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The Myth That Abortion is Safer Than Childbirth: Through the Looking Glass

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I. Abortion Mortality: Mythology and Methodology

Recent publications continue to put forth the same un-scientific and unsubstantiated claim that “The risk of death associated with childbirth is approximately 14 times higher than with abortion.”¹ However, a comparison of abortion mortality and maternal mortality is complicated by methodological problems:

- Incomplete reporting (Abortion Data Unreliable)
- Definitional incompatibilities
- Voluntary data collection
- Research bias
- Reliance on estimations
- Political correctness
- Inaccurate/incomplete death certificates
- Failing to include all causes of death such as suicide
- Incomparability with maternal mortality statistics

II. Incomplete Reporting: (Abortion Data Unreliable)

There are no federal reporting requirements for abortion in the United States.^{1,2} Only 26 states require providers to report.^{3,4} And the data provided are estimates:

“Many state health departments are able to obtain only incomplete data from abortion providers, and in some states, only 40-50% of abortions are reported.”⁵

The CDC collects maternal mortality data in 2 separate systems:

- National Vital Statistics System (NVSS)
- Pregnancy Mortality Surveillance System (PMSS)

For example 1995-97 NVSS reported 898 deaths while the PMSS reported 1,387 deaths. Only 54% reported in both systems.⁶ Due to the incomplete nature of the data collection, CDC cautions medical professionals not to make comparative statements on

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data. In other words, these data sets cannot be used to calculate comparative safety of abortion, nor an accurate abortion mortality rate.

Guttmacher Institute (GI) is only other reporting body. Guttmacher data is voluntary, not reliable and politically motivated.

Abortion is systematically underreported with:

- < 1/2 reporting abortions in face-to-face interviews.⁷
- No fetal death certificates-never appear in maternal mortality calculations.
- Most women (2/3's) never return to abortion clinics with complications-therefore not reported as abortion complications.⁸

III. Mortality Definition Issues

The World Health Organization (WHO) uses 7 different methods to estimate maternal deaths.⁹ Pregnancy status is not routinely reported in death certificates. It has been estimated that 50% of cases of maternal death certificates did not report pregnancy.¹⁰ Various methods and terminology are as follows:

- Maternal deaths (by WHO)-death of woman while pregnant or within 42 days of termination of pregnancy, irrespective of duration/site of pregnancy. (Does not include suicide, homicide,accidents)
- Late maternal deaths are defined as “the deaths of a woman from direct or indirect obstetric causes more than 42 days but less than 1 year after termination of pregnancy.”
- Pregnancy-related deaths-includes those from direct and indirect causes defined as “Death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.”
- Direct obstetric deaths-”those resulting from obstetric complications of the pregnant state (pregnancy, labor, puerperium).
- Indirect obstetric deaths- “. . .those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiologic effects of pregnancy.”
- Pregnancy-associated deaths-developed by Centers for Disease Control and Prevention and with Maternal Mortality Special Interest Group of ACOG: Death from any cause during pregnancy or within 1 calendar year of delivery or pregnancy termination, regardless of duration or anatomical site. (Includes accidents, homicide and suicide related to pregnancy)
- Another way to define mortality is using a national case-fatality rate, which is the number of known legal induced abortion-related deaths per 100,000 reported legal induced abortions.
- But calculation of this number assumes all deaths are identified from all causes up to 1 year post-abortion, which is not true, and therefore the numerator is inaccurate. Also, the total number of abortions (denominator) is not known. Therefore, it is impossible to calculate this number reliably, without a reliable numerator or a reliable denominator.

- Also this calculation uses only 2 criteria in identifying maternal death:
 - Medical causes of death
 - Timing of the pregnancy-related death

IV. Mortality Measurement Issues

Maternal mortality is usually defined as:

Number of maternal deaths during a given period per 100,000 live births during same period, or

Number of maternal deaths in give period per 100,000 women of reproductive age during the same time period.

Difficulties are evident in following:

- A. There are gross difficulties inherent in measuring maternal mortality and definitions regarding precisely what constitutes a death due to pregnancy vs birth.
- B. There is lack of consensus regarding how long after pregnancy resolution a death is linked to the pregnancy.
- C. The two national sources of abortion statistics (CDC and Guttmacher Institute) are plagued by underreporting to a huge degree.
- D. For various reasons (incomplete records, lack of fetal death records), deaths due to abortion are often not recorded as resulting from the procedure with only the immediate cause of death (embolism, sepsis, and hemorrhage) provided.
- E. Women experiencing life-threatening health complications from abortion go to hospital's ER's and are not usually seen by abortion doctors and thus their deaths not counted as abortion related.
- F. Abortion related deaths from (from physician complications of the procedure) are usually reported as maternal deaths.
- G. The death statistics tabulated for abortion focus on "uncomplicated" abortion, whereas statistics for childbirth incorporate complicated deliveries (c-sections). Comparing uncomplicated delivery to uncomplicated abortion shows the risk of dying from abortion is twice that of uncomplicated vaginal delivery.¹¹
- H. Available statistics do not address the long-term and less direct causes of death associated with abortion and childbirth. Risk of death associated with abortion increases over time (due to substance abuse, cancer, pregnancy complications, suicide) while that of term pregnancy show lessened risk. The present definitions of maternal death within 42 days of delivery will find those deaths due to full-term pregnancies. So, national data compares deaths associated with term deliveries to deaths associated with deaths from abortion at any point in pregnancy. This will give an inappropriate comparison group, as the appropriate comparison would be to compare the gestational age specific risk of abortion to the alternative of continuing the pregnancy at that gestational age.

IV. Mortality Measurement Issues

Maternal mortality is determined by dividing maternal deaths by live births as opposed to pregnancies. Deaths by ectopic pregnancy, molar pregnancy, miscarriage, and stillbirth are all included in the numerator but not the denominator. CDC notes that 40% of deaths occur in the other non-live birth category. This over-inflates the maternal mortality. This means that the live-birth mortality is actually only 60% of the reported maternal mortality.

Maternal mortality and abortion statistics are not analogous. Abortion statistics are by trimester. Live birth mortality ought to do the same. Statistics done by trimester find that mortality in abortion:

- 14.7/100,000 at 13-15 weeks;
- 29.5/100,000 at 16-20 weeks;
- 76.6/100,000 at > 21 weeks.¹²

Comparisons without regard to gestational age are flawed: Deaths during the first 6 weeks of pregnancy (when maternal morbidity and mortality are highest) are classified as maternal deaths and placed together with deaths due to birth and delivery. This is inappropriate since the intended outcomes are unknown. Women who reach the common point of awareness of pregnancy and make decision to abort (approximately 6 weeks) have already survived beyond the period of pregnancy's greatest risk. Abortions do not typically occur very early and are impossible > 9 months of gestation when most of the maternal deaths in the maternal mortality statistics occur. Therefore, valid gestational period comparisons must be done in the latter half of 1st trimester (after 6 weeks) and through the end of the third trimester.

During 2nd and 3rd trimesters, the abortion related mortality equals and then exceeds that of childbirth (childbirth-approximately 8-10/100,000).¹²

V. Abortion versus Childbirth-Evidence

Induced abortion is the 5th leading cause of maternal mortality in the U.S.¹³

Excluded from the abortion statistics are:

- suicide,
- avoidable deaths due to injuries, accidents, substance abuse, and contributory/cumulative disease states

A U.S. study spanning 8 years in California found in 2002:

- 62% increase in all cause deaths
- 154% increased risk in suicide¹⁴

A Finnish study in 1997 found:

- Deaths rates 4 times higher after abortion compared to childbirth up to 1 year.¹⁵

Subsequent studies in Finland showed:

- Maternal mortality-childbirth 28.2/100,000
- Abortion mortality-83.1/100,000 or 3 times higher¹⁶
- 6 times higher risk of suicide.¹⁷

Morgan et al. in UK found 8.1/1,000 suicide attempts in aborting patients versus 1.9/1,000 suicide attempts in those giving birth.¹⁸

Chang et al. in 2003 found 3 most common causes of maternal mortality in abortion:

- Infection (33.9%)
- Hemorrhage (21.8%)
- Embolism (13.9%)
- Deaths from hemorrhage 8 times higher and from infection 9 times higher in abortion compared to live-birth¹⁹

VI. Recent Mortality Evidence

“Imagination is the only weapon in the war against reality.”

Cheshire Cat to Alice in Alice in Wonderland

Carroll et al. 2011 found the maternal mortality rate to be 8-10/100,000 live births in England, Wales, and Scotland (nations with same liberal abortion philosophy as U.S.).²⁰ In contrast, Carroll et al. 2011 found the maternal mortality rate to be 1-2/100,000 in the Irish Republic (where abortion is illegal) in the same time frame.

Note that the rate in England, Wales and Scotland is almost same rate of maternal mortality of 8.8/100,000 live births in U.S. quoted by Raymond and Grimes in 2012 article.

The Raymond and Grimes abortion mortality rate of 0.6/100,000 is simply nonsense and not supported by good national database information, not estimates.

Koch et al. 2012 demonstrated in their study of maternal mortality in Mexico (abortion illegal) the fundamental issue with “estimation” when they found a 10-fold overestimation of maternal mortality without record linkage.²¹ In fact, Mexico actually saw a decrease in maternal mortality from 1.48 to 1.14 /100,000 live births with no abortion.²¹

Koch et al. 2012 also found in a 50 year analysis of Chile’s maternal mortality covering 2 epochs: 1957-1988-abortion legal and 1989-2007-abortion illegal²² that the legal status of abortion had no relationship to the reduction in maternal mortality in Chile- but was significantly related to better care and education.²²

Coleman et al. 2012 reviewed the mortality rates in Denmark for the 25 years from 1962-1993 with over 1 million women with complete reproductive outcomes: (Live births, Abortions, Miscarriages).²³ The authors noted an increased risk of death for women who aborted, demonstrating a dose related effect of abortion with mortality:

- 45% increased risk with one abortion
- 114% increased risk with 2 abortions
- 191% increased risk with 3 abortions

The authors also found:

- 6-fold increase risk death if never became pregnant vs delivered a term baby

Contrary to the belief that childbirth has excess mortality compared to abortion, the authors compared maternal death rates with a live birth compared to an abortion and found a decreased risk of death for live birth outcomes:

- Death rates reduced by 108% for 2 births
- Death rates reduced by 63% for > 3 births

Conclusions

- Accurate data are lacking the U.S. due to poor quality data collection and estimates.
- Linked database data demonstrates an increased maternal mortality in abortion compared to live-birth .
- A comprehensive, objective database with reproductive outcomes is sorely needed.

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