

## AAPLOG – AMERICAN ASSN OF PRO-LIFE OB/GYNS

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### AFRICAN-AMERICAN WOMEN, PRETERM BIRTH, AND ABORTION

#### WHAT IS THE ASSOCIATION?

The huge increase in preterm birth in the United States (30% increase since 1981) is a major public health concern, both from the standpoint of infant morbidity/mortality (it is the leading cause of infant mortality and morbidity), and from the standpoint of the immense cost burden this problem places on the health care system. Three years ago, the ACOG, partnering with the March of Dimes, began a nationwide campaign to examine the causes and find remedial action for this very troubling pregnancy outcome. The most recent and complete commentary on the preterm birth dilemma is found in the Institute of Medicine's newly published (National Academy of Science Press, July 06) 570 page resource book entitled "*Preterm Birth: Causes, Consequences, and Prevention.*" This report has been applauded by ACOG, SART, and ASRM as an exceptional work on this adverse pregnancy result. ACOG is a co-sponsor of this work.

**If one looks very carefully, one will find a reference to induced abortion as a risk factor.** The single reference will be found in the Appendix, on page 517-18, where abortion is noted as an "immutable" risk factor (meaning, once this pregnancy has started, there is no intervention to correct for the increased risk.) **Obviously, the risk is totally avoidable, if the woman, given adequate informed consent prior to the aborted pregnancy, would choose NOT to have an abortion.**

**This is not new information.** Over 59 previous epidemiological studies attest to this association, including the recent prospective studies in Europe (Epipage and Europop studies). The literature notwithstanding, the ACOG has positioned itself with a categorical denial of this association, both in their 2006 Compendium of Selected Publications (ACOG Practice Bulletin #26), and in their 2005 Amicus Brief for the 2006 Supreme Court case (Ayotte vs Planned Parenthood of New England.) (Note: Practice Bulletin #26 was replaced in Oct, 2006 with Practice Bulletin #67, which does not repeat this misinformation. However, neither is there correction of this misinformation in any ACOG literature we have seen to date.) The ACOG finds itself in the untenable situation of both denying and validating (as co-sponsor of the IOM report) this complication of induced abortion.

**What has this to do with African-American women and PTB and abortion??** Quite a lot. Consider the following information taken from the IOM report:

"African-American women deliver their infants before 37 weeks of gestation **twice** as often as women of other races, and deliver their infants before 32 weeks of gestation **three** times as often as white women. . ."

“Findings related to SES (socioeconomic status) suggest that the disparities in the rates of preterm birth between African-American and white women persist after attempts to adjust for socioeconomic differences (Collins and David, 1997; McGrady, 1992; Shiono, 1997; Schoendorf, 1992).”

“Other behavioral and social differences between African-American and white women have been evaluated as potential causes of the disparity in preterm birth rates. Proportionately fewer African-American women smoke cigarettes (Lu, 2005; Beck et al., 2002; Ebraham, 2000) and their rate of use of drugs and alcohol is no higher than white women’s (Serdula 1991).”

Isn’t it interesting that preterm birth rates remain increased for African-Americans after socio-economic-behavioral factors are controlled for? Further, smoking, which has been associated with preterm birth, is less in the African-American pregnant population.

**The recent European prospective studies demonstrated a stronger association of induced abortion with ‘very’ (<32 wk) preterm birth, compared to preterm birth overall (as do many of the previous studies). National statistics establish the fact that Black women have 3 times the rate of induced abortion as non-Blacks. And Black women have 3 times the rate of “very” preterm labor. SES and behavioral factors do not account for the difference. Perhaps ACOG should share these IOM findings with the March of Dimes, who might, in turn, share them with the women they seek to help, to prevent this difficult outcome. (The word “abortion” does not appear on the March of Dimes website material on preterm birth.)**

It is true that none of this establishes with certainty a specific cause—and-effect relationship as of yet, but shouldn’t this at least raise some intellectual research curiosity among those who, day-in and day-out, study this problem?

The IOM document repeatedly says that there are multiple and overlapping factors involved in the etiology of preterm birth. The writers spend a lot of time exploring things like environmental tobacco exposure, lead exposure, maternal stress/anxiety and so forth—all things which are in some ways harder to assess scientifically for a relationship to preterm birth than it would be to assess for induced abortion relationship to preterm birth. Yet IOM never brings up induced abortion, for which there is a substantial body of literature attesting its relation to preterm birth. Induced abortion affects probably as many women of reproductive age as tobacco use does in this country, and probably many more woman than are affected by lead exposure— yet the IOM report does not even bring abortion up for discussion. Abortion is relegated to a single notation in the appendix. AAPLOG believes the abortion association with PTB warrants a full discussion.