

**AAPLOG-AMERICAN ASSOCIATION OF
PRO-LIFE OBSTETRICIANS AND GYNECOLOGISTS**

EXECUTIVE OFFICE: 339 River Ave, Holland, MI 49423 USA

Website: www.aaplog.org

Telephone: (616) 546-2639

Email: prolifeob@aol.com

March 5, 2010

Dear Mr. Trost and Mr. Vellacott,

We have read the article by Joyce Arthur (“*MP’s use harmful misinformation,*” *Saskatoon Star Phoenix, March 4, 2010*) and we offer our medical perspective as obstetricians and gynecologists to counter the misinformation that Ms. Arthur presents.

The American Association of Pro-Life Obstetricians and Gynecologists is one of the largest groups within the American College of Obstetrics and Gynecology. Many of our members actively serve in resource-poor areas, and thus we are intimately familiar with the real issues of maternal mortality in these countries. We submit the following analysis of Ms. Arthur’s claims:

1. Ms Arthur claims that ***“every country that has legalized abortion has seen dramatic decreases in deaths and serious complications due to unsafe abortion.”***

What she doesn’t say is that “unsafe” abortion is defined by the World Health Organization as including “abortions done in countries where abortion is illegal.”

“For estimation purposes, safe abortions were defined as those that meet legal requirements in countries in which abortion is legally permitted under a broad range of criteria. Unsafe abortion is defined by WHO as any procedure to terminate an unintended pregnancy done either by people lacking the necessary skills or in an environment that does not conform to minimum medical standards or both. These include abortions in countries with restrictive abortion laws as well as abortions which do not meet legal requirements in countries with less restrictive laws.”¹

Using this quasi-legal WHO definition of “unsafe” abortion, when a country legalizes abortion, the deaths and complications that result from abortions done in Marie Stopes or IPAS clinics are no longer counted as deaths and complications from “unsafe” abortion. Presto! The “unsafe” abortion problem has “dramatically decreased”. The women continue to be injured or die from hemorrhage and infection, but are now uncounted in WHO statistics.

¹ Induced Abortion: Estimated Rates and Trends Worldwide” (Lancet Vol 370, Oct 13, 2007. The definition references a WHO document: “WHO The preventions and management of Unsafe abortion report of a technical working group. Geneva. World Health Organization 1992 (WHOMSM/92.5)

Making an unsafe procedure legal does not make that procedure “safe”. The recent study of 22,368 legal medical abortions in Finland, compared with 20,251 legal surgical abortions demonstrated that one out of twenty women who underwent “safe” surgical abortion and 25% of women undergoing “safe” medical abortion had complications including hemorrhage, incomplete abortion and need for repeat surgery². As obstetricians and gynecologists we are keenly aware that the risks of any surgical procedure include bleeding and infection. These complications may be adequately handled in resource-rich medical systems. But what happens to women who live in countries without ready access to antibiotics, blood transfusions and hospitalization?

Induced abortion is also associated with an increased risk of preterm birth in subsequent pregnancies as attested to by the Epipage³, Europop⁴, and IOM⁵ studies, and over one hundred other studies⁶, including the most recent review in the *British Journal of Obstetrics and Gynecology*⁷. In resource rich western nations, preterm birth accounts for a significant percentage of the cost of pediatric medical care⁸. In nations without an abundance of medical resources, these preterm births would translate into neonatal deaths.

² Niinimäki, M., M.D., Pouta, A., M.D. PhD, Bloigu, A., Gissler, M., BSc, PhD, Hemminki, E., M.D, PhD, Suhonen, S., M.D., PhD, Heikinheimo, O., M.D. PhD. Immediate Complications After Medical Compared With Surgical Termination of Pregnancy. *OBSTETRICS & GYNECOLOGY* Vol 114, No 4, October 2009 795-804

³ Survival of very preterm infants: Epipage, a population based cohort study B Larroque, G Bre´art, M Kaminski, M Dehan, M Andre´, A Burguet, H Grandjean, B Lede´sert, C Le´ve`que, F Maillard, J Matis, J C Roze´, P Truffert on behalf of the Epipage study group *Arch Dis Child Fetal Neonatal* Ed 2004;89:F139–F144. doi: 10.1136/adc.2002.020396.

⁴ Ancel PY, Lelong N, Papiernik E, Saurel-Cubizolles MJ, Kaminski M. History of induced abortion as a risk factor for preterm birth in European countries: results of EUROPOP survey. *Human Repro* 2004; 19(3): 734-740.

⁵ Institute of Medicine: Preterm Birth: Causes, Consequences, and Prevention *National Academy of Science Press*, July 06 Appendix B Table 5 “Immutable Medical Risk Factors Associated with Preterm Birth”.

⁶ AAPLOG submission to the United Nations High Commissioner on Human Rights, Nov 27, 2009. Attachment 1. Studies demonstrating an association between Abortion and Preterm Birth in subsequent pregnancies. (Total studies 113)

⁷ Shah P, Zao J on behalf of Knowledge Synthesis Group of Determinants of preterm/LBW births. Induced termination of pregnancy and low birthweight and preterm birth: a systematic review and meta-analyses. *BJOG* 2009;116:1425–1442.

⁸ Calhoun BC, Shadigian E, Rooney B. Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Informed Consent. *J Reprod Med* 2007; 52(10):929-937.

Over 100 studies in the medical literature demonstrate that women undergoing induced abortion have a significantly increased risk of subsequent suicide, major depression and substance abuse, as compared with women who bring to birth⁹.

Studies which have looked at long term consequences of medical abortion regimens have revealed risks similar to those for surgical abortion.¹⁰

In addition to the direct effects of induced abortion on women, there is the dangerous diversion of financial resources from interventions known to reduce maternal mortality: prenatal care, skilled birth attendants, antibiotics and oxytocin. It is scientifically, medically and morally unacceptable to divert resources from interventions proven to reduce maternal mortality and channel them to political agenda of global legalization of abortion.

What has been documented in every country where abortion has been legalized is that legalization has resulted in an increase in total numbers of induced abortion, not a decrease. Women experiencing known complications of abortion in resource poor countries do not have access to necessary emergency care, or are too ashamed to seek it. By increasing total numbers of abortions, legalization in resource poor countries effectively amplifies maternal morbidity and mortality.

2. Ms Arthur states: ***“The MPs commit a logical error by equating a country's overall maternal mortality rate with the legal status of abortion, because a wide variety of medical and social factors impact maternal health.”***

Ms. Arthur well states that nations with legalized abortion do not reflect lower maternal mortality rates. This is in fact the point that the MP's are making. The “wide variety of medical and social factors” which impact maternal health are well known: a) presence of skilled birth attendants, b) availability of emergency obstetrical care, c) availability of oxytocin and d) availability of antibiotics. These have long been recognized as the factors which correlate with decreased maternal mortality, and it is precisely these areas which deserve immediate funding.

3. Ms. Arthur states: ***“Unsafe abortion is only one cause of maternal mortality, although it's a major one that is entirely preventable. Thirteen per cent of deaths from pregnancy-related causes are due to unsafe, usually illegal abortion.”***

⁹ AAPLOG submission to the United Nations High Commissioner on Human Rights, Nov 27, 2009. Attachment 2. Studies demonstrating an association between Abortion and Adverse Mental Health Outcomes. (Total studies 102)

¹⁰ Virk, Jasmee, MS, MPH, Zhang, Jun MD, PhD, and Olsen, Jar MD, PhD. Medical Abortion and the Risk of Subsequent Adverse Pregnancy Outcomes N Engl J Med 2007;357:648-53.

According to “WHO Analysis of Causes of Maternal Death: A Systematic Review”, the breakdown of causes of maternal death attributable to abortion, from Table 1: Joint Distribution of Causes of Maternal Death¹¹ is as follows:

Africa: 3.9% of maternal deaths attributable to abortion;
Asia: 5.7% of maternal deaths attributable to abortion;
Caribbean: 12% of maternal deaths attributable to abortion;
Developed Countries: 8.2% of maternal deaths attributable to abortion.

There are two things to note:

A) The vast majority of maternal deaths (over 95% in Africa, 94% in Asia and 88% in the Caribbean) are from causes that could be reduced or eliminated by skilled birth attendance, emergency obstetrical care, antibiotics and oxytocin. It is grossly immoral to divert scarce resources needed to provide skilled birth attendants, emergency obstetrical care, oxytocin and antibiotics and instead channel those resources to providing abortion, which damages or kills the mother, and kills or maims the unborn child.

B) In Developed Countries, where induced abortion is legal, 8.2% of maternal deaths are due to abortion.

4. Ms. Arthur states: ***“At least 68,000 women die every year from unsafe abortion and eight million are injured, mostly in poverty-stricken regions in Africa, Latin America, and Asia.”***

Again, Ms. Arthur cites figures without references. In fact it is amazing that Ms. Arthur can state with such certainty numbers which are known to be educated guessing with many assumptions of unsubstantiated validity. In commenting on WHO statistics as published in the October Lancet 2007 series devoted exclusively to Maternal Mortality, the editorial by Yazbek refers to this statistical guesswork underlying maternal mortality statistics:

“What stands out beyond Hill and colleagues’ main findings, however, is that years after the launch of the MDG agenda, a crucial indicator such as maternal mortality remains so difficult to measure. The honesty of the authors, about the difficult methodologies used and the guesswork that continues to play too large a role, points to the continued challenges faced by countries and the global health community in measuring this important outcome. This failure comes from the inability of national health programmes to measure and explain the causes of maternal mortality, . . . We find ourselves in a situation in which a global effort, defined mainly by measuring outcomes and outputs (the MDGs), is unable to measure a crucial outcome and not likely to do so with any confidence at the national level for the foreseeable future. It is highly likely that, 5 years from now, the agencies that sponsored Hill and colleagues’ work will find themselves yet

¹¹ Khan, Khalid S, Wojdyla, Daniel, Say, Lale, Gulmezoglu, Metin, Van Look, Paul F. “WHO analysis of causes of maternal death: a systematic review.” Lancet 2006; 367:1066-74. March 2006. Table 1: Joint distribution of causes of maternal deaths. At page 1068.

again reporting on maternal mortality at the global and country level by using tortuous statistical techniques and educated guessing.”¹²

5. Ms. Arthur states: ***“Even where abortion is legal there may be many barriers to safe abortion, including cost, accessibility, a dearth of providers, stigma, and lack of confidentiality. For example, India has liberal abortion laws, but two out of every five abortions performed are still unsafe because of poverty and inadequate health-care systems in rural areas. Cambodia, Zambia, and South Africa are other countries with legal abortion but inadequate access to safe services.”***

This statement does not support Ms. Arthur’s premise that funding abortion services will decrease maternal mortality. Induced abortions are not safe even if they are legal. Funding induced abortion in the setting of resource poor nations who do not have the infrastructure to handle even the simplest complications of hemorrhage and infection is intrinsically dangerous. And even under the best of circumstances, the medical literature demonstrates that legal induced abortion greatly increases the risk of very preterm births, and the risks of suicide, hospitalizable major depression and substance abuse. Proliferation of induced abortion is a public health catastrophe for resource-poor nations.

6. Ms. Arthur states: ***“Illegal abortion has also become much safer in the last few years for women able to access some resources. Many women can now obtain drugs to induce a miscarriage -- either misoprostol from a pharmacy, or mifepristone (RU-486) over the Internet. Even when used without medical supervision, these drugs are far safer than traditional self-abortion methods, which include inserting sharp sticks into the uterus, drinking turpentine, or jumping off a roof.”***

Ms Arthur displays her gross ignorance of the facts about medical abortions, especially in resource poor nations whose medical system is not equipped to deal with the known complications.

The recent study of 22,368 “safe” medical abortions in Finland, compared with 20,251 “safe” surgical abortions demonstrated that medical abortion had complications including hemorrhage, incomplete abortion and need for repeat surgery.¹³

“The overall incidence of adverse events was fourfold higher in the medical compared with surgical abortion cohort (20.0% compared with 5.6%, $P < .001$). Hemorrhage (15.6% compared with 2.1%, $P < .001$) and incomplete abortion (6.7% compared with 1.6%, $P < .001$) were more common after medical abortion. The rate of surgical (re)evacuation was 5.9% after medical abortion and 1.8% after surgical abortion ($P < .001$). Although rare, injuries requiring operative

¹² Yazbek, Abdo. “Challenges in Measuring Maternal Mortality.” *Lancet*. Vol 370. Oct 13 2007, p1290-1.

¹³ Niinimäki, M., M.D., Pouta, A., M.D. PhD, Bloigu, A., Gissler, M., BSc, PhD, Hemminki, E., M.D, PhD, Suhonen, S., M.D., PhD, Heikinheimo, O., M.D. PhD. Immediate Complications After Medical Compared With Surgical Termination of Pregnancy. *OBSTETRICS & GYNECOLOGY* Vol 114, No 4, October 2009 795-804

treatment or operative complications occurred more often with surgical termination of pregnancy (0.6% compared with 0.03%, $P < .001$).”

An examination of the first 605 Adverse Event Reports submitted to the FDA in the United States in the first three years of “safe” mifepristone (*Mifegyne*) abortions in the United States, revealed that one third of the women with adverse events (237) experienced severe bleeding requiring emergency surgery, half of these required hospitalization, and forty two women bled over half of their blood volume; these events would be fatal in resource poor nations.¹⁴ The rate of complications seen with “safe” mifepristone and misoprostol abortions increases with the use of misoprostol alone. In a WHO sponsored study, one out of every five women who had “safe” misoprostol abortions failed to abort¹⁵ and required surgical intervention, or continued a pregnancy now exposed to a teratogenic drug^{16 17}. Medical abortion has been linked to deaths from *Clostridium sordelii* infection, for which the case fatality rate approaches 100%.

It doesn't take a rocket scientist to understand that promotion of medical abortion in resource poor nations will predictably increase the risk of hemorrhage, infection and incomplete abortion in medical systems unable to provide adequate medical care for these women.

7. Ms. Arthur states: ***“The expanded use of drugs for self-abortion appears to be significantly reducing maternal mortality rates in many developing countries”.***

Ms Arthur makes many assertions for which she cites no sources.

8. Ms Arthur states: ***“The MPs mention Guyana (in South America) as an example of a country with high maternal death rates and liberal abortion laws. But before Guyana legalized abortion in 1995, septic abortion was the third highest cause (19 per cent) of hospital admissions. Six months after the new law, there was a 41 per cent reduction in hospital admissions for septic abortions. Maternal mortality remains high in Guyana for***

¹⁴ Gary, M.M., and Harrison, D.J., Analysis of Severe Adverse Events Related to the Use of Mifepristone as an Abortifacient The Annals of Pharmacotherapy 2006 Feb. Vol 40 (Online, 27 Dec 2005, www.theannals.com, DOI 10.1345/aph.1G481).

¹⁵ von Hertzen H, Piaggio G, Huong NT, Arustamyan K, Cabezas E, Gomez M, Khomassuridze A, Shah R, Mittal S, Nair R, Erdenetungalag R, Huong TM, Vy ND, Phuong NT, Tuyet HT, Peregoudov A; WHO Research Group on Postovulatory Methods of Fertility Regulation. UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, Department of Reproductive Health and Research, WHO, Geneva, Switzerland. vonhertzenh@who.int . Efficacy of two intervals and two routes of administration of misoprostol for termination of early pregnancy: a randomized controlled equivalence trial. Lancet. 2007 Jun 9;369(9577):1938-46.

¹⁶ British Journal of Obstetrics and Gynecology 107 (April 2000): 519-23.

¹⁷ Vargas, FR, et. al. Prenatal Exposure to Misoprostol and Vascular Disruption Defects: A Case Control Study. Am Journal of Medical Genetics 95 (2000) 302-306.

other pregnancy-related causes, and is attributed to factors such as extreme poverty and political instability.”

Again, Ms. Arthur makes assertions with no cited references. It would be interesting to know where her data comes from.

WHO does not recognize the categories of “extreme poverty” and “political instability” as “pregnancy-related” causes of maternal mortality.

9. Ms. Arthur states: ***“Chile and El Salvador are cited by the MPs as examples of countries with strict abortion laws and low or decreasing maternal death rates. But in both countries -- as well as Nicaragua -- reductions in maternal deaths reflect other causes, including family planning programs and improvements to health systems.”***

This in fact underlines the importance of funding skilled birth attendants and adequate health facilities, not induced abortion, as the key to successfully decreasing maternal mortality.

10. Ms. Arthur states: ***“In fact, the latter figure for Nicaragua represents a new phenomenon -- the government passed an abortion law in 2008 that eliminated all exceptions, including for rape, incest, and the life or health of the woman. As a result, in the first 19 weeks of 2009, 16 per cent of all maternal deaths were from unsafe abortion, compared to none in the same period in 2008.”***

Again, Ms. Arthur has her facts wrong, as attested to by the letter from the Nicaraguan Medical Association published in response to such bogus statistics as purported by Ms. Arthur (*copied on next page.*)

Letters

Nicaragua and abortions

The Associated Press story "Nicaraguan abortion ban proves deadly" (World Briefing, Nov. 27) is misleading and grossly inaccurate.

The facts: In November 2006, with massive support of the people of Nicaragua and their elected representatives, legislation went into effect removing an outdated, phony "therapeutic" abortion exception that was open to abuse and incompatible with modern medical, moral and legal principles.

In the year since the pro-life legislative change went into effect:

1) Maternal deaths declined 23 percent in the first 47 weeks of 2007.

2) These maternal deaths reported by the Ministry of Health of Nicaragua include all kinds of deaths from the beginning of pregnancy until six weeks after delivery (accidents, murders, suicides and non-obstetrical deaths).

3) Eighty percent of those deaths occur at the end of pregnancy from conditions such as eclampsia, hemorrhages and puerperal sepsis.

4) No woman has died in Nicaragua for not having a "therapeutic" abortion since the practice was banned in November 2006.

5) As before, women with complications from pregnancy must be offered necessary treatment, even if such treatment may indirectly cause the death of their unborn babies. The law allows such medical procedures, and physicians failing to provide such care are liable.

The above positive results are similar to those in other countries with strict anti-abortion legislation, such as Chile, El Salvador and Ireland.

Another positive result, not in any way to be minimized, is that more Nicaraguan children have escaped the abortionists' knives, poisons and suction machines.

This AP story has helped fuel unprecedented international interference in Nicaragua's national life. For more than a year, our country has been subjected to intense pressure, not only from the usual radical feminist and mis-

guided human rights internationalists, but also from some foreign governments, including some European countries that have threatened to cut off their financial aid to our country if we don't change our law to suit their pro-abortion views.

Thankfully, Nicaragua has been able so far to resist this pressure. Our sovereignty is still intact. The entire free world needs to look up to Nicaragua as an example of courage and strength in the face of a never-before-seen effort to strip Nicaragua of its sovereignty and dignity.

DR. WALTER MENDIETA
President
Asociacion Medica Nicaraguense
Managua, Nicaragua

Lucia Bohemer
President
Asociacion Nicaraguense de la
Mujer
Managua, Nicaragua

Dr. Rafael J. Cabrera
Rector
Universidad de Ciencias Medicas
Managua, Nicaragua

In summary, the statements made by Ms. Arthur do not reflect medical fact. If the Canadian government is truly interested in decreasing maternal mortality in resource poor areas – a most laudable goal – then funding should go to those areas proven to decrease maternal mortality: funding of skilled birth attendants, emergency obstetrical care, antibiotics and oxytocin.

Respectfully submitted,

Donna J. Harrison, B.A., B.S., M.D. ABOG certified
President,
American Association of Pro-Life Obstetricians and Gynecologists
www.aaplog.org.