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Acceptable Losses: Behind the Fearmongering Over Cuts to Global "Sexual and Reproductive Health" Funding

By Rebecca Oas, Ph.D.

INTRODUCTION

The dismantling of the U.S. Agency for International Development (USAID) and cuts to many other areas of foreign assistance during the second Trump administration have left many sectors scrambling to adapt. They include family planning and "reproductive health" organizations—many of which promote abortion overseas. These groups are accustomed to funding cuts under Republican administrations and have perfected the arguments in favor of restoring their funding. This *Definitions* examines these claims and demonstrates that the more one examines their statistics, the weaker their arguments become. While people of good will can argue over what level and type of foreign assistance the U.S. should provide, U.S. family planning funding deserves to be subjected to particular scrutiny—both because of its misleading use of statistics and because it serves as a pipeline to the global abortion lobby.

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Funding cuts and boilerplate statistics

Approximately every four to eight years, when a Republican president is elected in the United States, certain executive orders are usually released calling for cuts to funding for the United Nations Population Fund (UNFPA) and from all foreign organizations that promote or provide abortions overseas. When these cuts are announced, or when the results of an election make them seem likely, a series of paint-by-numbers statistics appear almost immediately, detailing the predicted outcomes of the policy: more unintended pregnancies, more unsafe abortions,

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When Donald Trump was elected to his second, non-consecutive, term as U.S. president, many expected that he would follow the playbook of his first term: defund UNFPA, reinstate his policy banning funds to foreign abortion-promoting organizations (which had been expanded in his first term to include all global health assistance), but otherwise leave U.S. foreign aid largely intact. Foreign-focused pro-life groups advocated for Trump to do more, perhaps by further expanding the policy known previously as the Mexico City Policy and reinstated as Protecting Life in Global Health Assistance (PLGHA) to cover all foreign aid including humanitarian assistance and funding going to multilateral institutions and multisector partnerships. Perhaps Trump could rein in the USAID office for family planning and reproductive health, which has since its creation sought to undermine and circumvent pro-life policies and laws.[1]

Instead, Trump went farther than most of his critics and supporters expected, mandating a thorough audit of all U.S. foreign assistance, which resulted in drastic cuts, and shuttering USAID entirely. The 17% of grants that survived are now under the Department of State. While family planning and "reproductive health" organizations received the cuts they were bracing for, this time they were just one of many constituencies impacted by the loss of funding.

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Organizations like the Guttmacher Institute were quick to provide calculations estimating the impact of previous U.S. funding for family planning and related areas, usually expressed in women's lives saved. Some estimates looked forward, speculating on how many deaths would result from the loss of U.S. funding. A March report from Guttmacher, originally published in Ms. Magazine, was headlined "Foreign Aid Cuts Will Lead to 34,000 More Pregnancy-Related Deaths in Just One Year." To be clear, Guttmacher is not referring to deaths due to direct cuts to maternal health care. In the article, it is specified:

> If these critical funds are not renewed and spent as appropriated, over the course of one year, 47.6 million women and couples will be denied modern contraceptives, resulting in 17.1 million unintended pregnancies and 34,000 preventable pregnancy-related deaths.[2]

This assertion contains multiple parts that deserve to be examined in turn, all of which originate in the Guttmacher Institute's *Adding It Up* project, which has been ongoing for over twenty years.

Family Planning: Friend or Foe to Maternal Health?

In its assertion that 34,000 preventable pregnancy-related deaths would occur in a year due to U.S. funding cuts, the Guttmacher Institute limits its focus to women seeking to avoid pregnancy who would become pregnant because they were denied contraceptives. Guttmacher further postulates these women would die due to complications of pregnancy, childbirth, or its management. The phrase "or its management" deserves our special attention because it serves as a way to include deaths because of complications from induced abortion, which is entirely distinct from other leading causes of maternal death by being *artificially induced* rather than a natural complication to a natural process. Estimates of abortion-related deaths by pro-abortion organizations often take for granted the assumption that the only acceptable alternative to an "unsafe" abortion is a "safe" abortion.

The Guttmacher estimate does not include potential maternal deaths associated with pregnancies categorized as intended. The category of "unintended" includes a spectrum of levels of intention ranging from strong opposition to becoming pregnant to those open to welcoming a child despite less-than-ideal circumstances. It also does not differentiate between those whose family planning methods failed, those who tried and failed to obtain a method, and those who made no real effort to avoid pregnancy at all.

In the same article, the Guttmacher authors write that the majority of maternal deaths occur in places experiencing instability due to conflict or natural disasters, including in refugee camps. Therefore, they argue, "access to contraception is as essential as food and shelter."[3] Where maternity is not safe, they make the case that it is better to make it rare.

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Even where adequate medical services are available, it costs more to provide a full range of maternal and child health care than to prevent a pregnancy. For this reason, Guttmacher argues that for every dollar spent on providing contraceptives, three dollars can be saved "in pregnancy-related and newborn care costs." Guttmacher says this becomes an economic and security imperative. Furthermore, they claim women's increased labor force participation also generates economic activity that could otherwise be reduced by maternity leave and child care. Family planning advocates like the Guttmacher Institute often add up the costs associated with bringing a child into the world and providing for his or her upbringing, pointing to the potential savings in the public spending areas of health care and education if greater contraceptive use resulted in fewer

births. However, what is missing from this argument is the fact that, once children become adults, they begin to contribute to the economy and society in their own right. The shorter-term savings from preventing a birth would likely be more than offset by the lifetime of economic activity generated by that person, and even more so when his or her potential future offspring are also taken into consideration.

At least Guttmacher's arguments have been consistent; only the dollar amounts vary based on their latest analysis. In 2014, Guttmacher teamed up with UNFPA to release its latest *Adding It Up* estimates along with an infographic headlined "Why invest in reproductive health?"[4] The infographic contrasts two images: one depicting contraceptive methods including pills, syringes, and condoms and one depicting a mother cradling her baby. The contraceptives are accompanied by a plus sign: for every dollar spent, you save $1.47 on "the cost of pregnancy-related care, including HIV care for women and newborns." A large minus sign accompanies the mother and child. Reproductive health, according to Guttmacher, means less reproduction.

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Given this context, Guttmacher's hand-wringing about maternal deaths appears to be less about ensuring that birth is safe for mother and child and more about framing childbirth as both dangerous and costly. However, the problem extends well beyond the avowedly pro-abortion Guttmacher Institute. The fact is that while family planning and maternal health are often grouped together on thematic grounds, there are good arguments for keeping them separate with regard to both statistics and funding. Put simply, the claim that contraceptives save lives by preventing maternal deaths is strongest in contexts where maternal health care is weakest. Yet rather than advocate for improved maternal health care where it is most needed, family planning advocates like the Guttmacher Institute argue that with enhanced investment in family planning, the same result (fewer deaths) can be achieved for less money. Mothers and babies get the minus sign—those women who actually want to have children are on their own. We argue that investment in robust maternal health services will ensure that fewer women will die from complications of pregnancy and birth, regardless of whether the pregnancy was intended or not. In addition, we will be able to provide care for women suffering from abortion complications as well.

Access denied?

The claim that U.S. funding cuts would deny 47.6 million women and couples contraceptives is based on the claim that the

$607.5 million appropriated by Congress for international family planning in fiscal year 2024 (and several years prior) serves that number of people per year, who would otherwise go without.[5]

Like any modeling exercise, the Guttmacher Institute's methods have weaknesses. They rely on a linear approach to calculating the impact of funding cuts on individual people in a way that does not take into account the complexity of medical systems, nor does it allow for the ways in which both systems and people adapt to changes in real time. It also does not consider the possibility of other funding sources to shore up ongoing service delivery in affected countries.

Even if we take the Guttmacher estimates at face value, there is a broader context to consider: abortion-providing international family planning groups like the International Planned Parenthood Federation (IPPF) and MSI Reproductive Choices (formerly Marie Stopes International) have a long history of refusing U.S. funding if it comes with the requirement that they must abandon their abortion advocacy. Republican presidents have cut their funding, as well as that going to UNFPA, while Democratic presidents have restored it, resulting in a predictably unpredictable funding environment for these groups.

Time and time again, abortion and family planning advocates have complained that these funding cuts lead to shuttered clinics, and the denial of essential services apart from abortion.[6] To the extent that essential non-abortion services were being provided solely by one of these pro-abortion organizations in a given area, those services were held hostage to that organization's insistence on continuing its abortion advocacy. When IPPF and MSI affiliates refused to certify the Mexico City Policy and U.S. funding was cut, women and couples seeking uncontroversial services might be out of luck—but their situation was part of a useful statistic for Guttmacher and others to lobby against the Mexico City Policy.

The abortion "Trojan Horse"

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If uncoupling family planning from maternal health is difficult, it is even more difficult to uncouple family planning from abortion, because, with few exceptions, their advocates and providers are one and the same. As long as groups promoting "sexual and reproductive health" or sexual and reproductive health and rights (SRHR) were well-funded, some developing nations have come to rely on them as a way of providing some aspects of basic medical care. The organizations then took advantage of their presence to promote abortion and gender ideology. Given the

U.S.'s outsized role in funding these organizations, especially during Democratic administrations, the current withdrawal of U.S. funding for those organizations may force some countries to reconsider their approach and find other ways to ensure their citizens have access to health care.[7] This means more national ownership of health systems, ensuring they align with local priorities and values. The U.S. has also moved toward providing health assistance in a bilateral, rather than multilateral, way, ensuring greater oversight and accountability to ensure that the funding also aligns with U.S. priorities.

The argument in favor of integrating services is sensible on its face: housing different medical services in different locations makes accessing them more onerous for the client. However, the donor-to-nongovernmental-organization model of health service delivery often means that the services being integrated are determined by the priorities of the providers rather than those of the government or the citizens of a given country. For example, affiliates of IPPF and MSI that work in developing countries may be constrained by the laws and policies of those countries, though they may not always comply. We see this in the allegations of illegal abortions performed in Kenya by MSI.[8] However, as their publicly available materials make clear, these and other similar organizations are committed to fulfilling SRHR, which includes not only contraception and abortion on demand, but also comprehensive sexuality education for children.[9] Organizations whose mission is defined by their support for SRHR have also increasingly moved into the area of "gender-affirming care" such as cross-sex hormones. In October 2025, IPPF hosted a meeting of several of their member organizations in developing countries on the topic of "advancing trans inclusion in sexual and reproductive health and rights (SRHR)" where participants shared "practices and strategies for integrating gender-affirming care into existing SRHR services."[10]

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To the extent that certain services are restricted by law in a given country, SRHR-promoting organizations are able to leverage their presence in that country to lobby government officials to liberalize their laws. For example, in recent years, parliamentarians in Sierra Leone have been debating a bill on "safe motherhood and reproductive health" which would decriminalize abortion under some circumstances. MSI and other organizations, including UNFPA, have claimed credit for helping draft the bill and lobbying for its adoption.[11]

The Sierra Leone bill illustrates how the issue of maternal health can be hijacked to serve as a delivery mechanism for abortion in a largely pro-life country. It also demonstrates how family

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planning is the key link between the maternal health issue and pressure to liberalize abortion laws and increase access to it. It is important to note that IPPF, MSI, and UNFPA all had their origins as family planning advocates before "reproductive health" entered the global lexicon. As long as an international abortion lobby has existed, family planning has always been its more acceptable face.

The hollow logic of "unmet need"

Family planning advocates have long relied on the argument that there is a vast "unmet need" for contraceptives in developing countries, with varying estimates usually north of 200 million women in the global South with a purported "need." While organizations like UNFPA routinely paraphrase "unmet need" as "lack of access," this is entirely inaccurate.[12] None other than the Guttmacher Institute reported that when women with "need" are asked why they are not using a family planning method, only 5% cite lack of access, with most pointing to concern about health risks or side effects, personal or religious opposition, or infrequent sex.[13] Scholars have pointed out that the frequent misinterpretation (or misrepresentation) of "unmet need" obscures an inconvenient fact: a lack of demand for contraceptives exceeds a lack of supply "in all scenarios."[14]

When the Guttmacher Institute released its most recent *Adding it Up*, they introduced some new sub-categories for "unmet need," including what they call "unmet demand." Unmet demand includes women who "want to avoid pregnancy and say they are interested in or open to using contraception in the future."[15] Out of an estimated 214 million total women with "unmet need," only 78 million fall into the "unmet demand" category; the remaining majority are either using a traditional method of family planning such as abstinence or breastfeeding or have explicitly stated their opposition to using contraceptives. Even the most restrictive category of "unmet demand" is disingenuously inflated, as it lumps together women who intend to use contraceptives with those who have merely expressed an openness to using it. Even so, Guttmacher's new categories contain the implicit admission that most of "unmet need" applies to women who are essentially unreachable as they are not open to using contraception. They argue that including the "unmet demand" category can make the estimates "more grounded in women's own preferences." The report proposes that "[f]ocusing on this group helps prioritize limited resources, while recognizing that broader investments will ultimately be needed to reach the many other women who also face barriers to contraceptive

care." In other words, you can save money by first directing your products toward people who might actually accept them, but what's really needed is more money to wear down the resistance of the rest. Framing women's opposition to contraception as a "barrier to care" further illustrates the way in which the global family planning lobby has staked its identity on relentlessly promoting a solution in search of a problem.

From paternalism to improved maternal health

None of this is to say that there are not unmet needs in developing countries that result in preventable deaths. Every woman who dies from hemorrhaging in childbirth or a postpartum infection had an unmet need, and unlike her "need" for the contraceptives that might have prevented her pregnancy, her need for basic maternal health care is accompanied by an actual demand.

It is time to acknowledge that the champions for international "reproductive health" are the wrong partners to choose if your goal is to reduce preventable maternal mortality

However, it is time to acknowledge that the champions for international "reproductive health" are the wrong partners to choose if your goal is to reduce preventable maternal mortality. They use bad-faith metrics like "unmet need" to paternalistically claim to speak for women while downplaying women's own stated preferences and priorities. They use their presence in conservative countries to promote controversial issues like abortion and, increasingly, gender ideology. They argue that their services will reduce the need for maternal health care, siphoning resources toward contraceptives for which the market is already saturated. All the while, they use the tragic stories of women dying while giving life to demand more funding from donor governments and access from recipient governments.

We must not be deceived by their appeals on behalf of maternal health, because women giving birth are the human shields they use to promote a culture of death and confusion.

The U.S. during the second Trump administration is shaking up global health aid and calling into question many of the assumptions that had existed for decades regarding how development assistance works. Because of the Trump administration's pro-life stance, and also because the bureaucracy within the now-defunct USAID had worked hard to shelter its more controversial projects from dismantling by Republican governments, the global "reproductive health" lobby is experiencing real pain. We must not be deceived by their appeals on behalf of maternal health, because women giving birth are the human shields they use to promote a culture of death and confusion. The international family planning and "reproductive health" organizations that were founded decades ago to promote population control may have changed their messaging, but their proposed "solutions" have not changed.

What has changed is that around the world, women are aware of family planning, and most who want it can access it. Other developments in recent decades include the realization that the "population bomb" was wildly exaggerated and the decline in fertility in many parts of the world to levels well below replacement.

While much has been said in the media about cuts to international assistance, there is also innovation and realignment occurring, including in the Trump administration's new America First Global Health Strategy. This framework now requires country investment to help build an infrastructure that is sustainable.[16] Along with the U.S., other countries that have received our aid are adapting to these changes and finding new ways forward.

The same capacity to adapt and innovate is true at the personal level. One common theme in the boilerplate statistics predicting doom and death from cuts to "reproductive health" funding is the failure to account for the human ability to adapt to changing circumstances and respond to crises. Abortion advocates rely on a particularly lethal type of pessimism that insinuates that a crisis pregnancy can never result in a future where both the mother and child survive and thrive. Countless examples from around the world reveal that this is not the case, and the U.S. can play a pivotal role in ensuring that its funding is providing for these positive futures where the need is greatest.

If we are committed to making birth safe everywhere, what is needed is not controversial, and it will not be achieved by funding "reproductive health" organizations. It requires investments in civic infrastructure and utilities like electricity, water, and sanitation. It involves building good roads and hospitals and clinics, and staffing them with well-trained professionals equipped with modern technology. It will require maintenance and upkeep to ensure the benefits are long-lasting. This is the paradigm shift that is needed to deliver optimal health outcomes for women and children worldwide, and the time to put it in motion is now.

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ABOUT THE AUTHOR

Rebecca Oas is the Director of Research at C-Fam. Rebecca earned her doctorate in Genetics and Molecular Biology at Emory University.

2 Park Ave Suite 2004
New York, NY 10016

info@c-fam.org
www.c-fam.org

C-Fam | Center for Family & Human Rights
New York · Washington, DC