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To the Editor,

In response to the article "*MP's use harmful misinformation",* the American Association of Pro-Life Obstetricians and Gynecologists would like to address Ms. Arthur's misinformation. AAPLOG 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 are intimately familiar with the real medical issues surrounding maternal mortality in developing countries.

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 W.H.O. as including "abortions done in countries where abortion is illegal".

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.

Making an unsafe procedure legal does not make that procedure "safe".

The recent Finnish study comparing "safe" medical to "safe" surgical abortion demonstrated that 5% of women who underwent surgical abortion and 25% of women undergoing medical abortion had complications including hemorrhage, incomplete abortion and need for repeat surgery[1]. In the first 4 years that RU486 was approved in the U.S. at least 237 women experienced hemorrhage requiring emergency surgery, forty two women bled over half of their blood volume.[2] At least 10 women have died from

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[1] 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

[2] 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).

infection. What happens to women who live in countries without ready access to antibiotics, blood transfusions and hospitalization?

Complications increase with the use of misoprostol alone. In one W.H.O. study, 20% of women who had "safe" misoprostol abortions failed to abort[3] and required surgery, or continued a pregnancy now exposed to a teratogenic drug[4] [5].

Over 100 studies in the medical literature demonstrate that induced abortion (compared to birth) is associated with an increased risk of preterm birth in subsequent pregnancies[6]. In resource rich western nations, preterm birth accounts for a significant percentage of the cost of pediatric medical care[7]. In resource poor nations, these preterm births translate into neonatal deaths.

Over 100 studies demonstrate that women undergoing induced abortion (compared to birth) have a significantly increased risk of suicide, major depression and substance abuse[8]. In resource-poor nations, this becomes increased suffering for women.

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[3] 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.

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

[5] 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.**

[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] 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.

[8] 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)

Nations with legalized abortion do not demonstrate lower maternal mortality rates, in part because where abortion has been legalized, total numbers of abortions dramatically increase and so do the absolute number of complications from abortion.

The major causes of maternal mortality in resource poor nations are hemorrhage, infection, hypertension, obstructed labor and anemia.

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.

According to the W.H.O. the breakdown of causes of maternal death attributable to abortion[9] are as follows:

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

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 oxytoxin, not by promotion of induced abortion.

The success of Chile and El Salvador in reducing maternal mortality while protecting unborn human life demonstrates that promotion of abortion is unnecessary to reduce maternal mortality. Funding skilled birth attendants, emergency obstetrical care and adequate health facilities, not induced abortion, is the key to successfully decreasing maternal mortality.

A letter from the Nicaraguan Medical Association was published in response to the bogus statistics quoted by Ms. Arthur. In fact, maternal deaths declined 23% in the first 47 weeks after the prolife legislation went into effect, and no woman in Nicaragua died from not having an abortion.

If the Canadian government is truly interested in decreasing maternal mortality in resource poor areas- a most laudable goal- then funding should go to areas proven to decrease maternal mortality: skilled birth attendants, emergency obstetrical care, antibiotics and oxytocin.

Respectfully submitted,

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[9] 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.

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