

Ignoring Surgical Abortion's Effect on Infant Mortality in Ohio

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A popular indicator of a nation's health has been the rate of infant mortality (the death of an infant within the first year of life). Logic would seem to dictate that technologically and medically advanced countries like the United States would have low rates of infant mortality compared to other countries, but this is not the case. The U.S. infant mortality rate (5.8 deaths under one year of age per 1000 live births) is 71% higher than the comparable country average (3.4 deaths).¹

Over the last decade, the infant mortality rate in the United States has been a matter of great concern and debate. A majority of research on this subject seems to indicate that after accounting for reporting differences among countries, the mortality disadvantage in the U.S. is driven by poor birth outcomes among lower socioeconomic status individuals. A 2016 *American Economic Journal* article indicates that this accounts for 30 to 65% of the difference.²

According to the U.S. Centers for Disease Control and Prevention (CDC), the state of Ohio has had the dubious distinction of being among states that have the highest rate of infant mortality in the nation.³ When broken down by race/ethnicity, the infant mortality rate among black women is disproportionately higher. A 2017 comparison among the 50 states and the District of Columbia indicates that the nationwide rate of infant mortality that year among non-Hispanic black women was 10.9, and the infant mortality rate among non-Hispanic black women in Ohio was a dismal 14.5, second highest in the nation.⁴ A majority of studies find that the number one cause of infant mortality is premature birth, closely followed by low birth weight. For those who may not be aware how abortion could affect a future pregnancy, you must understand that in a pregnant woman, the cervix is integral to the maintenance of the pregnancy by forming an impenetrable barrier to prevent the ascent of any microorganisms into the vagina and uterus in order to keep the developing human being safe until birth. Weakness of the cervix can lead to deficiency of this barrier and is associated with subsequent preterm births. During a surgical abortion, the cervix is forced open in order to remove the child. Forced dilation of the cervix brings with it a potential for damage that can weaken it and increase the risks of infection, premature birth or the odds of experiencing a late term miscarriage in subsequent pregnancies.

Ohio has been proactive in developing programs to combat infant mortality rates, especially among black women. In 2012, the Ohio Department of Health and local partners came together in a collaborative effort to create the Ohio Equity Institute to address the racial disparities in birth outcomes in the nine Ohio counties with the highest disparities. Since that time, there have been many meetings to discuss the problem and to develop an action plan.

In 2016, a summit meeting sponsored by Ohio Equity Institute members was held in Akron to discuss the impact of racism on infant mortality, noting that some of the highest rates of infant mortality in Ohio were located in two zip codes in Akron with predominantly black populations. Shortly thereafter, a program called “Full Term First Birthday Akron” was developed with the mission of educating and informing citizens of programs available in the community that promote healthy, full term pregnancies so that every child celebrates a first birthday. The priority concerns of the program are: 1) to address structural racism (with the help of health and social services, education and workforce development, financial empowerment initiatives and housing initiatives); 2) to reduce prematurity (by promoting healthy pregnancies through pre-natal care, fatherhood involvement, progesterone therapy and birth spacing); and 3) to eliminate sleep-related deaths. These priority areas are used to identify those at risk for an infant mortality event.

At that very first summit meeting, Right to Life of Northeast Ohio (RTLNEO) requested to be part of the collaborative effort to combat infant mortality but were ignored. This was in spite of the fact that RTLNEO provided a packet of medical information that pointed to a link between surgical abortion and preterm birth in subsequent pregnancies. This information could be used to foster early intervention to help prevent preterm birth in post abortive pregnancies. Sadly, it was informed that abortion was not a variable that the group would consider in its quest to reduce infant mortality. Its request to be notified of subsequent meetings was also ignored. However, RTLNEO received notification from an inside source, and was able to attend many of the meetings. Ironically, the local Planned Parenthood, which does not provide prenatal care, was accepted as a formal group collaborator.

At the 2019 Akron Health Equity Summit meeting, RTLNEO submitted a statement for the Q & A session which pointed out that Akron’s Summit County had a black population of 15% but accounted for 50% of its abortions. It also noted that the zip codes with the highest rates of black infant mortality also had significantly higher abortion rates. It asked why prior abortion history was not being considered as a relevant variable in the quest to reduce future infant mortality incidents. The physician answering the questions said, “abortion is a safe medical procedure that has no bearing on infant mortality” and quickly moved on. Yet at the same meeting there were speakers who suggested we should measure cortisol levels in women’s hair to monitor the effect of stress on infant mortality, and also a speaker from Planned Parenthood who maintained that the key to preventing infant mortality was to teach responsible sex education in the schools.

In July of 2020, RTLNEO sent all of the information and documentation in this article to many local and state health department officials and members of the infant mortality prevention group asking for feedback, and again requested to be part of the group collaborative effort to combat infant mortality. To date, there has been no response.

A Brief Overview of Worldwide Studies Regarding Induced Abortion’s Effect on Future Pregnancies

There are over 140 studies in the medical literature (at least 18 done in the United States) that find induced abortion increases the risk of prematurity and/or low birthweight in subsequent pregnancies, thus posing risks for future, wanted children. Many of the earlier studies were reviewed by Calhoun et al.⁵ A 2009 compilation of 12 studies from around the world found that the odds of experiencing a preterm birth (less than 37 weeks) increased by 25% after one abortion to 51% following two or more abortions.⁶ Another report (2009) of 37 international studies, carefully chosen for their scientific rigor, concluded that women having a first or second trimester abortion increase the odds of having a preterm birth by 36% after one abortion, and by 93% after two or more abortions. The study also found the odds of delivering low birthweight (less than 5.5 pounds) infants increased by 35% after one abortion, and by 72% after two or more abortions.⁷ A more recent (2016) meta-analysis analyzed data from 36 studies, 28 of which involved 913,297 women who had surgical abortions.⁸ Compared to controls, women with a prior surgical abortion increased the odds of having a subsequent preterm birth by 52%, and of delivering a low birthweight child by 41%. Three of the groups studied involved 10,253 women who had a prior medical abortion. Compared to controls this group increased the odds of having a subsequent preterm birth by 50%. The chart below illustrates the increasing risk of premature birth after multiple abortions based on the 2009 and 2016 studies mentioned above.

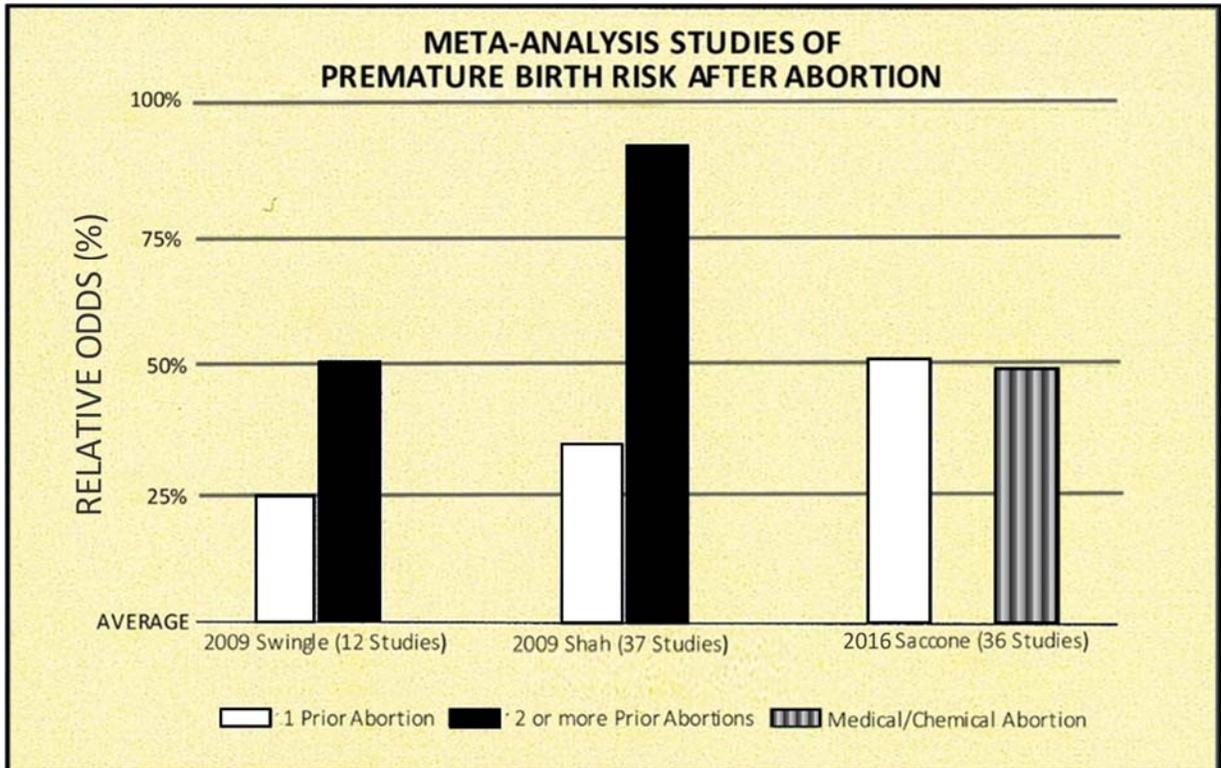


Chart adapted from the original in the companion booklet to the movie “HUSH—a liberating conversation about abortion and women’s health”

The most recent (2020) large study involved 418,690 first time Finnish mothers with singleton births between 1996 and 2013.⁹ The study population included 364,392 women who had no previous abortion, 46,589 who had an early induced abortion (less than 12 weeks gestation), and 7,709 who had a late induced abortion (12 or more weeks gestation). A regression analysis controlled for maternal age, marital status, smoking status, number of previous abortions, method of previous abortion, and the interval between pregnancies. When comparing groups, the authors found:

1. Women who had early induced abortions compared to those with no abortions were significantly more likely to experience perinatal deaths, low birthweight infants, and infants who were small for their gestational age. Women who had late induced abortions compared to those with no abortions were significantly more likely to experience perinatal deaths, “extremely” preterm births (less than 28 weeks) or “very” preterm births, (before 32 weeks), and infants with very low birthweight (under 1,500 grams) or low birthweight (under 2,500 grams).
2. And, as might be expected, women who had late abortions experienced greater adverse outcomes than those having an early induced abortion.

National Data

Prematurity is the leading cause of death among newborn infants. Between 1980 and 2005, the preterm birth rate in the U.S. increased by 43%, corresponding to the steady rise in legal induced abortions from 1969 through 1981.¹⁰ According to the CDC, babies who died of preterm-related causes accounted for 36% of all infant deaths in 2013.¹¹ Moreover, those who survive may face lifelong problems. These include mental retardation, cerebral palsy, breathing and respiratory problems, vision and hearing loss, and feeding and digestive problems.¹² Prematurity has also been linked to lower levels of education and more childlessness in both women and men followed into adulthood. Women who were preemies were more likely to give birth to preemies themselves.¹³

There has long been a racial disparity in the number of abortions. In 2016, although blacks made up approximately 13.9% of child-bearing aged women, they had 38% of the abortions, or 2.7 times the number of abortions one would expect, given their percent of the population.¹⁴ As mentioned earlier, there is also a racial disparity in black-white infant mortality rates. In 2016 the black infant mortality rate was 11.4 for every 1,000 live births, or 2.3 times higher than the white rate of 4.9.¹⁵ Similarly, black mothers are more likely to experience preterm births, particularly those prior to 34 weeks of completed gestation. In 2016, the black rate of early premature births was 4.93, which was 2.1 times higher than the white rate of 2.33.¹⁶

A recent national study of over 2.1 million birth certificates from 2015-2017 found that even women of high socioeconomic status who were black or mixed black/white race were more likely to experience premature

births than were white mothers. Unfortunately, although the study considered nine independent variables, it did not consider abortion as a possible causal factor.¹⁷

Ohio Data

As we can see in Tables 1 and 2 below, a nine-year review of black and white Ohio women of child-bearing age tends to mirror the national pattern. That is, black Ohio women have a disproportionate number of abortions, and a corresponding disproportionate rate of adverse pregnancy outcomes. These include a higher rate of overall infant mortality and of neonatal mortality.

Table 1. Abortion Disparity and Infant Mortality Disparity for Ohio Black and White Women of Childbearing Age (15-44), 2010-2018				
Year	% of Black Abortions	% of Blacks in Population	Black/White Abortion Disparity Score	Infant Mortality Disparity Score
2010	42.9	15.4	2.8	2.4
2011	42.5	15.5	2.7	2.5
2012	39.5	15.4	2.6	2.2
2013	40.5	15.4	2.6	2.3
2014	44.9	15.4	2.9	2.7
2015	46.8	15.4	3.0	2.7
2016	47.2	15.4	3.1	2.6
2017	47.4	15.4	3.1	2.9
2018	47.9	16.8	2.8	2.6

- *Percent of black abortions were calculated from Tables 5a in the Ohio Department of Health, “Induced Abortions in Ohio” for each year. Only black and white resident abortions were considered, since the U.S. Census collects its data from residents of each state.*
- *U.S. Census estimates for percent of Ohio black women (15-44) in the population were collected from its “American FactFinder” website during the week of March 15, 2020.*
- *Abortion Disparity Score is the percent of black abortions divided by the percent of black females of reproductive age in the population of black and white Ohio women aged 15-44, or the “excess” of black abortions that might be expected, given black women’s percentage of the population.*
- *Infant Mortality Disparity Score is the black infant mortality rate divided by the white infant mortality rate. Source: Ohio Department of Health, “2018 Infant Mortality Annual Report,” p. 7.*

As can be seen in Table 1 above, as abortion disparity scores increase or decrease, infant mortality disparity scores tend to increase or decrease. Pearson’s correlation coefficient between these two variables is positive and strong ($r = .86$), and the coefficient of determination (R^2) equals .74, indicating that 74% of the fluctuation in infant mortality disparity scores is accounted for by the fluctuation in abortion disparity scores.

Table 2. Abortion Disparity and Neonatal Mortality Disparity for Ohio Black and White Women of Childbearing Age (15-44), 2010-2018		
Year	Black/White Abortion Disparity Score	Neonatal Mortality Disparity Score
2010	2.8	5.3
2011	2.7	6.8
2012	2.6	4.9
2013	2.6	5.8
2014	2.9	6.6
2015	3.0	6.8
2016	3.1	6.4
2017	3.1	7.7
2018	2.8	4.7

- See notes 1-3, Table 1
- Neonatal Mortality Disparity Score is the difference between the black neonatal mortality rate and the white neonatal mortality rate in each year. Source: Ohio Department of Health, “2018 Infant Mortality Annual Report,” Figure 5, page 10.

As can be seen in Table 2 above, as abortion disparity scores increase or decrease, infant neonatal disparity scores tend to increase or decrease. Pearson’s correlation coefficient between these two variables is a fairly strong positive correlation ($r = .70$), and the coefficient of determination (R^2) equals .49, indicating that 49% of the fluctuation in neonatal mortality disparity scores is accounted for by the fluctuation in abortion disparity scores.

The article, “*Black Infants More Likely to Die in Ohio, Report Says*,”¹⁸ indicates that “in 2018, prematurity-related conditions remained the leading cause of infant death in Ohio, comprising almost one-third of deaths.” It also notes that “Nine Ohio counties accounted for nearly 66 percent of all infant deaths statewide.” Those counties and their 2018, Black/White Abortion Disparity Scores, were Butler (4.2), Cuyahoga (2.4), Franklin (2.5), Hamilton (2.4), Lucas (2.7) Mahoning (3.3), Montgomery (2.5) Stark (3.6) and Summit (3.3).¹⁹ Likewise, six of these counties had high Black/White Infant Mortality Disparity Scores: Cuyahoga (3.4), Franklin (2.3), Hamilton (3.8), Lucas (2.9), Montgomery (1.9), and Summit (4.3).²⁰

The *Ohio Commission on Infant Mortality* was created in 2014 with the goal of improving Ohio’s infant mortality rate. At the time the commission was created, Ohio ranked 46th in the nation for overall infant mortality and 50th for black infant mortality. This commission spearheaded Senate Bill 332, passed by the Ohio legislature in 2016, and then contracted with the *Health Policy Institute of Ohio* to collect data and produce a report on how to reduce infant mortality. Prior to the bill’s passing, RTLNEO contacted the bill’s sponsors requesting that they amend the language of the bill to require that prior abortion data be collected in infant mortality cases since there is currently no data base that can correlate the two statistics. Because there is

currently no data available to show how many Ohio infants who died in the first year of life were born to mothers who had prior abortions, collecting this information would be of extreme value in predicting risk factors in future pregnancies of wanted children. Neither of the bill's sponsors ever responded to the request, and the bill passed without the amendments. A 233-page report with policy recommendations regarding the effect of housing, transportation, education and employment on infant mortality was issued in December 2017. There is not one mention of the impact of prior abortion on infant mortality in the report.

The subject of abortion can be volatile and highly politicized but should never be ignored if it can be an indicator of the risk of premature birth or infant mortality. The work that the Ohio Equity Institute and collaborative groups do to address socio-economic issues which can affect birth outcomes is highly commendable. However, to ignore the risks associated with prior abortion can be a threat to achieving more positive pregnancy outcomes. Gathering information on the prior abortion history of women in this program can contribute to better outcomes for present and future pregnancies by identifying those at most risk of preterm/low-birthweight events so that progesterone or other medical therapies can be utilized at the earliest possible time. It is a tragedy that a mother would choose to end the life of her preborn child through abortion. It is also a tragedy that the risk prior abortion poses to subsequent pregnancies of wanted children is ignored.

To ignore the relationship between prior abortion and adverse outcome in future pregnancies for women in these and all Ohio counties would seem to be the result either of:

- unfamiliarity with the medical literature on this topic,
- racism,
- and/or the acceptance of the ideologies of the population control and pro-choice movements, which publicly deny the findings of science, and do not want to inform women that legal induced abortion is dangerous to their physical and mental health, and to the health of their future, wanted children.²¹

We cannot afford to be selective in our commitment to “following the science” wherever the facts lead us.

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