IN THE SUPREME COURT OF MEXICO

ACCIÓN DE INCONSTITUCIONALIDAD 146/2007

Re *Mexico, Federal District. Decree Reforming the Federal District Penal Code and Amending the Federal District Health Law. Official Gazette of the Federal District. No. 70. April 26, 2007.*

WRITTEN COMMENTS BY:

NATIONAL ABORTION FEDERATION

5 FEBRUARY 2008

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TABLE OF CONTENTS

I. Introduction.

1. The National Abortion Federation ("NAF") submits this brief in support of the legal reforms of the *Decree Reforming the Federal District Penal Code and Amending the Federal District Health Law* ("Decree").[1]

2. Specifically, this submission addresses the first article of the Decree, which redefines the crime of abortion as the "interruption of a pregnancy after the twelfth week of gestation."[2] In NAF's view, this reform, which would decriminalize abortion in the first trimester of pregnancy, is a precondition for reducing maternal mortality and morbidity rates and improving public health in Mexico.[3]

II. Statement of Interest.

3. NAF is the professional association of abortion providers in North America. NAF sets the standard for quality abortion care through evidence-based *Clinical Policy Guidelines*. NAF's textbook *A Clinician's Guide to Medical and Surgical Abortion*, and its other educational materials, are leading resources for health care providers around the world. NAF offers accredited continuing medical education and training in all aspects of abortion care. NAF also provides other services to support abortion providers and women with unplanned pregnancies. NAF's members include 400 non-profit and private clinics, women's health centers, hospitals, and private physicians' offices. NAF's members care for over half the women who obtain abortions each year in the United States and Canada.

III. Decriminalization will reduce the number of unsafe abortions.

4. Where abortions are restricted by law, it is well established that unsafe abortions bear a high risk of serious complications or death.[4] Countries with the most restrictive abortion laws experience the highest number of unsafe abortions.[5] Consistent with that

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[1] Mexico, Federal District. *Decree Reforming the Federal District Penal Code and Amending the Federal District Health Law.* Official Gazette of the Federal District. No. 70. April 26, 2007 ("Decree").
[2] *Decree*, *supra* note 1 at Art. 1, amending the Federal District *Penal Code*, Art. 144.
[3] NAF also supports legal abortion beyond the first trimester allowed under the Decree. Women need safe second-trimester abortion for many reasons, including medical reasons that develop during the pregnancy, fetal anomalies, changes in personal circumstances, such as a husband's death or partner leaving, or the inability to access safe abortion at an earlier time. *See* Marge Berer, *Making Abortions Safe: A Matter of Good Public Health Policy and Practice*, REPROD. HEALTH MATTERS, 2002, 31, at 35-36; *see also* Marge Berer, *National Laws and Unsafe Abortion: The Parameters of Change*, REPROD. HEALTH MATTERS, 2004, 1, at 6; WORLD HEALTH ORGANIZATION, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 87 (2003) ("Saving a woman's life might be necessary at any point during the pregnancy. Performing an abortion on grounds of fetal impairment is also likely to be in the second trimester since most diagnoses can only be made after 12 weeks.").
[4] Stanley K. Henshaw, *Unintended Pregnancy and Abortion: A Public Health Perspective*, *in* UNINTENDED PREGNANCY AND ABORTION – A PUBLIC HEALTH PERSPECTIVE 11, at 19 (National Abortion Federation, 1999); PREVENTING UNSAFE ABORTION AND ITS CONSEQUENCES 2 (Ina K. Warriner & Iqbal H. Shah, eds., 2006).
[5] David A. Grimes et al., *Unsafe Abortion: the Preventable Pandemic*, 368 THE LANCET, 1908, *7 (2006); *see also* Gilda Sedge et al., *Induced Abortion: Estimated Rates and Trends Worldwide*, 370 THE LANCET, 1338, *3 (2007).

reality, those countries have the highest abortion mortality and morbidity rates.[6] Such countries have an abortion fatality rate of approximately 34 deaths per 100,000 live births.[7] By contrast, where abortion is legally permitted, that ratio falls to one or fewer deaths per 100,000 live births.[8] Countries that permit abortion have a median unsafe abortion rate as low as two per 1000 women of reproductive age.[9]

5. Criminalizing abortion does not reduce the incidence of abortion.[10] Rather, the principal effect of such laws are high maternal mortality and morbidity. In one survey in Mexico, one of the reasons offered against liberalizing abortion laws was that people thought such an effort would increase maternal mortality, a view that is inconsistent with the pattern seen across the world.[11]

6. Decriminalizing abortion does not increase the number of abortions.[12] Rather, decriminalization tends to *decrease* the number of abortions.[13] Liberalization reforms shift clandestine, unsafe abortion to legal and safe abortion.[14] This outcome has been seen in countries such as the United States,[15] Barbados, Canada, South Africa, Tunisia and Turkey, which did not experience increases in abortion after decriminalization.[16]

7. In fact, the incidence of abortion is higher in countries that forbid it than in countries that permit it.[17] For example, the Netherlands has one of the lowest abortion rates in the world and, in that country, a woman may obtain free abortion and contraception.[18]

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[6] *See* Berer, *Making Abortions Safe*, *supra* note 3, at 34; *see also* Berer, *National Laws and Unsafe Abortion*, *supra* note 3, at 2-3.
[7] Grimes et al., *supra* note 5, at *7.
[8] Grimes et al., *supra* note 5, at *7; *see also* Berer, *National Laws and Unsafe Abortion*, *supra* note 3, at 2 ("Evidence from more and more countries is accumulating to show that when abortion is legal on broad socio-economic grounds and at a woman's request, and when safe, accessible services have been put in place, unsafe abortion disappears and abortion-related mortality and morbidity are reduced to a minimum. This has been shown in the United States in the 1970s and in Romania and South Africa in the 1990s, and well documented in data.").
[9] Grimes et al., *supra* note 5, at *7 (relying on World Health Organization's definition of unsafe abortion as "procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both.").
[10] *See Safe, Legal and Falling*, ECONOMIST (Oct. 20, 2007); Henry P. David, *Abortion in Europe, 1920-91: A Public Health Perspective*, STUDIES IN FAMILY PLANNING, Jan.-Feb. 1992, 8, at 17.
[11] Sandra G. Garcia et al., *Policy Implications of a National Public Opinion Survey on Abortion in Mexico*, 12 REPROD. HEALTH MATTERS, 65, 72 (2004).
[12] Grimes et al., *supra* note 5, at *7.
[13] Henshaw, *supra* note 4, at 14 ("A common pattern is for the abortion rate to rise briefly after legal restrictions are lifted and then to enter a period of slow decline. Some countries have achieved large reductions in their abortion rates without imposing restrictions.").
[14] Grimes et al., *supra* note 5, at *7.
[15] *See* Willard Cates, Jr. et al., *The Public Health Impact of Legal Abortion: 30 years later – Comment*, PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH, Jan./Feb. 2003, 25, at 25.
[16] Grimes et al., *supra* note 5, at *12.
[17] Henshaw, *supra* note 4, at 14; Susan A. Cohen, *New Data on Abortion Incidence, Safety Illuminate Key Aspects of Worldwide Abortion Debate*, GUTTMACHER POLICY REVIEW, Fall 2007, at 2 ("Incidence of abortion is higher in countries where illegal as opposed to countries where permitted. Abortion rates are lowest in countries where abortion is legal. Lowest abortion rates in the world are in Europe, especially western Europe (Belgium, Germany and Netherlands are below 10 per 1,000 women aged 15-44 in 2003."); David, *supra* note 10.
[18] Grimes et al., *supra* note 5, at *8.

A. Illegal abortions have high mortality and morbidity rates.

8. When abortion is illegal, women are driven to unsafe, underground abortions.

9. Such illegal abortions are associated with high mortality and morbidity rates. Worldwide, 68,000 women die each year because of complications from unsafe abortions.[19] In Latin America, the mortality rate is 119 deaths per 100,000 abortions.[20]

10. Complications of illegal abortions include infection as well as permanent infertility. Twenty to thirty percent of unsafe abortions result in reproductive tract infections, and of that group, twenty percent to forty percent result in upper genital tract infection and infertility. Worldwide, approximately two percent of women of reproductive age are infertile as a result of unsafe abortion, and five percent have chronic infections.[21] In Latin America, countries with restrictive abortion laws experience "[e]pidemic levels of unsafe abortion" and even higher rates of complications which affect thirty percent to forty-five percent of women that undergo unsafe abortion.[22]

11. In Mexico, despite current restrictive abortion laws, studies estimate that there are between half a million to almost one million cases of induced abortion per year.[23] The complications resulting from unsafe abortions are the fourth leading cause of maternal mortality in Mexico.[24] They are the third highest reason for admission to gynecological services in the metropolitan hospitals of the Mexican Social Security System.[25] In public hospitals alone, approximately 120,000 women seek treatment for abortion-related complications.[26] Botched abortions kill approximately 1,500 women in Mexico every year and are the third leading cause of death for pregnant women in Mexico City.[27]

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[19] Grimes et al., *supra* note 5, at *5.
[20] Berer, *supra* note 3, at 32.
[21] Grimes et al., *supra* note 5, at *6 (citing World Health Organization statistics).
[22] Rebecca J. Cook et al., *International Developments in Abortion Law from 1988 to 1998*, 89 AM. J. OF PUBLIC HEALTH, 579, 580 (1999).
[23] Carlos Brambila et al., *Estimating Costs of Portabortion Services at Dr. Aurelio Valdivieso General Hospital, Oaxaca, Mexico, in* POST-ABORTION CARE: LESSONS FROM OPERATIONS RESEARCH 108, at 108 (Dale Huntington & Nancy J. Piet-Pelon eds., 1999) (crediting the Alan Guttmacher Institute) (estimating half a million instances of induced abortion at the beginning of 1990s); Yolanda Palma et al., *Unsafe Abortion in Latin America and the Carribean: Priorities for Research and Action, in* PREVENTING UNSAFE ABORTION AND ITS CONSEQUENCES 198 (Ira K. Warriner & Iqbal H. Shah eds., 2006) (approximating 533,000 induced abortions in 1990); HUMAN RIGHTS WATCH, THE SECOND ASSAULT OBSTRUCTING ACCESS TO LEGAL ABORTION AFTER RAPE IN MEXICO § IV (2006) (relying on estimates putting the number of annual abortions in Mexico "closer to one million.").
[24] Deborah L. Billings et al., *Comparing the Quality of Three Models of Postabortion Care in Public Hospitals in Mexico City*, INTERNATIONAL FAMILY PLANNING PERSPECTIVES, Sept. 2003, 112, at 112; Brambila et al., *supra* note 23, at 108; Garcia et al., *supra* note 11, at 65; *see also* Susan Pick de Weiss & Henry P. David, *Illegal Abortion in Mexico: Client Perceptions*, 80 AM. J. OF PUBLIC HEALTH, 715, at 715 (June 1990) (describing complications from unsafe abortions as the fifth largest cause of maternal mortality).
[25] Pick de Weiss & David, *supra* note 24, at 715 (there are no reliable data available on women admitted to other services.)
[26] Billings et al., *supra* note 24, at 112.
[27] *Mexico City Legalizes Abortion*, AP Online, Apr. 25, 2007 (statistic attributed to Mexico City's Women's Institute).

B. Decriminalization can drastically reduce the risks to maternal health.

12. The public health evidence is "incontrovertible" that decriminalization of abortion is the best way to improve public health by reducing complications and deaths associated with unsafe abortions.[28] Bringing legal abortion out into the open is necessary to ensure the quality of medical care.[29] Guyana's recent experience in liberalizing abortion laws provides a telling example. Before 1995, when abortion was a criminal offense, most abortion providers were medical professionals.[30] Still, septic abortion was the third highest cause–nineteen percent–of hospital admissions.[31] Within six months of the decriminalization of abortion, admissions to the main public hospital for septic and incomplete abortions fell by forty-one percent because the same providers began to give prophylactic antibiotics in an organized manner.[32]

13. Other countries have also experienced dramatic improvements in public health following decriminalization of abortion. In Romania, the maternal mortality rate dropped by nearly half in the year after the law changed.[33] In South Africa, after changing its abortion law, deaths from abortion complications decreased by ninety-one percent from 1994 – 2001.[34]

14. Decriminalization is a critical component of making such public health improvements. Without legal status, the quality of abortion care is impossible to ensure. Instead, medical providers performing abortions are subject to professional and social stigma, as well as the risks of blackmail and prosecution.[35] Decriminalization allows for regulation of abortion care to monitor and enforce quality of care and standardize the safest, most effective methods.[36]

C. Decriminalization encourages medical assessment, training and innovation to advance the safety of abortion care.

15. Decriminalization greatly improves maternal mortality and morbidity related to abortion by bringing about a greater proportion of abortions earlier in pregnancy, generating research and innovations, and allowing opportunities for better training. In the United States, legalization led to women seeking abortion earlier in pregnancy,

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[28] Cohen, *supra* note 16, at 4 ("Still, the evidence is incontrovertible that the surest way to reduce the death and disability associated with unsafe abortion is to legalize it and bring it into the open."); Grimes et al., *supra* note 5, at *10 (2006), *citing* W. Cates Jr., *Legal Abortion: The Public Health Record*, SCIENCE 1586 (1982).
[29] Berer, *Making Abortions Safe*, *supra* note 3, at 39.
[30] Berer, *Making Abortions Safe*, *supra* note 3, at 39.
[31] Berer, *Making Abortions Safe*, *supra* note 3, at 39.
[32] Berer, *Making Abortions Safe*, *supra* note 3, at 39.
[33] Cook et al., *supra* note 22, at 580.
[34] *The Health Dangers of Unsafe Abortion*, UNSAFE ABORTION, Aug. 2007, at 2.
[35] Berer, *Making Abortions Safe*, *supra* note 3, at 40 ("Women remain vulnerable where safe abortion is not legally sanctioned, because quality of care cannot be assured, abuses cannot be challenged and both women and providers remain at risk of prosecution, blackmail, and social and professional stigma.").
[36] Berer, *National Laws and Unsafe Abortion*, *supra* note 3, at 5 ("Regulation by government of both public and private abortion services has been shown to be necessary in all countries to ensure quality of care, humane treatment, use of the safest methods, and provision of services free or at a cost that even the poorest women can afford.").

when the procedure is safer.[37] In 1980, only one in 10 abortions were performed at 13 weeks' gestation or later, which fell from four in 10 a decade earlier, when abortion was illegal in most states.[38]

16. Legalization also stimulates medical research into safer abortion methods. In the United States, suction curettage accounted for fifty-four percent of abortions and sharp curettage accounted for forty-six percent in 1970, before decriminalization. Research findings showed that suction curettage was faster and safer. By 1998, suction curettage was used for ninety-six percent of all abortions. For second-trimester procedures, researchers also determined that the dilation and evacuation ("D&E") method was safer than the prior method—intra-amniotic instillation of abortifacients such as saline to induce abortion—at 13 weeks or later, and by the mid-1990's, D&E accounted for ninety percent of all second trimester abortions.[39]

17. Decriminalization also led to new innovations in the development of medical abortifacients. Medical abortion through use of mifepristone (also known as RU 486) or methotrexate in conjunction with misoprostol can terminate pregnancies within 63 days of the last menstrual period, and therefore can be used earlier in a pregnancy when abortion is safer.[40] These innovations also have the advantage of not requiring a physician; a mid-level provider can administer the procedure safely and effectively.[41] In some places in Latin America, increased use of medical abortifacients may already be helping to diminish mortality related to unsafe abortion.[42] Although some types of abortifacients, such as misoprostol, are available in pharmacies in Mexico, use and knowledge is extremely low.[43]

18. In the United States, decriminalization gave medical providers an opportunity to learn and train, and manage abortion-related complications more effectively. It raised the skill level of providers and improved health outcomes.[44] In European countries where abortion is legal and performed under regulated conditions by trained providers, it is very safe and presents a risk of maternal death less than one per 100,000 abortions.[45] There, safety advances also came with decriminalization, which led to improved procedures, increased provider skill and greater experience treating complications.[46]

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[37] Cates, Jr. et al., *supra* note 15, at 25.
[38] Cates, Jr. et al., *supra* note 15, at 25.
[39] Cates, Jr. et al., *supra* note 15, at 25-26.
[40] Wendy Chavkin, *Topics for Our Times: Public Health on the Line – Abortion and Beyond*, 86 AM. J. OF PUBLIC HEALTH 1204, *3-*4 (1996).
[41] Berer, *National Laws and Unsafe Abortion*, *supra* note 3, at 6.
[42] Deborah L. Billings et al., *Women's Perspectives on Medical Abortion in Mexico, Colombia, Ecuador and Peru: A Qualitative Study*, REPROD. HEALTH MATTERS, 2005, at *3.
[43] CLAUDIA DIAZ ET AL., POPULATION RESEARCH COUNCIL, MEXICAN NATIONAL OPINION SURVEY ON REPRODUCTIVE HEALTH AND SOCIAL ISSUES (2006), http://www.popcouncil.org/projects/RH_MexicoRHSurvey.html (In a nationally representative survey, only one percent had used misoprostol.).
[44] Cates, Jr. et al., *supra* note 15, at 27 ("Improved training was one factor that helped to reduce abortion-related morbidity and mortality in the first decade of legal abortion.").
[45] David, *supra* note 10, at 8.
[46] David, *supra* note 10, at 8 ("Particularly promising are the newer manual vacuum aspiration techniques for early abortion.").

19. In Mexico, there is ample room for these same factors to bring about significant public health improvements. Lack of training and use of older methodologies, for example, are two areas that can be improved. In a 1997 – 1998 study of six Mexican Institute of Social Security Hospitals in Mexico City metropolitan areas, researchers found that most hospitals and personnel lacked post-abortion care training.[47] The predominant method used was sharp curettage instead of the safer method of vacuum aspiration.[48] The World Health Organization recommends that vacuum aspiration[49] be used to treat complications of unsafe and incomplete abortion to improve safety and quality of care.[50]

20. The medical community in Mexico recognizes that it lacks training and legal backing for some services. In February 2002, a survey of 468 health service providers at a workshop on sexual violence indicated a lack of understanding of the legal framework for providing abortion services for victims of sexual violence.[51] Barely half of physicians, nurses, and social workers had received information about sexual violence and abortion during their medical education.[52] Less than a quarter were trained to provide medical care, fewer than half were trained in use of emergency contraception, and only thirty-four percent of physicians were trained to use manual vacuum aspiration for abortion complications and abortion.[53]

D. The negative health effects of the criminalization of abortion disproportionately harm poor, rural, young and otherwise marginalized women.

21. The increases in mortality and morbidity described in this brief are not equally distributed across the population of women seeking abortions. Rather, the illegal abortion options available to poor, rural, young and otherwise marginalized women are

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[47] Billings et al., *supra* note 24, at 112.

[48] Billings et al., *supra* note 24, at 112; *cf.* Brooke R. Johnson et al., *Costs and Resource Utilization for the Treatment of Incomplete Abortion in Kenya and Mexico*, 36 SOC. SCI. MED. 1443 (1993). In a comparison study of sharp curettage and vacuum aspiration methods to treat complications resulting from incomplete abortion in five Mexican hospitals in the Mexican Social Security System (IMSS), researchers found that only two western states had implemented manual vacuum aspiration. *Id.* at 1444. The study concluded that manual vacuum aspiration provided "significant potential benefits for women, service providers, and the healthcare system" and recommended adoption of a policy preference for manual vacuum aspiration, procurement of appropriate medical instruments, new training, and implementation of clinical protocols as well patient-management practices. *Id.* at 1452-53.

[49] Suction curettage, discussed in ¶ 16, is a type of vacuum aspiration. "Vacuum aspiration empties the uterus with gentle suction of a hand-held suction device or with machine-operated suction. When it is performed with a manual suction device, it is sometimes called manual vacuum aspiration or MVA. When it is performed with machine-operated suction, it is sometimes called dilation and suction curettage or D&C." PLANNED PARENTHOOD, PROCEDURES, http://www.plannedparenthood.org/health-topics/abortion/procedures.htm (last visited Jan. 31, 2008).

[50] WORLD HEALTH ORGANIZATION, *supra* note 3, at 42. The WHO also recommends that "all possible efforts should be made to replace [sharp curettage] with vacuum aspiration, to improve the safety and quality of care." *Id.* at 33. *See also* David A. Grimes, *Reducing the Complications of Unsafe Abortion: The Role of Medical Technology*, *in* PREVENTING UNSAFE ABORTION AND ITS CONSEQUENCES 74 (Ina K. Warriner & Iqba H. Shah eds., 2006) (characterizing sharp curettage as an "obsolete practice" with "compelling evidence" against it).

[51] Deborah L. Billings et al., *Constructing Access to Legal Abortion Services in Mexico City*, REPROD. HEALTH MATTERS, 2002, 86, at 92.

[52] Billings et al., *supra* note 51, at 92.

[53] Billings et al., *supra* note 51, at 92.

more likely to result in mortality and morbidity than those available to wealthier, older and more urban women.[54]

22. The three most common abortion providers in Mexico are doctors, nurses and untrained people, as well as self-induced abortion. Studies have shown that wealthy women are most likely to obtain services from doctors or other trained practitioners, while poor women and those living in rural areas are most likely to obtain services from untrained providers.[55]

23. A study in Oaxaca, Mexico City and Acapulco found that wealthy women, better-educated women and older women were most likely to seek induced abortions from trained providers because they could pay for the service. Poor and less-educated women most often sought abortions from untrained providers. The study also showed that women who sought abortions from untrained providers were more likely to suffer complications than were women who sought abortions from trained personnel.[56] The decriminalization of abortion will reduce the inequality of mortality and morbidity rates among women seeking abortion, and will make it easier for marginalized women to seek necessary treatment for potential complications.[57]

IV. Conclusion.

24. The reforms of the Decree are important measures to improve women's access to sexual and reproductive health care services. As the experience in many other countries has shown, decriminalization of abortion will reduce mortality and morbidity among women seeking abortions and thereby improve public health. The Mexican medical community commits to "incidir en la salud de la población mexicana a través de estrategias de prevención, control de enfermedades y profesionalización de los trabajadores de la salud pública."[58] The medical community can only succeed in this mission with the assent of the government. The Decree represents an important step in that direction.

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[54] Billings et al., *supra* note 51, at 86; Cates, Jr. et al., *supra* note 15, at 25; Chavkin, *supra* note 40, at *3-*4 (1996); Rachel Benson Gold, *Lesson from Before Roe: Will Past be Prologue?* GUTTMACHER REPORT ON PUBLIC POLICY, March 2003, 8; Alan Guttmacher Institute, *An Overview of Clandestine Abortion in Latin America*, ISSUES IN BRIEF, 1996, 1.

[55] Davida Becker et al., *Knowledge and Opinion about Abortion Law Among Mexican Youth*, 28 INTERNATIONAL FAMILY PLANNING PERSPECTIVES 206 (2002); Alan Guttmacher Institute, *An Overview of Clandestine Abortion in Latin America*, ISSUES IN BRIEF, 1996, 1.

[56] Pick de Weiss & David, *supra* note 24, 715-16; *see* Maria del Carmen Elu, *Between Political Debate and Women's Suffering: Abortion in Mexico*, *in* ABORTION IN THE DEVELOPING WORLD (Axel I. Mundigo & Cynthia Indriso eds., 1999), at 248 (showing that poverty was a key factor in women seeking unsafe abortion in Mexico City); and Rachel Benson Gold, *Lesson from Before Roe: Will Past be Prologue?* GUTTMACHER REPORT ON PUBLIC POLICY, March 2003, 8 (arguing that poor women were disproportionately impacted by complications to illegal and unsafe abortion before abortion was decriminalized in the United States).

[57] Billings et al., *supra* note 51, at 88 (stating that "women living in marginalized areas were twice as likely to die from abortion complications as women living in other regions").

[58] Sociedad Mexicana de Salud Pública, A.C., Apr. – June 2007, http://www.uanl.mx/publicaciones/respyn/viii/2/enlace/enlace.htm

Dated: 5 February 2008

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