

Reproductive Health Care in the Context of the UN System

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In my role with the UN, and as a part of a coalition of pro-life/ pro-family NGOs, I have been extensively involved in all of the major UN conferences and their follow-ups since the 1994 Cairo Conference on Population and Development (ICPD). And, I have been involved in the pro-life movement as a volunteer for over thirty-one years.

National Right to Life and International Right to Life Federation are dedicated to the protection of all innocent human life from conception to natural death. We see human life as a continuum deserving compassionate protection and support beginning at conception and proceeding throughout the entire life cycle. We are committed to ensuring protection for all members of the human family from “the womb to the tomb”—regardless of age, degree of perfection, or status.

The focus of this report, “Reproductive Health Care in the Context of the UN System,” is very appropriate, because it appears to me that this terminology has been designed to accommodate the negotiating of problems in the UN system. As an obstetric nurse who has spent my life caring for mothers and their babies, I guess I was involved in reproductive health care. But, as I recall, we never called it that. Although I spent my life as a nurse specializing in Labor and Delivery caring for women having their babies, I don’t recall using or hearing the term “reproductive health” until I came to the UN. We used terms like maternal and child health care, prenatal care, perinatal care, etc.

In the context of the UN system, reproductive health care and/or reproductive health care services are ambiguous terms used to promote an agenda that would never be accepted if these terms were clearly defined. In most cases, they have become euphemisms for abortion advocacy.

The World Health Organization’s (WHO) definition of reproductive health includes abortion when it is not against the law and “methods . . . for regulation of fertility which are not against the law.” WHO’s definition of “fertility regulation” includes “interrupting unwanted pregnancies.”

My version of reproductive health includes the care and protection of at least two patients—the pregnant woman and her unborn child. It does not now and has never included abortion. I was taught to care for, not kill my patients

Right now, through the wonders of technology, I would like to introduce you to the youngest of those patients—a unique, never-repeated human being who came into existence at the moment of fertilization or conception—a human being with forty-six chromosomes—twenty-three from each parent. Only a human being has forty-six chromosomes and

his or her own genetic code. Contained in that first small cell is the totality of everything we are today—the color of our eyes and hair, our shoe size, our height, and all the other characteristics that make us special. All the genetic information necessary to build our body and our brain is present therein. Nothing is added except oxygen and nutrition.

This information as to the child in the womb, is relatively new in the history of humankind. It was only in the nineteenth century that we learned the scientific facts about the beginning of a new human life. Since then, the explosion of knowledge about life before birth has been incredible. We now have a “window to the womb” that allows us to see the child in the womb in action and in three-D.

Ultrasound Video—Eye Witness to the First Days of Life

You and I did not come from a fetus. We were once a fertilized ovum, an embryo, then a fetus, a newborn, a toddler, a teenager, and an adult; some of us are now senior citizens. These designations are merely names for stages of our growth and development. Less than three weeks from conception our heart began to beat with our own blood, often a different type than our mother’s. At just forty-two days from our conception (six weeks), we had detectable brain waves, and at eight weeks, even though we were only a little over an inch long, every organ we had when we were born was in place and our heartbeat could be heard on an office ultrasonic stethoscope. We had begun swallowing our amniotic fluid and could swim freely in it with a natural swimmer’s stroke. Our fingerprints had even begun to form. At this point, we were called a fetus, Latin for “young one.” At eleven to twelve weeks (four months), all our organ systems were functioning—we had eyelids, nails, and fingerprints. We were about two and a half inches long, could make a tiny fist, get hiccups, suck our thumb, wake up, and go to sleep.

Years ago, I thought, “If we only had a window to the womb, the world would become safe for unborn children.” But, unfortunately, I was wrong.

We are here talking about how we can make the world safe for children at a time when the document being negotiated for the November Special Session of the General Assembly on Children still contains language on reproductive health care and services that, if adopted, could contribute toward making the world very unsafe for unborn children.

On the second night of negotiations of the June Prep Com, a wonderful thing happened. A delegate asked a simple question and got an honest answer. He asked what the

term “services” means in the context of “reproductive health care.” The room was electrified when a delegate abandoned UN doublespeak and answered that “services” in that context included abortion. In response to disagreements on this point, it was suggested that the interpretation of such terms was left entirely to the discretion of the member states. This prompted vigorous objections from certain delegates. During the debate, it was the consensus view that the phrase “reproductive health care” *does not* include the provision of abortion services.

I would like to give a special thank you to the courageous delegates, some of whom are in this room, who took advantage of a wonderful opportunity and succeeded. They are an example of what can be accomplished when delegates speak with a strong voice together.

It is my understanding that the debate demonstrated, beyond reasonable dispute, that for purposes of documentation for the Special Session of the General Assembly on Children, when the phrase “reproductive health care” is used it cannot be construed to include abortion. Without this understanding, consensus could never have been reached on the particular paragraph that prompted the debate.

This was good news. However, consensus has not been reached on a subsequent paragraph that involves promoting the “right of adolescents (defined by WHO as including those aged ten to nineteen) to sexual and reproductive health, education, and information services.” Delegates from countries who have laws against abortion insist on this language because it is “agreed language” from previous conferences. They claim that while “services” may mean abortion for other countries, it does not include abortion for their countries. Language relating to parental rights is also presented in this paragraph, but that too is still pending.

There are some basic flaws in their thinking. First, there were numerous reservations and interpretive statements (over sixty) regarding the so-called “agreed language” in question, particularly in the Cairo ICPD and the Beijing Fourth World Conference on Women (FWCW). These reservations cannot be taken out of the context of the carefully negotiated and protective language in which they appear.

One has to ask why is there such an attachment to “agreed language” that can involve the destruction of unborn children? Why are we ignoring the “agreed language” in the *Universal Declaration of Human Rights* that says “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world” and also the “agreed language” in the *Declaration of Rights of the Child*, which states that “the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.” All UN negotiators should adhere to *this* “agreed language.” No UN

body should regulate and/or increase access to a practice (the killing of innocent human beings by abortion), which a large majority of its members regard as morally wrong and a violation of human rights, even though some countries have legalized the violation of these rights in their country. Nor should the UN explicitly or implicitly condone such killing even when some countries allow it.

Second, it is a serious mistake for a delegate to assume that because “my country has laws against abortion and my country does not interpret this language to include abortion my country is protected.” This kind of thinking indicates misunderstanding of the fact that international customary law can be established by repetition in these UN documents. Countries are bound to this customary law, which can bypass sovereignty, even if they have not ratified or signed applicable documents and/or treaties.

This fact is well documented by the Center for Reproductive Law and Policy (CRLP), which recently filed a lawsuit in the United States District Court Southern District of New York against U.S. President George W. Bush, Secretary of State Colin Powell, and Andrew Natsios, administrator of USAID. CRLP asked the court to block enforcement of the “Mexico City Policy” restored by President Bush in January. In the lawsuit they reveal their plan to establish legal abortion worldwide as a human right through customary international law and other UN instruments, thus bypassing sovereignty and the democratic process. The “Mexico City Policy” was issued by President Ronald Reagan in 1984 at the ICPD in Mexico City, and rescinded by President Clinton on 22 January 1993. (It was at this conference the UN adopted the policy stating, “In no case should abortion be promoted as a method of family planning.”)

Under the “Mexico City Policy,” which the CRLP dubs the “global gag rule,” family planning organizations that “perform or actively promote abortion as a method of family planning or provide financial support to any other foreign NGO that conducts such activities” are ineligible for USAID funds. The “Mexico City Policy” in no way decreases the dollar amount of USAID funding for family planning. The funds have and will be awarded to those family planning organizations that agree not to promote or perform abortions.

The CRLP is a tax-exempt, nonprofit NGO based in New York City. It was established in 1992 to promote legal abortion worldwide as an enforceable human right. Its central strategy is to collaborate with foreign NGOs and their staffs in order to develop partnerships that can effectively:

Insure recognition of women’s right to abortion as a human right in international legal documents, including treaties and other agreement among nations; lobby foreign governments to follow international agreements and decriminalize and liberalize their abortion laws, and to oppose new legal restrictions on abortion; campaign for greater access to

safe and accessible abortion, where abortion is already legal; lobby the U.S. government and other governments to endorse international agreements that recognize reproductive choice as a human right.

CRLP claims to have invested extensive resources in laying the groundwork for improving access to reproductive health care, including abortion law reform, in many countries in which “Mexico City Policy” impairs their progress and effectiveness. The organization expresses the hope of achieving an overwhelming international consensus that abortion should be protected as an international human right so that recalcitrant nations, including the U.S. and its constituent states, will experience increased international pressure to reform abortion laws.

In regard to customary international law, paragraphs seventy-eight and seventy-nine of the CRLP’s lawsuit state:

Customary international law also preempts inconsistent state statutes and policies. Thus by working to establish the right to abortion as a human right in customary international law, CRLP fulfills its mission of protecting women’s access to abortion from interference or prohibition by the states.

Customary international law is embodied, *inter alia*, in treaties (even if not ratified by the U.S.), the writings of international law jurists, and documents produced by UN international conferences. The *Restatement Third of the Foreign Relations Law of the United States* (American Law Institute 1987) defines customary international law as resulting ‘from a general and consistent practice of states followed by them from a sense of legal obligation.’

And, Paragraph 65 states, “CRLP advocates that laws criminalizing and restricting abortion violate internationally recognized rights. This political speech and advocacy is aimed at prompting a right to abortion in the United States and in every other country on Earth.”

CRLP boasts that, in the wake of the Cairo and Beijing conferences, several nations reformed their abortion laws. They take pains to note that this took place during the period (1993–2000) when the “Mexico City Policy was not in effect” and “[foreign] NGOs receiving USAID funds were free to promote abortion as a human right . . . and to urge decriminalization of abortion as a human right at these conferences.”

Their complaint, among other things, states that the “Mexico City Policy” interferes with:

Their ability to obtain clients in foreign countries who would bring legal actions in international legal tribunals or the legal tribunals of foreign countries and those whose circumstances would provide information to CRLP that would enable them to advocate for abortion law reform more effectively in legislative bodies or with government ministries; plaintiffs’ ability to achieve

abortion law reform in the United States, by interfering with plaintiffs’ efforts to establish the right to abortion as a human right internationally; plaintiffs’ efforts to persuade the United States government and the governments of the several states and the people of the United States that the right to abortion should be given the highest level of legal protection; their ability to form alliances with USAID recipient FNGOs for the purpose of influencing international conferences, international legal tribunals, and world public opinion; dissemination of their country reports and . . . their ability to conduct follow-up law reform activities, including, *inter alia*, lobbying in cooperation with [foreign] NGOs, litigation in cooperation with [foreign] NGOs, and public education campaigns in cooperation with [foreign] NGOs.

Another mechanism CRLP uses in their “game plan” for securing acceptance of reproductive rights is the preparation and publication of “shadow reports” on the status of reproductive rights and on access to reproductive health care, including abortion, in the U.S. and foreign countries. These reports “shadow” government reports to UN-treaty-monitoring bodies. The monitoring bodies then issue recommendations to governments concerning actions they should take to comply with treaty obligations. The CRLP claims their shadow reports are the first ever submitted to UN-monitoring bodies that focus on reproductive rights and that, in several instances, the UN-monitoring bodies have adopted or incorporated recommendations made in the reports.

During the period from 1997 to 2000, CRLP claim they have prepared such shadow reports on reproductive rights on the following counties and submitted them to the appropriate UN monitoring body:

- Committee on the Elimination of Discrimination Against Women: Mexico, December 1997; Zimbabwe, December 1997; Nigeria, June 1998; Peru, June 1998; South Africa, June 1998; Colombia, December 1998; Chile, May 1999; Lithuania, June 2000; Romania, June 2000.
- Children’s Rights Committee: Benin, May 1999; Russia, November 1999; Mali, November 1999.
- Committee on Economic, Social, and Cultural Rights: Cameroon, November 1999; Bolivia, April 2001.
- Human Rights Committee: Tanzania, July 1998; Argentina, October 2000; Peru, October 2000; Croatia March 2001.

In addition, CRLP states that they advocate the implementation and interpretation of existing treaties and other international human rights agreements that favor protection of reproductive rights, including abortion and internationally recognized human rights. One mechanism they use for this goal is to encourage foreign NGOs to obtain decisions from

international tribunals or national courts of foreign countries that favor such treaties and agreements.

CRLP engages in political speech and advocacy designed to promote abortion as an international human right in international forums with lawyers and advocates from the following countries: Albania, Armenia, Azerbaijan, Bangladesh, Benin, Bolivia, Botswana, Burkina Faso, Cambodia, Cameroon, Cote d'Ivoire, Dominican Republic, Ecuador, Egypt, El Salvador, Eritrea, Ethiopia, Gambia, Georgia, Ghana, Guatemala, Guinea, Haiti, Honduras, India, Jamaica, Jordan, Kazakhstan, Kenya, Kyrgyzstan, Liberia, Madagascar, Malawi, Mali, Moldova, Morocco, Mozambique, Nepal, Nicaragua, Nigeria, Paraguay, Peru, Philippines, Romania, Russia, Rwanda, Senegal, South Africa, Tajikistan, Tanzania, Togo, Turkey, Turkmenistan, Uganda, Ukraine, Uzbekistan, West Bank/Gaza, Yemen, Zambia, and Zimbabwe, and currently has projects in: Albania, Bangladesh, Benin, Bolivia, Burkina Faso, Cameroon, Cote d'Ivoire, El Salvador, Ethiopia, Ghana, Guatemala, India, Jamaica, Kenya, Mali, Nepal, Nigeria, Peru, Romania, Russia, South Africa, Tanzania, and Zimbabwe.

Now, I would like to turn to my other patient—the mother. I have often said that if I cared not one wit for the unborn child, I would still be against abortion because it is bad for women, particularly young women and adolescents.

The argument is made that we need to make abortion legal to save women's lives. Nothing could be further from the truth. Legalization of abortion in the developing world would increase maternal mortality. The notion that making abortion legal makes it safe is false and dangerous.

The obsession with “reproductive health care and services” at these conferences has not helped the women of the world. It is a scandal, for example, that although a decrease in maternal mortality in the developing world has been named as a top priority ever since the conference in Cairo, there has yet to be a significant decrease in maternal mortality in the developing countries.

The reason? The focus has been falsely placed on supposedly saving women's lives by limiting the number of births rather than by putting all possible resources into saving their lives by making births safe. Major development resources have been used on population control methods (including promotion of abortion) rather than on improving general and maternal health care that is known to be the key to saving women's lives.

Focus needs to be directed toward the real causes of high maternal mortality in the developing world. These include a lack of basic health, prenatal, and obstetric care. For example, anemia has been cited in several studies as a primary indirect cause of maternal deaths in African countries; malaria is a major cause of anemia in Africa and in areas where it is endemic, malaria has been associated with low birth weights, as well as maternal death and fetal loss.

Developed countries have known how prevent maternal deaths for more than forty years. WHO affirms this fact. WHO states in its 1991 “Maternal Mortality, A Global Factbook” that the dramatic decline in maternal mortality in the developed world (1941–1951) coincided “with the development of obstetric techniques and improvements in the general health status of women.” This has been true in the U.S., where the most significant impact of legalization of abortion has been an increase in the number of abortions (from approximately two hundred thousand per year to one million five hundred thousand per year), not a decrease in maternal mortality and morbidity. And in the U.S.—where abortion has been legal for over twenty-eight years and where health standards are high—women are still dying from botched legal abortions. The U.S. maternal mortality rate is four times that of Ireland, which has the lowest maternal mortality rate in the world and where abortion is not legal. Five years after abortion was made illegal again in Poland, a study found that women's and children's health there has improved. The number of legal abortions per year dropped from 59,417 in 1990 to 151 in 1999. In Finland, where abortion is legal, a recent unimpeachable study of pregnancy associated deaths (1987–1994) has shown that the risk of dying within a year of an abortion is several times higher than the risk of dying after miscarriage or childbirth.

It has been my observation during my many years of experience as a delivery-room nurse that women who are in poor health, have poor nutrition, or have not had good prenatal care are most vulnerable to maternal death and injury because their bodies do not have the resources to respond to an obstetric crisis that a healthy woman could withstand.

The key, therefore, to reduction in maternal mortality rates from all causes, including abortion, is the improvement of basic health care, nutrition, and prenatal care, not the legalization of abortion. In the developing world—where medical care, antibiotics, and even basic sterile technique are scarce or absent—promoting abortion would *increase, not decrease* maternal mortality. Dr. Donna Harrison, an obstetrician-gynecologist who has experience as a volunteer in a Haitian development cooperative, has stated that making abortion legal in the developing countries would result in increased maternal deaths and injuries.

As an obstetric nurse who has spent my life caring for women having babies, I have frequently made a plea to international bodies to put greater resources and emphasis toward improving health care in the developing world, particularly maternal health care. Women in many parts of the world need clean water, nutrition, and basic health care for themselves and their families—not the right to violently destroy their children before they are born. When a woman is sick or hungry, she does not call out for her reproductive rights, but for food and medicine.