

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

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Office of the United Nations High Commissioner on Human Rights
United Nations Office at Geneva
CH 1211 Geneva 10
Attn: Cecilia Moeller

Dear Commissioner:

The American Association of Pro-Life Obstetricians and Gynecologists is honored to offer to the Office of United Nations High Commissioner on Human Rights, information relevant to the preparation of the thematic study on Preventable Maternal Mortality and Morbidity and Human Rights. In brief introduction, AAPLOG is one of the largest special interest groups within the American College of Obstetrics and Gynecology 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.

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.

It is absolutely essential to recall that during that same Summit, the proposed goal of “Universal Access to Reproductive Health” was rejected by the member nations. Although this goal included many worthwhile targets, the goal included a target to eliminate “unsafe” abortion, defined as any abortion in a country where abortion was not legal.¹ That the phrase “Universal Access to Reproductive Health” necessarily includes universal

1 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

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.

access to elective abortion was recently asserted by Secretary of State Hillary Clinton in remarks before the U.S. Congress.² 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.

However, the monitoring mechanisms for achievement of MDG 5 have nevertheless implicitly incorporated the targets related to that rejected goal.³ 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 resource-rich nations and individuals, and violates the rights of 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 by resource rich member 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.

It is misleading to suggest that making abortion legal makes it safe and reduces maternal mortality. In resource poor countries, 5% of maternal mortality⁴ is attributed to abortion. The WHO quasi-legal definitions of “unsafe” and “safe” abortion, combined with the target to eliminate “unsafe” abortion, lead to the false conclusion that simply legalizing abortion in a country reduces maternal mortality. However, there are two pitfalls to this logic:

1. As witnessed in many resource rich countries, abortion incidence markedly increases with legalization,⁵ and that increase is accompanied by an absolute increase in mortality and

*Defined as countries in which abortion is legally permitted for social or economic reasons or without specification as to reason, and a few countries and territories with more restrictive formal laws in which safe abortion is nevertheless broadly available.

†Such abortions are currently too few to be included in these estimates.

2 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)

3 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

4 World Health Organization “WHO: Causes of Maternal Deaths: A Systematic Review” *The Lancet* Vol 367 April 1, 2006, the breakdown of maternal mortality causality is as follows:

1. Hemorrhage-31%
2. Hypertensive disorders-10%
3. Anemia -8%
4. Sepsis-11%
5. Obstructed Labor 7%
6. Indirect causes (such as malaria, infectious and parasitic diseases, etc) 14%
7. HIV 3%
8. Other Direct Causes 5%
9. Unclassified 6%
10. “Abortion” 5% Note that this category includes both spontaneous and induced abortions.

5 Nathanson, Bernard, Co-founder of NARAL Pro-Choice America (formerly National Abortion Rights Action League):

“I am personally responsible for 75,000 abortions. This legitimises my credentials to speak to you with some authority on the issue. I was one of the founders of the National Association for the Repeal of the Abortion Laws (NARAL) in the U.S. in 1968. A truthful poll of opinion then would have found that most Americans were against permissive abortion. Yet within five years we had convinced the U.S. Supreme Court to issue the decision which legalised abortion throughout America in 1973 and produced virtual abortion on demand up to birth. How did we do this? It is important to understand the tactics involved because these tactics have been used throughout the western world with one permutation or another, in order to change abortion law.

THE FIRST KEY TACTIC WAS TO CAPTURE THE MEDIA

We aroused enough sympathy to sell our program of permissive abortion by fabricating the number of illegal abortions done

morbidity; and

2. 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. Thus, as in resource rich countries, legalization in resource poor countries effectively amplifies maternal morbidity and mortality.

As obstetricians and gynecologists we are keenly aware of the risks of any surgical procedure include bleeding and infection. These complications may be adequately handled in resource-rich medical systems, but greatly increase fatalities in member nations whose female population does not have ready access to antibiotics, blood transfusions and hospitalization. The recent study of 22,368 “safe” medical abortions in Finland, compared with 20,251 “safe” 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 surgery.

An examination of the first 605 Adverse Event Reports submitted to the FDA 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.⁶ 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 abort⁷ and required surgical intervention, or continued a pregnancy now exposed to a teratogenic drug.^{8 9} Medical abortion has been linked to deaths from *Clostridium sordelii* infection, for which the case fatality rate approaches 100%.

The encouragement by UNFPA and WHO of the use of mifepristone (RU-486, *Mifegyne*) and misoprostol (*Cytotec*) as “safe” abortifacients in medically resource poor nations is unconscionable and a violation of the human right to health of women in resource poor medical systems. Promoting “safe” medical abortions in resource poor nations would predictably increase the risk 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 resource poor nations. The known morbidity and mortality from “safe” surgical or medical abortions¹⁰ would be disastrous to a female population already struggling

annually in the U.S. The actual figure was approaching 100,000 but the figure we gave to the media repeatedly was 1,000,000. Repeating the big lie often enough convinces the public. The number of women dying from illegal abortions was around 200-250 annually. The figure we constantly fed to the media was 10,000. These false figures took root in the consciousness of Americans convincing many that we needed to crack the abortion law. Another myth we fed to the public through the media was that legalising abortion would only mean that the abortions taking place illegally would then be done legally. In fact, of course, abortion is now being used as a primary method of birth control in the U.S. and the annual number of abortions has increased by 1500% since legalization.” Available at: <http://www.aboutabortions.com/Confess.html> (Nov. 30, 2009)

6 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).

7 von Hertzen H, Piaggio G, Huong NT, Arustamyan K, Cabezas E, Gomez M, Khomassuridze A, Shah R, Mittal S, Nair R, Erdene-tungalag 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.

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

9 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.

10 Niinimäki, M., M.D., Pouta, A., M.D. PhD, Bloigu, A., Gissler, M., BSc, PhD, Hemminki, E., M.D, PhD, Suhonen, S., M.D.,

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 pressure from resource rich donor nations to legalize abortion violates the right to health of women in resource poor nations by exposing them to the mortality and morbidity of induced elective abortion in situations where the available medical care cannot manage the predictable short or long term morbidity and mortality, nor provide adequate monitoring and surveillance.

An increase in short term morbidity and mortality, however, are not the only predictable consequences of "safe" abortion. The long term morbidity of "safe" abortion on women is well documented in the medical literature. "Safe" abortion is associated with an increased risk of preterm birth in subsequent pregnancies as attested to by the Epipage,¹¹ Europop,¹² and IOM¹³ studies, and over one hundred other studies,¹⁴ including the most recent review in the British Medical Journal.¹⁵ In resource rich western nations, preterm birth accounts for a significant percentage of the cost of pediatric medical care.¹⁶ In nations without an abundance of medical resources, these preterm births would translate into neonatal deaths.

Over 100 studies in the medical literature demonstrate that women undergoing "safe" abortion have a significantly increased risk of subsequent suicide, major depression and substance abuse, as compared with women who bring to birth.¹⁷ Studies which have looked at long term consequences of medical abortion regimens have revealed risks similar to those for surgical abortion.¹⁸

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 oxytocics. Abortion, spontaneous and induced, accounts for less than 5% of maternal mortality.¹⁹ It is scientifically, medically and morally unacceptable to divert resources from interventions proven

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.

11 **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.

12 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.

13 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".

14 See Attachment 1. **Studies demonstrating an association between Abortion and Preterm Birth in subsequent pregnancies.** (Total studies 113).

15 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.

16 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.

17 See Attachment 2. **Studies demonstrating an association between Abortion and Adverse Mental Health Outcomes.** (Total studies 102).

18 Virk, Jasmeer, 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.

19 World Health Organization "WHO: Causes of Maternal Deaths: A Systematic Review" *The Lancet* Vol 367 April 1, 2006. The breakdown of maternal mortality causality is as follows:

1. Hemorrhage-31%
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6. Indirect causes (such as malaria, infectious and parasitic diseases, etc) 14%
7. HIV 3%
8. Other Direct Causes 5%
9. Unclassified 6%
10. "Abortion" 5% Note that this category includes both spontaneous and induced abortions.

to reduce maternal mortality to the provision of abortion, under the guise of “decreasing unsafe abortion”. The better way to address the human rights dimension of maternal mortality and morbidity is to provide resources targeting the causes of 90% of maternal mortality.²⁰

In summary, we oppose the diversion of resources and attention to the legalization and provision of abortion, which under the guise of improving maternal mortality will result in increased maternal mortality and erosion of the attached human right to health in resource poor countries. We call on the Council to defend the right to maternal health by holding accountable NGOs that divert resources from interventions proven to decrease maternal mortality to the provision of abortion, and deliberately work to subvert national sovereignty and overturn member nations’ religious, moral and social norms and traditions. We implore the Council to refrain from supporting in law and policy, measures influenced by racist and eugenically influenced ideologies that have been empirically proven to hurt rather than help pregnant women. And finally, we call on the Council to defend the right to bodily integrity of all human beings from fertilization to natural death, especially in morally rich sovereign nations who recognize the human rights of fetal human beings.

Respectfully submitted,

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President,
American Association of Pro-Life Obstetricians and Gynecologists

20 Ibid. 1-8 above.

Attachment 1. Studies demonstrating an association between Abortion and Preterm Birth in subsequent pregnancies. (Total studies 113)

Studies published from 2000 to 2009. (30 studies)

1. Foix-L'Hélias L, Ancel PY, Blondel B. Changes in risk factors of preterm delivery in France between 1981 and 1995. *Paediatric and Perinatal Epidemiology*. Oct 2000;14(4): 314-323.
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5. Letamo G, Majelantle RG. Factors Influencing Low Birth Weight and Prematurity in Botswana. *J Biosoc Sci* 2001;33(3):391-403
6. Henriët L, Kaminski M. Impact of induced abortions on subsequent pregnancy outcome: the 1995 French national perinatal survey. *BJOG* 2001;108(10):1036-1042
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delivery: results of the EPIPAGE study. *British J Obstetrics Gynaecology* 2005;112(4):430-437 [France] [abstract online: <http://www.blackwell-synergy.com/links/doi/10.1111/j.1471-0528.2004.00478.x/abs/>]

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Studies prior to 2000: (83 studies)

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