Responses of Pro-Life and Pro-Family Organizations to the questionnaire of the special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on "the right to sexual and reproductive health – Challenges and Possibilities during COVID-19"

The organizations submitting this response to the call for inputs do so by virtue of their specific mission to protect children in the womb from arbitrary deprivation of life and to ensure that the right to life and other legal protections intended for all members of the human family are not applied in a discriminatory way against children in the womb.

1. UN Abortion Promotion During the Pandemic

Early in March 2020, as governments looked to the World Health Organization (WHO) for guidance on how to deal with the coronavirus, officials of the international health agency promoted abortion as "essential" in a guideline on "Clinical management of severe acute respiratory infection."[i]

"Women's choices and rights to sexual and reproductive health care should be respected irrespective of COVID-19 status, including access to contraception and safe abortion," the WHO manual reads.

Soon thereafter a WHO staffer said the WHO has been working to ensure abortion drugs are considered "essential" during a webinar hosted by a pro-abortion journal. She also promoted the WHO's official view that where access to abortion is difficult or illegal, women should self-administer abortions.[ii]

The UN Secretary-General's humanitarian plan to respond to the pandemic designated "sexual and reproductive health" an essential category in the COVID-19 response.[iii] It went beyond ambiguous euphemisms by calling for the global humanitarian response to the pandemic to be guided by the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Situations*. This manual not only treats abortion as a humanitarian right, citing UN treaty bodies and special procedures, but it also says that medical personnel in humanitarian situations must refer for abortions against their consciences.[iv]

These actions by the UN Secretary-General and UN mandate holders are *ultra vires*. There is no mandate from UN member states to promote abortion, and there is no international human right to abortion in international law. Experts in international law and health reject claims that abortion is a human right under any circumstance. This is demonstrated in the expert document "The San José Articles," which describes UN entities' actions that present abortion as a right as unlawful and *ultra vires*.[v] Such acts are incapable of contributing to the establishment of any new obligations on States according to the legal principle *ex injuria jus non oritur* (unlawful acts cannot give rise to legal obligations).

2. Normative Parameters of the Work of the Special Rapporteur

The concept of “sexual and reproductive health and rights (SRHR)” is not universally accepted nor defined by the UN membership, nor is the concept of “sexual rights,” one of the core components of SRHR. The rapporteur should avoid the use of non-agreed terminology in her report.

Any analysis by the Special Rapporteur should be drafted in light of the normative parameters established by UN member states at the 1994 International Conference on Population and Development (ICPD) and the 1995 4th World Conference on Women, which has been reaffirmed in every major UN social policy agreement since its creation. Through the negotiated outcomes of those conferences, UN member states agreed to use a definite terminology to avoid misunderstandings about the policies that enjoy international consent and the policies that do not enjoy international consent. The ICPD and 1995 4th World Conference on Women referred to “sexual and reproductive health” and to “reproductive rights” as distinct concepts, though interrelated, and defined the parameters for the policies that are to be considered consensual under those terms.

The ICPD is the *only time* the terms “reproductive health,” “reproductive rights,” “sexual and reproductive health,” “sexual and reproductive health services,” and related terminology has been defined in the UN context. In particular, the following two paragraphs of the ICPD Programme of Action are especially relevant:[vi]

The Special Rapporteur’s report should use as the normative framework only those norms adopted by the United Nations General Assembly or enshrined in binding human rights agreements, especially on sensitive topics like “sexual and reproductive health.” If the very terms of the report the Special Rapporteur is preparing are controversial, it is unlikely that the report will help further the end of discrimination against women and girls. Rather, it may serve to further divide the UN membership on these issues to the detriment of women and girls worldwide.

3. “Safe” Abortion

Post-abortion care—the provision of medical help for women suffering complications following an induced or spontaneous abortion after the unborn child is already deceased—is a matter of international agreement. “Safe” abortion, on the other hand, as the Special Rapporteur should know, is not.

UN member states have repeatedly affirmed since the 1994 International Conference on Population and Development (ICPD) and Beijing conferences, specifically paragraph 8.25 of the ICPD outcome, that abortion is something governments should help women avoid.

The consensus of the ICPD was against the international system promoting abortion, inasmuch as it rejected the notion of abortion as a human right.[vii] That was the only time in UN negotiations that abortion was addressed in UN policy. Previous negotiations simply left it out of agreements altogether as a matter for domestic legislation.

At the 1994 Cairo conference, UN member states agreed on a range of policies related to "unsafe abortion," but again, no consensus was ever reached on the promotion of abortion. Instead, the 1994 Cairo conference outcome document urged governments and UN agencies "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."[viii] It also set as an objective "to reduce greatly the number of deaths and morbidity from unsafe abortion,"[ix] and committed governments to carry out research on "unsafe abortion."[x]

The ICPD conference also agreed that "In circumstances where abortion is not against the law, such abortion should be safe."[xi]

These caveats, found in paragraph 8.25 of the ICPD conference outcome document, presume that abortion is illegal in many or all circumstances[xii] and that abortion carries inherent risks for mothers. Paragraph 8.25 also insists that abortion is an issue that is exclusively to be left to national legislation, and therefore not an international right or something the UN system should be involved in promoting.

The caveats in Paragraph 8.25 also include that "every attempt should be made to eliminate the need for abortion" and that "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."

A footnote in the conference outcome linked to the definition of "unsafe abortion" for public health purposes by the World Health Organization.

> Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (based on World Health Organization, The Prevention and Management of Unsafe Abortion, Report of a Technical Working Group, Geneva, April 1992 (WHO/MSM/92.5))[xiii]

Were it not for these caveats, it is unlikely that "sexual and reproductive health," "reproductive rights," and abortion in particular would have been included in the ICPD agreement in the first place.

The Special Rapporteur should track this agreed norm closely, and err on the side of caution, in order to avoid politicizing this sensitive topic and be perceived as promoting the breaking of the law.

4. Conscience Rights

The conscience rights of health providers and professionals are guaranteed in international human rights law under Article 18 of the International Covenant on Civil and Political Rights.

It is sad to note the now ever more frequent assertion of UN treaty bodies and UN special procedures, that conscience rights cannot be invoked by medical health providers and personnel to deny abortions and abortion referrals, as most recently in the report of the special rapporteur on freedom of religion or belief with a focus on gender-based violence and discrimination in the name of religion or belief (UN Document No. A/HRC/43/48, paras. 29 and 44 especially). This artificially creates a conflict in human rights law that does not need to exist.

There is an ongoing clash between abortion advocates and medical providers and health professionals. The abortion industry is a global industry, subsidized heavily by governments, but it faces frequent shortages of health workers willing to carry out procedures that take human lives rather than saving them. Quite understandably, many doctors, nurses, midwives, and other health workers are unwilling to be complicit in depriving a child in the womb of their life through abortion. For this reason, abortion advocates frequently cite the conscience rights of health care providers as a barrier to accessing "safe" abortion.

As a result, there are ongoing efforts by the global abortion lobby to force health care providers to become complicit in abortion. We urge the Special Rapporteur not to take the side of the global abortion lobby in this debate. Sadly, the same governments and powerful global entities that subsidize the abortion industry are attempting to force doctors and medical providers into performing and referring for abortions against their conscience, and they have been successful in convincing parts of the United Nations system to exceed their mandates by supporting this effort.

Since the WHO issued its 2012 technical guidance on "Safe Abortion," the international health agency has also promoted the notion of "abortion to the full extent of the law."[xiv] Far from respecting the caveats in the ICPD agreement by carving out space for national laws, the notion of safe abortion "to the full extent of the law" is designed to limit the ability of governments to regulate abortion and to force medical providers to refer for abortions against their conscience.

The WHO technical guidance challenges basic legal restrictions on abortion, such as limitations on abortion based on the gestational age of an unborn baby,[xv] medical authorization requirements,[xvi] and requirements for consent from a parents or spouses.[xvii] They are challenged as "legal, regulatory, and access barriers" that should be "eliminated" as a human rights matter.[xviii]

The WHO technical guidance explicitly states that health care providers who exercise their conscience rights and refuse to perform or participate in an abortion, still "must refer the woman to a willing and trained provider in the same, or another easily accessible health-care

facility." Where such referral is not possible, the guidance states that "the health-care professional who objects, must provide safe abortion to save the woman's life and to prevent serious injury to her health."[xix]

This same notion of "safe abortion to the full extent of the law" is repeated in the UN's *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, where conscience rights are also undermined.[xx] It was likewise promoted by the UN population fund at the 2019 Nairobi Summit:[xxi]

> Policy-makers and health-care managers working to provide reproductive health services should always ensure that safe abortion care is readily accessible and available to the full extent of the law.[xxii]

5. Maternal Health

It is often asserted that governments should provide "safe abortion" as a way to improve maternal health outcomes, a notion that is highly deceptive. Abortion always involves the death of at least one human being. As such, it should never be labeled "safe." Moreover, any surgical or chemical procedure may result in complications, including bleeding and infections.

Absent intervening factors, induced abortions inevitably expose women to risks to which they would not otherwise be exposed if they were to carry a pregnancy to term. Women in developing countries are exposed to exponentially higher risk from both medical and surgical abortions because of lack of access to health care, antibiotics, transfusions, transportation, skilled medical workers, and other key factors. [xxiii]

One study in Finland found that one out of twenty women who underwent so-called "safe" surgical abortion and 25% of women undergoing "safe" medical abortion had complications including hemorrhage, incomplete abortion and need for repeat surgery.[xxiv] In the United States, the Food and Drug Administration (FDA) documented 605 reports of complications from medical abortions in the first 3 years of the use of mifepristone in medical abortions, one third of which involved severe bleeding and emergency surgery.[xxv]

Medical studies increasingly document how induced abortion exposes women and their children to higher risks from pre-term birth, which is the leading cause of perinatal death.[xxvi] Numerous studies demonstrate that women undergoing "safe" abortion have a significantly increased risk of subsequent suicide, major depression and substance abuse.[xxvii]

In the context of public health, it is also not accurate to tie the notion of "unsafe abortion" to the status abortion in the law. Since the Millennium Development Goals began to focus the attention of the international health community on maternal health, abortion groups have diligently made abortion laws a component of maternal health policy, arguing that 13% of all maternal deaths are related to abortion. A more recent study published in *The Lancet* put the figure closer to 8%.[xxviii] Nevertheless, estimates of abortion incidence, and of abortion-related

maternal mortality, remain contentious subjects. One reason is the difficulty in distinguishing between induced and spontaneous abortions (miscarriages) in settings where women may be reluctant to accurately report the circumstances due to cultural stigma or fear of legal repercussions.

Another issue is the fact that, among the leading causes of maternal mortality such as infection or hemorrhage, “unsafe abortion” is unlike the others inasmuch as an induced abortion is not a naturally-occurring complication of pregnancy or childbirth. While the consensus at ICPD urged countries to provide women with alternatives to abortion, the discourse around reducing deaths due to “unsafe abortion” often omit the role of discouraging women from seeking abortions in the first place as a potential life-saving measure. Rather, they adopt a fatalistic view that a woman seeking abortion will inevitably obtain one, and the only remaining question is whether she will have the option to do so legally and “safely.” In other cases, the existing risks of maternal mortality are used to make the argument that abortion is “safer” than childbirth.

As we have already established, “there is no clear association between making abortion legal or more widely accessible and a reduction in the proportion of maternal mortality due to abortion.”[xxix] There simply is no evidence that making abortion legal and more widely accessible is a significant measure to improving maternal health. There is not a lower relative percentage of maternal mortality attributable to abortion in countries with more liberal abortion laws.[xxx]

6. Emergencies and Humanitarian Settings

The Special Rapporteur should help the UN system guard against abortion becoming a default response to rape.

Ultimately, the issue of abortion in international aid is not just about sovereign prerogatives, but it is about what women need in humanitarian settings. Women who conceive under tragic circumstances, including in humanitarian settings, do not make recourse to abortion. Studies show that these women opt to keep their children at the same or similar rates as women who become pregnant under other circumstances.[xxxi] They and their children need health care, not abortion. Abortion cannot become the default response to rape in humanitarian settings.

If the UN accepts the premise that abortion is a humanitarian necessity or that abortion should be a default response to rape, women will be under pressure to abort their children for a host of factors. This would create perverse incentive structures within international aid work, including the higher expense of humanitarian efforts to care for a mother and child throughout pregnancy and afterwards. Humanitarian operators and governments will also feel under pressure to offer abortion because of these economic considerations.

Moreover, any abortion in humanitarian settings is highly dangerous for women since they would not have access to basic health infrastructure for adequate follow-ups or the treatment of inevitable complications from abortion.

Conclusions

Global health, like humanitarian policy, is a delicate area of international cooperation. Abortion should never be a part of it. Women deserve better than abortion. Consistent with international human rights law and commitments, the Special Rapporteur should consider the following:

- **Abortion is not a human right but a subject to be addressed exclusively in national legislation.**
- **There is no obligation to permit abortion during a pandemic, including COVID-19.**
- **When UN mandate holders promote abortion, as they have done during the COVID-19 pandemic they are acting *ultra vires*. There is no international obligation for donor states to fund abortion as part of international aid or humanitarian responses.**
- **Humanitarian responders must respect the abortion laws of the countries in which they are working.**
- **Humanitarian response efforts of the UN system must help women avoid abortion, by providing them the best possible maternal health care, psychosocial support, and other essential support services, especially in cases of pregnancies resulting from rape.**
- **Every effort must be made to provide comprehensive support services to women and children who are victims of sexual violence in conflict settings, to ensure they are fully integrated in society and are not victimized by the stigma attached to rape as a weapon of war, and that children are not recruited as child soldiers.**
- **UN agencies and international humanitarian efforts must not discriminate against humanitarian groups on the basis of their religious or moral opposition to abortion.**

The above response is undersigned by the following organizations:

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Center for Family and Human Rights

Matthew Wojciechowski
Campaign Life Coalition

Annie Franklin
Family Watch International

Henk Jan van Schothorst
Transatlantic Christian Council

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Peter Smith
International Right to Life Federation

Bob Lalonde
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Priests for Life

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Please add Teresa S. Collett
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Senior VP Bioethics and Public Policy
Christian Medical Association

Wendy Wixom, President
United Families International

Brian Scarnecchia,
International Solidarity and Human Rights Institute (ISHRI)

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[i] WHO Clinical management of severe acute respiratory infection, available at https://www.who.int/docs/default-source/coronaviruse/clinical-management-of-novel-cov.pdf.
[ii] COVID-19: WHAT IMPLICATIONS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS?
27 MARCH, 2020, available at: http://www.srhm.org/news/covid-19-what-implications-for-sexual-and-reproductive-health-and-rights/
[iii] GLOBAL HUMANITARIAN RESPONSE PLAN COVID-19 UNITED NATIONS COORDINATED APPEAL, APRIL – DECEMBER 2020, available at: https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf?fbclid=IwAR2ESmB8EKJj7wJudGmccVIjEWZVpoD7bPdfxeqzz82F2rvH_vOZm7K3sBY.
[iv] Friday Fax, U.S. Blocks UN Agreement Over Pro-Life Concerns, UN Member States Ignore, June 4, 2020, available at: https://c-fam.org/friday_fax/u-s-blocks-un-agreement-over-pro-life-concerns-un-member-states-ignore/.
[v] "San José Articles. Abortion and the Unborn Child in International Law". The first five articles are especially relevant in this context: "As a matter of scientific fact a new human life begins at conception." (Article 1); **"**Each human life is a continuum that begins at conception and advances in stages until death. Science gives different names to these stages, including zygote, blastocyst, embryo, fetus, infant, child, adolescent and adult. This does not change the scientific consensus that at all points of development each individual is a living member of the human species." (Article 2); "From conception each unborn child is by nature a human being." (Article 3); "All human beings, as members of the human family, are entitled to recognition of their inherent dignity and to protection of their inalienable human rights. This is recognized in the Universal Declaration of Human Rights, the

International Covenant on Civil and Political Rights, and other international instruments." (Article 4). Finally, "There exists no right to abortion under international law, either by way of treaty obligation or under customary international law. No United Nations treaty can accurately be cited as establishing or recognizing a right to abortion." (Article 5). Each article is accompanied by an explanatory footnote. The articles and footnotes are available in their entirety at: http://sanjosearticles.com/

[vi] Report of the International Conference on Population and Development Cairo, 5-13 September 1994 UN Document No. A/CONF.171/13/Rev.l. See especially ICPD 7.24: Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counseling of women who have had recourse to abortion and ICPD 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 20/ 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.

[vii] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, UN Document No. A/CONF.171/13, paragraph 8.25.

[viii] Ibid.

[ix] Ibid., paragraph 8.20(a)

[x] Ibid., paragraph 12.17.

[xi] Ibid., note 1.

[xii] Over 60 countries in the world have highly restrictive abortion laws, prohibiting abortion in all or most circumstances. *See* Thomas W. Jacobson and Wm. Robert Johnston (eds.) Abortion Worldwide Report (2018), available at: https://www.globallifecampaign.com/abortion-worldwide-report (accessed June 2020).

[xiii] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, UN Document No. A/CONF.171/13, Note 20.

[xiv] WHO Safe abortion: technical and policy guidance for health systems, Second edition (2018), available at: https://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/ (accessed June 2020).

[xv] Ibid., supra, note 10, p. 93

[xvi] Ibid., supra, note 10, p. 94

[xvii] Ibid.

[xviii] Ibid., supra note 10, p. 89, Box 4.1

[xix] Ibid., p. 69.

[xx] Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (2018), p. 184, available at: https://iawgfieldmanual.com/ (accessed June 2020).

[xxi] Nairobi Summit Statement on ICPD25: Accelerating the Promise, Commitment 12, Available at: https://www.nairobisummiticpd.org/content/icpd25-commitmentshttps://www.nairobisummiticpd.org/content/icpd25-commitments (accessed 2020).

[xxii] World Health Organization, Safe abortion: technical and policy guidance for health systems (2012), p.64, available: http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/ (accessed June 2020).

[xxiii] See Press Release, 20 April 2018, available at: https://www.unodc.org/mexicoandcentralamerica/es/webstories/2018/unodc-onu-mujeres-unfpa-y-onudhmexico.html (accessed June 2020).

[xxiv] Niinimäki, M., M.D., Pouta, A., M.D. PhD, Bloigu, A., Gissler, M., BSc, PhD, Hemminki, E., M.D, PhD, Suhonen, S., M.D., PhD, Heikinheimo, O., M.D. PhD. Immediate Complications After Medical Compared With Surgical Termination of Pregnancy. OB- STETRICS & GYNECOLOGY Vol 114, No 4, October 2009 795-804.

[xxv] Gary, M.M., and Harrison, D.J., Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient The Annals of Pharmacotherapy 2006 Feb. Vol 40 (Online, 27 Dec 2005, www.theannals.com, DOI 10.1345/aph.1G481).
[xxvi] Swingle HM, Colaizy TT, Zimmerman MB, Morriss FH. Abortion and the risk of subsequent preterm birth: a systematic review with meta-analyses. Journal of Reproductive Medicine for the Obstetrician and Gynecologist 2009; 54(2): 95-108.
[xxvii] Sullins, Donald Paul. "Abortion, Substance Abuse and Mental Health in Early Adulthood: Thirteen-Year Longitudinal Evidence from the United States." SAGE Open Medicine 4 (2016): 2050312116665997. PMC. Web. 24 Aug. 2018.
[xxviii] Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J, Gülmezoglu AM, Temmerman M, Alkema L. Global causes of maternal death: a WHO systematic analysis. Lancet Glob Health. 2014;2(6):e323–e333. doi: 10.1016/S2214-109X(14)70227-X.
[xxix] Securing a Better Future for Mothers in the Post-2015 Development Agenda: Evaluating the ICPD Operational Review, available at: https://c-fam.org/briefing_paper/securing-a-better-future-for-mothers-in-the-post-2015-development-agenda-evaluating-the-icpd-operational-review/ (accessed June 2020).
[xxx] Ibid.
[xxxi] M. Holmes et al., "Rape-related pregnancy: Estimates and descriptive characteristics from a national sample of women," *American Journal of Obstetrics and Gynecology*175:2 (1996) 320-5.