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Governmental Coercion in Reproductive Decision Making: See It Both Ways

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Earlier this year, the world reacted with outrage as blind Chinese dissident Chen Guangcheng made headlines during his risky escape to the United States to flee persecution. Chen, a human rights lawyer, had exposed and protested coerced abortions, involuntary sterilizations and other abuses in China. Soon thereafter, photos of Feng Jianmei—a rural Chinese woman who was seven months pregnant and forced by local officials to have an abortion—went viral in China and around the globe.

Notably, Chen had never publicly advocated against abortion per se. Instead, he denounced forced abortions as a violation of human rights. Yet, U.S. antiabortion activists and policymakers predictably latched onto Chen's and Feng Jianmei's struggles as vindications of their cause, as they consistently have done when cases of coercive sterilizations or abortions have been uncovered in China.

Reproductive rights advocates, meanwhile, responded to the Chen and Feng incidents by reiterating their long-standing principle: Coercion in reproductive decision making—no matter what form it takes—is wrong. Forcing a woman to terminate a pregnancy she wants or to continue a pregnancy that she does not want both violate the same human rights: the right to decide freely whether and when to bear a child and the right to have that decision respected by the government.

Global Abuses

From time immemorial, societies, religions and governments have often defined women's value by their reproductive capacity. And they have subjected women, as childbearers, to coercion—either to have or to not have children for the greater good of those other than themselves. The means have ranged from explicit mandates to more subtle incentives or deterrents to steer reproductive decision making. No matter the motivation for such policies—fears of a population explosion or implosion and the resulting impact on economic or environmental security; the desire for more workers, soldiers or patriots; or religious orthodoxies, which continue in the modern era to be a driving force, in both developed and developing nations—the reproductive self-determination and human rights of individual women are sacrificed.

In the latter half of the 20th century, attention to reproductive rights violations has focused largely on actions by governments to curtail what they view as "overpopulation." History is overflowing with examples, but perhaps the most notorious was India during the 1970s. Amid anxiety about the impact of high population growth rates on deepening poverty, the national government of India established population targets, condoned mandatory sterilization laws among various Indian states and designed punitive disincentives for large families—all resulting in a dark era of widespread coercion and reproductive abuses, particularly among the poorest classes. Similarly, in the 1990s, under former President Alberto Fujimori's regime, Peru sanctioned coercive and forced sterilizations of more than 346,000 poor and indigenous women and almost 25,000 men through intimidation and force.[1] China's one-child policy—under which involuntary abortions are frequent if not technically condoned—fits this pattern.

Less attention, meanwhile, has been focused on equally reprehensible governmental efforts to control fertility at the other end of the spectrum: to compel pregnancy and childbirth. The height of such coercion in the modern era was experienced under President Nicolae Ceausescu's dictatorship in Romania from 1965 to 1989.[2] Under that repressive regime, the state implemented a radical pronatalist policy that outlawed all forms of contraception and banned abortion, except for women older than 45 who had at least five children who were still minors. Enforcement of these policies was carried out by mandatory monthly gynecologic exams, and special state agents were stationed in health settings to investigate illegal abortions. Combined with numerous other coercive incentives and disincentives, these policies reaped disastrous health consequences. Maternal mortality—mostly the result of unsafe, illegal abortions—skyrocketed by 1989 to the highest level in Europe. And because of its close relationship to maternal health, infant mortality also soared, while among those children who survived, thousands were abandoned in orphanages without basic food, health care and attention.

Similar although less draconian efforts continue to this day. In the last few months alone, the governments of both Turkey and Iran announced their intentions to alter policies to restrict family planning and abortion services. In June, the Turkish government proposed banning abortion after four weeks of pregnancy—a change from the current 10-week limit. The announcement was made after repeated statements by Prime Minister Recep Tayyip Erdogan calling for Turkish women to bear at least three children, equating abortion with murder and unpatriotic behavior, and asserting that family planning undermines economic development.[3] Although public outcry forced the government to scale back its ambitions, it still seeks to impose a range of restrictions on abortion access, such as the provision of information to dissuade women from abortions, followed by a four-day waiting period.

In Iran, Supreme Leader Ayatollah Ali Khamenei reversed course on family planning in July and is similarly urging Iranians to have more than two children to raise fertility rates, which have been falling substantially, in large part because of a highly successful government-backed family planning effort over the last two decades.[4] According to the most recent data from 2002, almost 60% of Iranian woman of reproductive age use a modern method of contraception.[5] Moreover, Iran has a highly educated female population and a youth cohort that faces double-digit unemployment.[6] Perhaps recognizing that convincing such a population to forgo a widely accepted and expected practice of contraceptive use would be challenging, the health minister suddenly announced that the "the budget for the population control program [i.e., family planning] has been fully eliminated and such a project no longer exists in the health ministry."[4]

U.S. Policy

The domestic and overseas family planning programs of the United States were forged in the 1960s, when a crosscurrent of social and political forces swept the country. Paul Ehrlich's *Population Bomb* warned of mass global starvation and environmental destruction from a population explosion,[7] even as the women's rights, civil rights and antipoverty movements were also shaping public consciousness. Among policymakers and advocates promoting access to family planning services, there was rising sensitivity to the United States' own troubled history with reproductive rights abuses, especially state-sanctioned involuntary sterilizations (see box).

Against this backdrop, official U.S. family planning policy—domestic and international—recognized the importance of voluntarism and informed consent from the very beginning. The earliest U.S. Agency for International Development (USAID) guidelines from the 1960s outlined key principles under which population assistance would be provided: that assistance be conditioned on the voluntary participation of individuals free to choose among available methods that align with their own beliefs, culture and personal desires, and that USAID not promote any specific family planning policies or methods but, instead, support the ability of "people everywhere [to] enjoy the fundamental freedom of controlling their reproduction, health, and welfare as they

desire."[12] These tenets were codified in the 1968 Foreign Assistance Act, which authorized assistance for "voluntary family planning programs to provide individual couples with the knowledge and medical facilities to plan their family size in accordance with their own moral convictions and the latest medical information."[13] This sentiment was later refined by USAID in simple and stark terms: "The underlying principles of U.S. assistance for family planning are voluntarism and informed choice."[14]

On the domestic side, in 1970 the Title X family planning program was created and very consciously designed not as a "population" program, but as a national effort to equalize access to contraceptive services between low-income women and their better-off counterparts. The stated purpose of Title X was to "assist in making comprehensive, voluntary family planning services readily available to all persons desiring such services."[15] The Title X statute and accompanying regulations established a set of principles to govern the ethical delivery of services supported by the program. They specify that the receipt of family planning services and information must be on a voluntary basis and that a woman's eligibility for other government assistance may not be conditioned on her acceptance of any contraceptive method. They require that a broad range of contraceptive methods and related counseling services be offered to clients, who may not be "subjected to any variation in quality of services because of the inability to pay."[16]

American History

U.S. history is filled with cases of nonconsensual sterilization of poor, minority and disabled women under official auspices. In 1907, Indiana became the first of 33 states to enact legislation to allow mandatory sterilization of those deemed "unfit," including those who were criminals, diseased, mentally incompetent, alcoholic, promiscuous, feeble-minded, disabled, or otherwise deformed or defective according to prevalent eugenic attitudes. These statutes were affirmed by the U.S. Supreme Court in the 1927 case Buck v. Bell, *which upheld Virginia's sterilization law. Writing for the majority opinion, Justice Oliver Wendell Holmes stated, "We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence."[8]*

During the 1960s and 1970s, many of these state statutes were repealed, but sterilization abuse continued, including the use of federal funds to involuntarily sterilize indigent women. Finally, outrage over the coerced sterilization of the Relf sisters, aged 12 and 14, in Alabama in 1973—and a lawsuit brought against the federal government by the Southern Poverty Law Center—generated enough public pressure to implement a new era of safeguards at the federal level. The Relf case led other low-income women of color who had been subject to coercive sterilizations to come forth. Congress held hearings, and ultimately regulations concerning federally funded sterilizations were finalized in 1978. These regulations, applicable to both Title X and Medicaid, mandate certain patient protections: minimum age requirement of 21 years; assurance that the patient is not mentally incompetent; informed consent that is based on a written form and the provision of specified counseling; information about the availability of alternative forms of birth control, to ensure that a real choice is made; and a 30-day waiting period before the procedure.[9]

Comparable safeguards were also formulated on the international side. USAID's current policy on voluntary sterilization—dating from 1982—lays out a number of requirements for USAID-funded sterilization services, including informed consent, readily accessible alternative methods of family planning to enable a choice and the prohibition of financial incentives to accept sterilization.[10] In light of the abuses uncovered in Peru, Congress enacted additional requirements in 1998 to protect clients in U.S.-funded family planning projects from quotas and financial incentives that could lead to coercion, and to promote the provision of comprehensible information on contraceptive methods.[11]

Meanwhile, propelled by ideological conservatives, U.S. lawmaking on abortion was moving in the opposite direction: to restrict voluntary decision making and compel childbearing. In 1973, only months after *Roe v. Wade* guaranteed a woman's constitutional right to choose abortion, Congress passed the Helms amendment to restrict U.S. foreign assistance for abortions. Overinterpretation of this policy has led to withholding of any funding for abortions overseas, even in extreme cases such as rape, incest or when the mother's life is in jeopardy. Soon after the Helms amendment came the domestic Hyde amendment, which in its current form prohibits federal Medicaid funding for abortion services for low-income U.S. women, unless the pregnancy would endanger the life of the woman or was the result of rape or incest. The proponents of the Hyde amendment were fully aware that they could not muster the support for a law to make abortion illegal throughout the country, but that they could make it extremely difficult, if not impossible, at least for poor women in this country to obtain safe abortion care. In fact, a Guttmacher review of a range of studies conducted between 1979 and 2008 concluded that the Hyde amendment blocks approximately one in four Medicaid enrollees from having an abortion they otherwise would have if Medicaid funding were available.[17]

At the state level, a growing list of abortion policies has been enacted, the underlying purpose and effect of which are to push reproductive decision making in one direction—toward pregnancy and childbearing. That such pressure violates the essence of anticoercion policies has never been acknowledged by conservatives who are quick to condemn coercive efforts to stop pregnancy.

Quite the opposite, the very principles of voluntarism and free choice have been increasingly coopted by antiabortion advocates and policymakers. Under the guise of informed consent, myriad laws have been enacted that require women to receive abortion counseling and information replete with inaccuracies and biases. The real purpose of these laws is not so much to inform women about the abortion procedure, as it is to dissuade them from having an abortion at all. These laws have proliferated at the state level, and women are now provided with misleading, exaggerated or invented information on the risks that abortion poses to mental health, breast cancer and future fertility (see "Troubling Trend: More States Hostile to Abortion Rights as Middle Ground Shrinks," Winter 2012, and "State Abortion Counseling Policies and the Fundamental Principles of Informed Consent," Fall 2007). For example, during this year, Arizona and South Dakota joined seven other states in requiring counseling on the negative mental health consequences of abortion, even though experts have thoroughly debunked this claim. In July, a federal appellate court upheld a South Dakota law that mandates that a woman be informed, inaccurately, that an abortion may cause suicide or suicidal thoughts.

With respect to U.S. foreign policy, laws purportedly passed to prevent coercion have been twisted to impede contraceptive access. Under the 1985 Kemp-Kasten amendment, U.S. funding is prohibited for any entity that "supports or participates in the management of a program of coercive abortion or involuntary sterilization," as determined by the president. Starting with Ronald Reagan, every Republican administration since then has used the provision to defund the United Nations Population Fund (UNFPA) for allegedly supporting coercion in China, despite the fact that multiple investigations—including one under the latter Bush administration—have found no evidence of UNFPA complicity.[18] In fact, investigations have found the opposite: that UNFPA operates in China to promote voluntary family planning and to push the Chinese government to respect principles of reproductive integrity.[19–21] Still, UNFPA's China program has been a perennial excuse for attempts to block a U.S. contribution to the agency.

Keeping Watch

In the face of continuous attacks on reproductive autonomy by countries around the world, the global reproductive rights movement has stood firm in condemning all forms of coercion. At the landmark 1994 United Nations International Conference on Population and Development (ICPD), a framework was adopted that puts women's human rights at the center of government policies on population, development and repro-

ductive health. The ICPD Programme of Action affirms the universal human right of "all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so."[22] And, specifically, governments should aim to support individuals to enable "responsible voluntary decisions about child-bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law." Finally, the ICPD views incentives or disincentives to alter fertility rates with suspicion.

To this day, reproductive rights advocates remain acutely sensitive to the real and ever-present potential for coercion, even among the ranks of family planning and reproductive health and rights advocates. Such vigilance was evident during the planning for the recent London Family Planning Summit, a high-level event sponsored by the Bill & Melinda Gates Foundation and the United Kingdom's international development agency (DFID) that garnered increased political and financial commitments for international family planning. Conference organizers came under criticism from many women's rights advocates for inadequately providing assurances that human rights were central to the summit's efforts. Concern was expressed that the summit's stated goal of obtaining 120 million additional contraceptive users by 2020 could lead to overzealous implementation efforts, including "coercive family planning programs where quality of care and informed consent are ignored."[23] In turn, the summit's hosts and supporters ensured that women's rights played a central role in the summit proceedings and pledged that they would continue to do so in its aftermath.

In a declaration signed by more than 1,300 civil society organizations from 177 countries in support of the new global initiative launched at the summit, the signatories announced their support for empowering women: "We commit to working with communities and reaching poor and vulnerable women and girls with evidence-based information so that they can make informed choices regarding their fertility and choice of contraceptive method."[24] Time and again, the global reproductive health and rights community has made clear that its priorities lie in upholding choices for women everywhere, and that coercion—whether to prevent childbearing or compel childbearing—violates reproductive autonomy and should be unequivocally condemned. Given the role of socially conservative forces in the United States and globally in impeding family planning and reproductive health access, even as they decry forced abortion and sterilization, it is clear that their priorities lay elsewhere. **www.guttmacher.org**

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