



The World Health Organization's Abortion Agenda

By Andrew M. Essig, Ph.D.

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PREFACE

How did the World Health Organization (WHO), the world's premier health institution, become one of the world's top abortion research and advocacy institutions? From the time it was founded to heal suffering people after World War II, WHO has gradually adopted a special agenda to train abortionists, conduct abortion experiments on pregnant women, and promote the highly controversial idea that access to "safe" abortion is a human right. WHO capitalizes on its good reputation and exploits the extensive networks forged with rich and poor nations from its original role in order to carry out the abortion agenda all over the world.

Along with other United Nations agencies, WHO intervenes in recipient countries pressing the belief, promoted as policy, that economic development is not possible without a host of progressive ideas. Among these ideas is the notion that building modern health systems requires "safe" abortion, contraception, emergency contraception, and sexual autonomy of adolescents. Much if not all of this corpus of beliefs runs counter to, and in effect undermines, the national and local traditions and cultures of WHO recipient nations.

The shift in focus may seem like a radical reorientation away from its mandate of healing and health, but the actors who caused the change did not necessarily see it that way. In fact, the change happened by degrees. It was the work of countless and largely nameless individuals on government delegations and bureaucratic staffs in Geneva. It was backed by elites in the halls of medicine, academia, and government from the mostly rich Western nations, who sought to use the institution they funded in order to promote a progressive agenda they believed in.

In "The World Health Organization's Abortion Agenda," Andrew Essig endeavors to show how far WHO has come from its original mandate, to expose the degree to which the abortion agenda has permeated its ideology, and who is providing the funding to promote it. The paper examines how WHO has emphasized family planning, including abortion, by eschewing other aims. All of this to the detriment of that institution's effectiveness and reputation. Finally, it offers recommendations for concerned policy makers in donor and recipient nations.

Dr. Essig's paper provides a well-deserved critique of the way the world's premier health organization has become the world's top abortion advocate. In so doing, Dr. Essig adds his voice to an ongoing debate about what WHO recipient nations can do to protect their pro-life laws and policies from WHO interventions.

Susan Yoshihara, Ph.D.

Director

International Organizations Research Group



Introduction

After World War II, members of the international community reached a consensus that health plays an important role in promoting friendly relations among nations. For this purpose they established the World Health Organization (WHO). Its original mandate prioritized malaria, tuberculosis, venereal disease, nutrition, environmental sanitation, and women's and children's health.

Over the decades WHO has achieved an impressive track record in disease control, immunization, and water sanitation, among other programs, resulting in the betterment of life for millions of people around the world.

Unfortunately, this record is being tainted by the organization's own efforts in controversial programs due in no small part to the adoption of a rights-based approach to programming that has entailed the promotion of highly controversial social policies as rights. The organization decided to include under the mantle of "health" such issues as "safe" abortion, family planning, and sexual health. Accepting these issue areas as part of its expanded mandate threatens the legitimacy of the organization. The reason is that its policies disregard the social-economic and cultural identities of targeted member countries, which rely upon WHO to help meet their basic health needs.

WHO is now deeply committed to the reproductive rights agenda and it possesses several strengths from which it can draw upon to promote it. It has the power to allocate funding which it receives from United Nations (UN) agencies, national governments, foundations, and other sources. It performs authoritative research and publishes reports which are reviewed by government officials and organizations. It sets the standard for acceptable medical practices, including family planning and abortion methods. It coordinates its activities with other UN agencies,

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as well as foundations and medical institutions worldwide, which also support abortion and family planning. WHO also develops strategies at the international, national, and local levels to promote its agenda.

Given these strengths — financier, information provider, legitimator, and coordinator — WHO policies in the issue areas of abortion, family planning, and sexual and reproductive health need to be examined if decision makers are to restore the functional operations of the organization to their primary purposes. By diverting attention and resources to controversial programs, WHO is spending less on tackling the issues of maternal and child health and welfare and other pressing global health concerns where it has proven its effectiveness.



Part I: Overstepping its Mandate or Wrong Mandate?

In the spring of 1945 delegates from fifty countries attended the United Nations Conference on International Organization in San Francisco to formally establish the United Nations. During these talks representatives submitted a proposal to convene an international conference for the purpose of creating a new world health organization. The delegates were convinced of the vital importance that health plays in the promotion of “conditions of stability and well-being which are necessary for peaceful and friendly relations among nations,” as stated in Article 55 of the Charter of the United Nations.¹ A preparatory committee met in Paris from March 18 to April 5, 1946 in order to draft a constitution for consideration at the June 1946 International Health Conference in New York City. On July 22, 1946 sixty-one states subsequently signed the constitution of the World Health Organization after four weeks of meetings.² The new organization was categorized as a specialized agency in accordance with Article 57 of the UN Charter.

The WHO constitution instituted a governance structure consisting of three organs: the World Health Assembly, the Executive Board, and the Secretariat. The World Health Assembly (WHA) is the supreme decision-making organ of WHO, and is comprised of delegates from the member states. Currently there are 193 member states each of which has one vote in the Health Assembly. Its main function is to determine the policies of the WHO, which it does at its general meeting in Geneva in May of each year. The WHA receives reports from the Executive Board and instructs it on matters pertaining to further action, investigation and study. The Executive Board consists of 34 members who are experts in various fields of health, and who tend to be representatives from the various state

1 World Health Organization, “Official Records of the World Health Organization No. 2: Proceedings and Final Acts of the International Health Conference held in New York from 19 June to 22 July 1946.” (June 1948), 5.

2 Ibid. 6.

health ministries of the member states. It sets the agenda for the WHA's general meetings, gives effect to decisions and provides advice. Lastly, the Secretariat consists of the director general, who is nominated by the Executive Board and appointed by the WHA, and approximately 8,000 technical and administrative staffers.³ The director general is the chief technical and administrative officer of the Organization.

In addition to establishing the governance structure, the WHO constitution also explains the organization's various functions, membership, regional organizations, voting, relations with other organizations, budget and expenses. In relation to this last mission, the director general is required to submit a budget to the Board, which reviews and forwards it to the WHA for approval. Once approved, expenses are apportioned among member states based upon a formula created by WHA.⁴ According to article 57 of the WHO constitution, WHO may also accept gifts from outside parties, as long as these contributions are in line with the institution's objectives and policies.⁵ The current budget is estimated at US\$ 4.5 billion. Approximately 79% of this expenditure is to be funded by voluntary contributions.⁶

The organs and budget, as well as other aspects of WHO serve the primary purpose of meeting its main objective. Chapter 1, article 1 of the WHO constitution states that this objective "shall be the attainment by all peoples of the highest possible level of health." In order to understand the vast scope of this article, the definition of "health" attributed by the member states needs to be taken into consideration. WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."⁷ The conditions for achieving

3 "Governance," World Health Organization, <http://www.who.int/governance/en/index.html>.

4 The United States contributes approximately 22% of WHO's core budget. "U.S. Participation in the United Nations: U.S. Financial Contributions," Bureau of Public Affairs, U.S. Department of State, Washington, DC, September 9, 2003. According to the WHO constitution the United States does not possess a formal veto on the budgeting process within the World Health Assembly, which approves the budget and apportions the expenses.

5 *Constitution of the World Health Organization*, Chapter XII, Basic Documents, Forth-fifth edition, Supplement, October 2006.

6 World Health Organization, *Proposed Programme Budget 2010-2011*, PPPB/2010-2011, Geneva, 2009, 74, http://apps.who.int/gb/ebwha/pdf_files/MTSP2009/PPB5-en.pdf. The reliance on voluntary contributions is not unique to WHO. The United Nations Development Program (UNDP) received \$1.12 billion in voluntary contribution in 2007, the United Nations Population Fund (UNFPA) received \$360.5 million.

7 Preamble to the *Constitution of the World Health Organization* as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the

this objective are formally expressed in the WHO constitution's preamble, which places a heavy emphasis on the importance of international cooperation. For instance, the third principle listed in the preamble states: "The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States." This clearly reflects the sentiments initially expressed by the delegates at the UN conference in San Francisco.

Over the decades WHO has expanded its operations to cover an ever-increasing number of activities which subsequently fall under its broad definition of health. A review of WHO's "health topics" index provides a good indication of its extensive efforts.⁸ Alphabetically these topics include anything from accidents and acupuncture to yellow fever and zoonoses.⁹ Sandwiched between these particular health issues, however, are other items such as: condoms, contraception, family planning, reproductive health, and sexual health. WHO adopted these into its very definition of health. In its introduction to "reproductive health" WHO's website explicitly states, "(w)ithin the framework of the WHO's *definition of health...* reproductive health addresses

WHO states that, "(w)ithin the framework of the WHO's definition of health... reproductive health addresses the reproductive processes, function and systems at all stages of life.....the capability to reproduce and the freedom to decide if, when and how often to do so."

the reproductive processes, functions and system at all stages of life." It goes on to say that people should have "the capability to reproduce and the freedom to decide if, when and how often to do so."¹⁰ This is the definition of reproductive health that WHO proposed for approval by the International Conference on Population and Development (ICPD) in Cairo in 1994, which was sponsored by the United Nations.¹¹

representatives of 61 States and entered into force on 7 April 1948. The definition has not been amended since 1948.

8 "Health topics," World Health Organization, <http://www.who.int/topics/en/>.

9 Zoonoses are any infectious diseases that can be transmitted from vertebrate animals to humans, such as rabies, anthrax, the plague, etc.

10 "Reproductive health," World Health Organization, http://www.who.int/topics/reproductive_health/en/ (emphasis added).

11 Anonymous World Health Organization official, email interview, 17 August 2009.

This is a far cry from WHO's original mandate. While mandates are regularly updated to meet new conditions, WHO's agenda in this particular area has changed in its essentials from meeting the basic needs of women and children to supporting and promoting controversial positions on contraception and abortion. When the first World Health Assembly convened in June 1948, its agenda, as stipulated by the Interim Commission of WHO, prioritized malaria, tuberculosis, venereal disease, nutrition, environmental sanitation and women's and children's health.¹² Its support for this last item was in full compliance with one of its functions declared in chapter 2, article 2 of the WHO constitution, "to promote maternal and child health and welfare." The basic approaches at that time towards this particular health issue focused on: the utilization of available foodstuffs, preventing communicable diseases among children, increasing knowledge about causes of ill health and the effects of economic and social changes on the development of children, which resulted in a dramatic decrease in maternal mortality. It called for expert investigations and assistance to governments to combat this problem. In addition to this its objectives were to pool knowledge and cooperate with other agencies.¹³ WHO came to the realization that many of the deaths among infants and mothers were preventable, if effective medical techniques were made available.

Currently WHO advocates that maternal and infant health can be achieved through heavy doses of family planning, eliminating "unsafe" abortions and promoting sexual and reproductive health. It does not view this, however, as a departure from its mandate, but a different method for achieving it. WHO's support for these activities purportedly derives from its pursuit for equity, among other things, which it argues has existed since its foundation. "For decades, equity has been pursued in health and development policies and strategies, explicitly or implicitly, as an end in itself or as a prerequisite for a more just society...From the beginning, improving sexual and reproductive health was seen as key to the achievement of a number of these goals."¹⁴ The goals referred to here are those stated in the United Nations Millennium Declaration in 2000: reducing maternal mortality; reducing mortality among children under

12 "Working for Health: An Introduction to the World Health Organization" World Health Organization, 2007, 4, http://www.who.int/about/brochure_en.pdf.

13 Official Records of the World Health Organization, No. 10: "Report on the Interim Commission to the First World Health Assembly, Part II Provisional Agenda," May 1948, 6-7.

14 Department of Reproductive Health and Research, *Sexual and Reproductive Health – Laying the Foundation for a More Just World Through Research and Action: Biennial Report 2004-2005*, 2006, vii.

five years; reversing the spread of HIV/AIDS; promoting gender equality; and empowering women.¹⁵ It is confounding that after so much success in reducing maternal and child mortality in the developed world through improvements of basic health care, WHO would switch positions to adopt an unproven rights-based approach in the developing world. WHO justifies saying that the new policies are advancing the “conditions of stability and well-being which are necessary for peaceful and friendly relations among nations” through its perceived creation of a more just world. But there is no evidence that they actually reduce pressing health problems.

The *Encyclopedia of Birth Control*'s entry on WHO states, “As part of *its mandate*, the World Health Organization (WHO), through its Department of Reproductive Health and Research, conducts research into reproductive health issues...”¹⁶ This mandate is based upon several sources: the non-binding outcome document International Conference on Population and Development in Cairo; the non-binding outcome document from the Fourth World Conference on Women in Beijing; WHO's commitments to the UN Millennium Declaration; and internationally agreed human rights declarations. Included among these rights are:

The basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; the right of women to have control over and decide freely and responsibly on matters related to their sexuality, including reproductive and sexual health, free of coercion, discrimination and violence; the right of access to relevant health information; and the right of everyone to enjoy the benefits of scientific progress and its applications.¹⁷

Thus, WHO has become a human rights activist organization by adopting a rights-based approach to programming, which does not reflect the original mandate of the organization. Furthermore, what it calls “rights” often derive from non-binding documents or misinterpretations of treaties by bureaucratic committees with no authority to interpret negotiated texts. While WHO still focuses on pressing global health needs, most of the new controversial programs in the areas of abortion and

15 Ibid.

16 Marian Rengel, *Encyclopedia of Birth Control*, Greenwood Press, 2000, 251. (emphasis added).

17 World Health Organization, *Proposed Programme Budget, 2006-2007*, Geneva, 2005, 73.

family planning come not from the WHA per se but from certain donor countries, WHO staff and a number of non-governmental organizations (NGOs) and foundations, who participate as members and observers in various governing bodies such as the Policy and Coordination Committee of the Reproductive Health Program.¹⁸

This particular rights-based approach within WHO harkens back to Jonathan Mann, the first director of WHO's Global Program on AIDS (GPA) in the 1980s. Mann believed that in order to effectively respond to the spread of HIV/AIDS a political as well as a medical response was needed. He argued that protecting the rights of those infected with HIV/AIDS, or any person who belonged to a vulnerable group, was a matter of vital public health policy, and therefore would help WHO pursue its mandate. From this point onward "WHO has consistently spoken of rights as being central to its operations and mandate."¹⁹ Even after Mann abruptly left the organization, his ideas had already been adopted by several state parties and had seeped into the bureaucracy within WHO, thereby making it difficult for it to return to its original mission.

Part of this bureaucratic inertia comes from the Department of Reproductive Health and Research (RHR), which is the focal point for WHO's activities in reproductive and sexual health. RHR's mission is to help "people to lead healthy sexual and reproductive lives." It pursues this end by strengthening "the capacity of countries to enable people to promote and protect their own health and that of their partners as it relates to sexuality and reproduction, and to have access to and receive quality reproductive health services when needed." WHO established RHR in 1998, and the department focuses on four primary objectives: to increase the availability of "high-quality" services; to broaden the range of "safe, effective, acceptable, and affordable" family planning and infertility technologies and interventions that is available to all women and men; to strengthen the capacity of national health systems to ensure the availability of "high-quality" and sustainable family planning programs and services in resource-poor settings; and to promote an environment at the international level that is supportive of family planning.²⁰

RHR integrated the research and program development activities of the UN Development Program (UNDP), UN Population Fund (UNFPA),

18 Anonymous WHO official, email interview, 17 August 2009.

19 Joel E. Oestreich, *Power and Principle: Human Rights Programming in International Organizations*, Georgetown University Press, 2007, 117-118.

20 "Promoting family planning," World Health Organization, http://www.who.int/reproductive-health/family_planning/index.html.

WHO, World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) and the former WHO Division of Reproductive Health Technical Support (RHT). The World Health Organization established HRP in 1972, and was joined by the other members in 1988.²¹ HRP's income, as reported in the "HRP 2006-2007 Financial Report" was more than \$21 million in 2007, and has been estimated at more than \$578 million since its inception in the 1970s. It receives its income from UN agencies, national governments, foundations and other abortion advocates and supporters such as: the Ford Foundation and the William and Flora Hewlett Foundation, among others.²² Overall in the reproductive health area, WHO reports an annual budget of \$332.7 million. Of this amount \$286.2 million comes from voluntary contributions.²³ These contributions consist of pledges from national governments, as well as foundations and other sources. WHO actively collaborates with other organizations in the UN system, as well as private and governmental agencies to coordinate numerous projects on family planning and reproductive health. WHO is thus able to get funding for controversial programming, and the activist NGOs and foundations gain legitimacy for their agenda by channeling funds through a UN institution.

In fact, a large percentage of WHO's income consists of voluntary contributions. This has led analysts to question the relevance of the organization as a world health institution after analyzing its budget. While the WHO constitution clearly states that contributions must be in line with WHO's objectives, Christopher Murray, adjunct professor at Harvard University's Department of Population and International Health, points out that WHO has become dependent on these contributions. "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."

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21 Department of Reproductive Health and Research, *Highlights of 2006*, WHO/RHR/07.4, 1.

22 HRP Policy and Coordination Committee (PCC) 21th Meeting, 23-25 June 2008, World Health Organization, Argentina, "Financial Matters," HRP/PCC(21)/2001/10. 2007 contributions (US\$000): the Ford Foundation – 400 and the William and Flora Hewlett Foundation – 861.

23 World Health Organization, "Proposed Programme Budget 2010-2011," PPPB/2010-2011, 74, 2009 http://apps.who.int/gb/ebwha/pdf_files/MTSP2009/PPB5-en.pdf.

and strategic guidance.²⁴ This raises serious questions about who directs the agenda for WHO. 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? Surveying the list of foundations and other sources which contribute voluntary funds to WHO, one finds that the vast majority are noted supporters of abortion, birth control, and population control.²⁵

While foundational contributions to HRP are substantial, it is the donor countries which have the strongest influence. In 2007, foundations contributed approximately 2.6 million dollars. Donor states, on the other hand, gave over 15 million dollars.²⁶ These contributions are extra-budgetary funds to the WHO budget, and this gives the donors the freedom to choose among programs. As a result, donor countries sit in on the governing bodies, such as the Policy and Coordination Committee (PCC) of the Reproductive Health Program, and are in a strong position to dictate the agenda. These donor countries, such as the Scandinavian countries, United Kingdom, the Netherlands, and Canada, support a progressive agenda and were directly responsible for WHO's move towards promoting abortion and contraception.²⁷ PCC helps to coordinate the interests of the members, and is responsible for reviewing and approving HRP's plan of action and budget.²⁸ PCC governs the use of the extra-budgetary funds and not the World Health Assembly, is the larger of the two. Furthermore, the agenda for the various WHAs falls under the responsibility of the director general (DG), which is finalized by the executive board. When they formulate the agenda, governing bodies like the PCC prepare documentation and propose resolutions, which are approved by the WHA.²⁹

A re-enforcing relationship has developed over the decades between these contributing groups and WHO which has created an iron circle. These groups had contributed large amounts of funds to WHO, and they

24 Laurie Garrett, "The Challenge of Global Health," *Foreign Affairs* (Jan/Feb2007) 86:1.

25 Other contributing foundations include: Andrew W. Mellon Foundation, John D. and Catherine T. MacArthur Foundation, Rockefeller Foundation, and David and Lucile Packard Foundation.

26 HRP Policy and Coordination Committee 21th Meeting, 23-25 June 2008, World Health Organization, Argentina, "Financial Matters," HRP/PCC(21)/2008/10.

27 Anonymous World Health Organization official, email interview, 17 August 2009.

28 "HRP's Governing body: the Policy and Coordination Committee," World Health Organization, <http://www.who.int/hrp/governance/pcc/en/>.

29 Anonymous World Health Organization official, email interview, 17 August 2009.

utilize each others' research to support their controversial agendas. For instance, International Planned Parenthood Federation (IPPF) frequently cites statistics from various WHO reports to promote its abortion agenda.³⁰ Likewise, the National Abortion Federation (NAF), an internationally recognized medical authority on abortion, has produced materials, such as *Clinical Policy Guidelines*, which have been consulted by WHO in preparation for developing its clinical policy guidelines for abortion practices.³¹ This relationship makes it very difficult for other groups to introduce policies, which contradict the current agenda of WHO, particularly in the area of sexual and reproductive health.

Even with this symbiotic relationship between groups like the Ford Foundation and WHO, WHO's relevance is also in question due to the sheer magnitude of money being spent by individuals, corporations, and foundations independent of WHO and other UN agencies. For instance, last year the Bill and Melinda Gates Foundation gave nearly \$10 billion for global health programs.³² In contrast, in 2006 WHO's core budget in 2010 is less than half that much at \$4.5 billion.³³ This seriously limits the effectiveness of the organization in terms of what it can do.

This does not mean WHO is completely irrelevant. On the contrary, it possesses several strengths.

Legitimacy. Garrett expresses one of these strengths when she suggests that WHO declare, "We are the only organization that every nation in the world is a voting member of."³⁴ In other words WHO adds legitimacy to health policy. It is an internationally recognized special agency of the UN with 193 member states and has been in existence since 1948. It has tackled very serious global health issues, such as polio and malaria, and currently focuses on potential pandemics like Severe Acute Respiratory Syndrome (SARS). Government officials, non-governmental organizations, and others, recognize WHO's research as authoritative in health policy.

30 Planned Parenthood, "Global Illegal Abortion: Where There Is No 'Roe,'" Sept. 29, 2006. <http://www.plannedparenthoodaction.org/campaigns/global-illegal-abortion-where-there-no-roe-an-examination-impact-o-589.htm>

31 "International Issues," National Abortion Federation, <http://www.prochoice.org/policy/international/>.

32 Bill and Melinda Gates Foundation. 2009. *Global Health Program Fact Sheet*.

33 World Health Organization, *Proposed Programme Budget 2010-2011*, PPPB/2010-2011, 74, 2009

34 Laurie Garrett, "Do No Harm: The Global Health Challenge."

Expertise. WHO is also a purveyor of information, which is a function explicitly stated in its constitution: “to provide information, counsel and assistance in the field of health.”³⁵ It publishes a multitude of journals, field manuals, reports, and studies. Health care providers, governmental agencies, non-governmental organizations and other individuals refer to its materials as the gold standard in the field of health. Associated with this, WHO develops, establishes and promotes international standards for combating numerous health issues.³⁶ It is a norm setting organization. What WHO decides to research and publish, and likewise what it considers not worthy of such attention, has an impact.

Global Reach. Another strength is WHO’s ability to coordinate health activities. Unlike the thousands of other organizations contributing to health issues whose efforts can be disjointed, wasteful and inefficient, WHO has the authority to provide direction to these efforts and decrease their deficiencies. WHO can use its bully pulpit to establish at least some crude guidelines for these efforts, whether it is the establishment of ethical guidelines, or the creation of a proper environment in how these organizations relate to one another. At most WHO can help to coordinate activities, which will produce sustainable health systems, rather than quick-fix solutions to complex health problems.³⁷

UN Network. A final strength is WHO’s ability to coordinate with other UN agencies. The HRP is an example of this. This agency includes WHO, World Bank, UNDP and UNFPA. The agency likewise coordinates with other governmental agencies from member states, like USAID and the Commission of the European Communities. Together these combined resources increase the effectiveness and relevance of WHO policies.

The result of the confluence of these four aspects, along with an emphasis on international agreements, developing internal mechanisms, cooperative efforts with other international agencies and funding from special interest organizations, is that WHO’s shift in mandate has not had the scrutiny it deserves. Previously WHO focused on nutrition, food safety and communicable diseases when it came to maternal and child health and welfare. Now it has reached the point where WHO

35 See Article 2(q) of the WHO Constitution.

36 See Article 2(u) of the WHO Constitution.

37 Laurie Garrett, “Do No Harm: The Global Health Challenge.”

is unabashedly committed to the pro-abortion, pro-family planning agenda and uses its strengths to promote it around the world. What has been the result of this dramatic but largely unexamined shift in funding and focus?



Part II: Abortion

One result of WHO's change in resources and priorities is that it now aggressively promotes abortion all over the world. This is true even though abortion is not even mentioned as an issue area under the WHO "health topics" index. WHO is actively involved in research, experimentation and training in this area, and it partners with organizations, such as UNFPA, IPPF and Ipas, which perform the services.

In May 2004 the 57th WHA adopted WHO's first global strategy on reproductive health.³⁸ The development of this particular strategy was in response to a resolution passed at the 55th WHA requesting the director general to devise a plan for accelerating the implementation of the Millennium Development Goals (MDGs) and other international goals to improve reproductive health.³⁹ Resolution WHA55.19 stated:

Recalling in particular the goals set out in the Millennium Declaration to have reduced, by the year 2015, maternal mortality by three-quarters, and under-five mortality by two-thirds, of their 1990 levels; Recognizing that increased access to good-quality primary health care information and services, including reproductive health, is critical for the attainment of the development goals contained in the United Nations Millennium Declaration.⁴⁰

The problem with this statement, however, is that the MDGs did not contain any goal or target for reproductive health. Where did WHO get

38 According to Rule 72 of the *Rules of Procedure of the Health Assembly* decisions on important questions shall be made by two-thirds majority of the members present and voting, including the adoption of conventions and agreements.

39 Resolution WHA55.19 "WHO's Contribution to Achievement of the Development Goals of the United Nations Millennium Declaration," 18 May 2002.

40 Ibid. This quote from WHA55.19 contains a footnote: "It is understood that 'primary health care services' do not include abortion except when consistent with national and, where applicable, local law, and with full respect for the various religious and ethical values and cultural background." The evidence, however, shows that this is not the case.

its authority to include it in the MDGs? It got it from the director general. Resolution WHA55.19 begins by referring to a note written by the director general which stated, “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.”⁴¹

The *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets*, which was produced by the Department of Reproductive Health and Research in 2004, targets five priority areas of reproductive and sexual health: improving antenatal, delivery, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections; and promoting sexual health.⁴²

Section 17 of the *Reproductive Health Strategy* relates directly to the topic of “unsafe abortion.” WHO defines “unsafe abortion” as a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both.⁴³ The *Reproductive Health Strategy* reports that approximately 45 million unintended pregnancies are terminated each year, an estimated 19 million of which are unsafe. WHO claims that these “unsafe” abortions kill 68,000 women, which accounts for 13% of all pregnancy-related deaths, and that a significant number of other women suffer from serious infection.⁴⁴ These statistics are frequently quoted by other organizations as the authoritative numbers for “unsafe”

41 Resolution WHA55.6 “WHO’s Contribution to Achievement of the Development Goals of the United Nations Millennium Declaration: Note by the Director-General,” 1 May 2002. (emphasis added). Since this statement in 2002, other UN agencies have sought to claim a new target for sexual and reproductive health under MDG 5, to reduce maternal mortality. UNICEF claimed that such as goal was established in 2005, even though nations specifically rejected the target in open debate that year. UNFPA claims that such as goal was not established until 2008. But to make the claim they refer to a document that was never debated by UN member states.

42 World Health Organization, “World Health Assembly adopts first global strategy on reproductive health and resolution on the family and health,” 22 May 2004. The Strategy was written by the Department of Reproductive Health and Research, including UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. The Strategy was adopted at the Eighth plenary meeting, 22 May 2004.

43 World Health Organization, *Reproductive Health Strategy: to Accelerate Progress Towards the Attainment in International Development Goals and Targets*, May 2004, 15.

44 *Ibid.*, 14. The actual number of abortions (45 million) does not seem to be a matter of concern to these groups according to their literature.

abortion. WHO, along with other UN agencies and non-governmental organizations, contends that this state of affairs calls for the development and strengthening of reproductive health programs among its member states.

The *Reproductive Health Strategy* was followed-up two years later by another WHO document entitled *Accelerating Progress Towards the Attainment of International Reproductive Health Goals* for the purpose of providing a framework to help member states implement the Strategy. This supplemental report provided detailed actions for implementation at the policy and program levels. Section 3.4 highlights inputs and outcomes in relation to eliminating “unsafe” abortions, providing indicators to monitor and evaluate programs in order to gauge their success or failure.

The 61st WHA has subsequently updated the assessment tools for monitoring the progress of the *Reproductive Health Strategy*. Five key areas received particular attention. The first is strengthening health systems’ capacity to ensure that the appropriate resources and personnel are in place to deliver reproductive services. Second, WHO hopes to improve information for priority setting by establishing accurate maternal death reviews. Third, is mobilizing political will by creating global and regional conferences for policymakers. Fourth, WHO supports the creation of national legislation that promotes greater access to reproductive health services. Finally, WHO wants to strengthen monitoring and evaluation of sexual and reproductive health through national development plans. WHO reports seeing progress in all five of these areas in countries around the world.⁴⁵ A second look at these areas, however, indicates that WHO is now in the business of supporting abortion services, generating evidence to support its agenda, playing the role of advocate and interfering in the national affairs of member states.

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

The Flawed Nature of WHO Data on Reproductive and Maternal Health

A closer examination of the statistics provided in the *Reproductive Health Strategy*, however, raises serious questions about their reliability. The authors of a 1993 report, entitled *The Prevention and Management of Unsafe Abortion*, admit that the exact number of deaths from “unsafe” abortion is difficult to determine. Nevertheless they project a minimum of 50,000 abortion-related deaths annually. Upward projections estimate 150,000 deaths.⁴⁶ Even given this self-admitted limitation on acquiring accurate statistics, WHO also has in place coding rules that make it difficult to determine the number of deaths due to abortion.

The Canadian Medical Association has responded to these rules,

Physicians need to know the risks of mortality and morbidity associated with termination-of-pregnancy procedures in order to communicate them to women...this information is not readily available, due in part to the World Health Organization’s coding rules.⁴⁷

The International Statistical Institute also expressed its concerns about the inaccurate recording of abortion deaths by WHO:

The problem...originates from the coding rules issued by the World Health Organization. Since they issue erroneous coding rules, they are responsible for correcting them.⁴⁸

Therefore, it is difficult to determine the exact extent of the contribution of abortion to maternal mortality. And yet policies that promote WHO’s abortion agenda are being created based upon this questionable data.

WHO’s numbers on “unsafe” abortion are also suspect. The organization, along with other UN agencies, frequently reports that 500,000 maternal deaths occur every year due to pregnancy complications

46 World Health Organization, *The Prevention and Management of Unsafe Abortion*, Geneva, 1993, 4-5.

47 Isabelle Begin, “False Abortion Statistics Exposed,” Real Women of Canada Newsletter, September 1999.

48 Ibid.

and childbirth.⁴⁹ As reported in WHO’s *Reproductive Health Strategy*, 13% of all pregnancy-related deaths are due to “unsafe” abortion. But the UN report *The World’s Women 2005: Progress in Statistics* shows that this is impossible to determine:

More than a third of the 204 countries and areas examined did not report the number of deaths by sex even once for the period 1995 to 2003. About half did not report deaths by cause, sex and age at least once in the same period. Moreover, from 1975 to 2003 there has been limited progress in the reporting of deaths and their causes.⁵⁰

Progress in Statistics goes on to say that,

Even where deaths are derived from a civil registration system with complete coverage, maternal death may be missed or not correctly identified, thus compromising the reliability of such statistics.⁵¹

Thus, the figures WHO uses to base its extensive programming in support of its abortion agenda are not verifiable.

WHO reiterates the challenges it faces in obtaining reliable data in its joint publication *Maternal Mortality in 2005*:

Assessing the extent of progress towards the MDG 5 target has been challenging, due to the lack of reliable maternal mortality data — particularly in developing-country settings where maternal mortality is high.⁵²

WHO admits that gathering this type of evidence is extremely difficult and yet it formulates policy prescriptions in the controversial issue area of abortion without reliable data. It then presents the information as being authoritative, which has an impact of the policies of its member states and other international organizations.⁵³

49 “*Making Pregnancy Safer*,” World Health Organization, http://www.searo.who.int/EN/Section13/Section36/Section129/Section396_1450.htm.

50 UN Department of Economic and Social Affairs, *The World’s Women 2005: Progress in Statistics*, 2006, 21.

51 *Ibid.*, 26.

52 World Health Organization, UNICEF, UNFPA, and World Bank, *Maternal Mortality in 2005*, 2007, 1.

53 For analysis of the way WHO coding impacts international health policy see Donna J. Har-

Experimenting with Abortion on the World's Women

In response to this call by the WHA to deal with “unsafe” abortion, as well as recommendations by the International Conference on Population and Development in 1994, RHR in conjunction with HRP produced a report entitled *Sexual and Reproductive Health – Laying the Foundation for a More Just World Through Research and Action, Biennial Report 2004-2005*. The purpose of the report was to provide an overview of the work performed by RHR. Its abortion program focuses on four main areas: generating evidence on the prevalence of “unsafe” abortion and practices; developing improved techniques and interventions for “safe” abortion; translating evidence into norms, tools and guidelines; assisting countries to develop programs and policies aimed at reducing unsafe abortions, increasing access to safe abortion and high-quality post-abortion care.⁵⁴

Thus, the goal of these areas is initially to prove the necessity of “safe” abortion by illustrating the predominance and consequences of “unsafe” abortion. To make its case this report points to the statistical data provided in the fourth edition of *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000* published by WHO in 2004.⁵⁵ Other reports which provide further statistical analysis will be mentioned below.

While generating this evidence RHR tests and provides the expanded means to perform abortions. For instance, HRP has performed medical trials involving 2,184 women to identify the lowest effective dose of Mifepristone for the two-fold purpose of improving safety and reducing the

risks, “Removing the Roadblocks from Achieving MDG 5 by Improving the Data on Maternal Mortality: How Faulty Definitions of ‘Abortion,’ and ‘Unsafe Abortion’ in Reproductive Health Indicators for Global Monitoring Lead to Miscalculating the Causes of Maternal Mortality,” *International Organizations Research Group Briefing Paper No. 5*, May 1, 2009, http://www.c-fam.org/docLib/20090514_Removing_the_Roadblocksfinal.pdf.

54 Department of Reproductive Health and Research, *Sexual and Reproductive Health: Laying the Foundation for a More Just World Through Research and Action, Biennial Report 2004-2005*, World Health Organization, 2006, 21.

55 For the statistics on “unsafe” abortion see Table 3: Global and regional estimates on annual incidence of unsafe abortion and mortality due to unsafe abortion, by United Nations region, around the year 2000, in World Health Organization, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000*, Fourth edition, 2004, 13.

cost of medical abortion. In South Africa and Vietnam⁵⁶ HRP determined, through various trials, that trained midwives can perform manual vacuum aspirations (MVAs) as safely and effectively as those provided by physicians. Furthermore HRP has completed a trial comparing sublingual and vaginal administration of doses of Misoprostol for the termination of pregnancy of up to 63 days.⁵⁷

Over a period of time RHR hopes to achieve a change in mindset towards the acceptability of abortion. For instance, the report states that “HRP’s work over the past three decades has contributed significantly to the emergence and *wide acceptance* of the current recommended regime” of medical abortion.⁵⁸ Finally, RHR has already assisted several countries in providing abortion services. In Mongolia, they have trained one-third of the gynecologists to perform surgical and medical abortions. In Romania, RHR was influential in having the Reproductive Health Law enacted in 2004. The law mandates the provision of abortions. In Vietnam, HRP launched the Comprehensive Abortion project under the leadership of Ipas, which introduces medical abortion with the training of ninety providers. Furthermore, in the Republic of Moldova RHR performed an assessment of providing abortion services and is currently producing a proposal for implementing its recommendations.⁵⁹ This report illustrates WHO’s deep commitment to promoting abortion whenever and wherever possible.

56 In Vietnam the study included 1,734 women. According to the HRP, it conducted the first controlled trial in a developing country that compares the safety of first-trimester abortion performed by mid-level providers with those performed by doctors with the purpose of decentralizing abortion services. Mid-level providers include: nurses, midwives, and assistant doctors. See “Mid-level providers in Viet Nam provide first-trimester abortion by MVA as safely as physicians,” HRP, http://www.who.int/reproductive-health/unsafe_abortion/vietnam_midlevelproviders.pdf.

57 UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, *Highlights of 2005*, 2.

58 *Ibid.*, 22. (emphasis added).

59 *Ibid.*, 23. In relation to Vietnam, HRP has issued an information flyer, “Mid-level providers in Viet Nam provide first-trimester abortion by MVA as safely as physicians.” One policy implication is the decentralization of abortion services. For the case of Romania see Peter Fajans and Mary Broderick, “Abortion and Contraception in Romania: A Strategic Assessment of Policy, Programme and Research Issues.” World Health Organization, 2004. <http://whqlibdoc.who.int/publications/2004/9739953166.pdf>.

Radical Roots of WHO Abortion Activism

The roots of WHO's abortion activism are deep. As early as 1967 the WHA adopted a resolution stating that, "abortions...constitute a serious public health problem in many countries," and requested the director general to "continue to develop the activities of the World Health Organization in the field of health aspects of human reproduction."⁶⁰ In 1993 under the mantle of the UN's Safe Motherhood Initiative, the Division of Family Health at WHO released the report of one of its technical working groups. The Safe Motherhood Initiative was the brainchild of abortion advocates such as Family Care International and IPPF. It has floundered since its launching at a pro-abortion conference in Nairobi in 1987. UN staff, along with its founding NGOs, have attempted to breathe life into it through the UN's Partnership for Maternal, Newborn and Child Health and its "Women Deliver" conferences of 2007 and the upcoming meeting in 2010.

The Prevention and Management of Unsafe Abortion presented a number of discussions about ways to manage the complications associated with "unsafe" abortion, including the post-abortion phase. In the report's preface, the technical working group recognizes that WHO "has a unique contribution to make in norm-setting and the establishment of agreed standards."⁶¹ The report places heavy emphasis on expanding access to care at the primary and referral levels for women who are experiencing the complications of an "unsafe" abortion. It also discusses the provision of immediate post-abortion contraception.⁶² This document was supported by several background documents prepared by Ipas.⁶³

This technical report contributes to WHO's attempts to generate evidence of the contribution of "unsafe" abortion to maternal mortality. It provides the percentages on the legal status of abortion around the world. For instance, it reports that 40% of the population has access to abortion services on request, whereas 25% are denied such service. It then attempts to make a connection between legal and "safe" abortion. In developed countries where abortion is legal, abortion-related mortality is reported to

60 World Health Organization, *Unsafe Abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*, Fifth edition, 2007, 1. Resolution WHA20.41.

61 World Health Organization, *The Prevention and Management of Unsafe Abortion*, Geneva, 1993, 1.

62 *Ibid.*, 1993, 13.

63 These Ipas reports are: "Clinical guidelines for Emergency Treatment of Abortion Complications at the First Referral Level" and "Clinical guidelines for Emergency Treatment of Abortion Complications at the Primary Care Level."

be at less than 1/100,000 procedures.⁶⁴ This number has allowed WHO to claim that a “safe” abortion is less of a risk than a pregnancy carried to term in the best of circumstances.⁶⁵

Pressuring Governments to Change Abortion Laws

Over the years WHO has continued its support of abortion, even given the shortcoming of data collection, by publishing a whole series of resources dealing with the topic: *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*; *Frequently Asked Clinical Questions about Medical Abortion*; and *Studying Unsafe Abortion: A Practical Guide*, just to name a few. More notable among the reports is *Safe Abortion: Technical and Policy Guidance for Health Systems*. WHO produced this 106-page report in 2003 to help government officials implement recommendations made at the ICPD+5 special session of the UN General Assembly in 1999.

The report discusses the causes of maternal death, one of them being the lack of access to appropriate services to end “unwanted” pregnancies. WHO prides itself in assisting “governments, international agencies and non-governmental organizations to plan and deliver maternal health services, including managing complications of unsafe abortion and providing high quality family planning services.”⁶⁶ And it maintains that it does all of this within the legal framework of the UN, referring to the Special Session of the UN in June 1999 when governments agreed that “in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women’s health.”⁶⁷

WHO is not just calling for the elimination of “unsafe” abortion, but promoting “safe” and accessible abortion services.

64 World Health Organization, *The Prevention and Management of Unsafe Abortion*, 4.

65 World Health Organization, *The World Health Report 2005: Make Every Mother and Child Count*, 2005, 50.

66 World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2003, 7.

67 Ibid. The Special session of the UN General Assembly on the International Conference on Population and Development, June-July 1999. Quoted from “ICPD+5 Key Actions Document,” paragraph 63.iii.

So WHO is not just calling for the elimination of “unsafe” abortion, but promoting “safe” and accessible abortion services. The report contends that pregnancy may pose a threat to a woman’s life or to her physical or mental health. This statement is immediately followed by a discussion on how nearly all countries have passed laws permitting abortion under specified circumstances, and that “[h]ealth systems need to respond accordingly.”⁶⁸

Arbitrarily Redefining “Pregnancy”

Safe Abortion further discusses methods of surgical abortion, such as vacuum aspiration,⁶⁹ dilation and curettage, along with methods of abortion for use in later pregnancy. It covers medical methods of abortion, including Mifepristone, Misoprostol, and Prostaglandin. And it concludes with the legal grounds for abortion and the creation of a policy environment conducive to providing abortion services.

In line with its advocacy of medical methods of abortion, WHO has supported the use of abortifacients, such as the morning-after pill (MAP) and the “abortion pill” RU-486. WHO has faced critical opposition on this issue, particularly in its efforts to promote such methods in the Americas, since this region is traditionally Roman Catholic. WHO overcomes this opposition by taking a different position on when pregnancy begins. Whereas Catholic doctrine declares that pregnancy begins with the fertilized ovum, WHO purports that it actually occurs when the fertilized ovum implants itself in the lining of the uterus. This WHO says permits the use of the morning-after pill since it prohibits implantation from occurring, thus placing it in the category of a contraceptive.⁷⁰

In the eyes of WHO this removes MAP from the category of an abortifacient, and therefore circumvents the criticisms of its opponents.⁷¹ However, RU-486 is different from the morning-after pill. RU-486 takes effect after implantation has occurred and is clearly an abortifacient according to WHO’s definition. The *British Medical Journal* reported that

68 Ibid., 7.

69 In order to perform Manual Vacuum Aspiration, see World Health Organization, *Clinical Management of Abortion Complications*, 1994, Annex 11.

70 “Emergency Contraception in the Americas,” Pan American Health Organization, Regional Office of the World Health Organization, <http://www.paho.org/English/AD/GE/emergency-contraception.pdf>.

71 Ibid.

WHO has approved RU-486 as an “essential” medicine for inclusion in a list of medicines for developing countries. Hans Hogerzeil, director of Medicines Policy and Standards at WHO and secretary of its Essential Medicines Committee, stated:

The inclusion of these drugs to the essential drug list is a real addition to the therapeutic alternatives for women who have to undergo abortion, especially in developing countries where surgical facilities are less easily available. We are aware that many women in developing countries die from unsafe abortion, and we are very confident that these medicines will help prevent such unnecessary and tragic death.⁷²

Thus, WHO defines pregnancy in a way that justifies its promotion of the morning-after pill, but takes it the next step further by actively supporting the “abortion pill.”

Funding WHO’s Abortion Agenda

Not only does WHO support the use of RU-486, it helps to fund its production. The Rockefeller Foundation has been working with a Bangkok-based organization called the Concept Foundation to fund companies that produce and export RU-486, mostly for the Chinese market. The Concept Foundation was established by WHO and the World Bank in 1989 to assist developing countries in making medical products at low cost.⁷³ It is also a founding member of the International Consortium for Emergency Contraception (ICEC) which began after 1995 with a pilot program to introduce Postinor-2 to Indonesia, Kenya, Mexico and Sri Lanka. It entered into a public-private-partnership (PPP) with a pharmaceutical manufacturer Gedeon Richter which provides emergency contraceptive products to over 37 developing countries. The Concept Foundation’s success in managing this partnership is even lauded as a model for future PPPs.⁷⁴ HRP has subsequently signed a

72 “WHO puts abortifacients on its essential drug list,” *British Medical Journal*, Vol. 331, 68, 9 July 2005.

73 “Chinese to Make RU-486 for U.S.” *Washington Post*, October 12, 2000, A1.

74 “Emergency Contraception: Founding Member of the ICEC,” Concept Foundation, http://www.conceptfoundation.org/EC_history.htm.

memorandum of understanding with the Concept Foundation “to expand the availability of medical abortion in developing countries wishing to introduce this technology.”⁷⁵

WHO has persistently reiterated its commitment to eliminating “unsafe” abortion, and aiding countries in providing the means for performing “safe” abortions. Ms. Thoraya Ahmed Obaid, executive director UNFPA, said in an address to the 60th annual World Health Assembly, “Today too many women are dying from unsafe abortions... we will not meet goals to reduce maternal mortality unless unsafe abortion is addressed.”⁷⁶ She continued by providing an extensive list of alternative means for reducing poor sexual and reproductive health, “[s]trengthened health systems should also deliver a steady and reliable supply of reproductive health commodities, including drugs for maternal health, contraceptives, HIV test kits and condoms.” No mention was made in her speech, or any of the reports listed above, about the benefits of promoting abstinence programs or natural family planning (NFP) for the reduction of abortion or HIV/AIDS.

WHO’s efforts to eliminate “unsafe” abortion are nothing more than a guise for promoting its abortion agenda. Returning to the *Reproductive Health Strategy* mentioned above, in order to eradicate the problem of “unsafe” abortion the WHA recommends the creation of innovative national strategies and strategic investment for the many countries who suffer from “unsafe” abortions. These national strategies apparently include the legalization of abortion or liberalization of existing abortion laws.

WHO frequently equates legalization of abortion with “safe” abortion. In an article published by WHO and the pro-abortion Guttmacher Institute, the authors provide the reader with a definition of “safe” abortion, “as those that meet legal requirements in countries in which abortion is legally permitted under a broad range of criteria.”⁷⁷ “Unsafe abortion” has been defined above, but the authors add to this definition, “These include abortions in countries with restrictive abortion laws, as well as abortions that do not meet legal requirements in countries with less restrictive laws.”⁷⁸

75 UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, *Highlights of 2005*, 2.

76 World Health Organization, “Keynote address by Ms. Thoraya Ahmed Obaid UNFPA Executive Director,” Sixtieth World Health Assembly, 15 May 2007.

77 Gilda Sedgh, et al. “Induced abortion: Estimated Rates and Trends Worldwide,” *The Lancet*, Vol. 370, Oct. 13, 2007, 1338.

78 *Ibid.*

“Unsafe and safe abortions correspond in large part with illegal and legal abortions.”⁷⁹ In other places, WHO has admitted that even liberal abortion laws do not guarantee that woman can obtain “safe” abortions.⁸⁰

This sheds light on the way WHO’s promotion of family planning services is in fact closely related to its promotion of abortion, contributing to the creation of a vicious cycle which interlocks the issues. For instance, in October 2006, *The Lancet Sexual and Reproductive Health Series* published an article entitled, “Unsafe Abortion: the Preventable Pandemic.” The authors said:

Ending the silent pandemic of unsafe abortion is an urgent public-health and human-rights imperative...Legalisation of abortion on request is a necessary but insufficient step toward improving women’s health...The availability of modern contraception can reduce but never eliminate the need for abortion...Access to safe, legal abortion is a fundamental right of women, irrespective of where they live. The underlying causes of morbidity and mortality from unsafe abortion today are not blood loss and infection but, rather, apathy and disdain toward women.⁸¹

First, the authors’ use of the word “pandemic” is a misnomer since WHO itself defines pandemic as a new disease that is infectious and spreads easily and sustainably among humans, causing serious illness.⁸² It is difficult to understand how “unsafe” abortions can be designated as infectious.

Second, contained within this quote is the vicious cycle referred to above. The assertion that legalization is necessary but not sufficient to a woman’s health is the portal through which international organizations can push their family planning programs. They make the argument that family planning can reduce the number of unwanted pregnancies which leads to abortion. And yet modern contraceptives can never eliminate abortion and therefore “safe” abortion services should be made legal and continue to be offered upon request. In other words abortion justifies the use of contraception and vice versa.

79 Ibid., 1343.

80 “Unsafe abortion,” World Health Organization, <http://www.wpro.who.int/sites/rph/data/abortion.htm>.

81 David A. Grimes, Janie Benson, Susheela Singh, et.al. “Unsafe Abortion: the Preventable Pandemic,” Journal Paper, Sexual and Reproductive Health 4, World Health Organization, 2006, 1

82 “Pandemic and Preparedness Response,” World Health Organization, http://www.euro.who.int/flu/publications/20060324_5.

The problem with this perspective is that access to legal abortion is nowhere to be found as a fundamental right of women under UN human rights treaties. WHO, however, uses principles agreed upon at the non-binding outcome documents from the International Conference on Population and Development, the ICPD+5, the Fourth World Conference on Women (FWCW) and FWCW+5 to present their case that legal abortion is a fundamental human right. And the conclusion, “irrespective of where they live” contravenes respect for the national laws of any given state that chooses to regulate the procedure. The final statement accuses those countries with pro-life policies based upon socio-cultural or religious traditions as being disdainful of women. This is symptomatic of the mindset that has predominated WHO’s sexual and reproductive health sector.



Part III: Family Planning as Human Rights Activism

The World Health Organization views family planning as “the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births.”⁸³ Similar to its approach to the issue of “unsafe” abortion, WHO generates statistical data to demonstrate the “urgency” for its activities in this issue area. It currently estimates that “over 120 million couples do not use contraceptives, despite wanting to space or limit their childbearing. In addition, many women who use contraceptives nevertheless become pregnant.”⁸⁴ The “120 million” figure is the generally quoted number throughout the literature, and is simply a lamentation for the lack of contraception which WHO believes should be made available. More often than not it is lumped in with other frequently cited annual statistics: unwanted pregnancies (75 million), unintended pregnancies terminated (45 million), abortion in unsafe conditions (19 million), deaths due to “unsafe” abortion (68,000), and deaths from pregnancy and childbirth complications (600,000).⁸⁵ Thus, WHO publishes the evidence which it believes confirms the necessity for family planning, and connects it with the provision of “safe” abortion to perpetuate the vicious cycle. So while according to paragraph 8.25 of the ICPD Programme of Action abortion should never be promoted as a form of family planning, it is inherently linked to it.

WHO uses the statistics to create a “demand” for family planning and abortion. Based upon questionable evidence, then, it allocates significant amounts of money to address them. In its sexual and reproductive health budget for 2010-2011, RHR allocated \$9 million to promote family

83 “Family planning,” World Health Organization, http://www.who.int/topics/family_planning/en/.

84 “Promoting family planning,” World Health Organization, http://www.who.int/reproductive-health/family_planning/index.html.

85 World Health Organization, “Working Towards Universal Coverage of Maternal, Newborn and Child Health Interventions: Biennial Report,” 60th WHA, Provisional agenda item 12.10, 19 April 2007.

planning, 13% of its entire budget, and \$8 million to preventing “unsafe” abortion, not including voluntary contributions.⁸⁶

WHO’s proposed program budget for 2010-2011 is also telling. This report breaks down financial allocations among thirteen strategic objectives. Strategic objective #4 specifically targets the issue area of sexual and reproductive health. Approximately \$332 million is allocated to this objective, \$286 million of which comes from voluntary contributions. Objective #9 explicitly addresses nutrition and food safety; and it receives only \$120 million.⁸⁷

Over the years, the strategic objectives have been broken down into “areas of work,” which further reveal the way reproductive health has come to permeate the work of WHO. For example, in one report the area of work entitled “making pregnancy safer” fell within four objectives,

WHO’s proposed program budget for 2010-2011 is also telling. This report breaks down financial allocations among thirteen strategic objectives. Strategic objective #4 specifically targets the issue area of sexual and reproductive health. Approximately \$332 million is allocated to this objective. [While] nutrition and food safety...receives only \$120 million.

receiving a total of \$61 million. The category of “reproductive health” was found within four strategic objectives, receiving approximately \$78 million. This is compared to the categories of “nutrition” at \$27 million; “immunization and vaccine development” at \$527 million; and “food safety” at \$27 million. Interestingly, “making pregnancy safe” and/or “reproductive health” were included in many seemingly unrelated strategic objectives, including: to combat HIV/AIDS, malaria and tuberculosis; to reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact; and to

improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.⁸⁸

86 World Health Organization, *WHO Sexual and Reproductive Health Medium-term Strategic Plan 2010-2015 and Programme Budget, 2010-2011*, 2010, 87.

87 World Health Organization, *Proposed Programme Budget 2010-2011*, PPB/2010-2011, Geneva, 2009, 74.

88 World Health Organization, *Medium-Term Strategic Plan 2008-2013 and Proposed Programme Budget 2008-2009*, Geneva, 2007, 168; 177-179.

These topics have little if anything to do with “reproductive health” and “making pregnancy safer,” yet WHO manages to garner resources for reproductive health from these budget items.

Given this perceived necessity and the money to back it up, WHO has made it its mission to provide family planning services to the maximum number of individuals. As its own statistics suggest, however, 137 million couples are still not receiving family planning services, and are rich targets for WHO’s controversial agenda.⁸⁹ It believes the following reasons contribute to this current state of affairs: lack of services or barriers to their access; poor quality of services, such as suboptimal interaction between clients and providers, substandard technical competence of providers, inadequate information, poor design and management of service delivery systems: technology issues, such as limited or inappropriate choice of methods and fear, or experience, of side effects; and broader social issues, such as an individual’s lack of knowledge, power imbalances with couples and families, and socio-cultural, religious and gender barriers.⁹⁰ This last reason once again illustrates the way WHO perceives religion and tradition as in conflict with its agenda, and belies even a certain disdain. Promoting a radically different view of society, and using its sources of power – information, legitimator, financier and coordinator – WHO promotes its agenda of family planning and abortion. So how does WHO plan to overcome these so-called barriers?

Fighting Religion and Tradition to Promote Family Planning

The RHR is once more the principal instrument WHO uses to overcome these barriers and achieve its family planning agenda. The RHR’s areas of attack are fourfold. First, it hopes to increase the availability of services. This poses the most serious challenge to the RHR’s efforts and is a common thread that runs through the obstacles which hamper WHO in this area. The idea is to break down any barriers that prohibit the provision of family planning services. Once a beachhead is created, WHO reinforces its position by providing further services until the target society assimilates its agenda, whether it likes it or not, through the creation of national laws or other equivalent actions. A 2007 report entitled *The*

89 “Promoting Family Planning,” World Health Organization, website http://www.who.int/reproductivehealth/topics/family_planning/en/.

90 “Promoting Family Planning,” World Health Organization, http://www.who.int/reproductivehealth/family_planning/index.html.

WHO Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programmes spells out the methodology behind the RHR's controversial activities. The program involves a three-stage process for developing institutions for large-scale sustainable services and policies, which will lead to greater access to reproductive health services. The three stages include: strategic assessment, limited scale testing of health service innovations and scaling up so that the program can reach more people. Some of the targeted countries participating in programs which introduced family planning services were Brazil, China, Oman, Vietnam and Zambia.⁹¹

Second, the RHR wants to broaden the range of family planning that is available, thereby saturating the market.⁹² WHO generates a plethora of family planning resources, which supply information on numerous types of methods and their effectiveness (Table 1).

In order to simplify this type of information for public consumption, and thereby increasing the market for its services, WHO has produced a wall chart "Do You Know Your Family Planning Choices?" which provides an inventory of available options including: combined oral contraceptives, female sterilization, vasectomy, injectable contraceptives, diaphragm with spermicide, condoms and contraceptive implants, to name a few. The wall chart also includes a table outlining certain health conditions which prohibit the use of some methods, as well as an effectiveness chart for these various methods.⁹³ What is remarkable about this is the amount of time, money, and resources WHO has spent – in collaboration with other family planning agencies – on this agenda, despite the weak evidence supporting it. The original mandate for improving women's and children's health, and the means used to achieve them, have a robust track record. These successes seem to have been forgotten and replaced with unproven, controversial methods.

In its attempt to gain evidence, however, HRP has performed numerous experiments testing Intrauterine Devices (IUDs) on women. For instance, in the case of copper-bearing IUDs HRP collaborated with Family Health International (FHI) to investigate the long term impact on women. Between 1989 and 1998 a total of 5953 women had an IUD inserted.

91 World Health Organization, *The WHO Strategic Approach to Strengthening Sexual and Reproductive Health Policies and Programmes*, 2007, 2-3.

92 "Promoting Family Planning," World Health Organization, http://www.who.int/reproductive-health/family_planning/index.html.

93 "Do You Know Your Family Planning Choices?," World Health Organization, <http://info.k4health.org/globalhandbook/wallchart/EnglishWallChartRevApril08.pdf>. No mention is made about natural family planning or abstinence.

TABLE 1: FAMILY PLANNING RESOURCES

YEAR	TITLE
2007	Family planning – a global handbook for providers
2006	Reproductive choices and family planning for people living with HIV – Counseling tool
2005	Decision-making tool for family planning clients and providers (Power Point)
2007	Provider brief on hormonal contraception and bone health
2007	Female condom Technical Review Committee – Report – Summary report
2004	The male latex condom – Specification and guidelines for condom procurement
1997	Post-abortion family planning: a practical guide for programme managers
2005	Levonorgestrel for Emergency Contraception
2002	Making decisions about contraceptive introduction –A guide for conducting assessments to broaden contraceptive choice and improve quality of care
1995	Requirements for the quality assurance of hormonal contraceptives

* Source: “Family planning services,” World Health Organization, http://www.who.int/reproductive-health/publications/family_planning.html

The most recent results examine subjects who used the method for 13 years. HRP is also performing experiments on women to compare the implantable contraceptives Jadelle and Implanon. Two thousand women in seven countries will be randomly allocated one of the two implants. The study will evaluate pregnancy rates, incidences of adverse effects, among other variables over a five-year period.⁹⁴

Third, WHO hopes to “build the capacity” of national health systems to ensure the availability of family planning programs and services in

94 “Safety and efficacy of existing methods,” World Health Organization, http://www.who.int/reproductive-health/family_planning/safety.htm.

resource-poor settings.⁹⁵ In order to bring countries around to accepting its capacity-building services RHR offers a 2-3 week course for health officials, policymakers, and others who might be involved in offering family planning services in order to indoctrinate them into the agenda, or what WHO calls helping them affect “positive” change in health care systems. The training enables “participants to grow in awareness, maturity, and self-reliance, and build their confidence and skills in communicating about reproductive and sexual rights and health.”⁹⁶ The language of this statement paints a patronizing picture for those who accept its policies, and likewise an unflattering one of those who do not.

Furthermore, WHO gets involved with countries to “build their capacity” to undertake research and activities in sexual and reproductive health through the WHO/UNFPA Strategic Partnership Program (SPP). SPP intervenes in countries’ health systems, seeking “to promote sexual and reproductive health at national and sub-national levels through support to countries in the introduction, adaptation and adoption of selected practice guides in family planning.” In a 2004 report entitled *Improving Maternal and Newborn Health – The Role of Family Planning*, WHO recognized that “barriers” to its family planning agenda exist at the national, district, community, family and individual level.⁹⁷ SPP attempts to overcome the first two levels. As of 2003 it has conducted six regional workshops to “educate” health ministry officials from 60 countries on WHO’s sexual and reproductive health guidelines. Some countries of particular interest where WHO has intervened to advance its agenda through SPP are found in Table 2.

Pitfalls of the Rights-based Approach

To fulfill its mission, SPP stresses the importance of human rights. A letter signed by the executive heads of WHO and UNFPA, states:

We are also putting greater emphasis on a rights-based approach to programming in reproductive health, in part through promoting

95 “Promoting family planning,” WHO, http://www.who.int/reproductivehealth/family_planning/index.html.

96 “Capacity building,” World Health Organization, <http://www.who.int/reproductive-health/gender/capacitybuilding.html>.

97 World Health Organization, *Improving Maternal and Newborn Health – The Role of Family Planning*, June 2004, 4.

TABLE 2: WHO/UNFPA STRATEGIC PARTNERSHIP PROGRAM PARTICIPATING COUNTRIES

REGIONAL WORKSHOP	COUNTRIES
Africa	Benin, Cameroon, Kenya, Nigeria, South Africa, Tanzania, Zambia, Zimbabwe
Americas	Honduras, Paraguay, Peru
Eastern Mediterranean	Afghanistan, Iraq, Morocco, Pakistan, Sudan
Europe	Armenia, Kyrgyzstan, Romania, Tajikistan, Turkmenistan, Uzbekistan
South-East Asia	Bangladesh, Indonesia, Myanmar, Nepal
South Pacific	Solomon Islands, Tonga, Vanuatu
Western Pacific	China, Mongolia, Vietnam

* Source: Department of Reproductive Health and Research, "WHO-UNFPA Strategic Partnership Programme (SPP)," p. 3. http://www.unfpa.org/rh/docs/brochure_spp.pdf.

human rights instruments which provide a powerful basis for advocacy in favour of legal, legislative and policy reforms to improve reproductive health.⁹⁸

This helps the RHR to complete its fourth major objective: to promote an environment at international level that is supportive of family planning.⁹⁹ The creation of the SPP itself is based upon the non-binding outcome document from the 1994 International Conference on Population and Development, the MDGs, and the WHO Global Reproductive Health Strategy.

WHO endeavors to have sexual and reproductive health placed on the list of fundamental human rights, which would subsequently permit unrestricted access to family planning services. Denial of such services

98 Department of Reproductive Health and Research "WHO-UNFPA Strategic Partnership Programme (SPP)," World Health Organization, <http://www.who.int/reproductive-health/spp/docs/flyer.pdf>. Link redirects again

99 "Promoting family planning," World Health Organization, http://www.who.int/reproductivehealth/family_planning/index.html.

could bring down international condemnation on a group or country. This places a tremendous amount of pressure on countries to adopt WHO's agenda, whether or not it violates a country's sovereign rights, not to mention its culture, traditions, or religious beliefs. Many of the underdeveloped member states rely upon WHO to help meet their basic health needs and are in a vulnerable position when faced with such an agenda.

One of the standard methods utilized by WHO for achieving this objective is to focus its efforts on treaty monitoring bodies for the various human rights treaties. These bodies issue comments and recommendations which can help to elaborate on the interpretation of the treaty. And RHR sees to it that this issue is adequately taken up by the various UN human rights committees.¹⁰⁰ After reviewing this type of activity, along with other previously stated ones, a serious question arises. Why is WHO involved in the advocacy business, when it should be focused on accomplishing its mandate of fighting diseases?

WHO has published several reports to consider how human rights laws can be applied to this health topic. One such report is *Advancing Safe Motherhood through Human Rights*. The purpose of this 2001 report is to facilitate initiatives by governmental and non-governmental agencies to force compliance with human rights to protect and fulfill a woman's right to safe motherhood. It "introduces human rights laws by identifying their sources and governmental obligations to implement them, and explains a range of specific human rights that can be applied to advance safe motherhood."¹⁰¹

Remarkably the authors of the report cluster the rights into four categories, one of which is, "rights to life, survival and security." They even quote the International Covenant of Civil and Political Rights: "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."¹⁰² Review of the material, however, indicates no references made to the life of the unborn child, or a woman's inherent dignity. The report concludes with various strategies which will pressure countries to implement WHO's version of "human rights" in national and international laws in reference to safe motherhood.

100 "Human Rights Tools," World Health Organization, <http://www.who.int/reproductive-health/gender/hrtools.html>.

101 World Health Organization, *Advancing Safe Motherhood through Human Rights*, 2001, 2.

102 *Ibid.*, 27.

Another report, *Consideration for Formulating Reproductive Health Laws*, analyzes the legal principles governing the relationship between health service providers and the recipients of reproductive and sexual health services. These primary legal principles include: privacy and confidentiality, free and informed decision making, the competent delivery of services, the use of conscientious objection, and nondiscrimination. The report relies upon the interpretations of national constitutions and international treaties to make its case for the protection of sexual and reproductive health. Once this is done the authors argue that states are bound to respect this form of rule of law. They conclude by discussing how the legal principles can be enforced through national and international procedures.¹⁰³ In other words, what WHO is attempting to do is convert non-binding resolutions into binding international legal obligations by linking the resolutions to constitutions and treaties. This violates the intents of the voting member states.¹⁰⁴

These reports provide a sampling of the strategy WHO uses in cooperation with other agencies. First, WHO attempts to have treaties reinterpreted through treaty monitoring bodies in order to promote its agenda. Second, national governments and international agencies are strongly encouraged to formulate laws and policies conducive to unrestricted family planning. Third, WHO focuses on individuals and groups. By relying upon legal principles, individuals and health service providers are pressured to use these “human rights” to make claims on the state. It is an aggressive multiple-level approach.

To further help in achieving these four-fold objectives in reducing the barriers to promoting family planning services to the largest number of individuals, the RHR created a series of documents, which combined are referred to as the “4 Cornerstones of Family Planning Guidance.” These “evidence-based” research guidelines are used to intervene in family planning programs among WHO’s member states. This is a part of WHO’s strategy to reinforce its position by providing services within countries which have already begun to adopt WHO policy in this issue area.

The first cornerstone publication is *Medical Eligibility Criteria for Contraceptive Use*. As the title suggests this report examines criteria for

103 World Health Organization, *Considerations for Formulating Reproductive Health Laws*, 2000, 1.

104 For a detailed analysis of this strategy see Douglas A. Sylva and Susan Yoshihara, “Rights by Stealth: The Role of UN Human Rights Treaty Bodies in the Campaign for an International Right to Abortion,” *International Organizations Research Group*, July 18, 2007, http://www.c-fam.org/docLib/20100126_IORG_W_Paper_Number8FINAL.pdf.

selecting methods of contraception. Its purpose is to supply information to national family planning programs in order to help them establish guidelines for service delivery of various contraceptive methods to individuals who experience certain medical conditions.¹⁰⁵

The second cornerstone is *Selected Practice Recommendations for Contraceptive Use*. Similar to the first cornerstone, this one targets policy-

Family planning will never be finished....in the next five years 60 million boys and girls will reach sexual maturity and unsurprisingly these young individuals will require family planning services.

makers and healthcare officials. This document “provides guidance for how to use contraceptive methods safely and effectively once they are deemed to be medically appropriate.”¹⁰⁶ While the first cornerstone outlines the most effective method of contraception given the conditions of the recipient, the second tells practitioners how to administer the prescribed method. Both of these cornerstone documents received funding and other support

from the IPPF and UNFPA, as well as the United States government.

The third cornerstone is an educational supplement entitled *Decision-making Tool for Family Planning Clients and Providers*. This flipchart presents simplified illustrations for explaining and understanding fourteen different forms of birth control. It provides medical eligibility criteria, side effects, and the proper use for each method.

Finally, in 2007 RHR published *Family Planning: A Global Handbook for Providers*, which completes the cornerstone series. This document commences with the standard “137 million” statistic. But goes even further to state that family planning will never be finished. The authors relate that in the next five years 60 million boys and girls will reach sexual maturity and unsurprisingly these young individuals will require family planning services.¹⁰⁷ WHO realizes that it must target young boys and girls if it is to

105 Department of Reproductive Health and Research, *Medical Eligibility Criteria for Contraceptive Use, 3rd Edition*, 2004, 1. This edition covers three new contraceptive methods, which were not included in the previous edition.

106 Department of Reproductive Health and Research, *Selected Practice Recommendations for Contraceptive Use, 2nd Edition*, 2005, 1.

107 Department of Reproductive Health, United States Agency for International Development, and Johns Hopkins Bloomberg School of Public Health, *Family Planning: A Global Handbook for Providers*, 2007, iv.

continue to achieve its agenda. Of special note is the list of collaborating and supporting organizations in this publication. It consists of the “Who’s Who” among family planning and abortion supporters. More than forty organizations are represented, including the Guttmacher Institute, the Population Council, Population Services International, IPPF and UNFPA.

WHO is deeply committed to its family planning agenda. It spends significant amounts of money, much of which comes from groups like IPPF and Ipas, which in turn receive legitimacy through WHO. It performs experiments on women and publishes numerous reports in the issue area. It sets the standard for family planning methods. It coordinates its activities with other family planning organizations, like the UNFPA and UNDP. And it develops strategies at the international, national, and local levels to advance its agenda.

What are the effects of this agenda and what can be done to restore balance in WHO’s approach to reproductive health?



Implications, Policy Recommendations, and Conclusions

WHO is seemingly in an advantageous position because of the internal strengths it possesses – information purveyor, legitimator, financier and coordinator. This is further buttressed by its inclusion in an international network of governmental and non-governmental organizations, which are considered legitimate, authoritative, wealthy, and well-positioned regionally and globally. What is more, its agenda has the backing of powerful governments around the world, such as member states of the European Union and the United States.

In the pursuit of its radical agenda, however, WHO's legitimacy is compromised. It has become one of many in the UN system which has departed from its original mandate in order to promote policies that threaten the lives and dignity of women and men, not to mention those of unborn children. It attacks the national sovereignty of nations through its reinterpretation of international law and its support for sub-national groups which place pressure on political regimes to adopt anti-natal policies. WHO views religion and tradition as barriers to its radical policies, both of which it believes must be neutralized if it is to achieve its objectives in the area of sexual and reproductive health. It has stretched its resources to the point where it has become vulnerable and reliant upon radical pro-abortion groups who use the organization to promote their world views.

Funding. WHO relies heavily upon voluntary contributions as a source of funding. In the "Programme Budget 2006-2007" the reproductive health area of WHO reported an annual budget of \$78 million, of which \$68.5 million came from voluntary contributions.¹⁰⁸ Some of this amount is supplied by abortion advocates and supporters such as the Bill and Melinda Gates Foundation, the Ford Foundation, and Ipas, among many others.

108 World Health Organization, Programme, Budget and Administration Committee of the Executive Board, "Programme budget 2006-2007: update," EBPBAC5/5, 7 December 2006.

Most, however, is provided by member states with “progressive” agendas. This trend towards private funding has skewed WHO’s focus away from its core purpose toward special interests. This current state of affairs runs counter to WHO’s original mandate. One could also argue that it violates article 57 of the WHO constitution, which states that WHO may accept gifts from outside parties, as long as these contributions are in line with the institution’s objectives and policies. Chasing these funds has resulted in a loss of independence, as well as legitimacy of the organization as it engages in these controversial programs. This strategy diverts essential funding from proven health policies that fit within the original mandate of the organization to those that are unproven and match the agenda of the pro-abortion industry.

Unverifiable data. The WHO constitution states that a primary function of the organization is “to provide information, counsel and assistance in the field of health.” It publishes numerous reports and studies for health care providers, government agencies and non-governmental organizations to provide them with the necessary expertise and to establish the norms in the field of health. In the area of “reproductive health” WHO admits that its data is unreliable, and yet it presents it as authoritative, which all takes place within the legal framework of the UN system. This information is then used by various entities to formulate and justify health policies which in turn may violate the religious beliefs, traditions, and national sovereignty of member states. This flawed data is also recycled throughout the pro-abortion, pro-family planning agencies to promote their agendas, and in return flows back into WHO by way of money and published reports, thus creating an echo chamber. When WHO does attempt to generate evidence, it is through experimentation on women. RHR tests and provides the expanded means to perform abortions. And the same case can be made for various forms of contraception.

Human rights activism. Since the 1980s WHO has become a human rights activist organization by adopting a rights-based approach to its programming. It often makes reference to non-binding resolutions or misinterpretation of treaties to promote its agenda. For example, WHO’s report *Consideration for Formulating Reproductive Health Laws* relies upon international treaties to make the case for the protection of sexual and reproductive health. Yet what it is actually occurring is the attempt to portray non-binding resolutions as law, which violates the intents of

the voting member states. Furthermore, in 2002 the WHA requested the development of a plan for accelerating the implementation of the MDGs goals to improve reproductive health, when no such goals actually existed. WHO's attempts at passing sexual and reproductive health off as a fundamental human right is a way to place even more pressure on member states to adopt its agenda, whether or not this violates a country's sovereign rights. Poor countries which rely upon WHO to meet their basic health needs will be the most vulnerable.

Recommendations. What can be done to help WHO get back in line with its original mandate, where the main objective “shall be the attainment by all peoples of the highest possible level of health”? First, WHO should return to its original interpretation of article 57 of its constitution and stop accepting money from pro-abortion organizations. Receiving these voluntary contributions raises serious questions about who directs the agenda for WHO. According to its constitution it should be the member states represented in the WHA and the technical experts of the executive board who set the agenda. Re-establishing its independence would not necessarily set a new precedent either. WHO has made attempts in the past to free itself from potentially controversial issues, such as when WHO director general Hiroshi Nakajima transferred the primary responsibility of HIV/AIDS to the Joint United Nations Program on HIV/AIDS (UNAIDS) agency.¹⁰⁹ WHO's relevance in the areas of abortion and contraception are already in question due to the large sums being spent by other agencies independent of WHO and the UN. It should reallocate the funds from these areas to those where WHO has a proven track record.

Second, WHO should get out of the business of using statistics to create “demand” that does not exist, and return to its mandate of addressing pressing global health issues. In its search for “verifiable” data in order to support its reinforcing pro-abortion/pro-contraception policies, WHO has become involved in controversial activities which hurts its legitimacy. It is experimenting on women with various forms of contraception and abortion techniques, it aids in the production of the abortifacient drug RU-487, and it makes abortionists out of doctors who should be focused on the business of saving lives and improving health systems. Furthermore, when WHO runs into barriers that block its ability

109 Joel E. Oestreich, *Power and Principle: Human Rights Programming in International Organizations*, Georgetown University Press, 2007, 118.

to meet this perceived demand, it creates strategies to destroy them. WHO officials should, on the other hand, respect the culture, tradition, religion and sovereign rights of the states in which they operate. They should not attempt to bypass the law by having treaties reinterpreted, or support grassroots organization which directly violate a state's pro-natal policies, or indoctrinate state health officials. This turns WHO into an organization that is exercising a form of cultural imperialism, rather than an organization that possesses an important mandate of providing the best health practices for its member states.

Third, WHO should stop acting as a rights-activist agency. When it pursues this role, WHO does it in a disingenuous manner. It should not accept misinterpretations of human rights treaties as the basis of programming; specifically they should reject the morphing of the right to life and other articles promoted by various treaty bodies to advance the abortion agenda. Nor should it take an active role in the treaty monitoring bodies, which is what RHR does in its attempts to have sexual and reproductive health placed on the list of fundamental human rights. These actions will put WHO in a position to force its agenda upon unsuspecting and unwilling member states, thereby turning the organization to a social engineering instrument. This in no way fits the mandate of WHO.

WHO has a decades-long track record in achieving the betterment of life for millions around the world. This record is being tainted by the organization's efforts in controversial issues such as "safe" abortion, family planning and sexual health. This threatens the legitimacy of WHO and creates a barrier for the organization to effectively help people in meeting their basic health needs. With effective and timely intervention, policy makers and concerned health professionals can begin to put WHO back on track towards its original, and far nobler, mandate.

LIST OF ACRONYMS

AIDS	Acquired immune deficiency syndrome
DG	Director General
FWCW	Forth World Conference on Women
GPA	Global Program on AIDS
HIV	Human immunodeficiency virus
HRP	Human Reproduction division of WHO
HRT	Reproductive Health Technical Support
ICEC	International Consortium for Emergency Contraception
ICPD	International Conference on Population and Development
Ipas	International Projects Assistance Services
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
MAP	Morning-After Pill
MDG	Millennium Development Goals
NAF	National Abortion Federation
NFP	Natural Family Planning
NGOs	Non-governmental Organizations
PCC	Policy and Coordination Committee
RHR	Reproductive Health and Research
UN	United Nations
SARS	Severe Acute Respiratory Syndrome
SPP	Strategic Partnership Program
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

BIOGRAPHY

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