

“Reproductive Health:” Code Name for Abortion and Other Evils

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Introduction

The promotion of abortion legalization in Latin America is not as evident as the pro-life movement would think. It is often covered up in strategies and euphemisms such as “reproductive health”, “reproductive rights” and “sexual health”. It is the purpose of this report to show how the legalization of abortion (both chemical and surgical) is indeed couched in terms such as the above and how to expose them, so that the people in these countries can defend themselves against the “culture” of death.

The “reproductive health” strategy has become so central to the pro-abortion movement that it has, in many respects, displaced other strategies, such as the “population bomb” strategy and the “family planning will stop abortion” strategy. In fact, “reproductive health” is actually an *umbrella* of strategies and sub-strategies, all connected together, to push for abortion legalization in Latin America, both chemical and surgical. It is then the object of this report to “unpack”, so to speak, this umbrella of strategies and sub-strategies and to help Latin American pro-lifers be aware of them and refute them.

Evidently, in order to show that the term “reproductive health”, as defined and used by anti-life organizations, especially the United Nations (UN), does include surgical and legal abortion, we have to analyze the documents issued by these organizations themselves. This is not only important in itself, but also because most Latin American countries are in economic trouble and thus they depend on foreign aid. This foreign aid comes primarily through UN agencies, with which these countries have signed international agreements. Therefore, the UN and its agencies, specially the ones having directly to do with “reproductive health”, have a special interest in pressuring these countries to accept their agenda. Moreover, and as we shall see towards the end of this report, the UN document where “reproductive health” has been defined *is a document that contains a program lasting at least a span of 20 years since its inception*. As a matter of fact, the language used in “reproductive health” bills in some Latin American countries, as are the cases of Uruguay¹ and Bolivia², are almost a *verbatim* copy of key UN documents, where this euphemistic term and others close to it have been defined.

1. First Strategy: Hiding the Promotion of the Legalization of Surgical Abortion under the “Reproductive Health” Euphemism by Means of the “Safe and Legal” Abortion Argument.

Let us begin then by taking a look at the definition of “reproductive health” that has been given by the United Nations Population Fund (UNFPA). This definition appeared in the final document of an international conference that the UNFPA carried out in Cairo in 1994. The document is titled “Programme of Action of the International Conference on Population and Development” (ICPD). The definition says:

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore 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. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.”⁵

Later on, in this same document, it is said that “Reproductive health care... should... include...*abortion* as specified in paragraph 8.25.”⁶ This controversial and contradictory paragraph begins by stating: “In no case should abortion be promoted as a method of family planning.”⁷ But then, in the very next sentence, it is stated that: “Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, *to deal with the health impact of unsafe abortion as a major public health concern...*”⁵ Then, a few lines later, it is also stated that: “In circumstances where abortion is not against the law, it should be safe”⁵.

These last two clever affirmations are nothing else than the pro-abortion argument, used over and over again, of “safe and legal abortion”, an argument HLI and VHI have refuted many times⁶. The argument consists of claiming that abortion should be legalized so that it becomes “safe” for women, given the “fact” that so many women are dying from clandestine abortions. As we shall see later, this pro-abortion argument is precisely what opened the ICPD definition of “reproductive health” to include the legalization of surgical abortion. That was the pro-abortion victory at Cairo. It opened the door to a wider interpretation of “reproductive health” so as to include legal surgical abortion.

1.1. Refutation of the “safe and legal” abortion fallacy

Before we go on to show why the ICPD is in fact including (or opening the way to include) abortion and the “safe and legal abortion” argument in its definition of “reproductive health”, let us first show in schematic form the way to refute the “safe and legal” abortion argument. The basic steps of the refutation of this fallacy are the following:

1. First, it must be clearly stated that no abortion, be it legal or illegal, is “safe” for any pre-born human being: male or female. Here, of course, the humanity of the pre-born child must be shown with photos and written descriptions. Emphasis must be given to the fact that at least half of abortion potential victims are *female*, thus defeating from the start any pretensions of turning the issue into a women’s “right-to-decide” campaign. Abortion methods must be described in words, so that people understand what it does to pre-born human beings.

2. Secondly, it must be shown that the statistics that pro-abortionists claim about the number of women dying from clandestine abortions are in fact false. It is true that if only one woman dies from an abortion, legal or illegal, we are already facing a tragedy. But demonstrating that the statistics regarding women's deaths by illegal abortions have been grossly exaggerated is to begin to strike a blow at what causes the tragedy in the first place. Concrete examples of these exaggerations must be given⁶.

3. Thirdly, it must be shown that legal abortion, even though is less dangerous than illegal abortion, is also dangerous and can be fatal for women. Here, two things must be shown: the risks of legal abortion in the U.S. and other first world countries; and statistics and concrete examples of women's deaths by legal abortions in those countries. Emphasis must be given to the fact that these deaths occur in first world countries, where medicine is supposed to be more advanced. Emphasis must also be given to the fact that laws protect more the abortionists and the abortion business than the women themselves. It must be said that the way the pro-abortion argument has been set forth is wrong. It is not the case of women's rights v. the rights of the pre-born child. It is rather the case of the rights of women *and* their pre-born children v. the money-hungry abortion business and the power-thirsty "culture" of death.

4. Fourthly, in the context of the above point # 3, it is also important to give information about post-abortion syndrome and the help that is available through the pro-life movement of healing and reconciliation. At the same time, this is the context for giving information about crisis pregnancy centers (CPCs) and their compassionate and loving care for pregnant women tempted by abortion. This, again, strikes a fatal blow at the ridiculous and unjust pretensions of the pro-abortion movement to make the "right" to abortion into a "woman's issue". At the same time, it shows that the pro-life movement is the real compassionate movement. It is the movement that is there for both: mother and child. "Love them both", as Dr. Willke rightly says.

In this context, it is important for the pro-life movement in Latin America to develop an authentic feminist movement. The male chauvinist "culture" in Latin America has been a "fruitful soil" for anti-life feminism. This needs to be corrected by a pro-life\family feminism or, to use a better, term, a pro-life\family *femininity* movement.

5. Lastly, it must be shown that when a country makes the fatal mistake of legalizing abortion, the number of abortions rises so dramatically that the *total* number of abortion-related female deaths or injuries tends to rise also⁶.

1.2. How the UN Has Interpreted "Reproductive Health" After Cairo

Let us now resume our demonstration of why the ICPD definition of "reproductive health" does include (or has been designed to eventually include) the legalization of surgical abortion. How can we be sure that this interpretation is true?

The answer to this question can be found in the way other UN agencies are interpreting and implementing the ICPD. One of those agencies is the World Health Organization (WHO). Indeed, it is logical that WHO should be the one carrying out the pro-abortion "reproductive

health” strategy, for the simple reason that WHO is in charge of “health” and *this strategy is about masking abortion as “health”, not as “family planning”*.

WHO publishes an official bulletin, titled *Bulletin of the World Health Organization*. The edition of 2000, vol. 78, no. 5, was dedicated to the “Special Theme: Reproductive Health”⁷. The editorial of said edition was titled very significantly “Reproductive Health: Widening Horizons”⁸. In it, the authors state:

“Ever since the concept of reproductive health was put forward at the International Conference on Population and Development (ICPD), held in Cairo in 1994, there has been debate about where its boundaries lie. Clearly, reproductive health is about preventing and treating disease, but it is also about supporting normal functions such as pregnancy and childbirth. *It is about reducing the adverse outcomes of pregnancy --including maternal deaths and disabilities, abortion complications, miscarriages, stillbirths and neonatal deaths--* but it is also about enabling people to have safe and fulfilling sexual relationships, and to decide if and when to have children... Though *it does not cover the full spectrum of the new concept*, the theme section in this issue of the *Bulletin* presents some of the *key components of reproductive health: family planning, abortion, maternal morbidity and mortality, prenatal and neonatal mortality, sexually transmitted infections...*”⁹

The theme article which the editorial refers to is also very significantly titled “Making Abortions Safe: A Matter of Good Public Health Policy and Practice”¹⁰. Notice that the second part of this title has been taken straight from ICPD, paragraph 8.25, quoted above. In this article the author states:

“Unplanned pregnancy and unwanted pregnancies constitute a serious public health responsibility... Even in countries where contraceptive prevalence is very high, there are still unplanned pregnancies and abortions... Making abortion legal is an essential prerequisite to making it safe... Good laws and policies on abortion, in addition to being legal instruments, are a sign of public acceptance of the limitations of contraception and contraceptive use, and of women’s need for abortion... *To make abortion safe, restrictive laws need to be annulled, amended or replaced; traditional and, in some cases, religious laws may also require attention when legal change is being contemplated. Countries have taken three main routes to this end: liberalizing the existing law within the penal or criminal code; partially or fully legalizing abortion through a positive law or a court ruling; and decriminalizing abortion by taking it out of the law altogether...* The earlier in pregnancy that an abortion takes place, the safer it is for the women’s health and the less complicated for the provider. Hence, on public health grounds, regulations that tend to delay the procedure should be avoided. Such regulations include putting the abortion decision into the hands of people other than the woman herself, weighting ‘conscientious objection’ clauses in favor of providers who want to opt out, or requiring a waiting period between obtaining permission for and having the abortion”¹¹.

These affirmations, especially the ones highlighted, are clearly and without a doubt the essence of the “safe and legal” abortion argument, whose refutation we have schematically laid out above. They also show beyond the shadow of a doubt that for the UN, “reproductive health” does include surgical legal abortion.

Nevertheless, the other affirmations not emphasized above are also so important, that they deserve separate considerations. In fact, they also constitute other anti-life strategies and sub-strategies that make up the umbrella of strategies and sub-strategies of “reproductive health” that we mentioned at the beginning of this report. Let us proceed then to analyze them one by one.

2. Second Strategy: Hiding the Promotion of the Legalization of Surgical Abortion by Turning Unsafe Abortions (= Illegal Abortions) into a Public Health “Concern”.

“Unplanned pregnancies and unwanted pregnancies constitute a serious public health responsibility...”¹¹

This sentence has been taken straight from ICPD, paragraph 8.25, quoted above, which goes to show that WHO is basing its wider interpretation of “reproductive health” to include surgical and legal abortion on Cairo’s definition of “reproductive health”. And again, such interpretation is not based on the consideration of abortion as a method of family planning, the diversion pro-abortion tactic employed at Cairo, but on health, or to be more exact, on the issue of “preventing and solving reproductive health problems”, as the ICPD definition of “reproductive health” states.

But notice that the above quote does not say that “unsafe abortions” (= illegal abortions for the anti-life movement) constitute a serious health problem. The quote actually says that “unplanned and unwanted pregnancies” are the ones that constitute a serious health concern. That’s only a diversion tactic. The implicit idea here in the mind of pro-abortionists is that women face these “unplanned” or “unwanted” pregnancies and then have recourse to “unsafe abortions” to solve their “reproductive health” problem. Thus “unsafe abortion” is really the public health “concern” that the anti-life movement is supposedly raising here. How can we be sure of this interpretation?

In order to answer this question, let us turn to another document published by WHO, titled “Global and Regional Estimates of Incidence of a Mortality Due to Unsafe Abortion”¹². In it WHO says:

“Where contraception is unavailable or inaccessible there will inevitably be large numbers of unwanted pregnancies. Furthermore, even if services are available and accessible, a proportion of unwanted pregnancies arise following contraceptive failure. Women may resort to unsafe abortion to terminate these pregnancies, putting their health and lives at risk. It is therefore important that governments, intergovernmental and non-governmental organizations deal openly with unsafe abortion as a major public health concern”¹³.

We have already proven above, when we dealt with the first strategy, that for WHO the “solution” to women’s resorting to “unsafe abortions” is legalizing or decriminalizing abortion and also that WHO identifies so-called “safe abortions” with legal abortions. But in this WHO document, there are two significant anti-life strategic points. The first one is precisely the identification that WHO does of “unsafe abortion” with illegal or clandestine abortions. Equating “unsafe abortions” with illegal or clandestine abortions is not explicitly given in the just quoted paragraph, but it is elsewhere in this same document:

“Unsafe abortions are characterized by the lack or inadequacy of skills of the provider, hazardous techniques and unsanitary facilities. Although the legality or illegality of the services may not be the defining factor of their safety...unsafe abortion has been defined as an ‘abortion not provided through approved facilities and/or persons’. What constitutes ‘approved facilities and/or persons’ will vary according to the legal and medical standards of each country”¹⁵.

In other words, for WHO, unsafe abortion is equivalent to an illegal abortion. It is very significant that the ICPD itself does not include this legal aspect in its definition of “unsafe abortion”¹⁵. Consequently, WHO’s “wider” definition can be considered as an homogeneous “advancement” of the UN abortion talk after Cairo, that is to say, an “advancement” in perfect ideological line with that conference.

It is also significant here WHO’s explicit admission that “the legality or illegality of the services may not be the defining factor of their safety”. That confession really lays at the feet of the pro-life movement, in a silver platter, so to speak, the refutation of this pro-abortion fallacy itself that claims that “safe” abortions = legal abortions and that “unsafe abortions” = illegal abortions.

In any case, there is another anti-life strategic point here. And that is expressed in the following statement that has been literally taken from the ICPD troublesome paragraph 8.25 quoted above and which we repeat for convenience: “It is therefore important that governments, intergovernmental and non-governmental organizations deal openly with unsafe abortion as a major public health concern”¹³.

What is the strategy here? It is simply to make the whole of society, in a country where abortion is illegal, “discuss”, “debate” or just “dialogue” about the “grave” crisis that “unsafe abortions” constitute. Instead of dealing with how to really enforce the laws that punish abortionists (not the women, they should not be punished, they are victims, too¹⁶, and should be encouraged to cooperate in the prosecution of the real killers); the anti-lifers shift the discussion, a discussion which they control by means of abortion friendly media and political elite, to “compassionate concern” for women’s “health”.

Here something similar happens to the strategy sex “educators” use to promote their immoral sex “education” programs. Sex “educators” claim that “there is a terrible problem of unmarried pregnancies; so, let us talk and talk and talk about sex and sex education to solve this problem”. The end result of so much “open” talk about sex, again controlled by the anti-lifers, is that kids end up *doing* sex, and not just talking about it. And then kids run to buy contraceptives and abortion “services” from the same sex “educators”, who later laugh all the way to the bank.

The same thing happens with so much “unsafe abortion” talk. People in society get duped by so much “unsafe abortion” talk, controlled by the anti-lifers, that they end up voting for “reproductive health” (read: pro-abortion) bills. That is why, again, pro-lifers need to debunk the “safe and legal” abortion myth, but also need to expose this other “tall-and-talk” strategy of the pro-abortionists for what it really is: a big smoke screen to push for abortion legalization.

3. Third Strategy: Hiding the Promotion of the Legalization of Surgical Abortion by Claiming that “Family Planning” is “Necessary” To “Stop” So Called “Unsafe Abortions”.

“Even in countries where contraceptive prevalence is very high, there are still unplanned pregnancies and abortions... Good laws and policies on abortion, in addition to being legal instruments, are a sign of public acceptance of the limitations of contraception and contraceptive use, and of women’s need for abortion...”¹¹

Here WHO is explicitly admitting that the availability of contraception is not going to stop the “need” for legal surgical abortion, thus refuting the myth that “family planning” (= contraception) is going to stop “unsafe abortions” (= illegal abortions). Pregnant women who think their pregnancies are risking their lives are still going, according to WHO, to seek “unsafe abortions” to “solve” their “reproductive health” problem. Latin American pro-lifers and those helping them should rid themselves of the illusion that anti-lifers are going to stop once they pass “reproductive health” laws that limit themselves to contraceptives. They are not. Aside from the fact, that there are abortifacient contraceptives, anti-lifers are going to push for surgical abortion legalization anyway.

Nevertheless, we know that anti-lifers speak from both sides of their mouths, this means that there is another pro-abortion strategy here, based also on the umbrella of strategies and sub-strategies of “reproductive health”, that claims that the availability of “family planning” (= contraceptives) will make surgical abortion unnecessary. The ICPD controversial paragraph 8.25 itself claimed that:

“All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services” (emphasis added).

Therefore this fallacy must be refuted. The essential steps of said refutation are the following¹⁷:

1. First of all, it must be shown that, except for sterilization and barrier methods, contraceptives can be abortifacient, by preventing in the womb the implantation of an already fertilized egg, i.e., of an early human embryo. We shall return to this point later, when we discuss the strategy of so-called “emergency contraception”.

2. Secondly, it must be shown that the number of abortions caused by anti-implantation contraceptives is actually *higher* than the number of surgical abortions. Statistics in the U.S. show this without a shadow of a doubt¹⁷.

3. Thirdly, it must be shown that couples or women who use contraceptives are more likely to have recourse to surgical abortion as a back-up for their contraceptive failure, than those who do not. Here the statistics from Planned Parenthood (PP) related think-tank Alan Guttmacher Institute are useful; as well as the admissions made by past PP leaders themselves, that as people turn to contraceptives there will be a rise in the number of abortions¹⁷.

Notice that the refutation of the “family planning will help reduce abortion” fallacy goes beyond itself. For it actually demonstrates that the widespread use of contraception will actually lead to an *increase* in the number of abortions and not simply fail to *reduce* it. This is important, because, after all, what the anti-life movement is seeking to accomplish with its “reproductive health” umbrella of strategies and sub-strategies is to legalize both pharmacological and surgical abortion in Latin America.

There are three other related points here that need to be addressed. The first is to tell the public, regarding step # 3 above, that we are talking about a *general* pattern in society and not about every single case. Obviously not every couple or woman who contracept and whose contraceptive fails is going to surgically abort later. Nevertheless, points # 1 and #2 above must be stressed, so that people know that when they contracept with potentially anti-implantation contraceptives, they are risking committing pharmacological abortions.

The other point is to remind people, and most Latin Americans are Catholic, that the Catholic Church teaches that the use of sterilization and contraceptives, be them abortifacient or not, is intrinsically and gravely evil. That is, it is gravely evil independently of the circumstances and motives.

Closely related to this second point is the fact that, until 1930, no Christian church ever approved of contraception. Both Catholic and Reformed theologians condemned it as gravely sinful¹⁸. After years of contraceptive-caused havoc, quite a few non-Catholic Christians are returning to their roots on this issue¹⁹. Sadly, at the same time, many Catholics are abandoning them.

The third point is to explain to people the health risks, especially for women, of contraception¹⁷. This will show that the euphemism “reproductive health” is neither.

Fourthly and finally, people must be shown the alternative of natural family planning (NFP) that married couples have, when they have non-selfish motives to space the births of their children²⁰.

4. Fourth Strategy: Promoting the Legalization of Chemical Abortion Through So Called “Emergency Contraception”.

This strategy is a kind of offshoot of the third strategy. It is actually the strategy that is currently more commonly used in Latin America to promote abortion legalization, in this case, chemical or pharmacological abortion.

“Emergency Contraception” (EC) is an euphemism used to mean the use of certain doses of contraceptive pills, the IUD or RU-486 (mifepristone) a certain number of hours after a sexual act where contraceptives were either not used or failed, in order to prevent pregnancy²¹.

What actually happens though, if fertilization has occurred, is that the newly conceived embryo cannot implant in his or her mother’s womb and dies. All EC methods have, among its mechanisms of action, this anti-implantation or abortifacient mechanism²¹.

Pro-aborts, however, especially when they are promoting EC in countries with pro-life laws, deny that EC can be abortifacient. They do this by playing dangerous word games. They have re-defined the beginning of pregnancy at implantation, instead of at fertilization or conception. Since abortion, by definition is the interruption of pregnancy, then, following the semantics of EC promoters, an anti-implantation effect could not be called “abortion”, since pregnancy has “not” yet started²¹.

Several Latin American countries are being subjected to this nonsensical yet fatal attack, despite the fact that these countries explicitly prohibit abortion in their constitutions and laws. As we write this report, Mexico²², Chile²³ and Peru²⁴ are being subjected to the harassment and deceptions of the EC promoters.

It is important to point out that the EC strategy is part of the “reproductive health” umbrella of strategies and sub-strategies. This follows from the fact that EC is considered part of “family planning”, which is an intrinsic part of the ICPD definition of “reproductive health” quoted above. It also follows from the fact that some of the countries that are attempting to legalize it are doing so, not by means of bills, but by means of norms that include it in their *health* ministries. Such are the cases of Mexico, Chile and Peru, just referred to above^{22,23,24}.

Actually, the EC strategy appears very clearly and detailed in another WHO document, titled “Post-Ovulatory Methods of Fertility Regulation”, located in the “reproductive health” section of WHO’s web site²⁵. Very significantly, the very first paragraph after the “Introduction” states:

“By definition, methods of fertility regulation with post-ovulatory mode of action exert their antifertility effect after ovulation, through interference with one or more of the processes involved in fertilization of the ovum, transport and implantation of the embryo, or the subsequent establishment of pregnancy. From this definition it follows that post-ovulatory fertility-regulation methods comprise those that are truly contraceptive, i.e., those that prevent fertilization and the establishment of pregnancy, *as well as methods that cause abortion of the embryo*. As a consequence, post-ovulatory methods, both existing and under development, represent important additions to the available range of contraceptives, as well as offer back-up in cases of contraceptive failure”²⁵.

Here WHO is explicitly admitting that certain contraceptives act sometimes as abortifacients. Moreover, later in this same document WHO discusses at length the use of hormonal contraceptives, IUDs and, especially, mifepristone (the abortion pill RU-486) as EC methods²⁶.

The basic steps to refute the EC abortion strategy are:

1. To show the abortifacient nature (anti-implantation effect) of all the EC methods^{17,21}.
2. In case anti-lifers continue to insist on their semantics game, show them that, no matter how they define the beginning of pregnancy and whether they call the anti-implantation effect an abortion or not, we are dealing here with *the killing of a live human embryo*, who cannot implant in his or her mother’s womb. In this context, it is very important to show them (and the public, too) the following three things:

a. That the ones who know the most about the mechanisms of action of the pill and other contraceptives are not doctors, not even gynecologists (for anti-lifers like to quote them, when they agree with their agenda), but *pharmacists*. Then give them the information provided by the same pharmaceutical companies that manufacture EC methods and the FDA itself²⁷.

b. That the ones who know the most about the development of pre-born human beings, again, are not doctors, not even gynecologists, but *embryologists*. And no embryologist will tell you that pregnancy begins at implantation, but at fertilization. They will also tell you that at fertilization you have the beginning of the life of an individual human being. Then give them a list of the most prestigious medical texts or medical dictionaries used in medical schools across the world²⁸.

c. If the anti-lifers still argue (they are very stubborn) that there are scientists who claim pregnancy begins at implantation or who deny personhood to the human embryo, then tell them that even if there is doubt, and there is certainly an overwhelming majority of embryologists who do *not* have any doubts, that doubt must always be in favor of life, otherwise we would be taking the risk of killing an innocent human being.

It is important here to note that we have been using the term “fertilization”, rather than “conception”, to refer to the union of ovum and sperm, the moment at which the life of a human being begins. This is the pro-life strategy that Dr. John C. Willke recommends in his excellent article on this EC issue, titled “Stem Cells, Cloning and ‘Emergency Contraception’”²⁹. The reason for this is because, as we have seen, EC promoters manipulate the term “pregnancy” to mean that it begins at implantation, rather than at “conception”. With the use of the term “fertilization”, pro-lifers make crystal clear that the life of the human being, and thus pregnancy, begins at the union of ovum and sperm (= fertilization) and not at implantation.

It is very disturbing to know that there is an International Consortium for Emergency Contraception (ICEC). The ICEC resulted from an international meeting of anti-life organizations, held in Italy in 1995, and convoked by the Rockefeller Foundation. Among the pro-abortion international organizations that belong to the ICEC are the International Planned Parenthood Federation (IPPF), the International Projects Assistance Services (IPAS), Catholics for a Free Choice (CFFC), the Center for Reproductive Rights (CRLP), the Population Council (PC), and the Pacific Institute for Women’s Health (PIWH). All of these organizations are based in the U.S. and are active in Latin America³⁰. In fact, there is what is called the Consorcio Latinoamericano de Anticoncepción de Emergencia (CLAE) or, in English, Latin American Consortium for Emergency Contraception. CLAE was established in New York in October of 2000, as a result of a meeting of organizations of Latin America and the U.S. that work in EC in the region³¹.

5. Fifth Strategy: Promoting the Legalization of Surgical Abortion under the “Reproductive Health” Euphemism by Going to International Courts with Special Cases.

“Countries have taken three main routes to this end: liberalizing the existing law within the penal or criminal code; partially or fully legalizing abortion through a positive law or a court ruling; and decriminalizing abortion by taking it out of the law altogether...”¹¹

As we said above, this is very clearly part of the promotion of abortion legalization masked as “reproductive health”. It is indeed part of the “reproductive health” umbrella of strategies and sub-strategies, because, recall, that “reproductive health” also means tackling the problems that affect it. And certainly, for the pro-abortion movement, rape, incest or a pre-born baby with malformation is a problem for the health of the pregnant mother, never for the pre-born child also.

The only comment to add here is to watch for “court rulings”. Anti-life organizations, such as the Center for Reproductive Rights (CLRP), based in New York, are aggressively pursuing difficult abortion-related cases to push for abortion legalization in Latin America. Thus, for example, the CLRP has approached the Inter-American Commission for Human Rights with the Paulina case, a young Mexican woman who was denied an abortion after *supposedly* being raped, to sue the Mexican government for “denying” Paulina the “right” to an abortion³³. It is disturbing to point out that close to 60 pro-abortion organizations, very active in Latin America, supported CLRP in this effort³².

The pro-life strategy here is:

1. First, to show that abortion is wrong in these cases, too. Abortion always kills a human being and hurts (emotionally and physically) the aborting mother. It only worsens, never solves, a difficult problem. In this context, it must also be shown that the pro-life movement really cares for the pregnant woman and her baby; whereas the pro-abortion movement only uses her to advance its own blood-thirsty agenda.
2. Then show how these cases are often manipulated by the pro-abortion movement and the abortion-friendly media.
3. Thirdly, demonstrate that exceptions to the abortion ban always lead eventually to abortion on demand (see next anti-life strategy below), as the U.S. experience amply shows. Besides, it makes a mockery of the pro-life and democratic principle that all human lives have intrinsic and absolute dignity/value, by not recognizing the intrinsic worth of whole classes of pre-born babies: those conceived out of rape or incest, those conceived with a malformation, etc³³.

6. Sixth Strategy: Expanding the Legalization of Surgical Abortion under the “Reproductive Health” Euphemism by Astutely “Limiting” Abortion Legalization to the First Trimester.

“The earlier in pregnancy that an abortion takes place, the safer it is for the women’s health and the less complicated for the provider. Hence, on public health grounds, regulations that tend to delay the procedure should be avoided. Such regulations include putting the abortion decision into the hands of people other than the woman herself, weighting ‘conscientious objection’

clauses in favor of providers who want to opt out, or requiring a waiting period between obtaining permission for and having the abortion”¹¹.

Pro-lifers need also to get rid of the illusion that abortionists are going to stop at abortion legalization in the first trimester and under certain cases. No, they always want more. They want it all: abortion on demand, paid by our tax money, without any conscience objection clause and without any waiting period or permission from parent or husband. This also needs to be brought to the attention of the public and law-makers, so that they can see what is truly at stake, when they are looking at “reproductive health” bills.

A “good” example of this pro-abortion expanding strategy is the abortion bill that the pro-life movement, which included HLI-VHI affiliates, was able to stop in Uruguay. The bill “limited” abortion on demand to the first trimester. But then it said that in cases of malformation or “grave health risks” to the mother, abortion could be performed *beyond* the first trimester limit³⁴.

The pro-life strategies here are the same as for the previous anti-life strategy explained above.

7. Seventh Strategy: Hiding the Promotion of the Legalization of Abortion under the “Reproductive Health” Euphemism by Means of Immoral Sex “Education”.

7.1. The immoral sex “education” of the UN.

The seventh and last strategy to be discussed in this report is immoral sex “education”. By immoral sex “education” we mean a sex information (or rather, *indoctrination*), usually (although not exclusively) given to children, adolescents, and young adults, which, subtly or not so subtly, promotes contraception and abortion, a relativistic “ethical” system and which deprives parents of their right and duty to be the first and foremost educators of their children, thus contradicting the subsidiary role that the educational system must have with respect to parents³⁵.

The importance of dealing with the sex “education” strategy is because it is the *door* for all the other evils, especially abortion. It is the door in two senses. First, because it entices people to use contraceptives, thus facilitating promiscuity, fornication and adultery --in a word, selfishness or the hedonistic mentality. This mentality in turn creates the anti-life or abortion mentality. Secondly, because sex “education” is given especially (although not exclusively) to impressionable children, adolescents and young people. This second aspect of the evil of sex “education” is even worse than the first one in the long run, because it creates a whole new generation of “bed hoppers”, contraceptors and pro-aborts.

After decades of implementation, sex “education” programs have proven to be a dismal failure in the U.S. and other first world countries. By failure we mean the dramatic increase in adolescent abortions, pregnancies and cases of sexually transmitted infections and HIV/AIDS precisely after said programs have been introduced³⁵.

This failure is indeed the best sociological refutation of so-called sex “education” in the schools. Of course, pro-lifers would add to this refutation the one based on the havoc caused by sex

“education” to intangible, such as the psychological drama of fornication, as well as the moral and spiritual harm that it also causes. There are no condoms for broken hearts and ruined lives. There is no penicillin for ingrained selfishness and the incapacity to love authentically and sacrificially in married and family life. Immoral or hedonistic sex “education” is a perfect recipe for personal failure later in life, unless moral regeneration comes to the rescue. There is no substitute for primary or secondary chastity in the successful pursuit of *any* vocation³⁶.

Immoral sex “education” is also part of the “reproductive health” umbrella of strategies and sub-strategies. This is implicitly stated in the Cairo “reproductive health” definition quoted at the beginning of this report, where it says:

“Reproductive health therefore 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. Implicit in this last condition are *the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice*, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant”⁵.

Notice that nowhere do the words “marriage” or “family” appear. The closest the paragraph comes to them is by means of the open-ended term “couple”. But any doubt as to the interpretation of the “right of men and women to be informed [about] family planning...and the right of access to...health-care services” to mean sex “education” for minors is dismissed when the following other ICPD passages are quoted:

“The *reproductive health* needs of *adolescents* as a group have been largely ignored to date by existing reproductive health services... In particular, *information* and *services should be made available to adolescents* to help them understand their sexuality and *protect them from unwanted pregnancies, sexually transmitted diseases* and subsequent risk of infertility”³⁷.

The word “information” refers to the sex “education” that the UN claims governments should implement in their countries to supposedly prevent unwanted pregnancies and sexually transmitted diseases (STDs): “Support should be given to integral sexual education and services for young people, with the support and guidance of their parents and in line with the Convention on the Rights of the Child”³⁸. We shall see later that the phrase “with the support and guidance of their parents and in line with the Convention on the Rights of the Child” is just one more case of the UN paying lip service to the rights of parents. It suffices for now to show that “information” means sex “education”.

Moreover, this sex “education” is really a promotion of contraceptives (including those which are abortifacient) among young people, masked as “services”. That “services” means distributing contraceptives is clear from ICPD paragraph 7.37, just quoted above our previous paragraph³⁷.

7.2. The inclusion or “integration” sex “education” strategy.

One thing the reader may have noticed in the above quoted paragraphs from the ICPD is that contraceptive “services” are mentioned in a wider context of positive things. Nobody in his or her right mind would object to preventing STDs, unwanted pregnancies or infertility among adolescents. The problem is *how* these problems are going to be prevented. It is typical of anti-life organizations to mix bad things with good things, all the while covering up the bad things with euphemisms. Thus the actual immoral promotion of contraceptives among adolescents is done by mixing them up or “integrating” them with the prevention of the aforementioned problems, all the while covering them up as “reproductive health services”.

But the inclusion or “integration” strategy to promote immoral sex “education” does not stop here. The ICDP actually mixes sexual abstinence (the only real solution) with the promotion of contraception among adolescents. In paragraph 7.44, the ICPD mentions the two objectives of its sex “education”, which are not, mind you, avoiding sin and growing in virtue, but avoiding STDs, pregnancies and “unsafe abortions”.

“(a) To address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, *through the promotion of responsible and healthy reproductive and sexual behavior, including voluntary abstinence*, and the provision of appropriate services and counseling specifically suitable for that age group; (b) To substantially reduce all adolescent pregnancies”³⁹.

With so much sexual pressure from your peers and *the sex “education” class itself*, plus hormones jumping up and down in the adolescent years, who is going to listen to the abstinence message lost in the midst of easily accessible contraceptives, especially when your own teacher (the authority figure standing before you) is telling you that “everything is going to be OK”?

Notice also the dreadful emphasis that the UN gives here to the prevention of “unsafe abortion” and adolescent pregnancies. This is nothing else than the “safe and legal” abortion argument that constitutes the first strategy of the “reproductive health” umbrella of strategies and sub-strategies.

Once the UN has paid its lip service to abstinence, then, elsewhere, the ICPD, without any regrets whatsoever and without mentioning a word about their failure rate, goes on to openly promote condoms to supposedly prevent STDs and HIV/AIDS:

“Promotion and the reliable supply and distribution of high-quality condoms should become integral components of all reproductive health-care services. All relevant international organizations, especially the World Health Organization, should significantly increase their procurement. Governments and the international community should provide all means to reduce the spread and the rate of transmission of HIV/AIDS infection”⁴⁰.

7.3. Rejection of parental rights through the strategy of highlighting sexual abuse

The inclusion strategy also uses the payment of lip service to parental rights to mix it with the adolescents’ “right” to confidentiality and interprets the latter with so unlimited characteristics, that it ends up treating children and adolescents as little autonomous adults.

“Recognizing the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and *sexual abuse*. In doing so, and in order to, *inter alia, address sexual abuse, these services* must safeguard *the rights of adolescents to privacy, confidentiality, respect and informed consent*, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, *remove legal, regulatory and social barriers to reproductive health information and care for adolescents*”⁴¹.

Notice how cleverly this paragraph of the ICPD has been drafted. On the one hand, the rights of parents *seem* to be given their proper recognition. But, then, on the other hand, said recognition crumbles before the “rights” of adolescents to “privacy” and “confidentiality”. The trick the ICPD uses to accomplish this is *giving the impression* that said adolescents’ “rights” come about “just” in the context of sexual abuse by incestuous parents. In such an abnormal context, it is understandable that third parties (the State) has the right to intervene to save the integrity of the child. But the mentioning of this context reveals itself to be just a smoke screen to cover up the real intentions of the UN, when one reads the phrase “inter alia” (= “among others”) in the middle of this tricky paragraph: “... in order to, inter alia, address sexual abuse, *these services* [= “reproductive health services”] must safeguard *the rights of adolescents to privacy, confidentiality...*” In other words, the “rights” of adolescents to “privacy” and “confidentiality” that must be safeguarded, according to this paragraph, do not only exist in especial cases of incest, but with regard to “reproductive services” as well.

The last references in this paragraph to “respecting cultural values and religious beliefs” are just more lip service on the part of the UN. This is so not only because of what has already been said before in this same paragraph, but also because of what is said next: “In this context, countries should, where appropriate, *remove legal, regulatory and social barriers to reproductive health information and care for adolescents*”. Besides, once you have established the “privacy” and the “confidentiality” of adolescent with health care providers, how can parents really know or have control of what sex “educators” will tell or give to their children, either at the “clinic” or in the classroom? How can they be sure that their and their children’s *ethical* (not just “cultural”) values and religious beliefs are respected?

But, how can we be sure that our interpretation of the intentions of the UN are correct? To answer this question thoroughly, leaving no doubts whatsoever, let us turn to another document by the UN: the Convention on the Rights of the Child, published in 1979. In this document, nothing is said about “reproductive rights” or abortion for adolescents. However, there are certain articles in it which have been drafted in such an open-ended fashion, that they lend themselves to “wider” interpretations so as to include “reproductive health and rights” for adolescents, *without even the knowledge or consent of the parents*.

How can we be sure of this? The best way to prove it is to see how other anti-life organizations, that collaborate very closely with the UN, are actually interpreting and applying this Convention.

One such organization, indeed, the most insidious and powerful one is the International Planned Parenthood Federation (IPPF)⁴². That IPPF and the UN collaborate very closely is explicitly stated in IPPF's *Corporate Brochure*:

“IPPF has long worked to develop and strengthen relationships with international governmental, inter-governmental and non-governmental organisations and agencies. The Federation --at the national, regional and international level-- works to build partnerships between other like-minded agencies *to intensify influence on the sexual and reproductive health agenda* and consolidate its efforts through meaningful collaboration. This involves, for example, a *close working relationship with many of the UN agencies and Funds* with which IPPF has *official relations* including the United Nations Population Fund (UNFPA), the World Health Organization, UNAIDS, and UNICEF; IPPF also has *Consultative Status at the United Nations*”⁴³.

In particular, IPPF played a key role in the Cairo Conference and continues to play it in the implementation of its “reproductive health” agenda:

“We aim to ensure that the Federation’s priorities and objectives are represented and reflected on the global agenda. Through advocacy, campaigning and networking, for example, the Federation has played an *integral key role at the International Conference in Population and Development (ICPD)*, Cairo 1994. Then-IPPF President Dr. Fred Sai was the Chairman of the main committee of the ICPD; he managed the negotiations which produced the Cairo 20-year Programme of Action.

“At Cairo and other international conferences, IPPF has been a *key player* in seeking international consensus on the right for all individuals to make free and informed choices regarding their own *sexual and reproductive health*, and to raise the visibility of key *sexual and reproductive health* issues. Undertaking strategic interventions such as Family Planning Association (FPA) representation on Government delegations, as well as support and liaison with UN agencies preparing the Conferences, IPPF works to ensure *global commitment* to, realisation of, *sexual and reproductive health and rights* for women, men and *young people*”⁴⁴.

There is no doubt, then, that IPPF is an official collaborator of the UN and, in particular, of Cairo’s 20-year agenda of implementing “reproductive health” in the whole world, which, as we have amply demonstrated, means the distribution of contraceptives (including those that are abortifacient) and the legalization of surgical abortion for any woman, *including adolescents*.

The only thing that remains to be proven is that IPPF is also an official *interpreter* of the UN regarding “reproductive rights” for children, adolescents and young people *even without parental knowledge or consent*. The denial to parents of their rights is very important for the UN, IPPF and the rest of the anti-life movement, because, aside from the Catholic Church and other faiths, parents are the ones who stand in the way of globalizing the “reproductive rights” agenda.

However, said proof is not difficult at all to accomplish. All we have to do is look at how IPPF interprets the UN Convention on the Rights of the Child. In this case, IPPF has already done the

work for us. Indeed, IPPF has published a document titled *The Young Person's Guide to the UN Convention on the Rights of a Child and Sexual and Reproductive health*⁴⁵.

Just to emphasize the fact that this “guide” is indeed what its title says it is, its introductory paragraph says: “This guide makes the links between the rights, as laid out in the Convention, and sexual and reproductive rights – traditionally one of the most controversial areas in UN discussions”⁴⁵.

Then, the paragraph goes on to emphasize how powerful this Convention is in making the governments which have signed it to respect children's rights, including *reproductive rights*:

“The United Nations Convention on the Rights of the Child is the *most powerful legal instrument* available to all children for the protection and *enforcement* of their human rights... By ratifying this instrument, national governments have committed themselves to protecting and ensuring children's rights and they have agreed to hold themselves accountable for this commitment before the international community. Despite this, there has been little progress in the protection and promotion of *adolescent sexual and reproductive health*”⁴⁵.

Whether governments are actually legally bound to the contents of this Convention or not is another matter. But what is beyond a shadow of a doubt is that IPPF has been working, and will continue to work, to ensure that all governments abide by the Convention and the “reproductive health” interpretation of it.

Let us look now at some key articles of this Convention and how IPPF has interpreted them in terms of “reproductive health”, especially in what it concerns parental rights.

For example, Article 16 of the Convention refers to the “right” of the child to his privacy: “No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honor and reputation”⁴⁵. Observe that this article, even though it mentions “family” and “home”, does not have an explicit reference to parental rights.

IPPF takes advantage of this loophole to interpret this Article 16 by telling children and adolescents the following: “If you tell a medical person or a teacher something that you don't want anyone else to know, then he or she should respect your privacy. If you have been abused, adults may have a duty to inform others who can help protect you or help you and your interests”⁴⁵.

Notice how IPPF has cleverly used here the same tactic as the ICPD, namely, to place this child's “right” to privacy in the context of children's abuse, so as to give the impression that it is only referring to exceptional situations.

IPPF interpretation of Article 24 of the Convention leaves no doubt whatsoever about its real intentions of denying parental rights, especially in what it concerns “reproductive rights”. Article 24 says: “States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and the rehabilitation of health.

State Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services”⁴⁵.

IPPF interprets this Article 24 by telling children and adolescents the following: “For example, you can visit a doctor or nurse to receive the full range of *sexual and reproductive health* services that are available and legal in your country, including *contraceptives, abortion* services, including understandable advice about your *sexual and reproductive health*. When you visit a health center you are made to feel welcome, safe and comfortable. Services should be affordable to you. *No one should turn you away or stop you from receiving services, or demand that you get someone else’s permission first (e.g., the permission of a parent or a spouse, in case you are married)*”⁴⁵.

7.4. The Promotion of Homosexual Activity by Means of “Reproductive Health” Sex “Education”.

The immoral sex “education” of the “reproductive health” agenda of the UN, IPPF et. al., does not stop at the promotion of contraception, abortion and fornication. It also includes homosexual behavior. We did not want to go into a topic beyond the scope that we set for ourselves in this report. But, we do sense the need to at least address briefly this issue, given the fact that homosexual behavior is also an intrinsic part of the “reproductive health” agenda and also, because parents, who are the last bastion against this assault on children, constitute a potentially powerful counter-“culture”-of-death force that needs to be awoken.

The ICPD definition of “reproductive health” quoted at the beginning of this report contains a statement that implicitly sets the homosexual agenda for its sex “education”:

“It [reproductive health] also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.”⁵

Notice that here there is no reference whatsoever to the normal sexual relations between a man and a woman, nor even to adults, much less to *married* couples constituted by members of the opposite sex.

Again, to demonstrate that our interpretation is not simply our own speculation, we shall refer to a concrete example of a sex “education” manual produced with the collaboration, among other organizations, of the UN and an IPPF affiliate. In El Salvador, the Ministry of Public Health and Social Assistance, published in 1999, *De adolescentes para adolescentes: Manual de salud sexual y reproductiva. Guía para facilitadores* (“From Adolescents to Adolescents: Manual of Reproductive and Sexual Health. A Guide to Facilitators”)⁴⁶. This manual was produced with the support, among other organizations, of the UN Children’s Fund (UNICEF), United States Agency for International Development (USAID) and the Asociación Demográfica Salvadoreña (“Salvadorian Demographic Association”, ADS)⁴⁷, which is IPPF affiliate in that country⁴⁸.

In this manual, it is stated that adolescence “begins approximately at the age of 10 and ends approximately at the age of 19”⁴⁹. Then, the manual tells children and adolescents, between the

ages of 10 and 19, that homosexual tendencies are “sexual preferences that have not been accepted by society”⁵⁰. And then, without any scientific source whatsoever to sustain it, the manual claims that “during our adolescence we develop and search for our sexual identity and half of us male adolescents and 30% of us female adolescents have the experience of having felt attracted to persons of the same sex”⁵⁰.

Aside from the morally neutral language used and aimed imprudently at children and adolescents, we have to take into account the wider context in which this manual situates homosexual behavior. Towards the end of this publication, there is a list of “Sexual and Reproductive Rights. The Most Human of All Rights”⁵¹. “Right # 4” says: “We have the right to decide on sexual issues, *when and with whom to have sexual relations*, as long as it is done in a healthy manner, *without obligations* and legally protected”⁵¹. In order to dispel any doubts regarding the fact that “legally protected” does *not* refer exclusively to marriage between one man and one woman, let us quote “Right # 8”, which says: “The right to sexual relationships *independently of age, civil status or family model*”⁵¹.

8. Eighth Strategy: The Ultimate Strategy. Promoting Abortion Legalization Under the Euphemism of “Reproductive Health” as a “Human Right”.

8.1. “Reproductive Health” as a “Human Right”.

This is indeed the ultimate strategy, for human rights are fundamental rights that transcend the sovereignty of nations and the laws of any State. Authentic human rights are not on the same level as political and civil rights. In fact, the latter derive their validity from the former. The human person and his or her inherent rights, such as the right to life, for example, antecede the State and society. By “antecede” we do not refer primarily to the order of time, but to the order of *importance*. Any sound philosophical anthropology will teach us that the State exists for the human person and not the human person for the State. The State does not “grant” any human rights, for the simple reason that it does not have the right to do so. But, the State has the grave duty of recognizing and protecting those rights. This means that when a particular State systematically violates those rights, the international community has a right to try to convince that State to stop doing so and to have recourse to some type of legitimate pressure to obtain the desired result.

The problem comes in when false “rights” are mistaken for authentic human rights. This problem is aggravated when the ones making the mistake, or rather, *re-interpreting* authentic human rights to actually turn them into perverted “rights”, are powerful institutions, such as the UN and IPPF.

This is exactly what has happened with the use of the euphemism “reproductive health”. This term has become a kind of a paradigm, in the perverted sense, to re-interpret authentic human rights and turn them into perverted “rights”, such as the “right” to legal and “safe” abortion.

This strategic use of the euphemism “reproductive health” is not difficult at all to prove. In fact, we have already referred to it in our discussions of the previous strategies. We only need now to make it more explicit.

If we look again at the ICPD definition of “reproductive health”, we will find the groundwork for this strategy already laid out there. Recall the following statements from said definition: “Reproductive health therefore 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. Implicit in this last condition are the *right* of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice...”⁵

We said at the beginning of this report that the anti-life victory at Cairo consisted in shifting the discussion of abortion as “family planning” to abortion as “health”. Now we can see how clever the pro-abortion movement was in doing so. The “right” that the ICPD definition of “reproductive health” talks about has “family planning” as its direct object. But “family planning” --and this is clear from the definition-- is part of and exists for the sake of “reproductive health”. *Therefore, “reproductive health” is much more a fundamental “right” than “family planning” itself.* In fact, the right to health, or, to be more precise, to the available means for maintaining or attaining health, is indeed a human right. Therefore, by extension, the right to the *means* for maintaining or attaining the health of the reproductive system is also a human right.

The problem, of course, is that what a decent moral person understands for “reproductive health” is not the same as what the UN, IPPF, et. al, understand by it. Any decent pro-life/family person takes this term to mean the health of the reproductive system of a man or a woman, i.e., the capacity of this system to bear children safely in the context of the marital union between a man and a woman. But, in the meantime, the anti-life movement is equating this term with things that actually destroy that capacity and its fruits: abortion, contraception, abortifacient contraceptives, sterilization, fornication, homosexual acts, etc.

We have already discussed how this perverted turn of things came about by means of the strategies and sub-strategies just explained. We actually accomplished this task when we discussed the very first strategy. The ICPD definition of “reproductive health” and the key paragraphs that followed it opened the way for the inclusion of abortion, by equating legal abortion with “safe” abortion for women and then calling governments, etc., to deal with the problem of “unsafe” (= illegal) abortions as a *public health* concern. The rest is history. We saw how the IPPF “guide” for children and adolescents actually did turn abortion into a “right”, by telling minors that they had the “right” to confidentially receive information and services regarding abortion. And all of that was done by explicitly interpreting the rights of children and other minors in terms of “reproductive health”.

8.2. Pressure From “Above”.

The scary thing about this “human right” strategy is that it is much more powerful and global than all the other strategies and sub-strategies. Indeed, if “reproductive rights” are “authentic” human rights, then *all* governments should respect them, since these “rights” transcend their sovereignty. Moreover, the “international community” (in this case the UN and the rest of the other anti-life organizations) have a right to “persuade” governments who do not comply. That is why we called this strategy “ultimate”.

Let us quote again the self-explanatory warning that IPPF itself gave at the beginning of its “guide”:

“The United Nations Convention on the Rights of the Child is the *most powerful legal instrument* available to all children for the protection and *enforcement* of their human rights... *By ratifying this instrument, national governments have committed themselves to protecting and ensuring children's rights and they have agreed to hold themselves accountable for this commitment before the international community.* Despite this, there has been little progress in the protection and promotion of *adolescent sexual and reproductive health*”⁴⁵.

Do not think for a moment that the last sentence of this statement is any sign of weakness on the part of IPPF (or the UN and other like-minded organizations, for that matter). It’s merely an excuse to continue its arm-twisting practices to cajole governments and societies into its “reproductive rights” agenda. Recall that the Cairo program is at least a 20-year plan. This is not a sprint; this is a marathon.

But, how can the UN and others impose their agenda without being accused of acting anti-democratically? The next and last sub-strategy will explain it.

8.3. Pressure From “Below”. The “Civil Society” Sub-Strategy.

One of the concrete ways in which the UN accomplishes the “ultimate” strategy is by a very shrewd sub-strategy called the “civil society” strategy. We all know that civil society refers to individual persons, families and the institutions they establish of their own initiative, together with the organic nexus they form among them. Civil society is very important for keeping democracy true to itself. Thanks to civil society the individual person is not alone before the powerful State. The institutions created by civil society, especially those non governmental organizations (NGOs) that have been established to defend authentic human rights, truly represent the needs and aspirations of people at the grassroots level.

The problem comes in when you have NGOs that do *not* represent the legitimate interests of individual persons and families, but the selfish interests of *international* groups with an anti-life/family ideology and agenda. Such is the case with IPPF affiliates and the plethora of other pro-abortion organizations, including feminist and homosexualist organizations. These anti-life organizations are NGOs, which do not represent the legitimate human rights of the women, children and families --in a word, the people-- of Latin America and the rest of the world.

These NGOs come in to Latin American countries and penetrate their institutions with their own agendas and ideologies *as if they were part of civil society*. They also get *easily* accredited before the UN. Then, they participate in the international meetings of the UN in gatherings parallel to the official ones. There, they lobby all they want in favor of abortion, abortifacients, sex “education” and a host of other evils, *as if they represented the legitimate interests of civil society* before the official delegates of those countries.

The UN itself is giving these NGOs more and more legitimacy and *at the same time it is making it harder and harder for pro-life/family NGOs to be accredited*. Recall what we quoted above about from the IPPF Corporate Brochure about its extensive collaboration with the UN, especially with regard to the Cairo Conference⁴³.

The objective of this so-called “civil society” strategy is to give an appearance of “democracy” to the actual process of arm-twisting and domination that goes on at UN meetings against pro-life delegations and in the UN dealings with pro-life countries.

Unless the people of Latin America and the pro-lifers who are helping them, wake up to these insidious strategies dressed up as “reproductive health”, we are not going to be able to stop the “culture” of death and establish the culture of life.

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Notes:

1. Proyecto de Ley de Defensa de la Salud Reproductiva, Sala de Sesiones de la Cámara de Representantes, en Montevideo, a 10 de diciembre de 2002. See especially Articles 4 and 5.
2. Oscar Arrien Sandoval, Presidente. Proyecto de ley sobre “Derechos Sexuales y Reproductivos”. Honorable Cámara de Diputados de Bolivia, 30 de abril del 2004.
3. UNFPA, Programme of Action of the International Conference on Population and Development, Cairo, Egypt, September 5-13, 1994, paragraph 7.2. Available at: http://www.unfpa.org/icpd/icpd_poa.htm#par7d6.
4. *Ibid.*, paragraph 7.6.
5. *Ibid.*, paragraph 8.25. Emphasis added.
6. For more information about this argument and its refutation, consult Brian Clowes, PhD, *The Facts of Life* (Front Royal, VA: Human Life International, 2001), 15-25. For information in Spanish about this same topic, consult Vida Humana International’s web site, <http://www.vidahumana.org>, the section titled “¿Legalizar el aborto para impedir las muertes maternas?”, at: http://www.vidahumana.org/vidafam/aborto/muertes_index.html.
7. “Special Them - Reproductive Health,” *Bulletin of the World Health Organization*, 2000, **78** (5), pages 569-714, available at: <http://www.who.int/docstore/bulletin/tableofcontents/2000/vol.78no.5.html>.
8. J. Patrick Vaughan and Carla AbouZahr, Editorial: “Reproductive Health: Widening Horizons,” *Bulletin of the World Health Organization*, 2000, **78** (5), page 569, available at: <http://www.who.int/docstore/bulletin/tableofcontents/2000/vol.78no.5.html>.
9. *Ibid.* Emphasis added.
10. M. Berer, “Making Abortions Safe: A Matter of Good Public Health Policy and Practice,” *Bulletin of the World Health Organization*, 2000, **78** (5), pages 580-592, available at: <http://www.who.int/docstore/bulletin/tableofcontents/2000/vol.78no.5.html>.
11. *Ibid.*, 580-582.
12. World Health Organization (WHO), “Global and Regional Estimates of Incidence of a Mortality Due to Unsafe Abortion”, available at: http://www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_table_of_contents_en.html.

13. *Ibid.* Introduction, last paragraph. Emphasis added.
14. *Ibid.* Chapter 2: “Unsafe Abortion: A Worldwide Problem,” paragraph 2.1, “Definition of Unsafe Abortion”. Emphasis added.
15. See ICPD, paragraph 20. It is ironic that this paragraph says explicitly that this definition is based on a document published by WHO, titled “The Prevention and Management of Unsafe Abortion”, Report by a technical task force, Geneva, April of 1992 (WHO/MSN/92.5).
16. When we say here that “women are victims, too” of abortion, we do *not* mean that they are victims in the same way that aborted babies are. Nor do we mean that aborted women do not bear some degree of moral responsibility --a responsibility that is hard to assess, given the different and often difficult circumstances in which their abortions occur. We do mean that in general women are victims of the abortion business, given the lies of the pro-abortion clout and the pressures to abort that many times surround women. The real killers are the abortionists themselves and the powerful elite (anti-life organizations, the media, pro-abortion politicians, etc) who, being in a position to really know what abortion is, choose to promote it for personal gain.
17. For a complete refutation of the “contraception stops abortion” fallacy and for more information on contraceptives, including the abortifacient nature of some of them and the health risks associated with all them, in English, see Clowes, 35-87. For the same type of information in Spanish, consult at <http://www.vidahumana.org>, the section “Anticoncepción”, at: http://www.vidahumana.org/vidafam/anticon/anticon_index.html.
18. See Charles D. Provan, *The Bible and Birth Control*, (Monongahela, Pennsylvania: Zimmer Printing, 1989), 63-97.
19. See, for example, Protestants Against Birth Control, POB 07240, Milw. WI 53207. Teléfono : (414) 483-3399. Fax: (414) 571-4226.
20. For more information in English about NFP, see Clowes, 89-110. In Spanish, see, at <http://www.vidahumana.org>, the section “Planificación Natural de la Familia,” at: http://www.vidahumana.org/vidafam/nfp/nfp_index.html.
21. The information on EC is astounding. For reliable pro-life information in English, visit, at HLI web site, at <http://www.hli.org>, the PDF file available at the link “Ravages of Emergency Contraception and Abortifacients” at: http://www.hli.org/bbc_other-condom-stats.html. See also, Clowes, 73. In Spanish, see, at <http://www.vidahumana.org>, the section “Anticoncepción de Emergencia”, at: http://www.vidahumana.org/vidafam/anticon/emergencia_index.html.
22. See “México: grupos provida y obispos impugnan norma abortista y anti-mujer,” *Boletín Electrónico de VHI*, vol. 8, no. 11, March 15, 2004. Available at: <http://www.vidahumana.org/news/15MARZO04.html>.
23. See “HLI envía carta al Cardenal Errázuriz de Chile,” *Boletín Electrónico de VHI*, vol. 8, no. 20, June 2, 2004. Available at: <http://www.vidahumana.org/news/2JUNIO04.html>.
24. See “Perú: HLI denuncia a Ministra de Salud por promover el aborto silencioso,” “Perú: Ciencia e Iglesia reaccionan al anuncio sobre la píldora abortiva,” *Boletín Electrónico de VHI*, vol. 9, no. 2, June 23, 2004. Available at: <http://www.vidahumana.org/news/23JUNIO04.html>.
25. H. von Hertzen and P.F. A. Van Look, “Post-Ovulatory Methods of Fertility Regulation,” *Annual Technical Report 1995* 49, p. 52. Available at http://www.who.int/reproductive-health/publications/HRP_ATRs/1995/049-071.pdf. Emphasis added.
26. *Ibid.*, pp. 59-61.
27. The information in this regard is overwhelming. Here is a partial list:

- 1) The Pill: <http://archfami.ama-assn.org/cgi/content/abstract/9/2/126>
 - 2) The morning after pill regimen:
<http://www.physiciansforlife.ca/Postfertilization%20Effect%20of%20Hormonal%20Emergency%20Contraception.pdf>
 - 3) Plan B: the package insert
http://www.go2planb.com/section/about/package_insert/?PHPSESSID=cd3874bb85850e5c615a12c82891be06
 - 4) Postinor, prescriber information:
<http://www.inhousepharmacy.com/bcp-hormones/postinor-information.html?PHPSESSID=c191f267b29fd4df358416dd7d5ea314>
Note that in the manufacturers information, it is stated that the drug can operate by preventing
- 28.** Here is a partial list of some of the most prominent medical texts/dictionaries, each one univocally stating what we have just affirmed: *Butterworth's Medical Dictionary*, 2nd Edition, 1978; *Gould Medical Dictionary*, 4th Ed., 1979; *Stedman's Medical Dictionary*, 26th Ed., 1995; *Harrup's Dictionary of Medicine and Health*, 1st Ed., 1988; *Mellon's Illustrated Medical Dictionary*, 3rd Ed., 1993; *Oxford Concise Medical Dictionary*, 4th Ed., 1994; *Pearce's Medical and Nursing Dictionary and Encyclopedia*, 15th Ed., 1983.
- 29.** J.C. Willke, MD, "Stem Cells, Cloning and 'Emergency Contraception'," *Life Issues Connector: May 2004*. Available at:
<http://www.lifeissues.org/connector/display.asp?page=04may.htm#stemcells>.
- 30.** "Introducing EC to the Mainstream", International Consortium for Emergency Contraception website, <http://www.cecinfo.org/html/ab-intro-to-mainstream.htm>, downloaded on 12/18/03.
- 31.** "Consortium Members", International Consortium for Emergency Contraception, <http://www.cecinfo.org/html/ab-members.htm>, downloaded on 12/18/03.
- 32.** See "México: abortistas manipulan caso difícil y derechos humanos," *Boletín Electrónico de VHI* (11 de septiembre del 2003, vol. 7, no. 15. Available at:
<http://www.vidahumana.org/news/11SEPT03.html>.
- 33.** For information in English about this pro-life argument, see Clowes, 181-204. In Spanish, see at <http://www.vidahumana.org>, the section "Engaños y estrategias para promover el aborto," at: <http://www.vidahumana.org/vidafam/aborto/enganos.html>.
- 34.** See source in note 1, Article 7.
- 35.** For more information on sex "education" and its failure in English, consult Clowes, 263-290; in Spanish, consult, at <http://www.vidahumana.org>, the section "Educación sexual", at http://www.vidahumana.org/vidafam/edusex/edusex_index.html.
- 36.** For more information on chastity in English, consult Clowes, 290-298; in Spanish, consult, at <http://www.vidahumana.org>, the section "Castidad", at http://www.vidahumana.org/vidafam/castidad/castidad_index.html.
- 37.** ICPD, paragraph 7.41. Emphasis added.
- 38.** *Ibid.*, paragraph 7.37.
- 39.** *Ibid.*, paragraph 7.44. Emphasis added.
- 40.** *Ibid.*, paragraph 7.33.
- 41.** *Ibid.*, paragraph 7.45. Emphasis added.
- 42.** For more information on IPPF in English, consult Clowes, 303; in Spanish, see at <http://www.vidahumana.org>, the section "IPPF," at: http://www.vidahumana.org/vidafam/ippf/ippf_index.html.

43. *IPPF Corporate Brochure*, London, p. 20, available in PDF file at: <http://www.ippf.org/about/corporatebrochure/index.htm>. Except for the phrases “official relations” and “Consultative Status at the United Nations”, the rest of the highlighted phrases have been emphasized *in the original*.
44. *Ibid.*, p. 21. In the first of the two paragraphs just quoted, the emphasis is *in the original*. In the second paragraph, the emphasis has been *added*.
45. IPPF, *The Young Person’s Guide to the UN Convention on the Rights of a Child and Sexual and Reproductive health*, London, available in a PDF file at http://www.ippf.org/youth/young_person.htm. Emphasis added.
46. *De adolescentes para adolescentes: Manual de Salud Sexual y Reproductiva. Guía para facilitadores*, Ministerio de Salud Pública y Asistencia Social, El Salvador, diciembre of 1999.
47. *Ibid.*, inside cover.
48. Web site of IPPF\Western Hemisphere Region (IPPF\WHR), section “El Salvador”, available at: http://ippfnet.ippf.org/pub/IPPF_Regions/IPPF_REGION.asp?region=WHR#EL%20SALVADOR.
49. *De adolescentes para adolescentes*, p. 11.
50. *Ibid.*, p. 87.
51. *Ibid.*, pp. 140-141. Emphasis added.