



The World Health Organization's Abortion Overreach

By Rebecca Oas, Ph.D.

IORG
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A Program of Center for Family & Human Rights

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FOREWORD

In April 2020, President Donald J. Trump halted funding to the World Health Organization for mishandling the novel coronavirus crisis, the virus that causes COVID-19. In the aftermath of that decision, policy analysts focused on ways to reform the WHO, circumvent it, or scuttle it with a view to creating a new organization. In this International Organizations Research Group White Paper, Rebecca Oas, Ph.D. examines an often-overlooked department within WHO that has had outsized influence in promoting a particular agenda, widespread legal and accessible abortion. Dr. Oas argues that this violates the mandate of the organization, impinges upon national sovereignty, and runs counter to, often deliberately misinterpreting, agreed upon international human rights.

The United State is the largest national donor to the WHO, contributing \$200-\$300M annually beyond the assessed membership dues of some \$110M. Between 2008 and 2016, UN agencies, influenced by left-leaning donor governments in Europe and the United States, to promote abortion as an international human right. The WHO, the UN Population Fund, UN Women, and, perhaps most surprisingly, the UN Children's Fund, UNICEF all promoted abortion as part of a right to "sexual and reproductive health." As Dr. Oas reveals in this issue, the bureaucracy did so even though nations rejected that interpretation in open debate at the UN General Assembly and elsewhere since 1994.

Dr. Oas shows the outsized influence that one bureaucratic office can have on global policy. Much of the WHO's research and guidance on abortion is from its specialized Department of Reproductive Health Research (RHR), recently renamed as the Department of Sexual and Reproductive Health and Research (SRH). WHO's Special Program of

Research, Development and Research Training in Human Reproduction” (HRP), which includes various UN agencies, is also an engine of abortion advocacy, Oas finds. The office is influenced by the political agenda of its donors, Sweden, the Netherlands, the United Kingdom, Norway, and Germany. Its policy is often at odds with the social and cultural traditions and political positions of recipient nations, often in Africa and elsewhere in the developing world.

Dr. Oas also reveals the influence of innocuous-sounding committees within the UN system. WHO is part of many multi-agency partnerships, starting with its own HRP, but also including the Inter-Agency Working Group on Reproductive Health in Crises (IAWG). WHO bureaucrats sit on the IAWG steering committee alongside prominent abortion proponents including the International Planned Parenthood Federation (IPPF), the Center for Reproductive Rights, Ipas, and Population Action International (PAI). Together they work to decriminalize abortion in the developing world by challenging pro-life laws through strategic litigation and demedicalizing abortion so it can be self-administered with abortion pills.

As Dr. Oas finds in this issue, by inserting abortion into maternal and child health, the WHO transformed an issue with rare global consensus and made it one of the most controversial. It also slowed progress on saving mothers’ lives. Every day more than 800 women die from preventable deaths associated with pregnancy and childbirth and approximately 15,000 children under the age of five die from poor hygiene and malnutrition. The UN Secretary-General announced a high-level global strategy to improve women’s and children’s health, with a target of saving 16 million lives. In 2015, however, the strategy’s enactment had only saved 2.4 million lives. Unlike the COVID-19 crisis, there has been no international investigation into the role of the WHO in this human tragedy, the avoidable death of millions of women and children.

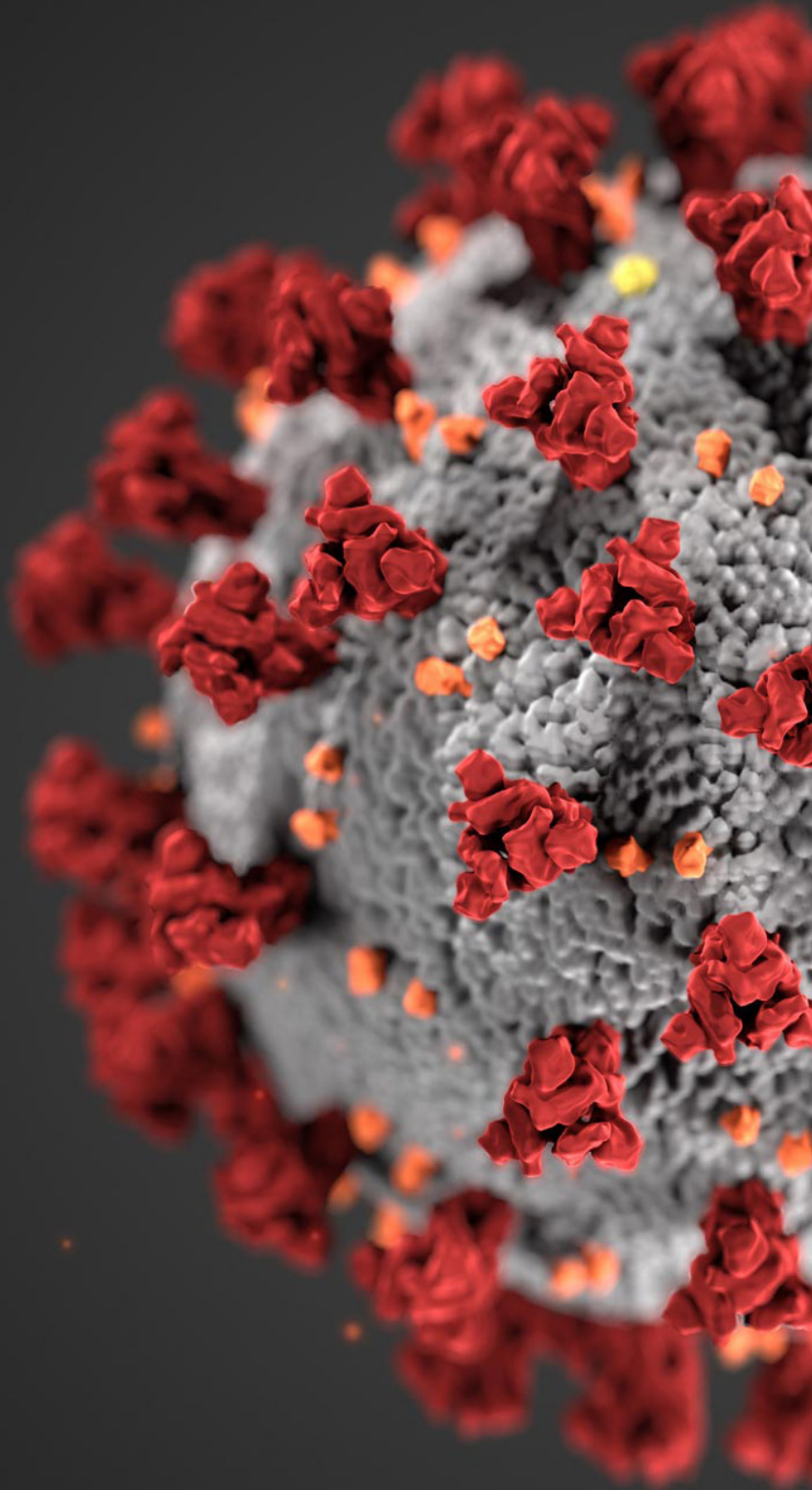
When President Trump took office in 2017, his administration attempted to halt U.S. promotion of abortion abroad. It expanded the Mexico City Policy beyond family planning, to all global health, and

its diplomats opposed language on “sexual and reproductive health” in UN negotiations, a phrase that had long been used to include abortion, and a right to abortion.

Yet, practically speaking, not much changed on the ground. By 2020, it became clear that ending U.S. involvement with the campaign to create an international right to abortion, and indeed U.S. funding for it around the world, would need a long-term approach, and one that investigated the role of the WHO and its partner UN agencies. In her recommendations, Dr. Oas urges policy makers to consider applying the Siljander Amendment to U.S. foreign aid law. The State Department used this law to defund the Organization of American States in 2019 when two of its organs were found promoting abortion, against the amendment’s prohibition that U.S. funds are used “to lobby for or against abortion.” Dr. Oas finds that the WHO and other UN agencies are indeed in violation of the Siljander Amendment and should reform or lose U.S. funds.

With this paper, written at a time when the whole world is in lock down due to a health pandemic, the International Organizations Research Group seeks to add heat and light to the ongoing debate about the future role of the World Health Organization. We hope that the insights and research herein help policy makers to return the organization’s institutional independence, raise its standards of ethics, and restore a respect for all human life and human dignity.

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Washington, D.C.
May 7, 2020



Introduction

The World Health Organization (WHO) faced criticism in 2020 for its lack of independence in handling the COVID-19 pandemic. Even before the pandemic, however, there were warning signs. In the area of child and maternal health, the WHO has long exhibited a lack of independence and a dangerous tendency to parrot the talking points of donors and its entrenched bureaucracy—with devastating effects for women and children.

Western donor nations, particularly the United States, criticized the WHO's most recent scandal. Rather than investigating the origins of COVID-19, the WHO echoed the Chinese Communist government's talking points. Likewise, global health experts criticized the WHO's failure to direct a global response to the pandemic. "Its coordinating authority and capacity are weak," *Lancet* editor Richard Horton told the *Guardian*. "Its ability to direct an international response to a life-threatening epidemic is non-existent."¹ Writing for the *Atlantic*, Professor Zeynep Tufekci stated that the WHO was "not designed to be independent. Instead, it's subject to the whims of the nations that fund it and choose its leader."²

The WHO receives \$400-500 million a year of U.S. funding. However, the Trump administration announced its intention to

1 Buranyi, Stephen. "The WHO v coronavirus: why it can't handle the pandemic." *The Guardian*, April 10, 2020. <https://www.theguardian.com/news/2020/apr/10/world-health-organization-who-v-coronavirus-why-it-cant-handle-pandemic> (accessed April 2020)

2 Tufekci, Zeynep. "The WHO Shouldn't Be a Plaything for Great Powers." *The Atlantic*, April 16, 2020. <https://www.theatlantic.com/health/archive/2020/04/why-world-health-organization-failed/610063/> (accessed April 2020)

defund the WHO until a full investigation of the organization was complete.³ This investigation provides an opportunity to ask if the WHO has been an effective investment in global health, even prior to the outbreak of COVID-19. Do the goals of the organization reflect those of the U.S. government, or are they working at cross purposes in critical areas? Or would investment in other areas, such as bilateral aid, lead to greater global health gains be made by investing in other areas? What could be done to depoliticize and perhaps streamline the work of the WHO, with greater accountability and less controversy?

This paper helps answer these questions by examining how the WHO has been too dependent on the special interests of donors, powerful lobbies, and entrenched bureaucratic interests regarding the issue of abortion. It examines cases in which the WHO promoted the liberalization of abortion laws using human rights arguments and trained doctors to perform risky abortions in countries where it is restricted legally. This was done despite the fact that many WHO nations restrict abortion because of its public health risks. It examines how the WHO has promoted abortion to the detriment of tackling other important public health issues such as maternal and child health. It shows how the WHO has provided UN cover for dangerous abortion techniques, unethical practices, and how it has lowered the bar for medical safety.

This paper makes recommendations in light of the WHO's promotion and endorsement of therapeutic abortion. It offers recommendations for how the embedded interests of the permanent

3 Klein, Betsy and Hansler, Jennifer. "Trump halts World Health Organization funding over handling of coronavirus outbreak." *CNN Politics*, April 15, 2020. <https://www.cnn.com/2020/04/14/politics/donald-trump-world-health-organization-funding-coronavirus/index.html> (accessed April 2020)

bureaucracy of the WHO might be addressed by removing funding from particular offices. It makes observations about how WHO undermines other internationally agreed upon health goals, and thwarts U.S. foreign policy goals. It provides recommendations on how the U.S. can help bring these back into alignment.



The World Health Organization's Internal Abortion Hub

Since its founding after World War II, the WHO's mandate has evolved. Keeping with the outcomes of the global conferences on population and development in 1994 and women's issues in 1995, the phrases "sexual and reproductive health" and "reproductive rights" entered its lexicon, and the WHO adopted a rights-based approach to health that was not part of its original mandate.⁴

Much of the WHO's research and guidance on abortion and contraception comes from its specialized Department of Reproductive Health Research (RHR), recently renamed as the Department of Sexual and Reproductive Health and Research (SRH). In 1988, RHR integrated the work of the multi-agency "UN Development Program (UNDP), UN Population Fund (UNFPA), WHO, World Bank Special Program of Research, Development and Research Training in Human Reproduction" (HRP). HRP was started by the WHO in 1972 and was joined by the other agencies in 1998.⁵

Donor governments, UN agencies, and other entities, many of which are longstanding proponents of international abortion,

4 Essig, Andrew. "The World Health Organization's Abortion Agenda," International Organizations Research Group: White paper No. 11., 2010

5 Essig, *ibid.*

including the Ford, MacArthur, and Packard Foundations fund these specialized programs. The governments include Sweden, the Netherlands, the United Kingdom, Norway, and Germany, all of whom have been outspoken in favor of abortion language in UN agreements. In the most recent list of donors, dating from 2016-2017, the U.S. was also listed as a specific donor to HRP.⁶

The International Planned Parenthood Federation (IPPF), the well-known abortion giant is also listed as an HRP donor. IPPF is also the sole member of the HRP Permanent Members that is not a member of the UN system, but is a nongovernmental organization.⁷

As in the case of the COVID-19 pandemic, it is important to ask who sets the agenda for the WHO. The relationship between the WHO and its donors has evolved over decades, and the WHO's learned reliance on various donor countries and organizations makes for a perverse incentive structure, both at the level of the WHO itself and at the level of the HRP and its output.

As professor and global health expert Christopher Murray points out, "If the WHO stopped chasing such funds...it could go back to concentrating on its true mission of providing objective expert advice and strategic guidance."⁸ The WHO's constitution requires that voluntary contributions must be in line with WHO's objectives, but as professor Andrew Essig asks, "Does WHO create policies in line with contributors' agendas in order to raise funds, or do contributors donate money because they support pre-existing WHO policies?"⁹

The WHO's second largest contributor, after the United States, is the Bill and Melinda Gates Foundation. This private philanthropic

6 World Health Organization. 2016-2017 HRP Donors. <https://www.who.int/reproductive-health/hrp/donors/en/> (accessed April 2020)

7 World Health Organization. 2016-2017 HRP Partners. https://www.who.int/reproductive-health/about_us/hrp/partners/en/ (accessed April 2020)

8 Garrett, Laurie. "The Challenge of Global Health." *Foreign Affairs*, 86:1, Jan/Feb 2007

9 Essig, *ibid.*

organization has become a major player in setting the agenda for global health. But, it derives its influence from the wealth of a single family, and is not subject to the norms that govern the UN and its agencies, such as the need for global consensus. Furthermore, the Gates Foundation has had a pivotal role in elevating the promotion of family planning as an international focus since it convened the London Summit on Family Planning in 2012. The Gates Foundation lists the WHO as one of the partners on its family planning strategy,¹⁰ and while it has shied away from the abortion issue in its promotion of contraception, it nevertheless funds leading abortion proponents like IPPF as part of its family planning work. (The foundation's financial forms for 2018 show several grants going to global abortion giants IPPF and Marie Stopes International, and Ipas for family planning.)¹¹

The Gates Foundation's willingness to form such partnerships with abortion groups suggests that the WHO's second largest donor—while not an outspoken proponent of abortion itself—will be unlikely to use its influence to curtail the WHO's own overreach in this area.

10 Bill and Melinda Gates Foundation. Family Planning Partners. <https://www.gatesfoundation.org/What-We-Do/Global-Development/Family-Planning/Partners> (accessed April 2020)

11 Bill and Melinda Gates Foundation. Form 990-PF for tax year 2018. <https://www.gatesfoundation.org/-/media/GFO/Who-We-Are/Financials/2018-BMGF-Form-990-PF-For-Public-Disclosure.ashx> (Accessed April 2020)



Photo: Aleksandar Popovski, Unsplash

The WHO Undermines Norms Set by Sovereign States

The World Health Assembly (WHA), the governing body of the WHO, adopted a strategy to contribute to the fulfillment of the Millennium Development Goals (MDGs). Despite the absence of any “reproductive health” language in the agreed text of the MDGs, the director-general of WHO justified its inclusion of the term in a preface to the resolution: “In addition, as recognized in the draft resolution submitted to the Health Assembly, work in areas not directly referred to in the Declaration, such as reproductive health, will contribute to the attainment of the goals.”¹²

Two years after the adoption of this term, the WHO launched its first global reproductive health strategy, with the justification of the WHA resolution. Among its focus areas was “eliminating unsafe abortion.” By 2008, the WHA had produced further strategy documents supporting the reproductive health strategy, which included the item: “WHO supports the creation of national legislation that promotes greater access to reproductive health services.”¹³

This raises immediate questions. At the International Conference on Population and Development (ICPD) in 1994, UN member states included abortion in its definition of “sexual and reproductive health” and “reproductive rights”. This inclusion pertained to legal abortion, adding that where it is legal, it must be “safe.” Significantly,

12 World Health Assembly. Resolution WHA55.19 “WHO’s Contribution to Achievement of the Development Goals of the United Nations Millennium Declaration,” 18 May 2002

13 World Health Organization. “Progress Reports on Technical and Health Matters.” A61/17 Add. 1, 14 April 2008

the outcome kept those two terms separate, rather than combining them into “sexual and reproductive health and rights” (SRHR), as this would imply the existence of “sexual rights,” which member states opposed.¹⁴ Nevertheless, the legality of abortion was left to individual

Nevertheless, the legality of abortion was left to individual countries to determine; UN members never agreed to an international human right to abortion

countries to determine; UN members never agreed to an international human right to abortion. Therefore, how does the WHO interpret its support for national legislation promoting access to reproductive health services?

In 2017, the WHO launched a database of international abortion laws, describing the project as a tool to “eliminate the barriers that women encounter in accessing safe abortion services.”¹⁵ The database is housed on the domain SRHR.org, in reference to the terminology embraced by WHO and some other UN agencies, such as the UNFPA, but thus far rejected by UN member states in General Assembly resolutions. When the term is defined, the most commonly-referenced definition

14 UN Population Fund (UNFPA). Report of the International Conference on Population and Development; 1994 Sep 5–13; Cairo. A/CONF.171/13/Rev.1; 1995. See paragraph 8.25: “In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family-planning services should be offered promptly, which will also help to avoid repeat abortions.”

15 Oas, Rebecca. “New UN Database Pressures Countries on Abortion.” *The Friday Fax*, C-Fam, June 29, 2017. https://c-fam.org/friday_fax/new-un-database-pressures-countries-abortion-2/ (accessed April 2020)

is set forth in a joint commission by the *Lancet* and the Guttmacher Institute, a pro-abortion research organization originally founded by Planned Parenthood (or use IPPF?) and named for one of its former leaders. They define SRHR as including “safe abortion services”. They also include “comprehensive sexuality education” and “sexual rights” in this definition, both long-rejected and lacking consensus among UN member states.¹⁶

The WHO database, a project of HRP, contains not only national laws and policies that pertain to abortion, but also a collection of the WHO guidance documents on the provision of abortion (more on that later), and a database of concluding observations by UN human rights treaty monitoring bodies that pertain to abortion laws. These bodies of independent experts, who monitor compliance by states to individual human rights treaties, have for decades gone beyond their mandates by inferring a right to abortion into the treaties, none of which include any reference to abortion, much less declare it as a right.¹⁷

The WHO was given a mandate to improve maternal and child health in accordance with the MDGs, and it justified the creation of a novel “reproductive health” strategy by arguing it was a necessary precursor for doing so. Similarly, the WHO has interpreted abortion as a necessary precursor to achieving the agenda set out at ICPD, even though that

The WHO lists restrictive laws, conscientious objection by health care providers, and other legal requirements such as mandatory counseling or waiting periods, parental notification or permission in the case of a pregnant minor, or “misleading information.”

16 Starrs AM, Ezeh AC, Barker G et al. “Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission.” *The Lancet*, 2018

17 Sylva, Douglas A., Yoshihara, Susan. “Rights by Stealth: The Role of UN Human Rights Treaty Bodies in the Campaign for an International Right to Abortion.” International Organizations Research Group, 2009

agreement rejected it as a human right.

On the WHO website, a quote from ICPD regarding the right to decide the number and spacing of one's children and attain the highest standard of sexual and reproductive health begins the section on abortion, which then states further that "Access to legal and safe abortion is essential for the realization of these rights."¹⁸ The WHO lists restrictive laws, conscientious objection by health care providers, and other legal requirements such as mandatory counseling or waiting periods, parental notification or permission in the case of a pregnant minor, or "misleading information." among the barriers to "safe" abortion. Given the clear ideological bias of the WHO, these could be interpreted quite broadly.

It is clear that the WHO, and HRP in particular, derive their agenda more from the desires of their donors and partners than the consensus positions of UN member states, which includes those developing countries who are not able to offer vast voluntary contributions to influence its output. The abortion law database is clearly designed to marshal further pressure toward precisely those developing countries, many of which have the most pro-life laws in the world, and to urge them to liberalize their abortion laws.

18 https://www.who.int/health-topics/abortion#tab=tab_1 (Accessed April 2020)



Photo: CAMFED

Taking Orders from Powerful Lobbies and Giving them Moral and Institutional Cover

In addition to the WHO's promotion of abortion on the legal front, it also works to advance a similar agenda within the medical community. Their research reports and technical guidance have one clear commonality: expand access to abortion at all costs, legally if possible, and illegally if necessary. In 2012, the WHO released the second edition of its technical and policy guidance on "safe abortion," whose development group emphasized the need to "demedicalize abortion care"—that is, to minimize the ways in which the medical and legal establishments might constrain access to it, even for the sake of protecting women's health.¹⁹

Many of the methods promoted fall short of the standards of health care in wealthy countries, and make assumptions about access to clean water, sanitation, electricity, and other basic

Many of the methods promoted fall short of the standards of health care in wealthy countries, and make assumptions about access to clean water, sanitation, electricity, and other basic necessities that are not necessarily warranted in resource-constrained environments.

¹⁹ Safe abortion: technical and policy guidance for health systems. World Health Organization, Geneva, Switzerland, 2012

necessities that are not necessarily warranted in resource-constrained environments. The guidance warns that using misoprostol alone, rather in conjunction with mifepristone²⁰ to perform an abortion, is prolonged, more painful, and more prone to side effects. Nevertheless, the guidance goes on to recommend the practice anyway, “because of misoprostol’s wide availability and low cost,” and because “the use of misoprostol alone appears to be common where mifepristone is unavailable.”²¹

In addition to lowering the bar for safety standards in providing abortions, the WHO sets its sights on another potential barrier to abortion access: provider shortage. They seek to both curtail conscience rights for medical workers and expand the potential pool of providers. In the “safe abortion” guidance, the WHO acknowledges that individual health care workers have a right of conscientious objection, but emphasize:

That right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk. In such cases, health-care providers must refer the woman to a willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-

That right does not entitle them to impede or deny access to lawful abortion services because it delays.

care professional who objects, must provide safe abortion to save the woman’s life and to prevent serious injury to her health.²²

The guidance also

20 Mifepristone, also known as RU-486, is used to induce abortions by causing the softening and dilation of the cervix. Misoprostol, which was originally approved for the treatment of gastric ulcers, induces cervical contractions, and is therefore used in conjunction with mifepristone to cause the expulsion of the unborn child.

21 Yoshihara, Susan and Rebecca Oas. Eleven Problems with the 2012 WHO Technical Guidance on Abortion. International Organizations Research Group, 2012

22 Safe abortion: technical and policy guidance for health systems, *ibid.*

encourages the use of “values-clarification exercises” to “help providers differentiate their own personal beliefs and attitudes from the needs of women seeking abortion services.”²³ This recommendation is supported by a citation to a paper in which the “values-clarification” materials were furnished by a South African group called “Health Workers for Choice.” This material was also used by the radical pro-abortion organization Ipas in developing their own “values-clarification” curriculum. In an explanatory note, Ipas offers a clarification of its own:

Unlike the traditional approach to values clarification, which does not posit any universal set of preferred values, the Ipas... toolkit [was] designed with an agenda: to move participants toward support, acceptance and advocacy for comprehensive abortion care and related sexual and reproductive health care and rights.²⁴

Clearly, the WHO’s own attitude toward conscientious objection is to minimize it through reeducation, and constrain it in practice, lest it in any way impede access to abortion. At a minimum, this includes forcing doctors to refer women for abortions against their consciences. At the same time, the WHO also issued a 2015 guidance (with support from the Norwegian government) on the role of health care providers in administering abortion. This guidance points out that the rise in medical rather than surgical abortion “has resulted in the further simplification of the appropriate standards and health worker skills required for safe abortion provision, making it possible to consider expanding the roles of a much wider range of health workers in the provision of safe abortion.” The specific workers addressed by this report, and recommended as potential providers, include midwives and nurses, in addition to both specialist and non-specialist doctors and associate and advanced associate clinicians. Additionally, the guidance called for future research on “the safety, effectiveness and feasibility of task sharing by health workers

23 Ibid.

24 Turner KL, Chapman Page K. “Abortion attitude transformation: a values clarification toolkit for global audiences.” Ipas, 2008

located outside of health-care facilities (i.e. in communities) or in pharmacies.”²⁵

Again, the guidance emphasized that “Conscientious objection, where allowed, should be regulated, and provision of alternate care for the woman ensured.”²⁶ A literature review, intended to support implementation of this guidance and conducted by members of the Norwegian Institute of Public Health and HRP, warned that technical training alone was unlikely to be sufficient: “The use

The latest stage in the quest to “demedicalize” abortion involves sidestepping medical personnel altogether and relegating abortion to the realm of “self-care.”

of values clarification workshops may be one way of addressing this issue. However, it may be important to involve all facility staff, including non-clinical staff, and to encourage participation or make participation mandatory.”²⁷

The latest stage in the quest to “demedicalize” abortion involves sidestepping medical personnel altogether and relegating abortion to the realm of “self-care.” According to the WHO, when it comes to abortion, “self-assessment and self-management approaches, can be empowering for individuals and help to triage care, leading to a more optimal use of health-care resources.”²⁸

In a 2019 guidance on self-administered health care for SRHR, the WHO stated:

Self-care for SRHR has perhaps the greatest potential to address

25 World Health Organization. “Health worker roles in providing safe abortion care and post abortion contraception.” World Health Organization, Geneva, Switzerland, 2015

26 Ibid.

27 Glenton, C., Sorhaindo, A.M., Ganatra, B. et al. “Implementation considerations when expanding health worker roles to include safe abortion care: a five-country case study synthesis.” BMC Public Health 17, 730, 2017

28 World Health Organization. “Self-management of medical abortion.” <https://www.who.int/reproductivehealth/self-care-interventions/medical-abortion/en/> (Accessed April 2020)

unmet needs or demands in marginalized populations or in contexts of limited access to health care, including, for instance, self-managed medical abortion in countries where abortion is illegal or restricted.²⁹

It is important to remember that all of these guidance documents fall notionally under the WHO's mandate to eliminate unsafe abortion and its harmful effects. Yet implicit in all these documents is an assumption that abortion is not harmful in itself, except when provided "unsafely," and that a woman seeking an abortion will either obtain it "safely" or "unsafely": any attempt to dissuade her or offer her other options is futile at best, coercive at worst.

The WHO's continued approach to remove safety standards from abortion, delegate it to lower and lower tiers of health workers, and ultimately eliminate health workers entirely, advances its goal to expand access to abortion at any cost. However, it also provides cover to individuals and organizations providing abortion by means that are not only illegal, but also unethical and dangerous.

In countries where abortion is illegal or heavily restricted by pro-life laws, individuals with or without medical training have set up hotlines or services to deliver abortion drugs by mail. The organization Women on Waves/Women on Web, founded by a Dutch doctor and notorious for providing

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29 World Health Organization. "WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights". Geneva: World Health Organization; 2019

illegal abortions around the world, recently launched Aid Access, a website designed to offer illegal abortion pills to women in the U.S. In a section for frequently asked questions, one inquiry asked if self-administered abortion by pills obtained online is safe. Aid Access offers this assurance in response: “Abortions are safe if they are done with a WHO-recommended method that is appropriate to the pregnancy duration, and if the person providing or supporting the abortion is trained.”³⁰

Another question on Aid Access asked, “Is access to abortion medicines a human right?”. The response points out that “the WHO listed the abortion medicines mifepristone and misoprostol as essential medicines since 2005.”³¹ This is true, although mifepristone was listed with a clear caveat: “Where permitted under national law and where culturally acceptable,” which restrictions Aid Access exists precisely to circumvent. Until last year, these drugs also included a further note: “requires close medical supervision.” The note of warning was removed in 2019, however. And the the drugs, packaged together, was transferred from the complementary list to the core list (which would likely make them more widely available). Most worrisome, this was done while stating, “based on the evidence presented that close medical supervision is not required for its safe and effective use.”³²

This change was the result of an extensive amount of lobbying by abortion advocacy groups including Marie Stopes International, the International Campaign for Women’s Right to Safe Abortion, and the International Federation of Gynecology and Obstetrics (FIGO). As for the medical evidence supporting the change, much

30 Aid Access. “Is it safe to do a medical abortion by yourself from pills online?” <https://aidaccess.org/en/page/428/is-it-safe-to-do-a-medical-abortion-by-yourself-from-pills-online> (Accessed April 2020)

31 Aid Access. “Is access to abortion medicines a human right?” <https://aidaccess.org/en/page/543/is-access-to-abortion-medicines-a-human-right> (Accessed April 2020)

32 World Health Organization. “Executive Summary. The Selection and Use of Essential Medicines 2019. Report of the 22nd WHO Expert Committee on the Selection and Use of Essential Medicines, 1-5 April 2019.” World Health Organization, Geneva. 2019

of that can be attributed to pro-abortion organizations like Gynuity, which lists among its accomplishments “expanded use of medical abortion pills,” “advocated for access to essential medicines,” and “filled evidence gaps about safety of mifepristone.”³³

The picture that emerges is one in which pro-abortion research organizations provide the evidence which WHO takes up and incorporates into its technical guidance documents. These documents are then cited by abortion providers on the ground as they promote increasingly risky and unsupervised methods, erode the conscience rights of health workers and force them into “values-clarification” reeducation seminars, and pressure governments to remove all legal restrictions on abortion that might stand in the way of ubiquitous access.

33 Gynuity. Achievements timeline. <https://gynuity.org/achievements> (accessed April 2020)



The Problem of Entrenched Bureaucratic Interests: The World Health Organization's Collaborations with other UN Agencies

While the WHO has its own governing body and mandate, it does not operate in isolation from other members of the UN system. This fact is particularly important to consider in terms of its abortion advocacy.

The WHO is part of many multi-agency partnerships, starting with its own HRP, but also including the Inter-Agency Working Group on Reproductive Health in Crises (IAWG). It sits on the IAWG steering committee alongside abortion proponents including IPPE, the Center for Reproductive Rights, Ipas

The WHO has lent its logo and its support to highly controversial “comprehensive sexuality education” curricula published by the United Nations Educational, Scientific, and Cultural Organization (UNESCO) in collaboration with other UN agencies.

and Population Action International (PAI).³⁴ The IAWG updated its Minimum Initial Service Package (MISP) for health care in crisis settings to include “safe abortion care,” calling it “a proven and life-saving intervention to prevent maternal death and morbidity and to manage the consequences of sexual violence in emergencies.” The IAWG insists that the MISP is “not a political document,” but acknowledges that “humanitarian actors will need to navigate legal barriers to abortion in some contexts.”³⁵

The WHO has lent its logo and its support to highly controversial “comprehensive sexuality education” curricula published by the United Nations Educational, Scientific, and Cultural Organization (UNESCO) in collaboration with other UN agencies. The WHO-endorsed sex education guidance documents from UNESCO have encouraged teachers to tell children aged 9-12 that “legal abortion performed under sterile conditions by medically trained personnel is safe.” It also stipulates that children aged 12-15 are expected to learn the “definition, reasons for, and legality of abortion” and the “health risks associated respectively with safe and legal abortion, and with illegal and unsafe abortion.”³⁶

In general, the different bodies of the UN frequently collaborate on reports and guidance documents. The WHO refers to the work of human rights treaty monitoring bodies and their pressure on countries to liberalize their abortion laws. UNESCO relies on the

34 Inter-Agency Working Group on Reproductive Health in Crises. Committee & Members. <https://iawg.net/about/committee-members> (accessed April 2020)

35 Inter-Agency Working Group on Reproductive Health in Crises. “Safe Abortion Care in the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health in Humanitarian Settings.” December 19, 2019. <https://iawg.net/resources/safe-abortion-care-in-the-minimum-initial-service-package-misp-for-sexual-and-reproductive-health-in-humanitarian-settings> (accessed April 2020)

36 Ells, Kimberly. “Another Reason To Ditch The World Health Organization Is Its Shocking Sex Propaganda For Kids.” *The Federalist*, April 20, 2020. <https://thefederalist.com/2020/04/20/another-reason-to-ditch-the-world-health-organization-is-its-shocking-sex-propaganda-for-kids/> (accessed April 2020)

WHO's guidance and research to affirm that abortion is "safe" in sex education curricula. The WHO also works alongside UNFPA and others in promoting the SRHR construct, absent any consensus from national governments. In this way, UN bureaucracy relies on a network of support across multiple agencies to promote abortion around the world.



Photo: mothers2mothers

What of the women and children?

In 2019, the United States celebrated the 40th anniversary of eradicating the global scourge of smallpox in which some 300-500 million died, and the WHO's role in this eradication. Despite the highly politicized Cold War environment, the WHO coordinated with the U.S. and the Soviet Union, as well as with top research and medical institutions and big pharmaceutical companies to successfully end the crisis. For the U.S., the case serves as a model, but today the WHO failed to use this model in the 2020 COVID-19 crisis.

Defenders of the WHO, including those within the pro-life community, cite the organization's work to promote global health, end infectious diseases like smallpox, and ensure that doctors and nurses around the world are equipped with the latest technical expertise, medicines, and equipment. Indeed, the WHO generated immense goodwill in the past for its work in promoting vaccines against diseases that have been all-but-eradicated. Yet the WHO squandered much goodwill with increased politicization on issues like abortion. Nowhere has the abortion agenda been more tragic, than in the WHO's compromising its ethical and medical standards with regard to maternal and child health.

In 2010, the UN Interagency Group (WHO, UNICEF, UNFPA, and the World Bank) published their maternal mortality estimates. According Professor Wendy J. Graham of the University of Aberdeen, "the persistence of a global total of half a million maternal deaths per

year—or one every minute—was communicated as a shared global responsibility for poor progress.”³⁷

The same year, the Institute for Health Metrics and Evaluation (IHME) published its own estimates of maternal mortality, which relied on different methodology and pointed toward a significantly lower global maternal mortality rate.³⁸ At the Women Deliver conference in June, a disagreement broke out between those who supported the UN estimates and wanted a “consensus” set of statistics and those who argued for greater academic independence, including IHME founder Christopher Murray and Richard Horton, editor of *The Lancet*, who published the study.³⁹ Horton had told the *New York Times* that advocacy groups pressured him not to publish the IHME estimates until after a summit on the UN’s development goals, which he refused to do.⁴⁰

Ultimately, the WHO and its partners published their own modified estimates, and since the most current estimates (for the year 2008) were similar to those offered by IHME, “further commentary on the existence of two sets of maternal mortality figures and on the significant differences between them for some low income countries... was primarily confined to scientific journals and to technical conferences.”⁴¹

According to Graham, attention was also diverted away from the discrepancies in the maternal mortality estimates by “arguably the most significant development” in the global maternal health

37 Graham, W. J. The politics of progress: the story of maternal mortality. In J. Hussein, A. M. McCaw-Binns, & R. Webber (Eds.), *Maternal and Perinatal Health in Developing Countries* CABI Press, 2012.

38 Hogan MC, Foreman KJ, Naghavi M, Ahn SY, Wang M, Makela SM, et al. “Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5.” *The Lancet*. 375: 1609–23, 2010

39 Yoshihara, Susan “Lost in Translation: The Failure of the International Reproductive Rights Norm”. *Ave Maria Law Review*, Vol. 11, No. 367, Spring 2013.

40 Grady, Denise. “Maternal Deaths Decline Sharply Across the Globe.” *The New York Times*, April 13, 2010. <https://www.nytimes.com/2010/04/14/health/14births.html> (Accessed April 2020)

41 Graham, *ibid*.

agenda: the launch of the United Nations Secretary-General's Global Strategy for Women's and Children's Health."⁴² This strategy promised to save 16 million lives by 2015. But in 2015, a progress report claimed the only 2.4 million deaths had been averted since 2010. To quote from the independent expert review group tasked with evaluating its success, or lack thereof:

This substantial difference between what was promised and what was delivered is hard to comprehend. There are at least two possible explanations. First, that the Global Strategy failed. Second, that the calculation of 16 million deaths was exaggerated or an error. If the former explanation is true, the global community needs to conduct a careful autopsy on what went wrong and why. If the latter explanation is correct, how did the full technical capacity of WHO and partner agencies make such a mistake? It is not good enough, as the Progress Report does, to gloss over this discrepancy in numbers by saying that the Global Strategy has delivered "substantial gains."⁴³

When it comes to maternal and child health, the WHO's and its interagency UN partners' metrics have publicly failed. In both of these cases, the commonality is a public relations emphasis. The *Lancet* was pressured by reproductive rights groups to suppress the competing estimates because they would prove highly awkward for the massive advocacy campaign the UN was running based on the global failure to make progress saving mothers in childbirth. As well, the global strategy, whose launch helped bury the story about the competing estimates, fizzled out spectacularly, yet that, too, has fallen largely off the world's radar.

There are two camps In the international maternal health world. Belgian researchers Rachel Hammonds and Gorik Ooms label these camps: the "maternal health community" and the "sexual and

42 Graham, *ibid.*

43 World Health Organization. "Every Woman, Every Child, Every Adolescent: Achievement and Prospects. The Final Report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health." World Health Organization, Geneva, Switzerland, 2015

reproductive health community”:

[W]e loosely define this community as including those who focus on safe motherhood and maternal health as distinct from the more broadly based sexual and reproductive health and rights community that advocates for holistic, structural solutions.⁴⁴

They quote interviewees stating that the maternal health community is not made up of advocates, and its members lack the tools for it. In contrast, the “sexual and reproductive health community” was described as thinking that maternal mortality should not be an issue anymore, and wants to “repoliticize” the agenda with issues like abortion that move it away from consensus and toward controversy. In the final analysis, Hammonds and Ooms note with disappointment

As one of the leading sources of health metrics, the WHO has an outsized impact on the global health agenda, for better or worse.

that a major aspect of maternal health, access to emergency obstetric care, remains neglected in global strategies. There is also no associated indicator in the WHO’s list of eleven measurements for maternal, newborn, and child health.^{45,46}

What doesn’t get measured often doesn’t get done. And, as one of the leading sources of health metrics, the WHO has an outsized impact on the global health agenda, for better or worse. Nowhere is this most tragically evident than in the issue of stillbirths. Twenty

44 Hammonds R, Ooms G. The emergence of a global right to health norm--the unresolved case of universal access to quality emergency obstetric care. *BMC Int Health Hum Rights*. 14:4, 2014, doi:10.1186/1472-698X-14-4

45 Hammonds and Ooms, *ibid.*; World Health Organization. *Accountability for Women’s and Children’s Health; Recommendation 2: Health indicators: The 11 indicators of maternal, newborn and child health.* https://www.who.int/woman_child_accountability/progress_information/recommendation2/en/ (Accessed April 2020)

46

years ago, the issue of stillbirth was essentially erased by the UN human rights system, a fact that was attributed directly to the WHO.

The International Convention on Economic, Social, and Cultural Rights (ICESCR), introduced in 1966, is one of the foundational UN human rights treaties. This treaty's text included a commitment to reduce stillbirth rates. From the outset, the treaty monitoring body, tasked with monitoring compliance among states party, largely neglected this obligation in their concluding observations. But in 2000, the committee issued a general comment that formalized their rejection of the stillbirth issue, and also enshrined abortion in its work. This was done despite abortion being entirely absent, even by euphemism, in the text of the treaty.⁴⁷ The committee justified its dropping of stillbirths in a footnote: "According to WHO, the stillbirth rate is no longer commonly used, infant and under-5 mortality rates being measured instead."⁴⁸

the "sexual and reproductive health" community dominate the struggle for control of the maternal and child health agenda at the international level has been dominated, at least in terms of high-level agenda-setting. What used to be referred to as the "MCH" (maternal and child health) agenda has since expanded into "SRMNCAH" (sexual and reproductive and maternal and newborn and child and adolescent health)—otherwise known as "the sneeze," according to then-president of the Guttmacher Institute Ann Starrs at a 2017 Wilson Center event on maternal health.⁴⁹

What does SRHNCAH mean in practice? One of the WHO's first uses of the was in a report outlining global targets and setting forth a strategy for meeting them in the Sustainable Development Goals (SDGs), published in 2015. The report states:

47 Yoshihara, Susan. The UN Human Rights System's Stillbirth Scandal. Center for Family and Human Rights (C-Fam), Definitions, Issue 13, April 2020

48 Committee on Economic, Social and Cultural Rights. "General Comment No. 14 on the right to the highest attainable standard of health." E/C.12/2000/4. 2000

49 Oas, Rebecca. "Event Highlights Divided Priorities in Global Maternal Health Agenda." *The Friday Fax*, C-Fam. December 15, 2017 https://c-fam.org/friday_fax/event-highlights-divided-priorities-global-maternal-health-agenda/ (Accessed April 2020)

All countries should increase efforts to reach vulnerable populations with high-quality primary and emergency SRMNCAH services... Vulnerable populations include: the urban and rural poor; adolescents; commercial sex workers; people who are marginalized; the socially excluded; lesbian, gay, bisexual, and transgender population; those living with disabilities or HIV;

By an unwieldy ever-expanding acronym, the WHO managed to make a report narrowly focused on preventable maternal mortality about, among other things, gay men.

immigrants; refugees; those in conflict/post-conflict areas; as well groups who experience disparities regularly.⁵⁰

By an unwieldy ever-expanding acronym, the WHO managed to make a report narrowly focused on preventable maternal mortality about, among other things, gay men. Again, as long as political agendas dominate the WHO, its efforts to improve the situation of actual mothers and babies on the ground will always receive short shrift.

50 World Health Organization. "Strategies toward ending preventable maternal mortality (EPMML)". World Health Organization, Geneva. 2015



Photo: Graham Crouch/The Elders

Implications and Recommendations for U.S. Foreign Policy

The Trump administration sought to reverse the UN's focus on the abortion issue by promoting global health policies meant to separate the issue of abortion from maternal health, and to explicitly protect human life at all stages. To do this, the administration reinstated and expanded the Mexico City Policy which blocks U.S. funding for foreign-based organizations that promote or perform abortions, and it also a stand against controversial "reproductive health" language in UN resolutions. In so doing, the U.S. aimed to curb the UN's endorsement of abortion and the pressure UN entities have brought to bear on developing, traditional nations, to liberalize the practice. The U.S. use the power of the purse more to restore higher standards of ethical and medical practice in the area of maternal and child health and to restore a measure of independence and professional objectivity.⁵¹

The U.S. has withdrawn financial support previously. In 2018, the U.S. announced its departure from the Human Rights Council in Geneva due to the council's frequent adoption of anti-Israel resolutions and the presence of countries notorious for their abuses of human rights among its members.⁵² The U.S. ceased funding for

51 For instance, see Howard, Jacqueline. "Trump administration pushes UN to drop mentions of reproductive health from official documents." *CNN Health*, September 23, 2019. <https://www.cnn.com/2019/09/23/health/alex-azar-united-nations-universal-health-coverage-bn/index.html> (accessed April 2020)

52 Morello, Carol. "U.S. withdraws from U.N. Human Rights Council over perceived bias against Israel." *The Washington Post*, June 19, 2018. <https://www.washingtonpost.com/world/national-security/us-expected-to-back-away-from-un-human-rights-council/2018/06/19/>

UNESCO in 2011 due to its recognition of Palestine as a member state, and then withdrew as a member in 2018, again citing anti-Israel bias.⁵³

It is important to note that the United States also defunded international organizations for reasons related to abortion. Republican administrations have defunded UNFPA when in office, citing the Kemp-Kasten Amendment to the foreign assistance appropriations law, which forbids funding to organizations involved in coercive family planning and abortion practices. This particularly related to cooperation with the government of China as it was enforcing its draconian one-child policy.⁵⁴ In 2019, U.S. Secretary of State Mike Pompeo reduced U.S. funding to two agencies of the Organization of American States (OAS) for their pro-abortion lobbying in Latin American countries. He cited the Siljander Amendment, which forbids the use of U.S. funds to lobby for or against abortion in foreign countries.⁵⁵

Financial inducements have been highly effective in the case of the Mexico City Policy. First introduced as an executive order by President Ronald Reagan in 1984, and reinstated by Republican presidents since then, President Trump expanded it to cover the entire global health assistance portfolio, not just family planning. The policy goes beyond the ban on direct U.S. funding for the promotion or provision of abortion (set in law in 1973 by the Helms Amendment), and it now blocks U.S. funding for foreign-based organizations that promote or perform abortion at all. While the

a49c2d0c-733c-11e8-b4b7-308400242c2e_story.html (accessed April 2020)

53 Rosenberg, Eli and Morello, Carol. "U.S. withdraws from UNESCO, the U.N.'s cultural organization, citing anti-Israel bias." *The Washington Post*, October 12, 2017. <https://www.washingtonpost.com/news/post-nation/wp/2017/10/12/u-s-withdraws-from-unesco-the-u-n-s-cultural-organization-citing-anti-israel-bias/>

54 Kaiser Family Foundation. "UNFPA Funding & Kemp-Kasten: An explainer." July 31, 2019. <https://www.kff.org/global-health-policy/fact-sheet/unfpa-funding-kemp-kasten-an-explainer/> (accessed April 2020)

55 Morello, Carol. "Pompeo cuts OAS funds over advocacy of legal abortion." *The Washington Post*, March 26, 2019. https://www.washingtonpost.com/world/national-security/pompeo-cuts-oas-funds-over-advocacy-of-legal-abortion/2019/03/26/4ea5314d-d7e0-48de-b636-e552447430b0_story.html (accessed April 2020)

policy is well-targeted—its impact has been most strongly felt by global abortion giants IPPF and MSI and their affiliates.⁵⁶ At the same time, the U.S. must aim to help global maternal health policy, and the WHO in particular, retain independence from these powerful lobbies.

Yet, the Mexico City Policy has critical loopholes. Specifically, it does not apply to humanitarian assistance, or to “national or sub-national governments, public international organizations, and other multilateral entities in which sovereign nations participate.”⁵⁷ Like other UN agencies, the WHO would fall under this exception. The United States must close this loophole.

the WHO’s U.S. funding falls under two categories: assessed contributions scaled according to the income and population of a country, and voluntary contributions, which can be made not only by national governments, but also private organizations and individuals.⁵⁸ Voluntary contributions, which can be earmarked for specific issues and projects, have overtaken assessed contributions as the larger source of the WHO revenue.⁵⁹ The U.S. assessed contributions are paid to the WHO from the Contributions to International Organizations (CIO) account, while voluntary contributions are paid through “accounts addressing health, security, and development.”⁶⁰

President Trump’s recent announcement that the U.S. was

56 U.S. Government Accountability Office (GAO). “Global Health Assistance: Awardees’ Declinations of U.S. Planned Funding Due to Abortion-Related Restrictions,” GAO-20-347 Washington, DC: GAO, 2020

57 United States Agency for International Development. Global Health Legislative & Policy Requirements. <https://www.usaid.gov/global-health/legislative-policy-requirements> (accessed April 2020)

58 Kaiser Family Foundation. “The U.S. Government and the World Health Organization.” April 16, 2020. <https://www.kff.org/global-health-policy/fact-sheet/the-u-s-government-and-the-world-health-organization/> (accessed April 2020)

59 World Health Organization. “WHO’s Financing Dialogue, 2016: A proposal to increase the assessed contribution.” 2016 <http://www.who.int/about/finances-accountability/funding/financing-dialogue/assessed-contribution.pdf>

60 Blanchfield, Luisa, Congressional Research Service. CRS In Focus IF10354, United Nations Issues: U.S. Funding to the U.N. System, updated March 2020

placing a hold on the WHO's funding due to its mishandling of the COVID-19 epidemic prompts a variety of questions regarding the relationship between the U.S. and the organization. This includes concerns about the WHO's activities to promote abortion around the world.

As the most generous donor to the WHO, the U.S. has significant leverage, but to what extent could that be used to curtail the WHO's abortion activities, particularly when they are often directly funded by European governments using voluntary contributions? Here are some steps the U.S. could take to limit this:

- Withdraw support for the multi-agency Special Program of Research, Development and Research Training in Human Reproduction" (HRP). This entity is the hub of the WHO's pro-abortion activities, and it lists the United States Agency for International Development (USAID) alongside IPPF as one of its major donors. The funding could be redirected toward bilateral support for maternal and child health in developing countries.
- Close the loopholes in the Mexico City Policy regarding multilateral organizations, humanitarian assistance and other issues.
- Evenly apply the Siljander Amendment and withhold funding from UN agencies, including the WHO, in a manner proportionate to their pro-abortion lobbying, as it has already done with the OAS.
- Insist that the WHO respect national sovereignty, stay within its mandate, and not overreach with respect to human rights and other norm setting. Funding should be withheld from the WHO offices that parrot misinterpretations of UN human rights agreements provided by the Office of the High Commissioner for Human Rights and other non-binding bureaucratic committees, and which they apply as policy in a rights-based approach to programming.

- The WHO should be urged to deny special status to powerful lobbying organizations such as the International Planned Parenthood Federation (the sole nongovernmental organization serving as an HRP partner) that represent private interests and not those of World Health Assembly member States.
- Efforts should be made to review the role of private global health donors on independence of the WHO, in terms of its positions on politically controversial issues, its focus of work, and its allocation of resources.
- For purposes of accountability, international organizations like the WHO should be held to reporting requirements in which they must provide transparency on programming and their implementing organizations.
- The U.S. should consider forming a partnership with like-minded countries to work on achieving improved maternal and child health in a manner consistent with laws and policies protecting life at all stages, including the unborn.

At a time when the WHO has been in the global spotlight for its lack of independence in responding to COVID-19, it is useful to examine the agency's track record more broadly. This includes its overreach in promoting abortion, its failures to achieve—or adequately measure—sufficient progress in the area of maternal and child health, and the degree to which it has allowed itself to become politicized at the prompting of powerful governments with particular agenda. There is no better time to restore the WHO's credibility and independence. Continued financial support without reform means lending American support, credibility, and endorsement to programs that fail the people they were intended to serve, and it also means exporting controversial agendas that run counter to the U.S. foreign policy goals.

BIOGRAPHY

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