PICK A NUMBER - ANY NUMBER

HOW INCOMPLETE DATA AND THE SUPPRESSION OF FACTS PUTS WOMEN'S HEALTH AT RISK

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How incomplete data and the suppression of facts puts women's health at risk

EXECUTIVE SUMMARY

For decades, it has been difficult to obtain any current and accurate statistics on abortion. In Canada, ONLY hospitals are required to report all numbers and demographics, but clinics (surgical facilities and doctors offices) have no such legislative requirement. With each passing year, data is lacking and often inaccurate. It would seem there is no other medical procedure for which incomplete data is permitted to perpetuate. In every other healthcare procedure, data collection is considered important, to ascertain the patient's journey, both before and after the procedure, to ensure best practices and informed decision making, to create a picture of the patient's history and to ensure follow-up. Why when it comes to abortion, are all the normal practices of medicine no longer valid?

We call on the provincial government of Ontario to craft legislation which would mandate any facility, providing abortion, whether surgically or chemically, to report all demographics and numbers of every woman undergoing the procedure and make it a requirement of receiving OHIP. If women's health matters as much as we are told it does, then we should see it in practice, especially with regard to induced abortion.

1. Induced abortion statistics provided by the Canadian Institute for Health Information (CIHI) are incomplete and unreliable
2. Induced abortion methods procured at "clinics" (includes, clinics, physicians offices, abortion facility other than a hospital) are not captured in the CIHI national report (CIHI 2019 Induced abortion data tables)
3. The Ontario Ministry of Health reported 45,363, prescription claims for Mifegymiso between August 10th 2017 and December 31st 2020. (email to AFLO February 26th 2021)
4. There is no Ontario provincial legislative requirement for mandatory reporting regarding induced abortion at "clinics" which procure 80% of induced abortions in Canada (CIHI 2019 Induced abortion data tables)
5. CIHI is unable to provide explicit counts for Mifegymiso (page 2)
6. A "written patient consent to use Mifegymiso" is not required. "While dialogue and information sharing between patients and health professionals is always important, the requirement for written patient consent to use Mifegymiso is being removed. https://www.healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/65034a-eng.php
7. In Ontario there is no "age" of consent category, which means that access to Mifegymiso may be had by girls and women of any age if they are perceived to be capable of understanding, the procedure and risks https://www.ontario.ca/laws/statute/96h02
8. "The overall incidence of adverse events was fourfold higher in the medical compared with surgical abortion cohort" https://pubmed.ncbi.nlm.nih.gov/19888037
9. From August 2017-July 2020 Health Canada reported 40 adverse reaction reports representing 26 individual women – one woman died, two experienced "life threatening" effects and 23 experienced "serious" side -effects (page 6)
10. Health Canada's originally strict and protective guidelines have been totally relaxed after lobbying by abortion advocates, resulting also in access to medical abortion extended by two weeks to 9 weeks. (page 5)
11. The Mitchell Creinin Study which purports to disprove the abortion pill reversal procedure, in fact ends up doing just the opposite, albeit evidenced in a very small study
12. Mifepristone, which is well known to cause heavy bleeding, was responsible for three cases of severe hemorrhage. (page 9)
13. Mitchell D. Creinin is a consultant for Danco Laboratories, [which manufactures Mifeprex] providing medical consultation for clinicians that contact Danco with questions regarding mifepristone. One of the co-authors, Laura Dalton is an employee of Planned Parenthood. http://allianceforlife.org/wp-content/uploads/2021/05/disclosure.pdf
14. It appears that while induced abortion, whether medical or surgical is referred to as a "medical procedure" or "women's health care" the approach to providing it by the medical community stands out as being one of callous disregard neither ensuring informed consent, proper follow-up nor interest in maintaining and researching statistics in order to follow induced abortion's effect on women's health.
15. While medical and political professionals make much about women's health, and abortion advocates clamour for women's access to induced abortion it appears that none actually have the interests of women at heart.
16. Induced abortion needs to be placed under a microscope in Canada and the real facts made available to women

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For decades, it has been very difficult to obtain current and accurate statistics on abortion. In Canada, ONLY hospitals are required to report all numbers and demographics, but clinics (surgical facilities and doctors offices) have no such legislative requirement. With each passing year, data is lacking and often inaccurate.

The WHO states that "today women's health has become an urgent priority, yet the data surrounding this issue are limited and often unreliable." Collecting empirical data is necessary to help shape health policy that will improve the health and well-being of women and girls.

WHAT WE KNOW

The statistics that we do have come from the Canadian Institute for Health Information (CIHI). In February 2021, CIHI released the latest (2019) Canadian induced abortion tables (www.cihi.ca, see "Access Data and Tables" then "Quick Stats").

In the Ontario tables a total of 27,911 abortions were recorded in 2019, the latest year for which we have any data. Of these, 7,326 abortions were procured in hospitals. This number is down by about 1,000 abortions from 2018. A further 20,585, (again a seemingly downward trend since 2018), of approximately, 700 was reported under "clinics". Although the numbers for those aged 17 and Under and 18-24 were provided by hospitals as 274 and 2,544 respectively, no clinics reported on the abortion numbers for either category. These clinic numbers are supposed to be captured in the "Unknown" Category for 24 years and Under – this column shows a figure of 5,389 abortions. However, given that Clinic numbers are approximately three times as many as hospital numbers in every other Age Category – some quick math finds that there is a possibility of 822 induced abortions for "Age Category" 17 and younger and 7,632 for the Age Category 18-24 - which surpasses 5,389 by a significant 3,000.

IMPORTANT NOTES WITH REGARD TO CIHI STATISTICS:

- Almost 80% of abortions in Ontario are procured in facilities which have **no legislative requirement to report numbers or demographics** and while five age categories are reported voluntarily no demographic information is made available for any of the seven categories by the "clinics".
- The 18-24 age bracket undergo the highest number of abortions in Ontario both in hospitals and clinics.
- **CIHI does not report the overwhelming majority of medical abortions**

In mid-February 2021, we asked the Ontario Ministry of Health and Long Term Care (MOHLTC) if it would be possible to obtain the number of prescriptions written out for the abortion medication, Mifegymiso, since Health Canada licensed its use, and the OHIP coverage program began in August 2017. On February 26th 2021 we received the numbers for "prescription claims" for Mifegymiso for that period – these would be the claims made for OHIP coverage from a "clinic," hospital or pharmacy when a prescription had been filled. Unlike the CIHI data which is collected as a calendar year, the MOHLTC data is collected from April 1st to March 31st and therefore it was necessary, in order to compare numbers and actually get a better understanding of them for each calendar year, to convert the MOHLTC numbers. The Ministry noted a total of 45,363 prescription claims between August 10, 2017 and December 31, 2020.

Table #1 (below) shows these Ontario figures for each calendar year since the program started in August 2017 until February 2021. We have taken the liberty to approximate a comparison of the prescriptions written in hospitals to those written in "clinics" based on the percentage of clinic to hospital abortions reported by CIHI and therefore these numbers are approximate, but as you can see the overwhelming number of claims would be written from "clinics".

PRESCRIPTION CLAIMS

Numbers adjusted to calendar year for comparison to CIHI figures –
Original numbers provided to Alliance for Life Ontario via email from MOHLTC February 26, 2021.

Calendar Years	Prescription Claims		
	Total	Hospital	Clinic
2017 (Aug-Dec)	2,290	991	1,299
2018	10,260	1,002	9,258
2019	14,575	936	13,639
2020	15,626	1,066	14,560
2021 (Jan/Feb)	1,067	141	926

Table #1

Please note that even though "clinics" have no legislative requirement to report these numbers or the demographics, and if our math is correct, they have 2-14 times as many prescription claims than hospitals in any given calendar year 2017-2021 in Ontario.

We are still not certain that Mifegymiso is included as "abortion numbers" in either the CIHI tables or the MOHLTC figures.

We asked CIHI if Mifegymiso prescription claims would show up as abortion numbers. See their reply which we received on March 2, 2021.

Thank-you for your interest in CIHI data. CIHI's annual abortion report here https://www.cihi.ca/sites/default/files/document/induced-abortions-reported-in-canada-in-2019-en.xlsx includes both hospital and clinic abortions, therefore, abortions with mifegymiso use (occurring in hospitals or clinics) may be included in volumes but we are not able to provide explicit counts for mifegymiso use. Please note these tables report on abortion volumes, not prescription claims. Method of abortion is not available for clinic data.

> *Re: Your question for Table 7, abortions induced by mifegymiso occurring in a hospital setting are included in the reported volumes. Again, method of abortion information is not available for clinic data, and there is no unique code for mifegymiso in the hospital data (i.e. unable to uniquely identify these cases).*
>
> *We hope this helps.*
>
> *Best regards,*
>
> *On Behalf of the CAD team*

We thought we would see what the comparison was between the numbers provided by CIHI which might possibly include Mifegymiso, as it is referred to as a "Medical procedure" and therefore the following figure reflects that comparison.

COMPARISON

Comparison between CIHI Canada wide numbers which include "Medical Abortion Procedure" and "Surgical and Medical Procedure", and MOHLTC Mifegymiso prescription claims numbers for Ontario only.

Calendar Years	CIHI Total (All Canada)	MOH Totals (Ontario Only)
2017	3,349	2,290 (*)
2018	3,665	10,620
2019	3,649	14,626
(*) Aug to Dec	"Medical Procedure" "Surgical & Medical Procedure"	Mifegymiso Prescription Claims

Table #2

The numbers reported by CIHI under its **"Table 7",** and shown in Table 2 are those listed under "Medical Procedures Only" and "Surgical and Medical Procedures." They represent hospital abortions only as we have no numbers for methods of abortion from the "clinics," and of course these represent the whole of Canada, whereas the Mifegymiso statistics represent the numbers in the province of Ontario only.

It is quite shocking when you look at the national figures compared to Ontario figures. Goodness knows what the number of Mifegymiso "prescription claims" is across the country as it appears they are not present in the CIHI numbers anywhere!

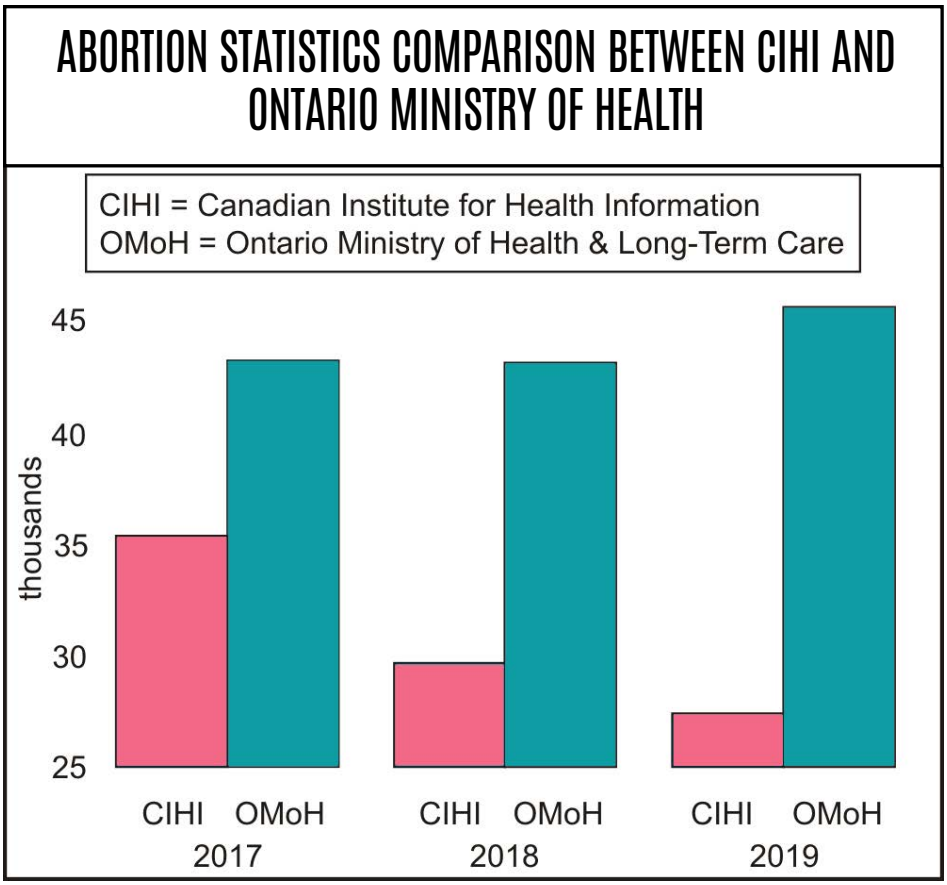


FIGURE #1

In the meantime, Pat Maloney, from Run for Life Blog made a request to the Ontario Ministry of Health for its numbers on abortions procured in Ontario and she received numbers for the 2014/2015 year up to the 2019/2020 and sent them out for our further information. Please see these figures converted to calendar years in Figure #1 as a comparison to those we received from CIHI for the years 2017, 2018 and 2019. The actual numbers were as follows:

CIHI Ontario 2017 = 35,587
- ***Versus*** Ontario MOHLTC = 43,379
CIHI Ontario 2018 = 29,513
- ***Versus*** Ontario MOHLTC = 43,338
CIHI Ontario 2019+ = 27,911
- ***Versus*** Ontario MOHLTC = 45,177

ONTARIO MIFEGYMISO PRESCRIPTION CLAIMS

Added to CIHI and Ontario MOHLTC statistics for the years 2017, 2018 and 2019

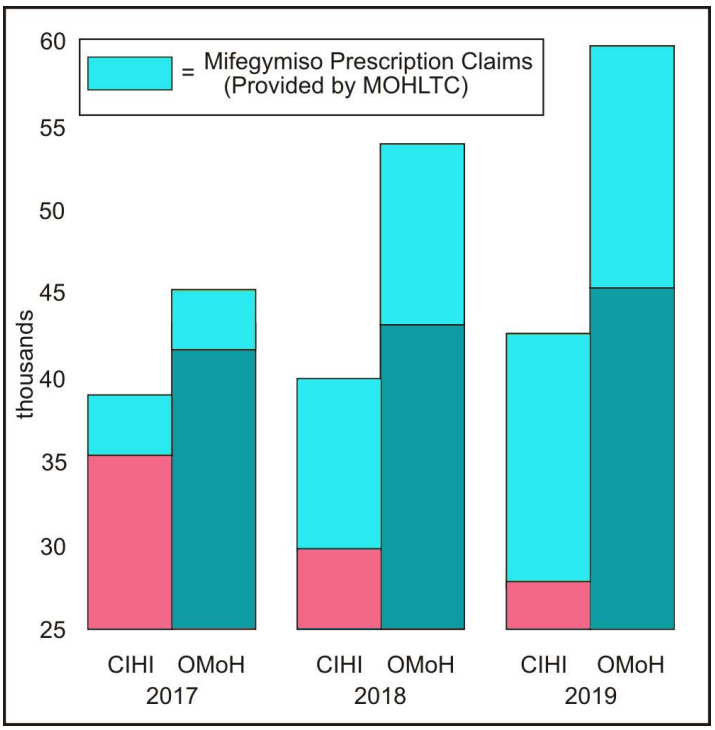


FIGURE #2

We were interested in seeing what the statistics would look like if the Ontario "Mifegymiso claims" were not included in either of the reported numbers from CIHI or MOHLTC. Figure 2 shows what the possibility might be if they are not. I believe it more likely that they are captured in the Ontario statistics but quite honestly with such a mishmash of statistics it is hard to tell. Here are the numbers which figure 2 represents. Ontario Mifegymiso "prescription claims" added to CIHI and Ontario MOHLTC statistics; for the years 2017/2018 and 2019, bearing in mind that Mifegymiso was only made available from August 10th 2017 and therefore the number for that year is only from August to December.

CIHI Ontario 2017 plus Mifegymiso prescription claims = 37,877 - ***Versus*** Ontario MOHLTC plus Mifegymiso prescription claims = 45,669
CIHI Ontario 2018 plus Mifegymiso prescription claims = 39,353 - ***Versus*** Ontario MOHLTC plus Mifegymiso prescription claims = 53,598
CIHI Ontario 2019 + 27,911 plus Mifegymiso prescription claims = 42,486 – ***Versus*** Ontario MOHLTC plus Mifegymiso prescription claims = 59,752.

What is absolutely horrifying about all this is that we have 80% of abortions taking place, whether surgical or medical, where prescriptions are written in facilities listed under the heading of "clinics" which are not required by provincial law to report numbers or demographics!

TIMES GREATER RISK

We know from the October 2009 Finnish study, "*Immediate complications after medical compared with surgical termination of pregnancy on surgical versus medical abortion"* that medical abortion poses a four times higher risk factor of the most serious side effects of surgical abortion.

The government of Finland uses a comprehensive network of medical registries that can be used to track abortion outcomes in that country's government-based medical system. From 2000 to 2006 all women (n=42,619) who had abortions up to 63 days (9 weeks gestation) were followed up until 42 days after the abortion.

The results of the study found:

- The overall incidence of adverse events was four-fold higher in the medical compared with surgical abortion cohort (20.0% compared with 5.6%, P<.001)
- Hemorrhage (15.6% compared with 2.1%, P<.001)
- Incomplete abortion (6.7% compared with 1.6%, P<.001) were more common after medical abortion. The rate of surgical (re)evacuation was 5.9% after medical abortion and 1.8% after surgical abortion (P<.001)
- Although rare, injuries requiring operative treatment or operative complications occurred more often with surgical termination of pregnancy (0.6% compared with 0.03%, P<.001) No differences were noted in the incidence of infections (1.7% compared with 1.7%, P=.85), thromboembolic disease, psychiatric morbidity, or death

Despite this reavealing study, the Canadian Ministry of Health licensed Mifegymiso in 2016 and MOHLTC has no mandatory legislative requirement for demographic information regarding a woman's health before or after a medical or surgical abortion if it is procured in a "clinic" setting in our province.

Putting Women's Health At Risk

The 2016 restrictions on Mifegymiso in Canada included the following:

- 7-week / 49-day gestational limit (since [first day of] last menstrual period);
- Physicians must receive training in order to be on a registry to prescribe;
- Physicians must dispense drug directly to the patient;
- Physicians must supervise the patient's ingestion of the first dose;
- Physicians must exclude ectopic pregnancy and determine gestational age by ultrasound.
- Women were asked to sign a consent form and take the Mifepristone tablet in front of the physician.
- Misoprostol was provided but were permitted to be take at home. A return visit 14 days later was strongly advised to ensure the abortion is complete and that there was no infection.

In November of 2017, at the behest of the abortion lobby, restrictions were loosened to include:

- MIFEGYMISO is now indicated for medical termination of a developing intra-uterine pregnancy with a gestational age up to nine weeks (63 days) as measured from the first day of the last menstrual period;
- MIFEGYMISO education program is no longer mandatory;
- MIFEGYMISO should be prescribed by health professionals with prior adequate knowledge of medical abortion and use of MIFEGYMISO or who have completed a MIFEGYMISO education program;
- Mifegymiso can now be dispensed directly to patients by a pharmacist or a prescribing health professional;
- As was always the case, patients should take the medication as directed by their health professional, either at a health facility or at home;
- Registration of health professionals with Celopharma (Canadian distributors of Mifegymiso) is no longer required in order to prescribe or dispense MIFEGYMISO.

Health professionals were once required to do the following prior to prescribing MIFEGYMISO:

- Ensure you have adequate knowledge of the use of these medications to prescribe Mifegymiso;
- Discuss informed consent with the patient and provide the patient with the current Patient Medication Information and a completed Patient Information Card;
- Exclude ectopic pregnancy and confirm gestational age by ultrasound;
- Counsel patients on the effects and risks of Mifegymiso, including bleeding, infection, and incomplete abortion;
- Ensure that patients have access to emergency medical care in the 14 days following administration of mifepristone; and,
- Schedule a follow-up 7 to 14 days after patients take mifepristone to confirm complete pregnancy termination and monitor for side effects.

But then in April 2019, Health Canada Further Loosened Guidelines:

Previously, the Canadian product monograph for Mifegymiso indicated that an ultrasound was required before prescribing Mifegymiso to confirm the gestational age (number of weeks pregnant) and to rule out an ectopic pregnancy (a pregnancy outside the womb).

- With the changes to the product monograph, prescribers now have the flexibility to use their medical judgement on how best to determine the gestational age and to rule out an ectopic pregnancy;
- Health Canada also responds to concerns that some patients may have been facing unnecessary barriers or delays in accessing this product.
- The product monograph still recommends an ultrasound when the gestational age is uncertain or an ectopic pregnancy is suspected.

The Abortion Pill Is Not Safe and Health Canada Knows It

On January 27, 2021, Pat Maloney, from Run for Life Blog reported the following:
"Health Canada issued 40 adverse reaction reports on this drug. Of these, there were 26 individual women.

One woman died. Two more experienced "life threatening" side effects. 23 women experienced "serious" side effects.

In 2017 there was one woman affected; in 2018 two women were affected; in 2019, it was six women. And in 2020 there were 16 women with serious side effects. (Note that the report is only until July 31, 2020, so 2020 will undoubtedly have more serious problems reported).

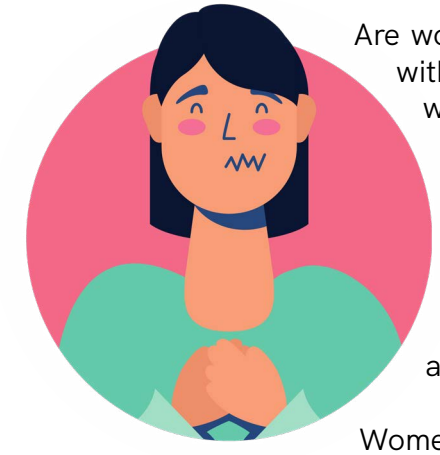
Notice the trend here? As the abortion pill becomes more popular, even more women will suffer from its life threatening and possibly fatal side effects.Not a safe drug at all.
Mifepristone (Search the database by active ingredient)

The woman who died was 27 years old. From the documented adverse reactions she experienced, it appears that her whole body, and all of her organs, went into extreme failure. Here were her symptoms:

> *Abdominal pain, Acidosis (a process causing increased acidity in the blood and other body tissues), Ascites (the abnormal buildup of fluid in the abdomen. Technically, it is more than 25 ml of fluid in the peritoneal cavity, although volumes greater than 1 liter may occur) Bacterial infection, Blood pressure decreased, Blood urea increased, Body temperature decreased, Cardiac arrest, Cardiovascular disorder, Chills, Dehydration, Dizziness, Endometritis, Gastritis haemorrhagic, Hyponatraemia (is a low sodium concentration in the blood), Hypoxia*

(is a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level), Leukocytosis (a condition in which the white cell is above the normal range in the blood. It is frequently a sign of an inflammatory response, most commonly the result of infection), Multiple organ dysfunction syndrome, Nausea, Oliguria (or hypouresis is the low output of urine specifically more than 80 ml/day but less than 400ml/day. The decreased output of urine may be a sign of dehydration, kidney failure, hypovolemic shock, hyperosmolar hyperglycemic nonketotic syndrome, multiple organ dysfunction syndrome, urinary obstruction/ urinary retention, diabetic ketoacidosis, pre-eclampsia, and urinary tract infections, among other conditions), Palpitations, Pelvic pain, Pleural effusion (is excess fluid that accumulates in the pleural cavity, the fluid-filled space that surrounds the lungs), Pyrexia (Fever, is defined as having a temperature above the normal range due to an increase in the body's temperature set point), Sepsis, Septic shock, Uterine spasm, Vaginal discharge, Vaginal haemorrhage, Vomiting." Recommended link: https://abortionpillreversal.ca/abortion-pill-health-risks

Second Class Health Care for Women



Are women still considered second class citizens by the Ministries of Health or within medical circles? What other form of health care has no regard for women's immediate safefy or future health?

Women are now encouraged to self-medicate with Mifegymiso at home alone, with no health care professional on hand to assist with any of the outcomes mentioned above, should they arise. Women can now diagnose their own pregnancy, ectopic or otherwise, date their pregnancy correctly, and treat themselves at home, with no professional oversight to ensure they are not under duress by an intimate partner or family member.

Women are left to go through the horror and pain of aborting their child at home, possibly alone. How are women to know whether or not they are experiencing infection, as not all infections cause fever? We have horror stories from all over the world of mothers who have seen their tiny children in toilets or on the floor in a pool of blood as they self-abort.

It would seem there is no other medical procedure for which incomplete data is permitted to perpetuate. In every other healthcare procedure, data collection is considered important, to ascertain the patient's journey, both before and after the procedure, to ensure best practices and informed decision making, to create a picture of the patient's history and to ensure follow-up. Why when it comes to abortion, all the normal practices of medicine are no longer valid?

The Ministries of Health appear to have no regard for best practices, data collection, informed consent or follow-up, let alone collection of demographic statistics of those undergoing procedures? As the old data adage goes, **You can not manage what you do not measure**.

There are numerous studies, meta-analyses and research papers examining the harm Mifegymiso has wrought on many women either, physically, mentally, emotional or psychologically, after either surgical or medical abortion. Yet, in 2021, we are left to rely on statistics that are two years old and so sorely incomplete that one cannot make head nor tail of them.

We call on the Ontario government to craft legislation which would mandate any facility, providing abortion, whether surgically or chemically, to report all demographics and numbers of every woman undergoing the procedure and make it a requirement of receiving OHIP. If women's health matters as much as we are told it does, then we should see it in practice, especially with regard to induced abortion.

What About The Mitchell Creinin Study?

A new study (*Mifepristone Antagonization with Progesterone to Prevent Medical Abortion: A Randomised Controlled Trial*) conducted in January 2020 is often cited as evidence that the Mifeprex (abortion pill) is safe while the Abortion Pill Reversal (progesterone) is dangerous. When infact, quite the opposite is true. (https://journals.lww.com/greenjournal/Fulltext/2020/01000/Mifepristone_Antagonization_With_Progesterone_to.21.aspx)

Critique:

On the Creinin study, and particularly in relation to using the findings in the study to attempt to demonstrate that APR is useless or ineffective, there are many shortcomings that need to be highlighted.

- The stated aim of the study was allegedly **to estimate the efficacy and safety of Mifepristone antagonisation with high-dose oral Progesterone.** In designing the study, it was estimated that the numbers that would be needed to demonstrate a significant difference between the treatment and placebo groups would be 40 patients with 20 in each group.
- This is obviously a very small cohort of study participants and it doesn't leave any room for a dropout rate which is inevitable in this type of study.
- **That might raise questions as to how serious the investigators really were in attempting to answer the questions relating to efficacy and safety.**
- • Two participants, one in each group, voluntarily withdrew from the study within a few days, and the study was discontinued after only twelve participants had been enrolled, allegedly because of safety concerns.
- Three participants, two in the placebo group and one in the Progesterone group, attended emergency departments due to concerns over bleeding
- It is important to highlight that bleeding did not occur in these ladies because of placebo or because of Progesterone. If anything, Progesterone might prevent or at least limit the degree of haemorrhage.
- **Mifepristone caused the bleeding in all cases. That is the nature of the drug and that is what it does. It interferes with the normal process of decidualisation (development of the endometrium in preparation for implantation and for maintaining pregnancy) by blocking Progesterone receptors, thereby preventing Progesterone from having its normal, intended, physiological effect.**
- Of the three who attended for emergency assessment, only one was deemed to be haemodynamically compromised so as to require a blood transfusion. **She was in the placebo group and did not receive Progesterone.**
- Because of these alleged safety concerns, the study was discontinued prematurely after only twelve participants had been enrolled.
- There were six in each group. **When two withdrew early on, it left only five study participants in each group.**
- **It is worth noting that, at the planned time of study end for each participant (before they were subsequently scheduled to proceed with their planned surgical abortion) at fifteen days, four subjects in the group treated with Progesterone still had ultrasonic evidence of continuing viable pregnancy (80%). Two subjects in the placebo group had evidence of continuing pregnancy (40%).**
- While the numbers are too small to reach any firm conclusion, it suggests that there **may already have been an early trend towards a significantly improved foetal survival rate in the Progesterone treatment group.** It is possible that this trend may have been noticed by the investigators who **may have then decided to terminate the study because of a possible "unwelcome" outcome if it was allowed to continue.**

- The main investigator was previously an outspoken critic of the notion that Progesterone administration after Mifepristone had already been administered could be effective in some cases in preventing abortion. He may have had a biased mindset in the designing of the study (flawed with too low intended enrollment numbers) and in the decision to terminate the study **(for fear that a previously held opinion might be undermined by study results)**. This, of course, is pure speculation, but may be worth considering.
- The main conclusion that the **authors attempt to derive from this very limited and inconclusive study** is that attempted Mifepristone antagonisation with Progesterone or expectant management (as per use of placebo in this study) after Mifepristone ingestion without subsequent Misoprostol administration in early pregnancy may be dangerous and may result in an increased risk of major haemorrhage.

This conclusion is quite remarkable

1. First of all, as mentioned above, the bleeding was caused in all cases by Mifepristone.
2. Haemorrhage, sometimes very heavy haemorrhage, is very common after its administration.
3. In first trimester pregnancy, our experience in the UK is that some degree of haemorrhage is almost inevitable after Mifepristone and we have to warn and also reassure our patients who seek rescue treatment that they are very likely to experience some bleeding.
4. Sometimes the haemorrhage starts within a matter of hours after Mifepristone, even before Progesterone can be administered.
5. Sometimes it occurs several days later.
6. Sometimes bleeding can continue for several days after Mifepristone.
7. Sometimes it is mild and short-lived.
8. Some women need to attend hospital for resuscitation measures, including blood transfusion.
9. Most women don't require emergency resuscitation.

- It is interesting and noteworthy that the Creinin conclusion regarding the potential danger of taking Mifepristone and not following it with Misoprostol is based on the results from this very small and incomplete study.
- In fact, the conclusion was based on the experience of three participants only (25% of the study co-hort).
- The authors ignored the fact that the improved foetal survival rate in the treatment group, although not statistically significant due to the small numbers, was based on the experience of six participants (50% of the study cohort).
- It is also worth noting that the author's conclusion that Mifepristone administration without subsequent Misoprostol may increase the risk of significant haemorrhage is contradictory to the advice generally given to women who change their minds about proceeding with abortion after they have already taken Mifepristone.

Those who do not accept the validity of abortion pill rescue tend to advise "expectant" management by doing nothing but watching and waiting rather than attempting to block the effects of Mifepristone with Progesterone.

A leading example of someone who advises "expectant" management is Daniel Grossman, another outspoken opponent of abortion pill rescue programmes (*Continuing pregnancy after Mifepristone and "reversal" of first-trimester medical abortion: a systematic review*. Grossman et al, Contraception 92 (2015):206-211).

Similarly, in the UK, before we established our rescue service, we tried to obtain support for the programme of offering reversal to mothers seeking help, by writing to the Royal College of Obstetricians and Gynaecologists, the Royal College of General Practitioners and NHS England. Our request for support was rejected by all bodies.

One of the reasons given for not supporting our proposal was that "expectant" management was the recommended **strategy in the highly unlikely event that a woman might change her mind about proceeding with abortion after taking Mifepristone.** If the Creinin study conclusion is correct, although certainly not conclusive, then this **would be the worst possible advice to offer mothers who change their minds after taking Mifepristone.**

Critique of the Mitchell Creinin Study by Dermot Kearney, Cardiologist and General Internal Physician working in the North-East of England. Current President of the Catholic Medical Association (UK), along with one other colleague, Dr Eileen Reilly in Glasgow. They have initiated and continued an Abortion Pill Rescue Programme in the UK since May 2020. (Written in an email to AFLO, January 19, 2021).

Some Facts Women Are Not Being Told

1. The overall incidence of adverse events was fourfold higher in the medical compared with surgical abortion cohort" https://pubmed.ncbi.nlm.nih.gov/19888037. 42,619 women who had an abortion up to 63, days were followed up until 42 days after undergoing either surgical (20,251) or medical abortion (22,368). The number of women used to prove the "safety analysis" for licensing Mifegymiso in Canada was a total 1,695 from 3 studies
2. The Abortion Pill Reversal is successful 64-68% of the time currently. https://stenoinstitute.org/resources/peer-reviewed-articles
3. Hundreds of babies have been saved to date with some in the US and Canada. Women do have a second chance at choice https://www.heartbeatinternational.org/aprn-lives-saved
4. Prior surgical uterine evacuation for either I-TOP or SAB is an independent risk factor for PTB. " https://pubmed.ncbi.nlm.nih.gov/2674350. (1-TOP is one termination of pregnancy, SAB is a Surgical Abortion, PTB is Pre-term Birth)
5. A huge 2011 study: Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009. https://pubmed.ncbi.nlm.nih.gov/21881096. "The article is comprised of 22 studies from 6 countries, 36 measures of effect and 877,181 participants (163,831 experienced an abortion). This review offers the largest estimate of mental health risks associated with abortion available in the world literature. The results revealed an 81% increased risk of mental health problems after abortion." https://aaplog.org/huge-2011-study-abortion-and-mental-health-quantitative-synthesis-and-analysis-of-research-published-1995-2009
6. Induced Abortion and Breast CancerRisk: https://www.bcpinstitute.org/uploads/1/1/5/1/115111905/ih_2005_3_vom_2005_10_20_1700_lanfranchi.pdf. Epidemiologic Studies: Induced Abortion and Breast Cancer Risk Updated April 2020 Total Studies = 76 Positive Association= 61 Statistically Significant = 41 Negative Association = 12 Statistically Significant = 4 Null (no effect) = 3 https://www.bcpinstitute.org/uploads/1/1/5/1/115111905/bcpi-factsheet-epidemiol-studies_2020.pdf

Suppression of Facts Leaves Women Uninformed

- The **Mifegymiso Monograph** states: *"Mifegymiso was studied in three open-label multi-center prospective studies. In these studies, a total of 1,695 women were included in the safety analysis."* (page 11 of 41- https://pdf.hres.ca/dpd_pm/00042012.PDF

- On Action Canada's website, **mifegymiso.com**, women are told: "There are two types of abortion in Canada: surgical abortion and medical abortion. Medical abortion uses medication rather than an internal procedure to end a pregnancy. **Both are safe procedures with exceptionally low complication rates and are not known to affect future pregnancies.** In July of 2015, after one of its lengthiest drug approval processes on record, Health Canada approved the abortion pill Mifegymiso. Mifegymiso is the Canadian brand name for the combination of the medications Mifepristone and Misoprostol. This combination of medications is set to replace the regimen that has been used in Canada up until

now to provide a medical abortion. Before the approval of Mifepristone, health care providers who offered medical abortion care were using a combination of Methotrexate prescribed off-label and Misoprostol. While the overall success rates, side effects and low complications rates are similar for both regimens, abortions induced with Mifepristone are offered "on-label', can be offered later in gestation and complete faster than those induced with Methotrexate. **The combination of Mifepristone and Misoprostol is the World Health Organization's recommended method for medical abortion** and has been on its list of essential drugs since 2005. Mifepristone has been used for close to 30 years with an outstanding safety and efficacy record and is available in over 60 countries around the world. Making it available to people in **Canada is an important step in ensuring access to the best possible care when it comes to sexual and reproductive health services.**" https://mifegymiso.com/about-mifegymiso.html

Mifesymiso, According to the Abortion Rights Coalition of Canada:

ARCC: However, Health Canada had initially imposed some **onerous restrictions**, such as:

- Requiring pharmacists to dispense to doctors instead of directly to patients,
- Mandating registration and training of providers and pharmacists,
- Limiting use of the drug to 7 weeks gestation, and
- Requiring an ultrasound to confirm gestational length and to rule out ectopic pregnancy
- Many restrictions have since been eased in response to an outcry and a campaign to ease the restriction. https://www.arcc-cdac.ca/wp-content/uploads/2020/06/Activist-e_winter-hiver-2018.pdf

Health Care Professionals No Longer Need To:

- Register with the manufacturer to prescribe or dispense Mifegymiso
- Undergo training. This will enable all to access the drug. However, Health Canada recommends that professionals in the field acquire appropriate knowledge and training. Anyone new to prescribing or dispensing Mifegymiso will find all necessary tools and training available on the supplier's website: www.celopharma.com.

To Obtain a Prescription for Mifegymiso, Patients No Longer Need To:

- Obtain an ultrasound to confirm the length of gestation
- Rule out ectopic pregnancy. In April 2016,the Journal of Obstetrics and Gynaecology Canada recommended alternative means to confirm gestational age and rule out ectopic pregnancy when ultrasound is not available to the physician. One possible barrier is so-called "conscientious objection" by providers. While Ontario has policies ensuring doctors provide their patients with abortion services even if the doctor is personally opposed, the rest of the country does not have such stipulations, meaning despite the availability of the drug, patients may not receive it. https://www.arcc-cdac.ca/wp-content/uploads/2020/06/28-Medication-Abortion.pdf

Federal Ministry of Health:

"While dialogue and information sharing between patients and health professionals is always important, the requirement for written patient consent to use Mifegymiso is being removed."
https://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2017/65034a-eng.php

It is shocking to us that the Ministry of Health would remove the requirement for written patient consent. We do not recall noticing this statement before in all the research that we have conducted in the last 5 years. Of note, we are of the opinion that the original consent form that was initially required carried at least one absolute lie in which patients were required to agree with the following statement: "I understand that Mifegymiso medical abortion is irreversible," which of course we know is not true.

Half Truths and Lies Cannot Continue to Misinform Women

Did the World Health Organization, the Canadian Ministry of Health and the Abortion Rights Coalition of Canada all somehow miss:

- The Finnish study, which showed a four times higher rate of adverse events compared to surgical abortion?
- Or perhaps, the abortion and premature birth studies, which have overwhelmingly proven that surgical abortion is an "immutable independent risk factor for premature birth"?
- Or possibly, even the abortion and breast cancer risk studies, 61 of 76 of which show a statistically significant link to raised breast cancer risk after induced abortion?
- Or maybe, even the Patricia Coleman abortion and mental health study and others which have shown **"a moderate to highly increased risk of mental health problems after abortion."**?

None of this should be surprising given the current environment in which we live – "protect abortion" is always the priority - even at the cost of women's health and possibly their lives.

It is unconscionable that:

- Canada has such incomplete data collection on both surgical and medical abortion procedures which makes it impossible to gauge the effect of induced abortion on women's health
- Important information on inherent risk factors of induced abortion and pertinent facts are withheld from women who have a right to know
- Canada compounds this callous disregard even further, since 80% of induced abortions in Canada are provided in facilities (at least here in Ontario) where there is no legal mandated requirement to report outcomes, including numbers or demographics.

Mifegymiso, is supposedly the "Gold Standard" of abortion care, and yet it carries a four times rate of adverse events compared to surgical abortion, and the one study ostensibly conducted to disprove the abortion pill reversal procedure, actually ended up proving that reversal using progesterone actually does work – also unexpectedly, for the authors at least, exposing the reality of the inherent dangers of medical abortion.

However, medical abortion is portrayed by Canadian medical and governmental bodies, together with, Canadian abortion advocates, to be so benign that written consent is not required. Women are abandoned to deal with the whole procedure of medical abortion without any particular oversight by medical professional - at home, alone, possibly coerced by an intimate partner, and apparently left to judge for themselves:

- If they are pregnant and how far
- If they are experiencing an ectopic pregnancy
- If the symptoms they are experiencing during the medical abortion process are normal

Induced abortion is not medically indicated for an illness, injury or disease and has been proven to harm many of the women who undergo one. Surely, presented with the evidence here, one can be drawn to no other conclusion except that induced abortion is second class healthcare (if one considers it healthcare at all)? There is a pressing need for truth, honesty and integrity in this nationwide discussion, if we are to protect Canadian girls and women from the many harms that induced abortion may have in store for their current and continued health, and this discussion needs to include the suppression of risk factors and facts, which is being perpetrated in order to protect the "safe" abortion rhetoric.