beginning I was not having success as a doctor because I did not understand the culture into which I was sent. During the first two weeks when I saw I was not succeeding, I decided to "be an anthropologist" and involving myself in understanding their way of life. Afterward, out of a group of people who got together for Bible studies in the Catholic church, we developed a program in which first the people in that group would be instructed in how to prevent diseases, especially infectious diseases, and they would augment vaccination coverage in their own family, and then when that was successful, they would show it to their neighbors. We were able to reduce the incidence of enteric infections by 50% among the population. Our vaccination coverage went up 100%.

EIR: Often various U.N.-related groups push the idea that indigenous groups are against modern medicine.
Maldonado: The population was open to anything that would help them, but they were not willing to give up their beliefs, their culture. For example, the population control office of Guatemala had a program which used what I would call blackmail.

EIR: This was a Planned Parenthood affiliate?
Maldonado: Yes, a woman wanted food for her children. She had to be doing some kind of population control with them. If she did not use it, she would not get the food. People went to a newspaper and said they thought it was unfair that only the indigenous were being targeted for population control, and not the Latinos or the European members of Guatemalan society. They felt it was a violation of their rights. I asked the people in the program that we did in Sacatepéquez if they wanted to control their families. They told me that for them children were blessings. If they were taught how to make better use of their lands, if people who taught agronomy would be brought in to show them how to make a better, wider, and ecologically safe use of their land, they would still have as many children as they wanted and they could feed them better. We were able to get some of the people from the agronomy faculty in Guatemala to teach them. Their production went up 102%. And they are not "planning" their families, which is a very private matter.

EIR: You lived with a family that had 13 children.
Maldonado: I asked the father, don't you believe that 13 children are way too much? His answer was, I think, irrefutable: He told me that he was an honest worker, a good husband, he did not drink or smoke, he worked hard to provide for his family, and he taught them the ways of the Lord. He took his children to Mass every Sunday and to Bible study. And even now that his children are older and most of them help him, he told me, "When I die I will face God, and I will tell him, 'I took good care of the children you gave me. Can I come into Heaven?' And I am quite positive He will say yes."

Documentation

Is abortion reproductive health?

Excerpts of Dr. Mario Maldonado's statistical study follow (tables and graphics are omitted). It was circulated at the Cairo PrepComm, but ruled out of official deliberations.

The maternal mortality rate is a good measure of the quality of health care services that a country may have. Are elective abortions correlated with low maternal mortality? What are the costs of elective abortions?

Many of the "pro-choice" abortion advocates try to justify abortion with the high incidence of maternal mortality (deaths due to complications of pregnancy per 100,000 live births in one year) in countries where elective abortions—that is, abortion on social and economic grounds and on request—are illegal and not permitted. They believe that unwanted pregnancies will result in unsafe abortions that lead to a septic abortion. They claim that maternal mortality claims the lives of 500,000 women a year in the world, and that a large portion of those lives can be spared by legalizing abortion.

To prove their point they present the low maternal mortality rates in developed countries where abortion is legal on all grounds. . . .

To analyze these data with an objective perspective, one has to analyze the maternal mortality rates not only in the developed countries where elective abortions are legal and in the developing nations where elective abortions are illegal. To be objective, the available statistics of abortion rates and maternal mortality rates from all nations have to be included, including developed nations where elective abortions are illegal, and developing nations where elective abortion is permitted. Finally, to be both objective and scientific, simple presentation of rates is not enough; statistical analysis must be employed.

The correlation formula compares the standard deviations of two sets of data (abortion rate and maternal mortality rate) and grades the correlation from -1 to $+1$. To be statistically significant, a directly proportional correlation must be from $+0.61$ to $+1$; therefore, any correlation between -0.60 and $+0.60$ is not statistically significant, and due to chance.

If by legalizing elective abortions, the maternal mortality rates will diminish, there should be an inversely proportional relation between abortion rates and maternal mortality

rates—in other words, the higher the abortion rate, the lower the maternal mortality rate. Based on the pamphlet "World Abortion Policies 1994," published by the United Nations Department for Economic and Social Information and Policy Analysis, Population Division, the maternal mortality rates were compared with the abortion rates of most of the nations of the world, regardless of the local policies on abortion, with the correlation formula.

The correlation value that should be obtained if maternal mortality depends on whether elective abortions are permitted is -1, but this was not the case, since the obtained correlation was -0.07, or almost zero. Therefore, there is no statistically significant correlation between abortion rates and maternal mortality rates. . . .

Another argument presented by those who are in favor of legalizing elective abortions is that a high rate of fertility is correlated with a high maternal mortality rate. . . . By using the data presented by "World Abortion Policies 1994," the total fertility rate (the average number of children that would be born alive to a woman during her lifetime if she were to live through all her child-bearing years, conforming to the age-specific fertility rates of a given year) and maternal mortality rate (deaths per 100,000 live births), the abortion advocates' hoped-for correlation would be $+1$, but the obtained correlation was 0.595, which is not statistically significant. . . .

The cornerstone is development

Maternal mortality is not only due to septic abortions; in fact the most common causes of maternal mortality are uncontrolled bleeding, pulmonary embolism, puerperal infections, and ectopic pregnancies. Septic shock secondary to unsafe abortions is the fifth cause of maternal mortality. The cornerstone to lowering maternal mortality is development, not legalizing elective abortions. In other words, only by improving reproductive health care can maternal mortality be reduced. It is true that after legalizing abortion in the United States, the number of unsafe abortions diminished. The deaths secondary to unsafe abortions reduced from 18 per 100,000 live births to 3 per 100,000 live births. Impressive, and effective, but at what cost? The actual abortion rate in the United States is 26.4 legal abortions per 1,000 women ages 15-44. There are 58.881 million women ages 15-44, so each year 1.544 million fetuses are murdered, that is, assuming all the abortions were performed in single pregnancies, so the number might get a little bigger. The estimated births per year in the United States is 3.904 million, so the number of abortions per 100,000 live births is 39,805. So, to justify saving the lives of 15 women, 39,805 lives per 100,000 live births are lost. . . . Why, instead of offering an abortion, doesn't the government offer adoption services so that the woman who does not feel responsible enough to care for a child is given an alternative to putting her life and the life of the unborn child in danger? Could it be that it's cheaper to pay for an abortion? Where are the ethics?

An elective abortion is the termination of pregnancy before 28 weeks (viability) on grounds of social and economic reasons, and on request. Viability is considered as when the baby can survive outside the mother's womb. When is that? It depends on the level of advancement of neonatology. For example, in some developed countries, viability is considered at 24 weeks of gestation, while in some developing countries it is as high as 34 weeks of gestation, due to a lack of technology. Biologically, there are no significant differences between a pregnant woman with 25 weeks of gestation in the developed and developing nations.

So what is the difference between a fetus that has a gestational age of 28 weeks, and the fetus with a gestational age of 27 weeks and 6 days? Is one less human than the other? Well, according to the people who believe in legalizing abortion, there is a difference, since the 28-week fetus is spared, and the one-day-younger fetus can be terminated. . . .

With the advance of technology the gestational age for viability is diminishing. So,meday, in the near future, neonatologists will be able to help a premature baby with a gestational age of 10 weeks.

When does a fetus start to be considered a human? When is he entitled to enjoy his basic human rights? When should the state defend that human? According to the pro-choice advocates, at 20 weeks. Biologically, an individual is defined by having a specific genetic composition, which is unique to that individual and is shared only by genetic twins. So when is it that this individual's genetic composition is defined? At the moment of fertilization, since it is at conception that the chromosomes of both parents are mixed to initiate a new human being. If pregnancy is not terminated, the most likely outcome is a newborn baby. Every single human being who populates the Earth began at this stage. Every human being has the right to life, and even the unborn fetus is a human being, because he or she has a genetic composition that is unique and makes him or her a human being.

According to the World Health Organization's concept of reproductive health, "every individual has 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." We must remember that throughout pregnancy, beginning with fertilization and ending in the birth of a child, there are two individuals involved, the woman and the fetus. Is an aborted fetus a healthy infant? . . .

The key to providing reproductive health to every human being is development: only through the improvement of economy, education, health care, and protection of each individual's human rights, from the moment that an individual begins to exist—conception—to his death, which should never be in the hands of another human being.