In the United States Supreme Court

Counsel against Abortion HA-14-5-22

Amices Curie: *Dobbs v. Jackson Women's Health Organization* 19-1392 (5th Cir.) 2021

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Hospitals & Asylums

Dear Justice Clarence Thomas:

17 young people were injured by a mass shooting in Milwaukee because the US Supreme Court leaked their draft abortion case to the Clerk of Congress email, miraculously no one was killed, praise be to the abortion bans. The Clerk of Congress email has a 100 percent rampage shooting rate, now one of two known witnesses to this treason, is a justice of the Supreme Court. Who and what is betraying the United States Clerk of Congress to the Federal Bureau of Investigation (FBI)? Snail mail is more explosive, yet also dosed by the FBI; eg. 9-11 suicide attack. While the duration of this leak, named Nancy Pelosi is disqualified from Speaker of the House and Democratic party leadership for being a spy on the Permanent Select Committee on Intelligence, may not constitute megamurder, like *Roe v. Wade* (1973), failing to prescribe hydrocortisone, eucalyptus, lavender, peppermint or salt helps water cure coronavirus colds, or the fentanyl patent(s), the United States must remove the FBI, Capitol Police informants, and any other electronic surveillance of the Clerk of Congress mail, to court any spies in that office, and liberate the Clerk of Congress from censure or murder 18USC§1111.

The Supreme Court of the United States recognized the constitutional right to abortion in *Roe v. Wade* (1973). In the decades since, the Court continued to affirm the fundamental right to abortion, including in *Planned Parenthood v. Casey* (1992) and *Whole Women's Health v. Hellerstedt* (2016). States have enacted more than 227 restrictions to restrict or ban between January 2014 and June 2019. More than a dozen cases challenging some of the most extreme restrictions—such as bans on abortions after six weeks' gestation—currently have the potential to reach the Supreme Court, and *Dobbs v. Jackson Women's Health Organization* 19-1392 (5th Cir.) 2021 poses significant challenges to the legal framework protecting abortion rights. If the Court undermines or overturns *Roe v. Wade,* this will likely exacerbate existing disparities in abortion access and may allow individual states to explicitly or effectively ban abortion altogether (Jones et al '19). Counsel is against abortion in the Hippocratic Oath. Considering the global megamurder of medical negligence regarding the right that 'hydrocortisone, eucalyptus (echinacea), lavender, peppermint or salt helps water cure coronavirus colds', the health propaganda regarding a woman's right to safe, legal, medical abortion is suddenly not so convincing, however banning abortion doesn't cure coronavirus either. It is hypothesized that the United States has a responsibility to provide maternity protection and child social security benefits for physicians to convincingly counsel pregnant women against abortion and adopt orphans of 'felony abandonment'. To protect Temporary Assistance for Needy Families (TANF) growth against cuts and theft by children services, who have better luck snatching extremely poor babies to make money selling children for adoption and foster care, but are in competition with abortion, it seems necessary to transfer the social security program from the Administration for Children and Families (ACF) to the Supplemental Security Income (SSI) Program, to punish both rich quack and impoverished baby snatcher in the Department of Health and Human Services (DHHS) to do banning abortion justice. Forced pregnancy is considered a crime against humanity. "Forced pregnancy" means the unlawful

confinement of a woman forcibly made pregnant, with the intent of affecting the ethnic composition of any population or carrying out other grave violations of international law. This definition shall not in any way be interpreted as affecting national laws relating to pregnancy in Art. 7(1)(g)&(2)(f) of the Rome Statute.

The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law Opinion E-2.01 of the AMA Code of Ethics. World Health Report of 2005 – Make every Mother and Child Count reports 68,000 women die every year from unsafe abortions and counsels for the legalization of abortion to ensure their safety. The constitutional principles regarding the right to an abortion are articulated by the Supreme Court in *Roe v. Wade* 410 US 113 (1973), and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life H-5.982 Health and Ethics Policies of the AMA House of Delegates. *Roe v. Wade* 410 US 113 (1973) established criteria for legal abortion based upon the development of the fetus as follows: 1. For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician. 2. For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health. 3. For the stage subsequent to viability the State, in promoting its interest in the potentiality of human life, may, if it chooses, regulate, and even proscribe, abortion except where necessary, in appropriate medical judgment, for the preservation of the life or health of the mother. Subsequently it was found to be important to protect professional organizations involved in the training and licensing of physicians who don't advocate or educate their pupils in abortion from discrimination under 42USC§238n (Sanders '19).

While abortions are legal at least under certain conditions in almost all countries, these conditions vary widely. According to a 2019 United Nations (UN) report abortion is allowed in 98% of countries in order to save a woman's life. Many countries and territories that allow abortion have gestational limits for the procedure depending on the reason; with the majority being up to 12 weeks for abortion on request, up to 24 weeks for rape, incest, or socioeconomic reasons, and more for fetal impairment or risk to the woman's health or life. As of 2022, countries that legally allow abortion on request or for socioeconomic reasons comprise about 60% of the world's population, virtually every advanced industrialized nation, with the highest COVID fatalities. The Soviet Union became the first modern state to legalize abortions on request—the law was first introduced in the Russian SFSR in 1920, in the Ukrainian SSR in July 1921, and then in the whole country. Abortion continues to be a controversial subject in many societies on religious, moral, ethical, practical, and political grounds. Though it has been banned and otherwise limited by law in many jurisdictions, abortions continue to be common in many areas, even where they are illegal. More than three in five unintended pregnancies end in abortion, and an estimated 45 per cent of all abortions are unsafe, carried out in countries where the procedure is illegal, restricted or unaffordable in safe settings. Unsafe abortion hospitalizes around 7 million women a year globally and is a leading cause of maternal death (Haworth '22). In the United States in 2014, 12% of non-hospital facilities reported that they had seen one or more patients who had attempted to self-manage an abortion, and these proportions were highest in the South (21%) and the Midwest (16%) (Jones et al '19).

Number of reported abortions, abortion rate and abortion ratio, United States, 2000–2017

Year	No. (in 000s)	Rate*	Ratio†
2000	1,313.0	21.3	24.5
2001	[1,291.0]	[20.9]	[24.4]
2002	[1,269.0]	[20.5]	[23.8]
2003	[1,250.0]	[20.2]	[23.3]
2004	1,222.1	19.7	22.9
2005	1,206.2	19.4	22.4
2006	[1,242.2]	[19.9]	[22.9]
2007	1,209.6	19.4	21.9
2008	1,212.4	19.4	22.5
2009	[1,151.6]	[18.5]	[22.2]
2010	1,102.7	17.7	21.7
2011	1,058.5	16.9	21.2
2012	[1,011.0]	[16.1]	[20.4]
2013	958.7	15.2	19.4
2014	926.2	14.6	18.8
2015	[899.5]	[14.2]	[18.5]
2016	874.1	13.7	18.3
2017	862.3	13.5	18.4

*Abortions per 1,000 women aged 15–44 as of July 1 of each year.†Abortions per 100 pregnancies ending in an abortion or a live birth; for each year, the ratio is based on births occurring during the 12-month period starting in July of that year. NOTE: Figures in brackets are estimated by interpolation of numbers of abortions and adjustments made to CDC Abortion Surveillance Reports. SOURCES: 2000–2014 abortion numbers, rates and ratios—reference 1. 2015 abortion numbers—special tabulations of data from the 2013–2014 Guttmacher Institute Abortion Provider Census. 2015–2017 population data—reference 12. 2015–2017 birth data—references 13 and 14.

After nationwide legalization of abortion in 1973, the total number, rate (number of abortions per 1,000 women aged 15–44 years), and ratio (number of abortions per 1,000 live births) of reported abortions increased rapidly, reaching the highest levels in the 1980s, before decreasing at a slow yet steady pace. Between 2011 and 2014, the U.S. abortion rate is reported to have declined from 16.9 to 14.6 abortions per 1,000 women aged 15–44, the lowest rate ever recorded and the continuation of a decades-long trend. Still, in 2014, almost one in five pregnancies ended in abortion, and given abortion rates in that year, an estimated one in four U.S. women will have an abortion in their lifetime. CDC abortion surveillances statistics exclude California, District of Columbia, Maryland, and New Hampshire. (Kortsmit et al '21). California performs the most abortions and the District of Columbia has the highest rate. New data from the Guttmacher Institute examined trends in abortion incidence and rates between 2014 and 2017. In 2017, an estimated 862,320 abortions were provided in clinical settings in the United States, representing a 7% decline since 2014 and the continuation of a long-term trend (Jones et al '19). CDC surveillance seems to be prematurely sounding the alarm regarding the number of the beast regarding the number of abortions in the United States and needs to make an honest estimate, back to 1973, when abortion was legalized, that includes California, District of Columbia, Maryland, and New Hampshire.

Number, percentage, rate,* and ratio† of reported abortions — selected reporting areas, United States, 2010–2019

Year	Selected reporting areas§	Continuously reporting areas¶		
	No.	No. (%)**	Rate	Ratio
2010	765,651	762,755 (99.6)	14.4	225
2011	730,322	727,554 (99.6)	13.7	217
2012	699,202	696,587 (99.6)	13.1	208
2013	664,435	661,874 (99.6)	12.4	198
2014	652,639	649,849 (99.6)	12.1	192
2015	638,169	636,902 (99.8)	11.8	188

Year	Selected reporting areas§	Continuously reporting areas¶		
	No.	No. (%)**	Rate	Ratio
2016	623,471	623,471 (100.0)	11.6	186
2017	612,719	609,095 (99.4)	11.2	185
2018	619,591	614,820 (99.2)	11.3	189
2019	629,898	625,346 (99.3)	11.4	195

Source: CDC

* Number of abortions per 1,000 women aged 15–44 years.

† Number of abortions per 1,000 live births.

§ For each given year, excludes reporting areas that did not report that year's abortion numbers to CDC: California (2010–2019), District of Columbia (2016), Maryland (2010–2019), and New Hampshire (2010–2019).

¶ For all years, excludes reporting areas that did not report abortion numbers every year during the period of analysis (2010–2019): California, District of Columbia, Maryland, and New Hampshire.

** Abortions from areas that reported every year during 2010–2019 as a percentage of all reported abortions for a given year.

The U.S. abortion rate dropped to 13.5 abortions per 1,000 women aged 15–44 in 2017, the lowest rate recorded since abortion was legalized in 1973. Abortion rates fell in most states and in all four regions of the country. A total of 339,640 medication abortions occurred in 2017—about 39% of all abortions. As in previous years, clinics provided the overwhelming majority of U.S. abortions (95%), while private physicians' offices and hospitals accounted for 5%. In 2017, 808 clinic facilities provided abortions, a 2% increase from 2014. However, regional and state disparities in clinic availability grew more pronounced; the number of clinics increased in the Northeast and the West, by 16% and 4% respectively, and decreased in the Midwest and the South, by 6% and 9%, respectively. Although the number of state abortion restrictions continued to increase in the Midwest and South between 2014 and 2017, these restrictive policies do not appear to have been the primary driver of declining abortion rates. There was also no consistent relationship between increases or decreases in clinic numbers and changes in state abortion rates. Fertility rates declined in almost all states between 2014 and 2017, and it is unlikely that the decline in abortion was due to an increase in unintended births. Factors that may have contributed to the decline in abortion were improvements in contraceptive use and increases in the number of individuals relying on self-managed abortions outside of a clinical setting (Jones et al '19).

Number of reported abortions and abortion rate in 2014, 2016 and 2017; and percentage change in rates between 2014 and 2017, all by region and state in which the abortion occurred

Region and state	No.			Rate*			% change, 2014–2017
	2014	2016	2017	2014	2016	2017	
U.S. total	926,190	874,080	862,320	14.6	13.7	13.5	–8
Northeast	240,320	232,040	224,310	21.8	21.2	20.5	–6
Connecticut	13,140	12,210	11,910	19.2	18.1	17.7	–8
Maine	2,220	2,060	2,040	9.5	8.9	8.8	–7
Massachusetts	21,020	19,200	18,590	15.3	14.0	13.5	–12
New Hampshire	2,540	2,310	2,210	10.4	9.6	9.2	–12
New Jersey	44,460	48,300	48,110	25.8	28.2	28.0	9
New York	119,940	110,840	105,380	29.6	27.6	26.3	–11
Pennsylvania	32,030	32,230	31,260	13.3	13.5	13.1	–1
Rhode Island	3,580	3,510	3,500	17.0	16.8	16.7	–2
Vermont	1,400	1,360	1,300	12.1	12.0	11.4	–5
Midwest	138,940	133,410	133,120	10.6	10.2	10.2	–4
Illinois	42,270	41,740	42,080	16.3	16.4	16.6	2
Indiana	8,180	7,630	7,710	6.3	5.9	5.9	–6
Iowa	4,380	4,250	3,760	7.5	7.2	6.3	–15
Kansas	7,240	6,820	6,830	12.9	12.2	12.2	–5
Michigan	29,120	27,280	26,630	15.4	14.6	14.2	–8
Minnesota	9,760	10,150	10,740	9.3	9.6	10.1	9
Missouri	5,130	5,290	4,710	4.4	4.5	4.0	–8
Nebraska	2,280	1,950	2,020	6.3	5.3	5.5	–13
North Dakota	1,260	1,150	1,160	8.7	7.9	7.9	–9
Ohio	22,730	20,520	20,630	10.3	9.3	9.4	–9
South Dakota	550	470	500	3.5	3.0	3.1	–10
Wisconsin	6,050	6,170	6,360	5.6	5.7	5.9	6
South	308,060	289,730	295,290	12.9	11.9	12.1	–6
Alabama	8,020	6,630	6,110	8.3	7.0	6.4	–23
Arkansas	4,590	3,300	3,200	8.0	5.7	5.5	–30
Delaware	3,010	2,240	1,900	16.7	12.5	10.5	–37
District of Columbia	5,820	1,910	5,630	32.7	10.4	30.2	–8
Florida	75,990	70,130	71,050	20.6	18.5	18.6	–10
Georgia	33,000	34,870	36,330	15.7	16.4	16.9	8
Kentucky	3,530	3,280	3,200	4.1	3.9	3.8	–9
Louisiana	10,150	10,500	9,920	10.8	11.2	10.6	–2

*Abortions per 1,000 women aged 15–44. NOTE: Numbers of abortions are rounded to the nearest 10. SOURCE: 2014 data—reference 1.

Number of reported abortions and abortion rate in 2014, 2016 and 2017; and percentage change in rates between 2014 and 2017, all by region and state in which the abortion occurred (continued)

Region and state	No.			Rate*			% change, 2014–2017
	2014	2016	2017	2014	2016	2017	
South (continued)							
Maryland	28,140	30,190	29,800	23.4	25.3	25.0	7
Mississippi	2,290	2,510	2,550	3.8	4.2	4.3	13
North Carolina	29,960	26,990	29,500	15.1	13.5	14.6	–3
Oklahoma	5,330	4,380	4,780	7.0	5.7	6.2	–11
South Carolina	6,040	5,730	5,120	6.4	6.0	5.3	–17
Tennessee	13,880	11,990	12,140	10.7	9.2	9.2	–14
Texas	55,230	53,780	55,440	9.8	9.2	9.4	–3
Virginia	21,080	19,590	17,210	12.5	11.7	10.2	–18
West Virginia	2,020	1,700	1,430	6.0	5.2	4.4	–26
West	238,860	218,900	209,600	15.6	14.2	13.5	–14
Alaska	1,470	1,260	1,260	10.0	8.6	8.6	–14
Arizona	12,870	13,330	12,400	9.8	10.0	9.2	–6
California	157,350	140,700	132,680	19.5	17.4	16.4	–16
Colorado	13,160	12,380	12,390	12.1	11.1	10.9	–10
Hawaii	3,760	3,100	3,200	14.0	11.6	12.0	–14
Idaho	1,320	1,270	1,290	4.2	3.9	3.9	–6
Montana	1,690	1,630	1,580	9.1	8.7	8.3	–9
Nevada	10,970	9,540	9,690	19.4	16.5	16.4	–15
New Mexico	4,650	5,350	4,620	11.7	13.5	11.7	0
Oregon	9,330	9,850	9,640	12.0	12.3	11.9	–1
Utah	2,960	3,030	2,990	4.6	4.6	4.4	–4
Washington	19,230	17,350	17,740	13.7	12.1	12.1	–12
Wyoming	120	110	140	1.1	1.0	1.3	22

*Abortions per 1,000 women aged 15–44. NOTE: Numbers of abortions are rounded to the nearest 10. SOURCE: 2014 data—reference 1.

In 2019, 629,898 legal induced abortions were reported to CDC from 49 reporting areas. Among 48 reporting areas with data each year during 2010–2019, in 2019, a total of 625,346 abortions were reported, the abortion rate was 11.4 abortions per 1,000 women aged 15–44 years, and the abortion ratio was 195 abortions per 1,000 live births. From 2010 to 2019, the number, rate, and ratio of reported abortions decreased 18%, 21%, and 13%, respectively. However, compared with 2018, in 2019, the total number increased 2%, the rate of reported abortions increased by 0.9%, and the abortion ratio increased by 3%. Similar to previous years, in 2019, women in their twenties accounted for the majority of abortions (56.9%). The majority of abortions in 2019 took place early in gestation: 92.7% of abortions were performed at ≤13 weeks' gestation; a smaller number of abortions (6.2%) were performed at 14–20 weeks' gestation, and even fewer (<1.0%) were performed at ≥21 weeks' gestation. Early medical abortion is defined as the administration of medications(s) to induce an abortion at ≤9 completed weeks' gestation, consistent with the current Food and Drug Administration labeling for mifepristone (implemented in 2016). In 2019, 42.3% of all abortions were early medical abortions. Use of early medical abortion increased 10% from 2018 to 2019 and 123% from 2010 to 2019. During 2010–2019, the percentage of abortions performed at >13 weeks' gestation remained consistently low (≤9.0%). In 2019, the highest proportion of abortions were performed by surgical abortion at ≤13 weeks' gestation (49.0%), followed by early medical abortion at ≤9 weeks' gestation (42.3%), surgical abortion at >13 weeks' gestation (7.2%), and medical abortion at >9 weeks' gestation (1.4%); all other methods were uncommon (<0.1%). Among those that were eligible (≤9 weeks' gestation), 53.7% of abortions were early medical abortions (Kortsmit et al '21).

	Abortions reported by area of occurrence**			**Abortions obtained by out-of-state residents**
State/Area	**No.**	**Rate**	**Ratio**	**No. (%)**
Alabama	6,009	6.3	103	1,040 (17.3)
Alaska	1,270	8.8	129	19 (1.5)
Arizona	13,097	9.4	165	67 (0.5)
Arkansas	2,963	5.1	81	338 (11.4)
Colorado	9,002	7.6	143	946 (10.5)
Connecticut	9,202	13.7	269	334 (3.6)
Delaware	2,042	11.3	193	277 (13.6)
District of Columbia	4,552	23.9	501	3,126 (68.7)
Florida	71,914	18.5	327	2,256 (3.1)
Georgia	36,907	16.9	292	6,500 (17.6)
Hawaii	2,003	7.6	119	49 (2.4)
Idaho	1,513	4.4	69	78 (5.2)
Illinois	46,517	18.6	332	7,534 (16.2)
Indiana	7,637	5.8	94	618 (8.1)
Iowa	3,566	6.0	95	490 (13.7)

State/Area	Abortions reported by area of occurrence**			Abortions obtained by out-of-state residents
	No.	**Rate**	**Ratio**	**No. (%)**
Kansas	6,894	12.3	195	3,372 (48.9)
Kentucky	3,664	4.3	69	643 (17.5)
Louisiana	8,144	8.8	138	1,358 (16.7)
Maine	2,021	8.7	172	107 (5.3)
Massachusetts	18,593	13.3	269	631 (3.4)
Michigan	27,339	14.6	253	1,435 (5.2)
Minnesota	9,940	9.2	151	888 (8.9)
Mississippi	3,194	5.5	87	335 (10.5)
Missouri	1,471	1.2	20	128 (8.7)
Montana	1,568	8.0	142	169 (10.8)
Nebraska	2,068	5.5	84	267 (12.9)
Nevada	8,414	14.0	240	434 (5.2)
New Jersey††	22,178	13.2	223	1,309 (5.9)
New Mexico	3,942	9.9	172	939 (23.8)
New York	78,587	20.3	355	6,989 (8.9)
New York City	49,784	27.2	472	4,668 (9.4)
New York State	28,803	14.1	248	2,321 (8.1)
North Carolina	28,450	13.8	240	5,079 (17.9)
North Dakota	1,121	7.6	107	289 (25.8)
Ohio	20,102	9.1	150	1,186 (5.9)
Oklahoma	4,995	6.4	102	407 (8.1)
Oregon	8,688	10.5	208	795 (9.2)
Pennsylvania	31,018	13.0	231	2,222 (7.2)
Rhode Island	2,099	10.1	206	274 (13.1)
South Carolina	5,101	5.2	89	312 (6.1)
South Dakota	414	2.6	36	82 (19.8)
Tennessee	9,719	7.3	121	1,823 (18.8)
Texas	57,275	9.5	152	1,303 (2.3)
Utah	2,922	4.2	62	146 (5.0)
Vermont	1,195	10.4	223	265 (22.2)

State/Area	Abortions reported by area of occurrence**			Abortions obtained by out-of-state residents
	No.	**Rate**	**Ratio**	**No. (%)**
Virginia	15,601	9.2	160	867 (5.6)
Washington	17,262	11.4	203	848 (4.9)
West Virginia	1,183	3.8	65	168 (14.2)
Wisconsin	6,511	6.0	103	139 (2.1)
Wyoming	31	0.3	5	5 (16.1)
Total	**629,898**	**NA**	**NA**	**NA**

Source: CDC
Abbreviation: NA = not applicable.

The overall number of clinics in the Midwest and the South declined. Texas had the largest drop, losing seven clinic facilities between 2014 and 2017. The 2014 figure included clinics that provided any abortions within that year, but a number of these facilities had stopped providing abortion care at some point in 2014 due to state abortion restrictions—in particular, the requirement that physicians providing abortions have admitting privileges at a nearby hospital.21 While this and other Texas restrictions have since been struck down by the U.S. Supreme Court,3 a number of clinics in the state have not reopened or reintroduced abortion care. The Texas legislature passed 10 additional abortion restrictions between 2014 and 2017, indicating continued attempts to restrict access to abortion care. Similarly, a state restriction passed in Ohio in 2013 that required facilities providing abortions to have a transfer agreement with a public hospital was amended to be even more stringent in 2015, requiring that the public hospital be within 30 miles of the facility; this development contributed to the continued decline of clinic facilities in that state. In 2014, four states had only one clinic providing abortion care—Mississippi, Missouri, North Dakota and South Dakota.1 In 2017, Kentucky and West Virginia were also down to one clinic facility, while Missouri has fluctuated between one and three clinical sites. All 10 states that had a meaningful increase in clinic numbers also showed declines in their abortion rates. Fertility rates declined in virtually all states between 2014 and 2017. Between 2014 and 2016, the proportion of women aged 15–44 using long-acting reversible contraceptive methods increased by 23%, from 13% to 16%; levels of sterilization were 25% and 26%, respectively (Jones et al '19).

Worldwide, on average, 121 million unintended pregnancies occur every year – 331,000 per day. The ability to decide whether to have children, how many and with whom, is fundamental to the reproductive rights of girls and women. When this right is ignored or compromised – by social constraints or abuse, lack of health services or the low priority in general placed on the female half of humanity – the consequences snowball. Unintended pregnancy impacts individual lives and whole societies, impeding progress in health, education and gender equality, increasing poverty and lack of opportunity and costing billions in resources. While modern contraceptives are increasingly available, no method is 100 per cent failsafe. Planned sexual abstinence can also fail, including due to coercion or violence. Other factors that undermine the ability of women and girls to exercise reproductive choice and bodily autonomy include gender inequality, poverty, shame, fear and gender-based violence. Men play a key role: worldwide, almost one quarter of women are unable to refuse sex. Rape causes unintended pregnancy at rates equal to, or greater than, consensual sex. Globally, around 257 million

women who want to avoid pregnancy are not using safe, modern methods of contraception. Of these women, 172 million use no method at all. Women with unintended pregnancies are less likely to use antenatal health services and more vulnerable to postpartum depression. Some studies link unintended pregnancy to preeclampsia and postpartum haemorrhage, both major causes of maternal death. Ultimately, when societies restrict women's reproductive agency, motherhood can become the default rather than a considered decision and desire. By contrast, when societies empower women to make their own choices, they recognize women's inherent value. Countries with higher levels of informed choice reduce both unintended pregnancies and their far-reaching negative consequences (Haworth '22).

The United Nations Population Fund (UNPF) has emphasized contraception access, providing 724 million male condoms, 80 million cycles of oral contraceptives and tens of millions of other forms of contraceptives in 2020 alone. Actually, rates of unintended pregnancy tend to be lower in countries with more liberal abortion laws, where access to safe abortion is available on request or in most circumstances. In countries where abortion is restricted or banned, more women get pregnant unexpectedly. When women have access to proper health services and the ability to exercise their rights to reproductive choice and bodily autonomy, rates of unintended pregnancy fall regardless of abortion laws. Despite more than 60 per cent of unintended pregnancies ending in abortion, not all are unwanted. A large survey in France found that women were more likely to say a pregnancy was unplanned than they were to say it was unwanted. Women's attitudes toward pregnancy can shift over time. Some are unsure whether to have children or add to their families. More research, and clearer definitions, are needed to disentangle these situations and to better provide opportunities for women to exercise real, informed choice over their bodies and futures. Medication abortion accounted for 39% of all abortions. Assuming that health care providers followed the FDA-recommended regimen that allows mifepristone to be administered up to 10 weeks' gestation. More than three in five unintended pregnancies end in abortion, and an estimated 45 per cent of all abortions are unsafe, carried out in countries where the procedure is illegal, restricted or unaffordable in safe settings. Unsafe abortion hospitalizes around 7 million women a year globally and is a leading cause of maternal death (Haworth '22). In 2014, 12% of nonhospital facilities reported that they had seen one or more patients who had attempted to self-manage an abortion, and these proportions were highest in the South (21%) and the Midwest (16%) (Jones et al '19).

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