Responses of Civil Society for the Family and the UN Family Rights Caucus to the Questionnaire of the Working Group on Discrimination Against Women and Girls on Women's and Girls' Sexual and Reproductive health and Rights in Situations of Crisis

This comment is provided by the Center for Family and Human Rights (C-Fam) and Family Watch International on behalf of the coalitions Civil Society for the Family and the UN Family Rights Caucus, representing approximately five hundred organizations dedicated to the protection of the family and the promotion of human dignity internationally. The official platform of Civil Society for the Family may be found at the website www.civilsocietyforthefamily.org. Information on the Family Rights Caucus can be found on the website https://unfamilyrightscaucus.org/.

1. DEFINITIONS

The questionnaire provided by the Working Group on Women purports to ask about women's and girls' sexual and reproductive health and rights (SRHR) in situations of crisis. It should be noted that the concept of "sexual and reproductive health and rights (SRHR)" as defined by the Working Group in footnote 1 of the questionnaire is not universally accepted by the UN membership, nor is the concept of "sexual rights," one of the core components of SRHR.

In this regard, the Working Group would be well advised to carry out its reflection in light of what member states agreed at the 1994 International Conference on Population and Development and the 1995 4th World Conference on Women. Through the negotiated outcomes of those conferences, UN member states agreed to use a definite terminology to avoid misunderstandings about what policies enjoy international consent and which do not. The conferences 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.

Never did member states agree to the notion of "sexual and reproductive health and rights (SRHR)" as defined by the Working Group in footnote 1 of the questionnaire. At those conferences, and ever since, member states have avoided controversial terms like "sexual rights," and especially in reference to "girls," which can refer to minor girls who are still under the protection and authority of parents.

The Working Group should use as the normative framework for its report 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 Working Group 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.

2. "SAFE" ABORTION

In its questionnaire, the Working Group asks for information about "safe abortion services including surgical and non-surgical methods of termination of pregnancy and humane post-abortion care, regardless of the legal status of abortion" (Paragraph 4(g)).

By promoting the notion of "safe abortion services… regardless of the legal status of abortion", the Working Group seems to invite groups and individuals to break the law in countries where laws protect the right to life of children in the womb and restrict and penalize abortion accordingly. While 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, the phrasing of this section in the questionnaire leaves ambiguous whether the term "regardless of the legal status of abortion" refers to post-abortion care alone. At a minimum, this needs to be clarified.

Regarding "safe" abortion, the Working Group should know that UN member states have repeatedly affirmed since the 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 1994 International Conference on Population and Development (ICPD) was against the international system promoting abortion, inasmuch as it rejected the notion of abortion as a human right.[i] 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 however on a range of policies related to "unsafe abortion."

The conference 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."[ii] It also set as an objective "to reduce greatly the number of deaths and morbidity from unsafe abortion,"[iii] and committed governments to carry out research on "unsafe abortion."[iv]

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

These caveats, found in paragraph 8.25 of the ICPD conference outcome document, presume that abortion is illegal in many or all circumstances[vi] 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))[vii]

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 Working Group 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.

3. CONSCIENCE RIGHTS

In its questionnaire the Working Group also asks for information about "Legal and policy safeguards against abuses and delays in the provision of SRH services for example in relation to confidentiality, referrals, informed consent, conscientious objection, and third party consent requirements" (Paragraph 4(m)).

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 you not to take their side 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 World Health Organization (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."[viii] 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,[ix] medical authorization requirements,[x] and requirements for consent from a parents or spouses.[xi] They are challenged as "legal, regulatory, and access barriers" that should be "eliminated" as a human rights matter.[xii]

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."[xiii]

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.[xiv] It was likewise promoted by the UN population fund at the 2019 Nairobi Summit:[xv]

> 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.[xvi]

4. MATERNAL HEALTH

In its questionnaire the Working Group also asks for information (Question 4(o)), "Other pertinent information that may affect the availability accessibility, affordability, acceptability and quality of SRH services and information."

It is often asserted that governments should provide "safe abortion" as a way to improve maternal health outcomes. But this notion 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 procedure may result in complications, including bleeding and infections.

Absent intervening factors, medical 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, etc. [xvii]

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.[xviii] 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.[xix]

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.[xx] Numerous studies demonstrate that women undergoing "safe" abortion have a significantly increased risk of subsequent suicide, major depression and substance abuse.[xxi]

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%.[xxii] 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 discouraging women from seeking abortions as a potential life-saving measure. Rather, they adopt a fatalistic view that a women seeking abortion will inevitably obtain one, and the only remaining question is whether she will have the option to do so legally and “safely.”

As we have demonstrated before, “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.”[xxiii] 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.[xxiv]

5. EMERGENCIES AND HUMANITARIAN SETTINGS

In its questionnaire the Working Group also asks for information (Question 8) “If your State has humanitarian aid programmes, please indicate whether SRHR are explicitly covered in the humanitarian aid strategy and how priorities on SRHR are set.”

The Working Group 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. It is about what women need in humanitarian settings. Women who conceive under tragic circumstances, including in humanitarian settings, do not abort at the same or similar rates as women who become pregnant under other circumstances.[xxv] They 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.

6. CONCLUSIONS

Humanitarianism is a delicate and revered area of international law and cooperation. Abortion should never be a part of it. Women deserve better than abortion.

Abortion is not a humanitarian right but a subject to be addressed exclusively in national legislation. This is simply a statement of fact reflecting humanitarian law and UN consensus in ICPD 8.25 and Agenda 2030. Consistent with these international agreements the Working Group should consider the following:

- **There is no international obligation for donor states to fund abortion as part of humanitarian responses.** This respects U.S. law, chiefly the Helms Amendment, which prohibits U.S. funds from being used to perform abortion or force doctors and medical providers to perform abortion. It is important to take this into account because the U.S. is such a large donor of humanitarian assistance.
- **Humanitarian responders must respect the abortion laws of the countries in which they are working.** This is especially important because some humanitarian groups like Doctors Without Borders and abortion groups like International Planned Parenthood Federation, Marie Stopes international, IPAS, and Women on Waves, just to name a few, have been documented providing abortions even where they are illegal. This is not only illegal, it undermines humanitarianism and good faith in international humanitarian efforts. It is highly controversial and endangers the lives of humanitarian responders.
- **Humanitarian response efforts of the UN system must help women avoid abortion, by providing them the best possible family planning, maternal health care, psychosocial support, and other essential support services, especially in cases of pregnancies resulting from rape.** This simply reiterates the ICPD consensus that helps prevent abortion from becoming the default response to rape. Even for those countries that promote and perform abortion in humanitarian settings, we should agree that abortion should not become the default response to rape, and that women have the real option of a healthy pregnancy, a safe delivery, and the ability to care for her child, regardless of how the child was conceived.
- **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.** Abortion can never be provided or promoted as a discriminatory measure to prevent the birth of children conceived in rape. It is essential to avoid abortion becoming a default response to humanitarian emergencies as it will pressure both humanitarian agencies

to promote abortion as more cost-effective than providing actual humanitarian assistance.

- **UN agencies and international humanitarian efforts must not discriminate against humanitarian groups on the basis of their religious or moral opposition to abortion.** This ensures that no humanitarian group or aid worker ever feels pressured to provide abortions against their conscience and religious beliefs, and to avoid discrimination from official aid agencies that cooperate with the UN system in providing humanitarian assistance. Unless all healthcare providers and professionals are able to exercise their profession according to their conscience, they will be increasingly excluded from public health programming to the detriment of all. Shutting religious providers and professionals out of international development, humanitarian, and health programming would profoundly harm the social fabric of already vulnerable societies. According to some estimates over 50% of all healthcare in least developed and developing countries is provided by religious healthcare providers. In humanitarian settings, where religious and faith-based groups are usually the first on the ground, and the only continuous presence before, during, and after a humanitarian situation has ended, the effect of their work is even more essential.

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[i] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, UN Document No. A/CONF.171/13, paragraph 8.25.
[ii] Ibid.
[iii] Ibid., paragraph 8.20(a)
[iv] Ibid., paragraph 12.17.
[v] Ibid., note 1.
[vi] 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).
[vii] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, UN Document No. A/CONF.171/13, Note 20.
[viii] 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).
[ix] Ibid., supra note 10, p. 93
[x] Ibid., supra note 10, p. 94
[xi] Ibid.
[xii] Ibid., supra note 10, p. 89, Box 4.1
[xiii] Ibid., p. 69.
[xiv] Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (2018), p. 184, available at: https://iawgfieldmanual.com/ (accessed June 2020).
[xv] 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).
[xvi] 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).

[xvii] 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).

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[xxiv] Ibid.

[xxv] 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.