

May 21, 2019

Working Group on Discrimination against Women in Law and Practice
c/o OHCHR-UNOG
Office of the High Commissioner for Human Rights
Palais Wilson
1211 Geneva 10, Switzerland

Dear Members of the UN Working Group on Discrimination against Women:

The purpose of this submission from reproductive rights and justice organizations is to detail the developments in the United States regarding reproductive rights and justice since the Working Group's visit to the U.S. in 2015. As reflected in this follow-up report, the United States has failed to implement recommendations made the Working Group at the conclusion of its visit. In addition, since 2015, the political and policy landscape in the United States for women's rights, including reproductive rights, has worsened considerably, resulting in a significant retrogression of rights.

In submitting this follow-up report, we respectfully urge the Working Group to note concern with the retrogression surrounding the reproductive rights law and policy landscape in the United States and remind the U.S. of its obligations to ensure women's rights to equality and non-discrimination and their rights to reproductive and sexual health.

Sincerely,

Center for Reproductive Rights
City University of New York Law School, Human Rights & Gender Justice Clinic
If/When/How: Lawyering for Reproductive Justice
In Our Own Voice
National Asian Pacific American Women's Forum
National Latina Institute for Reproductive Health

Report to the UN Working Group on the Issue of Discrimination Against Women in Law and in Practice

Follow-up to the Working Group’s 2015 Visit to the United States of America

Submitted on May 21, 2019
by:¹

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INTRODUCTION

This report to the UN Working Group on the Issue of Discrimination Against Women in Law and in Practice (“the Working Group”) provides an update to the Working Group’s findings and recommendations following its 2015 visit to the United States. This report covers developments related to general access to health care (Section I); access to contraception and family planning services (Section II); abortion access (Section III); maternal health and postpartum care (Section IV); sex education (Section V); and global access to reproductive health care (Section VI); and provides recommendations to the Working Group on steps the United States should take to eliminate discrimination and promote equality for women.

Since the Working Group’s visit in 2015, the political and policy landscape in the United States for women’s rights, including reproductive rights, has worsened considerably, resulting in a significant retrogression of rights.

The current Administration has shown open hostility toward women and reproductive rights and has proposed and implemented multiple federal restrictions on access to reproductive health care.² Federal agencies are led and staffed by appointees who seek to restrict access to evidence-based reproductive health care.³ Many appointed agency leaders hold explicitly anti-abortion, anti-woman, anti-health, anti-contraception, and anti-science views.⁴ As detailed in this report, these appointees have instituted numerous federal policies that have drastically curtailed access to reproductive health care both within the United States and globally. This is often done under the guise of prioritizing claims of religious conscience over the rights of women (and other groups) to access reproductive health services, by expanding conscience claims to include “moral” as well as religious refusals, and by allowing corporations to assert conscience claims.⁵

Federal legislators, too, have actively opposed or undermined programs that facilitate women's health and equal place in society. Lawmakers have (so far unsuccessfully) attempted to repeal the Affordable Care Act, defund Planned Parenthood, ban abortion after 20 weeks' gestation, and ban abortion coverage in state health insurance exchanges.⁶

State-level attacks on reproductive health, which have been on-going for the last two decades, have been emboldened in this environment. Twenty-six states severely restrict access to reproductive health care, and, as detailed in this report, policymakers are passing increasingly restrictive and punitive laws and policies each year.⁷ To date in 2019, states have enacted thirty-four laws restricting abortion access, including several near-total abortion bans.⁸

In the face of these threats, some federal and state policymakers are proposing measures to protect abortion care and women's health care, and a handful of states have passed laws protecting rights and expanding access.⁹ However, women's rights and reproductive freedom in the United States are under alarming and relentless attack.¹⁰

I. General Access to Health Care

Following its 2015 visit, the Working Group expressed concern about the lack of universal health insurance and regional and ethnic disparities in health coverage. The Working Group noted that over twenty-eight percent of people living in poverty in the U.S. were uninsured, and that lack of insurance primarily impacts women and, in particular, African-American and Hispanic women.¹¹ Immigrants continue to face additional barriers in accessing health insurance through Medicaid, and lesbian, bisexual, transgender and intersex persons face ongoing discrimination by health care providers.¹² In 2017, the number of overall uninsured

people increased by more than half a million for the first time since the implementation of the ACA in 2014.¹³

Rather than taking steps to expand access to care, such as removing eligibility requirements that exclude immigrants, the Administration has imposed additional barriers including: weakening the ACA, allowing states to impose work requirements on Medicaid recipients, and penalizing immigrants who access government funded health care.

A. Affordable Care Act and Medicaid

The ACA, passed in 2010, provided health care coverage for approximately 20 million uninsured Americans¹⁴ by (1) expanding eligibility for government insurance through Medicaid and (2) expanding an individual's ability to purchase private health insurance through state health care exchanges and tax subsidies.¹⁵ While Congress has not repealed the ACA, it has weakened it by eliminating a requirement that all individuals purchase health insurance.¹⁶ The federal government cut funding to assist consumers in enrolling in health plans by 80% since 2016 and has encouraged consumers to enroll in short-term plans that do not meet the stringent coverage requirements of the ACA.¹⁷ The federal government has also begun allowing states to impose work requirements on individuals receiving Medicaid.¹⁸ Separately, several states, including Texas, Tennessee, and South Carolina, have requested HHS' approval of Section 1115 Medicaid waiver applications that would restrict abortion providers from receiving Medicaid reimbursements for family planning services.¹⁹

B. Anticipated Rollback of ACA's Anti-Discrimination Provision

The ACA included an important provision that prohibited discrimination in health care which has been weakened by the courts and the Trump Administration.²⁰ Section 1557 prohibits discrimination based on sex by any health care programs that receive federal funding and plans on ACA state exchanges. Current HHS regulations define sex-based discrimination to include gender identity and termination of pregnancy.²¹ In December 2016, a Texas court enjoined enforcement of the regulation’s prohibition of discrimination based on gender identity or termination of pregnancy.²² Although other courts have held that Section 1557 does prohibit discrimination based on gender identity and the Texas decision is being appealed, the Trump Administration has announced that it will amend the regulation.²³

C. Attack on Immigrant Access to Care

In many states, lawfully present immigrants are eligible for certain Medicaid benefits and state health benefits. However, a regulation proposed by the Trump Administration changing the “Public Charge” rule would make using such health coverage a negative factor in evaluating requests to become legal permanent residents.²⁴ This could force immigrant families to choose between future permanent legal status and immediate needs to access health care, leading to devastating impacts on immigrant women’s health.²⁵ Already, the proposed regulation has generated substantial fear within immigrant communities and is affecting immigrants’ decisions to seek care.²⁶

II. Access to Contraception and Health Care Information

A. Access to Contraceptives for the Privately Insured Under the ACA

In addition to expanding health care coverage, the ACA includes a provision requiring nearly all private health care plans to provide coverage for contraception at no cost to plan beneficiaries.²⁷ The required benefit recognizes that contraceptive care is essential health care and that women were paying a disproportionate amount of health care costs. The Working Group emphasized that provisions requiring insured access to contraceptives should be “universally enforced” and that religious refusals should not effectively deny women’s access to health care.²⁸ However, new regulations drastically expand the number of plan sponsors who can opt out of the mandate, without requiring an alternative manner to make coverage available.²⁹

Initially, under the prior Administration, houses of worship were exempt from the mandate and an accommodation was created for non-profit religious organizations, such as religiously-affiliated hospitals.³⁰ As noted by the Working Group, *Burwell v. Hobby Lobby* (2014) gave privately held, for-profit corporations an accommodation based on their objections to providing health insurance coverage for contraceptive care based on religious grounds.³¹ Following *Hobby Lobby*, privately held, for-profit corporations with religious objections were given the same accommodation as non-profit religious organizations, which allowed the corporation’s insurer or third party administrator to provide contraceptive coverage in its place.³²

In 2017, the Trump Administration proposed regulations making it easier for entities to opt out of providing contraceptive coverage.³³ The rules include a religious exemption for “entities and individuals,” opening the door for any type of employer, including publicly traded corporations, to claim a religious exemption from the contraceptive mandate.³⁴ A companion rule also creates a “moral exemption” based on moral conviction not rooted in religious beliefs that can be claimed by individuals, non-profit organizations, and for-profit corporations that are not publicly traded.³⁵

These rules invite employers to assert religion or moral beliefs as a basis to avoid providing employees with contraceptive coverage. Further, the rules grant exemptions rather than accommodations.³⁶ Accommodations are now entirely optional, meaning that if an entity claims an exemption, there is no requirement that coverage be provided by a third party, or that the exempted entity give notice to its beneficiaries.³⁷ Final rules were scheduled to go into effect on January 14, 2019, but were enjoined.³⁸ The rules are the subject of ongoing litigation.

B. Access to Contraception and Health Care Information for Low Income Women

Low-income women who cannot afford private insurance rely on Title X, the sole federal grant program dedicated to providing low-income Americans access to comprehensive contraceptive and related family planning services.³⁹ Since its inception, Title X has set the standard of care for high-quality, evidence-based family planning.⁴⁰ Under Title X, the federal government sets program requirements and allocates funds to the states to distribute to health care providers. Title X funds a range of reproductive health services, including family planning, contraception, breast and cervical cancer screenings, and STD screenings but is prohibited by statute from funding abortion care.⁴¹

Following its visit, the Working Group recommended increasing funding to expand contraceptive access for individuals who lack insurance and preventing “politically motivated actions to exclude women’s health providers” from receiving funding.⁴² However, attempts to defund women’s health care providers continue. In April 2017, Congress overrode a rule prohibiting states from withholding Title X grants for reasons other than their ability to provide services, allowing states to exclude Planned Parenthood and other organizations that provide abortions from participating in Title X.⁴³ Many states have excluded Planned Parenthood and

other organizations that provide abortions from participating in health care programs receiving government funds.⁴⁴

On March 4, 2019, the Administration published new regulations that further and fundamentally alter and undermine Title X.⁴⁵ The new regulations prohibit Title X funds from going to providers who also perform abortions; discourages providers from referring for abortion; and imposes burdensome and unnecessary requirements that could force health care providers to shut their doors.⁴⁶ The regulations were set to go into effect on May 3, 2019, but were enjoined in late April 2019.⁴⁷ The content of the regulations is discussed in more detail below.

i. Violation of Patients' Rights to Health Information

Previous Title X regulations required that providers offer pregnant women the opportunity to be provided information and counseling on pregnancy options including abortion, adoption, and prenatal care.⁴⁸ The new regulations deleted language from the previous regulations requiring Title X projects “provide neutral, factual information and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling.”⁴⁹ The new regulation requires that all pregnant patients be referred to prenatal care and gives the provider the option of whether or not to provide pregnancy counseling.⁵⁰ Physicians and advanced practice providers (but not nurses) are permitted to provide “non-directive” counseling but are only permitted to share a list of comprehensive primary care providers, some but not all of which provide abortions, and are prohibited from identifying those

providers on the list that offer abortions.⁵¹ Further, pregnant patients must be referred for prenatal care, regardless of the patient's wishes.⁵²

ii. Costly Physical Separation Requirements

The final rule will also significantly and unnecessarily increase operating costs for family planning providers that perform abortions by imposing new physical separation requirements. Although Title X funds cannot currently be used to provide abortions, the new regulations would require physical as well as financial separation of abortion services at Title X recipients.⁵³ Compliance will likely require separate waiting rooms, separate patient records, separate entrances and exits, separate phone numbers, separate workstations, etc.⁵⁴

The change effectively prevents women's health providers that provide abortions, like Planned Parenthood, from participating in Title X unless they build separate facilities or undergo extensive renovations, which may be too costly or impractical. Currently, Planned Parenthood health centers serve 41% of women that rely on Title X.⁵⁵ The loss of Planned Parenthood as a Title X provider would dramatically shrink the number of available clinics,⁵⁶ and remaining providers would be unable to serve all patients in need of services.⁵⁷ One analysis showed that to serve the women who currently rely on Title X health centers, other sites would need to increase caseloads by at least 70%.⁵⁸

C. Failure to Regulate Anti-Abortion Counseling Centers

Since the Working Group's visit, the Supreme Court's decision in *N.I.F.L.A. v. Becerra* significantly limits state and local governments' ability to regulate faith-based, anti-abortion

counseling centers—also called crisis pregnancy centers (CPCs)—and fails to protect a woman’s right to receive accurate information from health care providers.⁵⁹

The goal of Crisis Pregnancy Centers is to prevent women from having abortions.⁶⁰ CPCs attract pregnant women to their facilities by offering limited prenatal services, which may include free pregnancy tests, sonograms, counseling, STI testing, and community referrals.⁶¹ Many CPCs employ deceptive tactics to lure women through their doors under the guise of providing comprehensive health services and instead provide misleading information regarding contraceptives and abortion.⁶²

Despite not being licensed doctors or nurses, many CPC workers dress in white lab coats, request medical history questionnaires from patients, and replicate the look of a medical office.⁶³ CPCs are often situated near comprehensive women’s health clinics, place advertisements online that pop-up when using search engines terms such as ‘abortions,’⁶⁴ and do not disclose to patients that they oppose abortions. One woman told her doctor that she visited a CPC, and the staff performed numerous ultrasounds, claiming that they could not provide an accurate date of conception or delivery, and told her she could have an abortion at any gestational age.⁶⁵ By the time she saw a doctor, she was into her third trimester and prohibited from having an abortion under New York state law.⁶⁶ In other instances, women with wanted pregnancies have been delayed in accessing necessary and legitimate prenatal care because they initially sought services at a CPC and were given medically inaccurate information about their pregnancies.⁶⁷

Because CPCs mislead pregnant women seeking care, California passed a law that required that (1) unlicensed CPCs disclose to patients their lack of medical certification and (2) licensed CPC facilities inform women of the availability of free or low cost abortion services and the number of a state agency that could provide referrals.⁶⁸ In 2018, in a 5-4 decision, the

Supreme Court struck down both notice requirements and ruled that any mandatory disclosures on behalf of CPCs were unconstitutional and violated First Amendment free speech doctrine.⁶⁹

The *NIFLA* decision will have a long-lasting impact on a woman's ability to receive accurate and complete information from health care providers. Low-income women, and those with limited resources, will be most affected as the delays caused by CPCs' deceptive practices cost them time and money they do not have. To visit a CPC, many women will have taken time off from work, thereby losing a day's worth of wages, and perhaps enlisted child care. If they are lucky, they will figure out that their time was wasted after only one visit. They will still have to find a clinic that will provide accurate information and a full range of services before their pregnancy progresses too far. Despite these realities, the Supreme Court's *N.I.F.L.A.* decision essentially allows CPCs' to conceal information about the limited services they provide, thus infringing a woman's right to accurate health information and safe and legal abortion.

CPCs now outnumber abortion clinics⁷⁰ and constitute a multi-million dollar industry with national umbrella organizations like the National Institute of Family and Life Advocates (NIFLA), Care Net, Birthright International, and Heartbeat International helping to fund and coordinate the activities of thousands of member or affiliate centers across the country.⁷¹ In addition to the resources provided by umbrella organizations, CPCs across the country receive significant funding from both federal and state governments. For example, CPCs receive funding from federal abstinence only programs,⁷² which include the Title V State Abstinence Education Grant Program, Competitive Abstinence Education program, and abstinence programs created by the Patient Protection and Affordable Care Act.⁷³ They also receive public assistance dollars from Temporary Assistance for Needy Families block grants,⁷⁴ and fourteen states directly fund CPCs from their state budgets.⁷⁵ While anti-choice lawmakers target abortion clinics with

onerous and medically unnecessary regulations aimed at shutting them down, anti-abortion counseling centers are largely able to avoid financial and regulatory oversight.

III. Access to Abortion

A. Threats to Constitutional Protection of the Right to Abortion

The Working Group found that since *Roe v. Wade* in 1973, subsequent Supreme Court decisions have chipped away at the right to abortion.⁷⁶ After the conclusion of the Working Group's visit, the Supreme Court issued a decision in the case of *Whole Woman's Health v. Hellerstedt*,⁷⁷ again affirming the core holding in *Roe*, as it had been reaffirmed over 25 years ago in *Planned Parenthood v. Casey*.⁷⁸ However, the Working Group's recommendations that the U.S. take steps to ensure that all women can exercise their right to terminate a pregnancy⁷⁹ have a renewed relevance, particularly in the current increasingly hostile legal and policy environment.

i. Constitutional Standard

The Working Group recognized that the Supreme Court's 2016 decision in *Whole Woman's Health v. Hellerstedt*, would "have major implications for the future of access to essential reproductive health care."⁸⁰ The case involved two sets of medically unnecessary regulations enacted by Texas requiring that an abortion provider obtain admitting privileges at a hospital within 30 miles from where the abortion is performed and that every abortion facility meet building specifications to essentially become mini-hospitals, known as ambulatory surgical centers (ASCs).⁸¹ If left in effect, the provisions would have left only seven or eight abortion

care facilities to care for approximately 5.4 million women of reproductive age in Texas.⁸² Prior to the restrictions, over 40 facilities provided abortion care in Texas.⁸³

On June 27, 2016, the Supreme Court struck down both the admitting privileges requirement and the ASC requirement as unconstitutional.⁸⁴ *Whole Woman's Health* clarified that unnecessary regulations that place a significant obstacle in the path of a woman seeking an abortion violate the undue burden standard announced in *Casey*.⁸⁵ Following the decision, similar restrictions in Alabama, Mississippi, and Wisconsin fell, Virginia removed its admitting privileges requirement, and a federal court invalidated two Tennessee laws in April 2017, citing *Whole Woman's Health* as precedent.⁸⁶ But as discussed below, recently, federal courts have rejected legal challenges to statutes virtually identical to the Texas law struck down in *Whole Woman's Health*, and states continue to enact restrictive laws.

ii. Legislative and Judicial Environment

Although *Whole Woman's Health* limits states' ability to target abortion facilities with unnecessary, burdensome regulations, states are enacting increasingly draconian restrictions on women's access to reproductive health care.⁸⁷ Thus far in 2019, states have enacted thirty-four laws restricting abortion access.⁸⁸ These include pre-viability bans on abortion,⁸⁹ such as laws banning abortion around 6 weeks of pregnancy.⁹⁰ For example, in May 2019, the Alabama governor signed a bill into law that bans most abortions and creates criminal penalties for doctors.⁹¹ States have also outlawed the procedure that is the standard of care for abortion after approximately 15 weeks of pregnancy.⁹² In addition, states have enacted bans on abortion for specific reason, including fetal diagnosis,⁹³ and enacted and expanded regulations that target abortion providers with medically unjustified regulations which subject women seeking abortion

to mandatory delays, multiple clinic visits, and medically inaccurate information.⁹⁴ As a result of these laws, the number of abortion providers in the United States continues to decline, and at least six states have only one abortion provider.⁹⁵

Further, with a new line up of justices on the U.S. Supreme Court and the Administration's spate of judicial appointments to the lower federal courts, the future of constitutional protection of abortion rights is under threat. For example, the Court of Appeals for the Fifth Circuit recently upheld the constitutionality of an admitting privileges law in Louisiana which is designed to close abortion clinics throughout the state, despite the fact that in 2016 the Supreme Court in *Whole Woman's Health* struck down a virtually identical law as unconstitutional.⁹⁶ The Supreme Court has blocked the law while it decides whether to review the Fifth Circuit's decision, thus setting up a potential show down at the Supreme Court.

B. Increased Criminalization of Self-Managed Abortion

Today, because of growing restrictions on clinic-based abortion care, the intimidation and harassment that women face at clinics, and the increased availability of medication abortion as a safe and effective method to terminate a pregnancy,⁹⁷ more women may be choosing to have self-managed abortions. Since the Working Group's visit, these women face increased threat of being criminally prosecuted.

In the U.S., there is growing political support for criminalizing women who have abortions. In April 2019, the Texas House of Representatives considered a bill that would have allowed the state to charge women who have an abortion or their doctors with criminal assault or homicide, which is subject to the death penalty.⁹⁸ Even without laws explicitly criminalizing women who have abortions, women who have self-managed abortions, miscarry, or experience

stillbirth outside a clinical setting are being criminally prosecuted. To do this, state prosecutors manipulate pre-*Roe v. Wade* statutes⁹⁹ and laws that were meant to regulate abortion providers¹⁰⁰ or criminalize harm to pregnant women and fetuses¹⁰¹ to prosecute and convict women for ending their own pregnancies and for miscarriages and stillbirths.

Recent cases illustrate prosecutors' ability to prosecute women who lose a pregnancy. Katherine Dellis, a 25-year old woman, was sentenced to five months in prison after suffering a stillbirth and passing out.¹⁰² After awakening, she disposed of the fetal remains and sought medical treatment. She was charged with "concealing a dead body." In 2018, the Virginia Court of Appeals upheld her conviction.¹⁰³ In 2016, Anne Bynum, an Arkansas woman, was charged with abuse of a corpse and concealing a birth after she went to a hospital and was suspected of ending her own pregnancy. The abuse of a corpse charge was dropped but she was sentenced to six years for concealing a birth.¹⁰⁴

Although many of the convictions are eventually overturned,¹⁰⁵ the women prosecuted suffer the mental, physical, and financial consequences of having to defend themselves and often spend a significant amount of time in jail or prison. Further, fear of criminalization places a barrier to necessary health care and inevitably endangers women's health. Prosecution under these laws target the most marginalized in U.S. society: low-income women and women of color. These women are more likely to have factors—such as lack of money, childcare, transportation, legal immigration status, and/or a mistrust of the medical system—that push or pull them to avoid professional health care or settings during pregnancy, or to self-managed abortion.¹⁰⁶

C. Government Efforts to Undermine Access to Abortion for Marginalized Communities

The Working Group has expressed concern about “ever increasing barriers” that undermine access to abortion services.¹⁰⁷ In addition to the use of government funded health programs to target Planned Parenthood and prevent patients from receiving information about abortion (see Section II.B), federal and state policies continue to obstruct access to legal abortion through restrictions on abortions for women detained in jails, prisons, and immigration facilities.

i. Preventing Access to Abortion for Women in Detention

Generally, health care services for pregnant women in prisons, jails, and immigration detention do not cover abortions, and state policies vary as to whether women will be granted permission to travel to an outside abortion clinic and whether they must pay for the cost of transport.¹⁰⁸ In recent years, women have sued jails that have denied a medical furlough or transport to clinics to obtain abortions.¹⁰⁹

Recent federal attempts to block a seventeen-year-old and several other adolescent girls in immigration detention from accessing abortion gained nation-wide attention. Unaccompanied minor immigrants who enter the U.S. without authorization are placed in the custody of HHS’s Office of Refugee Resettlement (ORR). In March 2017, ORR’s then-director Scott Lloyd issued a directive prohibiting federally funded shelters from taking “any action that facilitates” abortions without the ORR director’s approval.¹¹⁰ The policy came to light on September 2017, when Jane Doe, a seventeen-year-old girl in ORR custody in Texas sought an abortion, and ORR refused to allow her to leave the shelter.¹¹¹ Following a lawsuit, the D.C. Circuit Court of Appeals, sitting *en banc*, upheld a decision ordering ORR to allow Jane Doe to leave the shelter to obtain an abortion.¹¹² Justice Kavanaugh, then a D.C. Circuit judge, dissented, claiming that

the decision created “a new right for unlawful immigrant minors in U.S. Government detention to obtain immediate abortion on demand.”¹¹³

Similar stories have arisen since Jane Doe’s, including a young woman who took medication abortion and was forcibly sent to the emergency room before completing her abortion,¹¹⁴ and visits by government officials to federally funded shelters to dissuade young women from obtaining abortion care.¹¹⁵ With other women coming forward, the D.C. District Court ruled on March 30, 2018 that the *Doe* case could continue as a class action lawsuit, and it blocked the ORR policy while the case continues.¹¹⁶

ii. Restricting Health Coverage for Abortion for Low-Income Women and Others

The Working Group has called on the U.S. to repeal the Hyde Amendment, which bars the use of federal funds to cover abortion except to save the life of the pregnant person, or if the pregnancy arises from incest or rape.¹¹⁷ The Hyde Amendment effectively prevents Medicaid enrollees and other individuals who rely on the federal government for health care from using their coverage to obtain abortion care. Nearly one in six women of reproductive age rely on Medicaid, and 60% of these women live in states that restrict state coverage of abortion.¹¹⁸ Additionally, many states restrict private insurance from covering abortion.¹¹⁹

Since the Working Group Report, Congress has failed to repeal the Hyde Amendment and the Administration has sought to deter insurers from providing coverage for abortions under ACA health plans. In November 2018, HHS issued a proposed rule designed to make abortion coverage costlier and more burdensome by requiring health insurance plans found within the ACA insurance marketplaces to send separate invoices for abortion coverage.¹²⁰ In April 2019, HHS issued separate final rules that require that a Qualified Health Plan (“QHP”) issuer that

provides coverage of non-Hyde abortion services in one or more QHPs, to also offer at least one “mirror QHP” that omits coverage of non-Hyde abortion services throughout each service area in which it offers QHP coverage through the Exchange.¹²¹ HHS claimed that the reason for the rule is to increase enrollment of consumers with religious or moral objections to abortion as a benefit in their Qualified Health Plan, however it provided no facts or data supporting the need for this rulemaking.

Some states have nevertheless taken steps to ensure coverage for abortion. In 2017, Oregon enacted the Reproductive Health Equity Act, which requires insurers doing business in Oregon to offer coverage for reproductive health services at no cost.¹²² Oregon’s law will help ensure that women with private insurance plans have access to reproductive health and related preventative services with no cost sharing, including for family planning, abortion, and postpartum care.¹²³ In September 2017, Illinois passed a law providing state health insurance and Medicaid coverage for abortion and also ensuring that abortion will remain legal if the Supreme Court overturns *Roe v Wade*.¹²⁴

D. Failure to Protect Abortion Providers and Clinics

i. Freedom of Access to Clinic Entrances (FACE) and the Rising Tide of Clinic Violence

The Working Group has expressed concern about stigma attached to reproductive and sexual health care, which has led to acts of violence, harassment, and intimidation against those seeking or providing reproductive health care, and it has reminded the U.S. of its duty to combat the stigma and to investigate and prosecute violence or threats of violence.¹²⁵ However, the current environment is resulting in increasing rather than decreasing stigma. Anti-abortion extremist groups continue to routinely block parking lots, entrances, and sidewalks at clinics to

delay or prevent women from receiving abortion care,¹²⁶ and violence and threats of violence have increased following a mass shooting at a Planned Parenthood clinic in late 2015.

On November 27, 2015, Robert Dear opened fire at a clinic in Colorado Springs, killing three people and injuring nine.¹²⁷ At a December 2015 court appearance, Dear repeatedly made statements affirming his guilt and expressed anti-abortion and anti-Planned Parenthood views.¹²⁸ After the shooting, in the first half of 2016, 34.2% of U.S abortion clinics reported suffering from “severe violence and threats of severe violence.”¹²⁹ In 2018, the percentage of clinics reporting threats of severe violence decreased to 24%, but targeted intimidation and threats against doctors and staff increased to 52%.¹³⁰ In 2017, 62 death threats or threats of harm against providers were reported to the National Abortion Federation as well as an attempted bombing that required that a clinic be evacuated and closed for several days.¹³¹

The federal Freedom of Access to Clinic Entrances (FACE) Act makes it a crime to use force, the threat of force, or physical obstruction to prevent individuals from obtaining or providing reproductive health care, and fourteen states and the District of Columbia prohibit actions that block clinic entrances.¹³² Despite these laws, in addition to violence and threats of violence, in 2017 NAF members reported that instances of trespass tripled, obstruction nearly tripled, and clinic invasions increased.¹³³

IV. Maternal Health and Parenting

The Working Group expressed serious concern at the increasing maternal mortality ratio in the U.S and the distressing ethnic and socioeconomic disparities in maternal health outcomes, recommending that the U.S. address the root causes of maternal deaths, particularly among Black women.¹³⁴ Several root causes are addressed throughout this report including the lack of basic

health services for all who cannot afford to pay for them (Section I), access to reproductive health services and family planning (Section II), and comprehensive evidence based sex education (Section V). This section discusses health care policies concerning pregnant women, treatment of pregnant women in detention, and paid leave.

A. Maternal Mortality

In 2015, the World Health Organization and others surveyed global progress on Millennium Development Goal No. 5, improving maternal health. The study found that the U.S. was one of only thirteen countries in the world where maternal mortality is rising rather than falling.¹³⁵ According to the U.S. Centers for Disease Control and Prevention (CDC), every year, 700 to 900 women die from pregnancy or childbirth-related causes in the U.S. and 65,000 nearly die.¹³⁶ As noted by the Working Group, in the United States, maternal mortality is more common among Black women, who are nearly four times more likely to die than white women are, and twice as likely as white women to suffer severe maternal morbidity, or a life-threatening pregnancy complication.¹³⁷ Indigenous women, low-income women, and women in poor rural areas of the country are also disproportionately affected.¹³⁸ The majority of U.S. maternal deaths are preventable.¹³⁹ Despite troubling maternal health outcomes, the U.S. fails to adequately monitor maternal deaths or prioritize equitable access to safe and respectful health care, including maternal healthcare.

The lack of systematically collected maternal mortality and morbidity data often precludes meaningful comparison across states and regions and makes it difficult to determine the causes of maternal deaths and to identify policies to address racial and social inequalities in maternal health care.¹⁴⁰ The federal Centers for Disease Control collects and publishes data

through its “Pregnancy Mortality Surveillance System,” but this system relies on non-standardized data voluntarily submitted by states. Many U.S. states currently lack a maternal mortality review committee (MMRC),¹⁴¹ the CDC’s recommended mechanism for studying the causes, contributing factors, and preventability of maternal deaths in a state or jurisdiction and issuing policy recommendations based on that evidence.¹⁴² The MMRCs that do exist vary widely in their scope and efficacy. MMRCs that are primarily comprised of obstetricians tend to lack information relevant to the social determinants of health and biased health care delivery, including community perspectives on the impact of racial discrimination and income disparities.¹⁴³ In response, some MMRCs now include community leaders, nurses, forensic pathologists, epidemiologists, midwives, social workers, academic experts, and state Title V workers, among others, but participation of the communities most affected by poor maternal health in these review processes continues to be underutilized.¹⁴⁴ A recently enacted federal law, the Preventing Maternal Deaths Act of 2018, increases the funding available to states and tribal organizations for establishing and maintaining MMRCs, and reporting their findings to the Centers for Disease Control (CDC).¹⁴⁵

Some states and municipalities have adopted initiatives (often recommended by MMRCs) to improve care through improved data collection, standardizing care, providing training on bias, and working with communities.¹⁴⁶ California has been hailed as a particularly successful case study after interventions reduced the overall maternal mortality ratio in the state.¹⁴⁷ However, California has also failed to alleviate racial disparities in maternal deaths, simultaneously demonstrating how policies that are silent on issues of racial equity are unlikely to address the needs of the most marginalized women.

Despite recent increases in public attention to maternal health, much work is still needed to ensure that the health and autonomy of pregnant women are respected and prioritized in U.S. health care and U.S. policymaking. For example, Title V, the federal program that supports maternal and child health, allots just six percent of funding to mothers' health.¹⁴⁸ Women are most vulnerable after a pregnancy, yet as discussed in Section IV.D, the U.S. does not guarantee paid leave after childbirth.¹⁴⁹ Hospital programs and medical training and protocols also focus on fetal and infant safety rather than on maternal health.¹⁵⁰ In the last decade, at least twenty U.S. hospitals established fetal care centers,¹⁵¹ but only one hospital has a program for high risk mothers.¹⁵² Doctors specializing in maternal-fetal medicine can complete training without spending time in a labor-delivery unit.¹⁵³ At discharge, women are given information on infant care and breastfeeding but not on how to care for their own health postpartum, and they tend to visit their physician six weeks postpartum because that is what insurance allows, even though most complications take place earlier.¹⁵⁴

Further, structural discrimination contributes to racial disparities in maternal health outcomes. Black women have less access to health care across their lifespan, preventing many black women of the opportunity to enter pregnancy in the best health possible, and exposure to racism and inequality in daily life can result in toxic stress that can negatively impact birth outcomes.¹⁵⁵

B. Pregnant Women and Substance Use

Current criminal justice and child welfare policies criminalizing pregnant women who use substances deter pregnant women from seeking prenatal care (or treatment for substance misuse if needed), endangering both maternal and fetal health. Current concern about the health

implications of substance use by pregnant women has failed to address the lack of adequate prenatal care or voluntary treatment programs for pregnant women with substance use disorders. Instead, in many states, prosecutors are accusing women of endangering the health of their fetus and criminally prosecuting them for pregnancy outcomes or actions during pregnancy.¹⁵⁶ Most medical and public health professionals agree that such prosecutions are contrary to public health goals because they deter pregnant women from seeking healthcare and undermine their relationship with healthcare providers.¹⁵⁷

C. Pregnant Women in Immigration and Criminal Detention

In 2016, the Working Group expressed concern about inappropriate access to health care, the shackling of pregnant women, and the lack of alternatives to custodial sentences for women with dependent children.¹⁵⁸ Since the visit, there continue to be significant violations of the reproductive health rights of women in jails and prisons. Further, since 2017, federal policies recognizing that pregnant immigrants should not be detained have been ignored or repealed. With increased detention have come reports of cases in which denial of prenatal and emergency care for pregnant women may have resulted in miscarriages.

i. Immigration Detention

In December 2017, U.S. Immigration and Customs Enforcement (ICE) officially ended its policy not to detain pregnant women absent extraordinary circumstances and removed reporting requirements about their treatment.¹⁵⁹ ICE reported that in the less than a five-month

period between December 14, 2017 and April 7, 2018, 590 pregnant women were in immigration detention.¹⁶⁰

Civil and human rights organizations have documented numerous cases of mistreatment of people who are pregnant and in immigration detention, including delays and denials of access to prenatal and emergency care that in several cases may have resulted in miscarriages.¹⁶¹ In a recent news article, after a woman suffered a stillbirth in ICE custody in February 2019, an ICE spokeswoman stated that as of February 25, 60 pregnant women were in ICE custody and that 28 women “may have experienced a miscarriage just prior to, or while in ICE custody” between Oct. 1, 2016 and Aug. 31, 2018.¹⁶²

Further, common detention practices that may constitute cruel, inhuman, and degrading treatment for all people in detention, such as harsh physical conditions, work detail, and use of shackles, pose unique and acute dangers for pregnant women. Federal law and ICE policies prohibit shackling of pregnant women,¹⁶³ but the policies do not appear to be enforced. Since 2017, there have been multiple reports of pregnant women being shackled around hands, legs, and belly when transported between facilities and within a few hours after giving birth.¹⁶⁴ Following these reports, a group of U.S. Senators have called on the Inspector General of the Department of Homeland Security for an investigation into ICE policies and practices related to the alleged mistreatment of pregnant women in detention, including harmful and substandard conditions.¹⁶⁵

ii. Pregnant Women in Jails and Prisons

The U.S. does not maintain statistics on how many pregnant women are detained in jails and prisons, but in 2012, the ACLU estimated the number to be 12,000,¹⁶⁶ and it is currently

estimated that 1,400 women give birth in custody every year.¹⁶⁷ Shackling of pregnant women continues, both in jurisdictions with laws that prohibit it and in jurisdictions where there is no legal prohibition. Twenty-six states prohibit shackling women in labor, and some states and the federal government have broader legal restrictions banning the use of restraints for pregnant women.¹⁶⁸ No law prohibits shackling in 24 states.¹⁶⁹ In 2017, a lawsuit against the Milwaukee County jail alleged that at least 40 women were forced to give birth in shackles.¹⁷⁰ In jurisdictions with prohibitions, officers are often unfamiliar with the law or refuse to comply.¹⁷¹ In 2015, New York state passed one of the country's strongest anti-shackling laws, but, nevertheless, in February 2018, police officers in the Bronx handcuffed a woman in labor to a hospital bed and shackled her ankles, maintaining that police procedures requiring the restraints superseded state law.¹⁷²

There is a lack of data and no national standards regarding the treatment of pregnant women in jails and prisons. Pregnant women in prison report denial of medical care or long delays, including being ignored by guards when asking for medical care when they go into labor.¹⁷³ Even in states that prohibit shackling, pregnant women continue to be shackled, subjected to squat and cough strip searches, and denied adequate nutrition.¹⁷⁴ Pregnant women also have been placed in solitary confinement.¹⁷⁵ They have been denied family support in the delivery room while forced to have a correctional officer in the room, immediately separated from their infant, thus preventing bonding,¹⁷⁶ and denied the ability to breast-feed.¹⁷⁷

D. Paid Leave

In 2016, the Working Group was “appalled by the lack of mandatory standards for paid maternity leave.”¹⁷⁸ At the federal level, the Family and Medical Leave Act (FMLA) provides up

to 12 weeks of unpaid leave to care for a “newborn, adopted or foster child, or to care for a family member, or to attend to the employee’s own serious medical condition,” but only applies to private employers with 50 or more employees and public agencies, leaving small employers exempt.¹⁷⁹ This means that only about 60 percent of the U.S. workforce is eligible for FMLA unpaid leave protections.¹⁸⁰ Further, the FMLA falls short of international human rights standards which require at a minimum 14 weeks of paid leave and include paid paternity leave.¹⁸¹

This is a significant concern for women, who are the primary caretakers of children and make up half of the U.S. workforce.¹⁸² Without national requirements for paid family leave, upon the birth of a child or adoption, women must rely on voluntary employer policies, return to work shortly after birth, take unpaid leave, or quit their jobs to care for their children. There are some local and state initiatives to expand paid family leave and sick days. Six states—California, Massachusetts, New Jersey, New York, Rhode Island, Washington—and the District of Columbia require some form of paid family and medical leave.¹⁸³

At the national level, there have been unsuccessful attempts to require paid leave. Before leaving office, President Barack Obama issued a presidential memorandum urging Congress to provide federal employees 6 weeks of paid parental leave to put federal policy on par with leading private sector companies and other industrialized nations.¹⁸⁴ However, the policy was not enacted.

V. Sex Education - Teen Pregnancy Prevention

During the Working Group’s visit, the experts were informed that there is no national policy on sex education and that many schools teach abstinence-based programs in place of

scientifically based sex education.¹⁸⁵ Rather than trying to encourage sex education programs based on science, HHS is trying to divert funding away from science-based programs to abstinence only programs that are untested and not evidence-based.¹⁸⁶

The Teen Pregnancy Prevention Program (TPPP) was established in 2010 to fund a wide range of medically accurate programs to reduce teen pregnancy that would build the evidence base and encourage the replication of effective approaches.¹⁸⁷ TPPP was designed to support research and create programs that provide needed reproductive health information to young people in a manner that is empowering and informative. The program emphasized community collaboration and involved youth assessments and evaluations to coordinate messages across gender.¹⁸⁸

In May 2017, HHS announced it would terminate the TPPP program and informed all 81 grant recipients that their grants would be terminated three years into the five-year grant period, jeopardizing the scientific findings of five-year projects.¹⁸⁹ Following several lawsuits, HHS was ordered to accept and process grantees' year-four funding applications.¹⁹⁰

In the meantime, unable to end the program, the Administration has been trying to repurpose TPPP through future grants. It has released new Funding Opportunity Announcements (FOA) that would require a lower rigor for evaluation and push grantees to abstinence-only programs, also known as "Sexual Risk Avoidance."¹⁹¹ These FOAs have been the subject of ongoing litigation, but the Administration seems determined to continue this approach¹⁹² despite the fact that government funding policies that promote a moral viewpoint rather than adopting a public health approach have been widely rejected by medical and public health professionals as harmful and threatening to fundamental human rights to health, information, and life.¹⁹³

VI. Helms Amendment and the Global Gag Rule

The U.S. continues to implement and enforce the Helms Amendment to the Foreign Assistance Act, ¹⁹⁴ a law intended to prohibit foreign aid extended by the United States from being used to pay for the use of abortion “as a method of family planning.” In practice, the Helms Amendment is used to justify a complete ban on using federal foreign aid for abortion care.¹⁹⁵

In its 2016 report, the Working Group encouraged the U.S. to repeal the Helms Amendment and clarify that under the Amendment funding for abortions is permitted in instances where a pregnancy results from rape or incest, endangers a woman’s life or health or involves severe fetal impairment.¹⁹⁶

Rather than repealing Helms, in 2017 the U.S. increased restrictions on abortion funding with the adoption of the Protecting Life in Global Health Assistance policy, also known as the Global Gag Rule.¹⁹⁷ The Global Gag Rule prevents foreign nongovernmental organizations that receive U.S. global health assistance from providing legal abortion services or referrals and prohibits advocacy for abortion law reform, even if done with the NGO’s own, non-U.S. funds.¹⁹⁸ The rule only allows for exemptions in cases of rape, incest, or life endangerment.¹⁹⁹ Unlike previous versions of the Global Gag Rule, which only applied to international family planning funding, the Trump Administration expanded the rule to apply to all \$8.8 billion in U.S. global health funding annually, including HIV and AIDS funding, health systems strengthening, and water, sanitation, and hygiene programming.²⁰⁰ In March 2019, Secretary of State Mike Pompeo announced that the rule would be expanded to deny “assistance to foreign NGOs that give financial support to other foreign groups” that provide abortion care.²⁰¹

Previous implementation of the Global Gag Rule in its unexpanded form saw devastating impacts including clinic closures, loss of family planning services, weakened HIV/AIDS prevention services, an increase in maternal deaths, and an increase in abortions, many of them unsafe.²⁰² The current expanded rule has created broad confusion about how it is applied, has led to over-implementation driven by organizations' fear of losing funding, and has created a chilling effect on health service delivery and civil society dialogue and advocacy.²⁰³ Marie Stopes International and International Planned Parenthood Federation, two of the leading international aid organizations most impacted by the rule, estimate that they will forego a combined \$180 million dollars in aid, resulting in thousands more maternal deaths, unintended pregnancies, and unsafe abortions.²⁰⁴

CONCLUSION

At the conclusion of its 2015 visit to the United States, the Working Group expressed concern over a range of “‘missing’ rights and protections” for women in the United States, including accessible reproductive health care, and the extent to which the U.S. lags behind in its respect for international human rights.²⁰⁵ The Working Group noted that these gaps in protection impact all U.S. women, and especially women of color, low-income women, LGBTQIA+ individuals, and women with disabilities.²⁰⁶ As detailed in this report, the conditions for securing these rights have worsened considerably since 2015.

As a follow up to its 2015 visit to the United States, we respectfully urge the Working Group to note concern with the retrogression surrounding the reproductive rights law and policy landscape in the United States and remind the U.S. of its obligations to ensure women's rights to equality and non-discrimination, and their rights to reproductive and sexual health. Further, we

respectfully urge the Working Group to specifically recommend that the United States improve access to health care, including contraceptive care and abortion care; take steps to improve maternal health outcomes and reduce maternal mortality rates, including racial disparities in maternal health outcomes; implement and fund evidence-based sexual education programs; and repeal restrictions on global aid that hurt women and families.

¹ This report was prepared by the Human Rights and Gender Justice Clinic, Roxana Bedia, Christopher Pepe, Flor Ramirez and Kendall Walsh, Legal Interns and Cynthia Soohoo, Clinic Co-Director, in collaboration with the Center for Reproductive Rights.

² See Sunny Frothingham & Shilpa Phadke, *100 Days, 100 Ways the Trump Administration Is Harming Women and Families*, CTR. FOR AM. PROGRESS (Apr. 25, 2017, 9:01 AM), <https://www.americanprogress.org/issues/women/reports/2017/04/25/430969/100-days-100-ways-trump-administration-harming-women-families/> (highlighting how the current Administration's actions and policy proposals would harm women and families, including through attacks on reproductive rights).

³ These individuals include Secretary of Health & Human Services (HHS) Alex Azar and many other appointed officials within HHS, as well as Acting Attorney General Matthew Whitaker and Attorney General William Barr within the U.S. Department of Justice. *The Anti-Agency*, CTR. FOR REPROD. RIGHTS, <https://www.reproductiverights.org/anti-agency> (last visited Nov. 29, 2018); Jon Swaine, *Revealed: Matthew Whitaker favors hardline anti-abortion policies*, THE GUARDIAN (Nov. 26, 2018, 6:00 AM), <https://www.theguardian.com/us-news/2018/nov/26/revealed-matthew-whitaker-anti-abortion-policies>; Annie Grayer, *AG nominee William Barr in 1992 CNN interview: Roe v. Wade 'will fall'*, CNN, <https://www.cnn.com/2019/01/09/politics/william-barr-roe-v-wade-abortion/index.html> (last visited Feb. 25, 2019).

⁴ See *The Anti-Agency*, CTR. FOR REPROD. RIGHTS, <https://www.reproductiverights.org/anti-agency> (last visited Nov. 29, 2018).

⁵ Most recently, the Administration issued a rule broadening the scope of individuals and entities that can claim a religious or moral exemption to refuse to assist in the performance of or referral for health care service or research. See U.S. Dep't of Health & Human Servs., Press Release, HHS Announces Final Conscience Rule Protecting Health Care Entities and Individuals (May 2, 2019), <https://www.hhs.gov/about/news/2019/05/02/hhs-announces-final-conscience-rule-protecting-health-care-entities-and-individuals.html> (releasing the full text of the final denial of care rule). See also Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 45 CFR § 147.132 (2018) (exempting nonprofit and most for-profit employers with religious objections from the Affordable Care Act (ACA) contraceptive coverage requirement); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 45 C.F.R. § 147.133 (2018) (exempting all non-publicly traded employers with moral objections from the ACA contraceptive coverage requirement). In addition, in early 2018, the U.S. Department of Health and Human Services (HHS) created a Conscience and Religious Freedom Division to "restore federal enforcement of our nation's laws that protect the fundamental and unalienable rights of conscience and religious freedom." U.S. Dep't of Health & Human Servs., Press Release, HHS Announces New Conscience and Religious Freedom Division (Jan. 18, 2018), <https://www.hhs.gov/about/news/2018/01/18/hhs-ocr-announces-new-conscience-and-religious-freedom-division.html>. This new division could have devastating impacts if refusal claims are not balanced with patients' right to health care and non-discriminatory services, including access to safe pregnancy termination, miscarriage management, and contraception.

⁶ See *2017 NARAL Congressional Record on Choice*, NARAL PRO-CHOICE AM., <https://www.prochoiceamerica.org/wp-content/uploads/2018/03/2017-NARAL-Congressional-Record-On->

Choice.pdf (documenting key abortion-related House and Senate votes taken during the first session of the 115th Congress, including efforts to repeal the ACA and defund Planned Parenthood).

⁷ See *State Government*, NARAL PRO-CHOICE AMERICA, <https://www.prochoiceamerica.org/laws-policy/state-government/> (last visited May 14, 2019) (documenting the over 900 anti-choice measures passed in the states in the last two decades); *What If Roe Fell?*, CTR. FOR REPROD. RIGHTS, <https://www.reproductiverights.org/what-if-roe-fell> (last visited May 14, 2019) (noting 22 states are at highest risk of loss of the right to abortion if *Roe v. Wade* is overturned based on state executive, legislative and policy actions).

⁸ See, e.g., H.B. 314, 2019 Leg., Reg. Sess. (Al. 2019) (outlawing all abortions after six weeks, with no exceptions for rape or incest, and criminalizing the procedure for doctors, who could be charged with felonies and face up to 99 years in prison); H.B. 126, 100th Gen. Assemb., Reg. Sess. (Mo. 2019) (banning abortion at eight weeks pregnancy and only including an exception for medical emergencies but not for pregnancies caused by rape or incest); S. 2116, 2019 Leg., Reg. Sess. (Miss. 2019) (banning abortion after six weeks and only including an exception for medical emergencies but not for pregnancies caused by rape or incest; doctors performing the procedure after six weeks could face revocation of their state medical license); H.B. 481, 2019 Gen. Assemb., Reg. Sess. (Ga. 2019) (banning abortion after six weeks except to prevent death and irreversible bodily harm, and in cases of rape or incest in which a police report has been filed); S. 23, 133d Gen. Assemb., Reg. Sess. (Ohio 2019) (outlawing abortion after six weeks except to prevent death and irreversible bodily harm, but not for pregnancies caused by rape or incest; doctors performing the procedure after six weeks could face fifth-degree felony charges and up to one year in prison); see also K.K. Rebecca Lai, *Abortion Bans: 8 States Have Passed Bills to Limit the Procedure This Year*, N.Y. TIMES (May 17, 2019), <https://www.nytimes.com/interactive/2019/us/abortion-laws-states.html>.

⁹ Abortion Policy in the Absence of *Roe*, GUTTMACHER INST. (May 1, 2019), <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe> (tracking states that have approved laws protecting abortion rights without relying on *Roe*; currently ten states have laws that expressly protect the right to abortion); see also *State Activity Around Expanding Medicaid Under the Affordable Care Act*, KAISER FAMILY FOUND., <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited May 14, 2019) (tracking the number of states adopting the Affordable Care Act's Medicaid expansion).

¹⁰ See Alison Durkee, *These States Have “Trigger Laws” Banning Abortion on the Books in Case ‘Roe v. Wade’ is Overturned*, MIC (July 2, 2018), <https://mic.com/articles/190095/these-states-have-trigger-laws-banning-abortion-on-the-books-in-case-roe-v-wade-is-overturned#.AXVLccSE0> (describing states with “trigger laws” banning abortion that will go into effect if *Roe v. Wade* is overturned).

¹¹ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 61, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹² Compare UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 62, 63 U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016); with *Health Coverage of Immigrants*, KAISER FAMILY FOUND. (Dec. 13., 2017), <https://www.kff.org/disparities-policy/fact-sheet/health-coverage-of-immigrants/> (providing an overview of health coverage for noncitizens and noting a decrease in participation in Medicaid, CHIP and other programs due to factors including, uncertainty, fear, and reductions in enrollment assistance since the new Administration took office); and Shabab Ahmed Mirza and Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AM. PROGRESS (Jan. 18, 2018, 9:00 am), <https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/> (discussing recent data illustrating various forms of discrimination that LGBTQ people experience in healthcare settings and ongoing measures the Administration has taken to remove protections from discrimination in health care on the basis of gender identity and sex stereotypes).

¹³ *Key Facts about the Uninsured Population*, KAISER FAMILY FOUND. (Dec. 07, 2018), <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> (finding most uninsured people are in low-income families, people of color are at higher risk of being uninsured, and cost remains a leading factor in why people lack coverage).

¹⁴ Namrata Uberoi et al., Office of the Ass't Sec'y for Plan. and Evaluation (ASPE), *Issue Brief: Health Insurance Coverage and the Affordable Care Act, 2010-2016*, DEP'T OF HEALTH AND HUMAN SERVS. 1 (May 3, 2016),

<https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf> (estimating that since its enactment, the ACA has resulted in gains in health insurance for 20 million people through February 2016); *see also* Robin A. Cohen et al., *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2016*, NAT'L CTR. FOR HEALTH STAT. 1 (2017), <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201705.pdf> (finding that in 2016, 28.6 million Americans lacked health insurance, down from more than 48.6 million in 2010; 12.4 percent of adults aged 18-64 were uninsured, 69.2 percent had private plans, and 20 percent had public coverage; some 12.4 percent of adults aged 18 to 24 were uninsured, 69.2 percent were covered by private plans and 20 percent had public coverage).

¹⁵ *See* Namrata Uberoi et al., Office of the Ass't Sec'y for Plan. and Evaluation (ASPE), *Issue Brief: Health Insurance Coverage and the Affordable Care Act, 2010-2016*, DEP'T OF HEALTH AND HUMAN SERVS. (May 3, 2016), <https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf> (attributing gains in health insurance coverage resulting from the ACA in part to the coverage expansions that began in 2013); Kevin Quealy & Margot Sanger-Katz, *Obama's Health Law: Who Was Helped Most*, N. Y. TIMES: THE UPSHOT (Oct. 29, 2014), <https://www.nytimes.com/interactive/2014/10/29/upshot/obamacare-who-was-helped-most.html> (discussing data studies that show state marketplace insurance subsidies and tax credits that coincided with insurance expansion provisions in 2013 contributed to increased rates of insured Americans).

¹⁶ Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017) (repealing ACA individual mandate penalty for not having health insurance starting in 2019).

¹⁷ Promoting Healthcare Choice and Competition Across the United States, Exec. Order No. 13813, 82 Fed. Reg. 48385 (Oct. 17, 2017) (encouraging federal officials to make it easier for small businesses and people to purchase insurance, including short-term insurance, not bound by certain regulatory standards, including the required essential healthcare benefits of the ACA); *see also* *Sabotage Watch: Tracking Efforts to Undermine the ACA*, CTR. ON BUDGET AND POL'Y PRIORITIES, <https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca> (last updated Jan. 28, 2019) (noting in July 2018 that the Center for Medicare & Medicaid Services slashed funding for consumer enrollment assistance and outreach to \$10 million, down by 80 percent compared with its 2016 budget).

¹⁸ *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAMILY FOUND. (Jan. 23, 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/> (tracking the approved and pending section 1115 work requirement waivers officially accepted by the Centers for Medicare and Medicaid Services (CMS), a federal agency within the Department of Health and Human Services; as of January 2019, seven states work requirement waivers were approved and eight states pending); *Fact Sheet: The Stealth Attack on Women's Health: Medicaid Work Requirements Would Reduce Access to Care for Women without Increasing Employment*, NAT'L WOMEN'S LAW CTR. 1-3 (2017), <https://nwlc.org/wp-content/uploads/2017/04/Medicaid-Work-Requirements-1.pdf> (noting that “many of the arguments underlying work requirements are designed to stoke racial resentment about entitlement programs, particularly playing upon harmful stereotypes of women of color” and finding that low-income women are more likely than men to lose health care coverage under a Medicaid work requirement, because they are more likely to face barriers to employment; women having higher rates of disabilities than men and higher likelihoods of being primary caregivers of children or aging family members — factors that make it harder to meet work requirements).

¹⁹ MEDICAID.GOV: *Healthy Texas Women Section 1115 Demonstration Waiver Application*, TEX. HEALTH & HUMAN SERV. COMM. (June 30, 2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/tx-healthy-women-pa.pdf>; MEDICAID.GOV: *Division of TennCare: TennCare II Demonstration: Project No. 11-W-00151/4, Amendment 36*, TENN. DIV. OF TENNCARE (Aug. 10, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-pa4.pdf>; Medicaid.gov: *Transitioning to Preconception Care: Section 1115 Demonstration Waiver Application*, S.C. DEP'T. OF HEALTH & HUM. SERV. (Aug. 23, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-transitioning-preconception-care-pa.pdf>.

²⁰ Katie Keith, *ACA Roundup: Section 1557 on Horizon; CSR and Medicaid Litigation Updates, Focus on Employer Mandate*, HEALTH AFFAIRS (Feb. 19, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180219.671383/full/> (detailing Section 1557, resulting legal challenges, and efforts by the U.S. Department of Health & Human Services to revise the anti-discrimination provision via rulemaking).

²¹ 45 CFR § 92.4 (2016).

²² *Franciscan Alliance v. Burwell*, 227 F. Supp.3d 330 (N.D. Tex. 2016).

²³ See Defendants' Memorandum in Response to Plaintiffs' Motions for Summary Judgment, *Franciscan Alliance v. Azar*, No. 7:16-cv-00108 (W.D. Tex. April 5, 2019), 5 (stating that "HHS currently engaged in efforts to amend the challenged Rule"), <https://affordablecareactlitigation.files.wordpress.com/2019/04/us-summary-judgment-response-4-5-19.pdf>; Katie Keith, *More Courts Rule on Section 1557 As HHS Reconsiders Regulation*, HEALTH AFFAIRS (Oct. 2, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20181002.142178/full/> (discussing the increasing number of decisions from state courts that held that Section 1157 does prohibit discrimination on the basis of gender identity).

²⁴ Inadmissibility on Public Charge Grounds, 83 Fed. Reg. 51114, at 51157-60 (proposed Oct. 10, 2018) (to be codified at 8 C.F.R. pt. 103, 212-4; 245; 258) (expanding the definition of public charge to include an immigrant that receives "one or more public benefits," including Medicaid and other programs that address key needs).

²⁵ See *Proposed Changes to 'Public Charge' Policies for Immigrants: Implications for Health Coverage*, KAISER FAMILY FOUND. (Sept. 24, 2018), <https://www.kff.org/disparities-policy/fact-sheet/proposed-changes-to-public-charge-policies-for-immigrants-implications-for-health-coverage/> (finding proposed changes would likely lead to broad declines in Medicaid enrollment from eligible immigrants due to the fear that it would negatively affect them or their family's immigration status; leading to worse health outcomes, especially for pregnant or breastfeeding women, infants, or children); RANDY CAPPES ET AL., MIGRATION POLICY INST., GAUGING THE IMPACT OF DHS' PROPOSED PUBLIC-CHARGE RULE ON U.S. IMMIGRATION (2018), <https://www.migrationpolicy.org/research/impact-dhs-public-charge-rule-immigration> (finding the proposed rule would have a disproportionate impact on women, children, and the elderly).

²⁶ See Joan Alker et al., *Nation's Progress on Children's Health Coverage Reverses Course*, GEORGETOWN UNIV. HEALTH POLICY INST. CTR. FOR CHILDREN AND FAMILIES (Nov. 2018), https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018_Final_asof1128743pm.pdf (finding the rate of uninsured children rose for the first time in nearly a decade, due partly to policies deterring immigrant parents from enrolling their eligible children, which will likely worsen if the proposed "public charge" rule is put into effect); Suzanne Gamboa, *Immigrants drop subsidized food, health programs — fearing aid will be used against them*, NBC NEWS (Sept. 8, 2018), <https://www.nbcnews.com/news/latino/immigrants-drop-subsidized-food-health-programs-fearing-aid-will-be-n906246> (noting doctors and non-profit leaders seeing dropping rates of immigrants participating in public benefit programs, including Medicaid and CHIP, due to fears of the proposed rule, alongside other stepped-up immigration enforcement policies and regulations). See also Samantha Artiga et al., *Estimated Impacts of the Proposed Public Charge Rule on Immigrants and Medicaid*, KAISER FAMILY FOUNDATION (Oct. 11, 2018), <https://www.kff.org/report-section/estimated-impacts-of-the-proposed-public-charge-rule-on-immigrants-and-medicare-key-findings/> (finding that as a result of the proposed rule and overall chilling effect, approximately between 2.1 million and 4.9 million Medicaid/CHIP enrollees living in a family with at least one noncitizen would disenroll).

²⁷ 45 C.F.R. §147.130 (2011).

²⁸ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 71, 90(h); 95(i), U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

²⁹ Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 45 C.F.R. § 147.132 (2018)(exempting nonprofit and most for-profit employers with religious objections from the ACA contraceptive coverage requirement); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 45 C.F.R. § 147.133 (2018) (exempting all non-publicly traded employers with moral objections from the ACA contraceptive coverage requirement); see also Laurie Sobel et al., *New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women*, KAISER FAMILY FOUND. (Nov. 19, 2018), <https://www.kff.org/health-reform/issue-brief/new-regulations-broadening-employer-exemptions-to-contraceptive-coverage-impact-on-women/> (explaining how the new regulations, under the current administration, broaden employer exemptions from the ACA contraceptive coverage requirement).

³⁰ Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39870, 39896 (July 2, 2013) (to be codified at 45 C.F.R. pt. 147).

³¹ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 29, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

³² *Burwell v. Hobby Lobby*, 134 S. Ct. 2751 (2014).

³³ HHS Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47792 (interim final rules proposed on Oct. 13, 2017) (to be codified at 45 C.F.R. pt. 147). The final rules were published on November 15, 2018. 45 C.F.R. §147.132 (2018).

³⁴ 45 C.F.R. §147.132 (2018).

³⁵ 45 C.F.R. §147.133 (2018).

³⁶ 45 C.F.R. §147.132(a)(2) (2018); 45 C.F.R. §147.133(a)(2)(2018).

³⁷ *Id.*

³⁸ See *Commonwealth of Pennsylvania, v. Trump, et al.*, 351 F.Supp.3d 791 (E.D. Pa. 2019) (issuing a nation-wide preliminary injunction); *California v. Health and Human Svcs.*, 351 F. Supp.3d 1267, 1271 (N.D. Cal. 2019) (issuing a preliminary injunction in thirteen states and the District of Columbia).

³⁹ U.S. Dep't of Health and Human Servs., *About Title X Grants*, <https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/index.html> (last visited on May 14, 2019).

⁴⁰ See e.g., Christina Fowler et al., RTI Int'l, *Family Planning Annual Report: 2015 National Summary*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Aug. 2016), <https://www.hhs.gov/opa/sites/default/files/title-x-fpar-2015.pdf> (revised July 2017) (finding that Title X providers “are a critical source of high-quality and affordable reproductive health care for individuals with and without health insurance”); Kiersten Gillette-Piece & Jamila Taylor, *The Threat to Title X Family Planning: Why it Matters and What's at Stake for Women*, CTR. FOR AM. PROGRESS (Feb. 9, 2017), <https://www.americanprogress.org/issues/women/reports/2017/02/09/414773/the-threat-to-title-x-family-planning/> (finding that “Title X providers are a foundational source of high-quality, economical reproductive health care for women with and without insurance”). Evidence-based policies relate to practices that have had a record of success such as reducing teen pregnancy and preventing unintended pregnancy through the services Title X providers. See Haywood L. Brown, *Changes to the Title X Program Reject Science and Endanger Comprehensive Care*, AM. C. OF OBSTETRICIANS & GYNECOLOGISTS (Feb. 26, 2018), <https://www.acog.org/About-ACOG/News-Room/Statements/2018/Changes-to-the-Title-X-Program-Reject-Science-and-Endanger-Comprehensive-Care> (noting that “Title X has historically been grounded in evidence-based practices and has a record of success”).

⁴¹ *Fact Sheet: Title X*, NAT'L FAMILY PLANNING & REPROD. HEALTH ASS'N (Sept. 2018), <https://www.nationalfamilyplanning.org/file/Title-X-101-2018-.pdf>.

⁴² UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 95(a)-(b), U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

⁴³ Pub. Law. No. 115-23, 131 Stat. 89 (2017) (allowing states to exclude recipients of Title X grants from participating for reasons other than their ability to provide Title X services).

⁴⁴ *State Family Planning Funding Restrictions*, Guttmacher Institute, <https://www.guttmacher.org/state-policy/explore/state-family-planning-funding-restrictions> (last visited Feb. 11, 2019) (highlighting various states' abortion-related restrictions on the allocation of public funds, including funding for Title X funds, Medicaid, state, and family planning funds).

⁴⁵ HHS Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714 (Mar. 4, 2019) (codified at 42 C.F.R. pt. 59).

⁴⁶ HHS Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714-7720 (Mar. 4, 2019) (codified at 42 C.F.R. pt. 59); Laurie Sobel et al., *New Title X Regulations: Implications for Women and Family Planning Providers*, KAISER FAMILY FOUND. (Mar. 8, 2019), <https://www.kff.org/report-section/new-title-x-regulations-implications-for-women-and-family-planning-providers-issue-brief/> (discussing the impact the regulations will have on women and family planning providers).

⁴⁷ *Oregon v. Azar*, No. 6:19-cv-00317-MC (D. Ore. April 29, 2019) WL 1897475, *16 (issuing a nationwide injunction), https://coag.gov/sites/default/files/contentuploads/ca/azar_opinion_and_order.pdf; *California v. Azar*, No. 19-cv-01184-EMC (N.D. Cal. April 26, 2019) WL 1877392, *2 (enjoining implementation of the rule in California). The administration is appealing.

⁴⁸ HHS Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714, 7717 (Mar. 4, 2019) (codified at 42 C.F.R. pt. 59).

⁴⁹ *Id.*

⁵⁰ 84 Fed. Reg. 7714, 7789 (Mar. 4, 2019) (codified at 42 C.F.R. § 59.14 (b)(1))(requiring that if a patient is pregnant “she shall be referred to a health care provider for medically necessary prenatal health care”).

⁵¹ 42 C.F.R. § 59.14 (b)(1)(i) and (c)(2).

⁵² *Id.* at § 59.14 (b)(1).

⁵³ *Id.* at § 59.15

⁵⁴ *Id.* at § 59.15(b) and (c).

⁵⁵ *Title X: The Nation’s Program for Affordable Birth Control and Reproductive Health Care*, PLANNED PARENTHOOD, <https://www.plannedparenthoodaction.org/issues/health-care-equity/title-x> (last visited May 14, 2019) (noting that more than four million people depend on Title X funding for reproductive and other essential health care services and that Planned Parenthood serves 41 percent of all Title X patients).

⁵⁶ The Center for Reproductive Rights Comments on Notice of Proposed Rule on Compliance With Statutory Program Integrity Requirements [Docket No.: HHS–OS–2018–0008] at 3, 7, 37 (July 31, 2018), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CRR-compliance_with_title_x_statutory_program_integrity_requirements_final_comment_july_2018.pdf (noting, among other contributing factors, that the proposed regulations’ physical separation requirements would “undoubtedly lead to some providers leaving Title X for economic reasons alone and, as a result, lay off staff, reduce hours, or close their doors altogether”).

⁵⁷ See Kinsey Hasstedt, *Beyond the Rhetoric: The Real World Impacts of Attacks on Planned Parenthood and Title X*, GUTTMACHER INST. (Aug. 3, 2017), <https://www.guttmacher.org/gpr/2017/08/beyond-rhetoric-real-world-impact-attacks-planned-parenthood-and-title-x> (finding that “[Federally Qualified Health Center] sites alone could not sustain the current reach of Title X” under the proposed regulatory scheme).

⁵⁸ *Id.*

⁵⁹ *NIFLA v. Becerra*, 138 S. Ct. 2361, 2370-78 (2018) (holding that California’s Reproductive Freedom, Accountability, Comprehensive Care, and Transparency Act likely violates the First Amendment speech rights of crisis pregnancy centers).

⁶⁰ See *The Truth about Crisis Pregnancy Centers*, NARAL PRO-CHOICE AM. 1, 7-9 (Jan. 1, 2017), <https://www.prochoiceamerica.org/wp-content/uploads/2016/12/6.-The-Truth-About-Crisis-Pregnancy-Centers.pdf> (describing the measures CPCs undertake to prevent women from exercising their constitutional right to abortion and finding that CPCs target low-income women and women of color).

⁶¹ See e.g., *Services*, FREE ABORTION ALTERNATIVES, <https://freeabortionalternatives.com/services/> (last visited Nov. 30, 2018).

⁶² See e.g., National Institute for Reproductive Health, *A Report On: The Lies, Manipulations, and Privacy Violations of Crisis Pregnancy Centers in New York City*, NARAL PRO-CHOICE N.Y. FOUND. 10 (Oct. 2010), <https://www.nirhealth.org/wp-content/uploads/2015/09/cpcreport2010.pdf> (finding CPCs in New York were more likely to misrepresent the risks of abortion during in-person visits: “[e]ighteen percent of CPC counselors claimed abortion led to a higher risk of breast cancer, 64% cited future infertility, 73% mentioned ‘post-abortion syndrome’ or other mental health problems, and 82% overstated the risk of other health complications.”).

⁶³ See Lisa McIntire, *Crisis Pregnancy Centers Lie: The Insidious Threat to Reproductive Freedom*, NARAL PRO-CHOICE AM. 15 (2015), <https://www.prochoiceamerica.org/wp-content/uploads/2017/04/cpc-report-2015.pdf> (discussing findings from undercover investigations that NARAL affiliates conducted in ten states documenting CPCs scare tactics, lies, and deceptions).

⁶⁴ *Id.* at 5-6.

⁶⁵ Anna Merlan, *Anti-Abortion Crisis Pregnancy Centers Must Reveal If They Have Doctors on Staff*, *Appeals Court Affirms*, THE VILLAGE VOICE (Jan. 17, 2014) <https://www.villagevoice.com/2014/01/17/anti-abortion-crisis-pregnancy-centers-must-reveal-if-they-have-doctors-on-staff-appeals-court-confirms/>.

⁶⁶ *Id.*

⁶⁷ Brief of 51 Reproductive Rights, Civil Rights, and Social Justice Organizations as Amici Curiae in Support of Respondents, *NIFLA v. Becerra*, 138 S. Ct. 2361 (U.S. Feb. 27, 2018) (No. 16-1140), at 19-20, *available at* <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CPC-SupremeCourtCase-AmicusBrief-CivilRights-SocialJustice-Organizations.pdf>.

⁶⁸ Cal. Health & Safety Code § 123472 (2016).

⁶⁹ *NIFLA v. Becerra*, 138 S. Ct. 2361 (2018).

⁷⁰ In 2010, there were an estimated 1,969 network-affiliated CPCs in the United States, compared with an estimated 327 abortion clinics as of 2011. *Compare A Passion to Serve: How Pregnancy Resource Centers Empower Women*, PREGNANCY RESOURCE CTR. 1 (2011), <https://downloads.frc.org/EF/EF12A47.pdf> (summarizing the impact of CPCs are having on the local and national community with the anti-choice “pregnancy movement”); with Jenna Jerman and Rachel K. Jones, *Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment*, 24 WOMEN’S HEALTH ISSUES e419, e422 (2014), [https://www.whijournal.com/article/S1049-3867\(14\)00058-9/pdf](https://www.whijournal.com/article/S1049-3867(14)00058-9/pdf) (documenting access to abortion services in the United States); see also Amy G. Bryant and Jonas J. Swartz, *Why Crisis Pregnancy Centers are Legal but Unethical*, 20 AMA J. OF ETHICS 269-277 (2018), <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-04/pfor1-1803.pdf> (finding that “[a]lthough crisis pregnancy centers enjoy First Amendment rights protections, their propagation of misinformation should be regarded as an ethical violation that undermines women’s health”).

⁷¹ See Brief of 51 Reproductive Rights, Civil Rights, and Social Justice Organizations as Amici Curiae in Support of Respondents, *NIFLA v. Becerra*, 138 S. Ct. 2361 (U.S. Feb. 27, 2018) (No. 16-1140), at 5-9, available at <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/CPC-SupremeCourtCase-AmicusBrief-CivilRights-SocialJustice-Organizations.pdf> (discussing the national umbrella organizations that “fund, coordinate, and streamline the activities” of roughly 2,700 CPCs across the country).

⁷² U.S. H.R., Comm. on Gov’t Reform – Minority Staff, Special Investigations Div., *False and Misleading Health Information Provided by Federally Funded Pregnancy Resource Centers* i (July 2006), available at <https://www.motherjones.com/files/waxman2.pdf>.

⁷³ *Trump Gives Away Millions to Anti-choice Fake Clinics*, REWIRE (Sept. 7, 2017), <https://rewire.news/article/2017/09/07/trump-gives-away-millions-anti-choice-fake-clinics/> (reporting that at least \$3.1 million in grants have been awarded to CPCs).

⁷⁴ Bryce Covert & Josh Israel, *The States That Siphon Welfare Money to Stop Abortion*, Think Progress (Oct. 3, 2016), <https://thinkprogress.org/tanf-cpcs-ec002305dd18/>.

⁷⁵ *Who Decides? The Status of Women’s Reproductive Rights in the United States*, NARAL Pro-Choice Am. & NARAL Pro-Choice Am. Found. 17 (Jan. 2017), <https://www.prochoiceamerica.org/wp-content/uploads/2017/01/WhoDecides2017-DigitalEdition3.pdf> (listing the fourteen states that provide direct funding to PCs: Georgia, Indiana, Kansas, Louisiana, Michigan, Minnesota, Missouri, New Mexico, North Carolina, North Dakota, Ohio, Pennsylvania, Texas, and Wisconsin).

⁷⁶ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 28, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

⁷⁷ *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

⁷⁸ 505 U.S. 833 (1992). In *Casey*, the Court adopted the “undue burden standard” to separate permissible restrictions on abortion from those that are unconstitutional, noting that “[a]n undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.” *Id.* at 878.

⁷⁹ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 90(g), U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

⁸⁰ *Id.* at para 29.

⁸¹ *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2300 (2016).

⁸² *Id.* at 2301 (noting district court finding that if the surgical center provision went into effect, seven or eight providers would remain).

⁸³ *Id.*

⁸⁴ *Id.* at 2300.

⁸⁵ *Id.* at 2309, 2312-13, 2315-16, 2318 (recognizing that courts must “consider the burdens a law imposes on abortion together with the benefits those laws confer” and holding that the “the surgical-center requirement, like the admitting-privileges requirement, provides few, if any, health benefits for women, poses a substantial obstacle to women seeking abortions, and constitutes an ‘undue burden’ on their constitutional right to do so”).).

⁸⁶See *Planned Parenthood Southeast v. Strange*, 33 F. Supp. 3d 1330 (M.D. Ala. 2014); *Jackson Women’s Health Organization v. Currier*, 878 F.Supp.2d 714 (S.D. Miss. 2017); *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F. 3d 908 (7th Cir. 2016); *Adams & Boyle, P.C. et al v. Slatery, et al*, No. 3:15-CV-00705 (M.D. Tenn. Apr. 14, 2017) (Westlaw); see also *Virginia Board of Health Protects Women’s Access to Constitutionally Protected Health Care*, CTR. FOR REPROD. RIGHTS (Oct. 24, 2016), <https://www.reproductiverights.org/press-room/va-board-of-health-protects-womens-access-to-constitutionally-protected-health-care> (reporting on the Virginia Board of Health’s 11-4 vote on October 24, 2016 to remove the admitting privileges requirement from state regulations). Courts have applied the undue burden standard since *Whole Woman’s Health* to strike down other abortion restrictions, as well.

⁸⁷ In 2017, state legislatures enacted 63 laws restricting women’s access to reproductive health care, and in 2018, an additional 23 laws restricting abortion. Elizabeth Nash et al., *Policy Trends in the States, 2017*, GUTTMACHER INST. (Jan. 2, 2018), <https://www.guttmacher.org/article/2018/12/state-policy-trends-2018-roe-v-wade-jeopardy-states-continued-add-new-abortion>.

⁸⁸ This number is current as of May 21, 2019, according to legislation tracking and analysis by the Center for Reproductive Rights.

⁸⁹ Alabama, Arkansas, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Nebraska, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Texas, West Virginia, and Wisconsin all ban abortion pre-viability at 20 weeks or earlier with limited exceptions. See *An Overview of Abortion Laws*, GUTTMACHER INST. (May 1, 2019), <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>. These laws are being challenged in litigation and many have been blocked by the courts.

⁹⁰ Iowa, North Dakota, Kentucky, Mississippi, Ohio, Georgia, Alabama, and Missouri have all passed legislation banning abortions at about six weeks of pregnancy. As with the laws noted above, these laws are the subject of ongoing litigation or will be challenged in forthcoming litigation. See *Legislative Tracker: Heartbeat Bans*, REWIRE, <https://rewire.news/legislative-tracker/law-topic/heartbeat-bans/> (last updated on May 9, 2019) (tracking laws restricting abortion at six weeks gestation and ongoing litigation challenging the restrictions). See also H.B. 314, 2019 Leg., Reg. Sess. (Al. 2019) (outlawing all abortions after six weeks, with no exceptions for rape or incest, and criminalizing the procedure for doctors, who could be charged with felonies and face up to 99 years in prison); H.B. 126, 100th Gen. Assemb., Reg. Sess. (Mo. 2019) (banning abortion at eight weeks pregnancy and only including an exception for medical emergencies but not for pregnancies caused by rape or incest).

⁹¹ H.B. 314, 2019 Leg., Reg. Sess. (Al. 2019). The ACLU plans to challenge the Alabama law to prevent it from going into effect. See Elizabeth Watson, *We’re Suing to Block Ohio’s Abortion Ban*, AM. CIVIL LIB. UNION (May 15, 2019 3:30 pm), <https://www.aclu.org/blog/reproductive-freedom/abortion/were-suing-block-ohios-abortion-ban>.

⁹² Alabama, Arkansas, Kansas, Kentucky, Louisiana, Mississippi, Oklahoma, Texas, and West Virginia have all passed laws prohibiting the most common second trimester abortion procedure, dilation & evacuation (D&E) although the provisions have been challenged and are temporarily enjoined in all states except Mississippi and West Virginia. See *Bans on Specific Abortion Methods Used After the First Trimester*, GUTTMACHER INST. (May 1, 2019), <https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester>.

⁹³ See e.g., IND. CODE § 16-34-2-1.1 (a) (1)(K) (2018) (stating “Indiana does not allow a fetus to be aborted solely because of the fetus’s race, color, national origin, ancestry, sex, or diagnosis or potential diagnosis of the fetus having Down syndrome or any other disability”); *Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly*, GUTTMACHER INST. (May 1, 2019), <https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly> (tracking the number of reason based abortion bans and noting that “[w]hile disguised as a means to eliminate gender [race, and ableism] discrimination, these laws make abortion less accessible”).

⁹⁴ For an overview of barriers to access and their impact, see *Targeted Regulation of Abortion Providers*, GUTTMACHER INST. (May 1, 2019), <https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers>; *Counseling and Waiting Periods for Abortion*, GUTTMACHER INST. (May 1, 2019), <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion>; Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States*, 49 PERSP. ON SEXUAL AND REPROD. HEALTH 95 (2017).

⁹⁵ At minimum six states are down to one clinic — North Dakota, South Dakota, Kentucky, Mississippi, West Virginia, and Missouri. See Sabrina Tavernise, *“The Time is Now”*: *States are Rushing to Restrict Abortion, or to*

Protect It, N.Y. TIMES (May 15, 2019), <https://www.nytimes.com/2019/05/15/us/abortion-laws-2019.html?action=click&module=Top%20Stories&pgtype=Homepage>; see also Frances Lin, *Missouri Now Only Has One Abortion Clinic Left*, in *St. Louis*, OZARKSFIRST.COM (Oct. 4, 2018, 9:21 PM), <https://www.ozarksfirst.com/news/missouri-now-only-has-one-abortion-clinic-left-in-st-louis/1499245348> (noting only one abortion clinic remains in Missouri, following the denial of a clinic’s request to be temporarily exempt from certain abortion regulations pending the conclusion of ongoing litigation).

⁹⁶ *June Medical Services v. Gee*, 905 F.3d 787 (5th Cir. 2018), *petition for cert. filed* (U.S. Apr. 19, 2019) (No. 18-1323); Amy Hagstrom Miller, *A Year After Landmark SCOTUS Ruling Abortion Rights Are Still Under Attack*, TIME (June 27, 2017), <http://time.com/4835000/whole-womans-health-abortion-rights-supreme-court-anniversary/>.

⁹⁷ Medication abortion using Mifepristone (also known as RU-486) and Misoprostol (commonly referred to by its brand name Cytotec) is considered extremely safe--the rate and nature of complications is similar to that of spontaneous miscarriage; furthermore, both drugs are considered essential by the World Health Organization. Using Misoprostol alone is up to 85% effective in ending a pregnancy. These two medications together are up to 98% effective. Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion*, 18 GUTTMACHER POL’Y REV. 70, 72 (2015),

<https://www.guttmacher.org/sites/default/files/pdfs/pubs/gpr/18/3/gpr1807015.pdf>; see also SIA Legal Team and Human Rights & Gender Justice Clinic, *Submission to WGDAW – Criminalization of Women Who Self-Induce Abortions in the United States*, 4-5 (June 2017).

⁹⁸ H.B. 896, 2019 Leg., 86th Sess., (Tex. 2019); Julia Jacobs, *Failed Texas Bill Would Have Made Death Penalty Possible in Abortion Cases*, N.Y. TIMES (April 10, 2019), <https://www.nytimes.com/2019/04/10/us/texas-abortion-death-penalty.html> (discussing the impact the failed bill would have had on patients in Texas); See also Ally Boguhn, *Meet Joseph Silk: The Oklahoma Republican Trying to Make Abortion a Homicide*, REWIRE (Dec. 5, 2018), <https://rewire.news/article/2018/12/05/meet-joseph-silk-the-oklahoma-republican-trying-to-make-abortion-a-homicide/> (noting Senator Silk pre-filed SB 13 the “Abolition of Abortion in Oklahoma Act” that would criminalize abortion care and make it a felony homicide punishable by life in prison).

⁹⁹ At least seven state statutes explicitly provide that women can be criminally prosecuted for terminating their own pregnancy: Arizona, Delaware, Idaho, Nevada, New York, Oklahoma, and South Carolina. These laws are likely unconstitutional, but prosecutors continue to use them to prosecute women who self-manage abortions. Human Rights & Gender Justice Clinic, National Advocates for Pregnant Women & SIA Legal Team, *Submission to the United Nations Working Group on Discrimination Against Women*, 6 (October 1, 2018) [hereinafter HRGJ/NAPW/SIA Submission to WGDAW].

¹⁰⁰ Historically, these laws were understood to apply to people who perform abortions on others to *protect women from unscrupulous or unsafe abortion providers*; however, prosecutors have begun to use these laws to prosecute women for terminating their own pregnancies. *Id.* at 6.

¹⁰¹ At least thirty-eight states have laws criminalizing harm to fetuses. Ten of those states lack adequate exceptions for pregnant women. *Id.* at 7.

¹⁰² Christina Cauterucci, *Virginia Woman Given a Jail Sentence for “Concealing a Dead Body” After Her Stillbirth*, SLATE (May 10, 2018), <https://slate.com/news-and-politics/2018/05/virginia-woman-given-a-jail-sentence-for-concealing-a-dead-body-after-her-stillbirth.html> (last visited Mar. 10, 2019).

¹⁰³ *Katherine Nicole Dellis v. Commonwealth of Virginia* (Va. Ct. App. 2018) (unpublished) (Memorandum Opinion by Judge Teresa M. Chafin), *Available at* https://www.courtlistener.com/pdf/2018/04/24/katherine_nicole_dellis_v._commonwealth_of_virginia.pdf.

¹⁰⁴ Patty Wooten, *Judge Acquits Woman of Abuse of Corpse, Jury Convicts Her of Concealing Birth*, SEARKTODAY, (Mar. 6, 2016), <http://searktoday.com/judge-acquits-woman-of-abuse-of-corpse-jury-convicts-her-of-concealing-birth/> (last visited May 15, 2019).

¹⁰⁵ Bynum’s conviction was eventually reversed by the Arkansas Court of Appeals because the trial court abused its discretion by admitting prejudicial evidence, and Dellis was pardoned by the governor. *Bynum v. Arkansas*, 2018 Ark. App. 201 (CR-16-879) (Mar. 14, 2018), <https://law.justia.com/cases/arkansas/court-of-appeals/2018/cr-16-879.html>; Galina Varchena et al., *The Rising Trend of Criminalizing Pregnancy is Turning Everyone Into Suspects*,

BUSTLE (Aug. 16, 2018), <https://www.bustle.com/p/the-rising-trend-of-criminalizing-pregnancy-is-turning-everyone-into-suspects-10115792> (noting Dellis' pardon on June 1, 2018).

¹⁰⁶ HRGJ/NAPW/SIA Submission to WGDAAW, at 4.

¹⁰⁷ UN Human Rights Council, Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America, para. 68, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹⁰⁸ Rachel Roth, "*She Doesn't Deserve to Be Treated Like This*": *Prisons As Sites of Reproductive Justice*, in RADICAL REPRODUCTIVE JUSTICE 6 (New York: The Feminist Press et al. eds., 2017), <https://www.prisonpolicy.org/scans/Roth%202017%20Prisons%20Reproductive%20Injustice.pdf> (stating that "one-quarter of state prison systems have no official written policy on abortion" and "[l]ittle information exists about the nation's three-thousand-plus jails") [hereinafter Roth, *She Doesn't Deserve to Be Treated Like This*].

¹⁰⁹ *Id.* at 5, 6-7 (stating that in at least twenty states and DC, women have had to fight for access to abortion and describing lawsuit against Maricopa County, Arizona jail); see also Kristine Phillips, *A woman claims she was denied an abortion while in jail. Now she is suing for \$1.5 million*, THE WASH. POST (Jan. 11, 2017), https://www.washingtonpost.com/news/post-nation/wp/2017/01/11/a-woman-claims-she-was-denied-an-abortion-while-in-jail-now-shes-suing-for-1-5-million/?utm_term=.1caa079fa43c (reporting on a Tennessee woman suing law enforcement officials for denial of access to abortion while incarcerated in a county jail, as well as similar suits across the country).

¹¹⁰ *Garza v. Hargan*, 304 F.Supp.3d 145, 150 (D.D.C. 2018) (stating that in March 2017 ORR instructed employees at federally funded shelters that they "are prohibited from taking any action that facilitates an abortion without direction and approval from the Director of ORR" and requiring that they "notify ORR . . . immediately of any request or interest on any girl's part in terminating her pregnancy.").

¹¹¹ *Garza v. Hargan*, 131 HARV. L. REV. 1812 (Apr. 10, 2018), <https://harvardlawreview.org/2018/04/garza-v-hargan/>.

¹¹² *Garza v. Hargan*, 874 F.3d 735, 746 (D.C. Cir. 2017), cert. granted and vacated by 138 S. Ct. 1790 (2017).

¹¹³ *Garza*, 874 F.3d at 752 (D.C. Cir. 2017) (Kavanaugh, J., dissenting).

¹¹⁴ In this case, acting ORR director Kenneth Tota ordered ORR to escort the young woman "to the emergency room of a local hospital in order to determine the health status of [the teenager] and her unborn child. If steps can be taken to preserve the life of the [teenager] and her unborn child, those steps should be taken." See Ed Pilkington, *Trump Officials Considered Contentious Methods to "Reverse" Undocumented Teen Abortions*, THE GUARDIAN (Jan. 31, 2018, 3:42 PM), <https://www.theguardian.com/us-news/2018/jan/31/scott-lloyd-considered-controversial-method-reverse-abortion/>.

¹¹⁵ Renuka Rayasam, *Trump official halts abortions among undocumented, pregnant teens*, POLITICO (Oct. 16, 2017), <https://www.politico.com/story/2017/10/16/undocumented-pregnant-girl-trump-abortion-texas-243844> ("In some cases, a senior HHS official has personally visited or called pregnant teens to try to talk them out of ending their pregnancies.").

¹¹⁶ *Garza v. Hargan*, 304 F.Supp.3d 145, 150 (D.C. Cir. 2018) (granting plaintiff's motion for class action and motion for preliminary injunction).

¹¹⁷ UN Human Rights Council, Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America, para. 90(j), U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹¹⁸ *Hyde Amendment Fact Sheet*, ALL ABOVE ALL (Sept. 26, 2017), <https://allaboveall.org/resource/hyde-amendment-fact-sheet/>.

¹¹⁹ *Restricting Insurance Coverage of Abortion*, GUTTMACHER INST. (May 1, 2019), <https://www.gutmacher.org/state-policy/explore/restricting-insurance-coverage-abortion> (noting that 11 states have laws restricting private insurance coverage of abortion, including plans offered through health insurance exchanges established under the federal health care reform law).

¹²⁰ See Patient Protection and Affordable Care Act; Exchange Program Integrity, 83 Fed. Reg. 56015, 56023-025; 56028 (proposed Nov. 9, 2018) (to be codified at 45 C.F.R. pt. 155) (proposing a policy that requires insurers segregate funds and separate invoices for non-Hyde abortion services; anticipating a significant increase in the administrative burden for ACA qualified health insurance providers covering non-Hyde abortion services).

¹²¹ CMS Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 17454, 17546 (April 25, 2019) (codified at 45 C.F.R. § 156.280).

¹²² *What is the Reproductive Health Equity Act (HB 3391)?*, OR. HEALTH AUTHORITY, <https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/Pages/reproductive-health-equity-act.aspx> (last visited on May 15, 2019).

¹²³ See Oregon Health Authority, Reproductive and Sexual Health Equity Act, <https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/REPRODUCTIVESEXUALHEALTH/Pages/reproductive-health-equity-act.aspx> (last visited Mar. 10, 2019)/.

¹²⁴ *HB 40: Access to Abortion in Illinois*, AM. CIVIL LIBERTIES UNION OF ILL. (Sept. 28, 2017), <https://www.aclu-il.org/en/legislation/access-abortion-illinois>.

¹²⁵ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 70, 95(h), U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹²⁶ See *2017 Violence and Disruption Statistics*, NAT'L ABORTION FED'N 1 (2017) <https://prochoice.org/wp-content/uploads/2017-NAF-Violence-and-Disruption-Statistics.pdf> (reporting on the steep rise in clinic invasions, obstruction, and blockades in the United States) [hereinafter NAF 2017 Violence and Disruption Statistics].

¹²⁷ See Julie Turkewitz and Jack Healy, *3 Are Dead in Colorado Springs Shootout at Planned Parenthood Center*, N.Y. TIMES (Nov. 27, 2015), <https://www.nytimes.com/2015/11/28/us/colorado-planned-parenthood-shooting.html> (reporting on suspect entering Planned Parenthood in Colorado Springs and opening fire; killing three people- a police officer and two civilians- and wounding nine).

¹²⁸ See Sarah Kaplan, *'I'm a warrior for the babies' Planned Parenthood suspect declares in court*, WASH. POST (Dec. 10, 2015), https://www.washingtonpost.com/news/morning-mix/wp/2015/12/10/im-a-warrior-for-the-babies-planned-parenthood-suspect-declares-in-court/?utm_term=.80721eacae5 (reporting on statements made by Robert at his trial, including shouts and declarations of guilt; Dear faced charges on 179 counts of murder, attempted murder and other crimes related to the Planned Parenthood shooting).

¹²⁹ See Katherine Spillar et. al, *2016 National Clinic Violence Survey*, FEMINIST MAJORITY FOUND. 5 (Feb. 2017), <http://feminist.org/anti-abortion-violence/images/2016-national-clinic-violence-survey.pdf>.

¹³⁰ *Id.* at 4, 6.

¹³¹ *NAF 2017 Violence and Disruption Statistics*, NAT'L. ABORTION FED. 1, 2 (2017), <https://prochoice.org/wp-content/uploads/2017-NAF-Violence-and-Disruption-Statistics.pdf>.

¹³² 18 U.S.C. § 248 (1994).

¹³³ *NAF 2017 Violence and Disruption Statistics*, NAT'L. ABORTION FED. 6 (2017), <https://prochoice.org/wp-content/uploads/2017-NAF-Violence-and-Disruption-Statistics.pdf> (reported instances of trespassing increased from 247 (2016) to 823 (2017), obstruction increased from 580 (2016) to 1,704 (2018) and clinic invasions increased from 7 (2016) to 11 (2017)).

¹³⁴ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 72, 95(e), U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹³⁵ See WHO, UNICEF, UNFPA, & THE WORLD BANK, *TRENDS IN MATERNAL MORTALITY: 1990 TO 2015 70-77* (2015), https://www.unfpa.org/sites/default/files/pub-pdf/9789241565141_eng.pdf (examining global, regional, and country-level data to measure progress in reducing maternal mortality).

¹³⁶ Nina Martin, *Focus on Infants During Childbirth Leaves U.S. Moms in Danger*, NPR NEWS (May 12, 2017, 5:00 AM), <https://www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger>.

¹³⁷ See *Pregnancy-Related Deaths*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm> (last updated Feb. 26, 2019).

¹³⁸ See *Maternal Mortality in United States in 2018: Maternal Mortality – AIAN*, AM.'S HEALTH RANKINGS (2019), https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/population/maternal_mortality_aian/state/ALL (finding that the maternal mortality rate of American Indian and Alaskan Native women in 2018 was 38.8 per 100,000 live births, the second highest mortality rate behind the rate for Black women in the same year).

¹³⁹ *Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017*, Morbidity & Mortality Wkly Rep. (May 2019), CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html> (last visited May 20, 2019).

¹⁴⁰ See *Reproductive Health: Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html> (last updated June 29, 2017); Andrea A. Creanga et al., *Racial and Ethnic Disparities in Severe Maternal Morbidity: A Multistate Analysis, 2008-2010*, 210 Am. J. Obstet. Gynecol. 435, 437 (2014) (calling for the need for “a systematic review of severe maternal morbidities at the facility, state, and national levels to guide the development of quality improvement interventions to reduce the racial/ethnic disparities in severe maternal morbidity”).

¹⁴¹ See *MMR Map*, REVIEW TO ACTION, <http://www.reviewtoaction.org/content/mmr-map> (last visited Feb. 14, 2019).

¹⁴² Andria Cornell, *How Maternal Mortality Review Committees Can Begin Advancing Health Equity Now*, ASS’N OF MATERNAL & CHILD HEALTH PROGRAMS (2018), <http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/MarchApr18/Pages/How-Maternal-Mortality-Review-Committees-Can-Begin-Advancing-Health-Equity-Now.aspx>.

¹⁴³ *Id.*

¹⁴⁴ *Id.*; see also e.g., *Brief Overview of State MMR or PAMR: Florida*, REVIEW TO ACTION, <http://reviewtoaction.org/content/florida> (last visited on May 15, 2019).

¹⁴⁵ 42 U.S.C. § 247b-12 (2018) (authorizing funds of \$58,000,000 per year from 2019 through 2023 for the purpose of carrying out the law).

¹⁴⁶ Black Mamas Matter Alliance, Center for Reproductive Rights, *Advancing the Human Right to Safe and Respectful Maternal Health Care*, BLACK MAMAS MATTER ALLIANCE (2018), http://blackmamasmatter.org/wp-content/uploads/2018/05/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages-1.pdf (providing advocacy tools for advocates working on policy change to further Black maternal health, rights, and justice); Press Release, New York City Office of the Mayor, *De Blasio Administration Launches Comprehensive Plan to Reduce Maternal Deaths and Life-Threatening Complications from Childbirth Among Women of Color*, NYC.GOV (July 20, 2018), <https://www1.nyc.gov/office-of-the-mayor/news/365-18/de-blasio-administration-launches-comprehensive-plan-reduce-maternal-deaths-life-threatening> (noting New York City’s plan to reduce maternal deaths and childbirth complications among women of color by addressing “implicit bias, increase surveillance, enhance maternity care and expand public education”); *Maternal Deaths in US Are Up, So How Did California Cut Them By Half?*, HEALTHLINE (2018), <https://www.healthline.com/health-news/maternal-deaths-in-us-up-california-cut-by-half#2> (discussing California policies and measures taken to address preventable maternal deaths).

¹⁴⁷ See, e.g. *Maternal Deaths in US Are Up, So How Did California Cut Them By Half?*, HEALTHLINE (2018), <https://www.healthline.com/health-news/maternal-deaths-in-us-up-california-cut-by-half#2>; Julia Belluz, *California decided it was tired of women bleeding to death in childbirth*, VOX (Dec. 4, 2017, 11:23 AM), <https://www.vox.com/science-and-health/2017/6/29/15830970/women-health-care-maternal-mortality-rate>

¹⁴⁸ Nina Martin & Renee Montagne, *The Last Person You’d Expect to Die in Childbirth*, PROPUBLICA (May 12, 2017), <https://www.propublica.org/article/die-in-childbirth-maternal-death-rate-health-care-system>.

¹⁴⁹ *Id.*

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.* New York-Presbyterian/Columbia University Medical Center, in Brooklyn, NY, is the only hospital that has a program for high risk mothers in the United States.

¹⁵³ *Id.*

¹⁵⁴ Nina Martin & Renee Montagne, *Focus on Infants During Childbirth Leaves U.S. Moms in Danger*, NPR (May 12, 2017, 5:00 AM), <https://www.npr.org/2017/05/12/527806002/focus-on-infants-during-childbirth-leaves-u-s-moms-in-danger>.

¹⁵⁵ Linda Villarosa, *Why America’s Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. TIMES (April 11, 2018), <https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html> (discussing how the lived experience of being a black woman in America contributes to the racial disparities in maternal death rates).

¹⁵⁶ HRGJ/NAPW/SIA Submission to the United Nations Working Group on Discrimination Against Women 12-13 (October 1, 2018).

¹⁵⁷ See e.g., American Congress of Obstetricians and Gynecologists, *Toolkit on State Legislation: Pregnant Women and Prescription Drug Abuse, Dependence and Addiction*, 3, www.acog.org/-/media/Departments/Government-Relations-and-Outreach/NASToolkit.pdf (last visited May 15, 2019).

¹⁵⁸ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 81, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹⁵⁹ U.S. IMMIGR. AND CUSTOMS ENF'T, ICE DIRECTIVE NO. 11032.3, IDENTIFICATION AND MONITORING OF PREGNANT DETAINEES (2017),

https://www.ice.gov/sites/default/files/documents/Document/2018/11032_3_PregnantDetainees.pdf (eliminating the presumption that ICE should not detain pregnant women, except in extraordinary circumstances, and removing various oversight requirements of the detention system, including the deletion of a requirement to provide pregnant women with timely referrals for appropriate prenatal care); *contra* U.S. IMMIGR. AND CUSTOMS ENF'T, ICE POL'Y NO. 11032.2, IDENTIFICATION AND MONITORING OF PREGNANT DETAINEES (2016),

https://www.ice.gov/sites/default/files/documents/Document/2016/11032.2_IdentificationMonitoringPregnantDetainees.pdf (considering the “particular needs and vulnerabilities of pregnancy women detained in its custody” and instructing that absent extraordinary circumstances, pregnant women will not be detained by ICE, as well as providing protections for pregnant women that are detained).

¹⁶⁰ Ema O'Connor and Nidhi Prakash, *Pregnant Women Say They Miscarried in Immigration Detention and Didn't Get the Care They Needed*, BUZZFEED.NEWS (July 9, 2018, 2:44 pm),

<https://www.buzzfeednews.com/article/emaconnor/pregnant-migrant-women-miscarriage-cpb-ice-detention-trump> (citing numbers of pregnant detained women that ICE provided BuzzFeed News in July 2018).

¹⁶¹ See Am. Civil Liberties Union et al., Administrative Complaint, *Increasing Numbers of Pregnant Women Facing Harm in Detention*, Am. Immigration Council (Sept. 26, 2017),

https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_increasing_numbers_of_pregnant_women_facing_harm_in_detention.pdf (highlighting case summaries demonstrating lack of quality medical care and resulting consequences for pregnant women detained by ICE; filed with the Department for Homeland Security's Office for Civil Rights and Civil Liberties, and the Office of the Inspector General); see also Ema O'Connor and Nidhi Prakash, *Pregnant Women Say They Miscarried in Immigration Detention and Didn't Get the Care They Needed*, BUZZFEED.NEWS (July 9, 2018),

<https://www.buzzfeednews.com/article/emaconnor/pregnant-migrant-women-miscarriage-cpb-ice-detention-trump#.qgyrKyz9e> (describing immigration advocates' reactions and responses incidents of denial of medical care, shackling and abuse of pregnant women in immigrant detention; including the work of the Refugee and Immigrant Center for Education and Legal Services (RAICES), the American Civil Liberties Union and the American Immigration Council).

¹⁶² Mihir Zaveri, *Woman Delivers Stillborn Baby While in ICE Custody*, NY TIMES (Feb. 25, 2019),

<https://www.nytimes.com/2019/02/25/us/mother-birth-ice-custody.html>.

¹⁶³ First Step Act of 2018, 18 U.S.C. § 4322 (2018) (prohibiting the shackling of pregnant women in federal custody); see also U.S. Immigr. And Customs Enf't, 2011 Operations Manual ICE Performance-Based National Detention Standards 204 (revised Dec. 2016), <https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf> (prohibiting the use of restraints on pregnant women or women in post-delivery recuperation absent “truly extraordinary circumstances (...) as documented by a supervisor and directed by the on-site medical authority;” restraints prohibited without exception for women who are in active labor or delivery); U.S. IMMIGR. AND CUSTOMS ENF'T, ICE DIRECTIVE NO. 11032.3, IDENTIFICATION AND MONITORING OF PREGNANT DETAINEES 2 (2017),

https://www.ice.gov/sites/default/files/documents/Document/2018/11032_3_PregnantDetainees.pdf (holding ICE officials in charge responsible for ensuring agents are aware of “policy related to the use of restraints for pregnant detainees”). Senators re-introduced a separate bill on March 5, 2019 that would prohibit the Department of Homeland Security from detaining pregnant women or women during postpartum recovery unless the woman presents an immediate or serious threat of harm to herself or others. The bill also requires that detained pregnant

women have access to comprehensive health services, including reproductive health pregnancy care. *See Stop Shackling and Detaining Pregnant Women Act*, S. 648, 116th Cong. (as introduced in Senate, March 5, 2019).

¹⁶⁴ *See* Ema O'Connor and Nidhi Prakash, *Pregnant Women Say They Miscarried in Immigration Detention and Didn't Get the Care They Needed*, BUZZFEED.NEWS (July 9, 2018),

<https://www.buzzfeednews.com/article/emaconnor/pregnant-migrant-women-miscarriage-cpb-ice-detention-trump#.qgyrKyz9e>.

¹⁶⁵ Kamala D. Harris et al., Letter from Senators Kamala Harris, Tom Carper, Margaret Hassan and Patty Murray to Inspector General John Kelly, HARRIS.SENATE.GOV (July 13, 2019),

<https://www.harris.senate.gov/imo/media/doc/Letter%20on%20Pregnant%20Women%20and%20ICE%20detention.pdf>.

¹⁶⁶ ACLU Reproductive Freedom Project and ACLU National Prison Project, *ACLU Briefing Paper:*

The Shackling of Pregnant Women & Girls in U.S. Prisons, Jails & Youth Detention Centers, AM. CIVIL LIBERTIES UNION 2 (2012),

https://www.aclu.org/files/assets/anti-shackling_briefing_paper_stand_alone.pdf.

¹⁶⁷ *See* Carolyn Sufrin, *The Shameful Neglect of Pregnant Women Behind Bars*, UC PRESS BLOG (Mar. 15, 2018).

¹⁶⁸ *See* First Step Act of 2018, 18 U.S.C. § 4322 (2018) (prohibiting the shackling of pregnant women in federal custody); *see also* Ashley Southall and Benjamin Weiser, *Police Forced Bronx Woman to Give Birth While Handcuffed, Lawsuit Says*, N.Y. TIMES (Dec. 6, 2018), <https://www.nytimes.com/2018/12/06/nyregion/pregnant-inmate-shackled-lawsuit.html> (reporting that “New York is one of 26 states that prohibit shackling women in labor,” according to Dr. Carolyn Sufrin, an assistant professor in gynecology and obstetrics at Johns Hopkins Medicine.).

¹⁶⁹ Ashley Southall and Benjamin Weiser, *Police Forced Bronx Woman to Give Birth While Handcuffed, Lawsuit Says*, N.Y. TIMES (Dec. 6, 2018), <https://www.nytimes.com/2018/12/06/nyregion/pregnant-inmate-shackled-lawsuit.html>.

¹⁷⁰ Jason Silverstein, *Dozens of Milwaukee County Jail Inmates have been forced to give birth while shackled, lawsuit alleges*, DAILY NEWS (Mar. 19, 2017), <https://www.nydailynews.com/news/national/milwaukee-jail-inmates-forced-give-birth-shackles-suit-article-1.3002630> (noting that at least two other lawsuits and a class action have been filed against the jail).

¹⁷¹ *See e.g.*, Victoria Law, *Pregnant Women Are Being Shackled in Massachusetts-Even Though It's Been Illegal for Years*, REWIRE (June 15, 2016), <https://rewire.news/article/2016/06/15/pregnant-women-shackled-massachusetts-even-though-illegal-years/> (documenting continued used of shackles and finding that no prison or jail facility in Massachusetts had policies that complied with the law).

¹⁷² *See* N.Y. CORRECT. LAW § 611 (McKinney 2016); Compl. at 10-15, Jane Doe v. City of New York, et al, (S.D.N.Y. 2018) (No. 18 Civ. 11414) (filing a civil rights complaint alleging NYPD shackled Jane Doe before, during, and after her pregnancy; which led to excruciating pain, discomfort, trauma and severe emotional distress).

¹⁷³ Roth, *She Doesn't Deserve to Be Treated Like This* 8-10 (noting prison staff's failure to take bleeding seriously, failure to recognize when women are in labor, shackling and the failure to provide postpartum care); *see also* Victoria Law, *Pregnant and behind bars: how the US prison system abuses mothers-to-be*, THE GUARDIAN (Oct. 20, 2015), <https://www.theguardian.com/us-news/2015/oct/20/pregnant-women-prison-system-abuse-medical-neglect> (reporting first-hand accounts of denial of medical care in prisons, including being ignored or dismissed by guards and prison staff).

¹⁷⁴ Roth, *She Doesn't Deserve to Be Treated Like This* (noting reports and studies in Seattle and Massachusetts about conditions and lack of nutrition and that anti-shackling laws “lack meaningful enforcement provisions”); Victoria Law, *Pregnant and behind bars: how the US prison system abuses mothers-to-be*, The Guardian (Oct. 20, 2015), <https://www.theguardian.com/us-news/2015/oct/20/pregnant-women-prison-system-abuse-medical-neglect> (discussing strip searches, failure to comply with shackling ban and lack of adequate food and nutrition).

¹⁷⁵ *See e.g.*, Victoria Law, *'If This is a Problem Don't Come to Jail': Pennsylvania Jail Sued Over Treatment of Pregnant Women*, REWIRE (Dec. 20, 2016, 7:18 pm), <https://rewire.news/article/2016/12/20/problem-dont-come-jail-pennsylvania-jail-sued-treatment-pregnant-women/> (discussing a class action lawsuit against Pennsylvania jail challenging the practice of placing pregnant women in solitary confinement).

¹⁷⁶ *See* Tamar Kraft Stoler, Women Prison Project of the Corr. Ass'n of N.Y., *Reproductive Injustice, The State of Reproductive Health Care for Women in New York State Prisons*, CORR. ASS'N OF N.Y. 111-14, 117-19

(2015), <https://static.prisonpolicy.org/scans/Reproductive-Injustice-FULL-REPORT-FINAL-2-11-15.pdf> (documenting treatment of incarcerated pregnant women in labor and delivery in New York State).

¹⁷⁷ See Victoria Law, *Being Behind Bars Makes it Difficult – and Sometimes Impossible – for New Moms to Breastfeed*, REWIRE NEWS (Sept. 18, 2017, 3:26 pm), <https://rewire.news/article/2017/09/18/behind-bars-makes-difficult-sometimes-impossible-new-moms-breastfeed/> (describing various cases across the country of incarcerated mothers that are denied the opportunity to breastfeed).

¹⁷⁸ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 54, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹⁷⁹ 29 U.S.C. § 2601 (1993); see also *State Family and Medical Leave Laws*, NAT'L CONF. OF STATE LEGS. (July 19, 2016), <http://www.ncsl.org/research/labor-and-employment/state-family-and-medical-leave-laws.aspx> (providing an overview of the FMLA and state family and medical leave laws).

¹⁸⁰ *Paid Family Leave and Sick Days in the U.S.: Findings from the 2017 Kaiser/HRET Employer Health Benefits Survey*, KAISER FAMILY FOUND. 1 (Oct. 2017), <http://files.kff.org/attachment/Fact-Sheet-Paid-Family-Leave-and-Sick-Days-in-the-US-Findings-from-the-2017-Kaiser-HRET-Employer-Health-Benefits-Survey>.

¹⁸¹ See UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 54, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹⁸² See U.S. Dep't of Labor, *Women in the Labour Force Workforce in 2010*, <https://www.dol.gov/wb/factsheets/qf-laborforce-10.htm> (last visited Feb. 14, 2019).

¹⁸³ See *State Paid Family and Medical Leave Insurance Laws*, NAT'L PARTNERSHIP FOR WOMEN & FAMILIES (Feb. 2019), <http://www.nationalpartnership.org/our-work/resources/workplace/paid-leave/state-paid-family-leave-laws.pdf> (listing the coverage/eligibility and provisions of family medical leave per state/district, as well as what family members leave is provided to care for).

¹⁸⁴ Presidential Memorandum, *Modernizing Federal Leave Policies for Childbirth, Adoption and Foster Care to Recruit and Retain Talent and Improve Productivity*, 80 Fed. Reg. 3135-3137 (Jan. 15, 2015), <https://www.federalregister.gov/documents/2015/01/21/2015-01118/modernizing-federal-leave-policies-for-childbirth-adoption-and-foster-care-to-recruit-and-retain>.

¹⁸⁵ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 67, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹⁸⁶ See Press Release, Megan Uzzell and Charisma Troiano, *One Year of Successful Battles to Protect the TPP Program Against Trump Administration Unlawful Actions*, DEMOCRACY FORWARD (Feb. 29, 2019), <https://democracyforward.org/press/trump-administration-continues-unlawful-effort-to-dismantle-the-evidence-based-teen-pregnancy-prevention-program/#.XARHpaeZMnU> (summarizing attempts to terminate existing grantees and new funding announcements)[hereinafter Democracy Forward Feb. 29, 2019 Press Release].

¹⁸⁷ *About the Teen Pregnancy Prevention (TPP) Program*, U.S. DEPT. OF HEALTH & HUMAN SERV., <https://www.hhs.gov/ash/oah/grant-programs/teen-pregnancy-prevention-program-tpp/about/index.html> (stating that program was created in 2010 “with a Congressional mandate to fund medically accurate and age-appropriate programs”).

¹⁸⁸ See *Evidence-Based Teen Pregnancy Prevention Programs*, CTRS. FOR DISEASE CONTROL, <https://www.cdc.gov/teenpregnancy/practitioner-tools-resources/evidence-based-programs.html> (last updated Jan. 7, 2016).

¹⁸⁹ See *Healthy Futures of Texas v. Department of Health and Human Services*, CITIZEN, <https://www.citizen.org/our-work/litigation/cases/healthy-futures-texas-v-department-health-and-human-services>.

¹⁹⁰ Four lawsuits were brought by specific grantees and a class action lawsuit. Democracy Forward, Feb. 29, 2019 Press Release, *supra* note 183 (stating that courts held that the grants were illegally terminated in all five cases).

¹⁹¹ See Office of the Assistant Secretary of Health, FY18 Announcement of the Availability of Funds for Phase I New and Innovative Strategies (Tier 2) to Prevent Teenage Pregnancy and Promote Healthy Adolescence, U.S. DEPT. OF HEALTH & HUMAN SERVS. 11-13, <https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=61742> (last updated May 9, 2018) (stating “public health priorities” for implementation of “new strategies to prevent teen pregnancy,” including that

providers seeking funding should “place a priority on providing information and practical skills to assist youth in successfully avoiding sexual risk ... defined as engaging in any behavior that increases one’s risk for any of the unintended consequences of sexual activity, including, but not limited to pregnancy.”).

¹⁹² Office of the Assistant Secretary of Health, Announcement of Availability of Funds for Replication of Programs Proven Effective through Rigorous Evaluation to Reduce Teenage Pregnancy, Behavioral Risk Factors Underlying Teenage Pregnancy, or Other Associated Risk Factors (Tier 1) Phase I, U.S. DEPT. OF HEALTH & HUMAN SERVS. 12-13 (February 13, 2019), <https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=63295> (noting that “OAH continues to intend to pursue a substantially similar approach through Tier 1 funding in the future [referring to the Sexual Risk Avoidance programming] so as to optimally replicate effective programs for teen pregnancy prevention,” while recognizing that “two United States District Courts enjoined the issuance of awards under the 2018 Tier 1 FOA on the basis of that approach, and the appeal process for those cases is not yet complete”); *see also* Democracy Forward February 22, 2019 Press Release, *supra* note 183 (describing the FOA litigation and noting that despite a ruling that allowing unproven abstinence only programs to apply for TPP grants contradict Congress’s intent, that a new HHS FOIA was opened on Feb. 13, 2019 and that the government stated it “continues to pursue a similar approach”).

¹⁹³ John S. Santelli et al., *Abstinence-Only-Until-Marriage: An Updated Review of U.S. Policies and Programs and Their Impact*, 61 J. of Adolescent Health 273-280 (2017), [https://www.jahonline.org/article/S1054-139X\(17\)30260-4/pdf](https://www.jahonline.org/article/S1054-139X(17)30260-4/pdf) (detailing significant issues with abstinence-only programs, including the fact that they are ineffective and they violate basic human rights of young people by obfuscating accurate health information, stigmatizing or excluding many young people, and reinforcing damaging gender stereotypes).

¹⁹⁴ Section 104(f)(1) of the Foreign Assistance Act of 1961, P.L. 87-195; 22 U.S.C. 2151b(f)(1), as amended by the Foreign Assistance Act of 1973, P.L. 93-189, (Dec. 17, 1973).

¹⁹⁵ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 30, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016); *see also* Sneha Barot, *Abortion Restrictions in U.S. Foreign Aid: The History and Harms of the Helms Amendment*, GUTTMACHER INST. (Sept. 13, 2013), <https://www.guttmacher.org/gpr/2013/09/abortion-restrictions-us-foreign-aid-history-and-harms-helms-amendment>.

¹⁹⁶ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 90(i) U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

¹⁹⁷ Presidential Memorandum from President Donald J. Trump for the Secretary of State, the Secretary for Health and Human Services, and the Administrator of the United States Agency for International Development, Presidential Memorandum Regarding the Mexico City Policy (Jan. 23, 2017), <https://www.whitehouse.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy/> (directing the Secretary of State to implement a plan to extend the global gag rule to “global health assistance furnished by all Departments or Agencies”); Press Release, U.S. Department of State, Fact Sheet: Protecting Life in Global Health Assistance (May 15, 2017), <https://www.state.gov/protecting-life-in-global-health-assistance-2/> (announcing Former Secretary of State Rex Tillerson’s approval of the Protecting in Global Health Assistance Policy, noting that the term “global health assistance” includes funding for international health programs, such as those for...family planning and reproductive health.”).

¹⁹⁸ 82 Fed. Reg. 8495 (Jan. 25, 2017).

¹⁹⁹ *Id.*

²⁰⁰ Memorandum from President Donald J. Trump for the Secretary of State, the Secretary for Health and Human Services, and the Administrator of the United States Agency for International Development, Presidential Memorandum Regarding the Mexico City Policy (Jan. 23, 2017), <https://www.whitehouse.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy> (directing the Secretary of State “to take all necessary actions, to the extent permitted by law, to ensure that U.S. taxpayer dollars do not fund organizations or programs that support or participate in the management of ... abortion”); *Standard Provisions for Non-U.S. Nongovernmental Organizations*, U.S. Agency for Int’l Development 85 (revised Aug. 30, 2018), <https://www.usaid.gov/sites/default/files/documents/1868/303mab.pdf> (expanding policy to wider range of international non-governmental organizations that receive funding for global health assistance).

²⁰¹ Matthew Lee, *US expands ban on foreign aid to overseas abortion providers*, ASSOCIATED PRESS (Mar. 26, 2019), <https://www.apnews.com/5e11d44fa31c48e68cdebac26774259b>. (quoting U.S. Secretary of State Michael R. Pompeo’s remarks to the press at the Department of State regarding the expansion of bans on foreign aid).

²⁰² See Seema Jalan, *The Global Gag Rule: One Year Later*, UNITED NATIONS FOUND. BLOG (Jan. 23, 2018), <https://unfoundation.org/blog/post/the-global-gag-rule-one-year-later/>.

²⁰³ *So Far, So Bad, The Wide-Ranging Impacts of the Global Gag Rule Happening Now*, POPULATION ACTION INT’L (2018), <https://pai.org/wp-content/uploads/2018/07/So-Far-So-Bad-the-wide-ranging-Impacts-of-the-GGR-revised-7-17-18.pdf> (documenting the harm the reinstatement and expansion of the global gag rule has already had on nongovernmental organizations (NGOs), health systems and communities; including loss of services for vulnerable groups, diminished resources for key responders to humanitarian crises, a chilling on advocacy and partnerships, and rollbacks on domestic health priorities); see also *Assessing the Global Gag Rule: Harms to Health, Communities, and Advocacy*, PLANNED PARENTHOOD GLOBAL (Jan. 23, 2019), https://www.plannedparenthood.org/uploads/filer_public/81/9d/819d9000-5350-4ea3-b699-1f12d59ec67f/181231-ggr-d09.pdf (concluding that the expanded rule has wide-reaching harmful consequences on complying and non-complying organizations, disrupts the delivery of health care services, and “is driven by ideology instead of evidence”).

²⁰⁴ See *Press Release, Trump’s Global Gag Rule one year on: Marie Stopes International faces \$80 million funding gap*, MARIE STOPES INT’L (Jan. 19, 2018), <https://mariestopes.org/news/2018/1/global-gag-rule-anniversary/> (estimating an approximate \$80 million funding gap for Marie Stopes International in the remaining years of the current administration, meaning that “more than 2 million women will no longer have access to contraception services.”); *Policy Briefing: The Impact of the Global Gag Rule*, INT’L PLANNED PARENTHOOD FOUND. (Jan. 2019), <https://www.ippf.org/sites/default/files/2019-01/IPPF%20GGR%20Policy%20Briefing%20-%20January%202019.pdf> (estimating that “IPPF stands to lose up to \$100 million in lifesaving support over the course of the policy”).

²⁰⁵ UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 86, 87, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4, 2016).

²⁰⁶ *Id.*, para. 87.