No. 19-1392

In The Supreme Court of the United States

THOMAS E. DOBBS, State Health Officer of the Mississippi Department of Health, et al.,

Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF OF THE INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICUS CURIAE*

The International Federation of Gynecology and Obstetrics ("FIGO") is a non-profit organization that brings together professional societies of obstetricians and gynecologists from over 130 countries and territories, including the United States. FIGO is dedicated to improving women's health and rights, reducing disparities in healthcare available to women and newborns, and advancing the science and practice of obstetrics and gynecology.

One of FIGO's current projects is a three-year initiative to increase the capacity of its member societies to lead local advocacy efforts on safe abortion in their respective countries. This project builds on a previous FIGO initiative focused on preventing unsafe abortion.

FIGO has a strong interest in reducing maternal mortality and morbidity from unsafe abortion. Achieving this goal requires women to have access to effective contraception and safe abortion care. FIGO submits this brief to offer its scientific and medical perspective on the impact of legal restrictions on abortion safety.[1]

[1] No counsel for a party authored this brief in whole or in part, and no person other than *amicus* or its counsel made a monetary contribution to this brief's preparation and submission. All parties have provided blanket consent to the filing of *amicus* briefs.

INTRODUCTION AND SUMMARY OF ARGUMENT

Global experience consistently demonstrates that imposing legal restrictions on abortion care does not reduce the number of abortions. Instead, prohibiting or restricting abortion care only increases the proportion of *unsafe* abortions—*i.e.*, abortions performed by individuals without the requisite skills, in environments lacking satisfactory medical standards, or both—and therefore the incidence of maternal mortality and multiple other harms. Put simply, increased restrictions on abortion care cause increased health harms.

When performed by skilled providers using an appropriate method in a hygienic environment, abortion is an extremely safe procedure. Unsafe abortion, by contrast, poses a serious threat to women's health, equality, and opportunity. Worldwide, unsafe abortion is a primary cause of maternal death and disability. Unsafe abortion also generates major socioeconomic costs for women, families, communities, and broader health systems, with a disproportionate burden falling on already poor and marginalized women.

Legal access to abortion care is a critical factor in ensuring that abortions are safe. In countries where abortion care is available without restriction as to reason, almost all abortions are safe. In countries where abortion care is prohibited other than for health and socioeconomic reasons,[2] abortions still occur, but the

[2] Specific socioeconomic grounds differ by country, but can include "age, union and economic status, and ability to care for

majority of abortions are unsafe. And in countries where abortion care is prohibited altogether or allowed solely to preserve a woman's health or save her life, abortions still occur, but the vast majority of abortions are unsafe. The decision to permit or restrict abortion thus is a decision not about *whether* or *how many* abortions will be performed, but *how*—that is, whether they will be performed safely or unsafely.

Fortunately, the global trend over the last several decades has been overwhelmingly in the direction of eliminating restrictions on abortion care, including, most recently, in Mexico. This trend has led to a significant reduction in the incidence of unsafe abortion, maternal morbidity, and maternal mortality.

Mississippi asks this Court to buck that trend toward safety and to turn back the clock to a time in American history where abortion was widely restricted and consequently, for too many women, unsafe. If this Court grants Mississippi's request to overrule or roll back *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), the impact will be immediate and severe; there are 24 states poised to prohibit abortion entirely. Such a result would be catastrophic for women's health, as it will likely lead to an increase in the number of unsafe abortions performed in these states.

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existing children." Guttmacher Inst., *Abortion Worldwide 2017: Uneven Progress and Unequal Access*, 14-15 (2018), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf ("Guttmacher, *Abortion Worldwide*").

This Court should reject Mississippi's call to overrule or erode *Roe* and *Casey*. Allowing laws like Mississippi's would put the United States at odds with the health and human rights recommendations of professional societies of obstetricians and gynecologists worldwide as well as major international health bodies. Such laws would have little effect on reducing the total number of abortions. Rather, they would multiply the number of unsafe abortions in the United States, resulting in an entirely predictable rise in wholly preventable deaths, disabilities, and attendant harms to women, their families, and communities across the country. This Court has the power to prevent such a disastrous result.

ARGUMENT

I. Unsafe Abortion Poses A Significant Threat To Women's Health.

In the United States and around the world, abortion is an extremely safe medical procedure when carried out consistent with the World Health Organization's ("WHO's") standard of care—*i.e.*, when "done with a WHO-recommended method that is appropriate to the pregnancy duration, and [when] the person providing or supporting the abortion is trained." World Health Org., *WHO Launches New Guideline to Help Health-Care Workers Ensure Safe Medical Abortion Care* (Jan. 8, 2019), https://www.who.int/reproductivehealth/guideline-medical-abortion-care/en/; *see, e.g.*, World

Health Org., *Safe Abortion: Technical and Policy Guidance for Health Systems*, 21 (2d ed. 2012), https://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf ("WHO, *Safe Abortion*") ("When performed by skilled providers using correct medical techniques and drugs, and under hygienic conditions, induced abortion is a very safe medical procedure."); *id.* (case-fatality rate for surgical abortions performed after fifteen weeks is significantly lower than that for childbirth); *see also* Brief for Am. College of Obstetricians and Gynecologists as Amici Curiae Supporting Respondents, *Dobbs v. Jackson Women's Health Org.*, ___ S. Ct. ___ (2021) (No. 19-1392) (discussing overwhelming weight of medical evidence conclusively demonstrating that abortion is a very safe medical procedure).[3]

In two recent decisions, this Court recognized the safe nature of abortions performed in accordance with this standard-of-care. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2311 (2016) (collecting evidence demonstrating that "abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring on

[3] The WHO recommends the following methods for first-trimester (12 weeks or fewer) abortion: vacuum aspiration or medication abortion (*i.e.*, mifepristone followed by misoprostol or, where mifepristone is not available, repeated doses of misoprostol alone). For pregnancies later than 12-14 weeks, the WHO recommends: dilatation and evacuation or medication abortion (*i.e.*, mifepristone followed by repeated doses of misoprostol, or, where mifepristone is not available, repeated doses of misoprostol alone). WHO, *Safe Abortion* at 31-32.

account of the procedure"); *id.* at 2315 (explaining that in the United States, abortion is far safer than childbirth, which "is 14 times more likely than abortion to result in death"); *June Medical Servs., LLC v. Russo*, 140 S. Ct. 2013, 2131 (2020) (discussing similar evidence).

It is also possible for women to safely manage their abortion care on their own outside of a healthcare facility through medication (mifepristone and/or misoprostol). *See* World Health Org., *Medical Management of Abortion*, 2-3 (2018), https://apps.who.int/iris/bitstream/handle/10665/278968/9789241550406-eng.pdf?.

When women lack the resources or information to access safe abortion, however, they may resort to unsafe methods to end their pregnancies. Although abortion using known, effective medications can be safe, *see id.*, an abortion procedure is unsafe when it is performed by someone "lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both." WHO, *Safe Abortion* at 18. Unsafe and disturbing, but still too common, abortion procedures include inserting a foreign object or substance into the uterus, such as sticks, catheters, or crushed herbs; ingesting pharmaceutical products or harmful substances like bleach; outdated surgical methods performed incorrectly by an unskilled provider; applying external force to the abdomen; and engaging in traumatic or injurious physical activity like jumping from the top of the stairs. *See* Guttmacher, *Abortion Worldwide* at 22; WHO, *Safe Abortion* at 19, 41.

Unsafe abortion has long been a serious threat to women's health, equality, and opportunity, and remains so today. From as early as 1967, the World Health Assembly, the WHO's decision-making body, "identified unsafe abortion as a serious public health problem in many countries." WHO, *Safe Abortion* at 18. Today, "[u]nsafe abortions account for half of all abortions globally." Hedieh Mehrtash et al., *What's Needed to Improve Safety and Quality of Abortion Care: Reflections from WHO/HRP Multi-Country Study on Abortion Across the Sub-Saharan Africa and Latin America and Caribbean Regions*, BMJ GLOBAL HEALTH 1 (Aug. 19, 2021), https://gh.bmj.com/content/bmjgh/6/8/e007226.full.pdf.[4]

Globally, "[u]nsafe abortion is one of the four main causes of maternal mortality and morbidity," accounting for up to 13% of deaths and "20% of the total mortality and disability burden due to pregnancy and childbirth." *Id.* at 87. Thankfully, the absolute number of deaths and severe complications from unsafe abortions has declined over the last decade, likely in part because women are increasingly using medication abortion (primarily misoprostol) to end pregnancies outside formal and legal channels rather than more invasive methods. *See* Guttmacher, *Abortion Worldwide* at 30-32; Clara Calvert et al., *The Magnitude and*

[4] "[I]nternational and regional human rights bodies and national courts" have over the past 15 years "increasingly applied" principles of human rights, such as "the right to liberty and the right to security of the person" and "the right to be free from inhuman and degrading treatment," to ensuring access to safe and legal abortion. WHO, *Safe Abortion* at 87-88.

Severity of Abortion-Related Morbidity in Settings with Limited Access to Abortion Services: A Systematic Review and Meta-regression, BMJ GLOBAL HEALTH 11 (2018), https://gh.bmj.com/content/bmjgh/3/3/e000692.full.pdf (projecting decline in abortion-related mortality attributable to increasing access to misoprostol).[5] Nonetheless, tens of thousands of women still die globally every year from unsafe abortions. *See* Elizabeth A. Sully et al., *Adding It up: Investing in Sexual and Reproductive Health 2019*, Guttmacher Inst., 28 (2020), https://www.guttmacher.org/sites/default/files/report_pdf/adding-it-up-investing-in-sexual-reproductive-health-2019.pdf; *see also* Guttmacher, *Abortion Worldwide* at 33 (estimating 23,000 to 31,000 deaths each year); WHO, *Safe Abortion* at 17 (estimating 47,000 deaths in 2008); Susheela Singh, *Global Consequences of Unsafe Abortion*, 6(6) WOMEN'S HEALTH 849, 850 (2010), https://journals.sagepub.com/doi/pdf/10.2217/WHE.10.70 (estimating 70,000 deaths in 2005). Official statistics also likely "grossly underreport[]" the true number of maternal deaths resulting from unsafe abortion because "stigma and fear of punishment deter reliable reporting." WHO, *Safe Abortion* at 19; *see also* Singh at 850 (explaining that maternal deaths due to unsafe abortion may be underreported due to inadequate information on which to base cause of death, lack of medical certification of death, unknown pregnancy

[5] Although medication abortions are safer than more invasive methods, legal restrictions undermine their safety as well. For example, misoprostol can result in complications when used incorrectly due to lack of information or when the drug is adulterated. *See* Guttmacher, *Abortion Worldwide* at 32.

status at time of death, and unwillingness to report abortion as the cause of death due to stigma and illegality).

Unsafe abortion also leads to other serious medical complications such as incomplete abortion (failure to remove or expel all pregnancy tissue from the uterus); hemorrhage; infection, including septic shock; uterine perforation; damage to the genital tract and internal organs; other physical trauma; and chronic conditions such as pain, inflammation of the reproductive tract, and pelvic inflammatory disease. *See* World Health Org., *Preventing Unsafe Abortion* (Sept. 25, 2020), https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion ("WHO, *Preventing Unsafe Abortion*"); Singh at 852.[6]

Every year, seven million women in developing countries (which, by and large, have restrictive abortion laws) are hospitalized as a result of an unsafe abortion. WHO, *Preventing Unsafe Abortion*. Another nine million women in low- and middle-income countries (where restrictions are common) do not receive the care they need for complications following an unsafe abortion. Sully at 22. "[A]t least 9% of abortion-related hospital

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[6] These complications arise more often when unsafe abortions are performed later in pregnancy. *See* WHO, *Preventing Unsafe Abortion*; Singh at 852. By contrast, safe abortion—*i.e.*, abortion performed according to the standard of care—remains very safe at any point during pregnancy, including later in pregnancy. *See supra* at 4-6. As discussed below, the existence of legal restrictions, including gestational limits, makes it more likely that abortions occurring later in pregnancy will be unsafe rather than safe. *See infra* at 13-18; Guttmacher, *Abortion Worldwide* at 11.

admissions" in countries with limited access to abortion "have near miss complications"—*i.e.*, "complications which would have most likely resulted in death had the woman not made it to a hospital"—and 1.5% of such admissions result in death. Calvert at 2, 10.

Approximately one in four women who undergo an unsafe abortion are likely to develop a temporary or lifelong disability requiring medical care. WHO, *Safe Abortion* at 20; *id.* at 17 (estimating five million women became disabled from unsafe abortions in 2008). Every year, three million women will suffer the effects of reproductive tract infections, including chronic pain, due to unsafe abortion, and nearly two million women will develop secondary infertility. *See* Singh at 852.

Unsafe abortion imposes substantial financial and social costs on women, their families, and health systems. *See* WHO, *Safe Abortion* at 20 (detailing the "major physiological, financial and emotional costs" incurred by women who undergo unsafe abortion). Obtaining an unsafe abortion and seeking care for complications is costly, including "intermediate care" prior to hospitalization, transportation, out-of-pocket expenses while hospitalized, and drugs and other medical supplies. *See* Singh at 854. A 2008 study estimated that women in Sub-Saharan Africa collectively spent $200 million out-of-pocket to treat complications following unsafe abortions. *See* WHO, *Safe Abortion* at 26. For low-income households, "[a] sudden expenditure" necessitated by unsafe abortion complications "can push a household into poverty." Singh at 852.

In addition to these direct financial costs, women and their families suffer indirect financial burdens imposed by unsafe abortion. Health complications result in lost productive time, which is "an important consequence for the household." *Id.* at 854. Women lost almost $930 million in income in 2008 as a result of long-term disability resulting from unsafe abortion. *See* WHO, *Safe Abortion* at 26. Further, when a low-income family expends scarce medical resources on treating abortion complications, those finite resources become unavailable for other health needs. *See* Singh at 852. Plus, "a high proportion of women undergoing unsafe abortions are already mothers—the large majority in Asia and Latin America, and in some African countries . . . with large minorities in other African countries." *Id.* at 855. When a mother becomes ill or dies from an unsafe abortion, her children can suffer interruption or cessation of their education, poverty, malnourishment, and abandonment. *See id.* at 856.

Collectively, such costs from unsafe abortions have a ripple effect. "The cost to health systems of treating the complications of unsafe abortion is overwhelming, especially in poor countries." WHO, *Safe Abortion* at 26. Low- and middle-income countries spend around $1.7 billion annually for post-abortion care, almost all of which "is for treating complications from unsafe abortion." Sully at 27; *see also* Ctr. for Reprod. Rights, *The World's Abortion Laws* (2021), https://maps.reproductiverights.org/worldabortionlaws (global map of abortion restrictions). If unsafe abortions were instead carried out safely and women's contraceptive

and abortion-related care needs were met, those countries would save two-thirds of those costs, with the bill reduced from $1.7 billion to $0.6 billion. *See* Sully at 28; *see also* Guttmacher, *Abortion Worldwide* at 33 (noting that the cost of post-abortion care in developing countries would drop more than ten-fold if all abortions were provided safely); WHO, *Safe Abortion* at 26 (unsafe abortion cost Mexico City's health system $2.6 million in 2005, when abortion had not yet been legalized, and $1.7 million could have been saved had there been access to safe abortion).

Critically, the harms described in this section—death, medical complications, disability, and costs to women, their families, and health systems—do not accrue when abortions are performed safely. *See supra* at 4-6 (discussing safety of abortions provided consistent with the standard of care); David A. Grimes et al., *Unsafe Abortion: The Preventable Pandemic*, THE LANCET SEXUAL & REPROD. HEALTH SERIES 2 (Oct. 2006), https://www.who.int/reproductivehealth/publications/general/lancet_4.pdf ("Legal abortion in developed countries is one of the safest procedures in contemporary practice, with case-fatality rates less than one death per 100,000 procedures."). And as explained in the next section, ensuring that women have legal access to abortion care is a critical factor in ensuring that the abortions they have will be safe.

II. Legally Restricting Abortion Care Results In More Unsafe Abortions, Not Fewer Abortions Overall.

Imposing more legal restrictions on abortion care does not reduce the occurrence of abortion. Rather, abortion rates are roughly the same in countries where abortion care is available without restriction as to reason and in countries where it is prohibited altogether or allowed only to save a woman's life. Guttmacher, *Abortion Worldwide* at 8. Indeed, there is "no evidence" that abortion rates are lower in settings where abortion is legally restricted. Jonathan Bearak et al., *Unintended Pregnancy and Abortion by Income, Region, and the Legal Status of Abortion: Estimates from a Comprehensive Model for 1990-2019*, 8 THE LANCET GLOBAL HEALTH e1152, e1159 (Sept. 1, 2020), https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(20)30315-6.pdf. "Whether abortion is legally more restricted or available on request, a woman's likelihood of having an unintended pregnancy and seeking induced abortion is about the same." WHO, *Safe Abortion* at 17.[7]

Instead of reducing the total number of abortions performed, legally restricting abortion care serves only to make more of the abortions that are performed unsafe. *See* WHO, *Safe Abortion* at 17 ("The legal status of abortion has no effect on a woman's need for an

[7] If anything, restrictions on abortion care are associated with *higher* rates of abortion. *See* Bearak at e1159 (explaining that when China and India are excluded, as their large populations skew the data, abortion rates are *higher* in countries where abortion is restricted).

abortion, but it dramatically affects her access to safe abortion."). As demonstrated in the following graphic, the proportion of all abortions that are estimated to be least safe increases dramatically as abortion laws become more restrictive—jumping from less than 1% of abortions in the least-restrictive countries to 31% in the most-restrictive countries.[8] While 87% of abortions in countries with the least restrictive laws regarding abortion care are safe, only about 25% (1 in 4) of the abortions performed in countries with the most restrictive laws are safe.

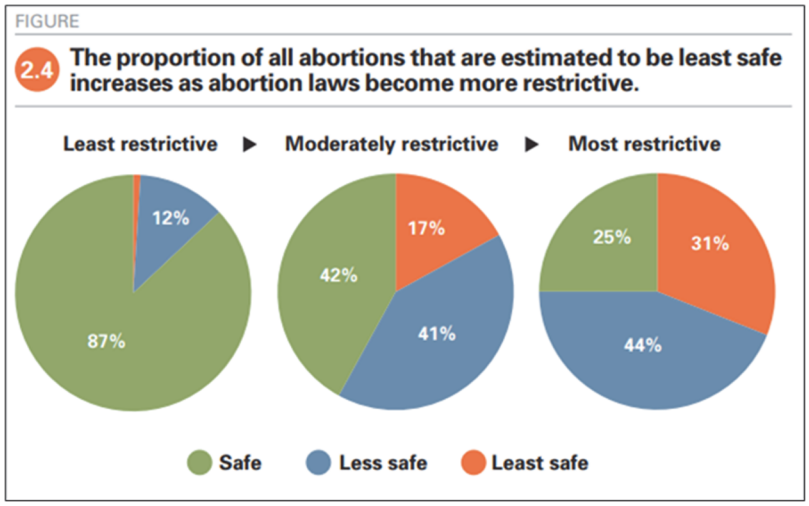

Figure 1. Guttmacher, *Abortion Worldwide* at 12, fig. 2.4.

[8] Less safe abortions are either performed using a recommended method or performed by an appropriately trained provider, but not both. Guttmacher, *Abortion Worldwide* at 5. Least safe abortions meet neither criterion. *Id.* Unsafe abortions include those that are less safe and least safe.

"[T]he public health rationale for preventing unsafe abortion is clear and unambiguous." WHO, *Safe Abortion* at 18. Accordingly, the WHO considers legal restrictions on abortions to be the first in a list of "[b]arriers to accessing safe abortion." WHO, *Preventing Unsafe Abortion*. To reduce the proportion of unsafe abortions, the WHO recommends that countries reduce legal barriers to abortion care, which promotes safe abortion. *See id.*

There is a clear reason that a strong relationship exists between legal restrictions on abortion care and the number of unsafe abortions: Legal restrictions limit the available options for safely terminating an unwanted pregnancy. *See* United Nations Dep't of Econ. and Social Affairs Population Div., *Abortion Policies and Reproductive Health Around the World*, 15-16 (2014), https://www.un.org/en/development/desa/population/publications/pdf/policy/AbortionPoliciesReproductiveHealth.pdf. By constraining women's options for accessing safe abortion care, "legal restrictions lead many women to seek services in other countries, or from unskilled providers or under unhygienic conditions, exposing them to a significant risk of death or disability." WHO, *Safe Abortion* at 23.[9] "In legally restrictive settings, women often get inadequate information on the

[9] There are "a small number of countries," including some in Europe, "where maternal mortality is low despite restrictive abortion laws." WHO, *Safe Abortion* at 23. That is so because "many women have access to safe or relatively safe abortion through seeking care from neighboring countries, through provision of safe, but illegal abortion care domestically, or through self-use of misoprostol." *Id.*

correct use of misoprostol, and the medication itself may be counterfeit or of poor quality." Guttmacher, *Abortion Worldwide* at 42; *see also* Medecins Sans Frontieres, *Unsafe Abortion: A Forgotten Emergency* (Mar. 7, 2019), https://www.doctorswithoutborders.org/what-we-do/news-stories/story/unsafe-abortion-forgotten-emergency. Moreover, several features of legally restrictive settings—including fear of prosecution, lack of access to accurate information, and limitations on medication, equipment, and providers—often lead women who undergo unsafe abortions under such regimes to delay seeking post-abortion care until their symptoms become life-threatening. Mehrtash at 3. Delaying care for these complications can lead to sepsis, shock, and death. Guttmacher, *Abortion Worldwide* at 28-30.

The legal status of abortion thus dramatically affects whether a woman who has an abortion is likely to die or experience other serious health complications. "Almost all deaths and morbidity from unsafe abortion occur in countries where abortion is severely restricted in law and in practice." WHO, *Safe Abortion*, at 87. Conversely, "[w]here there are few restrictions on access to safe abortion, deaths and illness are dramatically reduced." *Id.*; *see also* Grimes at 1 (unsafe abortion "mainly endangers" women in countries where abortion is highly restricted by law and countries where, though legally permitted, safe abortion is not easily accessible).

This data confirms that overruling or significantly rolling back *Roe* and *Casey* would not decrease the

number of abortions in the United States. Rather, it would increase the health harms suffered by pregnant women. Indeed, this result is already unfolding. Since *Roe v. Wade* confirmed that access to abortion care is constitutionally protected in the United States nearly 50 years ago, several states have circumscribed that protection by enacting restrictions on abortion. Those restrictions have been consistently associated with rising maternal mortality rates. Anusha Ravi, *Limiting Abortion Access Contributes to Poor Maternal Health Outcomes*, Ctr. for Am. Progress (June 13, 2018), https://cdn.americanprogress.org/content/uploads/2018/06/13052244/AbortionMaternalHealth-brief1.pdf; *see also* Terri-Ann Thompson et al., *Evaluating Priorities: Measuring Women's and Children's Health and Well-being Against Abortion Restrictions in the States*, Ctr. for Reprod. Rights & Ibis Reprod. Health 23 (2017), https://www.reproductiverights.org/sites/default/files/documents/USPA-Ibis-Evaluating-Priorities-v2.pdf (discussing evidence of inverse association between a state's number of abortion restrictions and women's health, children's health, and social determinants of health).

Abortion care restrictions are also associated with stigma that increases the likelihood that women will attempt to end their own pregnancy without clinical supervision, and deters women who do so from seeking post-abortion care or from openly sharing their medical history with healthcare professionals. *See* Janet M. Turan & Henna Budhwani, *Restrictive Abortion Laws Exacerbate Stigma, Resulting in Harm to Patients and*

Providers, 111(1) AM. J. OF PUBLIC HEALTH 37, 38 (Jan. 2021), https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2020.305998 ("[E]xperiences and fears of abortion-related stigma can result in . . . avoidance of needed services. This can include fewer people seeking reproductive health services because of fear of interpersonal and societal-level persecution and judgment."). Permitting more severe restrictions on abortion would exacerbate that already-existing stigma and its attendant harms, including discriminatory prosecution and criminalization for terminating one's own pregnancy. *See* Brief for If/When/How as Amici Curiae Supporting Respondents, *Dobbs v. Jackson Women's Health Org.*, ___ S. Ct. ___ (2021) (No. 19-1392) (abortion bans and resulting stigmatized status of abortion exacerbate the risk that people will suffer discriminatory prosecutions and be criminalized for self-managing abortions)

If *Roe* and *Casey* were to fall or be curtailed, 24 states stand poised to prohibit abortion entirely. *See* Ctr. for Reprod. Rights, *What if Roe Fell?* (2019), https://maps.reproductiverights.org/what-if-roe-fell. Global data suggests that such measures would likely mean that more women who are unable to access resources and information for safe abortion will be forced to resort to unsafe methods.

III. Poor And Marginalized Women Are Disproportionately Harmed By Unsafe Abortion That Results From Legal Restrictions.

The harms from unsafe abortion driven by legal restrictions are not distributed equally.[10] Rather, access to safe abortion care becomes "primarily a function of the ability to pay and having access to networks of safe, clandestine abortion providers." Guttmacher Inst., *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action*, 6 (Ina K. Warriner & Iqbal H. Shah eds., 2006), https://www.who.int/reproductivehealth/publications/unsafe_abortion/0939253763.pdf ("Guttmacher, *Preventing Unsafe Abortion*"). Put simply, "[i]n countries where abortion is legally highly restricted, . . . abortions that meet safety requirements can become the privilege of the rich, while poor women have little choice but to resort to unsafe providers, which may cause disability and death." *WHO, Safe Abortion* at 18.[11] Case studies

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[10] Inequitable abortion-care access and health outcomes result not only in countries where abortion is highly restricted but also in countries where access to safe services is limited in practice despite being legally permitted. *See* Singh at 850. In those countries, it is "common to find that . . . poorer women and other disadvantaged groups . . . will often go to providers who lack formal training, or attempt to induce the abortion themselves, resulting in health complications." *Id.*

[11] Even when wealthy women in countries with restrictive abortion laws have access to expensive clandestine clinics, the illegal nature of such clinics means that they escape government regulation and oversight. Amnesty Int'l, *On the Brink of Death: Violence Against Women and the Abortion Ban in El Salvador*, 30 (2014), https://www.amnestyusa.org/files/el_salvador_report_-_on_the_brink_of_death.pdf.

conducted in countries with legally restrictive settings revealed that a far higher proportion of poor and rural women had abortions performed by untrained providers (62% of abortions) or self-induced by a means other than misoprostol (55% of abortions) than did non-poor and urban women (36% and 38%, respectively). Guttmacher, *Abortion Worldwide* at 23.

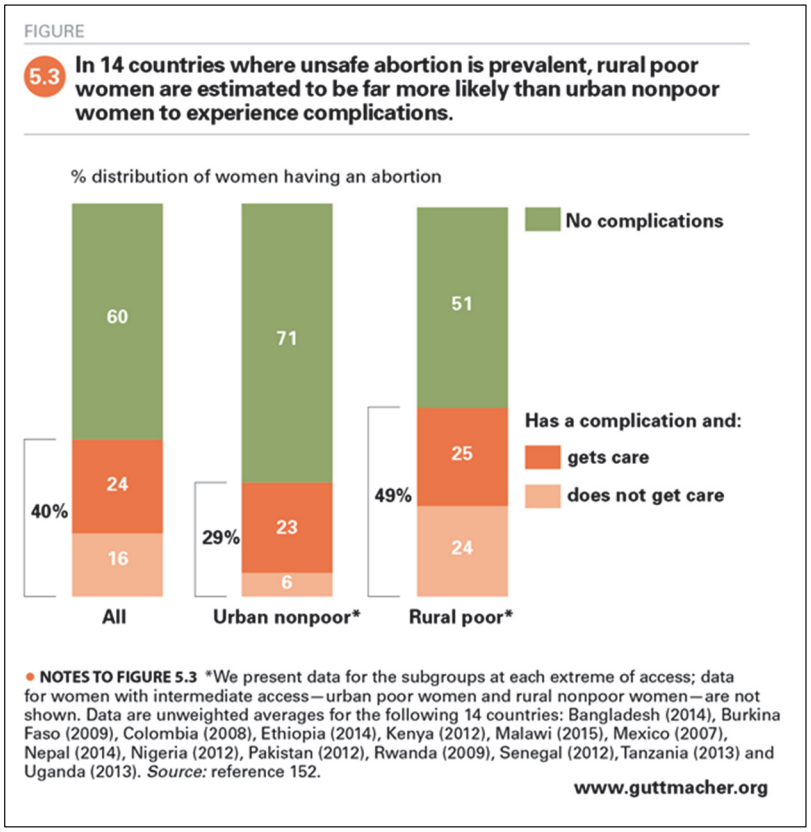

Figure 2. Guttmacher, *Abortion Worldwide* at 32, fig. 5.3.

Poor and rural women turn to unsafe abortion because, for them, the theoretical possibility of obtaining

a legal and safe abortion elsewhere is typically just that—theoretical. The cost and time of extensive travel, in addition to the abortion care itself, often make safe abortion care prohibitively expensive, and they must resort to unsafe abortion instead. *See* Sarah Van de Velde et al., *Characteristics of Women Who Present for Abortion Beyond the Legal Limit in Flanders, Belgium*, 51(3) PERSPECTIVES ON SEXUAL & REPROD. HEALTH 175, 175-76 (Sept. 2019), https://www.guttmacher.org/journals/psrh/2019/09/characteristics-women-who-present-abortion-beyond-legal-limit-flanders; Caitlin Gerdts et al., *Experiences of Women Who Travel to England for Abortions: An Exploratory Pilot Study*, 21(5) THE EUROPEAN J. OF CONTRACEPTION & REPROD. HEALTH CARE 401, 406 (2016), https://www.tandfonline.com/doi/full/10.1080/13625187.2016.1217325 ("[T]raveling for a wanted abortion represents a cost that may be very difficult to cover for low income/unemployed women, which is a serious problem . . . ."). Moreover, women who need to travel for abortion care due to gestational limits in their home countries are often the very women who are least likely to be able to travel, as women seeking abortion care later in pregnancy "are more likely to be socioeconomically vulnerable—that is, with limited education, impoverished or unemployed—and to experience problems finding and traveling to an abortion clinic." Van de Velde at 175.

The health and financial costs of unsafe abortion are also disproportionately incurred by poor and rural groups. "Because the large majority of women suffering complications" from unsafe abortion "are poor to

begin with, the costs of care can be overwhelming for them, especially when related costs—*i.e.*, transportation, child care and lost income—are considered." Guttmacher, *Abortion Worldwide* at 33. The inequity is "intensified" when access to post-abortion care is factored in, as the disadvantaged women who can least afford the costs of treating complications from unsafe abortion are the ones most likely to develop complications and need care. *Id.* at 23; *see also id.* at 29 (49% of rural poor women who need post-abortion care from complications do not receive it, as compared to 21% of urban non-poor women). And when poor and rural women do receive care for their complications, that care is more likely to require the diversion of "scarce health care resources" from public health services. Guttmacher, *Preventing Unsafe Abortion* at 6.

Adolescents and young women living in countries that legally restrict abortion are also disproportionately likely to experience unsafe abortions and their consequences. For instance, an estimated "59% of all unsafe abortions in Africa" are had by women under 25 years old. *Id.* at 7. "Mortality is frequently highest among adolescents since they are slow to recognize the pregnancy, are least able to afford appropriate care, and are most vulnerable to receiving poor quality care and using ineffective methods." *Id.* (collecting studies reporting "consistently high levels of unsafe abortion among adolescents in Africa," including Cameroon, Nigeria, and Uganda).

The disparate impact of the risks of and harm from unsafe abortion on poor and marginalized women

and girls is illustrated in many countries that have (or recently had) restrictive abortion laws. For example:

- **Mexico:** The vast majority of Mexico's states have highly restrictive abortion laws (though that may soon change given a recent decision from Mexico's Supreme Court recognizing the criminalization of abortion as unconstitutional). *See* Allyn Gaestel & Allison Shelley, *Mexican Women Pay High Price for Country's Rigid Abortion Laws*, THE GUARDIAN (Oct. 1, 2014), https://www.theguardian.com/global-development/2014/oct/01/mexican-women-high-price-abortion-laws; *see also infra* at 31. A 2010 study showed that "[p]oorer women [were] 2.5 times more likely to have an unsafe abortion than richer women," "[w]omen with more than 13 years of education [were] 93.5% less likely to have an unsafe abortion than women with no years of education," and indigenous women were "5 times more likely to have an unsafe abortion than non-indigenous women." Angelica Sousa et al., *Exploring the determinants of Unsafe Abortion: Improving the Evidence Base in Mexico*, 25(4) HEALTH POL'Y AND PLANNING 300, 306 (July 2010), https://academic.oup.com/heapol/article/25/4/300/556788.

- **Bangladesh:** In Bangladesh, where abortion is illegal except to save the woman's life, "women from the poorest-asset quintile [in rural Bangladesh] were

more than twice as likely to die from complications of abortion compared with women from the wealthiest-asset quintile; those with no formal education were more than 11 times more likely to die of unsafe abortion than those with 8 or more years of formal education." World Health Org., *Social Determinants Approaches to Public Health: From Concept to Practice*, 10 (Erik Blas et al., eds., 2011), https://www.who.int/social_determinants/tools/SD_Publichealth_eng.pdf.

- **Brazil:** In Brazil, where abortion is prohibited except to save the woman's life or in cases of rape, more than one million women every year have an unsafe abortion, with approximately a quarter-million being admitted to the hospital due to complications from that unsafe abortion. *See* Mirla Cisne et al., *Unsafe Abortion: A Patriarchal and Racialized Picture of Women's Poverty*, 21(3) THEMATIC SPACE: SOCIAL WORK: GENDER, RACE/ETHNICITY, GENERATIONS AND SEXUALITY 462, 466 (2018), https://www.scielo.br/j/rk/a/sVLLgJKMPHdvmxgr6JQSVDP/?format=pdf. Brazil's Ministry of Health has stated that "women from poor and marginalized communities" are more likely to undergo, and suffer the effects from, unsafe abortions due to "[v]ulnerabilities such as gender inequalities, cultural and religious norms, inequalities in access to education, and multiple poverty dimensions—

such as the lack of economic resources and alternatives, the difficulty of access to information and human rights, and unhealthiness." *Id.* (data shows "that the majority of women who submit to unsafe abortion and are hospitalized are young and poor"). A study published in 2013 found that, among all women that induced unsafe abortion, "the highest proportion was represented by [B]lack women, with low income, less than 4 years of school attendance and single," a proportion "approximately 5 times the proportion of white women, with higher instruction level and higher income and married, for the same occurrence." Carmen Linda Brasiliense Fusco, *Unsafe Abortion: A Serious Public Health Issue in a Poverty Stricken Population*, 28(1) REPROD. CLIM. 2, 7 (2013), https://core.ac.uk/download/pdf/82107626.pdf.

- **The Philippines:** Abortion is illegal under all circumstances and is highly stigmatized in the Philippines. Despite these restrictions, abortion remains common but is often performed under unsanitary conditions using outdated techniques. Guttmacher Inst., *Unintended Pregnancy and Unsafe Abortion in The Philippines: Context and Consequences*, 2013 Series, No. 3, 1 (2013), https://www.guttmacher.org/sites/default/files/report_pdf/ib-unintended-pregnancy-philippines.pdf. Poor women, rural women, and young women are

> particularly likely to seek unsafe abortions. *Id.* at 4 (44% of poor women obtaining abortion self-induce or employ the help of a partner or friend, rather than a trained provider, as compared to 30% of non-poor women). According to a national study in 2004, 22% of poor women used a form of so-called "massage" (heavy abdominal pressure to expel a fetus) or inserted a catheter or other object into the uterus in an abortion attempt, while no non-poor women tried those methods. *Id.*

The disproportionate harm from abortion care restrictions seen globally will manifest in the United States if this Court permits restrictions like Mississippi's to stand. Indeed, abortion care restrictions already have a disproportionate impact on marginalized communities in the United States, where the women who obtain abortions are disproportionately poor or low-income and women of color, particularly Black and Hispanic women. Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst., 1 (May 2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf ("In 2014, three-fourths of U.S. abortion patients were low income—49% living at less than the federal poverty level, and 26% living at 100-199% of the poverty level."); Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11(3) GUTTMACHER POL'Y REV. 2, 3 (Sept. 2008), https://www.guttmacher.org/sites/default/files/article_files/gpr110302.pdf (most abortions in the United States are obtained by minority women, with Black and Hispanic women

having the highest unintended pregnancy rates); Cristina Novoa & Jamila Taylor, *Exploring African Americans' High Maternal and Infant Death Rates*, Ctr. for Am. Progress (Feb. 1, 2018), https://www.americanprogress.org/issues/early-childhood/reports/2018/02/01/445576/exploring-african-americans-high-maternal-infant-death-rates/.

Given this demonstrated global and national experience, the risks of unsafe abortion stemming from Mississippi's law, were it permitted to stand, would be borne primarily by marginalized women and girls. Black women in Mississippi are disproportionately poor and also the majority of women obtaining abortion care in Mississippi. P.R. Lockhart, *Mississippi's New Abortion Ban Will Hit Black Women the Hardest*, VOX (Mar. 23, 2018), https://www.vox.com/identities/2018/3/23/17155628/mississippi-abortion-ban-black-women; *see also* Brief for Orgs. Dedicated to the Fight for Reprod. Just. as Amici Curiae Supporting Respondents, *Dobbs v. Jackson Women's Health Org.*, ___ S. Ct. ___ (2021) (No. 19-1392) (Mississippi's ban will disproportionately harm people of color and other marginalized people in Mississippi and Louisiana, worsening marginalized people's health and financial outcomes). Black women and infants in Mississippi are already disproportionately affected by maternal mortality and other complications. *See* Lockhart; Guttmacher Inst., *State Facts About Abortion: Mississippi* (Jan. 2021), https://www.guttmacher.org/sites/default/files/factsheet/sfaa-ms.pdf ("Guttmacher, *State Facts*"); *see also* Brief for Birth Equity Orgs. as Amici Curiae Supporting Respondents, *Dobbs v. Jackson Women's Health Org.*, ___ S. Ct. ___

(2021) (No. 19-1392) (Mississippi's maternal health crisis disproportionately affects Black women, who are at significantly greater risk of negative maternal health outcomes). And abortion care is already difficult to access in Mississippi, as 91% of women aged 15-44 in Mississippi live in a county without a clinic facility that provides abortion care. Guttmacher, *State Facts* (data as of 2017); *see also* Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst., 18 (Sept. 2019), https://www.guttmacher.org/sites/default/files/report_pdf/abortion-incidence-service-availability-us-2017.pdf.

Were this Court to uphold Mississippi's abortion ban and overrule or erode *Roe* and *Casey*, almost half of the states would likely attempt to ban abortion. Although some women will be able to travel out of state to obtain clinic-based abortion, or safely terminate their own pregnancy using medication, global experience teaches that banning abortion threatens marginalized communities in particular, exposing them to disproportionate risks of harm from unsafe abortion and criminalization.

IV. The Trend Toward Eliminating Abortion Restrictions Has Contributed To Increasingly Safe Abortions And Improved Maternal Health And Well-Being.

Globally, the trend in recent decades has overwhelmingly been toward less restrictive abortion laws, particularly in the developed world. Figure 3 illustrates the geographic diversity of countries that have reduced restrictions on abortion since 1994, when 179

countries signed the International Conference on Population and Development Programme of Action, a compact reflecting their commitment to preventing unsafe abortions and reducing maternal mortality.

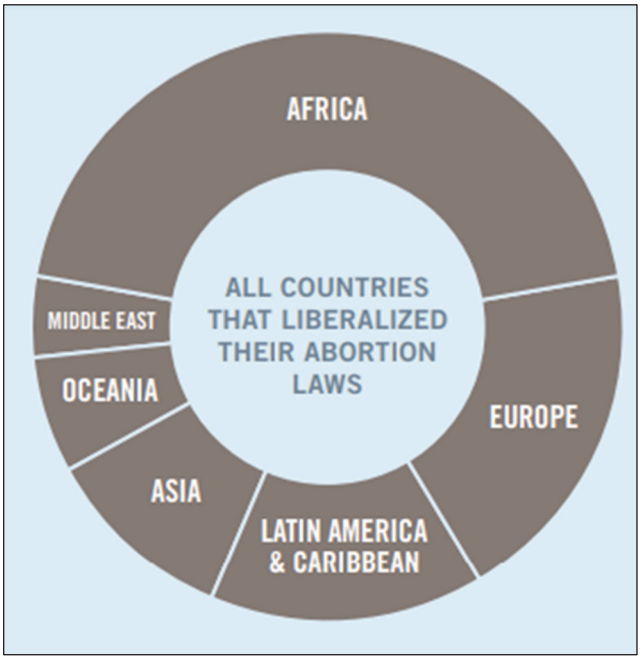

Figure 3. Ctr. for Reprod. Rights, *Accelerating Progress: Liberalization of Abortion Laws Since ICPD*, 2 (May 28, 2019), https://reproductiverights.org/wp-content/uploads/2020/12/World-Abortion-Map-Accelerating Progress.pdf.

Since 2000, 27 countries have expanded legal grounds to allow abortions without restriction as to reason, to protect a woman's health, or for socioeconomic reasons (*e.g.*, age, marital and economic status, ability to care for current children). Guttmacher, *Abortion Worldwide* at 4, 14-15. Today, only 5% of women of

reproductive age live in countries that prohibit abortion altogether, and only 22% live in countries where abortion is permitted only to save the life of the pregnant person. *See* Ctr. for Reprod. Rights, *The World's Abortion Laws* (2021), https://maps.reproductiverights.org/worldabortionlaws.

Figure 4. Rachel B. Vogelstein & Rebecca Turkington, *Abortion Law: Global Comparisons*, Council on Foreign Rels. (Oct. 28, 2019), https://www.cfr.org/article/abortion-law-global-comparisons.

Consistent with the global trend, in September 2021 Mexico's Supreme Court voted 10-0 to decriminalize abortion. *See* Santiago Pérez & David Luhnow, *Mexico's Supreme Court Decriminalizes Abortion in Historic Shift*, WALL ST. J. (Sept. 7, 2021), https://www.wsj.com/articles/mexicos-supreme-court-decriminalizes-abortion-in-historic-shift-11631049288. Chief Justice Arturo Zaldívar described the decision as a "watershed in the history of the rights of women and pregnant people, above all the most vulnerable." Mary Beth Sheridan & Alejandra Ibarra Chaoul, *Mexico Decriminalizes Abortion, a Dramatic Step in World's Second-Biggest Catholic Country*, WASH. POST (Sept. 7, 2021), https://www.washingtonpost.com/world/2021/09/07/mexico-abortion-supreme-court/.

The trend toward less restrictive regimes globally has been accompanied by improvement in the quality and safety of abortion care, and higher rates of maternal survival.[12] *See* Vogelstein & Turkington. Likewise,

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[12] Although legalization is necessary for generally safe abortion, it is not always sufficient. Even in countries with less restrictive laws, abortions may still be widely unsafe if, as a practical matter, women lack access to trained providers and quality health care. *See, e.g.*, Vogelstein & Turkington (discussing persistent maternal mortality in Zambia following liberalization of abortion laws in light of overall poor healthcare); Anibal Faundes, *Unsafe Abortion—The Current Global Scenario*, 24(4) BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY 467, 472 (Aug. 2010), https://pubmed.ncbi.nlm.nih.gov/20227350/ ("[T]here are basically two reasons for the existence of unsafe abortions: the persistence of restrictive laws and the incapacity of the government to provide safe services in countries in which abortion is legal.").

after this Court's 1973 decision in *Roe*, pregnancy-related deaths and hospitalizations due to complications from unsafe abortions in the United States "[a]lmost immediately" dropped effectively to zero. Susan A. Cohen, *Facts and Consequences: Legality, Incidence and Safety of Abortion Worldwide*, 12(4) GUTTMACHER POL'Y REV. 2, 2 (2009), https://www.guttmacher.org/sites/default/files/article_files/gpr120402.pdf. Globally, data from both the WHO and the Guttmacher Institute underscore the positive impact that less restrictive abortion laws have on maternal health. WHO, *Safe Abortion* at 23 ("The accumulated evidence shows that the removal of restrictions on abortion results in reduction of maternal mortality due to unsafe abortion and, thus, a reduction in the overall level of maternal mortality."); Guttmacher, *Abortion Worldwide* at 43 ("Decades of evidence reaffirms the benefit to the well-being of women and their families that comes with liberalizing abortion laws and broadening access to services."); *see generally* Su Mon Latt et al., *Abortion Laws Reform May Reduce Maternal Mortality: An Ecological Study in 162 Countries*, 19(1) BMC WOMEN'S HEALTH (2019), https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-018-0705-y.

Data from countries that reduced abortion restrictions in recent decades powerfully demonstrates the benefits doing so has on women's health and well-being. For example:

- **Romania**: In Romania, a communist dictatorship enforced significant abortion restrictions starting in 1965, such that by

1989 the country had the highest recorded maternal mortality rate in Europe. Janie Benson et al., *Reductions in Abortion-Related Mortality Following Policy Reform: Evidence from Romania, South Africa and Bangladesh*, 8(39) REPROD. HEALTH J. 1, 3 (2011), https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/1742-4755-8-39.pdf. When a new government came to power in 1989 and passed less restrictive abortion laws, it led to an "immediate and dramatic fall in abortion-related mortality." Anibal Faundes & Iqbal H. Shah, *Evidence Supporting Broader Access to Safe Legal Abortion*, 131 INT'L J. OF GYNECOLOGY & OBSTETRICS S56, S57 (2015), https://www.sciencedirect.com/science/article/pii/S0020729215001575. Over time, the maternal mortality rate fell 16-fold, from 148 maternal deaths per 100,000 live births in 1989 to nine per 100,000 in 2002. Guttmacher, *Abortion Worldwide* at 33.

- **South Africa:** Under apartheid, stringent abortion restrictions forced South African women to often terminate their pregnancies through unsafe means. *See* Benson at 4. When the post-apartheid Congress passed the Choice on Termination of Pregnancy Act in 1996, annual maternal deaths in public facilities from unsafe abortion procedures fell by 91% in just five years. Faundes & Shah at S57 (citing Rachel Jewkes & Helen Rees, *Dramatic Decline in Abortion Mortality Due*

to the Choice on Termination of Pregnancy Act, 95(4) S. AFR. MED. J. 250 (2005), https://pubmed.ncbi.nlm.nih.gov/15889846/).

- **Nepal:** Until the Nepali Parliament passed legislation in 2002 to reverse its abortion restrictions, Nepal reported one of the highest maternal mortality rates in the world, with a significant proportion of maternal deaths attributable to unsafe abortion. Ghazaleh Samandari et al., *Implementation of Legal Abortion in Nepal: A Model for Rapid Scale-Up of High-Quality Care*, 9(7) REPROD. HEALTH 1, 1 (2012), https://reproductive-health-journal.biomedcentral.com/track/pdf/10.1186/1742-4755-9-7.pdf. The maternal mortality rate dropped from 539 deaths per 100,000 live births in 1996 to 281 and 229 in more recent studies from 2006 and 2009. *Id.* at 7. A ten-year study observed "a significant overall decline in the proportion of total complications and septic abortion cases." Jillian T. Henderson et al., *Effects of Abortion Legalization in Nepal, 2001-2010*, 8(5) PLOS ONE 1, 4, (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3669364/pdf/pone.0064775.pdf.

- **Mexico:** With the exception of Mexico City, which made access to abortion less restrictive in 2007, almost all of Mexico's states have highly restrictive abortion laws (though such laws may soon fall given the Supreme Court's recent

decision decriminalizing abortion). *See* Guttmacher Inst., *Abortion Laws Liberalized in 16 Countries Since 1998* (Oct. 27, 2008), https://www.guttmacher.org/news-release/2008/abortion-laws-liberalized-16-countries-1998. Prior to Mexico City's 2007 policy change, "maternal mortality attributed to unsafe abortion procedures was the fourth or fifth cause of death for women in Mexico City."[13] Allison Ford, *Mexico City Legalizes Abortion*, 16(8) LAW & BUS. REV. AM. 119, 125 (2010), https://core.ac.uk/download/pdf/147642232.pdf. Since 2007, maternal mortality in Mexico City "sharply declined" to a "historic low" of 12.2 per 100,000 abortion procedures in 2015. Raffaela Schiavon & Erika Troncoso, *Inequalities in Access to and Quality of Abortion Services in Mexico: Can Task-Sharing Be an Opportunity to Increase Legal and Safe Abortion?*, 150(S1) INT. J. GYNECOL. OBSTET. 25, 28 (2020), https://omm.org.mx/wp-content/uploads/2020/08/Inequalities-in-access-to-abortion-services-in-Mexico.pdf. As of September 2019, there were no deaths out of the

[13] When Mexico City liberalized its abortion law in 2007, several other Mexican states tightened their restrictions, allowing researchers to do a comparative study. The study found a 10% reduction in abortion-related morbidity and a 40% reduction in rates of hemorrhage in Mexico City compared to non-reform states. Damian Clarke & Hanna Mühlrad, *Abortion Laws and Women's Health*, IZA Inst. of Labor Economics, 26 (Oct. 2018), https://conference.iza.org/conference_files/Gender_2019/27478.pdf.

216,755 first-trimester abortions performed in public facilities. *Id.*

- **Uruguay:** In 2012, Uruguay became the third South American country to recognize the right to abortion. The percentage of maternal deaths from unsafe abortions dropped sharply from 37.3% in 2001-2005 to 8.1% in 2011-2015. *See* Leonel Briozzo et al., *Overall and Abortion-Related Maternal Mortality Rates in Uruguay Over the Past 25 Years and Their Association with Policies and Actions Aimed at Protecting Women's Rights*, 134 INT'L J. OF GYNECOLOGY & OBSTETRICS S20, S22 (2016), https://www.sciencedirect.com/science/article/pii/S0020729216302454.

As these examples demonstrate, the recent global trend of permitting greater access to abortion care has immediate, positive impacts for women's health and well-being, while restricting access to abortion care jeopardizes women's lives and health.

* * *

Unsafe abortion is a significant but wholly preventable cause of maternal morbidity and mortality. Global experience confirms that one of the most effective means of preventing unsafe abortion is to provide broad legal access to abortion care. Despite the clear connection between legal access to abortion and safe abortion, and thus between legal access to abortion and improved women's health outcomes, Mississippi asks this Court to turn back the clock on women's health, in contravention of the core recommendations

of international public health bodies and professional societies of obstetricians and gynecologists. Laws like Mississippi's do not reduce abortion. Rather, for people without resources and information to access safe abortion care, they lead to more unsafe abortions, jeopardizing women's lives and their well-being, with the impact falling most acutely on poor and marginalized women. This Court should reject this call toward regression and instead reaffirm the existing legal framework that safeguards women's health and the well-being of their families and communities.

CONCLUSION

The judgment of the court of appeals should be affirmed.

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