

The Dublin Declaration on Maternal Health Care and Anti-Abortion Activism: Examples from Latin America

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Abstract

The Dublin Declaration on Maternal Healthcare—issued by self-declared pro-life activists in Ireland in 2012—states unequivocally that abortion is never medically necessary, even to save the life of a pregnant woman. This article examines the influence of the Dublin Declaration on abortion politics in Latin America, especially El Salvador and Chile, where it has recently been used in pro-life organizing to cast doubt on the notion that legalizing abortion will reduce maternal mortality. Its framers argue that legalizing abortion will not improve maternal mortality rates, but reproductive rights advocates respond that the Dublin Declaration is junk science designed to preserve the world's most restrictive abortion laws. Analyzing the strategy and impact of the Dublin Declaration brings to light one of the tactics used in anti-abortion organizing.

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Competing interests: None declared.

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I learned about the Dublin Declaration in 2014 while living in Santiago, Chile. Abortion has been completely prohibited in Chile since 1989, with obvious consequences: clandestine abortions are widespread despite the ban, and the burden of illegality falls most heavily on low-income women. Some of the ban's effects, however, are less apparent. I did not previously realize, for example, that the field of genetic counseling is virtually non-existent in Chile because, without the possibility of abortion for genetic anomalies, there is no point.¹ I was also surprised to hear some pro-life Chileans deny that the word "abortion" should apply to certain intentional medical terminations of pregnancy. This is precisely what then president Sebastián Piñera meant in 2012 when he explained that an operation to end a pregnancy is not technically an abortion if it is performed to save a woman's life. "If the mother opts for a treatment that will save her life but not that of her child," he said, "we would not be facing a case of abortion. In the same way, if she decides to opt for the life of her child while risking or sacrificing her own—a decision that must be respected—she would not be committing suicide."² The first part of his statement was baffling enough, but that the president of a country—in which abortion is *never* authorized—would suggest that a woman might prefer to die rather than have a life-saving abortion struck me as outrageous. How could a president be so cavalier about the endangered life of a pregnant woman? How could he suggest that the deliberate termination of a pregnancy would not be "a case of abortion"? It was in trying to understand Piñera's reasoning that I stumbled across the Dublin Declaration.

The Dublin Declaration on Maternal Healthcare was issued on September 8, 2012, by a group of self-described pro-life clinicians and researchers attending the International Symposium on Excellence in Maternal Health. It states that "direct abortion—the purposeful destruction of the unborn child—is not medically necessary to save the life of a woman."³ This simple, unequivocal declaration was designed to cloud one of the most compelling claims made by reproductive rights advocates—namely, that the option of safe, legal, therapeutic abortion is essential to protecting wom-

en's lives and reducing maternal mortality. As I dug deeper, it became clear that the Dublin Declaration was the latest salvo in a well-orchestrated campaign to spread disinformation about abortion. The overall strategy is not new; anti-abortion activists have long made dubious claims (about the existence of "post-abortion stress syndrome," for example, or the link between abortion and breast cancer) that they continue to promote despite being discredited by the scientific community.⁴ Increasingly, they try to get their research published in reputable scientific journals, which enhances their professional credibility and political clout. By inserting scientifically framed anti-abortion claims into the mainstream scholarly literature, they aim to derail the reproductive rights movement.

The Dublin Declaration is a global initiative designed to keep abortion bans in place by undercutting arguments about the need to offer therapeutic and medically necessary abortions. It offers authorities an excuse to deny requests for abortion based on medical necessity. It also provides moral camouflage for pro-life doctors who must occasionally end a pregnancy to save the endangered life of a pregnant woman. Its effects are especially insidious in Latin America, where five countries now ban abortion completely: Chile (since 1989), Dominican Republic (2009 and 2012), El Salvador (1998), Honduras (1997), and Nicaragua (2006). Authorities in these countries rely on the Dublin Declaration to justify intervening when a woman's life is threatened by pregnancy, without admitting that they allow "abortion." The goal of this article is to expose the Dublin Declaration as a strategy designed to sow doubt and spread disinformation about the medical necessity for abortion by showing how it was deployed in two high-profile cases, one in El Salvador and another in Chile.

Before delving into the analysis, I offer a word about why this matters. The Dublin Declaration is little known outside of pro-life circles. When I presented this paper at an abortion conference in Belfast, one Irish listener was astonished: "What? Are you talking about *our* Dublin? I had no idea!" This is not surprising; abortion politics are so intensely polarized that each side routinely ignores

the other's arguments until some outlandish claim gains enough legitimacy or notoriety to become the basis of a precedent-setting legal case, heart-wrenching bedside battle, or political scandal. Some readers will undoubtedly dismiss the Dublin Declaration as yet another iteration of the junk science that anti-abortion zealots churn out and refuse to let die. They might wonder why we should care, especially when "the opposition" already receives an outsized share of media attention.

As a feminist medical anthropologist studying the backlash against sexual and reproductive rights movements in Latin America, I argue that we should analyze the Dublin Declaration for two reasons. First, where pregnant women's lives are at stake, the Dublin Declaration offers politicians and clinicians a treacherous justification to withhold life-saving medical care. Second, it is important to understand the logic and legal strategies used by our adversaries, especially when their ideas move swiftly across national borders and language barriers. Many Latin American social scientists (far more than I can cite here) are working to identify, theorize, and challenge the strategies used by pro-life and pro-family activists. They have shown how religious ideologies are strategically translated into the secular discourses of biomedicine, bioethics, and human rights, and how conservative religious activism is promulgated through the expansion of sectarian private education, infiltration of government ministries and legislatures, and proliferation of anti-choice and pro-family nongovernmental organizations.⁵ This work matters; understanding the history, philosophy, social networks, and conditions for political and legal legitimacy of these movements allows us both to appreciate the moral integrity of those with whom we disagree and to challenge them more effectively.

Background

The Dublin Declaration is based on a centuries-old Catholic moral premise known as the "doctrine of double effect," which emphasizes that the *outcome* of an action may be judged by the actor's *intention*. This idea has been used by Catholic moral theo-

logians "to explain the permissibility of an action that causes a serious harm, such as the death of a human being, as a side effect of promoting some good end."⁶ An abhorrent act may be pardonable depending on the perpetrator's intent; hence the right to use reasonable force for the purpose of self-defense.

The Dublin Declaration holds that "direct abortion" is never permissible. This logic is predicated on the difference between intent and outcome. "In Christian morality," according to one Catholic news source, there is a difference "between a direct abortion, and the unintended though foreseen death of the child as a secondary consequence of certain treatments."⁷ The same logic is manifested in the *Ethical and Religious Directives for Catholic Health Care Services*, which states, "Abortion (that is, *the directly intended* termination of pregnancy before viability or the *directly intended* destruction of a viable fetus) is never permitted" (emphasis added).⁸ If, however, fetal death results from a medical intervention that is required to cure "a proportionately serious pathological condition of a pregnant woman" and it "cannot be safely postponed until the unborn child is viable," then the clinician and the pregnant woman may be absolved of culpability because the fetal death was unintended.⁹

This idea has been applied to the abortion debate for at least 50 years. A 1967 critique by British philosopher Philippa Foot said, "As used in the abortion argument this doctrine [of double effect] has often seemed to non-Catholics to be a piece of complete sophistry."¹⁰ Abortion rights supporters view the doctrine of double effect as a disingenuous attempt to deceive, while abortion opponents view it as a moral guide in life-or-death situations. The Dublin Declaration provides an escape clause for pro-life clinicians and their political allies who can use it to justify terminating a pregnancy when faced with events—such as ectopic pregnancy—that threaten a pregnant woman's life, by defining the treatment as something other than abortion. They reason that "the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women." The doctrine of double effect can protect a pregnant woman from being

held liable for an action—such as an accident—that unintentionally causes the death of her fetus. Why, we might ask, would the framers want to re-package this antiquated notion in 2012?

The Dublin Declaration coincides with the global expansion and consolidation of Catholic health care facilities. Catholic hospitals generally refuse to allow the termination of pregnancies as long as a fetal heartbeat can be detected.¹¹ The coordinated expansion of the doctrine of double effect seems designed to counteract the argument that maternal mortality rates can decline significantly only where therapeutic abortion is legal, safe, and accessible. It aims to preserve abortion bans while shielding medical personnel from criminal and moral culpability when treatments to preserve a pregnant woman's health inadvertently cause the death of a fetus. (If legally codified, it would also smuggle the Catholic moral precept of double effect into secular law.) In 2012, Ireland was in the midst of a debate over the relationship between abortion laws and maternal mortality rates. Abortion opponents cited low Irish maternal mortality rates as evidence that women are not harmed by the abortion ban, while critics charged that a combination of undercounting and travel to other countries for abortion could explain the “myth of low maternal mortality in Ireland.”¹² A 2012 inter-agency governmental assessment recommended sweeping changes in maternal mortality reporting. Ireland was also under increasing pressure from the European Court of Human Rights to ease its almost-complete ban on abortion, especially for reasons of medical necessity. The central question was the following: is access to legal abortion necessary to save women's lives?

The politicization of maternal mortality

Since the 1980s, the global health community has agreed that maternal mortality rates need to be controlled and that the means for doing so are within reach. In the 1990s, the international health community created “a broader sexual and reproductive health and (reproductive) rights paradigm,” in which maternal mortality would be addressed holistically, using a human rights-based approach,

along with HIV/AIDS, gender-based violence, access to safe childbirth and safe abortion, and the like.¹³ When the Millennium Development Goals (MDGs) were formulated in 2000, however, they focused narrowly on maternal mortality reduction. Only one of the MDGs mentioned sexual or reproductive health; MDG5 “called for improvement in maternal health and set a target of a 75% reduction in maternal mortality ratios (MMRs) from 1990 levels by 2015.”¹⁴ Many women's health advocates lauded the effort to hold “governments accountable for their failure to provide the required services to prevent maternal deaths.”¹⁵ Others felt that by skirting the issue of abortion, the MDG framers managed to shift the abortion conversation into the realm of maternal mortality.¹⁶ Maternal mortality became politicized; an issue that had been considered a settled matter turned into a proxy for the struggle to legalize abortion. This led abortion-rights supporters such as the Center for Reproductive Rights to redirect some of their advocacy toward maternal mortality reduction.¹⁷ Researchers at the World Health Organization prepared a study showing that approximately 13% of maternal deaths worldwide are attributable to unsafe abortion,¹⁸ and women's health advocates began to argue that abortion restrictions must be loosened to safeguard women's lives and reduce maternal mortality rates.

Conservative religious activists from both Catholic and evangelical churches across Latin America pressured political leaders, including leftist presidents, to resist sexual and reproductive rights movements.¹⁹ Among other things, they claimed that the movement to liberalize abortion laws “comes in the guise of reducing maternal mortality.”²⁰ It was at this point that the Dublin Declaration arrived on the scene to attack the claim that abortion is medically necessary. Writing with reference to the United States, political scientist Daniel Skinner says, “Those pro-choice actors who turned to the medical necessity frame were surely hoping that the lack of choice implied by necessity would serve as a backstop capable of securing access to abortion.”²¹ Skinner believes this assumption was misguided because advocates did not anticipate the backlash from pro-life physicians and their allies.

Certainly this was the case in Latin America, where pro-life scientists concocted an argument showing that maternal mortality rates were falling dramatically, even in countries that banned abortion. Hence, they said, there was no need to liberalize abortion laws.²²

One of these scientists was Elard Koch, a Chilean co-author of the Dublin Declaration and renowned abortion opponent. In 2012, he and his colleagues at the MELISA (Molecular Epidemiology in Life Sciences Accountability) Institute in Chile published an epidemiological study showing that maternal mortality rates *declined* in places that banned abortion, including some regions of Mexico as well as in Chile during the “natural experiment” created by the prohibition of therapeutic abortion in 1989. The authors attributed the decline to better education among women, access to modern medical care, and improvements in sanitation and hygiene. Their take-home message was that abortion restrictions lead to *lower* maternal mortality. Legalizing abortion would not reduce maternal mortality, the authors argued, nor would prohibiting abortion increase maternal mortality: “only marginal or practically null effects would be expected from abortion legalization or abortion prohibition on overall maternal mortality rates in [Mexico].”²³ Koch called the argument for therapeutic abortion “anachronistic.”²⁴

The fact that Koch’s study was published in the English-language mega-journal *PLoS One* allowed it to cross from the pseudoscientific fringe into the realm of scientific legitimacy. This infuriated some abortion supporters. In Belfast, one senior scientist railed that the article “never should have been published.” Yet the study did not go unchallenged. The Gutt-macher Institute issued two detailed rebuttals of work by Koch and his team.²⁵ The rebuttals showed that low maternal mortality rates in Chile could be attributed to factors that Koch and his team had not considered, including the increased availability of modern contraceptives, widespread use of misoprostol (medical abortion) as an alternative to surgical abortion, and good hospital protocols for post-abortion care.²⁶ The authors noted that maternal mortality is low in some other

countries that restrict abortion—such as Ireland, Malta, and Poland—because women travel to neighboring countries for the procedure.

Some abortion rights advocates were annoyed by the authors’ obvious political motivations. Joyce H. Arthur, director of the Abortion Rights Coalition of Canada, charged that “an anti-abortion bias had infected the study’s methodology and conclusion. This bias must be addressed, despite the authors’ efforts to take sanctuary under the mantle of scientific objectivity.” Arthur noted that Koch and colleagues

*are members of the group We Care [World Expert Consortium for Abortion Research and Education], a group of anti-abortion researchers and doctors that formed around 2011 to publish their own research in mainstream venues, in an apparent effort to put a gloss of scientific respectability on their anti-abortion stance ... [and] to create a false picture of scientific confusion and conflicting data in the abortion field.*²⁷

Breaking into the mainstream scientific journals was certainly a victory for Koch and his team, because it gave them the imprimatur of scientific legitimacy. Not all of the scholarship on the “myth of maternal mortality” was as well placed; other venues for this argument include *The Linacre Quarterly* (journal of the Catholic Medical Association) and *Issues in Law and Medicine*, a journal co-sponsored by the Watson Bowes Research Institute of the American Association of Pro-Life Obstetricians and Gynecologists.²⁸

The message promulgated by Koch and colleagues was clear: maternal mortality is not a justification for decriminalizing abortion. Their goal was to undermine global reproductive rights advocates who saw the MDGs as integral to relaxing the bans on abortion. “The aim of this study,” according to Koch et al., “was to assess the main factors related to maternal mortality reduction in large time series available in Chile in context of the United Nations’ Millennium Development Goals (MDGs).”²⁹ The competing claims allowed the media to depict the controversy as a dispute between two equal sides rather than an attempt by a small group of religiously motivated ideologues to derail

the scientific consensus.³⁰ The Dublin Declaration became the focal point for a North-South alliance of pro-life organizations (Personhood USA, VIFAC [Vida y Familia A. C. de Guadalajara], Alliance Defending Freedom, Construye A.C., and the Committee for Excellence in Maternal Healthcare) that prepared a short report entitled “Policy-Making to Reduce Maternal Mortality: A Holistic Approach to Maternal Care” for a presentation to the United Nations Commission on the Status of Women. Their press release said:

In accordance with Millennium Development Goal 5, delegates to the [United Nations Commission on the Status of Women] often discuss policies for reducing world-wide maternal mortality. Unfortunately, the International Planned Parenthood Federation and sympathetic delegations often use this admirable goal as a vehicle to advance resolutions which promote abortion in developing nations.³¹

The report emphasized that “education, not abortion” was the key to lowering maternal mortality in Chile and elsewhere. Crusaders set out to spread the message: new medical technologies such as early detection, hospital-based Caesarean birth, fetal surgery, and neonatal intensive care units make it easier to save women’s lives *as well as* those of the fetuses (“pre-born children”) they carry. Choosing one life over the other, they said, is no longer necessary. Skinner writes that “anti-choice actors are shrewd for taking this tactical route,” because it puts pro-choice groups on the defensive by requiring them to prove that any particular abortion is medically justified and by questioning the motives of doctors who plead medical necessity.³² Shifting abortion politics into the realm of maternal mortality practically guaranteed that opposing forces would square off during a hospital bedside crisis, with a woman’s life hanging in the balance.

News of the tragic death of Savita Halappanavar in Ireland came in October 2012, just a month after the Dublin Declaration was issued. Halappanavar was a pregnant 31-year-old dentist who had been admitted to a hospital in Galway with ruptured membranes and a miscarriage in progress. Doctors hamstrung by the Irish abortion ban

declined to perform a uterine evacuation because they could still detect a fetal heartbeat, even though at 17 weeks’ gestation the fetus had no chance of surviving. They were hampered by the Eighth Amendment to the Irish Constitution, which made “the life of a pregnant woman . . . equal to the life of the foetus she is carrying.”³³ As a result, Irish hospitals had a policy of refusing to perform elective or scheduled abortions (such as in cases of cancer or fatal fetal abnormality), in which case the woman usually went abroad for the procedure. Dr. Peadar O’Grady told me that until the law changed in 2014, medical emergencies were routinely handled but “denied as being abortions by arguing double effect.”³⁴ When Halappanavar died of sepsis, people disagreed about whether her death was the result of medical malpractice or Ireland’s Catholic “doctrine of double effect” banning abortion.³⁵ Some cited the Dublin Declaration as evidence that Halappanavar’s life could have been saved, while others cited it as evidence of why she died. Maeve Taylor of the Irish Family Planning Association explained that the law essentially forced doctors to do nothing while Halappanavar’s health deteriorated to the point that she *might* die—which meant in this case that she *did* die.³⁶ Doctors were put in the untenable position of needing to decide “exactly how endangered her life had to be” before they could legally terminate the pregnancy.³⁷ Similar tragic circumstances were reported elsewhere.³⁸ Valentina Milluzzo was a 32-year-old Italian woman who was pregnant with twins when she went into early labor and died in 2016; her family charges that doctors claimed “conscientious objector” status as their reason for not terminating the pregnancy while her condition deteriorated. Such deaths put a human face on maternal mortality and show it to be the direct result of religiously inflected state policy. To reproductive rights supporters, these deaths are a tragic repudiation of Dublin Declaration claims.

Pressuring politicians

Even after Halappanavar’s death, pro-life lobbyists continue to argue that abortion bans can remain in place without jeopardizing women’s lives. The

Dublin Declaration website offers the document in 18 languages and is widely circulated through pro-life Catholic and evangelical circles. In the United States, it is promoted by Live Action, a self-pronounced “new media nonprofit dedicated to ending abortion and building a culture of life.” Live Action is perhaps best known for distributing the heavily edited “sting videos” in 2015 that purported to show sales of fetal tissue at US Planned Parenthood clinics. Its director, Lila Rose, takes every opportunity to claim that abortion is never medically necessary; her Twitter website banner reads, “Love them both.” In 2014, she openly criticized Wisconsin Governor Scott Walker—at the time a Republican presidential candidate—for being “wimpy” on abortion; the following year, Walker signed a 20-week abortion ban and said during a televised debate that an “unborn child can be protected and there are many other alternatives that will also protect the life of that mother.” In response to his comment, Rose tweeted, “Abortion is never medically necessary.”³⁹

El Salvador

The impact of the Dublin Declaration has been felt in Latin America, where women’s health and reproductive rights activists are fighting to overturn complete abortion bans. Abortion has been completely prohibited in El Salvador since 1998, and authorities remain steadfastly opposed to making exceptions for rape, incest, fetal anomalies incompatible with life, or mortal threats to pregnant women’s lives.⁴⁰ The Salvadoran abortion ban captured the world’s attention in 2013, when a pregnant 22-year-old woman called “Beatriz” (a pseudonym) was denied an abortion by the Salvadoran Supreme Court, even though the fetus had anencephaly and full-term anencephalic infants rarely survive for more than a few hours after birth. Beatriz also suffered from lupus, a condition exacerbated by her pregnancy. When she requested an abortion, authorities stalled for several months, perhaps in an effort to enable the fetus to achieve the age of viability. Even with Halappanavar’s death fresh in advocates’ minds, the Archbishop

of San Salvador asserted that Beatriz represented a “strategy” that consisted of “finding an emblematic case to secure the legalization of abortion.” The bishop said, “What it tries to do is open the door to abortions in El Salvador. It is a strategy they have used in other countries.”⁴¹ The hospital acted only after the Inter-American Court of Human Rights ordered the Salvadoran government to provide Beatriz with access to life-saving medical care. Rather than providing an “abortion,” however, doctors performed what they termed a “premature induction of birth” via hysterotomy (a surgical incision into the womb similar to a Caesarean section) at 27 weeks’ gestation. To justify their logic, doctors arbitrarily defined 20 weeks’ gestation as the dividing line between an “abortion” and a “premature birth.” They reasoned that El Salvador’s restrictive abortion law would permit them to deliver a fetus after 20 weeks without labeling the procedure an abortion, even though they knew in this case that the fetus would not survive. The intent of an abortion, they said, was to kill a baby, whereas the intent of an induction was to save a pregnant woman’s life.⁴² This form of “preterm parturition” allowed authorities to claim that they were upholding the law and protecting Beatriz’s life, while doing everything possible to save the child’s life.⁴³

The child died; Beatriz lived. Anti-abortion forces nevertheless claimed victory, saying the Beatriz case proved that abortion is unnecessary to save a woman’s life imperiled by pregnancy. The Catholic news agency ACI Prensa ran a headline reading, “Beatriz’ Case Proves that Abortion Is Not Needed to Save the Life of the Mother.”⁴⁴ From Virginia, Lila Rose of Live Action issued a press release touting the Dublin Declaration: “Salvadoran Supreme Court Protects Lives of Both Mother and Child: Historic Decision from Pro-Life Latin American Nation.” She wrote:

El Salvador has shown what true medical compassion looks like, all while keeping in line with medical science and plain common sense. Hundreds of doctors in Ireland, another pro-life country, recently published the Dublin Declaration, which states unequivocally that abortion is never needed to save a woman’s life. These doctors have agreed that we

*don't have to pit the mother's life against the child: we can strive to protect them both.*⁴⁵

The implication was clear; “pro-life countries” will refuse to perform abortions, even when a woman’s life is threatened. If doctors do end a pregnancy to save a pregnant woman’s life, they will call it something other than abortion. Several English-language news sources accepted this framing uncritically, and in El Salvador a newspaper headline read, “Court Protects Life of Beatriz and Her Child.”⁴⁶

The fundamental premise of the Dublin Declaration is the notion that the fetus and the pregnant woman share an “equal moral status.”⁴⁷ Women’s health advocates disagree, citing contradictory statements in Catholic doctrine. Witness, for example, this statement from the United States Conference of Catholic Bishops’ Committee on Doctrine: “the risk to a woman’s life is entirely irrelevant, insofar as any intervention that can be classed as direct abortion would be impermissible regardless of the degree of risk to the woman.”⁴⁸ In practice, doctors guided by the doctrine of double effect have made pregnant women wait before initiating life-saving cancer treatments. They have also subjected women to invasive medical procedures (such as Caesarean sections, hysterotomies, and salpingostomies) that would otherwise have been unnecessary, thus multiplying the risks to their health.⁴⁹ The American College of Obstetricians and Gynecologists issued a statement opposing the Dublin Declaration in October 2012:

*Abortions are necessary in a number of circumstances to save the life of a woman or to preserve her health. Unfortunately, pregnancy is not a risk-free life event, particularly for many women with chronic medical conditions. Despite all of our medical advances, more than 600 women die each year from pregnancy and childbirth-related reasons right here in the US. In fact, many more women would die each year if they did not have access to abortion to protect their health or to save their lives.*⁵⁰

Meanwhile, the Dublin Declaration is evidence that claims of medical necessity are being attacked with “greater degrees of nuance and scientific sophistica-

tion.”⁵¹ In both El Salvador and Chile, authorities have justified their complete bans on abortion by claiming that “direct abortion” is never medically necessary.

Chile

In Chile, General Augusto Pinochet banned the practice of abortion in 1989, just prior to relinquishing power after 16 years. When Michelle Bachelet was elected president in 2014, she promised to legalize abortion for women whose lives were endangered by pregnancies, as well as in cases of rape or of serious fetal anomalies incompatible with life outside the womb. During the presidential campaign leading up to her election, the media was filled with news of Belén, an 11-year-old girl who became pregnant as a result of repeated rape by her stepfather. The case became a “bargaining chip” in the electoral campaign.⁵² No one denied the circumstances, but the political situation was messy. Belén’s mother said the sex between her 11-year-old daughter and her partner was “consensual” and that his arrest was “an injustice against my partner.”⁵³ Doctors said that Belén’s life was in danger as a result of her age; they recommended an abortion. When reporters located Belén, however, she told them that she planned to love her baby despite the rape; “It’s going to be like a doll I’ll hold in my arms. I’m going to love it a lot even though it comes from the man who did me harm, but I’m going to love it anyway.” Then president Sebastián Piñera went before the cameras to announce that abortion would not be necessary for Belén and that medical personnel were ready to induce a “premature birth” if they determined that the pregnancy endangered her life.

Piñera’s logic was rooted in the doctrine of double effect, just like the Dublin Declaration. This doctrine is promoted in Chile by a number of anti-abortion scholars, including Universidad de Los Andes Professor of Legal Philosophy and Natural Law Alejandro Miranda Montecinos, who wrote that the doctrine of double effect provides a “better and more consistent” framework than its alternatives and should be taken up in Latin American law, including with regard to abortion.⁵⁴ Miranda Montecinos is on record opposing induced abortion

in Chile. He signed a public letter urging the state to protect “both innocent children” in Belén’s case by offering medical and psychological help, prosecuting the rapist, and improving socioeconomic conditions to prevent “overcrowding, poverty, inequality, lack of education, and violence against women and children.”⁵⁵ His logic was clear: if the doctrine of double effect were incorporated into secular law, Chile would be able to retain its legal ban on abortion while offering legal protection to the medical personnel who act to save pregnant women’s lives at the expense of fetal lives.

Sowing doubt

The most pernicious effect of the Dublin Declaration has been to sow doubts about the medical necessity for abortion. Deliberately deceiving the public is a strategy that has been used by the tobacco, coal, pharmaceutical, and sugar industries, vaccine opponents, and climate change deniers.⁵⁶ According to Robert Proctor, the goal of such strategies is to produce public ignorance by intentionally generating contradictory statements that will mislead the public for commercial, political, or ideological purposes.⁵⁷ The strategy is especially effective, he explains, when the topic is technically (scientifically or statistically) complex, as is the case with the relationship between abortion and maternal mortality. The success of the strategy depends on publicity that will take the message to the highest levels of policymaking.

In Latin America, a history of coercive international population control programs unfortunately makes it easy to impugn the motives of reproductive rights advocates.⁵⁸ In Nicaragua, for example, where abortion has been totally banned since 2006, abortion opponents inflamed anti-imperialist sentiment by charging that so-called *organizaciones abortistas* (abortionist organizations) received financing from European governments that did not want more Third World babies, as well as from the pharmaceutical and medical industries that profited from abortion.⁵⁹ Reverberations of the Dublin Declaration were evident in an anonymous Nicaraguan op-ed titled, “Abortion to Save the Life

of the Woman?,” in which the writer upbraided any naïve soul who was taken in by the “echo chamber of those who manipulate our human sensibilities with the hypothetical situation in which a mother is sentenced to die if she can’t get an abortion—a situation that never happens.”⁶⁰

Reproductive rights advocates who are aware of the Dublin Declaration can respond by exposing the strategy and correcting disinformation. This is what liberal legislators in the United States did in the 2000s, after then president George W. Bush funded “pregnancy crisis centers” that spread misinformation about the effects of abortion.⁶¹ More recently, the French government banned “misleading” anti-abortion websites.⁶² Respected health authorities have gone on record in support of the need for abortion to reduce maternal mortality; these include the World Health Organization, European Board and College of Obstetrics and Gynaecology, American College of Obstetricians and Gynecologists, and International Federation of Gynecology and Obstetrics.

Conclusion

A revolutionary feminist wave is sweeping across Latin America.⁶³ Latin American reproductive rights are advancing at national, transnational, and international levels. Activists are organized and mobilized like never before, standing up for people’s rights to necessary medical services and to make their own decisions about reproductive and sexual matters. Increasingly, they are winning. Over the past 20 years, many Latin American countries have passed gender equity protections and seven have liberalized their abortion laws, with other initiatives pending. Momentum is building as activists appeal to international human rights bodies, invoke anti-discrimination laws and treaties, file judicial injunctions to protect fundamental rights, work to revise penal codes, and rewrite hospital protocols.⁶⁴ Successes of this magnitude do not, of course, go unchallenged. Abortion opponents in Latin America are active, too, with strategies that include constitutional reforms, creating new rights claimants (such as fathers, fetuses, and families),

expanding conscientious objection provisions, promoting religious liberty protections and national sovereignty, producing propaganda, and attacking international courts and agencies that support reproductive rights.⁶⁵ The Dublin Declaration can be seen as part of an ideologically driven attempt to influence national debates, create confusion and competing truth claims, and keep abortion criminalized in places like Ireland, Chile, Nicaragua, and El Salvador. History is not on their side, though, as momentum builds to overturn these bans.

Acknowledgments

Mount Holyoke College provided financial support for this project. I am grateful to Silvia De Zordo and Johanna Mishtal for inviting me to participate with Sonja Luehrmann in the panel “Shifts in Abortion Governance and Human Rights: The Circulation of Religious and Medical Discourses on ‘the Unborn Rights’ and Physicians’ Conscientious Objection to Abortion Care in Europe and Beyond” at the conference “Abortion and Reproductive Justice: The Unfinished Revolution II” in Belfast in June 2016. Thanks also to Catherine Conlon, Shoshanna Ehrlich, Rumi Handen, Emily Jetmore, Juliana Morgan-Trostle, Michelle Oberman, Peadar O’Grady, Veronica O’Keane, Jo Murphy-Lawless, Suzanne Trostle, James Trussell, and the reviewers for their generous assistance. All translations from Spanish are by the author.

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