

THE TRUTH UNRAVELED:
LOWERING MATERNAL MORTALITY

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INTRODUCTION

The purpose of this paper is to study the controversy surrounding the maternal mortality issue in the international community. This paper will argue that the United Nations (UN) and the World Health Organization have inflated numbers (evidenced by the *2010 Lancet Report*) in order to encourage donors to fund projects which promote “contraception and abortion” as the key approach to maternal mortality. This strategy promotes an ideology that breaches the fundamental rights of the child and disregards empirical data suggesting that maternal mortality can be reduced by increasing the availability of basic medical care.

The paper will be divided into three parts. Part I will give an overview of how the maternal mortality issue has developed over the years within the UN system and the related questions at stake, namely the rights of the child. Part II will discuss the *Lancet Report* and the scandal that occurred upon its release. Part III will compare and contrast the UN’s abortion-first approach with other responses to the issue including those promoted by the Holy See, the governing organ of Vatican City State and the Catholic Church.

I. THE DEVELOPMENT OF THE MATERNAL MORTALITY ISSUE

The UN body saw improving women’s health as the key to reducing poverty and inequality; therefore, maternal mortality became a major issue to take up.¹ The Millennium Development Goals (MDG) were put in place to encourage growth and advances in developing countries.² These goals were established after the Millennium Summit in 2000.³ In particular, MDG 5 was

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1. World Health Organization [hereinafter WHO], *The World Health Report 2005: Make Every Mother and Child Count* (2005), available at <http://www.who.int/whr/2005/en/index.html>.

2. United Nations Development Programme (UNPD), *Millennium Development Goals*, available at <http://www.undp.org/mdg/basics.shtml>.

3. *Id.*

set in place to improve maternal health.⁴ Specifically, target 5A was to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and target 5B, which was to achieve universal access to reproductive health by 2015.⁵

A. *What Is Maternal Mortality?*

Although there is no legally binding definition of maternal mortality, the World Health Organization (WHO) has defined it as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, not from accidental or incidental causes.”⁶ Obviously, it is important in crafting the solution to first identify the causes of these deaths. While there are a wide variety of direct and indirect causes, WHO lists the main causes as “severe bleeding, hypertensive diseases, and infections.”⁷ Other factors that WHO has identified are the early onset of sexual activity and adolescent pregnancy and lack of education among women.⁸ Again, accurate identification of the causes is key to correctly addressing the problem effectively (this raises the two opposing approaches discussed *infra*).

B. *How Does One Measure Maternal Mortality?*

A major obstacle that those working to reduce maternal deaths have faced is in measuring the actual number of women dying from pregnancy and/or childbirth. The lack of a precise measurement has made it difficult to ascertain and track the numbers and align them with efforts undertaken to lower the number of deaths.⁹ The measurement for maternal deaths becomes difficult for various reasons. For example, there may be no routine recordings of death or the pregnancy may not have been known at the time of

4. *Id.*

5. MDG Monitor: Tracking the Millennium Development Goals, Goal 5, available at <http://www.mdgmonitor.org/goal5.cfm>.

6. WHO, Maternal Mortality Ratio (per 100,000 live births), available at <http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html>; WHO, Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and The World Bank 1 (2005) available at http://www.who.int/whosis/mme_2005.pdf.

7. Khan KS et al., *WHO Systematic Review of Causes of Maternal Deaths*, LANCET (2006); 367: 1066-74.

8. WHO, The World Health Report 2005: Make Every Mother and Child Count (2005), available at http://www.who.int/whr/2005/whr2005_en.pdf.

9. WHO, Maternal Mortality in 2005, Estimates developed by WHO, UNICEF, UNFPA and The World Bank, available at http://www.who.int/whosis/mme_2005.pdf.

the woman's death.¹⁰ Further, maternal deaths may be underreported in developing countries where routine registration of deaths is not in place and the identification of the true number may require additional special investigations into the cause of deaths.¹¹

Although it is unclear how to best measure maternal mortality, WHO presents various approaches that it employs in its research. The first is the civil registration system, which involves routine registration of births and deaths (this is the ideal method).¹² Second, household surveys are employed to provide an alternative to civil registration systems.¹³ Third, the sisterhood method gathers information through interviews of a sample number of respondents about the survival of all of their adult sisters.¹⁴ Fourth, the reproductive-age mortality studies involve identifying and investigating the causes of all deaths of women of reproductive age in a defined area by using multiple sources of data.¹⁵ In this method, multiple sources of information must be used to identify deaths of women of childbearing age.¹⁶ Fifth, verbal autopsy is used to assign cause of death through interviews with family or community members, where medical certification of cause of death is not available.¹⁷ Records of births and deaths are collected periodically among small populations under demographic surveillance systems maintained by research institutions in developing countries;¹⁸ again there are various limitations. Finally, a census, which could produce estimates of maternal mortality; this approach eliminates sampling errors and hence allows trend analysis.¹⁹ All of these methods have their drawbacks; they are expensive, uncertain, and can be inaccurate.²⁰

The most recent study done by the British Scientific Journal, *The Lancet*, reports a new, lower number of maternal deaths, which they attribute to a more precise methodology.²¹ The methods used by *the Lancet* study were the vital registration data, sibling history from household surveys, data from censuses and surveys, and verbal autopsy studies.²² The improvements were

10. *Id.*

11. *Id.*

12. *Id.* at 6, box 3.

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.*

21. Khan, *supra* note 7, at 1.

22. *Id.*

made possible due to a number of factors. First, The Global Burden of Disease study has refined vital registration data that pinpointed deaths that were misclassified as maternal related deaths.²³ Second, improvements in techniques used for sibling history data were made.²⁴ Third, verbal autopsy studies have been done to measure maternal mortality nationally and subnationally.²⁵ Fourth, estimates of maternal deaths have been compiled from 1970 to 2010.²⁶ Finally, *the Lancet* reports, “methodological developments in other areas have provided improved methods for estimation.”²⁷ The Lancet study took advantage of all of the above resources to compile its numbers on maternal mortality.²⁸ The report, discussed *infra* in part II, also raised the issue of how best to eliminate maternal mortality.

C. *How is maternal mortality eliminated?*

There are two prevailing opinions on how to reduce maternal mortality, the abortion-first approach and the access to basic health care approach. The UN bodies promote the abortion-first approach. The idea with this method is that widely available access to abortion will lower the number of maternal deaths.²⁹ WHO, for example, stated that the realization of MDG 5 will require increased attention to improved health care for women, including prevention of unplanned pregnancies and unsafe abortions, and provision of high-quality pregnancy and delivery care, including emergency obstetric care.³⁰ It appears that they have successfully snuck abortion language into the maternal mortality goal. The UN promotes this abortion-first agenda by disguising it through the terms “unsafe” versus “safe” abortion. WHO considers any legal abortion to be a “safe” abortion. Conversely, any abortions (or related complications) performed in a country where abortions are not legal are considered “unsafe” and suggest that legalization would promote safety.³¹ So, for WHO estimation purposes, safe abortions were defined as those that meet legal requirements in countries in which abortion

23. *Id.* at 2.

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*

29. See generally C-Fam, Six Problems with “Women Deliver:” *Why the UN Should Not Change MDG 5*, IORG, Nov. 5, 2007 (Susan Yoshihara, Ph.D), available at http://www.c-fam.org/docLib/20080611_Women_Deliver_final.pdf.

30. WHO, *supra* note 9 at 18.

31. Samantha Singson, *Medical Experts Demand UN Action on Maternal Health, Not “Safe” Abortion* in Catholic Family and Human Rights Institute, Vol. 12, No. 41 (September 23, 2010).

is legally permitted under a broad range of criteria.³² As a result, any abortion complication occurring in a country where it is not legally sanctioned is considered a result of an “unsafe abortion,” which suggests the need for legalization.³³

In addition to WHO, International Planned Parenthood Federation (IPPF) is a proponent of the abortion-first strategy. Notably, IPPF had a 2008 income of almost 120 million dollars.³⁴ The number of abortion related services it provided doubled from the previous year and it is pushing to increase these services worldwide.³⁵ Despite evidence to the contrary, Planned Parenthood Federation of America, has emphasized that “[n]o effective maternal health improvements can occur without comprehensive reproductive healthcare, including access to contraception and safe abortion in the initiative.”³⁶ This statement is evidence of its agenda to promote abortion and inflate the organization’s income accordingly.

Those promoting access to basic health care maintain that increased abortions will not solve the problem, but will in fact make it worse.³⁷ Studies show that when abortion is legalized the number of abortions rises, as well as, the number of deaths among women.³⁸ In a country where access to basic health care is lacking, the effects of this could be devastating.³⁹ An abortion is a surgical procedure that requires sanitary medical equipment, emergency facilities and antibiotics; many developing countries are without these things, causing a risk to the woman and child.⁴⁰ Proponents of basic health care argue that what is needed is an improvement in the medical attention that these women receive.⁴¹ For example, Jeanne Head, UN representative for the National Right to Life Education Trust Fund promotes the view that the key to maternal health is in basic medical care improvements.⁴² In an intervention at the Economic and Social Council (ECOSOC) Annual

32. Sedgh, et al., *Induced Abortion: Estimated Rates and Trends Worldwide*, LANCET Oct. 2007.

33. WHO, UNICEF, UNFPA, WORLD BANK, *Trends in Maternal Mortality: 1990-2008*.

34. International Planned Parenthood Federation [hereinafter IPPF], Annual Performance Report for 2008-2009.

35. *Id.*

36. Terrence McKeegan, *G8 Countries Launch Global Initiative on Maternal Health without Reference to Abortion* Catholic Family and Human Rights Institute, Vol. 13, No. 29, 1 July 2010.

37. National Right to Life Educational Trust Fund and Minnesota Citizens Concerned for Life Global Out Reach, *Does Legalizing Abortion Protect Women’s Health?* (2009) available at <http://www.mccl.org/Document.Doc?id=250>.

38. *Id.*

39. *Id.*

40. *Id.*

41. Jeanne Head, R.N., National Right to Life Educational Trust Fund, ECOSOC AMR & High Level Segment delivered (July 1, 2010) (quoting WHO, *Maternal Mortality: A Global Fact Book*, 1991).

42. *Id.*

Ministerial Review, Head quotes WHO as stating, “[t]he majority of maternal mortality occurs in the developing world” and further that “declines from the 1940’s to 1950’s coincided with the development of obstetric techniques, the availability of antibiotics and improvement in the general health status of women.”⁴³ She, along with many others, believes that legalization of abortion is not the answer and the complications from abortions will exist, whether they are legal or illegal.⁴⁴ By simply looking at the main causes of these deaths, i.e., excessive bleeding and infection, it seems apparent that basic health care, a sanitary environment, and skilled birth attendants would be the obvious solution. WHO acknowledged this fact in its 2003 Report entitled, *Unsafe Abortion*, stating, “[i]n some countries, lack of resources and possibly skills may mean that even abortions that meet the legal and medical requirements of the country would not necessarily be considered sufficiently safe in high-resource settings.”⁴⁵ Although WHO must admit this seemingly evident fact, the organization continues to lobby for reproductive rights as the solution.⁴⁶

D. *What Do the Abortion Trends Show Among Various Countries?*

Comparisons between countries with restrictive abortion laws and those with more liberal laws are important to examine and are very revealing of the appropriate solution. In South Africa for example, there has been a “surge” in maternal deaths.⁴⁷ South Africa has some of the most liberal abortion laws in Africa, as well as the world, permitting abortion through the twentieth week for “socio-economic” reasons.⁴⁸ In comparison, Mauritius has the lowest African maternal mortality rate of any African nation, and it also has some of the most conservative laws on abortion.⁴⁹ The country of Chile has the lowest maternal mortality rate in South America, which constitutionally protects its unborn.⁵⁰ On the contrary, Guyana, a country with very loose abortion laws, has a maternal mortality rate that is thirty times higher than

43. *Id.*

44. *Id.*

45. WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003* (5th ed. 2007).

46. *Id.*

47. IPPF, *South Africa: Huge Surge in Maternal Deaths*, 27 July 2009. See also Aracely Ornelas, UN Health Data Show Liberal Abortion Laws Lead to Greater Maternal Death, Catholic Family and Human Rights Institute, Vol. 12, No. 35, August 2009.

48. www.un.org/esa/population/publications/abortion/doc/southafrica.doc, South Africa, Abortion Policy.

49. Ornelas, *supra* note 43.

50. *Id.*

Chile.⁵¹ Very insightful, is the reasoning used in liberalizing Guyana's law, which was "to enhance the 'attainment of safe motherhood' by eliminating deaths and complications associated with unsafe abortion."⁵² The contradiction in the reasoning used by Guyana is self evident; by "safe motherhood" they must be referring to no motherhood.

The UN Population Division released *The World Mortality Report: 2005*, which shows many more examples of countries showing negative effects of permissive abortion laws.⁵³ For example, two countries that have very liberal abortion laws, but are also highly developed are the United States and Russia. Interestingly, when these two countries are compared with two countries with strict pro-life laws, namely, Ireland and Poland, the number of maternal deaths shows a direct decline with the country's protection of the unborn.⁵⁴ Ireland has the lowest maternal mortality rate of all countries, "a nation that prohibits abortion and whose constitution explicitly protects the rights of the unborn."⁵⁵ The low death rates in Ireland and Poland can be linked with "skilled birth attendants and access to emergency obstetric care."⁵⁶

An example of the striking opposition between the two abortion "sides" occurred when Sweden eliminated its funding, reported to be twenty million dollars in foreign aid, to Nicaragua following the country's amendments to its laws granting full protection to prenatal life.⁵⁷ In addition, the human rights organization, Amnesty International, reported that Nicaragua's maternal death rates had actually increased following the implementation of the new laws.⁵⁸ The statistics, however, show that they have in fact declined.⁵⁹ Yet another example of the correlation between abortion laws and low maternal deaths are the maternal mortality rates of the South East Asia regions of Nepal and Sri Lanka. Nepal has no restrictions on abortions and has "the region's highest rate of maternal mortality".⁶⁰ Sri Lanka, on the

51. *Id.* See also The Christian Medical Fellowship, *The Untold Truth about Abortion in Kenya*, available at <http://www.eaclj.org>.

52. Ornelas, *supra* note 47.

53. Bradford Short, J.D., *U.N. Data Show Banning Abortion Doesn't Increase Maternal Mortality*, Catholic Family and Human Rights Institute, Vol. 9, No. 9, February 17, 2006.

54. *Id.*

55. Ornelas, *supra* note 47.

56. Samantha Singson, *Permissive Abortion Laws May Be Hazardous To Mothers' Health*, Catholic Family and Human Rights Institute, Vol. 12, No. 52, Dec. 10, 2009.

57. Ornelas, *supra* note 47.

58. *Id.*

59. *Id.*

60. *Id.*

other hand, has the lowest rate in the region, “with a rate fourteen times lower than Nepal.”⁶¹

Not only is it important to compare countries, but also, to study more closely those with low mortality rates. Dr. Elard Koch, an epidemiologist and Professor of Medicine at the University of Chile, stated that “from 1960 onwards, there has been a breakthrough in the public health system and primary care . . . highly trained personnel, the construction of many primary health centers and the increase of schooling of the population.”⁶² The data that he produced showed that the most important component in reducing maternal deaths is “accessibility to professional birth attendants in a hospital setting.”⁶³ Dr. Koch pointed to the importance of better education and medical care in improving maternal health and the direct correlation between them.⁶⁴ Even former leading abortionist, Dr. Bernard Nathanson, wrote in 1979 that “the argument that women could die from dangerous, illegal abortions in the United States ‘is . . . obsolete’ because ‘antibiotics and other advances [have] dramatically lowered the abortion death rate.’”⁶⁵ Another important aspect of Koch’s study was the finding that therapeutic abortions⁶⁶ do not decrease maternal mortality rates.⁶⁷ In actuality, Koch found that when Chile banned therapeutic abortion, the number of maternal deaths decreased.⁶⁸

It would also be prudent to look at the historical declines in maternal mortality and study what was happening legally and medically during these declines. Irvine Loudon, writing for the *American Journal of Clinical Nutrition* points out in a comprehensive analysis of the 1937 decline in the maternal death rate, that the main factors leading to this decline were the successive improvements in maternal care.⁶⁹ These improvements took place at a time before abortion laws were liberalized.⁷⁰ There also remains a concern over introducing abortion in a developing world setting without first

61. *Id.*

62. Susan Yoshihara & Piero Tozzi, *Chilean Maternal Mortality Study Undercuts Pro-Abortion Claims*, Catholic Family and Human Rights Institute, Vol. 13, No. 9, Feb. 11, 2010.

63. *Id.*

64. *Id.*

65. National Right to Life Educational Trust Fund and Minnesota Citizens Concerned for Life Global Outreach, *Does Legalizing Abortion Protect Women’s Health?* (2010).

66. Therapeutic abortion is performed to save the life of the mother as opposed to an elective abortion performed for any other reason. *Elective Abortion*, eMedicine Obstetrics and Gynecology, <http://emedicine.medscape.com/article/252560-overview> (last visited Mar. 12, 2011).

67. Lauren Funk, *Chile and Holy See Call on UN Commission to Protect the Unborn Child*, LIFE SITE NEWS, (Mar. 10, 2011).

68. *Id.*

69. Irvine Loudon, *Maternal Mortality in the Past and its Relevance to Developing Countries Today*, 72 AM. SOC’Y CLINICAL NUTRITION, 241S-246S (2000).

70. *Id.*

improving basic maternal health; doing so could result in an increase in the risk of maternal death due to the inability of health systems to respond to complications from invasive procedures such as abortion.⁷¹

Not only are mothers affected in this battle, but also, of utmost importance is the child, who is in potential harm from either abortion or complications from a birth without adequate medical care. The highly ratified UN Declaration of the Rights of the Child explicitly states, “the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth.”⁷² The UN Convention on the Rights of the Child (CRC) is the binding treaty declaring the rights of children⁷³. The treaty holds that every child has the inherent right to life.⁷⁴ Both the born and unborn child has rights that are inherent in his or her dignity as a human person, as declared by the highly cited, Universal Declaration of Human Rights.⁷⁵ The most notable binding international declarations have recognized this inherent dignity.⁷⁶ Taking it one step further, the American Convention on Human Rights declares that the child has these rights from the moment of conception and shall not be deprived of his life.⁷⁷ What these binding documents hold evident is that a child’s right to life is inherent, while the right to abortion appears to be convoluted. The child’s right to life is being pitted against the mother’s “right to life,” meaning her freedom to abort her child and live her life the way she wishes. However, as is apparent from these documents, killing the child is not an acceptable way to deal with the woman’s “dilemma.” One human’s life is not more valuable than another.

71. *Id.*

72. John Keown, *International Human-Rights Law and the Unborn Child*, National Review Online, available at <http://www.nationalreview.com/bench-memos/247662/international-human-rights-law-and-unborn-child-john-keown>.

73. Convention on the Right of the Child, G.A. Res. 44/25, at 167, preamble ¶ 9, U.N. GAOR, U.N. Doc. A/44/49 art. 1 (Nov. 20, 1989) [hereinafter CRC] (a child is defined as “any human being below the age of eighteen”).

74. *Id.* at art. 6.

75. Universal Declaration on Human Rights, G.A. Res. 217, at 71 Preamble ¶ 1, U.N. GAOR, 3d Sess., 183d plen. Mtg., U.N. Doc. A/810 (Dec. 12 1948).

76. *Id.* See also International Declaration on Human Rights, G.A. Res. 217A, at 71, Preamble ¶ 1, U.N. GAOR, 21st Sess., 1496th plen. mtg., U.N. Doc. A/6316 (Dec. 16, 1966). See also International Covenant on Economic, Social, and Cultural Rights, G.A. Res. 2200A(XXI), at 46, U.N. GAOR, 21st Sess., 1496th plen. mtg., U.N. Doc. A/6316 (1966).

77. American Convention on Human Rights art. 4 ¶ 1, Nov. 22, 1969, O.A.S.T.S. 36.

II. STATISTICAL MANIPULATION

It seems as though it would be obvious that accurate data records are essential to pinpointing the weak areas in the goal of improving maternal health; however, these numbers have been manipulated. As mentioned in Part I, *C supra*, WHO measures data using categories of “safe” and “unsafe” abortions. These terms provide a smokescreen for abortion-pushing policy makers. WHO defines unsafe abortions as abortions in countries with restrictive abortion laws.⁷⁸ Therefore, in a country where abortions are illegal, the abortion will be determined to be “unsafe” even if in the best possible medical facilities. The same is true for countries where abortion is legal, meaning “regardless of the subsequent morbidity and mortality which follows, (the abortion) is considered ‘safe.’”⁷⁹ Dr. Donna Harrison for the International Organizations Research Group, points out that a spontaneous abortion could not be illegal; therefore, the terms “safe” and “unsafe” are more legal than medical.⁸⁰ Next, Harrison points out that, “statistical manipulation generates further inaccuracy in estimates of morbidity and mortality from elective abortion worldwide.”⁸¹ She quotes the 2004 WHO report, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000* as acknowledging: “[f]or the purpose of these calculations and to circumvent the problem of induced abortion being misreported as spontaneous abortion, it was considered more reliable to use the combined incidence of spontaneous and induced abortion, when available, and to correct for the incidence of spontaneous abortion.”⁸² The problem with this seems to be apparent and the potential impact that could result from the changes to such important and sensitive data is significant. Therefore, the problem is the inflation of the number of maternal deaths. If we do not have an accurate measurement, tracking the success of various approaches to the problem will be impossible.

Dr. Harrison, brings forth a shocking and current example of this statistical manipulation when WHO researchers spoke at the UN sponsored,

78. David A. Grimes et al., *Unsafe abortion: the Preventable Pandemic*, LANCET (Sexual and Reproductive Health Series) October 2006.

79. Donna J. Harrison, M.D., *Removing the Roadblocks from Achieving MDG 5 by Improving the Data on Maternal Mortality: How Faulty Definitions of “Abortion,” “Safe 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.

80. *Id.*

81. *Id.*

82. *Id.* (quoting WHO, *Unsafe Abortion, Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2000*, available at http://www.who.int/reproductivehealth/publications/unsafe_abortion/9241591803/en/index.html).

Women Deliver Conference. At this conference, in October of 2007, Dr. Cindy Stanton, a WHO researcher, said, “[t]o participate in interpretation of pregnancy-related deaths requires that one be committed to ‘adjust the data.’”⁸³ It was later explained that to “adjust the data” meant, “eyeballing it to see if it makes sense from what we expect.”⁸⁴ She emphasized the importance especially with “pregnancy-related deaths.”⁸⁵ She explained the process by stating, “[w]e adjust the number of births or the number of deaths and we don’t change the number of pregnancy-related mortality.”⁸⁶ She went on to say that sometimes they would make “huge adjustments” to more than 50 percent of the numbers in order to “make them turn out right.”⁸⁷ Awareness of the manipulation of statistics is the first step to gaining control of the number of pregnancy related deaths. We must start with an accurate count before we proceed with a solution.

WHO’s 2006 report on sexual and reproductive health also promotes the abortion-first method of lowering maternal mortality.⁸⁸ The report addresses the issue of maternal health by focusing on specific areas of concern. Programs have been implemented to reduce preeclampsia⁸⁹ in women by administering calcium supplements to pregnant women in developing countries, which they found to be successful.⁹⁰ The report goes on to discuss the importance of skilled birth attendants.⁹¹ While the initial discussion seems promising and logical, eventually it takes a different turn. The prevention of unsafe abortion seems to take center stage of the report. It states, “[a]s a preventable cause of maternal mortality and morbidity, unsafe abortion must be dealt with as part of the MDG on improving maternal health and other international development goals and targets.” The difference between safe and unsafe abortions is that legal abortions are safe abortions.⁹² Studies conducted by the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) found that first-trimester

83. *Id.*

84. *Id.* (words of Dr. Stanton, WHO researcher).

85. *Id.*

86. *Id.*

87. *Id.*

88. WHO, *Sexual and Reproductive Health: Laying the Foundation for a More Just World Through Research and Action*, Biennial Report 2004-2005, 2006.

89. (Preeclampsia is defined by Mayo Clinic as “a condition of pregnancy marked by high blood pressure and excess protein in your urine after 20 weeks of pregnancy . . . [it] often causes only modest increases in blood pressure.”) Preeclampsia, MAYO CLINIC, <http://www.mayoclinic.com/health/preeclampsia/DS00583> (last visited Mar. 12, 2011).

90. WHO, *supra* note 88.

91. *Id.* at 9.

92. *Id.* at 21.

abortions performed by mid-level-health-care providers were equated to those performed by doctors in terms of safety.⁹³ This means that in poorer, developing countries, “safe” abortions could be available even when physicians were not.⁹⁴ It goes on to discuss making medical abortions safer through various means.⁹⁵ Finally, it states, “[s]ince contraception and abortion are two means of regulating fertility, it seems self-evident that increased use of contraception will lead to a decrease in induced abortion. However, in some countries, rising levels of contraceptive prevalence have been accompanied by a rise in the number of abortions.”⁹⁶ A recent study published in the journal *Contraception* proves that very point. The study was done in Spain and was conducted over a period of ten years on about two thousand women.⁹⁷ The researchers found that as the number of women using contraceptives increased (49% to 79%) the abortion rate more than doubled (from 5.52 per 1000 women to 11.49).⁹⁸ This study suggests that when contraception fails, abortion becomes the substitute “contraception” for these women facing motherhood.⁹⁹

IPPF takes a similar approach to the issue of maternal mortality. One of IPPF’s regional directors stated that “[u]niversal access to reproductive health is key to achieving the Millennium Development Goals.”¹⁰⁰ IPPF explains how reproductive health was not originally included in the plan to lower maternal mortality in regard to MDG 5. Further, it was not until 2007 that universal access to reproductive health was included in the plan to increase maternal health.¹⁰¹ In September of 2010, IPPF’s general director made a statement saying, “[t]hese investments . . . will require the need for the provision of safe, legal abortion as a key health intervention in order to prevent the needless deaths of 70,000 women and girls each year”¹⁰²

93. *Id.*

94. *Id.*

95. *Id.*

96. *Id.* at 24.

97. Patrick B. Craine, *Contraception Linked to Massive Rise in Abortion Rate*, LIFESITENEWS.COM, <http://www.lifesitenews.com/news/new-study-links-contraception-hike-with-increased-abortions/> (last visited Jan. 5, 2011).

98. *Id.*

99. *Id.*

100. IPPF, *IPPF Launches Initiative on Universal Access to Reproductive Health*, available at <http://www.ippfwhr.org/en/content/ippf-launches-initiative-universal-access-reproductive-health> (last visited Sept. 17, 2011).

101. *Id.*

102. Gill Greer, IPPF, Statement at Roundtable 2 – Health and Education, MDG Summit (Sept. 20, 2010), <http://www.ippfwhr.org/en/speech/statement-roundtable-2---health-and-education-mdg-summit> (last visited Sept. 20, 2010).

From these comments it is evident that IPPF has the agenda of increasing the number of abortions disguised as its solution to maternal deaths.

As mentioned above, Jeanne Head, a representative of the International Right to Life Federation believes that it is a lack of basic medical care that is keeping the number of maternal deaths from decreasing further.¹⁰³ An experienced obstetric nurse, Ms. Head emphasizes that “it is never necessary to directly attack the unborn child to protect the health of the mother”¹⁰⁴ WHO has reported that “the dramatic decline in maternal deaths from 1940 to 1950 coincided with the development of obstetric techniques, the availability of antibiotics and improvement in the general health status of women.”¹⁰⁵ It is very telling when those formerly within the abortion movement reveal facts that they previously worked to conceal. A former medical director for Planned Parenthood, Dr. Mary Calderone in 1960 stated that “it was no longer necessary to be concerned with abortions being dangerous because doctors were performing the abortions both legally and illegally.”¹⁰⁶ Although this seems logical and perhaps obvious when stated, there are still abortion proponents arguing that women are put at risk from illegal abortions because somehow the person performing them will be less skilled; again, it is a game of semantics.

As stated previously, WHO also acknowledged that legalized abortions will lead to more abortions, and this increase in abortions will cause an increase in maternal deaths (due to lack of basic medical care for the mother).¹⁰⁷ Ms. Head points out that whether abortions are legalized or not, without basic health care the woman is at risk during a birth or an abortion.¹⁰⁸ Further, as we have seen in the U.S., when abortion is made legal, the number of abortions performed rises, which would lead to the number of maternal deaths rising as well.¹⁰⁹ Ms. Head uses comparisons among countries with liberal abortion laws with those that have strong abortion restrictions. For example, “in India abortion is broadly legal, but maternal deaths are common due to dangerous medical conditions.”¹¹⁰ According to

103. Head, *supra* note 41. See also National Right to Life Educational Trust fund and Minnesota Citizens Concerned for Life Global Out Reach, Does Legalizing Abortion Protect Women’s Health?

104. Head, *supra* note 41.

105. *Id.*

106. Mary S. Calderone, *Illegal Abortion as a Public Health Problem*, 50 AM. J. PUB. HEALTH (July 1960) (“Abortion, whether therapeutic or illegal, is in the main no longer dangerous, because it is being done well by physicians.”).

107. Head, *supra* note 41.

108. *Id.* See also National Right to Life Educational Trust fund and Minnesota Citizens Concerned for Life Global Out Reach, Does Legalizing Abortion Protect Women’s Health?

109. Head, *supra* note 41.

110. *Id.*

Abortion Policies: A Global Review by the UNPD, “[d]espite the liberalization of the abortion law, unsafe abortions have contributed to the high rates of maternal mortality in India.”¹¹¹ Conversely, the maternal mortality rate in Paraguay is much lower, despite the prohibition of most abortions and the fact that “clandestine abortion is common.”¹¹² Head emphasizes the fact that abortion is never safe for the mother and obviously the defenseless child.¹¹³ Mothers are often harmed emotionally and physically by their abortions.¹¹⁴ A report by the National Right to Life Educational Trust Fund points out that,

[o]ften there is no birth attendant, the medical environment is not fully sanitary, emergency facilities and supplies are absent or inadequate, doctors are not trained or equipped to handle trauma, and basic medical and surgical supplies such as antibiotics and sterile gloves are scarce or unavailable. These dangers to pregnant women are present whether a pregnancy is ended by abortion or live birth.¹¹⁵

On May 8, 2010 the debate came to a head when *The Lancet* published a research report revealing flawed maternal mortality rates by the UN.¹¹⁶ The researchers were able to show a significant decline in maternal deaths, from 526,300 (number reported by WHO) in 1990 to 342,000 in 2008, for the first time in almost two decades.¹¹⁷ This data shows a drastic 35 percent drop in abortions over the course of just under twenty years. The reasons for the decline given in the study are: the declining pregnancy rates in some countries, higher income per capita, higher education rates for women, and increasing availability of basic medical care (including skilled birth attendants).¹¹⁸ Another important finding in the study was that 60,000 maternal deaths were attributed to HIV/AIDS and could be combated with access to antiretroviral drugs.¹¹⁹ Half of the maternal deaths came from the

111. National Right to Life Educational Trust Fund and Minnesota Citizens Concerned for Life Global Outreach, *Does Legalizing Abortion Protect Women's Health?* (2009), available at <http://www.mccl.org/document.doc?id=250> (citing United Nations, *Abortion Policies: A Global Review* (New York: United Nations, 2002), Sales No. E.01.XIII.18, 56-58).

112. Head, *supra* note 41.

113. *Id.*

114. *Id.*

115. National Right to Life Educational Trust Fund and Minnesota Citizens Concerned for Life Global Outreach, *supra* note 111.

116. Margaret C. Hogan et al., *Maternal Mortality for 181 Countries, 1980-2008: A Systematic Analysis towards Millennium Development Goal 5*, 375 LANCET 9726 1609, 1609-1623 (2010).

117. *Id.*

118. *Id.*

119. *Id.*

following countries: India, Nigeria, Pakistan, Afghanistan, Ethiopia and the Democratic Republic of the Congo. The majority of these countries have permissive abortion laws.¹²⁰ The study was revealing in drawing attention to the fact that the developed countries of the United States, Canada, and Norway have seen rises in maternal mortality numbers.¹²¹

The new numbers could mean that maternal mortality is declining and this would hamper the abortion advocates push for legalized abortion on demand.¹²² In fact, a report published on LifeSite News stated that “U.N. staff and abortion advocates told scientists they should ‘harmonize’ their findings or discuss them ‘in a locked room’ so that the press could not report maternal death numbers that conflicted with the ones they use to lobby policy makers and major international donors.”¹²³ They further report that “[w]hen he published the IMHE study, Horton told the press that he withstood significant pressure from activists not to release it until after major global funding conferences concluded this year; these include the G8 summit, UN General Assembly, and next week’s Women Deliver conference.”¹²⁴ It is obvious from these statements that organizations such as WHO and IPPF have been using the maternal mortality issue to push their abortion agenda.¹²⁵ Without the high numbers previously reported, these organizations may no longer have the opportunity to do so.¹²⁶ IPPF reports numbers of around one million dollars worth of abortion services worldwide and donations from various countries as well as groups such as The United Nations Population Fund and WHO.¹²⁷ In 2009, the IPPF had an income of 140 million dollars.¹²⁸ One of IPPF’s top five goals listed in the organization’s report was abortion.¹²⁹ It is obvious that IPPF and the UN have a vested interest in each other and will stop at nothing to reach the organizations’ “goals.”

120. *Id.*

121. *Id.*

122. Susan Yoshihara & Catherine Foster, *Researchers Asked to Hide Scientific Debate Over Maternal Deaths*, LIFE SITE NEWS, (June 3, 2010), <http://www.lifesitenews.com/news/archive/ldn/2010/jun/10060307>.

123. *Id.*

124. *Id.*

125. Steven Ertelt, *UN: Maternal Mortality Declines by One-Third Despite No Abortion Legalization*, Lifeneews.com, <http://www.lifeneews.com/2010/09/15/int-1645/> (15 Sept. 2010).

126. *Id.*

127. Samantha Singson, *Intl Planned Parenthood Report: 140M Income, More United Nations Money*, Lifeneews.com, <http://www.lifeneews.com/2010/06/03/int-1566/> (3 June 2010).

128. *Id.*

129. *Id.*

III. COMPARISONS AMONG VARIOUS APPROACHES TO MATERNAL MORTALITY

The UN's position on how to reduce maternal mortality differs from the Holy See and the Catholic Church's position.¹³⁰ There are a handful of non-binding UN documents requiring a reduction in maternal mortality through contraception and abortion. First, the 1994 Cairo Conference on Population and Development resolved to reduce mortality by half of the levels reached in the 1990s by the year 2000 and by half again by 2015.¹³¹ The Cairo document states that abortion should be avoided and should not be promoted as a method of family planning.¹³² The Holy See on the other hand has always promoted life and dignity above all else. The Holy See is a sovereign subject of international law that focuses its mission on morality and the general welfare of mankind.¹³³ In this sense, the Holy See's view is respected among the international community and has the capability to enter into binding agreements with States in the international sense.¹³⁴ In response to the UN, the Holy See supports any efforts to reduce maternal deaths and improve women's health. However, it emphasizes the dignity of the individual in all efforts to lower the rates of maternal deaths. The Holy See also states that while it will support the idea of "reproductive health," there needs to be a focus on holistic health.¹³⁵ By holistic health the Holy See is referring to treating minds and bodies in regard to what is best for them in their sexuality.¹³⁶ The Holy See regards the UN's current focus of reproductive health as too individualistic and states that a greater focus should be placed on irresponsible behavior.¹³⁷ The Holy See goes on

130. *Contra* International Conference on Population and Development, Summary of the Programme of Action, <http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm>; see Archbishop Renato R. Martino, Statement of Holy See-International Conference on Population and Development, (Sept. 7, 1994), available at <http://www.un.org/popin/icpd/conference/gov/940908193315.html>.

131. International Conference on Population and Development, Summary of the Programme of Action, available at <http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm>.

132. Brian Scarnecchia & Terrance McKeegan, *White Paper on The Millennium Development Goals In Light of Catholic Social Teaching*, International Organizations Group, available at http://www.c-fam.org/docLib/20090904_IORG_W_Paper_Number10.pdf Brian Scarnecchia.

133. Robert John Arujo, S.J., *The International Personality and Sovereignty of the Holy See*, 50 CATH. U. L. REV. 291 330-345 (2001).

134. *Id.* at 345.

135. Archbishop Renato R. Martino, Statement of Holy See-International Conference on Population and Development, (Sep. 7, 1994), <http://www.un.org/popin/icpd/conference/gov/940908193315.html>.

136. *Id.*

137. *Id.*

to say that education of “adolescents towards mature and responsible behavior” is key to keeping women from being exploited sexually.¹³⁸ The educators of these young women, the Holy See believes, should be the parents and they should “draw attention to the negative aspects of premature sexual activity . . . and endeavor to foster mature behavior on the part of adolescents.”¹³⁹

Second, the 1995 Beijing Conference for Women also addressed the issue of maternal mortality. The goal of maternal death reductions remained the same from the 1994 Conference discussed above.¹⁴⁰ This conference was followed by Beijing +5, +10, and +15 all addressing maternal mortality. These meetings were focused on women’s health, education, and political needs.¹⁴¹ For example, at the Beijing + 15, IPPF lobbied for universal access to abortion as a human right.¹⁴² The Holy See held a decisive view in regard to chapter IV; section C of the statement from the 1995 Conference. Chapter IV, section C addressed women and health and stated, “[r]eproductive health . . . implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”¹⁴³ In other words, it becomes about the individual person and his or her interests and not about self-giving and certainly not about the rights of the child. The conference document also discusses “unsafe” abortions and the need to improve this situation through “family planning” methods.¹⁴⁴ The Holy See felt that there was a “totally unbalanced attention to sexual and reproductive health in comparison to women’s other health needs.”¹⁴⁵ The Holy See also stated that it could not accept the ambiguous language used in the statements at the Conference, stating, “it could be interpreted as societal endorsement of abortion or homosexuality.”¹⁴⁶ Holy See representative, Mary Ann Glendon addressed the 49th Session of the Commission on the Status of Women in 2005 at the Beijing + 10. In her address she emphasized “motherhood” to the delegates

138. *Id.*

139. *Id.*

140. The United Nations Fourth World Conference on Women, Platform for Action <http://www.un.org/womenwatch/daw/beijing/platform/health.htm>.

141. Kristin Evans, *UN Conference Battles to Define Vision for Achieving Better World for Women*, NATIONAL CATHOLIC REGISTER, http://www.ncregister.com/daily-news/un_conference_battles_to_define_vision_for_achieving_better_world_for_women/.

142. *Id.*

143. The United Nations Fourth World Conference on Women, Platform for Action, *supra* note 140.

144. *Id.*

145. Mary Ann Glendon, Holy See’s Final Statement at Women’s Conference in Beijing, (Sept. 15, 1995), <http://www.its.caltech.edu/~nmcenter/women-cp/beijing3.html>.

146. *Id.*

and made the point that the UN founders strived to bring about both equality for women and protection of the family, motherhood and childhood.¹⁴⁷

In regard to MDG 5, the Holy See continues to advocate a holistic approach to health for women, which does not exclusively focus on a single aspect of a woman, but on her overall and comprehensive health care needs. Furthermore, women have the right to the highest standard of health care during pregnancy and the right to deliver children in a clean, safe environment, with adequate professional help.¹⁴⁸

There are a group of bodies that oversee the implementation of the international human rights treaties for the UN, these committees include the following: the Committee on the Elimination of Discrimination against Women (CEDAW), Committee on the Elimination of Racial Discrimination (CERD), Committee on the Rights of the Child (CRC), Committee on Economic, Social and Cultural Rights (CESCR), and the Human Rights Council (HRC).¹⁴⁹ All of the aforementioned monitoring bodies promote similar concerns about maternal mortality numbers and call for access to reproductive health services, reproductive health education, prohibition of child marriages, protecting women from discrimination, better access to health care service and safe abortion services, and ensuring access to contraceptives.¹⁵⁰ Because no binding UN treaty contains the language of a “right to an abortion,” CEDAW and HRC have used the phrase “right to life” from the treaties as justification for abortion.¹⁵¹ These groups believe that women’s right to life should be protected through abortions. The issue then becomes the right to life of the baby versus the right to be free from motherhood. The Holy See advocates for “right to life” meaning the mother and child both should be given the opportunity to life.¹⁵² Archbishop Tomasi, Permanent Observer at the UN for the Holy See, says that the mother and child’s right to life would be protected by clean and adequate health care and the babies allowed to be born into this world.¹⁵³

147. Scarnecchia *supra* note 132.

148. Scarnecchia *supra* note 132.

149. United Nations Human Rights: Office of the High Commissioner for Human Rights, Human Rights Bodies, <http://www.ohchr.org/en/hrbodies/Pages/HumanRightsBodies.aspx>.

150. Center for Reproductive Rights, *Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change*, available at, http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_br_maternal_mortality_in_india_2009.pdf.

151. Samantha Singson, C-FAM, *CEDAW Committee Abortion Misinterpretations Infect Human Rights Committee*, C-FAM, (Sept. 5, 2008), <http://www.c-fam.org/fridayfax/volume-11/cedaw-committee-abortion-misinterpretations-infect-human-rights-committee.html>.

152. EWTN News, *Holy See says Maternal Deaths Must be Combated while Respecting Rights of Children*, (Jun 18, 2010), <http://www.ewtnnews.com/catholic-news/Vatican.php?id=971>.

153. *Id.*

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has taken the view that “discrimination on grounds of gender, race, ethnicity, and other social factors is a social determinant of health.”¹⁵⁴ Illegal abortions, to them, means discrimination against women, therefore, this is a violation against a fundamental right that they possess.¹⁵⁵ The binding Human Rights Resolution 11/8 also generally endorses the idea that maternal mortality can be eliminated through anti-discrimination treaties and improvements in physical and mental health, including sexual and reproductive health.¹⁵⁶

There are various other initiatives that are promoting the reduction of maternal mortality. For example, the G8 summit launched a new global initiative on maternal and child health, the Muskoka Initiative, “to accelerate progress towards the MDGs dealing with maternal and child health.”¹⁵⁷ The initiative did not explicitly endorse abortion as a means to reduce the numbers. It did however; include the following language, “universal access to reproductive health by 2015.”¹⁵⁸ It is important to note that no binding document came from this initiative, it was just another attempt to push abortion into the women’s health issue. The UN-sponsored Women Deliver Conference 2010 also promoted abortion as a solution to maternal health. This conference had invented the UN’s Safe Motherhood Initiative twenty years earlier and the most recent conference attached abortion to maternal health.¹⁵⁹ The Vatican has replied to the UN by urging them to “honor motherhood.”¹⁶⁰ The Vatican goes on to say that men and women are not the same and “equality is not sameness.”¹⁶¹

A common thread between the UN and the Catholic Church’s position on this issue is the protection of basic human rights.¹⁶² It appears that the UN and the Catholic Church have the same end goal; it is in the means of getting to that goal on which they differ. The UN puts it as the right to survive

154. *Restrictive Regulation of Abortion and the Right to Health*, 18 Oxford J. Med. L. Rev. 2, 185-212 (2010) (“Special Rapporteur” is someone who is representing the United Nations).

155. *Id.*

156. United Nations, General Assembly, Report of the Human Rights Council on its eleventh session, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G09/167/66/PDF/G0916766.pdf?OpenElement>.

157. McKeegan *supra* note 36.

158. *Id.*

159. Wendy Wright & Susan Yoshihara, *Women Deliver a Ruse: Conference Organizers Push Abortion Cloaked as Health Issue*, WASHINGTON TIMES, June 4, 2010, <http://www.washingtontimes.com/news/2010/jun/4/women-deliver-a-ruse/>.

160. Kathleen Gilbert, *Vatican to UN: to Truly Empower Women, Honor Motherhood*, LIFESITENEWS.COM (8 July 2010), <http://www.lifesitenews.com/news/archive/ldn/2010/jul/10070811>.

161. *Id.*

162. Center for Reproductive Rights *supra* note 150.

pregnancy and childbirth—meaning the woman.¹⁶³ The Holy See on the other hand focuses on both the mother and the child.

CONCLUSION

The UN and the WHO have inflated key numbers regarding maternal deaths in order to encourage donors to fund projects which promote “contraception and abortion” as the key approach to lowering maternal mortality. Accurate scientific research and historical data provide the guide for effectively addressing the problem. Better access to basic health care and not legalization of abortion has been shown to be the best solution by those in the health and science fields. The promotion and implementation of abortion puts the rights of the child in direct conflict with the rights of the parents and specifically, the mother.

With a better understanding of the methodology, *The Lancet* report has produced more accurate numbers that suggest that maternal mortality can be reduced by increasing the availability of basic medical care. The UN and the Holy See are at odds on the best way to address maternal mortality. The UN focuses on “reproductive health,” i.e., access to abortion as the solution to maternal deaths. Whereas the Holy See refers to binding international documents citing a right to life for the unborn and the dignity of all life. The Holy See further encourages the UN to implement better access to basic medical care in developing countries.

163. *Id.*