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# Six More Problems with Women Deliver:

## Why Attempts to Redefine Maternal Health as Reproductive Health Threaten the World's Women

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# Six More Problems with Women Deliver:

## Why Attempts to Redefine Maternal Health as Reproductive Health Threaten the World's Women

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Prominent international abortion and family planning advocates met together in Washington D.C. at the second Women Deliver conference from 7–9 June 2010. The ostensible purpose of this UN-backed conference was to assess achievement of Millennium Development Goal (MDG) 5 to reduce maternal mortality, and to determine how to raise awareness and funding to meet the goal by its deadline in the year 2015. Echoing the first Women Deliver conference in 2007, abortion advocates, who organized the conference, used the issue of maternal health to campaign for broader sexual and reproductive health "rights" under the umbrella of women's rights. This paper evaluates six major problems with the strategy laid out in Washington. If UN member states adopt the agenda for maternal health proposed at Women Deliver, women all over the world will suffer more for it.

### Problem #1: The latest empirical data and statistics *do not* support the claim that abortion is an essential factor to globally reduce maternal mortality rates.

The fact that the maternal mortality rate (MMR) has been declining 1–3% per year globally contradicts the abortion advocates' bid for an additional $30B for reproductive health to meet MDG5. Evidence shows this money is better spent on the real causes of improved maternal health.

The Women Deliver agenda is based upon World Health Organization (WHO) reports that the number of maternal deaths is an estimated 500,000 per year globally, and that this figure has remained unchanged for the past twenty years. Yet this figure is proved outdated by a number of studies, and most recently by *The Lancet* medical journal.[1] In April, *The Lancet* produced a thorough and systematic study of WHO numbers conducted by the Institute for Health Metrics and Evaluation. This study used WHO data, which had been available to WHO for the last 20 years, clearly showing a decline in the MMR from 526,300 in 1980 to 342,900 in 2008. Among those deaths, 60,000 are attributed to HIV/AIDS. Without HIV/AIDS, the MMR was 281,500 maternal deaths worldwide, not 500,000 as claimed by outdated UN figures. This decline in the MMR was achieved through simple measures such as economic development, better healthcare systems, and increasing female literacy rates, as well as skilled birth attendants and emergency obstetric care.

Declines in maternal mortality are thus proven to happen without declaring abortion an international right. It is important to note that it took an outside organization to finally analyze information that has been available to WHO for the last 20 years. When asked about the study at the conference, WHO executive director Margaret Chan offered no explanation as to why this data was not analyzed or accounted for by the WHO in their outdated estimates of 500,000 maternal deaths per year.

However, the Office of the High Commissioner on Human Rights (OHCHR) continues to use the estimate of 500,000 maternal deaths per year,[2] and many other United Nation (UN) and family planning agencies in attendance at the Women Deliver conference ignored or even ridiculed the *Lancet* study. Asked to explain why the UN continued to use numbers which are so out of date, Thoraya Obaid, UN Population Fund (UNFPA) executive director, said, "if even one woman dies it is one too many." She also said that the UN's updated estimates will be published in September and should look similar to the *Lancet*'s. Contradicting Obaid, Thies Boerma, head of health statistics at WHO, said that the UN study would likely not be published until 2011 and Boerma would not commit to whether the UN would have the same findings. Dr. Chan admitted that there are "early signs of progress in reducing the number of women dying in pregnancy and child birth, in addition to the achievements in HIV, TB and malaria," but she erroneously stated that the new report demonstrated that legal abortion, as in the case of China, was a key factor in reducing maternal mortality. In fact, abortion was never even mentioned in the *Lancet* study.

## Problem #2: Activists are claiming that a new internationally recognized right to maternal health has been established and that governments must be held accountable for violations of that right.

Although most nations are rightly concerned for maternal health, this concern has been twisted by an assumption that "maternal health" is equivalent to the ill-defined term "reproductive health," which some activists and UN staff have equated to "reproductive rights" and further erroneously define as including abortion. As with the campaign for an international right to abortion, the legal strategy is to claim that the "right to maternal health," read to mean "reproductive rights," already exists and then work to make it so. The International Initiative on Maternal Mortality and Human Rights (IIMMHR) was launched merely two and a half years ago to bring about an internationally acknowledged "right to maternal health." Activists at Women Deliver are claiming that they have already successfully established the "right to maternal health" to mean "reproductive rights," and they held a number of legal strategy panels to educate conference attendees on how to attack governments on human rights violations. Abortion advocates are pinning the new right on a phrase that states, "preventable maternal mortality is a health, development and human rights challenge," found in a non-binding 2009 Human Rights Council (HRC) resolution. Their entire argument rests

on the assumption that "maternal health" is synonymous with reproductive rights. With a human right to "maternal health" in place, the assertion is that it is a human rights violation for a government not to have legal, government-funded abortion.

Alicia Yamin, of Harvard Law School, and other speakers from top law schools such as Rebecca Cook, from University of Toronto Law School, outlined how activists could secure "maternal" health services by utilizing the legal language of discrimination. Namely, activists would claim that the law must ensure fairness—all women should have equal access to health services. Any burden on access, be it due to poverty, adolescence/age, race or ethnicity, or law would then be deemed "discrimination" against the woman and thus a violation of her rights—a right to be treated equally and a right to "maternal" health care. From this perspective, the government must ensure equal access to all services provided by hospitals, clinics, and the like, including free services where needed.

While this overly broad use of "discrimination" has been adopted by the committee that monitors the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)[3] and is being widely used in international litigation, it has generally been rejected by the U.S. Supreme Court. According to the U.S. Supreme Court, the "disparate impact" of facially neutral and justified practices are not sufficient grounds for a "discrimination" claim. Moreover, the recipient of the "disparate impact" must also be part of a protected class that is disproportionately impacted. Achieving recognition of a right to maternal health at the international level, however, would increase pressure on states, including the U.S. government, to ensure equal access to services, including abortion.

## Problem #3: Using the "right to maternal health" as a guise, medical providers are recklessly distributing abortive and contraceptive drugs.

Despite the fact that the medical literature has shown that medical abortion has greater risk of hemorrhage, infection and need for emergency surgery than surgical abortion, the UN and non-governmental organizations (NGOs) are increasing maternal mortality and morbidity by recklessly distributing abortive drugs in areas where adequate health care infrastructure is inadequate to deal with known complications induced by these drugs. Niinimaki et al (2009) studied women who obtained abortions in Finland where health infrastructure allowed for immediate care of complications. Findings demonstrated that one out of every five women who underwent medical abortion under ideal settings experienced a complication from the medical abortion. The results of the study found:

> The overall incidence of adverse events was fourfold higher in the medical compared with surgical abortion cohort (20.0% compared with 5.6%, *P*<.001). Hemorrhage (15.6% compared with 2.1%, *P*<.001) and incomplete abortion (6.7% compared with 1.6%, *P*<.001) were more

> common after medical abortion. The rate of surgical (re)evacuation was 5.9% after medical abortion and 1.8% after surgical abortion (*P*<.001).[4]

The study stated, "Because medical abortion is being used increasingly in several countries, it is likely to result in an elevated incidence of overall morbidity related to termination of pregnancy."

In situations where emergency surgery is not available to deal with the bleeding and retained tissue after medical abortion, what will happen to the one out of five women who experience a complication from medical abortion? The reckless and unfounded push by UN and NGOs to "reduce 'unsafe' abortion" by increasing distribution of mifepristone and misoprostol while completely ignoring evidence-based medicine is not only unfounded, it is unconscionable. The activities that the UN and NGOs engage in to "reduce 'unsafe' abortion" actually increase maternal deaths.

Temple Cooley of Population Services International (PSI) gave Women Deliver participants the case of Cambodia, which legalized abortion in 1997. PSI initially conducted a study that found 77% of abortions were from drugs in packages written in Chinese, a language the patients were not able to read. PSI and the Concept Foundation convinced the government to allow them to import and distribute abortion pills, misoprostol and mifepristone, in blister packs. They argued that it was the most economical option.[5] In a follow-up study, PSI found that only 17% of those using their products had training to perform medical abortions. Cooley said "none" of those administering the drug could identify the correct dosage. She said failed abortions and complications were "common." Rather than desist, PSI instead recommended the government increase the number of people allowed to administer the pills and tried to change the behavior of the drugs' distributors through workshops called "medical detailing," with admittedly unproved results. Later, PSI found that some of the distributors were just selling the individual doses to women, an extremely dangerous practice, especially if the woman is not given the entire dosage of both misoprostol and mifepristone.

Dan Grossman, from Ibis Reproductive Health, spoke about how much higher mortality is for second trimester abortions in the United States and how U.S. abortion-related mortality has risen. He went on to recommend that second-term abortions be made more legal and accessible all over the world. Grossman suggested medical workers use a combination of dilation and evacuation with misoprostol for second trimester abortions in poor countries. He said that dilation and evacuation (used mostly in the U.S.) was preferable to induction (used in India) because 40 abortions per day can be done on an outpatient basis, whereas inductions are inpatient procedures and women might have to stay in the hospital 4 days. Emphasis was clearly placed on the expediency and economics of performing abortions without any concern given to the grave medical dangers to mothers and children.

The presentations by Cooley and Grossman demonstrate a willingness to implement

policy changes without any evidence of benefit, and in the face of much evidence of harm. It is not insignificant that the organizations that push such irresponsible policy implementation also stand to benefit financially from such policy implementation.

## Problem #4: UN staff and NGOs target religious leaders and youth to undermine traditional culture and values.

UN agencies are using UN resources to advocate their agenda on a local level in order to bypass cultural and religious resistance. Gamal Serour, president of the International Federation of Gynecology and Obstetrics (FIGO), reported that UNFPA has a program in 25 countries to lobby religious leaders into dropping objections to the agenda. These programs are aimed at "re-educating" religious leaders and convincing them that family planning does not go against their religious values, especially when taken from a medical point of view. Serour recounted that they had success in Nigeria, explaining that the UNFPA agenda was not just "Western" ideas, and that afterwards Muslim leaders "changed their attitudes completely." Members of UNFPA's executive board have repeatedly called on the fund's leadership to desist from such "awareness raising" programs, which amount to little more than ideological campaigns. Instead of using UN resources to overcome justifiable resistance to the controversial agenda, the fund should be used to provide better basic health care for women, which has proven to reduce maternal deaths.

Similarly, a representative of Catholics for Choice Mexico stated "we can be faithful and secular" and provided the crowd with handouts advertising condom use that stated "pleasure is not a sin, risking you and your partner's life is." John O'Brien, president of Catholics for Choice explained his organization's work claiming, falsely, that the Catholic bishops do not speak for the lay faithful; they "speak for the 350 bishops, not 50–60 million Catholics." Mary Robinson, former UN High Commissioner for Human Rights and former President of Ireland, asserted, "We will be able to get a lot more progress [in Ireland] in sexual education and emergency contraception now that the scandal has diminished the credibility of the Church." The International Planned Parenthood Federation (IPPF) was also present and strategizing on how to make young people "aware" of their sexual rights as young as 10–12 years old. This follows on the heels of the release of a highly controversial UN Educational, Scientific and Cultural Organization-backed (UNESCO) sexual education curriculum which promoted sexual activity for five-year-old children and abortion to children as young as nine years of age.[6] FIGO's Serour also advocated for adolescent-friendly clinics for emergency contraception to be "integrated" with maternal and child health so there are fewer "social stigmas," that is, so that there would be less parental and adult notification and consent. The advocates from Women Deliver take it upon themselves to speak for the community, even when they do not represent the voice of the community.

**Problem #5: UN senior staff recommend policies that, if followed, would siphon off funding from genuine health and development needs.**

UN Secretary-General Ban Ki-Moon opened the Women Deliver conference with the announcement of a new document titled, "Investing in our Common Future: Joint Action Plan for Women's and Children's Health," intended to accelerate progress towards MDGs 4 and 5. A draft of the Joint Action Plan circulated at Women Deliver gave examples of actions to be taken by governments and policy makers. The draft insists that States "*fully integrate the following into all primary healthcare facilities*," listing family planning and abortion-related care among other health issues. Elsewhere, the draft Joint Action Plan said States should "*increase governments' portion of budget allocated to health and build on existing regional commitments to increase access to sexual and reproductive health services.*"

By promoting the Joint Action Plan and participating in agreement on discussion panels urging diversion of funds to abortion services, UN staff members are complicit in furthering the abortion agenda that siphons funding from primary maternal health needs. On a panel dedicated to discussing the Joint Action Plan, WHO executive director Margaret Chan mentioned using women and girls as a new "entry point" to energize the Millennium Development Goals. Pius Okgong of FIGO followed, stating, "Maternity is not the only healthcare service that women need, but also family planning."

UN involvement in the abortion agenda in Africa was flaunted through promotion of the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA), a UNFPA-backed initiative of the African Union that promotes the controversial Maputo Plan of Action. The Maputo Plan, which was recently extended until 2015, promotes abortion in African states, regardless of whether they are party to the Maputo Protocol, a binding legal document that includes abortion.[7] According to its advocates at Women Deliver, CARMMA seeks to redirect the already scarce skills of birth attendants, community health workers, nurses and midwives and doctors, and link them to UN agencies (such as UNAIDS, UN Children's Fund, UN Development Fund for Women, UNFPA and WHO), and NGOs (such as IPPF and White Ribbon Alliance) in order to promote the reproductive health agenda—an agenda not always representative of the values and wishes of the UN member states.

Sounding a note of concern about the conflation of valid health care programs with the controversial abortion agenda was UN Special Rapporteur for HIV/AIDS Anand Grover. Grover stated cautiously, "before you have community support, you should not have a law." He discussed the need to link the grassroots movements with the legal movements in order to have a unified attack, and used the HIV/AIDS effort as a positive example. Paying little heed to such concerns, family planning advocates among the UN staff aggressively push to funnel UN resources into the already bloated family planning industry by "uniting" it to the fight against HIV/AIDS, malaria, and tuberculosis.

## Problem #6: MDG 5 target B regarding "reproductive health" remains highly controversial.

Every time the UN General Assembly (UNGA) debated the inclusion of "reproductive health" in the Millennium Development Goals—in 2000 and in 2005—it was flatly rejected. The origin of MDG 5 target B on access to "reproductive health" is dubious. It was inserted into an appendix of a Secretary General's report of work (Sixty-second Session Supplement No. 1 (A/62/1))[8] in 2007, which was adopted by the UNGA without any debate or discussion, indeed, without the awareness of many member States.

The target was inserted so stealthily, that there remains confusion among UN staff and NGOs about the nature and date of its establishment. UNICEF's 2008 annual report, "The State of the World's Children: Maternal and Newborn Health," asserted that the target was established in 2005.[9] Former International Planned Parenthood Federation president Steven Sinding asserts the same.[10] But UNFPA executive director Thoraya Obaid announced at the 2007 Women Deliver conference that she had thus far "failed to deliver" such a target, and promised prominent abortion advocates at that meeting that she would achieve success soon. UNFPA now asserts that the target was established in 2008, pursuant to the adoption of its mention in the appendix of the 2007 Secretary General's report. UN websites dedicated to the MDGs have only recently included reference to such a target.[11]

Uncertainty among UN officials about its origins, and lack of any open discussion or debate preceding its adoption—especially in light of open and widespread rejection in 2000 and 2005—makes it clear that there can be no claim to widespread international support for MDG5b.

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The Medical community has long known how to reduce maternal deaths: provide better health care that ensures healthy outcomes for mother and child. The attempt to redefine maternal health as "reproductive" health and to further include abortion is a dangerous agenda that UN member States should resist. As this analysis demonstrates, the attempt to promote abortion through the MDGs is an elitist agenda that would undermine medical practices, legal principles, and cultural and religious traditions. UN member States are right to continue to reject the Women Deliver agenda and seek instead to invest resources in verified medical practices that improve maternal, newborn, and child health.

## Endnotes

1 Margaret Hogan, et. al, "Maternal mortality for 181 countries, 1980—2008: a systematic analysis of progress towards Millennium Development Goal 5, *The Lancet*, Volume 375, Issue 9726, pp. 1609–1623, 8 May 2010. The study's findings stated, "We estimated that there were 342,900 (uncertainty interval 302,100–394,300) maternal deaths worldwide in 2008, down from 526, 300 (446,400–629,600) in 1980. The global MMR decreased from 422 (358–505) in 1980 to 320 (272–388) in 1990, and was 251 (221–289) per 100,000 live births in 2008. The yearly rate of decline of the global MMR since 1990 was 1.3% (1.0–1.5). During 1990–2008, rates of yearly decline in the MMR varied between countries, from 8.8% (8.7–14.1) in the Maldives to an increase of 5.5% (5.2–5.6) in Zimbabwe. More than 50% of all maternal deaths were in only six countries in 2008 (India, Nigeria, Pakistan, Afghanistan, Ethiopia, and the Democratic Republic of the Congo). In the absence of HIV, there would have been 281, 500 (243,900–327,900) maternal deaths worldwide in 2008."

2 Report of the Office of the United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights (A/HRC/14/39), (New York: United Nations, 2010), 4. Available at http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.39.pdf.

3 Convention on the Elimination of All Forms of Discrimination Against Women, Art. 1 states, "For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field." Available at http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#intro. The CEDAW committee has read this to include "direct and indirect" discrimination in both the "public and private spheres," (CEDAW/C/BHR/CO/2 Concluding Observations), (Bahrain: United Nations, 2008), accessed at http://www.upr.bh/un_treaty/CEDAW-Concluding.pdf; CEDAW General Recommendation 25, interpreting Art. 4, "Firstly, States parties' obligation is to ensure that there is no direct or indirect discrimination* against women in their laws and that women are protected against discrimination—committed by public authorities, the judiciary, organizations, enterprises or private individuals—in the public as well as the private spheres by competent tribunals as well as sanctions and other remedies. *Indirect discrimination against women may occur when laws, policies and programmes are based on seemingly gender-neutral criteria which in their actual effect have a detrimental impact on women."

4 M. *Niinimäki et al*., "Immediate Complications After Medical Compared with Surgical Termination of Pregnancy," *Obstetrics and Gynecology*, Volume 114, Issue 4, October 2009, p. 795.

5 According to Grossman, medical abortions—mostly done with mifepristone and misoprostol—cost $2–$24, whereas surgical abortions cost $17–$250.

6 International Guidelines on Sexuality Education: An Evidence Informed Approach to Effective Sex, Relationships and HIV/STI Education, (Paris: UNESCO, 2009), 30-53. Available at http://www.foxnews.com/projects/pdf/082509_unesco.pdf.

7 At the July 25–27, 2010 African Union summit in Kampala, Uganda, the Maputo Plan of Action was extended from 2010 to 2015. *See* http://www.unfpa.org/public/home/news/pid/6396.

8 Report of the Secretary-General on the Work of the Organization Supplement No.1 (A/62/1), (New York: United Nations, 2007), 67. Available at http://www.un.org/Docs/journal/asp/ws.asp?m=A/62/1(SUPP).

9 *The State of the World's Children 2009* (New York: UNICEF, 2008), 20. Available at http://www.unicef.org/sowc09/report/report.php.

10 Steven Sinding, presentation at the Bixby Center for Global Reproductive Health, University of California, Berkeley, 23 January 2009. Available at http://bixby.berkeley.edu/sinding.

11 Official UN websites began to include MDG5b after the meeting of the Commission on the Status of Women, March 2010.