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Date of submission: April 30, 2010

Submission to: United States Department of State

Re: Universal Periodic Review

Dear U.S. State Department Representatives:

The American Association of Pro-Life Obstetricians and Gynecologists is honored to offer to the United States Department of State information relevant to preparation for the Universal Periodic Review. In brief introduction, AAPLOG is one of the largest special interest groups within the American College of Obstetrics and Gynecology, representing 2000 members and affiliates, and we speak as obstetricians and gynecologists concerned with the medical care of women not only in the U.S. but also in resource poor nations, where many of our members have served or are actively serving.

We would like to address two issues of concern: I. Current Administrative policy concerning the rights of conscience of Hippocratic medical practitioners and II. Current U.S. Administrative policy concerning the inclusion of abortion in the definition of Reproductive Health, and its implications for US policy concerning MDG5.

**Part I. Current Administrative policy concerning the rights of conscience of Hippocratic medical practitioners.**

The Right of a human being to act according to his or her conscience is enumerated and protected in the Universal Declaration of Human Rights, in the following articles:

**Article 1.**

- All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

**Article 18.**

- Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance.

**Article 30.**

- Nothing in this Declaration may be interpreted as implying for any State, group or person any right to engage in any activity or to perform any act aimed at the destruction of any of the rights and freedoms set forth herein.

Preserving the right to conscientiously object from participation in procedures which cause patients harm is vitally important to the provision of health care in this nation for three reasons:

1) The Hippocratic physician acts as patient advocate in the healthcare setting, and physician-patient trust is merited on the premise that the physician will act in the best interests of the patient.
2) Protection of conscience in belief and practice is protected by the Universal Declaration of Human Rights, articles 18 and 30, as well as by the United States constitution since the founding of the United States.
3) Gutting the medical system of Hippocratic physicians by forcing performance of procedures violating their conscience will precipitate an unnecessary and dangerous shortage of medical care providers at a time when the U.S. is already facing a shortage of providers.

**1. The Hippocratic physician as patient advocate.**

Exercise of the right of conscience by healthcare workers originates in the Hippocratic Oath over 2000 years ago. The distinguishing characteristic of Hippocratic physicians is that they have vowed by all that they hold sacred to first do no harm to their patients, a vow which informs their conscience regarding their actions toward patients. This oath of "primum non nocere" specifically forbids the health practitioner from participating in both euthanasia and abortion It is this solemn oath that forms the basis of the trust inherent in the doctor-patient relationship. Thus the Hippocratic physician serves the vital role of advocate for their patients regarding life and death decisions in health care. It is the exercise of the conscience of the Hippocratic physician which forms the basis of the trust inherent in the physician-patient relationship, which is a necessary component of the healing art. . A Hippocratic physician or practitioner has vowed not to harm or kill his or her patients, and thus the patient can trust that recommendations given by the physician or practitioner are given with the intent to bring health, not harm to the patient.

Abortion does not heal, but rather harms patients. Induced abortion not only kills the unborn patient, it also damages the reproductive health of women. Immediate complications from

surgical and medical abortion include hemorrhage, infection and retained tissue requiring surgical removal. Medical abortion has increased risks of each of these complications.[1]

An examination of the first 605 Adverse Event Reports submitted to the FDA in the first three years of 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.[2] The rate of complications seen with mifepristone and misoprostol abortions increases with the use of misoprostol alone. In a WHO sponsored study, one out of every five women who had misoprostol abortions failed to abort[3] and required surgical intervention, or continued a pregnancy now exposed to a teratogenic drug[4], [5]. Medical abortion has been linked to deaths from *Clostridium sordelii* infection, for which the case fatality rate approaches 100%[6].

In addition to the immediate harms of voluntary induced abortion, there are long term harms to the woman:

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[1] [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. **["When comparing numbers of women with adverse events or complications, the difference between the two groups was notable: 20% of women in the medical-abortion group and 5.6% of women in the surgical abortion group had at least one type of adverse event." "In multivariable analysis, the risk of bleeding was almost eightfold higher, the risk of incomplete abortion was fivefold higher, and the risk of (re)evacuation was twofold higher after medical abortion compared with surgical abortion." "Because medical abortion is being used increasingly in several countries, it is likely to result in an elevated incidence of overall morbidity related to termination of pregnancy."]**

[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).

[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]Fischer, M. Bhatnager, J.,Guarner, J.,Reagan,S., Hacker, J., VanMeter, S., Poukens, V., Whiteman, D., Iton, A., Cheung, M. Dassey, D., Shieh, W., Zaki, S. "Fatal Toxic Shock Syndrome Associated with clostridium sordellii after medical abortion" NEJM Dec 1, 2005.

1) Increasing pre-term birth in subsequent pregnancies. Recent systematic reviews(SR) and meta-analyses (SRMA) reveal significantly increased preterm birth rates in subsequent pregnancies for women who have induced abortions vs. women who deliver[7], [8], [9], [10]. There are *zero SRMAs or SRs finding that prior induced abortions do not elevate premature birth risk.*

2) Damaging subsequent mental health of women. Studies with nationally representative samples and a variety of controls for personal and situational factors that may differ between women choosing to abort or deliver indicate abortion significantly increases risk for depression, anxiety, substance abuse, suicide ideation, and suicidal behavior [11], [12], [13], [14], [15], [16], [17], [18], [19], [20], [21],

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[7] Swingle HM, Colaizy TT, Zimmerman MB, et al. Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review and Meta-Analysis. Journal Reproductive Medicine 2009;54:95-108**. [64%increased risk of delivering newborn baby under 32 weeks' gestation in women with one prior abortion compared to women with no prior abortions]**

[8] Shah P. et al. "Induced termination of pregnancy and low birthweight and preterm birth: a systematic review and meta-analysis."BJOG,2009;116(11):1425-1442.
**URL:**http://www3.interscience.wiley.com/journal/122591273/abstract

**[Women with 1 induced abortion had an odds ratio of 1.35 increased risk (i.e. 35% increased risk) for preterm delivery. Women with more than one prior IA had an odds ratio of 1.93(95% increased risk of a premature delivery compared to women with zero prior induced abortions).]**

[9] van Oppenraaij RHF, Jauniaux E, Christiansen OB, et al. Predicting adverse obstetric outcome after early pregnancy events and complications: a review. Human Reproduction Update Advance Access 7 March 2009;1(1):1-13 **[ URL:** http://humupd.oxfordjournals.org/cgi/content/abstract/15/4/409 **]**

[**confirmed significant abortion and preterm birth risk. In addition, Dr. van Oppenraaij et al. confirmed 'Swingle' by finding that prior induced abortions significantly boosted the risk of a very preterm birth ( under 32 weeks' gestation)]**

[10] Appendix A Comprehensive bibliography of Abortion and Subsequent Preterm Birth.

[11] Broen, A. N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2004). Psychological impact on women of miscarriage versus induced abortion: A 2-year follow-up study. Psychosomatic Medicine, 66(2), 265-271.
[12] Broen, A.N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2005). The course of mental health after miscarriage and induced abortion: A longitudinal, five-year follow-up study. BMC Medicine, 3, 18.
[13] Coleman, P.K., (2006). Resolution of unwanted pregnancy during adolescence through abortion versus childbirth: Individual and family predictors and psychological consequences. Journal of Youth and Adolescence, 35, 903-911.
[14] Coleman, P.K., Coyle, C.T., Shuping, M., & Rue, V. (2009). Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey. Journal of Psychiatric Research, 43, 770–776.
[15] Coleman, P. K., Reardon, D. C., & Cougle, J. R. (2005). Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy. British Journal of Health Psychology, 10(2), 255-268.
[16] Cougle J., Reardon, D.C, & Coleman, P. K. (2003). Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort. Medical Science Monitor, 9(4), CR105-112.

[22], [23], [24], [25], [26], [27], [28], [29], [30]. Abortion is associated with a higher risk for negative psychological outcomes when compared to other forms of perinatal loss and with unintended pregnancy carried to term. Most social and medical science scholars agree that a minimum of 20% of women who abort suffer from serious, prolonged negative psychological consequences, yielding at least 260,000 new cases of mental health problems each year.

Since the Hippocratic practitioner has vowed not only to not perform abortion or euthanasia, but also vowed to "first do no harm", inducing an abortion violates conscience on two counts: the killing of the practitioner's unborn patient, and the harm done to the reproductive health of the patient who is pregnant.

A physician willing to kill their patient whether intra- or extra-uterine, at the command of the state, destroys the trust inherent in the Hippocratic doctor-patient relationship, transforming it into a vendor-customer relationship, in which the principle of "Caveat Emptor" prevails. Non-Hippocratic practitioners pursue their trade for a variety of reasons: financial gain, social prestige, etc. But none of these reasons intrinsically require that the best interest of the patient be the paramount guiding principle which may not be violated on oath. Thus a non-

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[17] Cougle, J., Reardon, D.C., Coleman, P. K. (2005). Generalized anxiety associated with unintended pregnancy: A cohort study of the 1995 National Survey of Family Growth. Journal of Anxiety Disorders, 19 (10),137-142.

[18] Dingle, K., Alta, R., Clavarino, A. et al. (2008). Pregnancy loss and psychiatric disorders in young women: An Australian birth cohort study. The British Journal of Psychiatry, 193, 455-460.

[19] Fergusson, D. M., Horwood, J., Ridder, E. M. (2006). Abortion in young women and subsequent mental health. Journal of Child Psychology and Psychiatry, 47,16-24.

[20] Fergusson, D.M., Horwood, J. H., & Boden, J. M. (2008). Abortion and mental health disorders: Evidence from a 30-year longitudinal study, The British Journal of Psychiatry, 193, 444-451.

[21] Gissler, M. et al. (1996). Suicides after pregnancy in Finland, 1987-94: Register linkage study. *British Medical Journal*, 313, 1431-4.

[22] Gissler, M., et al. (2005). Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. *European Journal of Public Health*, 15, 459-463.

[23] Goodwin P, Ogden J. Women's reflections about their past abortions: an exploration of how emotional reactions change over time. Psychology and Health 2007; 22: 231-248.

[24] Major, B., & Cozzarelli, C. (1992). Psychological predictors of adjustment to abortion. Journal of Social Issues, 48, 121-142.

[25] Pedersen, W. (2007). Addiction. Childbirth, abortion and subsequent substance use in young women: a population-based longitudinal study, 102 (12), 1971-78.

[26] Pedersen W. (2008). Abortion and depression: A population-based longitudinal study of young women. Scandinavian Journal of Public Health, 36 (4):424-8.

[27] Reardon, D. C., Coleman, P. K., & Cougle, J. (2004) Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study. American Journal of Drug and Alcohol Abuse, 26, 369-383.

[28] Rees, D. I. & Sabia, J. J. (2007) The Relationship Between Abortion and Depression: New Evidence from the Fragile Families and Child Wellbeing Study. Medical Science Monitor, 13(10), 430-436.

[29] Zolese, G., & Blacker C. V. R. (1992). The psychological complications of therapeutic abortion. *British Journal of Psychiatry, 160,* 742-749.

[30] Appendix B Abortion and Mental Health comprehensive bibliography.

Hippocratic physician or practitioner can be used as an agent to pursue the interests of the State, over and against the interests of the individual patient. This experiment has already been performed in Soviet and Nazi regimes, where Hippocratic physicians were systematically purged from the medical systems in order to allow for the medical systems to become political instruments, for the "good of the state".

**2. Exercise of Conscience is protected by the Universal Declaration of Human Rights.**

Efforts by the U.S. Department of State to force practitioners here and abroad to violate their Hippocratic Oath violates Articles 18 and 30 of the Universal Declaration of Human Rights, which guarantees the right of individuals to manifest their beliefs in practice. The recission of the HHS conscience protection regulations, [which were formulated in response to efforts pressuring Hippocratic obgyn doctors to perform or refer for abortions or else lose their board certification[31], [32]], leaves health care providers vulnerable to claims of "unethical behavior" for refusing to perform or refer for abortions[33]. The federal laws now in effect provide no protection of the rights of conscience of non-physician health care workers such as pharmacists, nurses, PA's and other practitioners. Further, this Administration has narrowed the protection of conscience rights of physicians limiting it to abortion, neglecting the conscience issues surrounding euthanasia, in vitro fertilization, and stem cell research. This lack of protection of health care workers allows for a violation of the workers human right to exercise their conscience in practice[34] in violation of Article 18 of the Universal Declaration of Human Rights, and allows for the state and other group to engage in activities aimed at destroying the health care workers right of conscience, in violation of article 30[35].

**3. The need for Hippocratic health care providers in the U.S. medical system.**

The growing shortage of physicians and health care practitioners across the United States has serious ramifications for the adequate delivery of health care, especially in underserved populations and regions of our nation and globally. The same ethic which causes the Hippocratic practitioner to care for his/her patients also causes many Hippocratic physicians to practice in rural or underserved areas where the need for health care is greatest. A recent national survey of faith based health care professionals revealed that 95% agreed ""I would rather stop practicing medicine altogether than be forced to violate my conscience."[36]

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[31] American College of Obstetrics and Gynecology "ACOG Ethics Statement # 385: The limits of conscientious refusal in reproductive medicine". November 2007.

[32] American Board of Obstetrics and Gynecology "Bulletin for 2008 Maintenance of Certification" The Vineyard Centre 2915 Vine Street, Dallas, TX 75204

[33] ACOG Ethics Statement # 385 "The limits of conscientious refusal in reproductive medicine". November 2007.

[34] United Nations General Assembly. "Universal Declaration of Human Rights", Article 18. Geneva. December 10, 1948.

[35] United Nations General Assembly. "Universal Declaration of Human Rights", Article 30. Geneva. December 10, 1948

[36] http://www.freedom2care.org/learn/page/surveys Highlight of survey of faith based health care professionals. Last visited 4/29/10.

Attempting to force Hippocratic health care providers to violate their oath by forcing performance of abortion under the guise of "reproductive rights" will cause tremendous shortage in the most underserved areas of the country, and of the world, in violation of Article 25 of the Universal Declaration of Human Rights:

- (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

In summary, the free exercise of the right of Hippocratic health care practitioners to practice conscientious medicine in accordance with the precept of "primum non nocere" is protected by the Universal Declaration of Human Rights. The current U.S. Administration's lack of conscience protections for all health care workers, for all procedures which may harm patients, is a violation of the Universal Declaration of Human Rights of both health care workers and their patients.

**Part II: The U.S. policy of promoting abortion under the guise of MDG5.**

The moral and legal principle under-girding the obligation to prevent maternal mortality and morbidity is the human right to life, which provides for the right to bodily integrity. The legal right to life has been enshrined in every major UN human rights document since the 1948 the Universal Declaration of Human Rights. This right leads to a right to the highest attainable standard of health, and thus to the need for increased access to health care for all human beings, from fertilization to natural death. Applauding the critically important function of mothers in sustaining the health of the family and community, member nations agreed on Millennium Development Goal 5: Improving Maternal Health, and specifically created a target of reducing the maternal mortality ratio by 75% between 1990 and 2015, after intense discussion. Member states rejected the proposed "Universal Access to Reproductive Health" because of its sponsors' clear intent to use this proposal as a means to promote legalization of elective abortion worldwide, as confirmed by comments of Secretary of State Clinton before Congress[37].

It is absolutely essential to recall that during that same Summit, the proposed goal of "Universal Access to Reproductive Health" was explicitly rejected by the member nations. Although this goal included many worthwhile targets, the goal included a target to eliminate "unsafe" abortion[38], by provision of "safe abortion", essentially mandating abortion legalization

[37] Reference for Hillary Clinton's remarks in response to U.S. Congressional Representative Christopher Smith. Available at: http://chrissmith.house.gov/News/DocumentSingle.aspx?DocumentID=123424. (Nov. 20, 2009)

[38] Sedgh, G, Henshaw, S and Singh, S. from the Alan Guttmacher Institute, and Ahman, E, and Shaw, from the World Health Organization. **Induced abortion: estimated rates and trends worldwide** *The Lancet* 2007; 370: 1338–45

worldwide. For this reason, member states rejected the proposed goal of Universal Access to Reproductive Health.

However, the monitoring mechanisms for achievement of MDG 5 have nevertheless implicitly incorporated the targets related to that rejected goal.[39] Incorporating targets of a goal which member states have explicitly rejected into the monitoring mechanism tied to development funding is tantamount to cultural imperialism on the part of the United States, and violates the rights of U.N. member nations to self-determination. Worse still, the accepted target of reducing maternal mortality has been undermined and subverted to serve a radically absolutist abortion-rights political agenda currently being pursued by the United States, and to impose that agenda on resource poor nations through development funding. This approach seeks to deny morally-rich member nations the right to recognize legal rights of personhood from the moment of conception. To the contrary, abortion rights advocates seek to impose their own morally impoverished, culturally biased views and pro-abortion agenda, often tainted with population-control ideology, through the mechanism of development funding. This sort of cultural imperialism not only violates the right of member nations to national sovereignty, but deprives the member nations of their right and duty to evaluate the medical and policy effects of elective induced abortion within their own religious, cultural, social and regional contexts.

Hijacking funding for MDG5 to advance the legalization of abortion worldwide will not improve maternal mortality, as evidenced in Chile[40], and other recent publications[41] ,[42]. Advancing "reproductive rights," defined as legalizing voluntary induced abortion, will likely increase maternal mortality[43]. Medical abortion will be especially dangerous in resource-poor nations which lack the health care infrastructure to handle the increasing number of complications of

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***Panel 1:*** **Definitions of safe and unsafe abortion**

**Safe abortions:** Abortions (a) in countries where abortion law is not restrictive,* and (b) that meet legal requirements in countries where the law is restrictive.†

**Unsafe abortions:** Abortions done either by people lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both. These include (a) abortions in countries where the law is restrictive and (b) abortions that do not meet legal requirements in countries where the law is not restrictive.

[39] World Health Organization, **National-level monitoring of the achievement of universal access to reproductive health: conceptual and practical considerations and related indicators – report of a WHO/UNFPA Technical Consultation, 13–15 March 2007, Geneva. ISBN 978 92 4 159683 1**

[40] Koch et al. Personal correspondence. publication pending. Appendix D abortion not significantly correlated with maternal mortality p value of 7.1.

[41]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.

[42] Hogan, M.C.,Foreman, K.J.,Naghavi, M.,Ahn, S.Y., Wang, M., Makela, S.M., Lopez, A.D., Lozano, R., Murray, C.J.L., "**Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5"www.thelancet.com.** Published **Online** April 12, 2010 DOI:10.1016/S0140-6736(10)60518-1

[43] Niinimaki-See footnote 11.

hemorrhaging, infection and surgery necessary to remove retained tissue.[44] Promoting drug-induced abortion, with its increased risks[45], is counter-productive to any efforts to decrease the maternal mortality of a resource-poor region. In the U.S., corresponding with FDA approval of medical abortion in 2000,[46]maternal mortality began to rise.

The encouragement by this Administration, through UNFPA and WHO, of the use of mifepristone (RU-486, *Mifegyne*) and misoprostol (*Cytotec*) as abortifacients in medically resource poor nations is unconscionable and a violation of the human right to health of women in resource poor medical systems, increasing the rate of hemorrhage, infection and incomplete abortion in medical systems unable to provide adequate medical care for these women. This policy increases, not decreases maternal mortality and morbidity in a female population already struggling with malnutrition, anemia, malaria, parasitic infections, etc. Nothing could be more contrary to the purposes underlying the Millennium Summit Declaration's purpose of protecting pregnant women.

The current U.S. policies promoting worldwide legalization of abortion under the guise of MDG 5 are misguided. While reducing maternal mortality is critically important because of the key role that mothers play in the life of their children and community. Strategies with proven effectiveness of decreasing the deaths of mothers in the process of pregnancy and delivery are:

1) Skilled birth attendance,

2) Adequate delivery facilities equipped with antibiotics, oxytocin and magnesium sulfate,

3) Increasing female literacy which empowers women to access health care.

Recent Chilean mortality data demonstrate these three factors directly attribute to the dramatic decline in maternal mortality.[47]

Reductions in maternal mortality have been achieved in the U.S.[48], and Chile[49], not by legalization of abortion, but by provision of 1) skilled birth attendants (who monitor for

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[44] 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. **["When comparing numbers of women with adverse events or complications, the difference between the two groups was notable: 20% of women in the medical-abortion group and 5.6% of women in the surgical abortion group had at least one type of adverse event." "In multivariable analysis, the risk of bleeding was almost eightfold higher, the risk of incomplete abortion was fivefold higher, and the risk of (re)evacuation was twofold higher after medical abortion compared with surgical abortion." "Because medical abortion is being used increasingly in several countries, it is likely to result in an elevated incidence of overall morbidity related to termination of pregnancy."]**

[45] Correspondance from research Dr. Ralph Miech, attached.

[46] Appendix E(2) Graph of U.S. maternal mortality 1960-2006.

[47] Koch, et. Al. Personal correspondence. Publication pending. Appendix D,C .

obstructed labor, hemorrhage, sepsis and other major killers of women who are giving birth), who can treat mothers in 2) a facility equipped to handle these complications. Dramatic decreases in maternal mortality accompany female literacy which allows women to access health care through written media, instead of relying on word of mouth.[50]

Implementing these interventions in nations with the greatest maternal mortality will provide the most rapid reduction in maternal mortality, paralleling the reductions in nations with similar interventions.

Respectfully submitted,

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Life. It's Why We Are Here.

[48] Appendix E. Graphs of maternal mortality in the U.S. [Note dramatic decreases in maternal mortality corresponding with introduction of modern obstetrical techniques and delivery in hospital settings, not with legalization of abortion in 1973. Note rise in maternal mortality beginning in 2000, correlating with the legalization of RU486 in the U.S.].

[49] Appendix C and D. Graphs of maternal mortality reduction corresponding to decreasing illiteracy in females, and provision of skilled birth attendants with safe delivery facilities.

[50] Koch, publication pending. Appendix C.

## Appendix A: Studies demonstrating an association between induced abortion and subsequent preterm birth:

List of 117 Significant APB Studies (last updated 12 April 2010)

1960s

1 Barsy G, Sarkany J. Impact of induced abortion on the birth rate and infant mortality. Demografia 1963;6:427-467.

2 Miltenyi K. On the effects of induced abortion. Demografia 1964;7:73-87.

3 Furusawa Y, Koya Y. The Influence of artificial abortion on delivery. In: Koya Y, ed. Harmful effects of induced abortion. Tokyo: Family Planning Federation of Japan,1966:74-83.

4 Arvay A, Gorgey M, Kapu L. La relation entre les avortements (interruptions de la grossesse) et les accouchements prematures. Rev Fr Gynecol Obstet 1967;62:81-86

1970s

5 Drac P, Nekvasilova Z. Premature termination of pregnancy after previous interruption of pregnancy. Cesk Gynekol 1970;35: 332-333.

6 Dolezal A, Andrasova V, Tittlbachova S, et al. Interruption of pregnancy and their relation to premature labous and hyptrophic foetuses. Cesk Gynekol 1970:36:331

7 Pantelakis SN, Papadimitriou GC, Doxiadis SA.Influence of induced and spontaneous abortions on the outcome of subsequent pregnancies. Amer J Obstet Gynecol. 1973;116: 799-805.

!!8 Van Der Slikke JW, Treffers PE. Influence of induced abortion on gestational duration in subsequent pregnancies. BMJ 1978;1: 270-272 [>95% confident of preterm risk for gestation less than 32.0 weeks].

9 Richardson JA, Dixon G. Effect of legal termination on subsequent pregnancy. British Med J 1976;1:1303-1304.

+10 Papaevangelou G, Vrettos AS, Papadatos D, Alexiou C. The Effect of Spontaneous and Induced Abortion on Prematurity and Birthweight. The J Obstetrics and Gynaecology of the British Commonwealth. May 1973;80:418-422.

+11 Bognar Z, Czeizel A. Mortality and Morbidity Associated with Legal Abortions in Hungary, 1960-1973. AJPH 1976;66:568-575.

12 Grindel B, Lubinski H, Voigt M. Induced abortion in primigravidae and subsequent pregnancy, with particular attention of underweight. Zentralbl Gynaekol 1979;101:1009-1114.

+13 Obel E, et al. Pregnancy Complications Following Legally Induced Abortion With Special Reference to Abortion Technique. Acta Obstet Gynecol Scand 1979;58:147-152.

14 World Health Organization Task Force on the Sequelae of Abortion. Gestation, birthweight and spontaneous abortion. Lancet 1979;1:142-145.

15 Ratten G et al. Effect of Abortion on Maturity of Subsequent Pregnancy. Med J Australia June 1979: 479-480.

16 Roht LH, Aoyama H, Leinen GE, et al. The association of multiple induced abortions with subsequent prematurity and spontaneous abortion. Acta Obstet Gynaecol Jpn 1976;23: 140-145.

17 Harlap S, Davies AM. Late sequelae of induced abortion: Complications and Outcome of Pregnancy and Labor. Amer J Epidemiology 1975;102:219-224.

18 Koller O, Eikhom SN. Late Sequelae of Induced Abortion in Primigravidae. Acta Obstet Gynecol Scand 1977;56:311-317.

19 Lean TH, Hogue CJR, Wood J. Low birth weight after induced abortion in Singapore, Presented at the 105th Annual Meeting of the Americal Public Health Association, Washington DC, Oct. 31, 1977.

20 World Health Organization. Special Programme of Research, Development and Research Training in Human Reproduction: Seventh Annual Report, Geneva, Nov. 1978.

21 Hungarian Central Statistical Office. Perinatalishalazons. Budapest: Hungarian Central Statistical Office, 1972.

22 Czeizel A, Bognar Z, Tusnady G, et al. Changes in mean birth weight and proportion of low-weight births in Hungary. Br J Prev Soc Med 1970;24:146-153.

23 Dziewulska W. Abortion in the past versus the fate of the subsequent pregnancy. State of the newborn. Ginekol Pol 1973;44:1143-1148 [Poland].

24 Kaminski M, Goujard J, Rumeau-Roquette. Prediction of low birthweight and prematurity by a multiple regression analysis with maternal characterisitics known since the beginning of the pregnancy. Intl J Epidem 1973;2:195-204

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* studies that included spontaneous and induced abortions but did not report PTB/LBW risk separately for each
\+ studies that found dose/response (the more SIAs, the higher the risk)

Eighteen (18) Statistically Significant AVPB and AVLBW Studies

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A17+ Levin A, Schoenbaum S, Monson R, Stubblefield P, Ryan K. Association of Abortion With Subsequent Pregnancy Loss. JAMA 1980;243(24):2495-2499

A18 Van Der Slikke JW, Treffers PE. Influence of induced abortion on gestational duration in subsequent pregnancies. BMJ 1978; 1:270-272 [>95% confident of preterm risk for gestation less than 32.0 weeks].

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* studies that included spontaneous and induced abortions but did not report PTB/LBW risk separately for each
\+ studies that found dose/response (the more SIAs, the higher the risk)
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## Appendix B Studies demonstrating an association between voluntary induced abortion and subsequent adverse mental health outcomes.


Allanson, S., & Astbury, J. (2001). Attachment style and broken attachments: Violence, pregnancy, and abortion. Australian Journal of Psychology, 53, 146-151.

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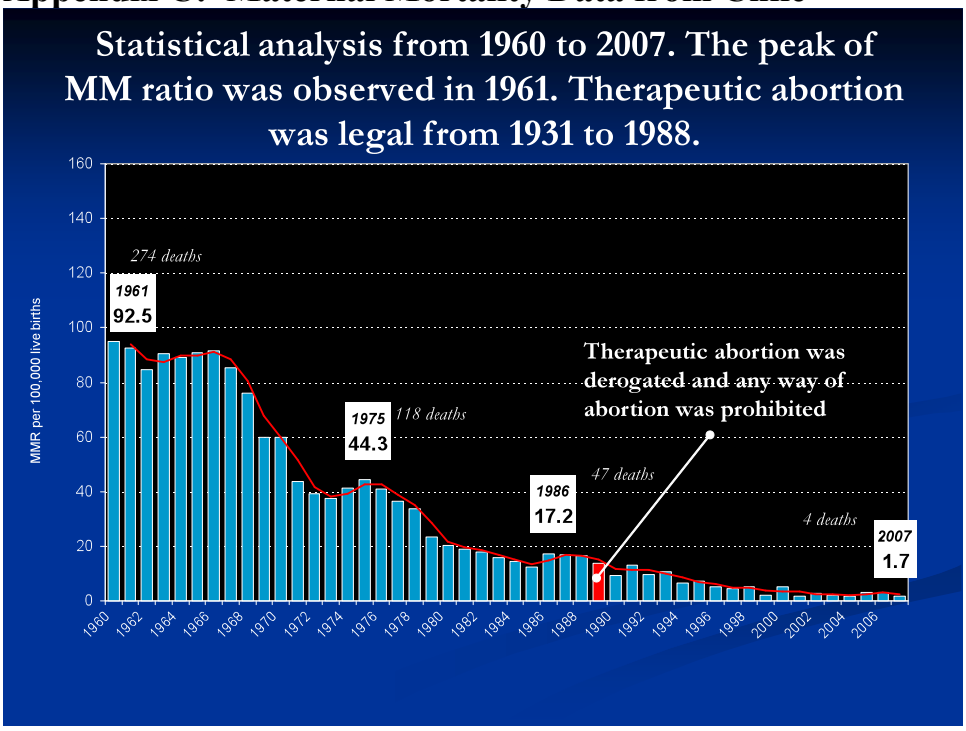
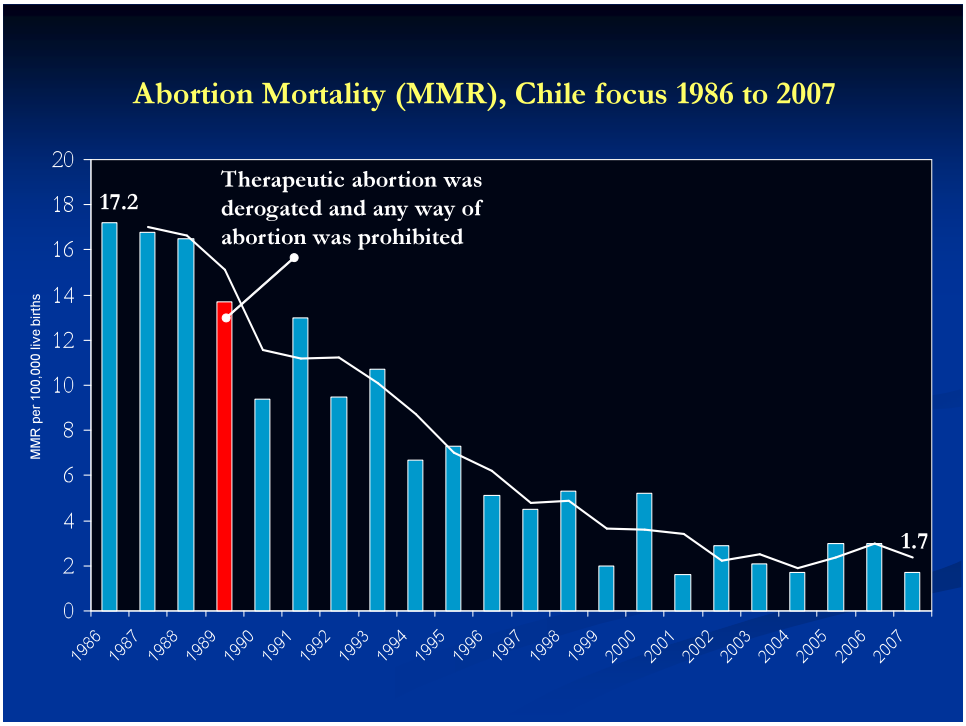
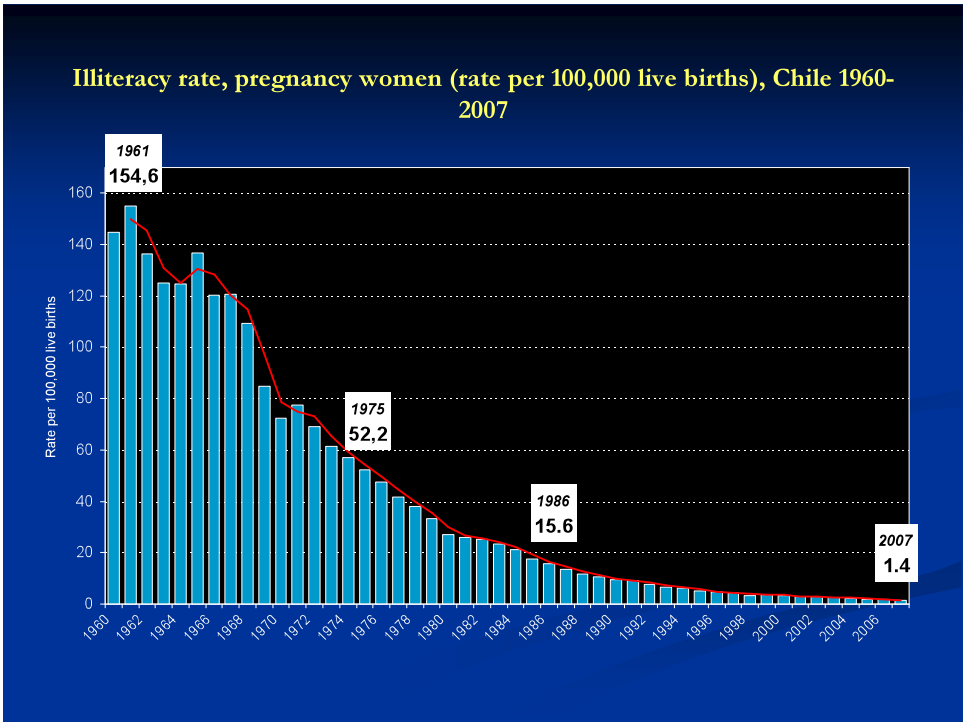
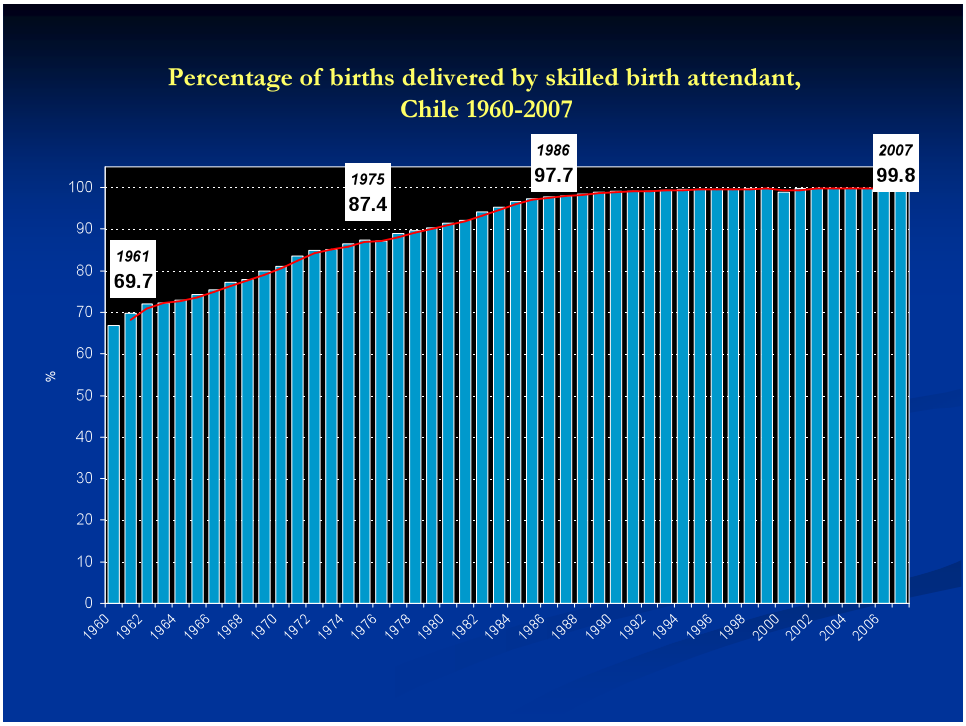
## Appendix C: Maternal Mortality Data from Chile



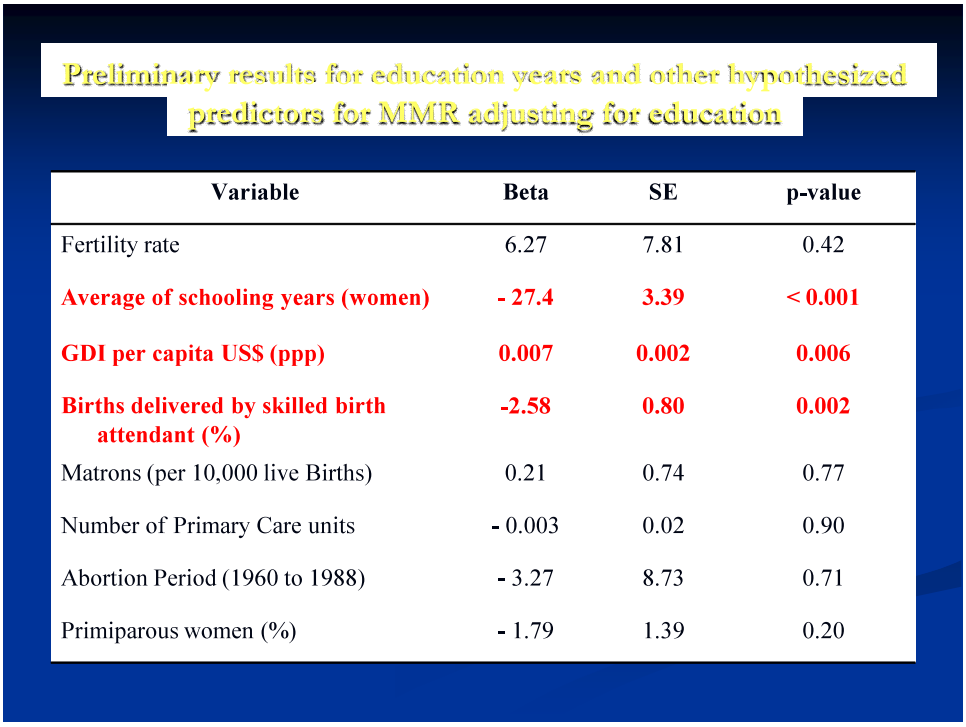

Source: Koch et. Al. publication pending.




Source: Koch et. Al. publication pending.

## Appendix D. Table of Maternal Mortality Variables and P value associations-Chile

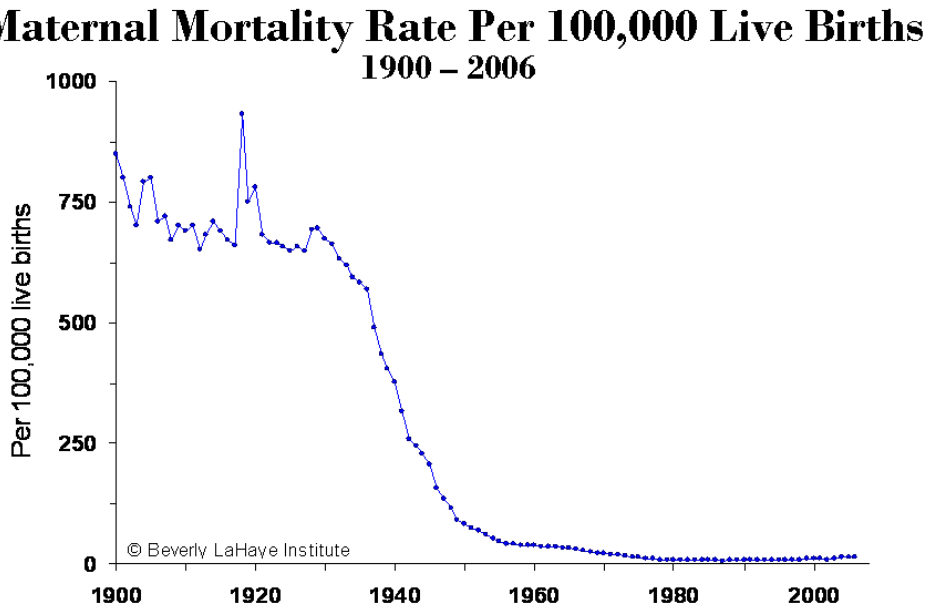


Preliminary results for education years and other hypothesized predictors for MMR adjusting for education

| Variable | Beta | SE | p-value |
|---|---|---|---|
| Fertility rate | 6.27 | 7.81 | 0.42 |
| **Average of schooling years (women)** | **- 27.4** | **3.39** | **< 0.001** |
| **GDI per capita US$ (ppp)** | **0.007** | **0.002** | **0.006** |
| **Births delivered by skilled birth attendant (%)** | **-2.58** | **0.80** | **0.002** |
| Matrons (per 10,000 live Births) | 0.21 | 0.74 | 0.77 |
| Number of Primary Care units | - 0.003 | 0.02 | 0.90 |
| Abortion Period (1960 to 1988) | - 3.27 | 8.73 | 0.71 |
| Primiparous women (%) | - 1.79 | 1.39 | 0.20 |

Koch, et al. Publication pending.

## Appendix E: United States Maternal Mortality 1900-2006




Source: National Center for Health Statistics, Table 33 Table 33. Number of maternal deaths and maternal mortality rates for selected causes, by race: United States, 2006, and earlier reports *www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf.*

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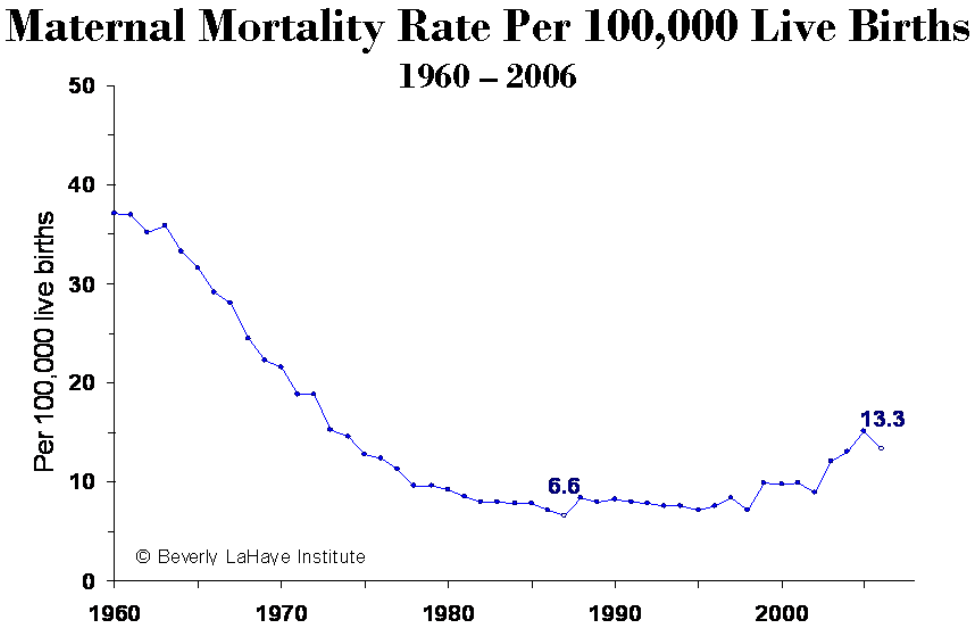


Source: National Center for Health Statistics, Table 33 Table 33. Number of maternal deaths and maternal mortality rates for selected causes, by race: United States, 2006, and earlier reports *www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf.*

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