's influence

Reagan was responsible for the introduction of the MCP executive order (1984) that prohibited the use of federal funds by NGOs globally for the provision of abortion and abortion related services (Starr, 2012: 485). Reagan's thoughts on abortion can be gleaned from an essay released in 1983, the 10th anniversary of the Supreme Court decision of Roe v. Wade (Reagan, 2010). Reagan viewed the anniversary as a '*good time to pause and reflect*' about the right to abortion during pregnancy (Reagan, 2010).

In the introduction**,** Franz describes how Reagan's great love for America originated from a society where all are free and equal before the law (Reagan, 2010). This freedom and equality is underpinned by a more fundamental principle: '…. *the intrinsic God-given dignity and value of each person. Without this fundamental principle, this endowment by the Creator, the invocation in the Declaration of Independence of the inalienable right-to-life, liberty and the pursuit of happiness would be a hollow statement, a noble statement of little consequence*' (Reagan, 2010). According to Franz, Reagan acted consistently with this principle, as scripted in the narrative content of the essay and matched by his deeds during his presidency. The pro-life legacy according

to Franz are exemplified by his pro-life actions, in defiance of the pro-abortion culture: these included the passing of the Baby Doe regulations to protect the newborn with disabilities; the institution of policies that prevented funding for experimentation on unborn children; the establishment of the MCP which targets abortion activities through foreign assistance funding; and the implementation of congressional directives to prevent family planning programs from advocating for abortion as a method of birth control (Reagan, 2010). Reagan supported efforts to overturn Roe v. Wade and to organize the pro-life movement into a formidable movement. Finally, Reagan taught perseverance as the pro-life cause is just and '*in the end, Roe v. Wade and its progeny will be reversed and, in spite of all temporary setbacks the "unalienable right-to-life" that is "endowed by the Creator" will be restored*' (Reagan, 2010).

Important themes are outlined by Reagan in his essay. Reagan challenged the legitimacy of Roe v. Wade as the Supreme Court ruling on the basis that the decision occurred without extensive consultation of voters or enactment by legislators. He writes that the decision was an '*act of raw judicial power*' and maintained that abortion on demand cannot be considered a constitutional right (Reagan, 2010). He viewed abortion, as a matter that affects all rather than the unborn child only and that it is not possible to diminish the value of a single category of life. By quoting John Donne's words '….. *any man's death diminishes me, because I am involved in mankind: and therefore never send to know for whom the bell tolls; it tolls for thee'* he incorporates the unborn as a full member of all human life and suggests that it is not possible to diminish the value of a single category of human life including the unborn (Reagan, 2010). Reagan compares Roe v. Wade with the Dred Scott decision of 1857 in two ways[15]. Firstly, he raises the *moral issue* of the ruling (and by implication Roe v. Wade) whereby African Americans were denied freedom on the basis of race that required the persistence of a *minority of Americans*, who understood the moral crisis of the decision, to eventually overturn the decision (Reagan, 2010). Secondly, he pointed out that it took a long period of time to reverse the Dred Scott ruling (Reagan, 2010). This perspective is

[15] The Dred Scott decision refers to the case *Dred Scott v. Sanford*, 1857. Dred Scott, a slave, argued that the time he spent in the free state of Illinois with his owner, Emerson, entitled him to emancipation on his return to the slave state of Missouri. The court decided that blacks, free or slave, could not claim U.S. citizenship, and therefore could not petition the court for freedom (https://www.britannica.com/event/Dred-Scott-decision). The Dred Scott decision created great controversy and is considered the worst decision ever made by the Supreme Court. It is viewed as an example of wrongly imposing a judicial solution on a political problem.

highly relevant to the decades old attempt to reverse Roe v. Wade and which is ably described in a Washington Post article written in April 2018 as the USA was preparing for mid-term elections.[16]

Reagan identifies a '*real issue*' and the '*real question*' related to abortion. The '*real issue*' in abortion is that two lives rather than one only are involved – the mother and the unborn child (Reagan, 2010). The '*real question*' according to Reagan is not about when life begins but '*what is the value of real life*' and '*whether that tiny human life has a God-given right to be protected by the law – the same right we have*'(Reagan, 2010). These comments seem to refer to the essence of Roe v Wade where the pregnant woman, especially early in the pregnancy, is accorded a '*privacy status*' that enables her to make an independent decision about abortion which is not subject to any influence by the state or federal government (United States Report (US), 1973). This status changes as the fetus gains viability to survive outside the womb when states are accorded a role in protecting the life of the fetus. A further key element of Roe v Wade is whether the fetus can be viewed as a person which is denied by Roe v. Wade. This remains one of the most contested areas in the discussions around Roe v. Wade by pro-life groups (Becker, 2012: 277)[17]. The definition of the fetus as a person accords interests to the fetus (to remain alive) and consequently a set of rights (not to be killed). According to Dworkin, the vesting of interests and rights in the fetus provides to government a derivative responsibility to protect the fetus against abortion – this would nullify Roe v Wade (1994: 11).

Reagan draws a linkage to the '*real issue*' to the Baby Doe case from Bloomington Indiana [18]. Drawing from Baby Doe, Reagan suggests that the basic issue is '*whether to value and protect the*

[16] https://www.washingtonpost.com/politics/abortion-wars-are-heating-up-ahead-of-november-elections/2018/04/19/74c7b4ee-3d8f-11e8-974f-aacd97698cef_story.html?utm_term=.83155f2a676d

[17] Roe v. Wade argues that if personhood for the fetus can be established it would lead to the acceptance that the fetus has a right-to-life that would need to be protected under the Fourteenth Amendment. The Roe v. Wade decision pointed out that no case had successfully been argued that a fetus is a person as defined in the Fourteenth Amendment (United States Report (US), 1973).

Pro-life groups argue that America is founded upon the Judeo-Christian belief that all persons are *'endowed by his Creator with certain unalienable rights,*' including the right-to-life is a most basic right (Becker, 2012, p. 277). According to Becker, the Supreme Court in the US incorrectly applied personhood to '*born persons*' only thereby '*restraining*' the right-to-life (Becker, 2012; 277).

[18] Baby Doe was born with two conditions - Down's syndrome and a tracheoesophageal fistula in Bloomington Indiana in 1982. The tracheoesophageal fistula, a surgically correctable condition, prevents oral feeding as the esophagus is not connected to the stomach. The attending obstetrician advised the parents to deny the baby further treatment due to the presence of Down Syndrome. The parents agreed to the guidance that the presence of Down's Syndrome would prevent Baby Doe from living a worthy life and that it was not in the family's best interests to pursue further treatment and care. In a court case brought by the hospital, the judge ruled that the parents had the right to decide about treatment

lives of the handicapped and whether to recognize the sanctity of life'(Reagan, 2010). This same basic issue applies to abortion. He cites the example of the 1981 Senate hearings on the beginning of human life where conclusions about certain agreements and disagreements were reached. The hearings confirmed, citing existing scientific evidence, that the unborn child can be viewed as being alive, as a distinct individual and a member of the human species. Disagreement existed about the '*value questio*n' and whether value could be accorded to life at the early stages of existence (Reagan, 2010). He raises the issue as it relates to the USA as follows

> '*Every legislator, every doctor, and every citizen needs to recognize that the real issue is whether to affirm and protect the sanctity of all human life, or to embrace a social ethic where some human lives are valued and others are not. As a nation, we must choose between the 'sanctity of life ethic' and the 'quality of life ethic'* (Reagan, 2010).

The '*quality of life*' issue is an important issue for pro-life groups as this is deemed as a '*slippery slope*' problem when decisions are based on an individual's perceived value to society (Luker, 1985: 144-146; Callahan, 1970: 394).

Finally, Reagan addresses the issue of managing unwanted pregnancies. He suggests the creation of a society in which abortion is not the necessary response to an unwanted pregnancy. He cites examples of individuals and groups who provide for unwed mothers, often at great personal sacrifice. This includes the development of mechanisms to provide for the adoption of children born to unwed mothers (Reagan, 2010). He cites Mother Theresa as follows: '*If you don't want that little child, that unborn child, give him to me'* (Reagan, 2010). He links mechanisms that care for the unborn child to faith – '*I have often said that we need to join in prayer to bring protection to the newborn. Prayer and action are needed to uphold the sanctity of human life*' (Reagan, 2010).

The MCP beyond the Reagan Era

After Reagan, the MCP took on a partisan flavor. Democratic presidents rescinded the MCP while Republican presidents re-enacted the MCP. Most recently, President Trump not only re-enacted the MCP but greatly extended the policy to include funding streams not previously affected by the

options. The Indiana Supreme Court supported this view and Baby Doe died six days after birth. Subsequently, President Reagan ordered the Department of Health and Human Services to withhold funding from hospitals that withdraw medical treatment of disabled infants with the intent of euthanizing them. The essence of the ethical debate in the case of Baby Doe was whether children with Down's Syndrome should be valued less than other people (https://www.rtl.org/prolife_issues/BabyDoeCase.html).

MCP such as malaria, maternal and child health and HIV/AIDS (USAID, 2018). Table 1 below demonstrates periods of enactment and rescission of the MCP.

Table 1: Periods of enactment and rescission of the MCP

President	**Period**	**In effect**
President Reagan (R)	1985-1989	Yes
President Bush (R)	1989-1993	Yes
President Clinton (D)*	1993-2001	No
President Bush (R)	2001-2009	Yes
President Obama (D)	2009-2017	No
President Trump (R)	2017 -	Yes

* There was a temporary, one-year legislative imposition of the policy (October 1999 to September 2000), which included a portion of the restrictions in effect in other years and an option for the president to waive these restrictions.
Source: https://www.state.gov/r/pa/prs/ps/2017/05/270866.htm

Concluding remarks

This section describes how the attempts to prevent USG funding support for abortion-related activities, originally expressed through the Helms amendment, was expanded through the MCP to control all abortion-related activities for organizations receiving USG funds irrespective of the funding sources. Population control approaches shifted from the perspective that developing countries would remain economically and socially constrained unless population growth was reduced by ensuring large scale access to modern family planning methods to a perspective whereby the free market, with its economic stimulus and deregulation approaches, was perceived as the more effective means to reduce population growth.

The voluntary nature of participation in family planning program was emphasized and language about respect for human life, enhancement of human dignity, strengthening of the family and avoidance of coercion in family planning was introduced. Ethical concerns that included notions of respect for human rights and the fundamental right of each individual and couple to determine

the size of its own family were articulated through the MCP (Finkle and Crane, 1985: 12). Curtailing support for anti-abortion measures was highlighted with the introduction of text stating that '*the United States does not consider abortion an acceptable element of family planning programs'* (Fox, 1986: 630). The traditional role of the State Department in coordinating the development of the policy statement and conference participation was usurped by the White House. This allowed the introduction of influences by the right-to-life movement with a '*pro-life*' agenda.

The status of women assumed controversial status in the MCP. The strong position on abortion was linked both politically and ideologically to the position of conservative groups and was aligned with expectations of members of the right-to-life movement and the New Right who discouraged attempts to enhance the status of women (Finkle and Crane, 1985: 14). They opposed the principle that women should have equal rights with men including control over fertility with access to abortion counseling and services. This was a consequence of a traditional view of the family and the role of women in society including the perspective that abortion is immoral (Finkle and Crane, 1985: 14). Furthermore, conservative groups felt it to be morally and politically acceptable to expand concerns about domestic policies about population and family planning to the international arena (Finkle and Crane, 1985: 16).

The presence of domestic politics expressed itself in the MCP. The emergence of coalitions since the seventies composed of the right-to-life movement, Protestant fundamentalism, and importantly, the New Right wing of the Republican Party, actively expressed themselves on *personal morality, women's rights and opposition to abortion. This included a desire for government support for religious institutions and practices* (Finkle and Crane, 1985: 18). The New Right coalition took an interest in the Mexico City Conference and international population issues in pursuance of their objectives such as establishing international networks of the right-to-life movement and impacting policy making at the UN (Finkle and Crane, 1985: 18-19).

Reagan's thoughts were expressed through his essay on *Abortion and the Conscience of a Nation*. These include the use of the Dred Scott incident as a source of inspiration to reverse Roe v Wade, emphasizing the value of the unborn life, promoting the extension of legal protection to the fetus and finally, encouraging a clear distinction between the affirmation and protection of the sanctity

of all human life in contrast to the alternative of an ethical approach whereby where some human lives are valued less than others.

Chapter 5. The stakeholders of the Mexico City Policy

Several stakeholders participate in the abortion and family planning debate as it pertains to the MCP. Prominent among these are American women who reflect their individual experiences of family and childbearing, the Christian Right, politicians, and organizations that focus on expanding abortion as a fundamental element of reproductive choice for women. A further group is constituted by women who are the subject of much of the discussion. These women are the recipients of family planning through foreign aid and who rely on this aid for access to family planning methods. The views of women who receive their family planning through foreign aid are not well described, however, through inference from a political debate in congress it is possible to build a picture of their motivations, fears and concerns.

This section will detail the origins of controversy such as pro-life and pro-choice views and the influences that led to the development of the abortion controversy, the linkage to the larger political process as expressed through foreign assistance and the MCP, and the groups who support and oppose the enactment and rescission of the MCP. The section will begin with the politics of motherhood in America, the role of the Christian Right followed by perspectives of the opponents of the MCP, a description of the voiceless recipients of foreign aid and the convergence of these perspectives in the American political process through the lens of a Congressional Hearing on the MCP that took place in 2007.

Women and mothers; the politics of motherhood in America

Kristin Luker in her book *Abortion & the Politics of Motherhood* examined perspectives on both sides of the abortion conflict in the USA. This oft cited work looks at the issues, beliefs and people who engaged as activists in the abortion conflict, draws out the social worlds inhabited by activists, and explores the complex relationships between the social values typical of pro-life and pro-choice groups. Moral positions on abortion, she argues, reflect views on sexual behavior, the care of children, family life, technology, and the importance of the individual (Luker, 1985). Her writings provide a perspective and further understanding about factors that ultimately feed into the controversy of abortion in the USA. It also serves to understand how ideological perspectives on motherhood and their linkages with the Christian Right influenced the political process giving rise to the 1984 enactment of the MCP.

Barry and Popkin lay out the relevance of Luker's work. They ask why abortion had become such a prominent issue in the late twentieth century? In response they suggest that women by the late twentieth century had attained the ability to incorporate children and marriage into a '*long-term career plan'* (Luker, 1985: x). The controversy about abortion evolved from an initial focus on the status of the fetus to one that incorporated the status of motherhood in the USA (Luker, 1985: xi). This controversy is rooted in a debate about the role and place of women in society and the proper constitution of families (Luker, 1985: xi). The comparison by Luker of pro-choice and pro-life women served to highlight an important question in American society which was and likely continues to be a '*set of struggles about the distribution of careers and jobs in America*' (Luker, 1985: xi). Pro-choice women rely on their ability to manage and plan childbearing in relation to the fulfillment of their potential as human beings. Pro-life women see children and family as being central to their lives (Luker, 1985: xi). The right-to life-movement is portrayed as an attempt to form a '*moral cartel*' that deploys '*state power*' to define the '*social role of women*' (Luker, 1985: xi). This attempt is aimed not only to protect the fetus but also to elevate family above women's careers while also ensuring the homemakers are not delegated to a lower status compared to women who work outside of the home (Luker, 1985: xi). Luker's work demonstrates how the rise of movements aim to put the power of state behind moral positions and which serves to help us understand why many people attempt to validate their moral positions through the legitimization of political institutions (Luker, 1985: xi).

Abortion, the topic that strongly divides pro-choice from pro-life groups, is described by Luker as the '*tip of an iceberg*' that represents different beliefs about the roles of the sexes, the meaning of parenthood, and human nature (Luker, 1985: 158). The prism of abortion provides a '*rare opportunity*' to examine a set of values that are rarely discussed and debated (Luker, 1985: 158). Discussion and debate about abortion creates the sense that a group's worldview is under '*assault'* (Luker, 1985: 158). These worldviews and the values they represent are deeply held and dear to individuals and often individuals do not recognize that they hold these worldviews – it is rather viewed as a '*reality'* with an expectation that others share similar perspectives (Luker, 1985: 158).[19] Issues such as the controversy around abortion bring individuals to the realization that others have different perspectives. This leads to surprise, outrage and vindictiveness as these deepest values are unmasked (Luker, 1985: 159).

This section will describe both the origins of the pro-choice and pro-life movements, and subsequently these groups will be compared and contrasted by their social, educational and work-life characteristics together with their perspectives on abortion, family life and morality. Luker's work provides important insights into the forces that have driven the political debate we continue to see in the USA today. For instance, the ongoing effort to nullify Roe v Wade draws from the right-to life movement within which women constitute a powerful voice and an important source of activism with a strong linkage with groups such as the Christian Right (the Fox news article provides a contemporary perspective[20]). On the other hand, pro-choice groups actively promote the right of women to decide on abortion. The most recent contemporary and bitter event focused on preventing Trump's Supreme Court pick, Brett Kavanaugh, from being elected to the Supreme Court. Kavanaugh is viewed as being strongly pro-life and his addition to the court could prepare the pathway to overturning Roe v Wade.[21]

Emergence of the pro-abortion movement

Prior to 1967 in California, where Luker conducted her study, the abortion debate was largely restricted to professional men and women with intellectual ties who aimed to adjust existing

[19] Worldview definition, Luker: '*The areas covered by a 'worldview' are those parts of life we take for granted, never imagine questioning and cannot imagine decent moral people not sharing*' (Luker, 1985: 158).
[20] https://www.foxnews.com/opinion/how-the-march-for-life-and-the-womens-march-value-women-differently
[21] https://www.theguardian.com/world/2018/aug/09/pro-choice-groups-fight-against-trump-supreme-court-pick

abortion laws through calm, collegial debate (Luker, 1985: 92). These debates were subsequently overtaken by women who valued motherhood but wanted to time childbearing in accordance with their personally determined schedules. They introduced a claim that it was the mother's right to decide whether to have an abortion or not. This right was essential for their right to equality that validated them as individuals rather than as potential mothers (Luker, 198: 92). Importantly in the abortion debate, women wanted to make decisions about the need for abortions rather than rely on the recommendations made by medical doctors (Luker, 1985: 94).

The notion of a woman's right to an abortion together with abortion on demand followed profound structural changes in American society, particularly for women. Previously, men were expected to be employed in the paid workforce while women were perceived as nurturing homemakers caring for their families. This distinction was seen not only as descriptive but also prescriptive (Luker, 1985: 113). This expectation was not uniform since poor women and women of color did not have the luxury of nurturing their families fulltime as need had forced their incorporation into the paid labor force (Luker, 1985: 113). The sixties and seventies brought dramatic change to traditionally perceived roles. Firstly, women increasingly entered the workforce which saw a rise in formal employment of women from 29.6 percent in 1950 to 33.4 percent in 1960, 38.1 percent by 1970 and 43% by 1981 (Luker, 1985: 115). Secondly, women increasingly intermeshed their careers with motherhood and were less likely to drop out of the workforce after bearing the first child (Luker, 1985: 115). Thirdly, after 1960 there was a rapid decline in marriage rates. In 1975 women in the age group of 20 - 24 years were 12 percent less likely to marry than their peers in 1960 (Luker, 1985: 116). Fourthly, a steady increase in divorce rates meant that women increasingly took on the role of sole breadwinner (Luker, 1985: 116). Finally, smaller family sizes led to shortened periods of active child rearing (especially in families with the norm of two children); consequently, women were faced with extensive periods of time during which the active child rearing role did not constitute a full-time responsibility (Luker, 1985: 116).

These changes stimulated women to question the traditional idea that paid work was an adjunct and complementary activity to the traditional family role. They began to question the meaning of work in their lives and the jobs typically assigned to women as wife and mother; jobs typically characterized by segregation, low pay, lack of job security, and limited opportunity for promotion. Women came to see these jobs as unjust especially when work was perceived as an essential component of life (Luker, 1985: 117). Many women had acquired the education, skills and

capacities enabling them to compete with men which challenged existing notions that men should receive higher pay and access to better jobs; this revolutionized the way in which women thought about work. Women came to realize that their '*human capital'* was similar to that of men and found that they were paying a '*very high price for being women*' (Luker, 1985: 118). Luker suggests that

> '*the mobilization of significant numbers of women around the issue of abortion laws can be seen as an attack on the traditional linchpin that held together a complicated set of assumptions about who women were, what their roles in life should be, what kinds of jobs they should take in the paid labor force and whose jobs should be rewarded*' (Luker, 1985: , 118).

Additionally, since women were already linking work and family, the idea that women should be penalized economically on the basis of gender and associated family commitments was perceived as extremely unfair (Luker, 1985: 118). It is within this context that the notion emerged that women had '*a right to their own bodies*'. As women began to envision being productive for most of their adult lives, the intrusion of an unplanned pregnancy was perceived as a tragedy. Therefore, the perception that men, the state or physicians controlled a woman's pregnancy, together with the considerable impact of a pregnancy on women's careers, education and social status, was seen to be '*eminently wrong and cruelly oppressive*' (Luker, 1985: 118). For women who viewed their role in life as not being primarily a mother and caregiver the facts of biology created a dilemma. If they accepted their primary role as one of wife and mother, then control over one's body had little relevance as motherhood and the biology of reproduction implied that it was not necessary to control one's body. However, when a women's role becomes incongruent with the reproductive role, then the facts of biology and reproduction can be perceived as being at odds with life's aims and goals. In this instance, as women assumed the capacity for choices about how they lived their lives, the right to have an abortion enabled greater control over their lives (Luker, 1985: 118).

This understanding had important implications for women. Unimpeded access to abortion allowed women to argue that childbearing, while important, was not the most important aspect of a woman's life (Luker, 1985: 120). Fertility control also enabled women to contest the idea put forward by employers that only certain jobs were appropriate for women, allowing them to argue against discrimination in the workforce based on gender. The justification for gender discrimination in an America recently traumatized by events of the Civil Rights Movement was very difficult (Luker, 1985: 121) . Women also wanted to be empowered to make decisions about abortion rather than leaving these decisions in the hands of others. Some activists felt that the only

difference between men and women engaged in the workforce was that women bore children and paid '*high opportunity costs*' for pregnancy (Luker, 1985: 121). Pregnancy polarized the interests of men and women as these costs did not apply to men. Importantly, relying on someone else to make a decision about a woman's access to abortion implied that the traditional model of women's roles, symbolically and practically, would be upheld (Luker, 1985: 121). Additionally, in a very practical sense, a pregnancy could lead to women being denied opportunities that were available to men which served the confirm the existence of discrimination (Luker, 1985: 121).

A further element in relation to abortion and women's claims to control their own bodies was the role and relationship of children to women. Historically children have played a central role in society and kinships. Prior to the modern era children represented a '*concrete investment in the future*' and as a marker of '*marital alliances*' that could expand resources available to the '*kinship network*' and as a '*producer*' within the nuclear family. Toward the end of the 1800s, the economic and social value of children began to decline while their emotional value increased (Luker, 1985: 125). This was brought about by an increased emphasis on schooling and education leading to their separation from the workforce. In most urban and industrialized countries parents chose to have less children and invest more resources into children. Consequently, the American birthrate declined, with abortion playing an important role, from seven children per couple in 1800 to slightly more than three children per couple by 1900 (Luker, 1985: 125). Activism by women to access abortion on demand in the 1960s represents a second phase of this historical process. During the twentieth century the economic value of children as producers in the nuclear family remained low while the costliness of children due to prolonged education and exclusion from the workforce continued to increase. Abortion in this phase represents a second form of controversy in American society. The first controversy was the application of abortion to control fertility in the 1800s as family size declined. The second controversy according to Luker was the response by women to the increasing economic cost of children. The ability to gain control over the timing and spacing of pregnancy enabled women to prevent the very substantial consequences of an '*untimely or unintended birth*' (Luker, 1985: 125). The option of abortion provided women with a control over their fertility was especially relevant and meaningful within the changing context of their lives. Roe v Wade therefore was an important event for women seeking to expand the control over their lives as individuals (Luker, 1985: 125).

Emergence of the right-to-life movement

Roe v Wade in 1973 struck down all state abortion laws including liberal '*reform'* laws enacted by states (Luker, 1985: 126). This '*ushered in a new era'* and changed abortion from being a '*technical, medical matter controlled by professionals*' to a '*public and moral issue of nationwide concern*' (Luker, 1985: 127).

Pro-life groups had difficulties to comprehend the push to liberalize abortion policies in the USA. They assumed that others shared an unwillingness to discuss abortion based on similarly shared values integral to the social fabric of life. They believed that all persons thought abortion was wrong which made it difficult to cope with attempts to liberalize abortion. Pro-life groups also believed that the pro-choice groups would not get very far; they assumed that the '*unsavory connotation*' of abortion was based on a deep belief that embryonic life is sacred, and subsequently were caught unawares that this belief could change so rapidly (Luker, 1985, p. 130). They anticipated and relied on an expression of public outrage to contest the liberalization of abortion yet there was none. Additionally, the implicit assumptions they held about abortion made it difficult for them to lobby support from persons with similar shared values and beliefs. This occurred because they assumed that everyone shared a common understanding about the moral issues of abortion leaving them with few arguments to counteract those who were aiming to liberalize abortion laws (Luker, 1985: 130-131).

Roe v. Wade served as a catalyst to drive the establishment of the activist pro-life movement for two reasons. Firstly, post-1973 activists who initially engaged in the movement against the liberalization of abortion laws possessed particular characteristics driving them toward activism. These women typically had a high school education only, were married with children and were not employed outside the home. Few had been through the experience of an abortion or knew women who had had abortions. They lived in relatively closed communities with similar shared experiences and it was unlikely that they would ever need an abortion. These women were not politically active, they had no ties to professional associations or labor unions and were even unlikely to vote (Luker, 1985: 138-139). Secondly, the Supreme Court decision was highly significant for this group since the word '*person'* based on the judge's interpretation of the Fourteenth Amendment, excluded the '*unborn.'* Similarly, the Court was also unable to answer

the difficult question of when life begins. For pro-life groups this idea of personhood turned fact ('*everyone knew'*) into a matter of '*opinion*' (Luker, 1985: 139-140).

The Supreme Court decision raised many concerns for those with a pro-life perspective. Firstly, the Supreme Court legitimized the view that the embryo is a '*potential'* person rather than a person; an anathema to pro-life groups (Luker, 1985: 140). Secondly, by noting that '*reasonable people*' were unable to agree on the status of the embryo as a person, the Court had accorded equal respectability for opposing sides in the debate (Luker, 1985: 140). Finally, it removed the right of the state to regulate the embryo implying that the embryo no longer could rely on institutional protection while entrusting decision-making about the meaning and value of the embryo to the discretion of women and their doctors. This was a shocking idea since the prevailing majority opinion held that the embryo is equivalent to a person with a value equal to that of any human life now became one of several different opinions (Luker, 1985: 140). Furthermore, this opinion was deemed to belong to the '*private sphere*' like a religious preference rather than a strongly vested '*social belief'* (Luker, 1985: 140). This was a significant departure from traditional views and caused many to realize that the legalization of abortion represented a powerful movement (Luker, 1985: 141).

The introduction of personhood into the debate following Roe v. Wade thus provided impetus for the incorporation of new groups into the anti-abortion movement. Pro-life people who constituted these groups shared certain common experiences as part of their ant-abortion activism. Almost all recruits held the view that the embryo is a person (Luker, 1985: 146). Most were self-recruited which is the opposite to pro-choice groups who were recruited through '*consciousness raising*' (Luker, 1985: 146). Finally, many had a personal experience that motivated them to become part of the anti-abortion movement (Luker, 1985: 146). Factors that contributed to personal experiences included problems with conception, experience of miscarriages, and children lost to congenital disease or childhood illness (Luker, 1985: 151-152).

Luker's research identified additional factors that drove the creation of the pro-life movement. Pro-choice arguments raised concern that abortion promoted the devaluation of the lives of babies perceived as '*damaged'* with death as a '*blessing in disguise*' (Luker, 1985: 154). This highlights an important value conflict between pro-choice and pro-life groups. Reagan taps into this issue by raising the Baby Doe case as shared in his essay on *Abortion and the Conscience of the Nat*ion

(Reagan, 2010). For pro-choice persons, who consider the embryo as a '*potential'* person, termination of a pregnancy is preferable to life as an individual with '*diminished capacities'* (Luker, 1985: 154). Pro-life groups, by contrast, who believe in the personhood of the embryo see the promotion of abortion as trivializing '*great human loss'*. More significantly, it draws a distinction between the '*perfect and not-so-perfect*' (Luker, 1985: 154). This notion is further expanded when the '*unborn'* can have their lives ended by the individual choice of the mother and is perceived to foster a '*general disrespect for life'* (Luker, 1985: 154). The idea of '*general disrespect for life*' among some pro-life supporters is associated with larger historical and social issues such the relationship between Nazi's and genocide, the treatment of the Irish by the British or the use of abortion for population control especially the poor. This association, according to Luker, was essential in turning this group into activists and this occurred by making a connection between the embryo and a vulnerable group (1985: 154-155). The logic of this association confuses those who are not pro-life supporters. For pro-life people however, who take it for granted that an embryo is a child, abortion '*in principle defines all embryo's as "nonpersons" or persons who lack equal rights'* (Luker, 1985: 155). This stands in contrast to those who are pro-abortion who in fact believe that the rights of the embryo are indeed less than those of actual persons which in turn accords the right of pregnant women to terminate their own pregnancies. This logic '*deeply'* offends pro-life people (Luker, 1985: 156). This leads to a conclusion by pro-life groups

> *'For people who really do believe that embryos have always been treated with respect – and our data suggest that almost all pro-life people believe this-the wide acceptance of abortion in American society is truly frightening because it seems to represent a willingness of society to strip the rights of personhood from ''persons'' who have always enjoyed them. If the rights of personhood can so easily be taken from babies (embryos), who among us will be next'* (Luker, 1985: 156).

Furthermore, the relationship between mother and child is viewed as the '*most intimate, most sacred, and most satisfying relationship of all*' (Luker, 1985: 156). If this relationship can be disrupted, then all relationships become unsafe or as verbalized by one of Luker's research participants '*if a baby can't be safe in his mother's womb, where can he be safe'* (Luker, 1985: 156). Pro-life persons draw two forms of offense from abortion; firstly, the death of the embryo and secondly, the rationale of the death (Luker, 1985: 156). The pro-choice logic is perceived to enable the development of a '*totalitarian society like Orwell's Animal Farm where some are more equal than others*' (Luker, 1985: 156). This leads to a conclusion that when abortion becomes

acceptable it implies that a person's life may be defined by his or her '*social worth*' which in turn may be dependent on the decisions of those persons whose motives may not be trustworthy. Embryo's therefore '*represent a non-negotiable boundary*' for pro-life persons (Luker, 1985: 157). Luker concludes

> '*By definition, embryos cannot pull their own weight socially; they are at the most dependent and least "productive" stage of their life cycle. Nor is it surprising that people who belong to socially vulnerable groups, or identify with them, find the plight of the embryo so distressing: it is innocent, it is human (at least at the genetic level), and all of its social worth is yet to come. To argue that embryos are entitled to the rights of personhood, despite their conditions of dependency, because they possess the entry card of 46 human chromosomes is to emphatically assert that personhood is a natural, inborn and inherited right, rather than a social contingent and assigned right'* (Luker, 1985: 157).

Differentiating between pro-life and pro-choice perspectives: How the divide emerges?

This section will describe the stark differences that exist between women who align themselves with either the pro-life or pro-choice movements. Socio-economic profiles of income, inclusion in the formal workforce, education, marriage and family profiles and religious attachment predict the opportunities women are likely to have in life. For example, the education and skill set of pro-choice women give them the option to compete against men in the formal labor force. Similar opportunities do not exist for the typical pro-life women who subsequently need to seek other forms of self-validation in life, especially since their life circumstances have made them comparably more vulnerable than pro-choice women. The previous sections explored and explained those factors that drove the formation of the two different movement. By looking at issues such as contraception, abortion, and family it becomes possible to understand how women ultimately begin to display different moral perspectives and worldviews according to the affiliation in favor of or against abortion. Ultimately this plays out at a societal level including political life and the generation of policies such as the MCP.

Pro-life profile. In Luker's study, one in seven (about 15%) pro-life women reported an annual family income of above $50,000. Forty four percent reported an annual family income of less than $20,000/annum. Pro-life women were less likely to work compared to pro-choice women; 63

percent of pro-life women were not absorbed into the paid labor force and those who did tended to be unmarried. Of those pro-life women who worked in the paid labor force, half earned a personal income of less than $5,000/annum and for the other half personal income varied between $5,000 - $10,000. They were more likely to be married to a skilled worker or small businessowner (Luker, 1985: 194-195).

Pro-life women had lower levels of education compared to pro-choice women. Ten percent had a high school education or less, 30 percent did not complete college while only six percent had achieved a law degree, medical degree or Ph.D. Pro-life women tended to be housewives; those who worked were teachers, social workers and nurses. Sixteen percent of women had never married, 5 percent of women had been divorced and on average women had two to three children with almost one in four women having five or more children (Luker, 1985: 195-196).

Almost 80 percent of pro-life women in Luker's study were Catholics, 69 percent indicated that religion was important in their lives and half attended church on a regular basis (Luker, 1985: 197).

Pro-choice profile. One third (33%) of pro-choice women reported an annual family income of above $50,000. Only twenty-five percent reported an annual income of less than $20,000/annum and these women tended to be at the start of their careers. Almost all pro-choice women (94 percent) were incorporated in the paid labor force with more than half of them earning salaries that put them in the top 10 percent of working women in the USA. One in ten women had an annual personal income of more than $30,000. They were likely to be married to men who earned good incomes (Luker, 1985: 195).

Thirty-seven percent had undertaken graduate work beyond a B.A. degree level and 18 percent had achieved a law degree, medical degree or Ph.D (Luker, 1985: 195). Pro-choice women tended to work in the major professions, as administrators, as owners of small businesses and as executives. Twenty three percent had never married, 14 percent had been divorced and on average had one to two children (Luker, 1985: 196).

Sixty three percent of women professed that they had no religion while 22 percent thought of themselves as vaguely Protestant. Twenty five percent said they ever attended church and most of those who attended did so occasionally. No Catholics were found in Luker's sample during the study (Luker, 1985: 197).

Contraception. Pro-life groups condemn 'a*rtificial contraception*' and rather promote natural family planning approaches such as abstinence from sex during periods of fertility; they do not require 100 percent protection from family planning methods (Luker, 1985: 165-168). In turn, pro-choice groups view contraception as part of routine health care and they carry no moral convictions about the use of contraceptives; contraception allows them to achieve intimacy with their partner while protecting against pregnancy (Luker, 1985: 179).

Abortion. Pro-life groups view abortion as wrong for three reasons. Firstly, it is wrong to take a human life; women are seen to have a special role in sustaining and nourishing this new life. Secondly, when women are empowered to make decisions about fertility it leads to the disintegration of a finely tuned set of social relationships that exist between men and women that have traditionally encompassed and protected women and children. Thirdly, abortion deemphasizes and diminishes traditional roles of men and women (Luker, 1985: 160-162). Ultimately, abortion is wrong as it 'plays *havoc with this arrangement of the world*', diminishes male responsibility and decision-making power and rather than freeing women tends to oppress them (Luker, 1985: 162). Pro-life people divide the world into '*male and female spheres*' and are saddened by the loss of the '*female sphere'* (Luker, 1985: 163). The '*female sphere'*, exclusive to women, includes values such as tenderness, morality, emotionality and self-sacrifice. Importantly, everyone loses when traditional roles are lost; men suffer the loss of nurturing by women which is important in tempering male behaviors such as destructive and aggressive urges, women suffer the loss of protection and cherishing provided by men while children may lose the full-time loving provided by at least one parent as well as the modelling of behaviors provided to children by parents (Luker, 1985: 163).

Pro-choice groups exhibit an important concern about the relationship between abortion and sexuality. They oppose the use of abortion as a method of contraception and do not see abortion as a preferred method of birth control. Two reasons underlie this perspective; firstly, there is a concern that repeated abortions may create health risks and secondly, their moral perspectives on the personhood of the embryo creates moral '*anxiety'* (Luker, 1985: 179-180). Pro-choice reasoning acknowledges the existence of the personhood of the embryo. While denying the existence of personhood at conception, they believe that personhood evolves progressively as the pregnancy progresses, also known as a '*gradualist'* approach (Luker, 1985: 180). Pro-choice

persons accept that under certain circumstances the rights of the mother outweigh the potential rights of the embryo. However, when a woman arbitrarily allows a pregnancy to occur without taking the necessary preventive precautions, she is seen to diminish the rights of the embryo which offends their moral sense (Luker, 1985: 180). A further morally troubling contradiction occurs in instances of multiple abortions. This seems somewhat illogical since if it is acceptable to end one pregnancy through abortion why is it problematic to terminate more than one pregnancy in the same fashion. However, according to Luker both contextual and gradualist moral reasoning is used to draw the distinction between a first abortion and repeat abortions. The first abortion represents the lesser of two evils in those circumstances where the pregnant woman is perceived as being unable to effectively parent the child which in turn justifies an abortion. However, most women are provided with contraceptives after an abortion and follow on pregnancies ending with abortions would be viewed as not exercising the option to avoid the pregnancy – this seems to represent a form of negligence which is morally wrong (Luker, 1985: 180-181).

Parenting and motherhood. Pro-life persons believe that the raising of children and caring for families is the most fulfilling role for women and the priority for women is to be '*wives and mother*'s first' (Luker, 1985: 160-161). Mothering is demanding and equivalent to a full-time job; women who cannot fully commit to motherhood should rather avoid it (Luker, 1985: 161). Requirements of financial stability, homeownership, job achievement and educational attainment prior to setting up a family, an important consideration for pro-choice families, is seen as a distortion of values by pro-life persons (Luker, 1985: 168). Pro-life women view an unanticipated pregnancy as being temporarily unwanted in contrast to the child who is viewed ultimately as wanted. This is in keeping with values, often originating in childhood, and available social resources that lead pro-life women to believe that it is possible to '*make room for one more*' while also strongly believing that abortion is '*cruel, wicked and self-indulgent*' Luker, 1985: 198).

Pro-choice persons prioritize future opportunities for their children, hence appropriate conditions need to be created that will provide the necessary emotional, psychological, social and financial resources for children needed to capitalize on future opportunities (Luker, 1985: 181). The duty of the parent is to nurture and grow their children accordingly; therefore, these parents shape their lives to provide as best as they can to provide for their children. For instance, childbearing is timed based on the availability of adequate financial capacity to support the child and the establishment

of the necessary maturity needed to raise children who feel loved, have self-esteem and '*who feel good about themselves'* (Luker, 1985: 181). The emphasis on readiness for childbearing by pro-choice persons is perceived as '*unfathomable'* by pro-life persons (Luker, 1985: 181). Pro-choice persons feel that too many persons are pushed into parenthood by an unexpected pregnancy when not ready for this important task which, in turn, influences their perspective on abortion (Luker, 1985: 181). Abortion, by preventing an unwanted pregnancy, is viewed as a means to strengthen the '*quality of parenting*' by making parenting a choice rather than an unavoidable outcome. (Luker, 1985: 182).

Moral perspectives on abortion. Pro-life persons exhibit strong views on the nature of morality. As a group, pro-life persons adhere to '*explicit and well-articulated moral codes*' (Luker, 1985: 174). Morality is defined through a clearly articulated set of rules (i.e. the Biblical Ten Commandments and Judeo-Christian law) that lay out moral behavior through the provision of standards by which behavior can be judged. As these rules originate from a '*Divine Plan*', principles are seen as eternally valid '*transcendental principles*' irrespective of time, cultural context and individual beliefs (Luker, 1985: 174). Abortion therefore insults the moral convictions of pro-life persons. The Divine Law of '*thou shalt not kill*' breaks one of the commandments since during an abortion the embryo, deemed equivalent to a person, is killed (Luker, 1985: 174). Arguments used by pro-choice persons, including the Supreme Court judges in the Roe v. Wade decision, clashes with the moral reasoning of pro-life persons. The embryo is a human life, or it is not – there is no intermediate step such as a potential human life (Luker, 1985: 174).

The conceptions of morality for pro-choice persons influences their ideas of sex, conception and abortion which is recognized by their pro-life opponents. Pro-life persons describe the ethics of pro-choice persons as '*situational ethics*'[22] (Luker, 1985: 183). The moral reasoning of pro-choice

[22] **Situation ethics** in ethics and theology contextualizes moral decision making to specific situations. The guiding framework for moral decision making includes loving actions, maximization of harmony and reduction of conflict, and the enrichment of human existence. Situation ethics was developed by American Anglican theologian Joseph F. Fletcher. Fletcher objected to both moral absolutism and moral relativism. The general Christian norm of brotherly love underpins situation ethics. For example, if abortion is viewed as morally wrong then abortion can never be allowed irrespective of the circumstances of the pregnancy. Fletcher held the perspective that an absolute position denies the contextual reality of each situation and can result in callous and inhumane ways of managing situations. Alternatively, without principles at all, the decision making can take on a spur of the moment nature without considering the real moral implications. Fletcher's perspective was that while considering the context of the situation, decisions should be based on the most loving or right action. https://www.britannica.com/topic/situation-ethics

persons is characterized as '*situational'* due to their pluralistic worldview and is based on a belief that no single moral code can suffice for all (Luker, 1985: 183). The pro-choice group tend to be more secular in nature and deny the legitimacy of Judeo-Christian codes as a means to provide absolute moral standards. Their perspective is that morality is not defined by behavior that complies to a rigid set of rules such as the Ten Commandments but rather that behaviors are guided by '*a few general ethical principles*' (Luker, 1985: 183-184). When this outlook is combined with a strongly held belief in the rights of the individual, a perspective emerges that individuals rather than governments or churches, are best placed to make ethical decisions, an approach that Luker likens to being '*quintessentially protestant, in a secular rather than religious sense*' (Luker, 1985: 184).

Pro-choice persons therefore emphasize decisions about abortion as being an '*individual, private choice*' (Luker, 1985: 184). The moral logic of pro-choice persons is characterized by three features. Firstly, there is a distinction between the embryo and a child. Secondly, the embryo is alive and possesses some moral rights. Thirdly, the bias of pro-choice persons is pluralistic in nature; individuals should follow their consciences based on their moral perspective on abortion (Luker, 1985: 184). Morality for pro-choice persons is therefore based on considering a range of competing issues and attempting to develop an appropriate response through the consolidation and reconciliation of the issues while relying on the guidance provided by general moral principles rather than compliance with rigid moral rules (Luker, 1985: 184). This is referenced by Luker as a form of morality expressed through the New Testament and Joseph Fletcher when determining moral principles to guide abortion (Luker, 1985: 184). Moral choice making for pro-choice persons is based on asking the question '*what is the loving thing to do*' (Luker, 1985: 185). This demonstrates that pro-choice persons exercise their moral reasoning through a '*subjectively reasoned application of moral principles*' rather than by relying on external moral codes (Luker, 1985: 185). The moral reasoning based on application of principles creates challenges for pro-choice persons. Pro-choice persons tend to debate moral dilemmas through individual reflection. When issues are not viewed as intrinsically right or wrong, decisions about moral conflict are made through the application of moral principles; this can create moral conflict (Luker, 1985: 185).

According to Luker, moral conflict for pro-choice persons about abortion is the mirror image of the conflict experienced by pro-life persons (Luker, 1985: 185). Pro-life persons tend to be conflicted by the need to accommodate challenging real-life situations through compliance with

strict moral codes when becoming pregnant and needing an abortion for themselves. By contrast, the flexible moral guidelines pro-choice persons use requires immense mental effort in distinguishing right from wrong. Since their decision-making about moral issues relies on a delicate weighing of competing interests, they are often left feeling insecure as to whether they have fully considered all relevant issues. Luker concludes that given the different approaches to resolving moral issues and conflict it can be said that '*the demon of pro-life people is guilt while the demon of pro-choice people is anxiety*' (Luker, 1985: 185-186).

Comments

This explanation of the origins of the pro-life and pro-choice movements allow important issues to emerge. The abortion debate is initiated by women striving to exert control over their own lives as they seek to establish themselves as individuals in addition to the responsibilities of motherhood and family commitments. Abortion is an important mechanism that enables pro-choice women to take control of their lives. They seek self-validation through work and career which relies in turn on education and the development of skills. The profile of the pro-choice women reflects these desires through educational attainment, income and management of marriage and families. They develop particular perspectives about pluralism which influences their moral perspectives, evolve toward greater secular engagement that separates many from religion and they are '*interventionists'* who believe that humans have the capacity to solve human problems. Moral conflict arises from a process of moral reasoning based on principles and leads to moral anxiety. Justification for abortion is provided by arguments which promotes the right of women to make individual decisions about the termination of a pregnancy which is supported through sophisticated reasoning about the evolution of personhood in the embryo.

The pro-life woman in turn is motivated by the injustice done to the embryo and fetus while still in the womb and emphasize that the priority for women is to be '*wives and mother's first*' (Luker, 1985: 160-161). While pro-choice women invoke reason in their thinking about their lives, pro-choice women are guided by rules and codes. This is exemplified by their reliance on religious codes such as the Ten Commandments, an emphasis on distinct traditional roles for men and women and even the clear-cut nature of their expression of the start of life which is believed to occur at conception. The profile of pro-life women compared to that of pro-choice women suggests that their opportunity in life is much more limited. This leaves them vulnerable and with the need

to seek self-validation in marriage and family. They remain intensely religious compared to pro-choice groups which creates in turn opportunity for mass mobilization through churches and religion as they seek a return to traditional values and prevent the process of secularization[23]. Hence the interest in overturning Roe v Wade. The emergence of controversies related to bioethical end of life issues such as euthanasia and abortion are starkly opposed through the pro-life non-interventionist approach and pro-choice interventionist approach.

In an interesting way, the 2016 US Presidential campaign highlighted the difference between the two groups described above. Hillary Clinton, viewed as being representative of the '*coastal elite*'[24] made the comment that many of Trump's supporters belonged in a '*basket of deplorables*' (Balz, 2016). This comment, made at a LGBTQ[25] fundraiser (another point of controversy for pro-life groups) in New York, referred to racists, sexists, homophobes, xenophobes, and Islamophobes who constitute an important component of Trump's current constituency (Balz, 2016). It also, indirectly, refers to the separation of wealth and status in America where wealth and status is largely distributed along the east and west coasts while poverty and social problems trend toward the '*middle'* or that area between the coasts.[26] This separation, while somewhat of a generalization, follows political demarcations (Republicans dominant in the '*middle'* and Democrats largely dominant along both east and west coasts), social status (the '*middle'* is poor, rural, and less educated while the coast is rich, urban and well educated) and religion, especially in the middle, where religion is a core element of life. We can therefore see the emergence of battle lines in America, which is represented by conflict between the '*deplorables'* and '*non-deplorables*' or another way to characterize the pro-life and pro-choice groups in an indirect fashion. Abortion is central to this battle and the MCP through its antagonism toward liberalized abortion assumes a significance similar to the idea of '*tossing a bone to the dog*' as a form of appeasement to the Religious Right by the Republican Party (Economist, 2003). The internal battle over abortion in

[23] See Cavanaugh's comments on the Christian Right movement which is perceived as a traditionalist bloc that opposes secularization and encourages the return to customary restrictions (Cavanaugh, 1986: 251).
[24] The term coastal elite derives from educated professionals who live either in urban settings in California along the coast or along the eastern seaboard in the USA. https://www.salon.com/2016/11/20/real-americans-vs-coastal-elites-what-right-wing-sneers-at-city-dwellers-really-mean/
[25] The acronym LGBTQ stands for lesbian, gay, bisexual, transsexual, and queer or questioning. https://www.thefreedictionary.com/lgbtq
[26] Middle America finds its origins by contrast with the east and west coasts of America. The term is mostly used in a derogatory fashion. The Middle is seen as secondary in importance to the coasts and inhabitants are caricatured as being provincial and unsophisticated.
https://www.urbandictionary.com/define.php?term=middle%20america

the USA is intense and politically challenging which illustrates how the MCP can easily be used as a form of appeasement depending on which political party is in power.

Finally, following this overview it is necessary to identify themes that will illustrate linkages to other sections of this thesis. A first prominent theme that emerges is the notion of rights of women to decide on abortion introduced by the initial pro-abortion activists. This right was deemed essential for their right to equality, validating them as individuals rather than as potential mothers only. This idea of rights is accompanied by the interest of pro-choice women to manage and plan childbearing in relation to the fulfillment of their potential as human beings. This set of ideas become prominent in organizations that tend to oppose the MCP. Secondly, ideas such as the value of the fetus, quality of life and religiosity emerges as a central theme that creates conflict between the two movements. These ideas are incorporated into the political process as was demonstrated through comments made by Reagan and ultimately were and continue to be well reflected by the partnership between the Christian Right and the Republican party. Thirdly, it is likely that the contrast of religion versus reason contributes to the intractability of the problem of abortion which subsequently spills out beyond the boundaries of America in the form of foreign assistance policies such as the MCP.

The Christian Right

The Christian Right in the USA played an important political role in the lead up to the enactment of the MCP under Reagan in 1984. Their political engagement continues to the current day with the religious constituency making a major contribution to the election of Trump (Gaddini, 2019). Eighty percent of white evangelicals voted for Trump in the November 2016 presidential election which constituted the largest '*evangelical vote'* in nearly two decades (Gaddini, 2019). A careful examination of the Christian Right[27] is likely to reveal the linkages that exist between the initial Supreme Court decision on Roe V. Wade in 1973 and the subsequent religious mobilization which terminated in the ultimate enactment of the MCP. The proposed thread can be explained as follows. Roe v. Wade generated a backlash and created the impetus for groups such as evangelical Protestants and orthodox Catholics to organize themselves into an anti-abortion movement. As the movements grew and organized, they assumed political influence and successfully lobbied the Republican Party to incorporate Christian Right objectives into the political process. Capitalizing on the anti-abortion feelings of Reagan, the Christian Right was able to influence American foreign assistance activities in the area of family planning and abortion by insisting that no US foreign assistance funds would be used to support or promote abortion activities. The policy that explicitly prohibited abortion-related service delivery by international organizations receiving US funding, including funding privately sourced from non-USG sources, became known as the MCP.

This chapter provides some historical background to the movement, the tactics deployed to promote the political influence of the movement and the identification of those factors that illustrate traditional and ideological inconsistencies displayed by the movement. The example of a movement known as the Moral Majority is used to describe a representative religious right organization together with their organizational and tactical approaches in the political sphere.

[27] The Christian Right originated in the seventies as a social movement that mobilized evangelical Protestants and right-wing Catholics with the aim of influencing US politics domestically and internationally. Examples of groups includes the Family Research Council, Priests for Life, Focus on the Family and Concerned women for America (Gezinski, 2012: 839). The Christian Right is underpinned by religious values that promote prayer in public schools, abstinence-only education and the free market while opposing abortion, same-sex marriage, stem cell research, euthanasia and big government (Gezinski, 2012: 839).

The origins of the Christian Right

Several factors led to the origin of the Christian Right inclusive of evangelical Christians and orthodox Catholics. These include '*hot button*' issues, economic growth factors, political factors and societal changes impacting religious denominational groups (Green, 2006: 40). He suggests that the Christian minority in the USA used '*hot-button*' issues such as abortion, euthanasia and gay marriage to expand their membership, power and presence (Green, 2006: 40). Underlying this phenomenon is a cultural uprising by the marginalized against the ruling elites through a process termed '*cultural ressentiment'* [28] (Green, 2006: 41).

The growth of the evangelical movement, according to Green, accompanied the shift of America's economic center of gravity America's during the last third of the Twentieth Century to the South and Southwest of the USA leading to the rise of the American South as '*an economic and cultural powerhouse*' (Green, 2006: 40). The increased economic capacity facilitated an expansion of '*traditional southern attitudes*' throughout the US which included '*southern-based forms of evangelical religion*' with religious characteristics typical of the once-marginalized south (Green, 2006: 41). This religion drew from Pentecostal traditions with '*born-again*' religious piety characterized by '*highly emotional and anti-intellectual worship'* (Green, 2006: 41). This tradition encouraged '*direct religious experience and charismatic authority*' hostile to advanced education and academic elites (Green, 2006: 41). Economic and demographic growth generated a '*cultural aggressiveness*' accompanied by an eagerness to assert their presence in greater America. This was accompanied by a political shift to the right as the Republican Party capitalized on the changes in the south to extend their influence (Green, 2006: 41). Republican representation in the south grew from two representatives with no senators in 1950 to carrying the majority for both delegations fifty years later (Green, 2006: 41). The political process and shift to the right was accompanied by a shift toward the introduction of Christian education. Conservative Christian schools were established in an attempt to avoid school integration following the effects of the civil rights movement that had featured prominently in the American South. These schools subsequently became an important platform for disseminating conservative values. In 2006, of 6 million students

[28] Ressentiment: deep-seated resentment, frustration, and hostility accompanied by a sense of being powerless to express these feelings directly. https://www.merriam-webster.com/dictionary/ressentiment

enrolled in private schools about 50 percent attended Catholic parochial schools with about 25 percent attending conservative Protestant schools (Green, 2006: 41).

This period saw the growth of other conservative religious groups in certain parts of the US. The establishment of these conservative groups filled a vacuum left by the decline of strong personal linkages to ethnic and other groups (Green, 2006: 42). The Catholic experience exemplifies attempts to fill this vacuum. The election of John F Kennedy as President in 1960 symbolized Irish American economic and cultural success. The consequence of entering '*mainstream American life*' on an '*equal footing*' with Protestants was the loss of Catholic and ethnic identity, which is the tendency to display lifelong ethnic-religious affiliation characterized by physical security, employment and well-being attached to the ethnic grouping (Green, 2006: 42). John F. Kennedy's election brought the era of ethnic enclaves typical of Roman Catholic life to an end. This change challenged the church as institution, which for decades through parish life and Catholic schools had been the center of protection for Catholic identity (Green, 2006: 42). This raised the question for the church about how to maintain the loyalty of Catholics now incorporated into mainstream American life. Roe v. Wade, according to Green, became the rallying cry for the maintenance of a Catholic identity with several factors contributing to maintaining Catholic loyalty (2006: 42). Catholics strongly oppose abortion, and this served to unite Catholics despite ethnic origin. The antiabortion position brought Catholics into confrontation with the American establishment – among others, the Supreme Court, feminists, liberal intellectuals and advocates for family planning (Green, 2006: 42). Abortion for some church leaders became a mechanism to reestablish Catholic loyalty by emphasizing religious-political differences. Others promoted a social justice approach that confronted the business establishment and other traditional opponents of the Catholic working class (Green, 2006: 42-43). The adoption of strong opposition to abortion was a new value that was dismissively scorned by the larger society but found appeal in long marginalized Catholics. Instead of relying on ethnic identity and persecution to sustain in-group reinforcement, antiabortion rhetoric came to serve as '*countercultural religious value*' to achieve the same goal (Green, 2006: 43).

Exertion of political power through the Christian Right: The Moral Majority

The Moral Majority (MM), formed in 1979 under the leadership of Jerry Falwell, was a political action group consisting of evangelical Christians that aimed at influencing public policy (Banwart,

2013: 133). The MM evolved into a movement as a backlash to the upheavals of the 1960s and 1970s. A major driver of the movement was the legalization of abortion and later other social issues were added including women's liberalization, gay rights, the sexual revolution and secularism in schools (Banwart, 2013: 133). These issues were viewed as indicative of the moral decline of the nation and a departure from '*a God-fearing nation*' (Banwart, 2013: 134). The MM became a vehicle for evangelical Christians to reverse this secularizing trend. As a political organization, the MM sought to address societal ills through legislative processes. Key priorities included, among others, lobbying for the end to abortion, re-instatement of school prayers and re-emphasis of traditional gender roles (Banwart, 2013: 135).

The movement was structured and organized by tapping into a network of existing Christian infrastructure, such as Bible colleges, Christian bookstores, magazines and newspapers that allowed evangelicals to reach a wide audience who were disengaged from American public life. The network enabled individuals like Falwell to coalesce this audience into a politically engaged movement ultimately destined to become a major constituency of the Republican Party (Banwart, 2013: 137-138). Roe v. Wade was a significant event that mobilized the socially conservative constituency to undertake the long-term objective of overturning of Roe v. Wade as a high priority political task (Banwart, 2013: 139).[29] The movement assumed this task as abortion was viewed as '*a practice deemed offensive, barbaric, savage and a violation of God's precious handiwork on earth*' (Banwart, 2013: 139).

The movement incorporated two closely related issues – '*gay rights*' and '*women's liberation*' and together with abortion consolidated these into a '*family issue*' and promoted this grouping of issues as an assault on the traditional family structure (Banwart, 2013: 139)

> *'If women could get an abortion, no longer did they need a man to take care of them. No longer would they be confined to the kitchen, household or local PTA meeting. Their newfound independence could result in a full-frontal assault on the traditional nuclear family, which many conservatives believed to be the way God the family structure to look like'* (Banwart, 2013: 139).

In order to strengthen their pursuit of objectives a coalition of common interests was established. Typically, Catholics and Protestants are often at odds and may hold opposing viewpoints on many

[29] Compare the alignment with Reagan's comments on the Dred Scott ruling and the need for persistence – '*the Dred Scott decision of 1857 was not overturned in a day, or a year or even a decade*' (Reagan, 2010).

issues (Banwart, 2013: 140). Even evangelicals incorporate different groupings including fundamentalists, Pentecostals and neo-evangelicals and throughout the 20th century much hostility was reported between the different groups (Banwart, 2013: 140).[30] In the wake of the Roe v. Wade decision, these groups put aside their differences to focus on common interests (Banwart, 2013: 140). In terms of consolidating common interests the different groups had to address a number of issues. Catholics saw abortion as a *'life'* issue while Protestants had difficulties in aligning themselves with this issue as they were nervous about political and religious alliances (Banwart, 2013: 140). Social conservatives from the southern United States found it difficult to disagree with the Supreme Court's interpretation of the Fourteenth Amendment that emphasized the protection of private decisions from the public sphere and additionally, the absence of government interference in such matters (Banwart, 2013: 140). The creation of alliances was promoted by the intervention of theologians such as Francis Schaeffer who called for Christians to fight the culture of depravity and prevent '*rampant immorality*' in the country (Banwart, 2013: 140). A key point was made that abortion was equivalent to infanticide and evangelical voters could not allow the murder of unborn children (Banwart, 2013: 140).

Falwell and his MM chose to unite the diverse religious groupings under a common cause '*the family*' (Banwart, 2013: 141). Organizing around the slogan of '*uniting the family*' the core agenda of the MM was developed to oppose abortion, civil rights protection for gays and lesbians, and the passage of the Equal Rights Amendment (Banwart, 2013: 141). By linking abortion, feminism and gay rights with a '*tripartite assault on the family*', the Christian Right was able to present America's decay with issues that were important to evangelicals (Banwart, 2013: 141). Subsequently, they could advocate the MM fight as one aimed at restoring '*moral sanity'* (Banwart, 2013: 141). The promotion of '*positive family values in government*' was viewed as a moral imperative not limited by theocratic boundaries and more than a religious agenda (Banwart, 2013: 142). Language couched to emphasize '*family issues*' engaged the interests of the non-religious and social conservatives and prevented the creation of a perception that the goal of the movement was to institutionalize a theocracy in America (Banwart, 2013: 141). Quoting Dowland, Banwart writes

[30] Evangelism and fundamentalism. Fundamentalist Christians base their faith on the Bible which is interpreted as the literally true '*Word of God*' not subject to individual '*understanding and inspiration*'. This fundamentalism demands strict compliance with the expectations of the '*Word of God*' including strict moral requirements. Evangelism is not as strict in its expectations and the main purpose is to win '*souls for Jesus*' (Banwart, 2013: 136).

> '*Critics of the Christian Right called its agenda narrow-minded and divisive, but the genius of the movement was to frame opposition to abortion, feminism and gay rights as "defense of the family." By the end of the 1970s, the Christian right had devised rhetoric that made liberal reformers enemies of the family ……. opposing abortion, feminism and gay rights in the view of the Christian right would benefit many Americans'* (Banwart, 2013: 143).

The MM actively opposed prominent major social issues during the 70s including the Equal Rights Amendment[31] and the Gay Rights movement[32] (Banwart, 2013: 143). Ratification of the Equal Rights Amendment, according to Falwell, would allow legal homosexual marriage, send women into combat and harm the '*dignity of the traditional family*' (Banwart, 2013: 143). The amendment was presented in terms of '*anti-family legislation*' proposed by groups composed of feminists, unisexualists and secular humanists and '*a satanic attempt to destroy the biblical concept of the Christian home*' (Banwart, 2013: 143). Evangelical Christians viewed the amendment as a '*secret government attack*' on the '*biblical*' idea of the family (Banwart, 2013: 143). The worldview of evangelicals called for a family composed of '*two heterosexual parents'*; the father works and the mother cares for children and the house while both parents contribute toward growing children with appropriate moral values (Banwart, 2013: 144). This gender diversity emphasizing traditional male and female roles is essential for bringing children up appropriately (Banwart, 2013: 144). The Equal Rights Amendment Act would serve to undermine the so-called '*natural order*' ordained by God (Banwart, 2013: 144). This led to the development of the 'Family Manifesto' which declared that

> '*male and female were established in their diversity by the Creator….. and extends to psychological traits which set natural constraints on gender roles …..the role of the male is most effectively that of provider, and the role of the female one of nurturer*' (Banwart, 2013: 144).

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[31] The Equal Rights Amendment was passed by the U.S. Senate in 1972 and sent to the states for ratification. Originally proposed by the National Woman's political party in 1923, the Equal Rights Amendment, provided for '*legal equality of the sexes'* and the prohibition of '*discrimination on the basis of se*x.' The revival of feminism in the sixties led to its introduction to Congress with subsequent approval by both Congress and Senate. The amendment experienced opposition at state level due to the conservative backlash against feminism during the seventies. By 2017, only 36 states had ratified the amendment. Ratification by 38 states is required for incorporation into the US Constitution. (https://www.history.com/this-day-in-history/equal-rights-amendment-passed-by-congress)

[32] The gay rights movement in the United States has actively worked to reduce discrimination based on sexual orientation. Important outcomes of the gay rights movement include the removal of discriminatory laws restricting homosexual activity, enabled lesbian, gay, bisexual, and transgender individuals to serve openly in the military and provision for legal same-sex marriage and adoption of children in all 50 states (https://www.history.com/topics/history-of-gay-rights)

Falwell associated patriotism with the family and '*morality in politics'* (Banwart, 2013: 147). He promoted '*trust and faith in God*' as a pre-requisite for a successful America, emphasizing that American prosperity had originated from being God-fearing, hard working and living in accordance with '*Biblical teachings and practices'* (Banwart, 2013: 147). The Protestant work ethic was highlighted and promoted in contrast to the risk of growing federal welfare programs that compensated laziness for those reluctant or refusing to work. This allowed Falwell to associate the American economic crisis of the seventies with the abandonment of moral clarity and a strong work ethic since welfare spending contributed to inflation and economic problems (Banwart, 2013: 147). According to Falwell, it was the secular humanists that *'refused to live and work according to biblical principles that were responsible for the regulations and increased taxes on hard-working Protestants that were trying to start a business and make something for themselves'* (Banwart, 2013: 147).

The MM chose to endorse Ronald Reagan rather than Carter as presidential candidate in 1980 (Banwart, 2013: 148). Carter was viewed as being ineffective in implementing relevant legislation and executive orders promoting the Evangelical agenda during his administration (Banwart, 2013: 148). Their aim was to establish a dependable '*real, Evangelical, social conservative*' in the White House (Banwart, 2013: 148). The MM worked with pastors to encourage congregations to vote for candidates who were '*pro-family and pro-morality*' (Banwart, 2013: 148). Evangelical activists drove voter registration drives, created '*morality ratings*' for candidates, contacted voters and assisted with the transport of voters to the polls (Banwart, 2013: 148). The MM's contribution to Reagan's election was viewed as presenting and influencing '*moral concerns*' to Reagan's administration that became an '*integral part of the Reagan Revolution*' (Banwart, 2013: 149). In an effort to address antiabortion rights, the MM introduced an ultimately unsuccessful antiabortion Bill titled the '*Human life Bill*' that attempted to legislate the idea that '*life begins at conception and that a fetus is a living person*' (Banwart, 2013: 151). Reagan in his essay *Abortion and the Conscience of a Nation*, refers to the '*Human Life Bill*' and the importance of America choosing between a '*sanctity of life ethic*' or a '*quality of life ethic'* (Reagan, 2010).

The Moral Majority dissolved in 1989 (Banwart, 2013: 154). The long-term impact of the MM in American politics remains subject to discussion. They did expand the influence of religious conservatives in American politics (Banwart, 2013: 154). Over time, perceptions of younger voters about abortion and gay rights have changed and become more tolerant, causing younger voters to

break their connections with the traditional religious right (Banwart, 2013: 155). Despite the inability to define a clear impact of the MM, a clear consequence following the MM movement is the mobilization of Christian voters into a political block and prioritizing politics in churches (Banwart, 2013: 155). This created a new political force, the evangelical voter, with a significant role in many subsequent presidencies including both Bush Administrations and the Trump Administration (Banwart, 2013: 155).

The Christian Right and American Foreign Policy

The MCP is expressed internationally through restrictions that are placed on international NGOs providing services in less developed countries. An important question to understand is how this occurs?

Gary Bauer, erstwhile Leader of the Family Research Committee articulated the idea that America's foreign engagement in the world should be anchored in '*moral values'* (Martin, 1999: 79). The larger American society believes that their engagement in the world should see the '*triumph of their values abroad*'(Martin, 1999: 79). Even the Clinton administration, the antithesis of the Christian Right, advocated the American-based '*God-given right-to-life, liberty and the pursuit of happiness'* (Martin, 1999: 79). However, according to Martin, the appropriate interpretation and definition of '*American values*' is fluid with the Christian Right always being willing to provide their particular perspectives on values (1999: 79). Institution's such as the Family-Research Council promotes the Judeo-Christian value system centered around the traditional family unit, and advocacy of Biblical principles (Martin, 1999: 66).

The Christian Right has developed mechanisms to influence the political process in America. The movement has strong connections to Washington insiders and uses technology very effectively to reach millions through radio and television (Martin, 1999: 69). The Christian Right prioritizes support for Israel, defunding global multilateral agencies such as the UN and IMF and arms control and defense (Martin, 1999: 67). A major motivation, similar to the religious conservative domestic agenda, includes distrust of secular government, threats against '*traditional family values'*, threats against religious freedom, and a belief that globalization will fulfill the Biblical prophecy of Christ's return and Armageddon (Martin, 1999: 67). The term '*evangelical'* in fact spells out the intent of this group of Protestants which is to share the '*Word'* in accordance with Jesus's instruction '*unto all the world*' (Martin, 1999: 67).

According to Martin, religious conservatives were rebuffed by Reagan who paid little attention to their key concerns of banning abortion and their efforts to allow prayers in school again (1999: 71). The inability to influence Reagan domestically led to key constituencies increasing their efforts in support of conservative political and economic policies internationally. This was expressed in multiple areas: Reagans strong position against communism and Russia's '*labelling'* as the '*Evil Empire*', ideological and financial support to anticommunist forces in Central America (Honduras, El Salavador, Nicaragua and Guatemala), support for Apartheid in South Africa by characterizing the ANC as a Soviet Puppet and support for Mobutu Seso Seko in Zaire (Martin, 1999: 71-72).

Political influence extends to both houses of Congress and through Congress influence is exerted on US foreign policy (Martin, 1999: 72). Areas that have been strongly influenced include opposition to initiatives that may weaken parental powers to control children, promote abortion, expand homosexual rights and diminish the idealized notions of mother and homemaker (Martin, 1999: 72). Examples of attempts at influencing foreign policy are illustrated by an almost successful attempt to block funding to the IMF in 1998 as the organization had been funding institutions that promote abortion as an essential element of family planning and population control (Martin, 1999: 74). A further example is the denial of funds to UNFPA during periods when the MCP is enacted (Martin, 1999: 75; USAID, 2018).

The Christian Right views the UN as a mechanism allowing the '*secular elite*' to threaten the '*traditional family'* globally (Martin, 1999: 74). Therefore, they have attempted to limit programs that promote abortion, sterilization or contraception by representing these as forms of '*population imperialism'* attempting to '*globalize the safe-sex ideology* (Martin, 1999: 74). Religious conservatives argue that American support for these initiatives will offend much of the rest of the world; Patrick Buchanan, strongly supportive of the Christian Right, warned that such '*moral imperialism will disfigure America's reputation in in the Catholic countries of Latin America and the traditional societies of Africa and play perfectly into the hands of Islamic extremists already making strides vilifying America as the Great Satan of the Muslim World'* (Martin, 1999: 75). The impact of this campaign against the UN led to decreased funding of the UN Population Fund in 1998 reducing contraceptive availability for almost 1.4 million women in 150 countries (Martin, 1999: 75). Funding has additionally been tied to legislative language prohibiting aid to organizations that provide or promote abortion services (Martin, 1999: 75).

Assessing the foundations of the Christian Right; are their claims valid?

The Christian Right represents a select group of religions largely drawing from evangelical Protestants and right-wing Catholics. This raises questions about the validity of the Christian Right position. Firstly, are they representative of major religions writ large including the broader diversity of Christian denominations? Secondly, is the Christian Right able to lay claim to a solid foundation in terms of the ideologies they propagate? Cavanaugh explores these ideologies through a lens of tradition and the secular role of the Christian Right.

Legitimacy of the evangelical and Catholic positions on abortion; to what extent do they represent global religious perspectives?

The question arises as to what extent the religious based perspective of the MCP effectively represent the perspectives of other religions including the broad diversity of Christian denominations? The Christian ethics approach vests the sanctity of life in God, the '*creator of everything*'; this creates disadvantages. Firstly, all humanity is not Christian and hence Christian ethics is unable to serve and provide the basis for consensual norms for all. Secondly, it does not allow for nonbelievers who may assert that sanctity of life exists in the absence of God (Callahan, 1970: 313).

When looking at abortion within Christianity and from the perspective of other major global religions it becomes clear that there is no uniform, universal perspective on abortion. For example, within the broader Christian tradition there is strong opposition to abortion from Roman Catholics, Maronite and Eastern Orthodox Churches and some Evangelical and Pentecostal churches (Kalasa and Mora, 2016: 54). Mainline Protestant churches have a nuanced stance toward abortion and see decisions about abortion as a matter of personal conscience (Kalasa and Mora, 2016: 54).

Different religions are likely to support abortions under different circumstances such as when the health of the mother is at stake or in instances of rape. Hindus prioritize the life of the mother when the pregnancy is a threat to her well-being and allows abortion for fetal abnormalities; India has implemented a liberal abortion policy which include medical, economic and social reasons (Kalasa, Mora, 2016: 51)[33]. Buddhists permit abortions to save the mother's life and following

[33] Considerable stigma is attached to abortion in India which together with a lack of awareness about safe abortion services forces women to make use of unsafe services. In practice, a woman dies from an unsafe abortion every two hours in India. http://world.time.com/2013/07/19/world-population-focus-on-india-part-2-unsafe-abortions/

rape; Thailand has liberalized abortion to the extent that abortions are available to protect the mother's life and well-being (both physical and mental components) (Kalasa, Mora, 2016: 52-53). Muslims have variable perspectives but there is a general view that abortion is legal prior to the ensoulment of the fetus which may begin at 40, 90 or 120 days after conception (Kalasa, Mora, 2016: 56). Tunisia is an important exception where abortion was legalized in 1965 and further liberalized in in 1973 to allow abortions in the first trimester of pregnancy (Kalasa, Mora, 2016: 58). Globally, regional variations exist in terms of opposition to abortion with especially strong opposition in sub-Saharan Africa, Latin America, and Muslim countries in the Middle East and Asia (Kalasa, Mora, 2016: 49). Western Europe, Australia, Canada and Japan tend not to frame abortion as a moral issue (Kalasa, Mora, 2016: 49). These variations therefore also influence the occurrence of safe and unsafe abortions with an increase in unsafe abortions where a restrictive approach toward abortion exists.

It becomes clear that, with this wide diversity both within the Christian tradition and other global religious faiths, no universal perspective on abortion exists. Certainly, this must serve as a serious challenge to the MCP that relies on the imposition of conditions based on narrow religious perspectives. It is likely that it be very difficult to frame conditions that respect every religious or regional difference that exists globally. Should variation according to religious and regional differences be implemented it is unlikely that exceptions can be defended in a consistent fashion.

The ideologies of the Christian Right; the role of tradition and secularization

Cavanaugh writes about social movements through the perspectives of historical sequences and the external cultural environments and the resultant implications for traditionalism, the functions of religion, and the study of countermovements (Cavanaugh, 1986: 251). The Christian Right or right-to-life movement is perceived as a traditionalist bloc that opposes secularization and encourages the return to customary restrictions (Cavanaugh, 1986: 251). Two ideas contradict the perceptions about traditionalism and anti-secularism. Firstly, the idea of a traditionalist bloc is countered by the limited evidence in the traditions of Western religion that supports a '*grounding*

in an ideology of rights' or a categorical right-to-life[34], [35] and instead appears to be of recent social construction (Cavanaugh, 1986: 251; Luker, 1985: 107-108). Existing historical references of opposition to abortion emphasize the rights of fathers and their entitlement not to be deprived of a child.[36] Secondly, since the traditionalist block exhibits limited historical evidence, the movement's ideology is then best viewed as the product of secularizing processes rather than standing in opposition to secularizing processes such as discourse about rights and the separation of church and state or possibly as an unintended import from non-Western religion (Cavanaugh, 1986: 251).

The traditional pedigree tends toward tolerance of abortion. Cavanaugh's work assists in the understanding some of the contestable claims made by the Christian Right and the ideological manipulation that emanates from the movement. Events in the Twentieth Century, including large-scale mortality associated with the two world wars and other conflicts and disasters, heightened awareness about the '*conditions of human life*' including abortion (Cavanaugh, 1986: 259). This resulted in increased tendencies to demonstrate caution and thoughtfulness about beginning and end of life decisions with the contextualization of the right-to-life appeal in late twentieth century '*commonsense*' about the conditions of human life (Cavanaugh, 1986: 260). The right-to-life claim gained further appeal when the claim was accompanied by the belief that tradition, until the onset of modern ideas that destabilized social stability and moral order, governed the lives of individuals and society (Cavanaugh, 1986: 260). Cavanaugh refers to this as the myth of a recent '*fall from grace*' which forms part of '*ordinary secular commonsense*' (Cavanaugh, 1986: 260). The appeal, however, is subject to critique.

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[34] According to John Irving, the author of the novel, 'The Cider House Rules' the term "*right-to-life"* was coined by Pope Pius XII in a 1951 papal encyclical — an 'Address to Midwives on the Nature of Their Profession.' "*Every human being, even the child in the womb, has the right-to-life directly from God and not from his parents, not from any society or human authority*." https://www.nytimes.com/2019/06/23/opinion/anti-abortion-history.html.

[35] According to Luker the right-to-life claim emerged only when women began to claim a right to abortion.

[36] Abortion was accepted in both ancient Rome and Greece. Opposition to abortion was not presented as the protection of the newborn but rather to prevent a father feeling deprived of a child that he felt entitled to. Early philosophers argued that the foetus began to live at least 40 days after conception for a male, and around 80 days for a female. Biblical references (Old Testament) deal with abortion as a loss of property and not about the sanctity of life. The New Testament does not explicitly refer to abortion. In Western history abortion was not viewed as criminal prior to quickening between 18 and 20 weeks into the pregnancy.
http://www.bbc.co.uk/ethics/abortion/legal/history_1.shtml

In contrast to the claims of an anti-abortion tradition, the contemporary position in the USA that is closest to a '*traditional pedigree*' is one that supports freedom in decision-making when abortion is considered (Cavanaugh, 1986: 260). This tradition is one that historically made abortion medically available, legal and occurred below the '*threshold of moral awareness*' (Cavanaugh, 1986: 260). Evidence is provided by firstly, a common law tradition which allowed abortion over a period of centuries and perceived abortion as a '*technical service*' that women had access to from a variety of healers (Cavanaugh, 1986: 260). Secondly, during the 19th century, a movement was started by physicians to declare abortion as a criminal offense. This occurred as a byproduct of the struggle for medical professionalization and was part of an initiative by the medical profession to secure a monopoly over medical service provision using legislative state power (Cavanaugh, 1986: 260). By declaring abortion immoral and illegal the achievement of this objective was promoted. The result of these endeavors was that whereas in the United States no laws existed against abortion at the start of the 19th century, by the end of the 19th century, abortion had been declared a criminal offense by all states (Cavanaugh, 1986: 260). Considering the history of abortion in the United States, this enables a different light to be shed on the Roe v. Wade decision; rather than interpreting Roe v. Wade as a liberalization of existing laws it should be viewed as a return to an original status quo that existed prior to interference by the medical profession (Cavanaugh, 1986: 261). Consequently, the traditionalist claim by the Christian Right cannot be substantiated. However, this has not prevented manufactured '*traditions'* from being used successfully to devise rhetoric making liberal reformers enemies of the family and generating opposition toward abortion, feminism and gay rights and enabling the Christian Right to powerfully engage with the political system in America and promote policies such as the Helms Amendment and the MCP (Cavanaugh, 1986: 264).

The engagement of the Christian Right in a secular world. Modern secularization is interpreted as the release of action from the domination of religious culture and institutions which reflects both the causes but also the effect of modern moral change (Cavanaugh, 1986: 268). One obstacle faced by the right-to-life movement is that they do not display significant capacity to dismantle modern established secular societies (Cavanaugh, 1986: 258). As a movement, the Christian Right is required to accommodate to rather than change secular societies and, paradoxically, as anti-secularists they take on the role of a secular actor (Cavanaugh, 1986: 259). If the evidence is lacking that tradition supports the idea of right-to-life, what indeed is the source of the views

advocated for by the right-to-life movement? Two alternative sources are proposed. Firstly, the right-to-life ideology is manufactured as a consequence of '*secular culture and sociocultural modernization*' or secondly, if the idea is indeed based on genuine religious tradition, then the tradition is '*exotic and materialistic'* (Cavanaugh, 1986: 268). Several secular factors facilitated the growth of the right-to-life ideology.

Firstly, the demographic transition in Europe changed the valuation of infants and children by parents. In the pre-industrial era in Christianized Europe, infanticide was a common mechanism used for fertility control (Cavanaugh, 1986: 269). Hence parents were reluctant to direct or invest much emotional energy in their children and tended not to sentimentalize children. Increased prosperity and the demographic transition increased the probability of surviving the first year of life and strengthened the ability to support the development of children economically. Increased valuation of children and the trend toward sentimentalizing children allowed the establishment of a principled revulsion against infanticide (Cavanaugh, 1986: 269). Revulsion against infanticide can be easily extended to abortion by raising the question whether infanticide is the moral equivalent of abortion (Cavanaugh, 1986: 269). As Cavanaugh suggests, this allows a fortiori conclusion to be drawn that this comparison of moral equivalence between infanticide and abortion reflects a '*highly modernized consciousness*' of relatively recent origin (Cavanaugh, 1986: 270).

Secondly, the modern era saw the introduction of natural rights ideology[37] with an accompanying shift in the frames of moral reference from '*honor'* to *dignity'* (Cavanaugh, 1986: 270). This shift occurred when '*honor'* that was associated with the Aristotelean tradition and membership of the polis was replaced by '*dignity'* which included all humans in the broader community of human beings (Cavanaugh, 1986: 270). The essence of the shift is that '*moral worth*' is not defined by social status but rather by membership of the human species and is framed as '*dignity.'* The principle of '*dignity'* in the modern era has become an important element of '*open political discourse*' (Cavanaugh, 1986: 270). The boundaries of '*dignity'* lie in a biological definition of the human species characterized by equality of all members (Cavanaugh, 1986: 271). The substitution of '*dignity'* for '*honor'* simplifies political and moral status by removing aspects related to social stratification and its related disputes (Cavanaugh, 1986: 271). Highlighting the right-to-life for the

[37] Natural rights emphasize privileges or claims to which an individual is entitled. https://plato.stanford.edu/entries/locke-political/

fetus as a potentially '*viable human*' and the attempt to attach '*political status*' to the unborn may be perceived as an unintended consequence of '*modern political thought about citizenship and strata*'; however, according to Cavanaugh this cannot be deduced as being a '*logically inevitable consequence*' nor '*politically inevitable'* as the principle of '*dignity'* is widely accepted while opposition to abortion is not universally held (Cavanaugh, 1986: 271).

A further factor about secular and religious influences is whether the religious sources that inform the right-to-life notion originated from Christianity. Cavanaugh contends that the concept of reverence for life held by Albert Schweitzer originated from the Hindu non-dualistic traditions (Cavanaugh, 1986: 275). The concept of '*ahimsa*' promotes the doctrine of non-violence to animals and men. Cavanaugh suggests that this concept may have been imported into Western Christianity following the Enlightenment. This concept incorporated by Schweitzer could have further spread through his works (Cavanaugh, 1986: 275). Within the context of the right-to-life movement, ahimsa-focused asceticism transformed into an activist-based right-to-life ideology. Cavanaugh concludes that despite the heterodox and materialistic content of ahimsa, the conservative Christian moralists appear to have no qualms in applying the ideology for its purposes (Cavanaugh, 1986: 275).

Cavanaugh's work suggests that elements of the foundations of the Christian Right are contrived in order to promote the stimulation the growth of opposition against abortion and the message that is brought to individuals, communities and nations throughout the world. The Christian Right engages deliberately in those secular institutions such as government despite the intent to separate government and religion in the US and the political process to further its causes and this engagement eventually becomes expressed through the implementation of policies such as the MCP.

Comments

Using the Moral Majority movement as an example it is clear how the upheavals of the sixties and seventies and the legalization of abortion through Roe v. Wade initiated a large counter-response by conservative Christian groups. They seized on ideas of moral decline and the departure from '*a God-fearing nation*' to inspire action against secularization (Banwart, 2013: 134). By linking abortion to gay rights and women's liberation they were able to frame these issues as an attack on the family thereby serving to unite the movement into protection of the family. The promotion of

'*positive family values in government*' was viewed as a moral imperative not limited by theocratic boundaries and more than a religious agenda (Banwart, 2013: 142). The Christian Right was ultimately successful in exerting a strong influence on the Republican Party even contributing to the election of Reagan in 1980 and playing important roles in the election of subsequent Republican presidents.

The growth of the movement was strongly facilitated by economic growth in the American South thereby allowing a rapid expansion throughout the US of influence typical of '*southern-based forms of evangelical religion*' with conservative values (Green, 2006: 41). While the American South was growing its influence there was a decline in linkages to ethnic and other groups. Religious groups capitalized on the decline of linkages by offering community and emotional fulfillment irrespective of family background or ethnic groupings. Among Catholics, Roe v. Wade became an important rallying cry for the maintenance of a Catholic identity. The use of abortion allowed Catholic groups to unite by emphasizing that abortion went against Catholic teachings and values. Catholics entered into conflict with the American establishment – among others, the Supreme Court, feminists, liberal intellectuals and advocates for family planning. Through this process there emerged a strong movement with conservative values possessing substantial influence in the Republican Party. In addition to a domestic agenda, the movement has a global interest in extending their conservative domestic agenda to protect '*traditional family value*s', and prevent threats against religious freedom, among others (Martin, 1999: 67). Their '*evangelical'* intent is to share the '*Word'* in accordance with Jesus's instruction '*unto all the world*'(Martin, 1999: 67). The scene is set for an intervention as exemplified by the MCP.

However, the capacity of the Christian Right to represent their perspectives on abortion to the larger body of Christian and non-Christian religions can be strongly questioned. In addition, claims by the Christian Right about abortions drawn from tradition and their role in the anti-secularization process can be contested. Furthermore, Cavanaugh suggests that elements of the foundations of the Christian Right are contrived in order to stimulate the growth of opposition against abortion.

The MCP opposition

Three organizations, the Planned Parenthood Federation (PPF), the International Planned Parenthood Federation (IPPF) and Marie Stopes International (MSI), have played an important

role in expanding access to family planning service delivery globally. They have stood strongly in opposition to the implementation of the MCP during the periods following its initial enactment by President Reagan and re-enactment by subsequent Republican Presidents. It is helpful to explore the historical origins and organizational goals and objectives as a further step in understanding the controversy created by the MCP.

Planned Parenthood Federation

Planned Parenthood Federation, a US-based organization, aims to educate and empower communities, provide health care, lead the reproductive health movement and advance global health. Institutionally, PPF believes that sexual and reproductive rights are basic rights (Planned Parenthood Federation, no date b). Institutional goals incorporate, among others, the promotion of individual rights to secure and access reproductive and sexual health care both in the US and globally. This is achieved through advocacy for access to reproductive and sexual health care, education, and the individual's right to '*make empowered, informed decisions about health, sex, and family planning*' (Planned Parenthood Federation, no date b). Globally, PPF promotes access to health care and education by advocating for legal, social, and political improvements in communities (Planned Parenthood Federation, no date b).

The founder, Margaret Sanger, opened the first birth control clinic in the US in Brownsville, Brooklyn in 1916. The clinic was shut down nine days later and the providers were charged for distributing information about birth control. Sanger refused to pay the fine and was jailed for 30 days. The growth of PPF in the US echoes societal changes and the history of the 20th and early 21st century. The organization was founded on a '*revolutionary idea*' that women deserve access to information and care enabling them to live healthy lives and fulfill their dreams (Planned Parenthood Federation, no date c). Noteworthy events since the initiation of the first birth control clinic included the extension of clinics to African American suburbs such as Harlem and Baltimore, advocating for women's rights and access to sexual and reproductive health care services, the initiation of research into the birth control pill, the establishment of the International Planned Parenthood Federation, the legalization of birth control for married couples in 1965, the approval of the first progestin-only emergency contraceptive (1999) and RU-486 (mifepristone) also known as the '*abortion pill*' in 2000 (Planned Parenthood Federation, no date c).

In response to the re-enactment of the MCP in 2017, PPF called for US policy makers to act. '*Politics and ideology*' should not disturb the relationship between the patient and her provider (Planned Parenthood Federation, no date a: 4). According to Latanya Mapp Frett, Vice-President, Planned Parenthood America, '*U.S. foreign aid should never be used as a tool to limit women's access to health care or to impose unfair restrictions on the decision-making ability of independent organizations overseas. The women of the world need information and services, not censorship and restrictions*' (Planned Parenthood Federation, 2011).

International Planned Parenthood Federation

The international Planned Parenthood Federation (IPPF) is a global civil society movement that advocates for and provides FP service delivery that is discrimination free and promotes individual choice about sexuality and well-being (International Planned Parenthood Federation, 2017). Emphasizing a rights-based approach, IPPF aims to address inequalities, discrimination, and unjust power relations that limit people's human rights (International Planned Parenthood Federation, no date b). IPPF is the largest non-governmental provider of contraception in the world (International Planned Parenthood Federation, 2017). In 2016, IPPF provided 182.5 million sexual and reproductive health services and contributed to 175 policy and legal changes on sexual and reproductive health and rights at national, regional and global levels (International Planned Parenthood Federation, 2016).

The IPPF was created at the 3rd International Conference on Planned Parenthood in 1952 incorporating eight national family planning associations. IPPF evolved from a campaign that was started during the early 1950s aimed at promoting the right of women to control their own fertility. In 2018, IPPF had grown to incorporate 141 Member Associations working in 152 countries.

IPPF's vision promotes a discrimination free world where all persons are able to make free choices about individual sexuality and well-being. Their mission is to build a civil society movement that provides services and promotes sexual and reproductive health and rights for all, especially the under-served. Core values include social inclusion emphasizing the rights of the under-served, diversity that respects all irrespective of age, gender, status, identity, sexual orientation or expression and to inspire others to challenge and seek social justice. This is all encapsulated by

the following quote '*IPPF is fighting for a world where women everywhere can say "I decide"*' (International Planned Parenthood Federation, no date a).

The IPPF has taken a strong stance against the MCP. Following the re-implementation of the MCP on January 23, 2017, IPPF responded as follows

- *The IPPF believes in the right of every individual to decide about their own health and well-being.*
- *As an organization that seeks to protect and improve the lives of women, men and children around the world, IPPF ……. will not sign a policy that denies human rights and puts the lives of women at risk.*
- *We cannot—and will not—deny life-saving services to the world's poorest women. We will work with governments and donors to bridge the funding and service gaps the Global Gag Rule creates. We will ensure that women can exercise their rights and access safe abortion and family planning* (International Planned Parenthood Federation, 2019).

Marie Stopes International

Marie Stopes International (MSI) is a non-governmental organization that provides contraception and abortion services in 37 countries globally (Marie Stopes International, no date c). MSI emphasizes in their mission, the importance of women's ability to control their futures by controlling their own reproduction. This enables women to complete their education, pursue a career and spend time with their children they may have in accordance with the slogan that states '*We believe that every woman and girl should be able to have children by choice, not chance*' (Marie Stopes International, 2017 b)**.** As a provider of contraception and safe abortion systems across the world, MSI assists individual girls and women to build the lives they want. Each maternal death that is averted, assists by keeping families together and contributes toward the development of the country. MSI is concerned about the impact of several pregnancies in quick succession that keeps women in a cycle of ill health and poverty. Women struggle to keep their children healthy, fed and educated and are limited in their pursuit of future education and career opportunities (Marie Stopes International, no date c).

MSI is named after Dr Marie Stopes, born in 1880 in Edinburgh, Scotland. She pioneered planning service provision in the UK. Her marriage had not been consummated after 5 years of marriage leading to the ultimate annulment of her marriage. This stimulated her interest in female sexuality; if she, as a university educated middle-class woman lacked all knowledge of sexual issues how much more so for poor, less educated women? The opening of her first family planning clinic in

Holloway, London was controversial. Services were provided by a small team in simple surroundings focusing on the poor. She was attacked by the medical establishment for being female, not medically qualified and relying on nurses for service delivery (Marie Stopes International, no date a). The efforts of Dr Marie Stopes and the service platform created by her in the UK served as the inspiration for Dr Tim Black, CBE, to create MSI. During the 1960s when Tim Black was working as a district medical officer in Papua New Guinea he was shocked by an incident when a widowed mother expressed unhappiness after the hospital's successful efforts to save the life of her three-month-old girl. The mother, already burdened by the need to look after five children, did not want the child to survive. This incident helped Black understand the burden of care, caused by an additional mouth to feed, that was placed on the uneducated, single parent mother without an income or a future (Marie Stopes International, no date a).

Subsequent to the re-enactment of the MCP in 2017, MSI shared their perspective on the conditions imposed through the MCP (Marie Stopes International, no date b). Specifically, MSI referred to the condition that receipt of USAID funds prohibits acceptance of funds from other non-USG sources for abortion services even in countries where abortions are allowed (Marie Stopes International, 2017b). MSI responded by emphasizing the role of safe abortions as a vital component of women's reproductive health and the right of women to choose whether and when they have children. MSI states that the restriction on the use of non-USG funds for abortion services contradicts their core principles as an organization, and consequently MSI is not able to accept the conditions of the Global Gag Rule and will not partner with USAID during the period when the Global Gag Rule remains in effect (Marie Stopes International, 2017b). The re-enactment of the MCP will additionally slow USAID's efforts to end extreme poverty and promote the development of resilient, democratic societies (Marie Stopes International, 2017a).

MSI emphasizes the following issues related to the re-enactment of the MCP (Marie Stopes International, 2017a). The removal of safe abortion services from reproductive healthcare packages compromises the health of pregnant women. Unwanted pregnancies drive 21.6 million women every year to end their pregnancies through unsafe abortion. By agreeing with the MCP, MSI by implication is turning its back on women who depend on the support that MSI provides; restrictive approaches and decreased family planning aid is unlikely to reduce the need for abortion. Rather, enactment of the MCP expands the already existing challenge of providing

adequate opportunities to women to time and space childbearing. Girls and women are prohibited from making those choices that can prevent unwanted pregnancies and avert life threatening unsafe abortions. Per MSI, '*The impact of the Mexico City Policy will be catastrophic, and it is women in developing countries who will pay the price'* (Marie Stopes International, 2017a).

Comments

The language contained in the descriptions of opponents to the MCP express a few core themes. The term *'rights'* occurs regularly in the context of sexual and reproductive rights as basic rights, the right of the individual to decide about their own health and well-being, the right of women to control their own fertility and the individual's right to make empowered, informed decisions about health, sex, and family planning. PPF writes that the period 1936 – 1956 saw the '*start of a movement'* with IPPF joining the movement that advocated for women's rights and access to sexual and reproductive health care services (Planned Parenthood Federation, no date c). The idea of the '*right to abortion*' followed in the mid-sixties (Luker, 1985)[38].

The terms *'choice and decision' feature* regularly. The terms are contextualized as the individual's right to make discrimination-free, empowered and informed decisions about health, sex, and family planning.

There is a reliance on the use of terms such as inequality, discrimination and social justice. These highlight the existence of unjust power relations that limit people's human rights. Core values include social inclusion emphasizing the rights of the under-served, diversity that respects all irrespective of age, gender, status, identity, sexual orientation or expression and to inspire others to challenge and seek social justice.

[38] Luker in her description of women and the right to abortion mentions that the notion of a 'right to abortion' originated in California in the mid-sixties (Luker, 1985: 92). Prior to 1967, abortion in California was mostly discussed and debated by professional men and women in a '*spirit of compromise and civility*' who were related through bonds of '*colleagueship and sociability*' (Luker, 1985: 92). These conversations reflected the engagement of lawyers, public health officials and physicians. However, the collegial debate receded as abortion debates increasingly incorporated elements of '*intense passions and moral concerns*' (Luker, 1985: 92). This was driven by women who valued motherhood yet were interested in becoming mothers according their personal schedule introduced the idea of abortion as a woman's right. They additionally linked this right to an abortion with the right to equality – '*and the right to be treated as individuals rather than as potential mothers'* (Luker, 1985: 92). The consequence of this change was to present abortion in an entirely new '*framework'* (Luker, 1985: 92).

The 'voiceless she'

The question should be raised about the profile of the typical woman who is exposed and made vulnerable when the MCP is repeatedly enacted and rescinded. The following perspectives are drawn from speakers originating from Ghana, Nigeria, and Kenya and assist in constructing such a profile (Committee on Foreign Affairs, 2008). The typical woman is simply referred to as '*she'*. Representatives from Ghana and Nigeria spoke against the MCP while the Kenyan representative spoke in support of the MCP.

In Ghana, she is likely to live in a rural area and experiences difficulties in accessing birth control methods. As a result, she is exposed to unprotected sex and the risk of pregnancy is high. If she is between 15-19 years, she is two times as likely to become pregnant compared to her peer in the city. She has a 1 in 35 chance of dying in childbirth compared to one in 2500 pregnant women in the USA (Committee on Foreign Affairs, 2008: 33).

In Nigeria, she will often be exposed to unsafe abortion when an unwanted pregnancy occurs (Committee on Foreign Affairs, 2008: 25). Annually, in Nigeria, an estimated 760,00 induced abortions occur and about 60 percent of these abortions are unsafe (Committee on Foreign Affairs, 2008: 25). She may be one of 10,000 women who die annually following complications of unsafe abortions (Committee on Foreign Affairs, 2008: 26). She is likely to be part of a group where almost one out of three women report an unwanted pregnancy and about half attempt an abortion (Committee on Foreign Affairs, 2008: 28). She may be below 25 years and choose to abort as she is unmarried or too young, wants to complete her education or she may have been raped or abandoned by her partner (Committee on Foreign Affairs, 2008: 28). If she is older, she may want to extend the period between successive pregnancies, does not want more children, or cannot afford an additional child. She relies on unsafe methods to terminate the pregnancy. She may receive a concoction, tablet or injection from a chemist shops run by people without medical or abortion training. If she lives in a rural area she will turn to quacks, traditional healers or attempt a self-induced abortion sometimes with help of her friends. She will use '*chemicals, sticks, herbs, and knives'* (Committee on Foreign Affairs, 2008: 28). Traditional healers will give her *'ground ginger, alligator pepper, local chalk and native alum'*. Quacks and traditional healers will use sharpened sticks taken from cassava plants or Bahaman grass (Committee on Foreign Affairs, 2008: 28). She may suffer from injuries such as uterine perforation, bowel damage, bleeding and

sepsis. She has a one in four chance to develop a complication (Committee on Foreign Affairs, 2008: 28).

This contrasts sharply with the experience of a peer in America with an unwanted pregnancy. In the US safe choices exist, there is access to good antenatal care and delivery services if they choose to deliver the baby (Committee on Foreign Affairs, 2008: 30). Those who choose to terminate have the option of safe abortion services allowing them to live their lives to the fullest. The opposite applies for Nigeria. In Nigeria she does not have access to information about controlling her fertility and for her pregnancy is like being a soldier on the frontlines – it is simply dangerous (Committee on Foreign Affairs, 2008: 30). She is limited by her access to contraception that will avoid an unplanned pregnancy, and the access to good services that will ensure a successful pregnancy. Similarly, she does not have the choice to terminate her pregnancy safely (Committee on Foreign Affairs, 2008: 30).

In Kenya she will be encouraged to follow existing cultural practices which consider the context and faith of the Kenyan woman (Committee on Foreign Affairs, 2008: 40). In Kenya she is told that pregnancy prevention relies on abstinence before marriage. She is told that modernization together with the influence of the media is contributing to the breakdown of social systems that cause pregnancies in unmarried women (Committee on Foreign Affairs, 2008: 52). She will be the object of behavior change programs that will bring African women to the '*original state*' where Africans abstained from sex before marriage (Committee on Foreign Affairs, 2008: 52). If she is married her husband still holds extensive decision-making power over her and if her husband is not made aware of her need to prevent pregnancies, she is unlikely to receive permission to use family planning methods. She will have to discuss and persuade her husband about the impact of multiple pregnancies and help him understand that it is difficult to effectively nurture and care for many children in the African context (Committee on Foreign Affairs, 2008: 57). If she becomes pregnant and tries to access an abortion, she may be exposed to health workers who are inadequately trained and hence increasing her risks of experiencing complications (Committee on Foreign Affairs, 2008: 41). She may hear that attempts to legalize abortion is part of a foreign agenda and a '*form of recolonization'* (Committee on Foreign Affairs, 2008: 41).

Obengo in his work on the ethics of abortion in Kenya summarizes the importance of socio-economic factors that drive girls and women toward abortions (2016). A critical factor, according

to Obengo, is the absence of alternatives when an unwanted pregnancy occurs (2016, 53). The absence of alternatives is accompanied by no or only limited support from friends, relatives or counselors which greatly increases the vulnerability of such girls and women (Obengo, 2016: 53). Stigma is a factor in certain communities, especially where sexual activity before marriage is frowned upon (Obengo, 2016: 54).

Negative community perspectives about pre-marital sex is often associated with poor availability of planning methods which increases the risk of unwanted pregnancy (Obengo, 2016: 54). In certain instances, families simply lack the resources to support an additional child (Obengo, 2016: 55). Others suggest that increasing sexual permissiveness among teenagers and the breakdown of traditional African values including decreased respect for religious moral values and lack of respect for women (Obengo, 2016: 55). Poverty is mentioned as a factor that drives women toward abortions and includes situations where older men, '*sugar daddies'*, take advantage of younger women or where young girls engage in sexual activity in search of money that will allow them to acquire basic necessities (Obengo, 2016: 55). Young girls may pursue abortions in Kenya since educational policies require pregnant girls to be expelled from school (Obengo, 2016: 57).

Obengo confirms the use of '*crude methods*' of abortion that are done by unqualified medical personnel at home, in the bush, or the back streets of urban centers (2016; 58). Obengo serves to confirm the vulnerability of women and the lack of options when facing an unplanned and an unwanted pregnancy which is exacerbated by MCP enactment on providers such as IPPF and MSI when they withdraw services in underserved areas.

Political perspectives on the MCP; Democratic and Republican ideologic expression

The Committee on Foreign Affairs met on 31 October 2007 (about one year before the transition from George W Bush to Barack Obama in 2009) to discuss the impact of the of the MCP on family planning and reproductive health (Committee on Foreign Affairs, 2008). Participants included Democratic and Republican members of the committee of Foreign Affairs. Representatives from the states of Colorado and New York provided prepared statements while representatives from the Johns Hopkins Bloomberg School of Public Health, Ipas Nigeria, PPF Ghana and a consultant obstetrician and gynecologist from Kenya provide technical inputs. This section summarizes pro-life and pro-choice perspectives expressed by politicians and invited participants and the key themes discussed during the hearing.

Democratic and Republican perspectives on the MCP enactment

The pro-choice group in Congress raised several points to challenge the implementation of the MCP. Globally, women are fighting for their reproductive rights, to control the number of children they will bear, to have access to contraceptives and the right to obtain a safe and legal abortion (Committee on Foreign Affairs, 2008: 1). International organizations are working to support women as they strive to achieve the rights described above (Committee on Foreign Affairs, 2008; 1). Instead, the USG refuses to work with these groups due to the restrictions of the MCP. By implementing the MCP, the President is hoping *to reduce abortion rates; however, all that is being achieved is to make abortion more unsafe* (Committee on Foreign Affairs, 2008: 1). The MCP therefore assumes a harmful nature that hurts women across the globe. The MCP counters one of the goals of the US foreign policy which is to spread democracy. In reality, the enactment of the *MCP is inconsistent with the goal of spreading democracy* as it forces foreign partners to relinquish their right to free speech (Committee on Foreign Affairs, 2008: 9). The domestic and international application of the MCP is inconsistent. Restrictions are applied externally yet not domestically where it would be deemed *unconstitutional (*Committee on Foreign Affairs, 2008: 10*).* Furthermore, it does become very problematic when the most powerful nation in the world implements a policy that is designed to prevent a debate on abortion. The MCP is a multi-faceted policy. In incorporates aspects of freedom of speech, ideological imperialism, reproductive choice and national sovereignty. The MCP is a lightning rod as it represents US values. It is an instrument

through which the country projects its beliefs and what the US '*believes others should believe*' (Committee on Foreign Affairs, 2008: 18).

Pro-life representatives claim that abortion rates have declined during periods when the MCP has been in place (Committee on Foreign Affairs, 2008: 3). They deny that the enactment of the MCP has endangered the lives of women by providing no exceptions for abortion forcing women to seek unsafe abortions. The MCP does allow abortions in instances of rape, incest or if the life of the pregnant woman is endangered by the pregnancy (Committee on Foreign Affairs, 2008: 3). The MCP also allows women to receive compassionate care when post-abortion care services are required and does not block '*passive'* referrals when a woman who has decided to abort a child, directly requests information from a health worker about abortion (Committee on Foreign Affairs, 2008: 3).

Since money is fungible, the provision of US funds to organizations that use private funds to provide abortion services effectively provides a subsidy to the abortion efforts of the organization; the MCP attempts to prevent organizations from redirecting funds in support of abortion activities. US domestic policy prohibits funding of organizations that support abortion as a method of family planning and the MCP brings similar consistency to international family planning assistance. The central goal of family planning programming is to prevent abortions (Committee on Foreign Affairs, 2008: 3)[39]. Rescission of the MCP would diminish the importance of other methods of family planning and could lead to preventive family planning methods being replaced by abortion. The core of the MCP is indeed an effort to protect the basic human rights of all members of society including women and children (Committee on Foreign Affairs, 2008: 3). Future generations of Americans would ask why an enlightened society such as America with a strong capacity to protect and vulnerable human life actively engaged in the promotion of death of children by abortion both in the US and abroad (Committee on Foreign Affairs, 2008: 4). Moreover, while making strong commitments in support of human rights the US precludes the '*most persecuted minority in the world, unborn children'* (Committee on Foreign Affairs, 2008: 4). Human life begins at conception; each second that follows is a stage of development. Unborn babies, even the unwanted,

[39] The official justification for the MCP is that its enactment will reduce the number of abortions (Committee on Foreign Affairs, 2008: 7)

possess dignity, inherent value and infinite worth and this why governments should protect their human rights (Committee on Foreign Affairs, 2008: 4). As stated by a speaker

> *'Abortion, Mr Chairman, is violence against children. It is extreme child abuse. It is cruelty to children. Abortion treats pregnancy as a sexually transmitted disease, a parasite, a piece of junk to be destroyed, and the whole notion of wantedness and unwantedness turns a child into an objection. Feminists had it right; no human being can be construed to be an object'* (Committee on Foreign Affairs, 2008: 5).

The MCP lies at the heart of the of the integrity of US foreign assistance programs. Around the world, people look to the US for '*justice, hope and compassion*' hence the US should be very careful in what it exports (Committee on Foreign Affairs, 2008: 6). The West should display the necessary sensitivity about imposing cultural norms in places where different norms are held (Committee on Foreign Affairs, 2008: 6). The MCP, through its prohibitions, is perceived as limiting the rights of foreign partners to free speech. That is not the point – what the MCP does is to prevent the use of American funds to advocate for abortion. The MCP is a pro-family policy that protects women and their children (Committee on Foreign Affairs, 2008: 12).

> *'On a more fundamental level, women deserve better options than terminating their pregnancies. Abortion should not be exported overseas where many nations hold strong life-affirming principles and laws. Poor women in developing nations are not asking for help to abort their children. They are asking for food, housing and medicine to care for themselves and their families'* (Committee on Foreign Affairs, 2008: 13).

Foreign aid dollars should be used to assist developing countries with their needs and preserving lives (Committee on Foreign Affairs, 2008: 14). Congress must advocate a culture that promotes life and ensures that the taxes paid by many US taxpayers who oppose abortion are not used to encourage abortion activities abroad (Committee on Foreign Affairs, 2008: 14).

> '*We need to export a life-saving policy that provides poor women with food, housing and medicine, not policies that are destructive to women and children. As a pro-life woman in Congress, I want to do the very best for women and their children around the world. I believe that human rights begin in the womb and I support the Mexico City Policy…'* (Committee on Foreign Affairs, 2008: 14).

Themes emerging during the Congressional Hearing

The status of the fetus features prominently. Deniers of the personhood of the fetus are compared to believers in a '*flat earth policy and that somehow the earth isn't round*' (Committee on Foreign

Affairs, 2008: 47). Other perspectives emerge that the transition of the fetus to a person is a philosophical question and that the philosophical perspectives of persons with different viewpoints will not necessarily coincide (Committee on Foreign Affairs, 2008: 50). Personhood is associated with human rights emphasizing that human rights incorporate all persons including the disabled while age and dependency should not be used to establish the human rights of an individual (Committee on Foreign Affairs, 2008: 50).

The status of abortion in Africa; imposed by foreigners or established for generations? Discussants emphasize that abortion has been part of the '*African system*' since time immemorial (Committee on Foreign Affairs, 2008: 51). Woman use concoctions and remedies that are handed down from grandmothers including materials that are inserted into the vagina. Young girls grind bottles to drink but do not have the understanding that the digestive system is not directly connected to the reproductive system (Committee on Foreign Affairs, 2008: 51). The pro-life perspective in turn counters the existence of an age-old institution of abortion in Africa since systems exist in African culture that prevent young girls from getting pregnant by relying on abstinence before marriage. Modernization including media influence has contributed to the breakdown of social systems which in turn results in pregnancies in unmarried women (Committee on Foreign Affairs, 2008: 52). Behavior change programs are required that will bring African women to the '*original state*' where Africans abstained from sex before marriage (Committee on Foreign Affairs, 2008: 52).

Imposition of a Western paradigm and the role of foreign aid. Some discussants suggest that It is important to carefully examine assistance practices to ensure that '*cultural imperialism*' is not promoted through the imposition of a '*Western paradigm*' with consequent disruption and the undermining of traditional norms (Committee on Foreign Affairs, 2008: 53). Norms subject to '*cultural imperialism*' include those norms that maintain the innocence of children, the structure of the family and human dignity and which are continuously subject to assaults by aggressive globalization, the sexualized content of messaging disseminated through the internet and the availability of pornography (Committee on Foreign Affairs, 2008: 53). The integrity of foreign assistance should emphasize the dignity and value of life, promote the ideal of '*a nurturing mother*' supported by a '*caring, protective father'*, and is sensitive to the indigenous cultural norms of populations (Committee on Foreign Affairs, 2008: 53).

The impact of the MCP on medical decision-making. This issue is contextualized by examining the impact of multiple repeat pregnancies and the subsequent toll on mothers, the future prospects of children at birth, the need for medical care of those who have self-aborted and the impact on the health system (Committee on Foreign Affairs, 2008: 56). What happens when women are unable to access medical care and all treatment options do not exist? Pregnancies that occur at short intervals can affect the mother's health by weakening the womb with consequences such as uterine rupture with its catastrophic outcomes such as hysterectomy or death. Young women, adolescents who become pregnant often deliver children with a low birth weight and many women develop fistula with its disruptive consequences[40]. The provision of contraceptives and family planning plays an important role in preventing some of the issues described above (Committee on Foreign Affairs, 2008: 56-57).

The role of men in family planning in the African culture. Engaging and involving men in family planning is important (Committee on Foreign Affairs, 2008:57). The man still holds extensive decision-making power over his wife; if men do not understand the needs of women to prevent pregnancy, he is unlikely to allow the wife to use contraception. Therefore, it is important to educate the men about the impact of multiple pregnancies and help them understand that it is difficult to effectively nurture and care for many children in the African context. It is '*still the same man who will not be able to get enough resources to take those children to school, and therefore the poverty, the lack of education, all those things will continue on*' (Committee on Foreign Affairs, 2008: 57).

The interest of Americans (Mike Pence, Current US Vice President). He states categorically that he is pro-life and that personally he believes that abortion is morally wrong. He distinguishes the issues at hand as a separate moral wrong. This moral wrong is defined by taking the tax dollars of pro-life Americans and using this to promote abortion (Committee on Foreign Affairs, 2008: 74). He argues that the MCP has allowed the expansion of family planning by removing the ongoing argument about abortion. He continues by stating that he would like to see the imposition of something like the MCP in the US especially since the largest recipient of money for family planning in the US (PPF) is also the largest provider of abortion in the US. This based on the

[40] *Secondary infertility, chronic skin irritation due to incontinence, stigmatization due to offensive odor, isolation and loss of social support, divorce or separation, worsening poverty, worsening malnutrition, as well as suffering, illness, and premature death'* (Drew *et al.*, 2016: 1).

argument that that 74 percent of Americans do not want to see their tax dollars being used for abortions (Committee on Foreign Affairs, 2008: 75). Rescission of the MCP may compromise funding for family planning. In response, the point is made that the Helms Amendment dealt very effectively with the abortion issue by ensuring that no tax dollars are channeled to '*support or promote abortion as a method of family planning*' (Committee on Foreign Affairs, 2008: 75). The issue at stake is the fungibility issue and the indirect funding of organizations or NGOs to provide abortions or promote abortions. Pence responds by suggesting that the re-injection of the fungibility issue into the conversation will compromise the vitality of the program and ongoing support by the US for ongoing funding of family planning programs (Committee on Foreign Affairs, 2008: 75). In response the comment is made that many regard the imposition of MCP conditionalities not only as un-American but that it restricts freedom of speech. In response, Mr. Pence cautions Democrats and others in favor of the rescission of the MCP that this may impact the provision of funds for family planning programs. The MCP, in fact, addresses the moral concerns of Americans who believe it is morally wrong to take tax policy dollars to fund '*directly or indirectly abortion overseas*' (Committee on Foreign Affairs, 2008: 76).

Concluding remarks

In the introduction to the section on the Christian Right, I proposed the idea of a thread that links Roe v. Wade with the MCP. Roe v. Wade set in motion a series of consequences that included the mobilization of women, engagement of the political process and as an ultimate conclusion of that process, the formulation of the MCP. I want to conclude this chapter with a few remarks on this relational thread between Roe v. Wade and the MCP. I will use the themes of family and choice as a means to develop the concluding remarks which will focus on the validation of the relational thread and the consequences that emerge.

Luker describes the importance of family to the pro-life group. This group believes that the raising of children and caring for families is the most fulfilling role for women and the priority for women is to be '*wives and mother*'s first' (Luker, 1985: 160-161). Pro-life women view an unanticipated pregnancy as being temporarily unwanted in contrast to the child who is ultimately wanted. This is in keeping with values, often originating in childhood, and available social resources that lead pro-life women to believe that it is possible to '*make room for one more*' while also strongly believing that abortion is '*cruel, wicked and self-indulgent*' Luker, 1985: 198). This view is further

nuanced through the '*Family Manisfesto'*, as devised by the MM, which succinctly defines male and female roles

> '*male and female were established in their diversity by the Creator….. and extends to psychological traits which set natural constraints on gender roles …..the role of the male is most effectively that of provider, and the role of the female one of nurturer*' (Banwart, 2013: 144).

The focus on the family is taken further by Falwell and his MM, as representatives of the Christian Right, as a means to unite the diverse religious groupings under a common cause '*the family*' and using this slogan to oppose abortion, civil rights protection for gays and lesbians, and the passage of the Equal Rights Amendment (Banwart, 2013: 141). In Congress, the idea of family becomes a justification for the MCP. The MCP is a pro-family policy that protects women and their children (Committee on Foreign Affairs, 2008: 12): '*On a more fundamental level, women deserve better options than terminating their pregnancies. Abortion should not be exported overseas where many nations hold strong life-affirming principles and laws'* (Committee on Foreign Affairs, 2008: 13).

This short description illustrates how the idea of the family flows from the perspectives of American women who belong to the pro-life group all the way into Congress and the enunciation of these perspectives into foreign policy. The Christian Right expresses itself on foreign policy issues that may weaken parental powers to control children, promote abortion, expand homosexual rights and diminish the idealized notions of mother and homemaker (Martin, 1999: 72). They proceed to attack the UN as a mechanism that allows the '*secular elite*' to threaten the '*traditional family'* globally (Martin, 1999: 74).

The consequences of the expression of family, including the incorporation of abortion into this idea of family, leads to outcomes that are unexpected. The central goal of family planning programming is to prevent abortions (Committee on Foreign Affairs, 2008: 3). It is the pursuit of this goal that leads to the unintended consequences following MCP enactment. As illustrated through emerging evidence, the incidence of abortions increases rather than decreases when the MCP is enacted. This creates much harm as described in the section on the '*voiceless she*' as women bear the consequences of often needing to turn toward unsafe abortion as the only form of induced abortion available to them. The direct impact of the harmful consequences of unsafe abortion is in fact the harm that is done to families when a woman dies or is left with significant morbidity that hampers her ability to effectively nurture her family. Similarly, the impact on young

women who need to stop their education or a parent who is unable to earn an income due to child rearing duties has an impact on the individual, the family and their communities. The ultimate expression of the MCP is therefore, at times, incongruent with the original intent of the focus on family. In addition, a conversation emerges from the '*voiceless she*' that pregnancy prevention relies on abstinence before marriage, that modernization together with the influence of the media is contributing to the breakdown of social systems that cause pregnancies in unmarried women and that she needs to participate in behavior change programs that will bring African women to the '*original state*' where Africans abstained from sex before marriage (Committee on Foreign Affairs, 2008: 52).[41] Embedded in this statement is the expectation of returning to earlier and more traditional societal values, that is unlikely to be met in the modern world. It reflects a lack of acknowledgement of a changing world and the need to adapt which further limits the possibility of achieving the intended objective of the MCP.

The emphasis on choice is manifest as follows by the stakeholders. Luker describes how American women increasingly acquired education, skills and capacities that enabled them to compete with men and came to realize that their '*human capital'* was similar to that of men (Luker, 1985: 118). Roe v Wade therefore assumed significance for women seeking to expand the control over their lives as individuals (Luker, 1985: 125). This idea is carried forward by IPPF as follows: IPPF's vision promotes a discrimination free world where all persons are able to make free choices about individual sexuality and well-being which is expressed as follows '*IPPF is fighting for a world where women everywhere can say "I decide'"*' (International Planned Parenthood Federation, no date a). MSI's slogan states that '*We believe that every woman and girl should be able to have children by choice, not chance*' (Marie Stopes International, 2017 b). Democratic representatives emphasize that women are fighting for their reproductive rights, to control the number of children they will bear, to have access to contraceptives and the right to obtain a safe and legal abortion (Committee on Foreign Affairs, 2008: 1). These views are best expressed during

[41] The effectiveness of abstinence only programs is succinctly described by Underhill, Montgomery and Operario. They conducted a systematic review by assessing 30 electronic databases to determine the effects of sexual abstinence only programs for HIV prevention in high income countries. The study included 15,940 youths in 13 trials. No programs affected the incidence of unprotected vaginal sex, the number of partners, condom use, or sexual initiation. The authors concluded that the exclusive encouragement of abstinence from sex appears not to affect the risk of HIV infection in high income countries (Underhill, Montgomery and Operario, 2007: 248).

periods when the MCP is not enacted and when only the Helms Amendment restricts the use of USG funds for abortion. Once again it is possible to see how the relational thread can be drawn between the perspectives of American pro-choice women and a perspective of the world which sees the rescission of the MCP when Democratic Presidents assume power.

The expression of foreign policy by Democrats, although it restricts access to abortion, is more benign when compared to the consequences of MCP enactment and certainly enables greater access to family planning and a more comprehensive suite of reproductive health care. Emerging evidence suggest that less harm accrues during periods when the MCP is rescinded. In terms of abortion incidence, it is more likely to achieve the outcome desired by Congress which is to prevent abortions. It is certainly more beneficial for the '*voiceless she*' and appears to be aligned with contemporary social trends globally about the role of women in society and their striving toward greater empowerment.

What emerges from the discussion about stakeholders is how ideology and beliefs influence foreign policy, in this instance, through the MCP. It indicates the fault lines that separate these two groups as well as the sources of conflict that divides them, essentially, the right to exercise choice versus a prohibition on choice. It is apparent that these ideologies and beliefs are deeply set in stone and potentially how difficult it is to bridge this divide. This understanding suggests how mitigation steps may be developed when attempting to address the global impact of the MCP. Considering the intensity of beliefs and ideologies it is likely that efforts aimed at containing harmful consequences may be more susceptible to intervention compared to trying to close the gap between those who hold these divergent worldviews.

These brief comments set the tone for the ethical evaluation of the MCP and the development of recommendations. Before proceeding with the ethical evaluation, it is important to document the global public health problem of abortion and to explore the question whether it is possible, in the foreseeable future, to avoid abortions.

Chapter 6. The global public health problem of abortion

Abortion and its related controversies stand at the center of the MCP. It is the driving force that has led to the creation of the policy and the political controversy that surrounds the enactment and rescission of the policy. Abortion is a global public health problem and is associated with substantial morbidity and mortality. A WHO systematic analysis published in 2014 cites abortion as an important cause of maternal deaths globally causing 7.9 percent of maternal deaths (Say *et al.*, 2014: e323). The scale of abortion-related deaths is significant and any discussion about the MCP is incomplete without considering the burden of morbidity and mortality of abortion. A further issue that should be discussed is whether the world can do without abortions. While the intent of the MCP is clear in stating that US support for abortion as a method of family planning is prohibited, it is important to understand the role of abortion in relation to fertility control. The epidemiology of abortions provides insight into the substantive challenge of eliminating abortion and achieving the goal espoused by Bill Clinton to make abortion '*safe, legal and rare*' (Newman, 2018). A long-term study on abortion trends from France is presented to demonstrate how, despite the ready availability of contraception, there continues to be a reliance on abortion as a method of family planning.

The global epidemiology of abortions

Hodgson draws on data from a report released in 2007 by the Guttmacher Institute to provide insight into the epidemiology of abortions. Best estimates for the number of pregnancies annually is 210 million. Approximately 130 million result in live births, 38 million in spontaneous abortions and still births, 22 million in legal abortions and 20 million in illegal abortions (Hodgson, 2009: 480). About 80 million pregnancies are estimated to be unintended. About half of these are terminated through induced abortions both legal and illegal (Hodgson, 2009: 480). The Guttmacher Institute estimated that 22 million legal abortions occurred in 2003. Five countries were responsible for almost 60 percent of abortions; China (7,215,000), India (2,400,000), Russia (1,504,000), United States (1,287,000) and Vietnam (540,000)(Hodgson, 2009: 480).

When analyzing the epidemiology of abortion different perspectives are helpful in painting a fuller picture of its manifestations. These include geography, (by nation and region including access to abortion), population size and national developmental status.

Countries that allow access to abortion. Access to legal abortion services increased globally between 1996 and 2007. As of 2007, 56 out of 179 countries (31 percent) with populations of more than 100,000 allowed abortion on request with 67 (37 percent) allowing abortion for economic or social reasons. This implies that about one third of countries globally permit abortion as a '*means of fertility control*'(Hodgson, 2009: 482). During the same period, access to abortions using mental health criteria as justification saw the greatest increase from 94 (53 %) to 118 (66%) countries (Hodgson, 2009: 482).

Proportion of global population that live in countries that allow abortion for any reason. By 2007, approximately 60 percent of the world's women had uncomplicated access to abortion services (Hodgson, 2009: 484). There was a decline in the percent of women with uncomplicated access[42] ('*On request'*) to abortion services. The explanation for this seemingly contradictory trend is explained by the relatively slower population growth in Europe and North America in comparison to countries with high rates of population growth and limited access to safe abortion services. This trend will continue until countries with restrictions against abortion, especially populous countries, begin to liberalize their abortion laws (Hodgson, 2009: 484).

Regional distribution of countries with laws that allow access to abortion. Geographically, uncomplicated access to legal abortion is most restricted in 52 African countries and 30 Latin American countries (Hodgson, 2009: 484). Eight percent of countries (or 7 percent of the total population) in Africa (2007) and 17 percent of countries (or 2 percent of the total population) in Latin America (2007) permit abortion on request or for economic or social reasons (Hodgson, 2009: 484). In Europe and North America, by contrast, 90 percent of countries in Europe and 100 percent in North America allow abortion on request or for economic and social reasons (Hodgson, 2009: 484).

Developmental level of countries and access to abortions. A further approach to analyzing abortion related data is to compare the development level of countries with access to abortion. In terms of

[42] Uncomplicated access to abortion is defined as 'living *in a country that permits abortion on request or for economic and social reasons*.'

uncomplicated access to abortion, four out of 48 countries classified as least developed permitted abortion; 23 out of 86 countries classified as less developed permitted abortion and 40 out of 45 countries classified as more developed permitted abortion (Hodgson, 2009: 486-487). This clearly demonstrates how uncomplicated access to abortion increases as the developmental levels of countries increase. Differences between least developed and most developed countries are stark; seven percent of women in least developed countries have access to uncomplicated legal abortion compared to 93 percent in the developed world (Hodgson, 2009: 487). [43]

Further comparison of population growth and total fertility rates in least and less developed countries generate further insights. Women in the least developed group of countries with uncomplicated access to abortion had lower annual population growth rates (1.9 percent versus 2.4 percent) and lower total fertility rates (3.7 versus 4.8) compared to those without uncomplicated access to abortion (Hodgson, 2009: 487). In the group of less developed countries similar trends emerge; in countries with uncomplicated access to abortion there was lower annual population growth rates (1.0 percent versus 1.5 percent) and lower total fertility rates (2.2 versus 2.9) compared to those without uncomplicated access to abortion (Hodgson, 2009: 487). This demonstrates the impact of abortion availability on annual population growth and total fertility. Additionally, the population with uncomplicated access has a 30 percent higher use rate of "*any contraception*" and a 32 percent higher use rate of "*modern contraception*" than the population with restricted access (Hodgson, 2009: 487).

Abortion and fertility transitions. The relationship between abortion and contraception benefits further from an analysis of fertility transitions. Current understanding of fertility transitions[44] suggest that a rapid decline in '*desired family size*' as typically experienced during the early and middle stages of fertility transition, increases the potential for unintended pregnancies (Hodgson,

[43] Updated incidence of global abortions and unrestricted access (2017). Globally (total of 1.64 billion women) - 37% have unrestricted access; developed countries (total of 244 million women) - 81% have unrestricted access; developing countries (total of 1.39 billion) - 29% have unrestricted access; developing (excluding China and India – total of 784 million) - 13% have unrestricted access. https://www.guttmacher.org/report/abortion-worldwide-2017

[44] Demographic Transition Theory. '*The central thesis of the theory was generally presented as a three-stage model: the first stage consisting of pretransition societies characterized by high fertility and mortality; a second transitional stage, consisting of societies with declining mortality and, after a lag, declining fertility; and a third and final stage, consisting of post transitional societies, which have low mortality and fertility.*'
https://www.encyclopedia.com/social-sciences/encyclopedias-almanacs-transcripts-and-maps/fertility-transition-socioeconomic-determinants

2009: 487). Countries undergoing the early and middle phases of fertility transition experience increases in contraceptive use and demand for induced abortion. This suggests that women make use of both forms of interventions to control fertility in line with '*declining desired fertility'*(Hodgson, 2009: 487). A consequence of the pattern of increased demand for induced abortion is that in countries with limited access to abortion there will be an associated increase in illegal abortions as prohibition on abortion has not served to prevent women from seeking out abortions during pregnancies (Hodgson, 2009: 487).

The epidemiology of unsafe and illegal abortions. Data from 2003 in Africa shows that 12 percent of all pregnancies (5.5 million abortions; 98 percent of all abortions) were illegally terminated (Hodgson, 2009: 488). Similarly, in Latin America and the Caribbean, 21 percent of all pregnancies (3.9 million abortions; 95 percent of all abortions) were illegally terminated (Hodgson, 2009: 488). A very direct consequence is the impact on the health of women who terminated their pregnancies through illegal abortions. The WHO estimates that the case fatality rate (deaths per 100,000 abortion procedures) in 2003 was 650/100,000 for women in Africa and 50/100,000 for women in the Caribbean (Hodgson, 2009: 488). The case fatality rate for legal abortions in the US in 2007 was 0.6/100,000 (Hodgson, 2009: 488). '*It is estimated that annually 65,000 to 70,000 women die as a result of unsafe abortions, five million suffer a period of disability, three million experience infections of their reproductive tracts and 1.7 million experience secondary fertility*' (Hodgson, 2009: 488).

The epidemiology of the public health problem demonstrates important issues. Drawing from 2007 data, about 40 million abortions are done annually for unintended pregnancies; many occur in countries with restricted access to abortion. Typically, these countries are found in Africa and Latin America. The level of development is associated with the ease of access to abortion; least developed countries are more likely to face restrictions on abortion compared to more developed countries. Differences between least developed and most developed countries are stark; seven percent of women in least developed countries have access to uncomplicated legal abortion compared to 93 percent in the developed world. Least developed countries experience higher population growth rates and total fertility rates. Fertility transitions in the early and middle stages of transition appear to drive a rapid decline in desired family size which increases the potential for unintended pregnancies. A consequence of the pattern of increased demand for induced abortion is that in countries with limited access to abortion there will be an associated increase in illegal

abortions. This has very direct consequence for women who terminate their pregnancies through illegal abortions. Global mortality rates illustrate the stark differences between the developing and developed world; the case fatality rate in 2003 was 650/100,000 for women in Africa and 50/100,000 for women in the Caribbean. The case fatality rate for legal abortions in the US in 2007 was 0.6/100,000. USAID through its support for family planning is most active in least developed nations, especially in Africa.

Family planning and abortion in France; a trend analysis

Family planning and the relationship with abortion using data from France clarifies how they interact. France, since the early 1980s has promoted the use of contraception by providing information through sexual education and national contraception campaigns and by easing access through publicly funded family planning clinics. Costs are covered through the national health insurance system (Bajos *et al.*, 2014). Abortion is legally available and since 1981 costs were partially reimbursed through the national health insurance system. (Bajos *et al.*, 2014).

France has through a series of six probability surveys, starting in the seventies, tracked trends in contraceptive behaviors and reproductive health outcomes (Bajos *et al.*, 2014). This has allowed researchers and policy makers to conduct retrospective analyses about contraceptive behaviors, fertility intentions, and recourse to abortion over four decades. The studies show important outcomes and results. During the last four decades rates of sexual activity have remained stable (Bajos *et al.*, 2014). Age at first birth has increased consistently from 23.9 years in 1978 to 27.9 years in 2010 (Bajos *et al.*, 2014). The ideal number of children per woman has remained steady at 2.4 children in women between 25-34 years of age (Bajos *et al.*, 2014).

Increased contraceptive use has been accompanied by a decrease in unwanted pregnancy rates (Bajos *et al.*, 2014). Unwanted pregnancy rates declined more sharply in younger women when compared to older women. In women under thirty, unwanted pregnancy rates declined from 0.82 (1973-77) to 0.49 (2005-09) unwanted pregnancies per women. In women over thirty, unwanted pregnancy rates declined from 0.41 (1973-77) to 0.28 (2005-09) unwanted pregnancies per women and increased to 0.35 (2005-09) (Bajos *et al.*, 2014). The likelihood of a pregnancy ending in termination in women under thirty increased from 44 percent (1973-77) to 59 percent (1993-97) and has since remained stable (Bajos *et al.*, 2014). In women over thirty, termination rates for

unwanted pregnancies initially increased from 66 percent (1973-77) to 74 percent (1978-82) and dropped to 54 percent by 2005-09 (Bajos *et al.*, 2014).

The French example provides important insights into the relationship between contraception, unwanted pregnancies and termination of pregnancy. The authors conclude that abortion rates are not only a reflection of increased contraceptive effectiveness with a decreased need to terminate unwanted pregnancies through an abortion but also changing social norms about childbearing (Bajos *et al.*, 2014). With the increasing tendency to initiate childbearing later in life, differences have emerged between younger women below 30 and older women over thirty. Younger women are more likely to terminate unwanted pregnancies while older women are less likely to terminate a pregnancy (Bajos *et al.*, 2014). Changing trends in pregnancy termination are likely to reflect social changes including greater enrollment of women in educational opportunities and a greater participation in the labor force. Greater availability of contraception and access to abortion have enabled French women to elect the most suitable age for childbearing and the initiation of parenthood. Children can be born at the appropriate time within the context of a woman's educational and professional career trajectories (Bajos *et al.*, 2014).

Concluding remarks

The epidemiological data shared in this chapter suggests that abortion is and will continue to be an option for fertility control. The approximately twenty million unsafe abortions per annum in the developing world suggest that women in these settings are especially disadvantaged by the lack of access to family planning methods and safe abortion. The example of France (which most likely echoes many developed nations) indicates that abortions will persist, despite widespread availability of contraceptives, as the risk of unintended pregnancy cannot be fully excluded following sexual activity, even if protected. Similarly, the USA is not excluded from the burden of unintended pregnancies. In 2011, 45 percent of pregnancies were unintended with 27 percent wanted and 18 percent unwanted. Unintended pregnancies were higher in low income women of colour, women between 18-24 years and cohabiting women. In 2011, 42 percent of unintended pregnancies ended in abortion (Guttmacher Institute, 2019b). Nearly one in four American women (23.7%) will have an abortion by age 45 (Guttmacher Institute, 2017). The conclusion can be drawn that the problem of abortion will not disappear soon, especially in a world where demographic transitions are under way, and as girls and women strive to improve their education

and opportunities in life. It is additionally impossible in the short term to avoid the negative consequences of women opting for unsafe abortions which may include death, damage to their reproductive tracts and secondary infertility. The ongoing burden of unsafe abortions cannot be neglected by policymakers including those who implement the MCP.

Chapter 7. Ethical evaluation of the Mexico City Policy

The preceding chapters have assisted us in understanding the historical origins and the process of development of the MCP as well as the positions and ideologies of the stakeholders involved in actions following enactment and rescission of the MCP. The next step is to conduct an ethical evaluation of the MCP. The evaluation should be built on establishing the relevant facts and the correct and appropriate application of relevant principles in an impartial fashion as possible (Rachels and Rachels, 2015: 12). In addition, an effective stance toward the analysis of the MCP should be defined.

The focus of the ethical evaluation will address the following three questions. Firstly, the imposition introduced by the USG on international NGOs and governments. To what extent may such impositions be justified? Secondly, the oscillation between the enactment of rescission of the MCP has a very direct effect on the continuity of care that is provided to many persons across the globe who receive global assistance from the USG. This raises the question about the ethical status of especially withdrawal of services from communities that rely on the provision of these services. Thirdly, a dilemma is created for NGOs who receive US funds when the MCP is enacted. Does the enactment of this policy suggest the need for more flexible approaches by international NGOs during periods of policy enactment in order to ensure and sustain the health and well-being of persons who rely on their service provision?

I propose to approach the analysis of the MCP in three ways. Firstly, I will conduct an analysis that will explore the internal consistency of the policy. Assuming the policy is internally consistent and coherent we can conclude that the policy stands on strong moral foundations. Secondly, I will explore the impact of the MCP on the external world. The global health system is characterised by severe inequalities (Van Niekerk, 2005: 90; Benatar and Upshot, 2011: 14-15; Pogge, 2007: 28). Within a setting of severe inequality the assumption can be made that if the application of the MCP were just, we would anticipate that at the least there would follow no further increase in global health inequality or at best there would be a decrease in global health inequality. Pogge writes that when an institutional order is shaped, the order as such, should not directly contribute toward an increased burden of disease even though it may prevent the occurrence of other diseases (Pogge, 2007: 27). The institutional order, as such, should be designed to prioritize the prevention of those

diseases it contributes toward (Pogge, 2007: 27). Pogge adds that many social institutions contribute toward an increased burden of disease that is largely mediated through poverty (Pogge, 2007: 28). Evidence is drawn from the experience of structural adjustment policies introduced by the World Bank and International Monetary Fund and its contribution to increased economic inequality and the inability of countries to meet basic health needs (Labonte and Schrecker, 2011: 31).

Thirdly, in order to round out the ethical evaluation and in preparation for the development of recommendations, it is important to add additional components to the ethical analysis. These include, an analysis of the ethical validity of the restrictions imposed through the MCP; an assessment of the problem of the pendular nature of MCP re-enactment and rescission; and finally, the introduction of ethical principles that determine the distribution the duties and responsibilities between states and international organizations.

Evaluating the internal consistency of the MCP

An important question is whether the MCP, as such, has an internally coherent structure that can validate its restrictive approach globally. It has been demonstrated how religious thinking forms a central theme for justification for the MCP. Can the religious influence be justified and validated? Does the policy exhibit internal contradictions that will disturb its coherence? Does the policy meet the requirements of a diverse and pluralist world since its application is global? I propose to explore these questions through a framework proposed by Callahan.

Daniel Callahan set out to develop a moral and legal policy on abortion. His book, *Abortion: Law, Choice and Morality*, was published in 1970 (Callahan, 1970). The book encompasses his concern to assist individuals to reach a '*coherent position on the moral legitimacy of abortion'*, for society to find legal solutions that preserves the rights and values needed for its welfare, for man to apply scientific technology in moral ways and for people to display the necessary sensitivity and tolerance for those who differ from them (Callahan, 1970). The work of Callahan, as far as I am concerned, provides an interesting perspective and framework from where to view the problem of abortion and analyze the perspectives of different stakeholders engaged in the abortion debate. It provides an opportunity to assess the MCP and its underlying ideologies against a framework that aimed to define a coherent policy on the legitimacy of abortion.

In outlining his framework, Callahan initially defines a common point of consensus that allows stakeholders groups to examine the problem of abortion; this point of consensus is the principle of the '*sanctity of life*'. He proposes the use of the sanctity of life principle as it provides a strong foundation for the development of a moral policy (Callahan, 1970: 305). He then introduces an approach to reduce the associated ambiguity of meaning attached to the principle of the sanctity of life through the development of a system of principles and related rules. Finally, he introduces three schools of opinion for the evaluation of the starting point of life which assists in understanding the points of departure and related conflict for conflicting groups.

The religious foundations of the MCP and the relationship with the sanctity of life

Callahan sets out to define a point of departure for establishing moral consensus on abortion. He proposes that the principle of the sanctity of life provides such a starting point by enabling us to frame moral rules, claim and defend human rights and establish cultural, social and political priorities. Luker suggests that both pro-choice and pro-life groups view abortion in a serious light. Pro-life groups view it as morally wrong. Pro-choice groups acknowledge the importance of the personhood of the fetus despite their pro-abortion outlook; hence, decision-making about abortion is not a trivial matter (Luker, 1985: 179-180). Reagan refers to the sanctity of life idea as follows '*Every legislator, every doctor, and every citizen needs to recognize that the real issue is whether to affirm and protect the sanctity of all human life ….'* (Reagan, 2010). Dworkin proposes a similar idea to that of Callahan, although he refers to life as being '*sacred or inviolable*'; in this terminological framework the term '*inviolable'* can be used interchangeably with '*sanctity'* (Dworkin, 1994: 73). The idea of the principle of the sanctity of life is expressed by Congress as follows: '*Unborn babies, even the unwanted, possess dignity, inherent value and infinite worth* ….' (Committee on Foreign Affairs, 2008: 4). The different perspectives described above demonstrates that the idea of the principle of the sanctity of life is well accepted by both pro-choice and pro-life groups. In his pursuit of developing consensus, Callahan examines both religious (Christian) and non-religious principles that underlie the sanctity of life.

Christians base the idea of the sanctity of life in respect of and awe for life granted by God to man. For example, both Catholics and Protestants imbue the sanctity of life with a '*divine origin and*

preservation' (Callahan, 1970: 311). In the absence of the principle of the sanctity of life there is no other principle available to replace this idea other than '*personal taste'* (Callahan, 1970: 311).

Callahan points out that God is not the only entity involved in sanctity of life decisions but includes a role for man (Callahan, 1970: 312). This indicates an inherent limitation to God's proposed control over the sanctity of life; it is not absolute. Christian theology permits man and the state to take the life of other men implying that God has granted man some degree of control over the life and death of others (Callahan, 1970: 312). God also does not intervene directly or miraculously to protect life in human affairs to back up the idea of the sanctity of life (Callahan, 1970: 312). Therefore, man has some role to play in human affairs including decisions about life and death. This poses a key dilemma for Christian ethics as a distinction needs to be drawn between the extent of God's lordship and the boundaries of his decision-making and those instances where man is pressed to make practical decisions (Callahan, 1970: 312).

The Christian-centered approach carries advantages and disadvantages. The most important advantage accrues from locating the idea of man's dignity beyond the remit of other human beings since worth is accorded by God rather than by men. Sanctity of life is thus not subject to judgment dictated by man's inconsistency whether in the form of laws or mores. Additionally, the sanctity of life is ultimately grounded in God, the '*creator of everything*' (Callahan, 1970: 312-313). Disadvantages emerge since all humanity is not Christian and hence Christian ethics is unable to serve and provide the basis for consensual norms for all. The externalization of man's intrinsic dignity to God renders man's dignity indeterminate in the absence of the Christian God; it implies that man in his own right may be less valuable. Finally, it does not consider the perspectives of nonbelievers who may assert that sanctity of life exists in the absence of God (Callahan, 1970: 313).

Non-religious approaches prioritize the sanctity of life in ways that differ from the Christian approach. Shils proposes that the revulsion of interfering in matters of life and death originates from something more fundamental than human beliefs. He proposes that the sanctity of life finds its origins in a '*deeper, protoreligious natural metaphysic*' which explains how all humans can express respect for human life irrespective of a specific religion (Callahan, 1970: 313). Shils' approach gains substance since the idea of sanctity of life does not require justification beyond the boundaries of human life such as God. This enables the nonreligious or nonbelievers to express

their belief in the sanctity of life (Callahan, 1970: 314). Philosophical rejoinders exist. Firstly, the mere attribution of something as valuable does not necessarily lead to the conclusion that something is indeed valuable; an initial perception of '*value'* may be followed by actual doubts about '*real value*' (Callahan, 1970: 314). Secondly, Shils' approach requires that all humans, under all conditions, have valued human life. Thirdly, the idea of the sanctity of life is a human concept that is applied to human experiences; it presupposes the existence of a '*conceptual and linguistic system*' that can be applied to describe and evaluate experience. (Callahan, 1970: 314).

Medawar proposes a similar defense of the sanctity of life which is, according to Callahan, '*sketchier'* since he builds his case on the *'a certain natural sense of the fitness of things, a feeling that is shared by most kind and reasonable people even if we cannot define it in philosophically defensible or legally accountable terms'* (Callahan, 1970: 314). Objections include the wide variety of interpretations that can be applied to the '*sense of the fitness of things*' and its inability to serve as a reliable criterion required for the resolution of ethical dilemmas (Callahan, 1970: 314). For example, in the abortion discussion it may be considered '*fitting'* that some women should not risk bearing a deformed child while others would find it '*fitting'* that women should bear a deformed child (Callahan, 1970: 314). We are not sure which is right or wrong and this becomes even more difficult when we rely on relative vague notions of the '*fitness of things*' to fashion decisive criteria (Callahan, 1970: 315).

What we draw from Callahan's work is that different perspectives exist about the principle of the sanctity of life and that the Christian approach is not central to or even essential for this idea. This allows a weakness to emerge in one of the central ideologies underlying the MCP. The ideology behind the MCP is largely religious, as demonstrated by the linkage between the Christian Right and conservative Republicans and is exemplified by the Moral Majority's perspective on abortion*; 'a practice deemed offensive, barbaric, savage and a violation of God's precious handiwork on earth'* (Crimm, 2012: 632; Banwart, 2013: 139).

The emphasis on a largely Christian religious ideology opens the door to criticism for two reasons. The Christian religious basis for the MCP is compromised since the belief in '*divine origin and preservation*' is subject to criticism (Callahan, 1970: 311). As Callahan points out; God's proposed control over the sanctity of life is not absolute (Callahan, 1970: 312). Man plays a role in matters of life and death and hence the religious underpinnings of the MCP cannot be purely religious –

man has an influential role in moral policy development for life and death decisions. This weakens the notion of '*divine origin and preservation*' as a core idea aimed at justifying the MCP; where man becomes involved things become more messy. (Callahan, 1970: 311) . Van Niekerk writes that based on a traditional perspective of human reproduction, the morally legitimate purpose of a '*clump of embryonic cells*' is to develop into a human baby (Van Niekerk, 2006). New reproductive technologies have changed this perspective by bringing to our attention the greater engagement of humans in determining the future outcomes of embryos (Van Niekerk, 2006). This insight draws our attention to the earlier observation that humans play an influential role in determining moral policies that determine life and death decisions. This reinforces the notion that God's proposed control over the sanctity of life is not absolute. Secondly, all humanity is not Christian and hence the foundation provided by the Christian religion for the MCP is unable to serve and provide the basis for consensual norms for all. Hence, we can conclude that the strong Christian religious basis for the MCP is unable to provide a solid underpinning for global application of the MCP; there are societies and other religions that validate the sanctity of life in different ways.

Detecting contradictions in the MCP by using moral principles and rules

Simply establishing the relevance of the principle of the sanctity of life is necessary but not sufficient to pursue a concrete moral discussion on abortion within the context of the MCP. Callahan in his framework proceeds to further define and clarify a '*singularly abstract and ambiguous*' principle (Callahan, 1970: 321). The principle, dependent on human interpretation, may be translated and expanded in many ways. This justifies additional effort to make sense about the principle of the sanctity of life by clarifying and adding content to the meaning of the principle and by establishing its relationships with associated rules (Callahan, 1970: 321).

Two elements are required for this effort. Firstly, it is necessary to add words and terms to further expand and clarify the meaning of the term '*sanctity'*. Through the addition of alternative terms such as dignity, worth, and importance or by applying different combinations of phrases a '*cluster of final meanings*' emerges (Callahan, 1970: 323). This process serves to establish that the purported indeterminateness and vagueness of the sanctity of life it is not meaningless as it seems, since it expresses the idea that human life in all states and stages should be '*affirmed, cherished and respected'* (Callahan, 1970: 323). Therefore, when we use the principle to interrogate lower

level rules, we are able to explore questions such as '*Do the rules foster respect for human life?*; and '*Do the rules lead people to protect human life'* (Callahan, 1970: 324)? When a '*no*' answer is provided to these questions it becomes possible to reject, modify or change the rule. The result of this clarification of the term '*sanctity'* enables the application of the principle to interrogate lower level rules (Callahan, 1970: 323).

Secondly, once the principle of the sanctity of life is further clarified, its relationship with rules needs to be established. A multiplicity of moral rules exist that aim to moderate and influence human acts, human relationships and moral dilemmas (Callahan, 1970: 324). Rules guide implementation and provide solid content to commitments associated with the principle. This creates a situation of reciprocity between rules and principles whereby rules add content to principles while principles judge rules (Callahan, 1970: 326). A further dimension to the discussion about rules focuses on the identification of relationships between rule systems (Callahan, 1970: 326). Greater exposure to the relationships between different rule systems provides a deeper understanding and meaning to the sanctity of life while illuminating relationships that constitutes the framework of rules and rule systems (Callahan, 1970: 326). Callahan writes

> '*Our rules should form a coherent system, each rule consistent with and supporting the other, both within particular rule systems and among them, and all in turn, serving and supporting the ultimate principle of the sanctity of life*' (Callahan, 1970: 326).

Callahan identifies five separate areas for rule systems related to the sanctity of life; survival and integrity of the human species, integrity of family lineages, integrity of bodily life, integrity of personal choice and self-determination, mental and emotional individuality and integrity of personal bodily individuality (Callahan, 1970: 327). Callahan contends that none of these systems have been excluded from the impact of medical, scientific, technological and social change. This, together with an increasing scope for moral decisions, has served to challenge traditional rules and force debate about whether the '*old rules*' still effectively serve the sanctity of life (Callahan, 1970: 327). Callahan proceeds to describe each of the rule systems in greater detail.

The survival and integrity of the human species. This rule promotes the survival of the human species; more specifically, the recognition by current generations that future generations will require adequate resources to survive on earth, that nations and individuals should not compromise the viability of the human species through irresponsible behaviors, and the responsible use of resources. It is assumed that the sanctity of life principle assists the development of moral rules

that protect human life writ large. Within the context of abortion, this system addresses '*eugenic'* and '*socioeconomic'* indications for abortion[45]. Any abortion that threatens the survival of the human species (or significant subcommunities) will be judged negatively against the sanctity of life principle (Callahan, 1970: 328-330).

The survival and integrity of family lineages. This rule promotes the freedom of individuals and families to procreate, determine family size and perpetuate family lineages. The state should not interfere with these freedoms including interference in procreative practices such as dictating who may or may not have children, or tamper with the process of procreation. The underlying intent is to ensure respect for voluntary procreative choice and family lines. Any rule that harms procreative freedom and family lineage falls within the sanctions of the sanctity of life (Callahan, 1970: 330-331).

The integrity of bodily life. This rule in its general application relies on the protection afforded fellow human beings to individuals to live and enjoy their lives. Couched in human rights language this is referred to as a fundamental *'right-to-life'*. This implies that neither the state nor individuals have the right to deprive from individuals their lives or allow social, economic, medical or political conditions to exert such an effect. The assumption underlying this rule is that the protection accorded to all humans and the preservation of life is similarly accorded to individuals. This system of rules extends protection to both the pregnant woman and fetus (Callahan, 1970: 331).

The integrity of personal choice and self-determination, mental and emotional individuality. This rule guides individual decision making and those choices which affect the individual's personal fate. It entitles individuals with the freedom to determine how to live their own lives. In rights language, this is referred to as the right to self-determination. The sanctity of life principle applies by ensuring respect for personal identity, choice and self-determination. This rule has no direct application to indications for abortions but is relevant when women request an abortion; it entitles women to personal choice that is free of coercion (Callahan, 1970: 332).

[45] Eugenics is a term used to describe the process whereby desired heritable characteristics are selected with the aim of improving future generations. It is typically used with reference to humans. https://www.britannica.com/science/eugenics-genetics

The integrity of personal bodily individuality. This rule addresses the protection afforded to individuals that prevents violation of an individual's body and the contents of the body such as organs. Rights language expresses this as '*right to bodily inviolability'*. Abortion-related questions arise where a refusal to do an abortion may affect a woman's bodily health or in instances of rape where abortion would correct an earlier violation of a woman's body (Callahan, 1970: 332-333).

Further comments are required to clarify and explain the relationship between the principle of the sanctity of life and the associated rules systems. Firstly, the five-rule system provides is broad-based and spans a diversity of topics (Callahan, 1970: 333). Secondly, the rule systems are not distinct but rather overlap and together constitute an unruly whole. For example, it is not possible to address the survival of the species and familial lineages without referring to the integrity of personal choice (Callahan, 1970: 334). The larger system of rules rely on a measure of alignment, consistency and harmony. This is compromised when rules or rule systems are drawn into conflict with one another creating some of the most difficult moral dilemmas such as occurs when rules about individual procreative rights conflict with rules that aim to address social issues such as overpopulation (Callahan, 1970: 34). Rule systems are subject to different interpretations from different perspectives; in some instances, a rule may pass the test of the principle when viewed from one perspective yet fail a similar test when viewed from a different perspective (Callahan, 1970: 335). An example is when fetal rights prioritized through the '*right-to-life'* rule come into conflict with the pregnant woman's '*right to self-determination*' rule.

The identification of these rules and their relationships enable us to scrutinize the internal consistency as well as guidance that flows from the policy (e.g. abortion cannot be considered as a method of family planning). The analysis of the MCP through the five areas of the rules system demonstrates how the MCP prioritizes the integrity of bodily life of the fetus over that of the pregnant woman even if she faces serious medical or mental health problems (*the integrity of bodily life)*. The same rule through its application within the MCP de-emphasizes the women's right to self-determination. This prioritization ignores or is dismissive of several rules as they relate to the pregnant women and the fetus. It does not allow abortion for socio-economic constraints even through families may be consequentially burdened through the addition of more children in poorly resourced and under-developed settings (t*he survival and integrity of the human species).* It impacts the rule that promotes the freedom of individuals and families to procreate, determine family size and perpetuate family lineages (*the survival and integrity of family lineages)*. It violates

women's capacity for personal choice and freedom from coercion when abortion as an option is under consideration (*the integrity of personal choice and self-determination, mental and emotional individuality*). In terms of personal bodily individuality, the MCP acknowledges instances of rape as an indication for abortion while it denies consideration for the impact of a pregnancy carried to term by a pregnant woman (*the integrity of personal bodily individuality*).

The MCP disrupts measures of alignment, consistency and harmony required by the five-rule system linked to the principle of sanctity of life. The disruption is caused by rules that are drawn into conflict thereby creating some of the most difficult moral dilemmas. The MCP is uninterested in harmonizing the dilemma created when fetal rights prioritized through the '*right-to-life'* rule come into conflict with the pregnant woman's '*right to self-determination*'. The MCP displays limited flexibility in its consideration of human situations and needs. This rigid approach leaves no place for alternative considerations that are associated with the flexibility that a principle aims to achieve; indeed, the purpose of the principle behind the principle of the sanctity of life is to enable the exploration of multiple, diverse issues framed by respect for human life which is '*affirmed, cherished and respected'* (Callahan, 1970: 323). The MCP restricts rather than encourages diverse perspectives.

Callahan outlines those issues that are important in moral policy development. Moral policy development depends on cultural, philosophical or religious inputs to devise, relate or order moral rules which may be selected, given or accepted. Communities differ in the way that these rules are ordered and arranged based on the moral polices that prevail in a particular community. The MCP displays little sensitivity to the origins and expressions of cultural, philosophical or religious issues in nations and communities, where moral policy about abortion legitimately should develop. Rather, as stated by Gillespie, the MCP acts as a lightning rod for US values and an instrument through which the country projects its beliefs and what the US '*believes others should believe'* (Committee on Foreign Affairs, 2008: 18).

Based on Callahan's proposed five-rule system, the assessment of the MCP shows several problems emerging. The MCP does not show itself to be aligned, consistent and harmonious. In addition, it creates and fuels the creation of moral dilemmas rather than attempting to reduce, contain or manage them. This has very practical consequences for persons impacted by the MCP through US foreign assistance. One such example is when a mother or parents may be denied an

abortion in instances where the fetus may display severe developmental problems thereby creating several long-term problems for the family unit. Similarly, women with unwanted pregnancies may be driven towards unsafe abortions to terminate their pregnancies with the associated harmful consequences.

Building moral policies drawn from the beginning of human life discussion

Callahan in his framework extensively discusses issues related to the beginning of human life. Since abortion stands at the heart of the MCP we cannot avoid some of the key issues that infuse controversy around the abortion debate, one of which is the issue of the beginning of life and its nuances. Abortion naturally associates the beginning of life and the killing of life. It raises the question at what point in the development of the embryo or fetus can we consider abortion as killing (Callahan, 1970: 377). The beginning of life is further complicated by the inability of biology to determine when human life begins. Justice Blackmum, who authored the Row v Wade decision, side-stepped this issue as follows:

> '*Texas urges that, apart from the Fourteenth Amendment, life begins at conception and is present throughout pregnancy, and that, therefore, the State has a compelling interest in protecting that life from and after conception. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer'* (United States Report (US), 1973).

According to Callahan two important questions inform the discussion about abortion; firstly, what is the relevance of the beginning of human life and secondly, as an adjunct to the previous question, when should value first be assigned to human life (Callahan, 1970: 349). This answer is provided by a generally understood conviction about the beginning of life which in turn determines whether we perceive life to be present in a conceptus or not. This issue may further be expanded to mean that while life may be present at a specific point in time it may not be assumed that life at that specific point in time is fully valued or in need of full protection. The moment when life is viewed to have begun may not necessarily correspond with the time when full protection from killing is required (Callahan, 197: 378).

To address the question at what point life attracts the attribute of '*value',* a moral policy is needed that addresses the question when life begins. This requires the joint contribution of moral policy

development assisted by a philosophical policy that defines the moment of the '*beginning'* (Callahan, 1970: 378). Three basic schools of opinion have developed in response to these two questions. One school relies on criteria dependent on data provided by genetics, the second assumes a development approach which relies on morphological criteria and the third relies on social criteria (Callahan, 1970: 378).[46]

The genetic school. John T Noonan describes the essence of this school: '*Once conceived, the being was recognized as a human being because he had man's potential'* (Callahan, 1970: 379). The key point is that conception by human parents entails the conceived being's humanity. The genetic argument proposes activation of life at the moment of conception; the period between conception and birth is a matter of subsequent growth and development. The genetic school enables a perspective that all fertilized ova need to be protected based on an assumption that the chances of destroying a particular human being through abortion is much more likely than destroying a being which does not a human potential (Callahan, 1970: 382). This point is made in a discussion that explores the likelihood that a particular fertilized egg is destined to develop into a fetus rather than aborting spontaneously or developing into a hydatiform mole (Callahan, 1970: 382). It is in effect a '*full protectionist policy*' with the embryo accorded the status of full equality with the pregnant women (Callahan, 1970: 397).

Arguments made by the genetic school meets several criteria outlined earlier. Genetic evidence is seriously considered, potentiality is acknowledged, criteria for the teleological perspective are met and the policy is '*safe'* from a moral perspective (Callahan, 1970: 381). An important criticism leveraged against the genetic school is that the development of the fetus is not determined only by its genotype but also by the interaction with the environment which contributes to the development of the phenotype (Callahan, 1970: 382). Sole reliance on a genetic foundation as the core of the argument produces a moral norm which respects all forms of human life without relative valuation between different individuals (Callahan, 1970: 395). Note how this statement aligns with the

[46] Callahan proposes that the beginning of life be assessed on the following four criteria. Firstly, any answer that refers to a single human characteristic as a core idea is suspect (a negative conclusion). Secondly, any answer to the question needs to incorporate the idea of potentiality (positive conclusion). Thirdly, the answer that rejects the biological and genetic basis in human development and individuality needs to be rejected (negative conclusion). Finally, the temporal course of life and human development is best analyzed through a teleological perspective (positive conclusion) (Callahan, 1970: 368).

comment by Reagan how all persons (US Citizens) '*need to recognize that the real issue is whether to affirm and protect the sanctity of all human life, or to embrace a social ethic where some human lives are valued and others are not (*2010)*.'*

In terms of guiding abortion decisions, the genetic school is manifest as a policy that contains abundant caution. As Callahan writes

> '*Put another way, by the logic of the genetic school the outcome of any abortion dilemma is de jure decided in advance: a pregnant woman is, by definition, a woman carrying human life in her; she may not, therefore, have an abortion*'(Callahan, 1970: 400).

The policy is clear and does not require the need to make distinctions based on the weighing and contrasting of lives. Its liability in abortion cases lies in the inability to do justice to a conflict of values, especially in terms of the pregnant woman. The approach of the genetic school can lead to socially unacceptable conclusions. The school claims the '*right-to-life*' to the exclusion of all other values (Callahan, 1970: 399). Certainly, other things have value. Does God, for instance, value the need for a qualitative life (Callahan, 1970: 400). Or put differently, when making choices about abortion, what other issues need to be considered when making the decision?

The developmental school. This school uses the genetic basis to signify the existence of human life but adds the requirement of further development before according the status to the embryo or fetus as an '*individual human being'* (Callahan, 1970: 384). This school is unable to elaborate what constitutes an appropriate degree of development before the embryo or fetus is recognized as an individual human being. Hayes suggests that the first fully fertilized cell with its package of genetic requires subsequent development to produce '*new form and function*' (Callahan, 1970: 384). Ehrensing proposes that the presence of actual neural material is required to attribute personhood (Callahan, 1970: 385). Schenk suggests that the transition point to humanness is reached when the fetus may be expected to exhibit self-awareness (Callahan, 1970: 385). These proposed distinctions enable further refinement of moral policy; if the embryo has not attained human personhood, it is possible to accord a greater weight to the welfare and interests of the pregnant woman over that of the developing human tissue (Callahan, 1970: 385). The developmental school tends to balance the interests of the fetus and the mother. A key criticism leveraged against the developmental school is that it relies on subjectively defined development norms that may be manipulated (Callahan, 1970: 390). Considering the wide range of possible development points, it becomes clear how slippery the choice of a development norm may be. Once a norm has been

established, in principle, the pathway is created for the abuse of the norm. The best course of safety is therefore to rule out the creation of such norms and prevent any possibility of manipulation of such norms (Callahan, 1970: 390).

In terms of guiding abortion decisions, the developmental school is manifest as a policy that is more nuanced and incorporates the genetic, biological foundation while acknowledging those factors that shape the forms and stages of developing life. From a moral perspective, the acknowledgement of distinctions in the shaping of developing human life in the womb, facilitates the choices required when making decisions about abortion (Callahan, 1970: 395). Abortion decisions can be constructed in accordance with the range of values that are stake and it allows the weighing and valuation of the different lives that need to be considered in such decisions (Callahan, 1970: 396). The school biases policy decisions toward the weighing of the interests of both the developing embryo or fetus and the pregnant woman as well (Callahan, 1970: 397). The major distinction here between the genetic and developmental school is that while both agree that individual human life begins at conception there is disagreement of the valuation of life that is accorded to life at conception (Callahan, 1970: 397). The consequence is that the developmental school argues for a moderate policy allowing the needed flexibility required when making difficult decisions that considers both the mother and the conceptus at conception and its subsequent stages of development (Callahan, 1970: 397).

The social-consequences school. Callahan draws from the work of Williams and Hardin to introduce the social-consequences school. Williams suggests that it is important to draw the distinction between the beginning of '*life'* and '*human life*'. Since conception, for instance, occurs when a live sperm fertilizes a live ovum and subsequently continues development as a live zygote and embryo it makes no sense to argue that life begins at conception (Callahan, 1970: 390). Hardin proposes that the major contribution made by parents is the transfer of information that scripts the further development of the fertilized ovum. The zygote which contains this information is not a human being and possesses no intrinsic value since little human effort has been invested in the zygote (Callahan, 1970: 391). The conclusion that can be drawn from Hardin and Williams is that it is a matter of definition rather than a matter of fact whether the fetus is or is not a human being. (Callahan, 1970: 391). Since abortion creates substantial human problems it is unwise to equate the fetus to a human (Callahan, 1970: 393). Hardin provides as evidence that no state (circa 1970) obligated similar treatment (burial obligations) of the dead fetus as compared to a dead person

(Callahan, 1970: 392). The school's approach highlights that adult human beings ultimately define what constitutes a human rather than relying on biological facts to determine the status 'human' (Callahan, 1970: 392). Given the conflict of values involved in the abortion dilemma and the preferences of women, the social-consequences school prefers to define '*human'* in a way that criteria do not prohibit abortion (e.g. where abortion is equated to murder) (Callahan, 1970: 392).

This school ignores biological data in determining the start of human life. The school does not take account of potentiality in its definition of human. It is apparent that the social-consequences school is interested in presenting an argument with a moral policy that is designed to permit abortions (Callahan, 1970: 392-393). The critical point Callahan makes about this school of thought is that '*human'* can be defined '*as one wishes*' which creates very dangerous social consequences through the extension of the same moral policy to the chronically ill, the senile, and the elderly with a justification for taking their lives (Callahan, 1970: 394). Luker points out the concerns of pro-life persons about the fact that human can be defined as '*one wishes*' in the following statement: '*If the rights of personhood can so easily be taken from babies (embryos), who among us will be next'* (Luker, 1985: 156)*'*

The school biases decisions toward the interests of the pregnant woman in need of an abortion while downgrading the value of the zygote or embryo (Callahan, 1970: 397). The school's approach leads to socially unacceptable conclusions which assigns the status of '*social utility*' to '*humans'* (Callahan, 1970: 400). The denial of human status to the conceptus when abortion is being considered, removes the need for making judgements in individual cases or the need to weigh opposing values that may be in conflict with one another (Callahan, 1970: 401). Since the weighting is so heavily in favor of the pregnant woman the moral problem is '*defined out of existence*' in advance. The consequence is that rather than seeking to extend the protection of human life this approach serves to narrow it (Callahan, 1970: 401).

The insight from the schools of opinion adds greater perspective to the MCP. The MCP follows the approach of the genetic school through the simple and concise application of the emphasis on life which begins at conception. The genetic school prioritizes a '*full protectionist policy*' with the embryo accorded the status of full equality with the pregnant women (Callahan, 1970: 397). The consequence of this approach is that there is limited flexibility in decision-making when faced with difficult choices that impact both the pregnant woman and the zygote and fetus from

conception through the subsequent stages of development. Flexibility is reduced to those situations where the life of the pregnant woman is endangered by the pregnancy or pregnancy has followed rape of incest. The reality is that the woman and fetus are subject to a broader range of issues both within the womb and after birth – these issues are not acknowledged through the MCP. This inflexibility is untenable with the demands of real life suggesting that some form of compromise is necessary. Compromise necessitates the consideration that while human life has great value it does not have absolute value (Van Niekerk, 2006). Meyer and Nelson make the point that sometimes people are necessitated to kill things despite the existence of a deep respect toward the being that is killed (Meyer and Nelson, 2001). Native American hunting cultures held the animals they hunted in high regard and killing was associated with a high level of reverence (Meyer and Nelson, 2001). The Japanese follow a ritualized practice, *miziku kuyo*, to honor the spirits of their actively aborted fetuses (Meyer and Nelson, 2001). These examples suggest the development of a more nuanced approach about life and death decisions in acknowledgement that the value of life is not absolute and that humans play an influential role in determining moral policies. We can only return to the observation by Luker that thoroughly emphasizes how persons experience the loss of abortion '*the demon of pro-life people is guilt while the demon of pro-choice people is anxiety*' (Luker, 1985: 185-186). These emotions connect a decision about the great value of life together with the need to intervene with a human decision. This is the essence of the human compromise required when faced with the dilemma of an unintended pregnancy, especially when many other issues are involved.

The presentation of the three different schools of opinion bring three issues to the fore in terms of the MCP. Firstly, the source of coercion, conditionality and prescription is now clearly apparent through the reliance of the MCP on the approach of the genetic school. Secondly, greater insight into its limitation of application is gained. The perspectives of the developmental and social consequences school illustrate the broad range of views that may be held when considering the moral issues related to abortion which in turn reflects the diverse views and perspectives of societies and communities. By contrast, the MCP with its origin in the genetic school represents only a narrow segment of perspectives. Finally, the reasoning behind the strong objections to the MCP by institutions such as IPPF and MSI clearly emerge. Both IPPF and MSI have a strong focus on maternal rights and the ability to make reproductive decisions through choice rather than coercion. The fact that pro-life persons largely find themselves in the camp of the genetic school

and pro-choice persons find themselves somewhere in or between the camps of the developmental and social-consequences schools explains the intensity of the conflict around abortion.

Comments

This chapter began with the question whether the MCP, as such, has an internally coherent structure that validates its restrictive approach and justifies global application. The MCP is largely rooted in narrow religious perspectives, mostly Catholic and Evangelical. The discussion on the principle of the sanctity of life demonstrates that religion is not the sole basis for validating this principle. Non-religious perspectives exist that similarly validate the principle of the sanctity of life. A further weakness that can be attributed to the Christian-based validation of the principle of the sanctity of life is that it cannot be applied globally across a diversity of cultures. This creates a significant weakness for the MCP.

The application of the five-rule system described by Callahan highlights the inability of the MCP to be aligned, consistent and harmonious. In addition, it creates and fuels the creation of moral dilemmas rather than attempting to reduce, contain or manage them.

Finally, the schools of opinion demonstrate the moral source of the MCP. The moral source of the MCP, based on insights drawn from the other schools of opinion, is contestable in a diverse and pluralistic society and, in addition, illustrates why certain groups react strongly in opposition to the MCP. We can conclude that several arguments can be made that contests the internal coherence of the MCP which exposes weaknesses in the moral foundation of the policy.

Evaluating the impact of the MCP on the external world

A first question that emerges when evaluating the impact of MCP enactment on the external world is to determine the point of departure. Since the MCP as applied by the USG is ultimately expressed externally through American foreign assistance, I propose to turn towards the emerging framework provided by global health ethics. According to Hunter and Dawson, global health ethics identifies global wrongs related to health and aims to address global injustice (Hunter and Dawson, 2011: 78). Van Niekerk writes that global health ethics raises questions of justice as it relates to inter-societal health care delivery (2005: 89). It emphasizes a macro and meso level of health which addresses order and justice in communities and emphasizes equitable access to health care, public health and the common good and incorporates elements of justice, '*social contract*' and utilitarian

perspectives (Benatar, 2005: 77). The MCP and its related consequences needs to be evaluated at the macro and meso levels to the greater extent since much of its impact is felt at the population level. Therefore, much of the following discussions find themselves anchored in concepts that arise from global health ethics.

In order to proceed systematically, I will initially define the approach through which the MCP and its impact on the external world can be evaluated. The second step will be to apply the evaluation approach. The final step is to confirm, whether it is possible to justify harm that may be associated with the MCP.

Developing the approach to evaluate the impact of the MCP on the external world.

Daniels suggests that health inequalities emerge between social groups when the unjust distribution of socially controllable factors affect population health (Daniels, 2011: 97). Ten Have supports this notion by suggesting that inequities emerge when health differences can be avoided and are unnecessary (Ten Have, 2016: 220). The idea of the emergence of health inequalities suggests that a full execution of the evaluation of the MCP requires the establishment or exclusion of the existence of inequalities and inequities that may follow MCP enactment.

Daniels continues to further clarify the concept of inequality. Inequality does not necessarily signify inequity if the health differences emerge because of health practices in different social groups that may lead to better outcomes (2011: 98). For instance, a religious group representative of a social group may not experience certain health problems as a result of the group's behaviors. One such example is provided by nuns who are not exposed to cervical cell carcinoma since they practice celibacy. In addition, the explanation of the origin of injustice and inequality within a particular society cannot necessarily be extrapolated to infer that inter-societal health inequalities are unjust (Daniels, 2011: 98). Therefore, justification is required to reach a conclusion that inter-societal health inequalities indeed exist and are unjust. In order to develop a strategy that is able to determine the existence of inter-societal inequalities Daniels suggests a marriage of '*cosmopolitan'* and '*statist'* approaches (2011: 98). The '*cosmopolitan'* approach suggests that a disadvantage that any person suffers through no fault of their own can be viewed as unjust. This same principle of justice applies to all persons globally and no distinctions are drawn between individuals (Daniels, 2011: 98). Beauchamp and Childress explain this approach as drawing from

Singer's theory of utilitarian beneficence and which focuses on the obligations of persons and governments to address injustices (2013: 278). Cosmopolitanism is enhanced by the addition of '*statist'* principles of justice that originate from nations or states as developed by Rawls and Nagel (Daniels, 2011: 98). Daniels' proposal is to marry the two different approaches (cosmopolitan and statist) and develop a minimalist strategy that defines an international obligation of justice. The approach is characterised by the avoidance of harm to people or by '*causing deficits*' in their ability to achieve their human rights (Daniels, 2011: 98). The essence of this '*marriage'* is determined by a reaching common agreement on the negative duty not to harm while acknowledging that positive duties may continue as a source of disagreement (Daniels, 2011: 98). The example of charity and foreign aid fall within the realm of positive duties. In many instances, charity and foreign aid do not address the '*injustice of social structures*' (Ten Have, 2016: 221). An example is provided by international food relief that often distorts and damages local food production over the longer term (Ten Have, 2016: 221). The distinction of a negative duty not to harm and an agreement to disagree about ensuing positive duties provides an additional criterion to evaluate the MCP.

Finally, Daniels identifies sources of inequality. Three sources of international health inequality are defined – firstly, domestic injustice, secondly, international inequalities that arise from natural factors such as poor availability of natural resources or socio-economic constraints that derive from problems of human capital or political culture and thirdly, inequality that arises from international practices such as treaties that may harm the health of countries (Daniels, 2011: 101). The MCP fits into the third category allowing us to determine the impact of an international practice such as a treaty on the health of a country.

Pogge suggests that if a country pursues a practice or policy that worsens the health of those in poorer countries and which also decreases the prospects of realizing a human right to health or health care then a '*deficit'* in human rights is created (Daniels, 2011: 98-99). If this deficit falls short, when compared to existing international standards of justice that strongly promotes the protection of human rights, then a harm is established. A harm established through imposition is considered as unjust (Daniels, 2011: 98-99). Ten Have complements Pogge's ideas by suggesting that wealthy countries have a duty not to impose a '*harmful global order*' on poor countries (Ten Have, 2016: 221). A final evaluation criterion can be distinguished which is to determine whether there is any reason that harm and injustice that follows MCP enactment is potentially justifiable.

This discussion now provides the tools through which the consequences of the external impact of the MCP may be evaluated. These tools should contribute toward the confirmation or rejection of the assumption that the MCP represents a just policy intervention.

Assessing the consequences of MCP enactment.

We can now proceed with the evaluation of three aspects as they relate to the MCP. Firstly, establish whether MCP enactment increases or decreases inequalities and inequities, secondly, whether we can establish a clear negative duty not to harm and thirdly, to determine whether the MCP can be considered as a source of inequality.

Health inequalities reflect significant health differences that exist between countries. For instance, the life expectancy in one country may be much higher than in another country. Or a child may be much more likely to die before the age of 5 in one country compared to another country. Emerging evidence following enactment (the causal relationship) of the MCP demonstrates either the maintenance of existing inequality or a widening of inequality. The Congressional Hearing in 2007 on the MCP heard evidence from Ghana that the young Ghanaian adolescent has a 1 in 35 chance of dying in childbirth compared to one in 2500 pregnant women in the USA (Committee on Foreign Affairs, 2008: 33); this suggests a huge inequality. The enactment of the MCP in Ghana has been shown to increase abortion rates by 50 % among rural women (Jones, 2015: 56-57). It is likely that the increase in abortions will contribute to increased morbidity and mortality among rural women. This suggests that in Ghana it is unlikely that MCP enactment will contribute toward decreased inequality based on the increased incidence of induced abortions and its associated sequalae. Marie Stopes International reported in January 2019 that they continue to face a funding gap of $50 million. This gap amounts to an estimated 1.8 million unintended pregnancies, 600,000 unsafe abortions, and 4,600 preventable maternal deaths (Marie Stopes International, 2019). In periods when the MCP is not enacted, services would be available and the sequence of unintended pregnancies, unsafe abortions and maternal deaths would in all likelihood be reduced. We can conclude that the MCP is associated with either the maintenance of the status quo of inequality or an increase in inequality.

The next step is to establish whether the negative duty not too harm can be validated during MCP enactment. Republicans in Congress provide a perspective on the meaning of the negative duty not to harm. Firstly, they claim that abortion rates have declined during periods when the MCP has

been active (Committee on Foreign Affairs, 2008: 3). Secondly, they deny that the enactment of the MCP has endangered the lives of women by providing no exceptions for abortion as the MCP allows for abortion in instances of rape, incest or if the life of the pregnant woman is endangered by the pregnancy (Committee on Foreign Affairs, 2008: 3). Thirdly, the MCP also allows women to receive compassionate care when post-abortion care services are required and does not block '*passive'* referrals when a woman who has decided to abort a child, directly requests information from a health worker about abortion (Committee on Foreign Affairs, 2008: 3).

The work of Bendavid and Brooks suggests that the incidence of induced abortions increase rather than decrease when the MCP is enacted (Bendavid, Avila and Miller, 2011: 873; Brooks, Bendavid and Miller, 2019: 1). Both authors conclude that the MCP is associated with increases in abortion rates in sub-Saharan African countries. This is likely to lead to increased morbidity and mortality among women. While the MCP indeed allows for abortion in select instances it is likely that with the withdrawal of international NGOs and their local affiliates during periods of MCP enactment may reduce access to these services. The reduction of services is also likely to impact women seeking post abortion care or those seeking referral to abortion services. The MCP in addition creates indirect harms through its restrictions that limit the ability of providers to provide services in accordance with their local standards of professional ethics. The restrictions placed on passive referrals for abortion services exemplify the obstacles that women need to navigate as they seek abortion services.[47] Evidence suggests that the MCP is unable to comply with the negative duty not to harm.

Different stakeholders contribute toward this harm based on their ideological stance. The ideology of the USG is well known through its statements on the elimination of abortion. Organizations such as IPPF and MSI take opposing positions on abortion that further contribute to the creation of harm although probably not at a commensurate scale. The contradiction that emerges, especially for IPPF and MSI, is that in many of the countries where the MCP would apply and where they are providing services already have legislation in place to prevent abortion on demand (Bingenheimer and Skuster, 2017: 283). The question can then be asked, if in those countries where

[47] Health workers may provide a passive response to a question where a safe, legal abortion may be accessed; this is not considered as active promotion of abortions. The passive response is further qualified; she has already made the decision to have a legal abortion, she inquires specifically about the location and availability of abortion services, and safe abortion is legally available per national guidance and policy.

IPPF and MSI are active and where access to abortion is limited, whether it is justifiable to withdraw from service provision since IPPF and MSI by definition should be in in compliance with national abortion legislation? In addition, other organizations display a more pragmatic approach and accept the restrictions imposed by the MCP thereby preventing disruption of service provision during periods of MCP enactment.

Given the context described above and IPPF and MSI's reluctance not to sign the MCP despite existing abortion restrictions that exist in many countries, several questions can be raised about their position. The framework by Callahan lays out the respective positions people may hold on abortion. It could well be that the positions of these organizations are so strongly anchored in rights and choice that they choose to ignore the consequences of withdrawal from service provision when the MCP is enacted to the detriment of recipients of services. It may also be that the MCP has so deeply affronted these organizations by the dramatic intrusion of the policy restrictions on their service provision and advocacy activities that they therefore decide to oppose the MCP out of principle. These positions raise the question to groups such as MSI and IPPF whether a more pragmatic responses to MCP enactment is not required?

Finally, it is clearly established that the USG enacts the MCP to be applied in other countries. We can conclude that the MCP, as a representative example of an international practice such as a treaty, contributes toward increased inequality which is unnecessary and avoidable.

The evaluation of these three aspects of the MCP establishes that MCP enactment is likely to increase inequality, that the existence of a negative duty not to harm cannot be validated and that it represents an example of an international practice capable of producing inequality. What remains is to determine whether harm and inequality caused by the MCP is justifiable.

Can the MCP be justified despite the harm it seems to contribute towards?

The MCP introduces a significant shift compared to the Helms Amendment which simply aims to prohibit the use of US foreign assistance funds to pay for abortions in foreign nations. Through the MCP, conditionality progresses to the imposition of active measures to oppose abortion in all countries where USG support is provided. Gillespie commented in the Congressional Hearing (2007) that the persons who formulated the MCP wanted to eliminate the fungibility issue, they wanted to eliminate any ambiguity about the US position on abortion and they wanted to stop

abortion service delivery, legal or illegal, safe or unsafe as well as any activities aimed at making abortion legal and safe (Committee on Foreign Affairs, 2008: 18).

One way to explore harm related to the MCP and to determine whether the harm may be justified is to compare the harms associated with periods where the MCP is inactive with periods when the MCP is active through the rule of double effect (RDE). During periods of MCP inactivity, the Helms Amendment applies; US foreign assistance is prohibited from paying for abortion as a method of family planning or to motivate or coerce the practice of abortion. Organizations such as IPPF and MSI provide family planning services in accordance with national legislative guidance and non-USG funds may be used to support abortion activities. When the MCP is enacted, additional conditions are applied to those of the Helms Amendment and organizations such as IPPF and MSI reject USG funding. Enactment of the MCP and withdrawal of service delivery through IPPF and MSI is associated with several harms as previously discussed; harms can be attributed to the additional restrictions that are applied through the MCP.

The RDE represents an attempt to justify that a single act, which has one good effect and one harmful effect, is at times morally acceptable. The example that is often provided is that the risk of death or the actual act of dying is justifiable as a consequence of treatment in those instances where someone is treated for severe pain and suffering. If the treatment is not provided, then the suffering person will be subject to severe pain and suffering. Should the physician provide treatment for this pain and suffering then death may be hastened. The reasoning then follows that since treatment was provided to relieve the pain and suffering and the intention was not to cause death then the act of increasing the risk of dying or hastening death is not immoral. Four conditions apply to the RDE. Firstly, the nature of the act must either be morally neutral or good and is independent of the consequences. Secondly, the intent of the agent is aimed at producing a good and not a bad effect. The negative effect may be foreseen, tolerated and permitted but not intended. Thirdly, an important distinction between bad and good effects is that the bad effect should not be the means to achieve a good effect. If the bad effect causes the good effect, then the intent of the agent is viewed as applying the bad effect to cause a good effect. Finally, the good effect must be larger than the bad effect; the bad effect is allowable since the good effect adequately compensates for the anticipated harm (Beauchamp and Childress, 2013: 165).

Applying the RDE during periods when the MCP is inactive and only the Helms Amendment applies, suggests that the reduction of abortions through the prohibition of support for abortion can be considered as the good effect. Bad effects are minimal since institutions continue to provide family planning service delivery and can use private funds in support of abortion activities – a full package of reproductive health services are available. Harm is therefore minimized and the RDE is minimally applicable. Applying the RDE during periods when the MCP is active suggests that the avoidance of abortion through the enhanced prohibition of support for abortion signifies the good effect. It is clear from earlier discussions that harmful consequences (the bad effect) accrue during periods when the MCP is active. Harmful consequences can be described in different ways. There is a set of ultimate consequences which present themselves at the level of public health such as reductions in service delivery, increased numbers of unwanted pregnancies, more unsafe abortions and increased numbers of maternal deaths. There is also a level of proximate effects such as restrictions on self-determination and autonomy of organizations, gagging of health workers to provide a full range of reproductive health care and restrictions imposed on pregnant women whose health may be compromised by the pregnancy or the imposition of giving birth to a child with severe deformities in settings with limited access to health and social support. The MCP exerts its impositions at the level of proximate effects.

We can then apply the RDE to determine whether the good effect may be justified by the bad effect by exploring the extent to which the four conditions may justify the double effect. Each condition is necessary and together the four conditions constitute sufficient justification for morally permissible actions. *The first condition stipulates that the nature of the act must either be morally neutral or good and is independent of the consequences.* There appears to be general consensus that most persons would prefer to see either a reduction of or avoidance of the need for abortions including persons with pro-choice views (Luker, 1985: 179-180; Dworkin, 1994: 73). A reduction in the incidence of abortions leads to a decrease in the abortion-related morbidity and mortality and the social impacts related to abortion such as individual guilt and societal conflict. However, when restrictions are applied through the MCP, a direct line can increasingly be drawn between policy enactment and harm – this violates the stipulation of independence from consequences. *The second condition is aimed at establishing that the intent of the agent is aimed at producing a good and not a bad effect*. US foreign assistance, when viewed from a health perspective, is unlikely aimed at causing harmful effects whether the MCP is active or inactive. In both situations

allowance is made for abortions under certain circumstances (the mother's life is at risk due to the pregnancy or in instances of rape and incest) and post abortion care is allowed for those women who have undergone an abortion. During periods when the MCP is active, it is increasingly becoming apparent that harm may be foreseen although it is not clear to what extent agents who apply the policy may tolerate or permit harmful consequences. Supporters of the MCP argue that service provision lapses, when organizations refuse to comply with the MCP, will be filled by other organizations capable of similar service delivery capacity. Hence, the argument goes, harm will not occur or will be minimized. Provisions of the MCP are silent on other aspects of harm such as gagging health workers to discuss abortion as an option that may be available to pregnant women or managing the impact of the pregnancy on the mother's physical or mental wellbeing or managing fetal abnormalities identified during pregnancy. The MCP cannot clearly be shown to breach this condition.

The third condition stipulates that the bad effect should not be the means to achieve a good effect. If the bad effect causes the good effect, then the intent of the agent is viewed as applying the bad effect to cause a good effect. Drawing a distinction between means and effects and concluding that the bad effect does not provide the means to the good effect requires thorough analysis to determine whether the MCP meets this particular condition for the RDE. The restrictions imposed through the MCP intends to reduce or totally avoid abortions through different mechanisms. Firstly, restricting the capacity of organizations to access non-USG funds limits their rights to self-determination and autonomy as an organization while forcing them to reduce or cease their service delivery activities with several consequences. Secondly, restricting health workers from providing a full package of reproductive health services imposes on the obligation to provide ethical care that originates from the fiduciary nature of the patient-provider relationship. Thirdly, restricting abortion as an option for women who face health challenges as a consequence of a pregnancy or from making a choice whether she wants to carry an impaired fetus to term severely imposes on her autonomy as an individual. Hence, through consideration of the proximal bad effects described above, it becomes clear that the reduction of abortions (good effect) is based on the application of proximal bad effects which become the instruments for achieving the good effect of avoiding abortions. I contend that the condition that the bad effect should not serve as the means to achieve the good effect suggests that this particular condition of the RDE cannot be met. *The final stipulation suggests that the good effect must be larger than the bad effect; the bad effect is*

allowable since the good effect adequately compensates for the anticipated harm. The burden of morbidity and mortality that is emerging from those periods when the MCP is active suggests that the harmful effects are likely to outweigh the good effect of preventing abortions. This is especially so when scientifically there is no proof that indeed the MCP contributes to decreased rates of abortions but rather serves to drive abortions underground with significant associated morbidity and mortality. The mere fact that about one in four women in the United States may have an abortion during their lifetimes and the reliance on abortion as a method of family planning as described in France suggest that a world free of abortions is a futile exercise for the foreseeable future (Bajos *et al.*, 2014; Guttmacher Institute, 2017).

By applying the RDE to compare the harmful effects between periods when the MCP is active and inactive enables us to develop a clearer picture of the harmful consequences related to the MCP. It is not possible to meet the four conditions required by the RDE to justify the harm (the bad effect) associated with the MCP (the good effect of reductions in the number of abortions) as morally acceptable. We can conclude that injustice follow the enactment of the MCP and that the harm associated with MCP enactment is unjustified.

Comments

The evaluation of the MCP and its impact on the world shows that MCP enactment firstly, is likely to add rather than decrease existing inequalities and inequities, secondly, that it is not possible to establish a clear negative duty not to harm, thirdly, that the source of inequality follows from international practices such as treaties that may harm the health of countries and finally, that injustice following the enactment of the MCP and the associated harm is unjustified. The assumption that a just policy, at the least, would not lead to an increase in global health inequality or, at best, a decrease in global health inequality cannot be validated.

Evaluating the legitimacy of the conditionality attached to the MCP

The essence of the MCP lies in its restrictive approach aimed at reducing abortions. This raises the question whether these restrictions can be validated based on ethical principles that underlie the attachment of restrictions? Two larger questions may assist in the assessment of this question. Firstly, does the attachment of conditionality meets it intended objective which is to reduce the

occurrence of abortions? Secondly, does it meet those ethical standards attached to the impositions of restrictions in foreign assistance?

The MCP restricts financial support to those institutions who refuse to certify that they will not provide or promote abortion as a method of family planning. This restriction is a form of '*conditionality'* that refers to conditions and restrictions that are attached to recipients of foreign aid by donor governments (Collingwood, 2003: 55). The essence of conditionality is that it is a form of power that links the promise of aid with the threat of sanctions (Collingwood, 2003: 55). Collingwood approaches the analysis of conditionality through the lens of the provision of financial aid to recipient states, especially institutions such as the World Bank or International Monetary Fund. Here the conditionality is associated with the idea of good governance (Collingwood, 2003: 55).[48] In the case of the MCP, the conditionality of good governance can be replaced by the conditionality imposed on service provision provided through international NGOs associated with family planning and reproductive health service delivery.

The attachment of often '*deeply intrusive*' conditions, that are not morally defensible, has been taken for granted by the development community although its legitimacy has rarely been questioned (Collingwood, 2003: 55). Conditionality cuts to the core of what relational issues are between institutions and recipient countries. For instance, the question is raised by drawing examples from Collingwood's paper '*what these institutions (e.g. World Bank, International Monetary Fund) are for, in whose interests they should act, and how deeply they should be involved in the recipient countries' internal affairs'*(Collingwood, 2003: 56). In her paper, Collingwood explores whether it is morally defensible to attach good governance as a condition for aid.

Two arguments support unconditional aid. Firstly, there is the perspective that the North has a duty to aid the South for reasons of historical injustice or structural inequality (Collingwood, 2003: 57). This notion of recompense for historical injustices and structural inequality is not restricted to conditionality only but emerges in the discussion about justice and harm in global health (Hunter and Dawson, 2011: 80). Secondly, following the ideas of Peter Singer, political conditionality is

[48] Good governance includes the following elements: increased public accountability and transparency; respect for and strengthening of the rule of law and anti-corruption measures; democratization, decentralization and local government reform; increased civil-society participation in development; and respect for human rights and the environment. https://www.ucl.ac.uk/dpu-projects/drivers_urb_change/urb_economy/pdf_glob_SAP/BWP_Governance_World%20Bank.pdf

perceived as immoral since it prevents the immediate provision of aid and prolongs suffering (Collingwood, 2003: 57).[49] Singer's ethical approach is countered by the problem of unrestricted aid which may be easily abused where governance is poor and associated with corruption and theft. Historical and structural arguments are countered by the example of abuse of resources if there are no strings attached in nations lead by dictators or repressive regimes (Collingwood, 2003: 58). A further perspective is that when aid is unconditional, there may be no positive outcome or results in recipient countries, or the situation may even worsen (Collingwood, 2003: 58). Benatar points out the important role that developing nations have to manage donor aid in a responsible fashion (2005: 5).

Overall there is a tendency to add conditions to foreign aid. Two moral arguments exist in support of conditionality. The first moral justification is that intended beneficiaries should not be harmed through the distribution of aid such as may occur when economic support is provided to corrupt or repressive governments (Collingwood, 2003: 59). Secondly, aid should be effective and reach its intended beneficiaries. In this way aid can be targeted toward the needy while ensuring that it is used for the appropriate purposes such as health care or provision of water and sanitation (Collingwood, 2003: 58-59).

The attachment of conditions needs to be constrained to an extent in order to prevent repressive interference or coercion. The question should be asked to what extent conditionality should apply before being perceived as repressive interference? Especially, in instances of economic desperation when countries may be economically vulnerable, does this entitle donors to attach conditions as they see fit? And when does conditionality assume a coercive nature (Collingwood, 2003: 60)? Donors tend to deny that their aid is coercive in nature, but this claim is undermined by the vulnerability of recipient nations whether it be for economic or other reasons (Collingwood, 2003: 61). The idea of coercion may be counteracted by stating that recipient states have the choice to accept or reject aid (Collingwood, 2003: 62). However, many states have limited options due to socio-economic or other reasons which increases the risk of being coerced. In these situations, it becomes possible for donor states to impose conditions that may be viewed as a form of '*cultural hegemony*' including the imposition of values foreign to recipient states (Collingwood, 2003: 62).

[49] Collingwood uses Singer's analogy of the child drowning in the lake who needs immediate assistance rather than delaying assistance; delay is unforgivable (Collingwood, 2003: 57).

Collingwood argues that limitations should be placed on conditionality for two reason. Firstly, she indicates that there is great and unavoidable tension between conditionality and the right to self-determination. Secondly, she argues that the rules of the international economy are, similar to governance of individual countries, equally contestable and are indeed in need of reform (Collingwood, 2003: 56). She reaches two main conclusions. Firstly, the use of conditionality should be anchored in the idea of basic '*human rights*' and supported by more '*equitable'* rules in the global economy. Secondly, encouraging good governance in states needs to be accompanied by the '*greater democratization*' of international institutions (Collingwood, 2003: 56). In terms of the MCP the issue of basic '*human rights*' and more '*equitable'* rules are most relevant.

Application to the MCP. Collingwood's ideas when applied to the restrictions imposed by the MCP allow several issues to emerge. The idea that restrictions should aim to prevent harm and reach intended beneficiaries is compromised by the MCP. The accompanying increase in unintended and unwanted pregnancies, demand for abortion and additional social stress related to caring for children in poorly resourced settings is likely to increase harm and suffering for both individuals and families and societies at large. The increasingly strong evidence about the effect of the MCP in terms of promoting rather than preventing unsafe abortions is one example of how harm and suffering is increased through increased morbidity and mortality that is associated with unsafe abortions. Aid to beneficiaries is reduced as international NGOs withdraw and reduce family planning service provision in many countries. This fuels the cycle of unsafe abortions and other negative effects when the MCP is enacted. Following Singer's perspective on unconditional aid and the idea of the child drowning in the lake, the effect of the MCP and its associated restrictions is to stop or delay the provision of aid with consequent suffering. Since the objective of the MCP is to decrease the occurrence of abortion, reality dictates that this objective is not achieved.

The impact of coercion related to the MCP is felt in several ways. Through the restrictions placed on the discussions about the promotion of abortion, it discourages conversations that aim to acknowledge and discuss the problems associated with unsafe abortions and population growth in many countries, especially those with existing repressive legislation against abortion. It impacts effective patient – health worker relationships since the health worker is often not able to provide an appropriate range of reproductive health services. One of the purported benefits of conditionality is to encourage states to change their behavior as a condition for receiving aid. It

will be argued later that states have a duty to protect their citizens from the negative impacts of donor aid. With increasingly strong evidence emerging that the MCP has a negative impact, the duty falls to the state to protect the rights of its citizens from the harms imposed through donor conditionality (DeCamp, 2011: 123). However, states with limited options due to socio-economic or other reasons are weakened in their ability to withstand the imposition brought by the MCP. In these situations, it becomes possible for donor states to impose conditions that may be viewed as a form of '*cultural hegemony*' including the imposition of values foreign to recipient states (Collingwood, 2003: 62). This idea was clearly formulated by Duff Gillespie in his presentation to Congress where he likened the MCP to a '*lightning rod*' for American values while the Christian Right has indicated the need for "*moral values*" to anchor American foreign affairs activities (Committee on Foreign Affairs, 2008: 18; Martin, 1999: 79). Finally, the MCP impacts on the rights of individuals to make individual reproductive choices as has been alluded to while the autonomy of institutions and organizations to accept funding from non-US sources or engage in activities based on their own choice is impacted. In this way Collingwood's suggestion that the use of conditionality should be limited and be anchored in the idea of basic '*human rights*' and supported by more '*equitable'* rules remains a valid observation. We can draw the conclusion that, overall, ethical standards that are proposed for conditionality are breached by the MCP.

The ethical problem of reducing and scaling up service delivery

This aspect speaks to firstly the disruption caused by change every four to eight years as political administrations change, and secondly raises the question what obligations rest on the USG and other providers in terms of ensuring the service provision is not reduced or summarily stopped. The literature seems apparently silent on the ethical obligations of donors when they reduce support or change the package of support for recipient nations. This issue is being discussed as reductions of PEPFAR support occurs for middle-income countries such as South Africa. Davis writes that the reductions of funding for HIV/AIDS in middle income countries can be viewed as a human rights violation (Davis, 2019).

The USG is the major donor of family planning funds globally. These funds support the procurement of family planning methods, support training of health workers and funds are also channeled to service provision organizations (USAID, no date a). An example from MSI following the re-enactment of the MCP by Bush in 2001 suffices to explain the impact on service provision.

MSI Kenya was forced to reorganize its service delivery structure, raise service fees, terminate about 20 percent of its staff, reduce the salaries of remaining staff, and cut back on the services they offered in order to avoid having to close seven clinics and a nursing home. The diminished service delivery impacted more than 300,000 clients and left one of the poorest urban communities without a clinic to provide health services. (Center for Health and Gender Equity, 2018: 17).

In the absence of clear-cut answers or guidance the following ideas can be considered in framing obligations. When service provision with donor funds is initiated, it is likely that a relationship is established between the service provision organization and patients receiving services. Patients, especially in under-resourced settings such as slum settings or rural community settings, may come to depend on this form of service provision especially when few or no other services are available. A woman receiving family planning methods therefore expects on a regular basis to receive a supply of contraceptive pills, condoms or longer acting methods such as hormonal injections that provide protection against pregnancy for up three months. Women may also receive longer term methods such as intra-uterine devices or implants. Service provision is essential not only for providing methods but also for managing side-effects that may occur. Withdrawal or reduction of services of this nature therefore are likely to have a significant impact on communities dependent on these services. Two ethical norms can assist in framing an ethical response. Firstly, we can draw from obligations of a similar nature that exist to manage physician-patient relationships and the termination of a patient-physician relationship. The American Medical Association provides guidance that the physician has an obligation to support '*continuity of care*' for their patients (American Medical Association, no date).[50] This obligation includes notification by the physician of an intent to terminate the relationship and support for transfer of care when appropriate [textbox]. This concept is similarly supported by the World Medical Association (WMA) who insist that patients are entitled to receive the information they need to provide informed consent and that continuity is provided even when providers do not provide abortion services (Barot, 2017:

[50] Code of Medical Ethics Opinion 1.1.5

Physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients. At the beginning of patient-physician relationship, the physician should alert the patient to any foreseeable impediments to continuity of care. When considering withdrawing from a case, physicians must:(a) Notify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician.(b) Facilitate transfer of care when appropriate (American Medical Association, no date).

76). Secondly, and closely related to the issue of continuity of care, the '*duty of care*' concept outlines the responsibility of a health worker to '*reduce or limit*' the amount of harm or injury that may be caused to the patient (Australia Department of Health, 2004).

While this guidance addresses the interaction between patient and health worker it serves as a starting point as to how those who fund, and support service delivery can be held more accountable. The Office for the High Commissioner for Human Rights through its General Comment No.14: *The Right to the Highest Attainable Standard of Health (art.12)* in 2000 provided guidance on standards of health for nations (United Nations, 2017). The Right to Health is qualified by four '*interrelated and essential elements*'. Firstly, the argument is made for the availability of services in sufficient quantities in nation states. Secondly, health services need to be accessible to citizens of nation states. Accessibility encompasses four concepts; prevention of discrimination, physical access, economic access (affordability) and information access (which is the opportunity to seek and discuss information about health and health services). Thirdly, health services need to be acceptable and respectful. Finally, service provision should be of an acceptable quality (United Nations, 2017). While much of these ideas are aspirational in nature it does begin to indicate the obligation of the state and the types of health services that need to be provided. There are many instances, for example PEPFAR, where donors provide direct support for service delivery. When this support begins to complement resources provided by governments, substantive consequences emerge when donor support is reduced our cut (McNeil, 2014). The re-enactment of the MCP holds similar consequences in certain instances and hence some responsibility should shift to donors to manage the fallout and potential harm that may follow when resources are reduced. Based on duties that accrue to providers such as continuity of care and the duty to care together with the human rights implication of withdrawing services it becomes possible to argue that donors who engage in support of service delivery should be held to some degree of accountability. Accountability may be influenced by resource availability, political influence or other factors but this should not exclude a conversation that places patients and service recipients at the forefront of the debate.

Assigning responsibility for global health

An important aspect of discussion in global health is to determine who is responsible to solve the problems of global health, in particular, the roles of state and non-state actors. In order to frame

the roles and responsibilities of institutions involved in global health, Buchanan and DeCamp outline conditions for the inappropriate attribution of responsibilities, factors that should be considered when outlining roles and responsibilities, and the distinction between determinate and indeterminate duties. This is also referred to as the '*The Problem of Concrete Responsibilities'* (Buchanan and DeCamp, 2011: 119).

The first point made by Buchanan and DeCamp is the importance of avoiding the inappropriate attribution of responsibilities to different parties involved in global health, a phenomenon known as 'd*uty dumping*' (Buchanan and DeCamp, 2011: 119). '*Duty dumping'* occurs when obligations are inappropriately ascribed to individuals and institutions and holding them accountable for health effects without adequately justifying such obligations (Buchanan and DeCamp, 2011, p. 120). As an approach '*duty dumping*' is unprincipled, evasive and in certain instances counterproductive (Buchanan and DeCamp, 2011: 120). A further component of *'duty dumping*' is that it becomes a means to evade responsibility. Responsibility is evaded by assigning an obligation to an institution or individual while denying that a larger obligation exists that may involve collective and broader groupings of institutions and individuals (Buchanan and DeCamp, 2011: 120).

The determination of roles and responsibilities of institutions considers three aspects. Firstly, it should identify all entities with the responsibility to address global health issues. Secondly, '*responsibility gaps'* should be identified that need to be addressed. Thirdly, the responsibility to hold institutions accountable for global health is a collective responsibility with an enhanced responsibility that falls to those with a surplus of personal resources and strong '*political clout*' (Buchanan and DeCamp, 2011: 121).

The creation of determinate responsibilities relies on distinguishing determinate from indeterminate responsibilities. Cosmopolitan justice considers two sources of moral concern in global health. Firstly, there is an obligation that every person has access to institutions capable of protecting their basic human rights such as the human right to health and secondly, beneficence otherwise referred to as the '*imperfect obligation of humanity*' (Buchanan and DeCamp, 2011: 121). These obligations tend to be indeterminate and are unable to provide adequate guidance on managing the challenges of global health. The identification of '*determinate duties*' generally relies on the creation of institutions. Institutions are able to synthesize abstract ideas into concrete shape as occurs when a particular '*justice regime*' is selected from a range of such '*justice regimes*'

(Buchanan and DeCamp, 2011: 121-122). Institutions, in addition, are able to gather resources required to effectively provide justice and to ensure the equal distribution of costs related to ensuring justice (Buchanan and DeCamp, 2011: 122).

The discussion about determinate and indeterminate responsibilities highlights a further important point. Despite the establishment of institutions, it is not possible in all instances to meet human needs. This failure to meet the needs of all does not necessarily reflect a failure of someone's determinate duty but rather as a failure of collective action (Buchanan and DeCamp, 2011: 122). Buchanan and DeCamp use the example of HIV/AIDS and ARV treatment to further clarify the point. The fact that many persons were unable to access treatment during the height of the AIDS epidemic did not indicate a failure by any particular party to perform a determinate duty but rather a failure of many persons and institutions to take collective action to ensure a morally justifiable and effective response (Buchanan and DeCamp, 2011; 122).

It is now possible to further describe the roles of different actors including state actors and non-state actors (global institutions such as the World Bank and World Health Organization, development agencies such as USAID and international NGOs such as Marie Stopes International and IPPF).

Responsibilities of states. The first basis for states to reduce many harmful health effects at the global level is through an appeal to '*uncontroversial standards of justice'* (Buchanan and DeCamp, 2011: 123). States may impact health firstly, by committing acts of injustice that have a health-harming impact and secondly, through their participation in the state system whereby one state through their membership in the state system condones actions of another state that may violate the health of their citizens or deprive citizens of the resources needed to live a healthy life. According to Buchanan and DeCamp states have a moral responsibility not to condone or ignore practices of other nations responsible for injustice toward their citizens (2011: 123-124).

A further responsibility of state actors ensues from the responsibilities of states to protect the human rights of their citizens. This responsibility arises from obligations assigned to states to define and specify human rights norms within framework of distributive justice required to sustain the system of human rights in a state (Buchanan and DeCamp, 2011: 124). At times, states may be unable to ensure basic health entitlements for their citizens such as may occur with '*failed'* states or very under-resourced states. In this instance there rests on wealthier states an obligation to

support and assist failed or under-resourced states to more effectively discharge their responsibilities (Buchanan and DeCamp, 2011: 125).

Drawing from the work of Pogge which suggests that an injustice occurs if a country pursues a practice or policy that worsens the health of those in poorer countries or impacts a human right to health (Daniels, 2011: 98-99). This implies that states who are impacted by the MCP have a moral responsibility not to condone or ignore practices that follow the imposition of MCP conditionalities. Firstly, states have the duty to step in to prevent the harm that accrues to the MCP. Since the MCP largely impacts service delivery by international NGOs, the state is left with the burden of filling gaps left by departing international NGOs. Unfortunately, often states may not have the necessary resources to fill newly established gaps in service delivery with a consequential deepening of the harm that accrues to the MCP during periods of enactment. Clearly though, as outlined previously, and despite the important role of MCP enactment, the harm and injustice that emerges, represents an element of collective failure and requires all involved institutions (USG, states and international NGOs) to take collective action to ensure a morally justifiable and effective response. A subtle aspect of '*duty dumping*' is also created whereby the MCP attracts the majority of blame. Secondly, states have the duty to protect the human rights of their citizens. One example of such protection is drawn from South Africa where under certain circumstances the MCP cedes authority to local legislation that exists for abortion. In countries where abortion is legal, providers are obliged to provide to the patient all the legal options and referral to abortion services where appropriate. In South Africa the so-called '*affirmative defense*' applies which allows exceptions to the MCP restrictions without triggering a violation (Center for Health and Gender Equity, 2018: 27).

Responsibilities of non-state actors. The attribution of responsibilities for actions and resulting harm requires a nuanced discussion since the attribution of responsibility when harm occurs is often too indeterminate to provide moral guidance (Buchanan and DeCamp, 2011: 126). Attribution of harm may be unproblematic in instances where a direct relationship exists between the actions of an institution and a harmful effect that follows the action. Often, however, the contribution to harm is insufficient to attribute a responsibility for harm since several parties may be involved. Therefore, it is difficult to propose obligations that arise from harm caused as a solid basis for addressing global health problems (Buchanan and DeCamp, 2011: 126).

Buchanan and Decamp suggest an approach that is based on the isolation of harmful factors with a subsequent attribution of responsibility (2011: 126). This is achieved by examining the responsibilities of '*global governance institutions'* [51] and '*global corporations*'. An example of such an attribution is drawn from global governance institutions when an institution acts contrary to its stated intent. For instance, the World Trade Organization through the Agreement on Trade-Related Aspects of Intellectual Property (TRIPS) acted contrary to an agreement reached with the World Health Organization to affirm '*human health as important in the highest degree'* (Buchanan and DeCamp, 2011: 126). The contradiction was established through the imposition of global agreements that raised the prices of drugs and prohibited the manufacture of generic drugs in developing nations thereby worsening rather than improving certain global health problems. Buchanan and DeCamp suggest that '*global corporations*' have three responsibilities in terms of global health (2011: 127). Firstly, there is an obligation (negative duty) to avoid those actions and policies that may significantly contribute to or act in a directly harmful manner. The challenge that emerges is not the determination of responsibility but rather how to ensure accountability for these actions. Secondly, institutions should not support governments who participate in actions that unjustly harm the health of their citizens. Thirdly, corporations should not impede the actions of governments or other international institutions that that aim to promote the health of the global population (Buchanan and DeCamp, 2011: 127). The assumption of a role that assists in the amelioration of global health problems implies that corporations assume new responsibilities that demand accountability (Buchanan and DeCamp, 2011: 127). Over and above the self-assumption of such responsibilities there remains little obligation toward corporations to address global health problems. Buchanan and Decamp suggests though that the least that corporations can do is to refrain from impeding the actions of those with the declared objective of improving global health. One example of such harmful action that may occur is when a drug manufacturer insists on the maintenance of intellectual property agreements which maximizes their profits while preventing the access by poorer countries to necessary drugs (Buchanan and DeCamp, 2011: 127).

One important insight emerges from the responsibilities of non-state actors. Global governance institutions should act in alignment of its stated intent while corporate institutions have an

[51] Global governance institutions refer to a diverse group of institutions that range from '*government networks*' of bureaucrats to institutions such as the World Trade Organization; global corporations assume a private sector role such as drug manufacturers.

obligation not to harm, nor support governments or impede governments through actions that cause unjust harm to citizens. We may now further assess the action of USAID and NGOs such as IPPF and MSI loosely against the obligations identified for non-state actors since neither USAID nor the IPPF and MSI exactly fit the categories proposed by Buchanan and DeCamp.

For USAID, assuming it can be viewed as a global governance institution, a contradiction emerges between the stated intent and the enactment of the MCP. The rhetoric from Congress suggests exporting '*a life-saving policy that provides poor women with food, housing and medicine, not policies that are destructive to women and children'* while USAID's Mission suggests the application of development assistance '*that save(s) lives, reduce(s) poverty, strengthen(s) democratic governance, and help(s) people emerge from humanitarian crises and progress beyond assistance* (Committee on Foreign Affairs, 2008: 14; USAID, no date b). It can be argued, from the evidence provided following MCP enactment, that the MCP does not contribute toward the saving of lives, the reduction of poverty or strengthened democratic governance (following restrictions on NGOs, pregnant women and health workers). Furthermore, MCP enactment does not follow the obligation not to harm while it also impedes the actions of governments or other international institutions that that aim to promote the health of the global population. It can be concluded that the USG through its enactment of the MCP acts contrary to obligations defined for non-state actors.

For institutions such as the IPPF and MSI the attribution of responsibilities appears to be less direct. Firstly, they act in response to MCP enactment and there is justification to a certain extent for their response, since their rights as institutions are abused by the MCP and its restrictions on funding. Secondly, as institutions they do not impede government in any fashion, rather they voluntarily step in to fill the gaps left by government's inability to provide a broad package of services to all its inhabitants. Thirdly, they do not directly develop policies that may lead to harm for the inhabitants of countries they support. However, the principled stance of MSI and the strong stance towards human rights by IPPF does lead to actions that increase harm such as when they withdraw their services following MCP enactment.

It should be noted that despite the ability to assign roles and responsibilities to both states and non-state actors there continues to be a significant challenge to assign accountability to global institutions (Flaherty, Higgins and Hoodbhoy, 2005: 117). The reason that is provided is that

international human rights law is almost silent on transnational human rights obligations in general (Flaherty, Higgins and Hoodbhoy, 2005: 117). This leaves the need to reconsider how this accountability may be enhanced through the development of obligations based on the '*continuity of care*' and the '*duty of care*' at a global health level.

Concluding remarks

The ethical evaluation set out to answer three questions: firstly, whether the imposition introduced by the USG on international NGOs can be justified; secondly, to examine the ethical implications of repeated scale up and withdrawal of health services as political administrations change in America and finally, whether MCP enactment suggests the need for more flexible approaches by fund recipients during periods of policy enactment in order to ensure the health and well-being of persons dependent on their service provision?

A critical element and a dominant theme of the MCP is the coercion, conditionality and prescription that arises from the policy. For the restrictive conditions of the MCP to maintain a firm moral status it requires solid moral foundations. It emerges from the evaluation of the internal consistency and coherence of the MCP that the policy itself is exposed to weaknesses such as its narrow reliance on the Christian religion to guide global application while moral dilemmas are created through the internal contradictions that exist within the policy framework. We can conclude that the internal coherence of the MCP is compromised that further suggests an incapacity and inability to impose restrictions on a moral basis. The assumption that a just policy at the least would not lead to an increase in global health inequality or at best a decrease in global health inequality cannot be validated. The application of conditionality by the USG follows US interests to reduce abortion as a means of family planning. This impacts the right to self-determination and autonomy of institutions, at times the imposition of values foreign to recipient states through its reliance on strict anti-abortion restrictions which potentially impacts countries with relatively liberal abortion laws and a prolongation of suffering through increased morbidity and mortality. In some instances, the conditionality, rather than improving the targeting of aid toward those most in need produces the opposite effect by reducing access to health care for the neediest. The conditionality associated with the MCP appears to be largely negative to those constituencies dependent on US funded development assistance for reproductive health services in many developing countries. The combination of these elements described above suggest that

the MCP does not rest on a firm foundation which in turn raises questions about the legitimacy of the restrictions and coercion.

The process of MCP enactment or rescission requires donors such as USAID and service providers such as IPPF and MSI to consider their ethical obligations to the populations they serve. This aspect speaks to firstly the disruption caused by change every four to eight years as political administrations in the USA change, and secondly raises the question what obligations rest on the USG and NGO service providers in terms of ensuring the service provision is not reduced or summarily stopped. The literature is almost silent on the ethical obligations of donors when they reduce support or change the package of support for recipient nations. Two ethical norms can assist in framing an ethical response which include '*continuity of care*' and '*duty of care*'. Based on these norms together with the human rights implication of withdrawing services it becomes possible to argue that donors and NGO providers who engage in support of service delivery should be held to some degree of accountability although this needs to be more clearly defined.

The assignment of responsibilities to state and non-state actors further clarifies key aspects of MCP enactment. States have the duty to step in to prevent the harm that accrues to the MCP and to protect its citizens from the infringement of human rights. Harm and injustice that follow MCP enactment represents an element of collective failure and requires all involved institutions (USG, states and international NGOs) to take collective action to ensure a morally justifiable and effective response. A subtle aspect of '*duty dumping*' is also created whereby the MCP attracts the majority of blame. For USAID, as a global governance institution, a contradiction emerges between the stated intent and the enactment of the MCP. This contradiction is created by rhetoric that promotes the saving of lives, reduction of poverty and promotion of democracy while the consequences of the MCP produces the opposite effect. The conclusion can be drawn that both the USG to a greater extent and MCP opponents such as the IPPF and MCP to a lesser extent at times act contrary to the obligations defined for non-state actors. It should be noted that, despite the ability to assign roles and responsibilities to both states and non-state actors, there continues to be a significant challenge to assign accountability to global institutions. This leaves the need to reconsider how this accountability may be enhanced.

Ultimately, we can conclude that significant evidence exists that the MCP as a broadly applicable policy is morally challenged. This severely decreases the legitimacy of the policy in its global application.

Chapter 8. Conclusion and recommendations

We have seen how a direct thread may be drawn between the Roe v. Wade decision made almost fifty years ago and those women currently receiving family planning services with USG assistance. Woven into the thread are the conflicting strands of gender, religion, politics and morality that express a conservative perspective on the world. We have seen how the MCP creates inequality and harm as one of the consequences of policy enactment while influencing the autonomy of organizations, the choices of mothers and parents and the professional practice and judgement of health workers. It is also clear that abortion as an intervention to terminate unwanted pregnancies will not go away since globally there remains a large unmet need for family planning services. In addition, the current demographic transition in many developing countries together with increased opportunities for girls and women will continue to drive the need to access family planning services. In order to optimize development opportunities for girls and women, fertility control becomes an imperative and, if family planning is not readily available, many will fall back on the ultimately definitively reliable method of abortion, notwithstanding the consequences. This necessitates the making of compromises that shifts from an emphasis on ideology to an emphasis of reducing harm for those impacted by the policy. Ultimately, the global public health problem of abortion needs to be addressed, especially the morbidity and mortality that significantly influences the lives of vulnerable women.

Three important problems have been associated with the MCP. Firstly, the imposition and associated stifling through the MCP of international NGOs, foreign government service provision, women and health providers. Secondly, the challenge of ensuring continuity of care as the MCP is either enacted or rescinded with the associated consequences of restricting of service delivery or scaling up of service delivery. Both reduction and scale up of service delivery carries opportunity costs which decreases the efficiency of available resources for service delivery. Thirdly, the role of stakeholders of the MCP such as IPPF and MSI and their response to policy enactment. We have noted how a variety of themes are merged into the MCP and these themes should be considered when recommendations are formulated. Based on the ultimate impact of MCP enactment, most recommendations are likely to be tailored toward the mitigation of the effects of the MCP. Recommendations should also be couched within an ethical framework that enables ethically valid responses, especially considering the global impact of the MCP. Recommendations

should in addition emphasize the aspect of compromise as a core element in moving forward to reduce the inequality and harm associated with the MCP. The following factors need to be considered when proposing recommendations.

Emphasizing the 'voiceless she'. I propose to tailor recommendations that aim to reduce the inequality and harm associated with the '*voiceless she'* since it this is the group of girls and women who ultimately are at the receiving end of the MCP. The reduction of inequality and harm, additionally, aligns with the spirit of global health ethics and the attempt at redressing existing wrongs (Hunter and Dawson, 2011, p. 78). The '*voiceless she*' may be further understood through the work of John Irving and Ronald Dworkin. John Irving, author of *The Cider House Rules* – an acclaimed novel about abortion, writes that anti- abortion crusaders do not care what happens to an unwanted child after the child is born nor do they care about the mother. Irving feels that '*one job of a society with a social conscience is to rescue its citizens who are trapped, who are painted into a corner*.' [52] Ronald Dworkin in his book *Life's Dominion* refers extensively to the work done by Carol Gilligan. Gilligan interviewed 29 women contemplating abortion and found that women in the face of difficult moral decisions feel a greater responsibility to care and nurture others and to prevent pain (Dworkin, 1994: 58). This differs from men who tend to focus on abstract moral principles. One of Gilligan's core finding was that the women in her study did not agonize about whether the fetus is a person with a right-to-life; rather the '*conventional feminine voice*' defined herself as an individual who finds worth through the basis of caring for and protecting others (Dworkin, 1994: 59). The different pictures presented by Irving and Gilligan frame the conflict inherent to the MCP. On the one hand, attempts through the MCP to reduce abortions ultimately creates those conditions for women, who according to Gilligan, need to balance their self-interests as a confident individual with a complex set of responsibilities that involves education, family and dignity which results in harm and injustice (Dworkin, 1994: 59). We see a picture emerge through these writings of girls and women who find themselves with an unwanted pregnancy and who through the moral perspectives promoted through the MCP are denied the choice for reproductive health decisions that impact the rest of their lives, yet are unsupported by very same persons who originally promote the policy. This stands in contradiction to what Irving proclaims about a society

[52] https://www.nytimes.com/2019/06/23/opinion/anti-abortion-history.html

with a social conscience that should rescue rather than neglect or harm. Herein lies much of the immorality of the MCP.

Developing means to mitigate the problem of extremism. One of the conclusions that can be drawn from the examination of the MCP is that we are faced with the problem of extremism which sees the emergence of radically opposing positions rather than a tendency for opposing parties to cluster around the center with a greater possibility for achieving consensus. Examples include the differences between those who are either pro-choice or pro-life despite a common consensus that abortion is best avoided to the greatest extent possible, and the extreme application of foreign policy such as the MCP which generates '*offended'* opposition from groups such as the IPPF and MSI. Harm and injustice intensify when groups such as IPPF and MSI are driven to withdraw service delivery activities. This suggests that mitigation is strategically approached through by mitigating extremes and by reliance on practical and prudent approaches that seeks workable compromises between opposing groups. The evidence for the mitigation of extremes can be drawn from several examples which assumes the assumption of a middle ground that enables negotiation. The Pew Research Center through a survey in 2018 indicated that almost 6 out of 10 Americans feel that abortion should be available in all or most instances (Pew Research Center, 2019). This certainly contradicts the views and perspectives of the Christian Right and many who hold a position in the Republican Party. Moral policies, as proposed through the developmental school, exist that can enable decisions about abortion that weigh and value both fetal and maternal interests. The ethics associated with conditionality in foreign assistance suggests the need for the balancing of opposing interests and viewpoints. Collingwood proposes that conditionality should be anchored in the idea of basic '*human rights*' and supported by more '*equitable'* rules (Collingwood, 2003: 56). Collingwood's work emphasizes greater equality between those providing and receiving aid which promotes a departure from extreme positions. Ten Have through the concept of solidarity provides a similar perspective; solidarity introduces greater symmetry including equality in relationships (2016: 17). It is clear, based on the examples mentioned above, that opportunities exist for promoting discussions that are able to move opposing parties to the middle ground where compromises may be found to reduce inequality and harm associated with MCP enactment.

Applying phronesis as a means for developing ethically valid decisions. The discussion about extremism highlights the fierce opposition that exists between different groups involved in the

debate and conversation about abortion and the manifestation of abortion through the MCP. For instance, pro-life and pro-choice groups and their allies, whether churches or politicians or academics, are engaged in an acrimonious and rancorous debate. Groups that oppose the MCP, such as IPPF and MSI, similarly attempt to bring the consequences of MCP enactment to the attention of the world aiming to reverse the impact of this policy. Governments react strongly to the issue of imposition and conditionality by external donors who bring foreign assistance.

Positions held by opposing groups emerge from strongly held beliefs and values. This is exemplified by the description provided by Luker about the moral beliefs held by women and their perspective toward abortion. Luker writes that pro-life persons, as a group, adhere to '*explicit and well-articulated moral codes*' defined through a clearly articulated set of rules (i.e. the Biblical Ten Commandments and Judeo-Christian law) that lay out rules for moral behavior (1985: 174). Pro-choice groups, by contrast, draw their moral perspectives from '*a few general ethical principles*' rather than a rigid set of rules (Luker, 1985: 183-184).

Understanding these differences provides new insights into how a different ethical approach may serve to bridge the divide. This approach, the ethics of responsibility and phronesis as introduced by Van Niekerk, provides such an opportunity (2006). The ethics of responsibility is potentially able to break the impasse between rule morality and utilitarianism and demonstrates that while moral argument is drawn from a recourse to rules and principles, day to day reasoning requires us to seek the greater good through practical flexible application of these rules (Van Niekerk, 2006). Phronesis, (or prudence) relies on the application of knowledge that is based on *'precepts or action guides'* to inform actions which are applied to a situation and enables the recommender to abide with the consequences of actions and decisions (Van Niekerk and Nortjé, 2013). Application is based on deliberation and a rational interchange that allows movement between the norm and the requirement of the situation or stated otherwise '*a distinctive mediation between the universal and the particular*' (Van Niekerk and Nortjé, 2013). Phronesis thus becomes a form of reasoning which produces an '*ethical know-how*' developed and molded through the engagement of universals and particulars (Van Niekerk and Nortjé, 2013). In the words of Aristotle:

> '*Prudence is concerned with human goods, i.e. things about which deliberation is possible; for we hold that it is the function of the prudent man to deliberate well; and nobody deliberates about things that cannot be otherwise, or that are not means to an end, and that end a practical*

> *good. And the man who is good at deliberation generally is the one who can aim, by the help of his calculation, at the best of the goods attainable by man. Again, prudence is not concerned with universals only; it must also take cognisance of particulars, because it is concerned with conduct, and conduct has its sphere in particular circumstances'* (Van Niekerk and Nortjé, 2013).

Phronesis and the ethics of responsibility is further contextualized by Van Niekerk. He writes that the ethics of responsibility aims to make people accountable for the world which we inhabit and create through science and technology (Van Niekerk and Nortjé, 2013). It is an ethics that acknowledges the '*moral ambivalence'* that exists in the social world of the world and proposes that moral judgement should not be consistent with a '*single paradigm*' but rather that responsibility is taken for any '*line of action*' that is embarked upon (Van Niekerk and Nortjé, 2013). It is an ethics that distinctly separates us from reliance on morality determined by rules, codes and laws thereby denying people the ability to avoid an escape from justifying the moral decisions associated with morally complex situations. It is an ethics that demands accountability. It furthermore suggests that the basis of morality lies in being accountable to others as the only sustainable basis for morality (Van Niekerk and Nortjé, 2013). The ethics of responsibility draws from two ideas, firstly, that failure is possible, and that the moral agent should accept responsibility for the failure and secondly, that action guides such as rules and principles are taken into account when moral decisions are made. This ethics relies on a '*logic of validation*' with conclusions that reflect probability rather than certainty (Van Niekerk and Nortjé, 2013).

The ethics of responsibility and phronesis, by bridging the impasse between the rule morality and utilitarian consequentialism, enables opposing groups to enter the middle ground where rational deliberation becomes possible. This is essential for managing existing conflict and reaching compromise.

A strategic approach toward decision-making. Strategically, as recommendations are developed, it is important to consider what recommendations are most likely to bring about a meaningful impact. Due to high levels of partisanship in the US with a decreasing capacity for effective bipartisanship, it is unlikely that a strong emphasis on mitigation through the political process in the USA will bring much results. Roe v. Wade stands strongly in the center of a partisan and bitter battle between Democrats and Republicans as ongoing attempts proceed to rescind or reduce the

impact of Roe v. Wade by Republicans and its alliance partners such as the Christian Right.[53] Since the origins of the MCP in the American political process are unlikely to be susceptible to change, recommendations should look toward mitigation of impact. Here discussions about conditionality, continuity of care issues and harm and injustice are likely to be more susceptible to change. It should be pointed out though that change should not be expected to be rapid, rather change is likely to be incremental.

We must not underestimate the complexity of the context that solutions that have to be found to mitigate the impact of the MCP. Challenges are many including the partisan nature of the American political process and its expression at a global policy level, the complex world of foreign assistance, the capacity of aid recipients to argue for greater equality in the decision-making associated with conditionality and the need for states and other stakeholders to convert good ideas into practical application. This suggests the need to develop recommendations that are flexible to situational needs and that are practical in nature.

Using values to guide the development of recommendations. If we explore the profile developed for the '*voiceless she*' a few critical issues can be discerned. Often, she is rurally based and is likely to be poor or if urbanized may originate from desperate slum settings. She has limited options for antenatal and effective maternity care when she becomes pregnant, may be stigmatized by society and has limited access to guidance when deciding about options for managing the pregnancy. She may be exposed to abortionists who use unsafe methods. She is concerned about losing access to education and even future opportunities for marriage. She may have experienced rape and other forms of gender-based violence. If married, she may be disempowered to the extent that her husband makes all decisions for her. It is within this context and the need to address the challenges experienced by the '*voiceless she*' that we need to define relevant values that will influence the development of recommendations. In addition to the focus on the individual exposed to an unintended pregnancy, we need to consider the context and structure of the health care system

[53] During 2019, the New York Times reports that nine states have voted to reduce abortion rights by reducing the standard for viability from between 24-28 weeks (Roe standard) to periods that range from six weeks (five states) up to 18 weeks (three states). One state, Alabama, proposed an almost near total ban on abortions. Six states each have only one abortion clinic left: Kentucky, Mississippi, Missouri, North Dakota, South Dakota and West Virginia. By contrast liberal-leaning states are moving to strengthen abortion rights. This occurs either through the strengthening of laws that protect abortion or by working to repeal old restrictions that leave them vulnerable id Roe is overturned. https://www.nytimes.com/2019/05/15/us/abortion-laws-2019.html

within which care will be provided as well as those agencies (ministries of health, donors and NGOs) who provide health services in under-resourced settings.

Benatar proposes values for global health that aim to improve health and well-being globally. These values are aimed at promoting respect for the dignity of all people and extend beyond a narrow economic model as the necessary and sufficient measure of human flourishing (Benatar, Daar and Singer, 2011: 130). He suggests a range of values that includes respect for human life, human rights, equity, freedom, democracy and solidarity (Benatar, Daar and Singer, 2011: 130-135). Ten Have suggests that global bioethics draws from deliberations about human rights and the '*moral ideals of cosmopolitanism*' (Ten Have, 2016: 213). He proposes a set of principles that overlap and align well with those proposed by Benatar and adds the principles of respect for human vulnerability and social responsibility (Ten Have, 2016: 215-222).

Solidarity is proposed as a core value since it represents a set of attitudes and determinations that promotes a global common good in an era of interdependence and where progress is characterised by expanding capabilities and social justice (Benatar, 2011: 130). Solidarity is important to the extent that it provides the mechanism to prevent the avoidance of distant inequalities, violations of human rights, inequities and other expressions of injustice. Within this context the idea of '*mutual caring*' emerges between developed and developing countries and the promotion of constructive global change (Benatar, Daar and Singer, 2011: 130). Human vulnerability avoids the emphasis on individual autonomy but rather draws a distinction between the inherent fragile vulnerability associated with being a human and special vulnerability brought about by exposure to social, political and economic conditions in mostly developing nations. The importance of special vulnerability is that it is amenable to change while the inherent human vulnerability is more resistant to intervention and change (Ten Have, 2016: 214-215). Social responsibility addresses social determinants of health and promotes the idea that scientific progress should benefit all. It includes two ideas; firstly, health outcomes are the joint responsibility of many states, individuals, and private and public organizations and secondly, global health problems should be viewed as common challenges requiring joint actions (Ten Have, 2016: 223-224).

All these values have relevance in terms proposing recommendations to manage the consequences of the impact of MCP enactment. Recommendations should aim to reduce the impact of the MCP on human rights, justice, and equity. One proposed intervention would be to ensure that there is

sustained service delivery when the MCP is enacted; ongoing service delivery can go a long way toward addressing the issues of abuses of human rights, inequality and inequity. Since many stakeholders are involved in supporting ongoing service delivery it is important to emphasize the values of solidarity and social responsibility. Both values promote the idea of '*mutual caring'* proposed by Benatar and provides mechanisms that are capable of preventing human rights violations and other forms of harm by, for example, encouraging stakeholders to take steps to provide family planning methods and services during periods of MCP enactment (Benatar, 2011: 130). One example of these values in action are the steps taken by the Netherlands in 2017 to ensure the sustainability of service provision for those service delivery institutions impacted by reduced USG funding.[54] This culminated in the establishment of a global movement known as '*She Decides'* which expresses, through their manifesto, the idea of advancing *'the right of girls and women everywhere to decide.'* [55]

The relevance of values is to provide guidelines that assist stakeholders as they engage and support those impacted through MCP enactment in a way that promotes the dignity and health and well-being of effected persons.

Recommendations aimed at addressing important issues

1. *Issue: the narrow emphasis on the fetal right-to-life in comparison to the rights of the pregnant woman*

   Callahan's elaboration of rules systems, that define the content of the principle of the sanctity of life, identifies anomalies brought about by the MCP that emphasizes the fetal right-to-life while de-emphasizing the women's right to self-determination. Several consequences emerge. The MCP does not consider abortion for socio-economic constraints that at times feature strongly in decisions that pregnant women need to consider. It impacts on the freedom of individuals and families to procreate, determine family size and perpetuate family since reproductive choices are reduced. It violates women's capacity for personal choice and freedom from coercion when abortion as an option is under consideration.

   <u>Recommendations</u>

[54] https://www.nytimes.com/2017/02/20/health/lilianne-ploumen-abortion-gag-rule-she-decides.html
[55] https://www.shedecides.com/

a. Expand the availability of and access to family planning service delivery especially in settings with poor service coverage. Increased availability of services is one strategy to prevent girls and women from experiencing an unplanned and unwanted pregnancy and prevents exposure to the negative consequences that accompany these pregnancies induced through MCP enactment. This represents a practical '*workaround'* strategy that will aim to reduce those situations where the MCP impact is felt.

b. Governments should actively engage with the USG with the express purpose of ensuring that the provision of assistance, including family planning service delivery, under the auspices of the MCP is compliant with national policies guiding abortions. Governments have a particular role to play in the prevention of abuses of human rights and in preventing any forms of harm that may follow the enactment of the MCP. This type of engagement will serve to shift, where feasible, the narrow emphasis on the MCP's '*full protectionist policy.*'.

2. *Issue: international NGO actors who withdraw service delivery when the MCP is enacted.*

The IPPF and MSI are staunch supporters of choice for abortion and draw their inspiration from the rights for sexual and reproductive health. Both the IPPF and MSI promote the freedom of individuals and families to procreate, determine family size and perpetuate family lineages which aligns to the rules that accompany the principle of the sanctity of life. They emphasize women's personal choice, freedom from coercion and the right to self-determination when abortion is an option during pregnancy. IPPF and MSI are similarly afflicted as the MCP by being drawn into conflict when fetal rights prioritized through the '*right-to-life'* rule come into conflict with the pregnant woman's '*right to self-determination*' rule.

<u>Recommendations</u>

a. As international NGOs such IPPF and MSI implement service delivery activities with USG funding they should always prepare for those instances where the MCP may become enacted. This implies developing interventions capable of mitigating the consequences of MCP enactment. This is important since the US political process is beyond the control of international NGOs who implement family planning activities. Withdrawal of service delivery may be seen as a form of '*duty dumping*' with MCP enactment and represents a convenient excuse to step away from their service delivery responsibilities while blaming the USG and MCP enactment. Despite the important role of MCP enactment, the harm and

injustice that emerges, represents an element of collective failure and requires all involved institutions (USG, states and international NGOs) to take collective action to ensure a morally justifiable and effective response when the MCP is active.

b. This represents an instance where international NGOs should resort to ethical value systems that consider the practical realities of service withdrawal. Phronesis and the ethics of responsibility is one such an approach that seeks appropriate ethical solutions through deliberation and a rational interchange that allows movement between the norm and the requirement of the situation. It enables greater harmonization between rule-based approaches and utilitarian approaches as stakeholders strive toward the best outcomes for those impacted by service withdrawal. Rather than focusing on a principle-based approach only, that suggests that abortion is required to ensure a full package of reproductive health services, phronesis would guide that it is preferable to prevent the harm associated with service withdrawal even in the absence of abortion in the service delivery package. The possibility of providing abortion services under restrictive legal conditions is in any case rarely allowable and it begs the question why the need to pursue a principle to the extent that it adds to injustice and harm?

3. *Issue: Managing conditionality to ensure greater harmony for MCP implementation*

The application of conditionality by the USG follows US interests to restrict any form of abortion. This has several consequences including restriction of the right to self-determination and autonomy by institutions, the imposition of values foreign to recipient states, and the reduction of access to health care for the neediest. Collingwood argues that limitations should be placed on conditionality by stakeholders involved in the provision and receipt of foreign assistance. One of her recommendations is particularly applicable to the MCP which is that the use of conditionality should be anchored in the idea of basic '*human rights*' and supported by more '*equitable'* rules (Collingwood, 2003: 56). This is a challenging area especially if great power imbalances exist between those providing and those accepting foreign assistance and is further complicated by the controversial nature of abortion.

Recommendations

a. The use of global institutions and forums provides one option to clarify and reach agreement on applicable human rights and more equitable rules. Examples exist for such approaches. The '*Three Ones*' approach for HIV coordination represents such an example

where agreements at an international level were reached in 2004 to coordinate the scale up of national AIDS responses (World Health Organization, no date). This was a successful approach that greatly contributed toward the tremendous global success in controlling HIV/AIDS. The controversial nature of abortion as a method of family planning may hamper global efforts. Yet through focused discussions that emphasizes the interchange of universals and particulars of phronesis can lead to greater sensitivity by the USG toward the associated harm and injustice of the MCP.

b. The impact of MCP conditionality should be addressed through bilateral negotiations between the USG and individual nations that aims to define the boundaries of MCP application. Successes have been documented from South Africa where impositions dictated through the MCP cedes authority to local legislation that exists for abortion. Active pursuit of this approach where national legislation exists for abortion is one option to mitigate the impact of MCP enactment.

4. *Issue: Mitigating the impact of service interruption*

The process of MCP enactment or rescission requires donors and service providers to consider their ethical obligations to the populations they serve. This issue acutely raises the problem of ensuring appropriate levels of '*continuity of care*' and '*duty of care*' and the accountability that applies to donors and service providers involved in family planning service delivery.

Recommendations

a. Deliberate efforts should be made at global and national levels to formulate ethical principles that may strengthen accountability for '*continuity of care*' and '*duty to care*'. This is an area that is not well described in the literature and suggests that efforts should be made to develop practical approaches that can be applied at a global health level. Development workers often refer to the importance of sustainability[56] when implementing

[56] Identifying a working definition for sustainability is surprisingly difficult. One perspective is to define what it does not look like. An emphasis on inflexible vertical disease-specific programs that lacks the capacity to address systems challenges; constructing bricks-and-mortar facilities that are empty or underused due to inadequate planning; and an emphasis on training without establishing appropriate working conditions for those who are trained. Sustainability, in contrast, sees facilities staffed by regularly salaried staff with acceptable working conditions and running water and electricity with the necessary equipment and supplies. As Partners In Health co-founder Dr. Paul Farmer puts it, the "staff, stuff, space and systems" necessary to be able to treat patients anywhere as they deserve to be treated. http://www.vancouversun.com/opinion/editorials/opinion+sustainability+global+health/11792375/story.html

programs and projects. Sustainability refers to the utilization of foreign assistance to develop interventions and activities that are appropriate to the developmental context of nations and are viable over the longer term. This differs somewhat from the ideas of '*continuity of care*' and '*duty to care.*' However, sustainability may be enhanced by insisting that foreign assistance considers approaches that emphasize the prevention of interruption of service delivery. Addressing problems related to '*continuity of care'* and '*duty to care*' within the framework of sustainability can contribute significantly to the reduction of harm as it relates to policies such as the MCP. Global level efforts should be accompanied by direct deliberation between nations and donor institutions when considering foreign assistance activities.

5. *Issue: Addressing harm and injustice.*

The USG through the MCP and IPPF and MSI through their opposition to the MCP both contribute toward inequalities, harm and injustice. Pogge suggests that where a policy is imposed by one country on another country and that the policy compromises or creates a deficit in the human right to health, then the harm is considered unjust. The scale of harms associated with the MCP is increasingly being quantified through evidence-based research. This research becomes invaluable in generating those conversations that will begin to mitigate the impact of the MCP.

<u>Recommendations</u>

a. Numerous groups have spoken out against the MCP. As evidence emerges, groups who strive to contain the impact of the MCP should increasingly bring this information to all stakeholders who either are responsible for the implementation of the MCP and those who oppose it. Dissemination of information should occur through a variety of media targeting the scientific community (scientific papers and technical briefs), those who formulate policy (policy briefs, testimonials and hearings, public events hosted by think tanks, universities and other similar institutions) and those who are directly affected through the MCP (here a variety of media are applicable including film, newspaper, and social media for example). Dissemination should consider all those locations where the MCP is discussed – the USA, sites where international agencies are located such as the UN in New York and Geneva, through conferences and other international meetings and nations affected by the MCP.

b. Donor agencies often dispense foreign aid through projects that rely on partners to do the actual implementation. Implementation partners may include international NGOs, country-based NGOs and CBOs, and universities. Populations served by these organizations have little recourse to redress when problems crop up such as inadequate quality of services that are provided or harmful effects that may follow. At times projects may close early leaving those who have become dependent on those services with few options and little recourse. The MCP demonstrates these challenges clearly. Ross has raised the question whether the '*global health enterprise needs an ethics framework that creates jointly held accountability among global health funders, program implementers, and national governments'* (Ross, 2019)*?* Clinical research is well guided through established mechanisms to mitigate the harmful effects of research through the use of Institutional Review Boards and other entities engaged in research ethics such as university ethics committees. Ross suggests that it is important to clearly make explicit the benefit and harms that are inherent to projects. Ethical review can assist in protecting project beneficiaries from the violation of their rights.[57] This requires the establishment of ethical review that addresses ethical challenges that may occur throughout the project lifecycle from idea generation, implementation and closure and involves global health funders, program implementers, and country participants. The incorporation of this process into the project life cycle is likely to generate meaningful discussion from various perspectives about the ethical issues associated with a project and project implementation. In terms of the MCP, this would ensure that a meaningful discussion between relevant stakeholders is generated and that will support the mitigation of harms.

6. *Issue: Strengthening 'domestication' efforts to implement recommendations that address the negative consequences of the MCP – a cross cutting recommendation*

   As outlined previously and despite the pivotal role of MCP enactment in creating harm and injustice it has been shown that the harm and injustice that emerge represents an element of collective failure and require all involved institutions (USG, states and NGOs) to take collective action to ensure a morally justifiable and effective response. The question can be raised how best to ensure collective action and the actual implementation of mitigation

[57] Ethical review of health projects is not a standard practice. The idea of Ross is a new and needs to be pursued with the aim of establishing ethical review as a standard practice in project proposals.

reduction measures. Ten Have introduces the mechanisms for change of global health practices (Ten Have, 2016: 188). He contends that change does not occur through the identification of global standards that are assumed to filter their way from the international to the local level (Ten Have, 2016: 188). Often normative frameworks have been developed at the international level yet have not been implemented at the country level. This diffusion of internationally determined standards often does not occur since an assumption is made that states actors carry the major responsibility for the local application of global frameworks (Ten Have, 2016: 188-189). He argues that many non-state actors are involved in the localization of implementation. The term '*domestication*' is introduced to describe how local implementation occurs – a process whereby domestication is strongly enhanced by local actors, in particular through grass roots organizations (Ten Have, 2016: 190). Local organizations not only take on a responsibility to tackle injustices but adapt activities to the local context and values and engage in collective agency to address injustices through ethical-political work. Through this process '*moral asymmetry*' is converted into '*socio-political'* symmetry. According to the work of Fuyuki Kurasawa on global justice

'…struggling against global injustice produces transnational practices of bearing witness, forgiveness, foresight, aid and solidarity. The practice of bearing witness is fundamental for bearing justice. It gives voices to abuses and structural violence, providing testimony of injustices and overcoming silence, incomprehension and indifference'. It clears the way for the other practices of forgiveness, foresight (preventing harm) and humanitarian assistance'(Ten Have, 2016: 191).

Recommendations

a. Several recommendations touch on the role of government and other players to prevent the consequences of MCP enactment. This includes the mitigation of the impact of service delivery, the consequences of conditionality and harm and injustice. The discussion of Ten Have's ideas on domestication indicates that there is a need to expand the reliance on governments only for the mitigation of the consequences following MCP enactment to include country-based grass-roots institutions who can actively collaborate in this process.

Examples of the Treatment Action Campaign (TAC)[58] in South Africa and Equinet[59] – a regional network based in Harare, Zimbabwe provide examples of such a grass roots institutions. The engagement of grass roots institutions can ensure the development of the voice of civil society that in turn lobbies government and the USG to consider the impact of policies such as the MCP whilst actively contributing toward the process of domestication.

b. The process of ensuring domestication should also consider the development of the capacity of recipient nations to argue for appropriate conditions when discussing with donors the receipt of foreign assistance. This theme touches upon a number of other recommendations. This includes ensuring that MCP enactment complies with local conditions such as the regulatory framework for termination of pregnancy, that conditionality should be anchored in the idea of basic '*human rights*' and supported by more '*equitable'* rules and that foreign assistance is accompanied by an agreement from those providing aid or charged with service delivery implementation are held to their commitments to ensure '*continuity of care*' and the '*duty to care*'. Activities that should be considered include ensuring transparency about financial resources made available through aid and the intended uses and the development of effective oversight mechanisms by government and other stakeholders such as civil society. Some will refer to this as '*country ownership – a shared responsibility and accountability among numerous partners within the country, including the public and private sector, women and men, urban and rural, rich and disenfranchised.'* [60] The major effort is to develop this capacity in nations especially when severe power imbalances exist between developing nations and those with the capacity to disburse development aid.

Concluding remarks

Despite the strict conditionality and impositions proposed through the MCP, options exist to engage with the USG to mitigate the harmful and unjust consequences that follow MCP

[58] The Treatment Action Campaign (TAC) represents users of the public healthcare system in South Africa, and campaigns and litigates on critical issues related to the quality of and access to healthcare.
[59] EQUINET, is a Regional Network on Equity in Health in East and Southern Africa. It draws a network of professionals, civil society members, policy makers, state officials and others together as an equity catalyst, and to promote and realize shared values of equity and social justice in health. http://www.equinetafrica.org/
[60] https://www.msh.org/blog/2010/09/14/what-is-country-ownership

enactment. While limitations exist in terms of changing and influencing the political process in the USA due to the hyper partisan political process opportunities exist to address the consequences that emerge following policy enactment. Progress will be achieved by engaging a range of actors that range from international institutions to local grass root organizations. An emphasis on those who are largely '*voiceless'* and are made most vulnerable when the MCP is enacted serve to provide a focus for drawing stakeholders together with a common aim and purpose. This conversation should emphasize the injustice and harm incurred during MCP enactment and the necessary mitigation strategies to ensure an appropriate compromise in the best interests of those most affected by this policy. By addressing the problems created through the MCP, global health ethics can further be refined and strengthened to address problems of a global nature. The complexity of issues that need to be addressed together with the need to adapt the application of the MCP by geography of nation and state suggests that phronesis together with the ethics of responsibility is an important ethical approach to address those ethical issues that follow MCP enactment since in no instance can we assume similar conditions in states where the MCP is applied.

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