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Induced Abortion & the Increased Risk of Maternal Mortality

After years of failure to obtain accurate statistics on maternal mortality, the United States has noted a sharp increase in its maternal mortality rate, with widening racial and ethic disparities. While some of this increase may be a result of improved data collection, pregnancy-related deaths are occurring at a higher rate in the United States than in other developed countries. In order to implement effective strategies to improve pregnancy outcomes, this must be investigated in an unbiased manner, and novel contributing factors need to be considered.

Background

A pregnancy question was added to the United States standard death certificate in 2003 in order to improve the identification of maternal deaths. The individual states were initially inconsistent in implementing a pregnancy checkbox on death certificates, rendering data so useless that the United States (U.S.) did not publish an official maternal mortality report between 2007 and 2016.[1]

Using novel correction factors to standardize death certificate data, a 2016 report shocked the nation by documenting a 26% increase in maternal mortality from 18.8/100,000 live births in 2000 to 23.8 in 2014. Suggested etiologies of the rise included: artifact as a result of improved maternal death surveillance,[2] incorrect use of ICD-10 codes,[3] health care disparities,[4] lack of family support and other social barriers, substance abuse and violence,[5] depression and suicide,[6] inadequate preconception care, patient noncompliance, lack of standardized protocols for handling obstetric emergencies,[7] failure to meet expected standards of care,[8] aging of the pregnant patient cohort with associated increase in chronic diseases and cardiovascular complications,[9] lack of a comprehensive national plan, and defunding women's healthcare by "demonizing Planned Parenthood."[10,11] State maternal mortality review committees suggested that 60% of these deaths may be preventable.[12]

Maternal mortality definitions

Deaths are categorized based on their causation and proximity to the end of the pregnancy:

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- "Maternal death" is the death of a woman while pregnant or within 42 days of the end of her pregnancy, irrespective of the duration or site of the pregnancy or its management, excluding accidental or incidental causes.
- "Late maternal death" is the death of a woman from direct or indirect obstetric causes more than 42 days, but within 365 days of the end of the pregnancy.[13]
- "Pregnancy-related death" is the death of a woman while pregnant or within 365 days of the end of pregnancy, in which pregnancy may have contributed to the cause of the death.
- "Pregnancy-associated death" is the death of a woman while pregnant or within 365 days of the end of pregnancy from a cause that is either not related to pregnancy or pregnancy-relatedness cannot be determined.

The World Health Organization reports only deaths occurring during pregnancy or within 42 days of the end of pregnancy in defining maternal mortality, while the Division of Reproductive Health at the Centers for Disease Control and Prevention (CDC) reports all pregnancy-related deaths occurring within one year of the end of pregnancy. Both report maternal mortality rate as the number of maternal deaths/1000 women of reproductive age.[14]

An ideal mortality rate would be achieved by calculating the number of maternal deaths/100,000 pregnancies. That is not feasible because the number of spontaneous pregnancy losses are difficult to record and induced abortion data is not shared. Since the number of live births can be accurately measured due to mandated reporting on birth certificates, epidemiologists assume that the number of live births is a good representation of the number of pregnancies.[15] They developed a measure of disease known as the maternal mortality ratio and define it as the number of pregnancy-related deaths/100,000 live births. This is a mortality ratio, not a rate.

Similar to the total "number of pregnancies" needed in the denominator, the number of "pregnancy-related deaths" in the numerator is not known. Two out of three maternal deaths occur in conjunction with a live birth.[16] The rest may be separated from the end of pregnancy by days, weeks, or even months, and include spontaneous and induced end of pregnancy events. The U.S. does a poor job of accurately detecting maternal deaths,[17] and studies show as many as 50% of maternal deaths may be missed on death certificates.[18,19]

Racial and ethnic disparity

Maternal mortality in minority women, particularly non-Hispanic Black women, has skyrocketed. Black women have maternal mortality rates 3.3 times higher than white women.[20] Unfortunately, there have been accusations that this is a result of implicit racism held by healthcare providers – the care provided to Black women or poor women is not as good as the care provided to non-Hispanic white women or affluent women. Limiting the discussion to implicit racism does a disservice to women of color

and women in poverty by ignoring other factors that contribute to maternal mortality.

Poverty is certainly a risk factor for failure to obtain appropriate medical care and might be expected to contribute to the excess maternal mortality rates in Black women (20% of whom live in poverty, compared to 16% Hispanics and 8% whites). Domestic violence and mental health disorders are also seen more commonly in impoverished communities. In 2011, Illinois reported that 13% of its maternal deaths were the result of homicide. Black mothers bore the greatest risk, accounting for 43% of the maternal homicide deaths while composing only 14% of the population.[21] Texas has been noted to have extremely high maternal mortality rates, and an examination of deaths in 2011-2012 found that overdoses, homicide, and suicide accounted for almost 20% of the maternal deaths.[22] Poverty and poor social and family support are causes of the disparity noted in maternal mortality rates.[23]

Giving birth and caring for a child without a partner places a woman at an obvious disadvantage. She is more likely to live in poverty without the resources she may need to seek health care. If she should become ill during or after pregnancy, she may not seek emergency care due to lack of social support, childcare, or transportation. It should be noted that only 5% of married couples live in poverty. In 2017, 67% of Black women were unmarried when they gave birth to children, compared with 39% of Hispanic women and 27% of white women.[24] Prior to 1950, a Black woman was more likely to be married than a white woman, with marriage rates nearing 80%, but marriage rates for Black women have since plummeted.[25] Could the breakdown of the Black family be a root cause of the disparity in maternal mortality rates?

It is noteworthy that there are significant differences in birth outcomes in Black women compared with non-Hispanic white women. The rates of natural losses are similar (16%), but 34% of pregnancies in Black women end in induced abortion, compared to 11% for white women. Less than half of pregnancies in Black women result in the birth of a live baby (48%). Induced abortion is 3.7 times more common in Black than in non-Hispanic white women, and Black women more commonly have later abortions (13%) compared with white women (9%).[26] It is known that the risk of death increases by 38% for every week after eight weeks gestation.[27] It is possible that the higher rate of legal induced abortion may account for most of the racial disparity noted in pregnancy mortality.

Genetic determinants of health are important. For example, thrombophilia is more prevalent in non-Hispanic Black women and this is a risk factor for pulmonary embolus or thrombotic strokes, both causes of maternal mortality.[28] Social determinants of health are paramount; poverty is linked to obesity, diabetes, and hypertension. Obesity is more prevalent in Black women (46.8%) and Hispanic women (47%) than white women (37.9%).[29] Diabetes is higher in Black (12.7%) and Hispanic (12.1%) than in non-Hispanic white women (7.4%).[30] The rates of hypertension are higher among Black (40.4%) compared to non-Hispanic white (27.4%) or Hispanic women (26.1%).[31] If a woman is predisposed to hypertension, the likelihood that she will develop preeclampsia or eclampsia increases substantially. Obesity,

diabetes, and hypertension predispose women to early obstetrical interventions and Cesarean sections, both of which are linked to increased maternal mortality.

A ten-year Harvard study completed in 2016 found that implicit bias based on race decreased by 17% and explicit bias decreased by 37%.[32] If racial bias reported in the Harvard study was the sole cause of maternal mortality, pregnancy-related mortality in the non-Hispanic Black community should have decreased. It has not. To discuss the effects of years of legalized racism without identifying antecedent enslavement is implicit bias and it promotes the idea that Black and non-Black women start on an equal playing field. It confirms the stereotype that Black women, through their reckless behavior, place themselves far behind the rest of the population. Victim-blaming subtly diverts attention from racism, discrimination, segregation, and the powerlessness of the ghetto.[33] Victim-blaming leads to inappropriate ventures, such as placing abortuaries in Black neighborhoods. Abortionists are like carpetbaggers,[34] nonresidents seeking gain by taking advantage of communities of color. Compounding structural inequality, abortion advocates effectively perpetuate Jim Crow era suppression.

The effects of family disruption by enslavement's forced displacement followed by a long history of voluntary migration due to legalized racism are still apparent in the separation of family units, structural inequality, and the resultant high prevalence of poverty. Poverty is a cause of physical disease, emotional stress, and mental health distress. Victim-blaming abortion advocacy organizations have a long history of targeting minority communities. Inflicting abortion, often in advanced pregnancy, is documented to lead to increased risk-taking behavior that results in death from drug overdose, suicide, or homicide. Induced abortion may be a root cause of the racial and ethnic pregnancy-related mortality disparity. Addressing contextual-level social determinants of health could eliminate this disparity.

Determining pregnancy-related deaths

The Centers for Disease Control and Prevention (CDC) rely heavily on death certificates to determine maternal deaths, but death certificates have been proven unreliable in accurately identifying all maternal deaths. Deaths due to live births are likely to be the most accurately recorded because most live births occur in a hospital setting or with the assistance of medical personnel. However, deaths from other pregnancy outcomes, such as induced abortion, are not accurately reported.[35] Inconsistent implementation of a pregnancy checkbox on death certificates and search engine failures to provide ICD-10 obstetric-specific codes for abortion-related deaths thwart this documentation.[36] For example, the Texas Maternal Mortality Task Force discovered that more than 50% of the maternal deaths identified by ICD-10 obstetric codes showed no evidence of pregnancy and another 10% had insufficient information to determine whether a pregnancy had occurred.[37] Either these deaths were erroneously coded as pregnancy-related, or the deaths were subsequent to spontaneous or induced losses early in pregnancy and not able to be correlated with fetal birth or fetal death certificates. Independent providers perform almost all abortions in Texas and these records are not available. In Finland,

73% of maternal deaths were not identified on death certificates, demonstrating the clear inadequacy of death certificate data alone.[38] The quality of U.S. pregnancy-related mortality data is poor.

Determining induced abortion deaths

Published abortion mortality rates are inaccurate because the total number of legal abortions performed in the U.S. is not known.[39] Estimated numbers of abortions are voluntarily reported to the CDC by state health departments. California, the state with the largest volume, does not report any data.[40] The Guttmacher Institute also tracks these numbers and it consistently reports higher numbers than the CDC. For example, the CDC reported 652,639 abortions in 2014 while the Guttmacher Institute reported 926,000.[41,42] Twenty-seven states require abortion providers to report complications but there are no enforcement penalties for noncompliance. Only 12 states require coroners, emergency rooms, and other healthcare providers to report abortion-related complications or deaths for investigation.[43]

If an abortion initiates a cascade of events resulting in death, only the closest antecedent events may be listed on the death certificate due to space limitations and provider time constraints. Since most abortion providers lack hospital admitting privileges, other healthcare providers are required to provide hospital care. The physician certifying the death may be unaware of the abortion or mistakenly believe that a miscarriage led to the complications. Furthermore, ideological commitments may lead a certifier to omit this information.[44,45] Due to the social stigma surrounding abortion, families of women dying from complications are unlikely to initiate malpractice lawsuits. Correlating public documentation of malpractice cases with autopsy reports, an investigative reporter was able to document 30% more abortion-related deaths nationwide than the CDC. The reported death rate from abortion represents only the tip of the iceberg, a problem much larger than it appears.

There has been widespread misinformation about abortion. It seems as if deaths rarely occur and abortion is perceived to be a very safe procedure. When discussing maternal and induced-abortion-related mortality, consideration is often given only to complications that can occur in a term, gravid uterus rather than recognizing that physiologic changes begin as soon as a pregnancy commences. Induced abortion interrupts this normal physiology and there are unique risks due to this intervention. Historically, surgical dilation and sharp curettage (utilizing a sharp curette rather than a suction catheter) had been used in the first trimester of pregnancy, but this more frequently resulted in uterine trauma.[46]

Significant complications may occur with a surgical abortion, so it is not surprising that women opt to have mifepristone-induced pregnancy terminations (medical abortions) performed instead. Accounting for 31% of U.S. abortions, medical abortions are performed until 10 weeks gestation by administering mifepristone and misoprostol. A medical abortion disrupts hormones that maintain the pregnancy and causes uterine contractions that eventually expel the baby and the placenta. Yet, most women are unaware that the complication rate is four times

higher with this procedure than with surgical abortion. The most common complication is hemorrhage with almost 8% of women experiencing incomplete abortions requiring surgical completion. Other serious complications of medical abortions include uterine perforation (0.2-0.5%) and uterine rupture (0.28%) in women who have had prior Cesarean sections.[47] Animal models of medical abortion warn of the potential for long-term negative well-being indicative of depression and anxiety.[48] Both mifepristone and misoprostol disrupt innate immunity and fatal cases of septic shock following medical abortion have occurred.[49,50] In 2003, 40% of legal induced abortion deaths occurred following medical abortions.[51]

Beginning in the second trimester, dilation and evacuation (D&E) is the surgical method necessary because the pre-born baby has grown large enough that it cannot be removed through a suction cannula.[52] The risks of D&E abortions include hemorrhage and cervical laceration (3.3%) and retained body parts and/or placental tissue (1%). Non-intact D&E is commonly referred to as a "dismemberment" abortion because the preborn baby is removed in a piecemeal fashion with instruments. Intact D&E, also known as dilation and extraction (D&X) or "partial birth" abortion, has been illegal in the U.S. since 2003.[53] During that procedure, the preborn baby's feet first appear, which the abortionist grabs and pulls until the body delivers. Once the bottom of the baby's head is exposed, the abortionist evacuates its brain with a vacuum, causing its skull to collapse, which finally enables delivery. The increased size of the pre-born baby and increased amount of placental tissue requires a greater degree of cervical dilation, while the thin, relaxed uterine myometrium is more likely subject to mechanical perforation and resulting catastrophic hemorrhage.[54,55]

Historically, saline or prostaglandin was infused into the amniotic sac in late-term abortions to kill the pre-born baby and induce labor. Maternal deaths occurred due to fluid imbalances and infections. Hysterotomy abortion (performing a Cesarean section to complete a late-term abortion) is rarely used because it is a major surgical procedure.

Labor induction is the method used to perform extreme late-term abortions. Labor-induction abortions are often complicated by immediate maternal hemorrhage, requiring an invasive surgical procedure to extract retained placental tissue. A large European study documented that more than half of the babies survived delivery in post-viability induced abortions.[56] If a baby is born alive, the abortionist may complete the abortion by performing active or passive infanticide.[57] Many abortionists perform feticide via intracardiac or intra-amniotic injections to avoid this dreaded complication.

Severe physical injuries occur from surgical abortion. Experienced abortionists not infrequently damage adjacent organs or major blood vessels as they insert suction curettes or grasping forceps into the soft, gravid uterus.[58,59] Injury to adjacent major blood vessels and/or gynecologic, genitourinary, or gastrointestinal organs requires emergency abdominal surgical exploration to perform a hysterectomy, bowel resection, bladder repair, or other repair.[60,61] Death from induced abortion can occur due to vaginal and intra-

abdominal hemorrhage, sepsis, thrombotic emboli, intravascular amniotic or air emboli, complications of anesthesia, and cardiac or cerebrovascular events.

Forcibly opening a cervix that is designed to remain closed until natural childbirth may result in cervical trauma and cervical incompetence in future pregnancies. This weakened cervix may dilate early in a subsequent pregnancy, predisposing the woman to premature rupture of membranes, intrauterine infections, and possible sepsis. Statistically significant studies show a connection with preterm birth. One meta-analysis found that there was a 25% increased risk of premature birth in a subsequent pregnancy after one abortion, 32% after more than one, and 51% after more than two abortions.[62] Another meta-analysis found a 35% increased risk of delivery of a very low birth weight infant after one abortion, and 72% after two or more abortions.[63] Obstetrical interventions for the management of preterm birth raise the risk of maternal mortality.

Instrumental trauma to the endometrium may result in faulty placentation in subsequent pregnancies. The Placenta Accreta Spectrum (PAS) is abnormal placentation in which the placenta invades into the cervix, uterine wall, or other adjacent organs; it includes placenta accreta, placenta increta, and placenta percreta. In 1950, the incidence of PAS was 1:30,000 deliveries, but in 2016, the incidence was reported to be 1:272 deliveries.[64] This 110-fold increase in incidence raises the risk of pregnancy-related mortality, occurring in women with a history of uterine surgery, including induced abortion.[65] PAS can cause massive hemorrhage. Deaths occur even in high-level hospitals, and the fortunate survivors often require transfusion of scores of units of blood to save their lives.[66]

The frequency of abortion complications increases as the pregnancy advances due to greater technical complexity related to the anatomical and physiologic changes that occur.[67] Compared to early abortions, the relative risk of death was 76.6 times higher beyond 21 weeks (rate 8.9/100,000). It is known that the risk of death from abortion increases by 38% for each additional week beyond 8 weeks.[68,69,70] The American Board of Medical Specialties recognizes the inherent danger of late-term abortions. In 2018, it approved the new American Board of Obstetrics & Gynecology subspecialty "Complex Family Planning" to train abortionists to perform late-term abortions.[71]

In addition to the immediate physical risks to a woman from an abortion, there are long-term complications that increase a woman's risk of death. Stress accompanying voluntary or spontaneous pregnancy loss may adversely impact a woman's health and wellness.[72] Delivering a baby may have a protective emotional effect, whereas induced abortion may have a deleterious emotional effect.[73] A large meta-analysis found that women experienced an 81% increased risk of mental health problems after induced abortions: 34% increased risk of anxiety, 37% increased depression, 110% increased alcohol abuse, 230% increased marijuana abuse, and 155% increased suicidal behavior.[74] An eight-year retrospective study showed that those who aborted had significantly higher age-adjusted risks of death from suicide (254%) compared to those who delivered a baby.[75] A comprehensive record-linkage

study from Finland found that following an abortion, a woman was two to three times as likely to die within a year, six times as likely to commit suicide,[76] four times as likely to die from an accident, and fourteen times as likely to be murdered,[77] compared with a woman who carried to term.[78] Finnish studies also revealed that the risk of death from abortion (101 deaths per 100,000 ended pregnancies) was almost four times greater than the risk of death from childbirth (27 deaths per 100,000 ended pregnancies).[79] Mental health issues may contribute to drug overdoses, suicides, homicides, or even accidents due to risk-taking behavior, but our current system of data collection is not capable of linking these events to induced abortion.

Due to the paucity of complication data available in the U.S., the actual abortion-related mortality rate is undoubtedly much higher than reported.[80] Legal or ideological motivation can obscure the initiating event that led to death. In addition, the failure of most abortion providers to maintain hospital privileges forces a different hospital-based healthcare provider to treat the resulting complications.[81] It is not possible to link deaths related to early pregnancy events to an infant's birth or death certificate. Even in Finland, a country with single-payer healthcare and exceptional data linkage, 94% of abortion-related deaths are not identified on death certificates.[82] Due to restricted data access, poor record keeping, and lack of mandatory complication reporting, the actual induced abortion-related mortality rate in the U.S. cannot be determined.

Report of the National Academies of Sciences, Engineering, and Medicine (NAS)

In spite of these documented risks of abortion-related mortality, the NAS published a book that stated that induced abortion is extremely safe.[83] They concluded that serious complications or long-term physical or mental health effects are virtually non-existent; specifically, they denied that abortion increases the risk of preterm delivery or mental health disorders. They did not consider the increased risk of hemorrhage due to PAS that can occur with subsequent pregnancies. Abortion is so safe, they wrote, that it does not need to be performed by physicians. Trained midlevel practitioners can perform abortions in an office-based setting via telemedicine without the need for hospital admitting privileges, special equipment, or protocols for emergency transport of women with complications. They wrote that the only risks associated with abortion are the imposition of "barriers to safe and effective care" by some state legislatures.

Selection bias against the existence of delayed morbidity is obvious in the literature chosen by the NAS. A meta-analysis revealed a curious lack of interest by most investigators in the question of whether abortion is safer than childbirth. They purposefully excluded the eleven studies that provided results allowing comparison between the death rates associated with all possible pregnancy outcomes. These studies showed that the risk of death within 180 days is over twice as high following abortion compared to delivery and this risk remains elevated for at least ten years.[84] Compared with those who delivered a baby, those who underwent induced abortion had significantly higher

age-adjusted risks of death from all causes (162%), from suicide (254%), as well as from natural causes (144%).[85] The risk of death in a given year for a woman who was not pregnant was 57/100,000 women, but after an abortion, the risk was 83/100,000; after miscarriage, 52/100,000; and for those who carried a pregnancy to term, 28/100,000.[86]

Danish studies reported that the risk of death within 180 days after a first trimester abortion was 244% higher than the risk of death after childbirth; the risk of death after a late-term abortion was 615% higher than that after childbirth.[87] Stringent selection criteria allowed the NAS to disqualify these and other valid reports due to "study defects." For immediate morbidity, they allowed abortionists to control the dialogue by only discussing reports authored by them or their aligned organizations. This is known as "incestuous citing," allowing abortionists to cite each other to prove their points.[88] In California, Planned Parenthood aborts an alarming number of pregnancies and 317,000 of these abortions were reviewed.[89,90] Severe complications and deaths, particularly from nonaligned late-term abortion providers, have been reported in the media.[91] The refusal of California to report and the paucity of voluntary reporting nationwide yield the outcome that abortion advocates demand: most abortion complications are never identified. The NAS was aware of its selection bias and should have made a call for more studies, not a categorical dismissal that abortion complications are nonexistent.

Safety of abortion vs. childbirth

Epidemiologists define the abortion mortality rate as the number of induced abortion-procedure deaths/100,000 induced abortions. There are many pregnancy events that may result in mortality that are excluded from the denominator "100,000 induced abortions." If abortion-procedure deaths were erroneously or intentionally classified as pregnancy-related maternal deaths, this would inflate the maternal mortality ratio and decrease the abortion mortality rate. For example, a death from an induced abortion following intentional feticide could be coded as a death caused by a procedure to evacuate an intrauterine fetal demise. The abortion death rate must be higher than published because deaths from abortion are underreported and the numbers of abortions are inflated.

A widely-reported study concluded that abortion was 14 times safer than childbirth.[92] Abortion advocates even argue that since childbirth is so dangerous, abortion should be readily available so women can "opt out" of being pregnant. Is abortion really safer than childbirth? Abortion-related deaths were compared to the number of legal abortions, whereas pregnancy deaths were compared to the number of live births. One cannot compare the abortion-related mortality *rate* to the pregnancy-related mortality *ratio* – this is a meaningless exercise. Of the four variables used in the abortion-related mortality rate and the pregnancy-related mortality ratio, the number of live births is the only variable that can be accurately determined. The study used three impossible-to-quantify variables to compare

two disparate outcomes – a false equivalence.

Finland has universal health and data linkage, allowing it to use "ended pregnancies" as a common denominator when studying abortion-related vs. childbirth-related mortality. They reported that the risk of death from abortion (101 deaths per 100,000 ended pregnancies) was almost four times greater than the risk of death from childbirth (27 deaths per 100,000 ended pregnancies).[93]

This data is not available in the U.S., so one must implement different methodology to compare outcome-specific rates of abortion-related and childbirth-related mortality. Since abortion and most childbirth deliveries are done vaginally, and since abortion may increase the percentage of women undergoing Cesarean section in subsequent pregnancies due to preterm birth and abnormal placentation, Cesarean deliveries should be excluded when comparing the safety of childbirth and abortion. To make a valid comparison, an outcome-specific rate for maternal mortality must be used: mortality associated with vaginal childbirth. The vaginal delivery maternal mortality rate is calculated as the number of vaginal-childbirth-maternal deaths/100,000 vaginal deliveries.[94] Using outcome-specific rates, the mortality rate for vaginal delivery is 3.6 deaths/100,000 vaginal deliveries,[95] while the rate for abortion performed at 18 weeks or later is 7.4 deaths/100,000 abortions.[96] Put another way, the risk of death from these abortions is more than double that for women who deliver vaginally.

Summary of Recommendations and Conclusion

Recommendations:

1. Advocate for better data collection, especially correlating current outcomes and historic early pregnancy events. Since the risk of death within 180 days of the end of pregnancy is over twice as high following induced abortion compared to childbirth, death certifiers must document early pregnancy events in order to increase the accuracy of mortality data. Access to study all deaths occurring within one year of the end of pregnancy will allow unbiased researchers to correlate current pregnancy outcome with early pregnancy and prior pregnancy adverse events, including legal induced abortion.
2. Enforce mandatory reporting of abortion complications and abortion-related deaths, with strict noncompliance penalties, to improve data collection and more accurately reflect abortion-related deaths.
3. Direct attention to the association of legal induced abortion with subsequent pregnancy complications requiring obstetrical interventions that increase risk of maternal mortality – sepsis and catastrophic hemorrhage.
4. Raise awareness that induced abortion is also associated with very preterm deliveries in subsequent pregnancies, forcing obstetrical interventions that

could increase the risk of maternal mortality.

5. Be aware that a woman's mental health status following legal induced abortion may be associated with increased risk-taking behavior leading to becoming a victim of homicide, suicide, or drug overdose.
6. Encourage additional research of the abortion-linked complications that have not been adequately studied, such as the abortion and breast cancer link.
7. Consider social determinants of health disparities, particularly as they contribute to the increased mortality of ethnic/racial minority mothers. Particular emphasis should be given to encouraging paternal engagement and increasing familial support.

Conclusion

Biased academic physicians have led the discussion on maternal mortality. Having economic ties to the abortion industry, these elite abortion advocates publish articles that document "safety" for an industry that profits from widespread abortion access. To increase their credibility, each one quotes the others' poor data. Journal editors frequently have conflicts of interest,[97] and readers are not assured that independent reviewers have critically evaluated submissions by academic abortion advocates before publication. People were not content to blindly believe the tobacco industry when reassured that smoking was safe and did not cause cancer. People must refuse to be deluded by the abortion industry as it protects its product by reassuring that abortion is safe, an assertion based on deliberately deceitful and inadequate data. The politics of pregnancy-related mortality and induced abortion must not be allowed to continue to obstruct root cause analyses of maternal mortality.

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