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REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE

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Submitted by: The Center for Reproductive Rights, a global organization that uses the power of law to advance reproductive rights as fundamental human rights around the world. Within the United States, the Center engages in litigation, policy, and advocacy work at the state, national, and international levels. (<https://reproductiverights.org/>)

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Amnesty International

Black Mamas Matter Alliance

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National Asian Pacific American Women's Forum

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I. Summary

1. Reproductive health, rights, and justice in the United States are under alarming and relentless attack, in violation of the rights to life, equality, health (including sexual and reproductive health), privacy, information, freedom from discrimination and violence, and freedom from torture, cruel, inhuman and degrading treatment, among others.
2. Since the United States' last UPR, the political and policy landscape in the U.S. for reproductive rights and justice has worsened dramatically, resulting in a significant retrogression of rights, with a particularly harmful impact on marginalized communities and people experiencing multiple and intersecting forms of discrimination, including immigrants, people living in poverty, women of color, people living in rural areas, LGBTQI+ people, and people with disabilities.
3. This retrogression of rights has resulted in limits on access to health care and health care information; attacks on immigrant access to care; refusals to provide reproductive health care based on religious or moral beliefs; attacks on access to abortion; racial disparities in maternal mortality and morbidity; mistreatment of pregnant people in immigration and criminal detention; and imposition of the Helms Amendment and Global Gag Rule.
4. U.N. human rights treaty bodies and independent experts have firmly established and consistently recognized that reproductive rights are human rights, grounded in the Universal Declaration of Human Rights and the core human rights treaties.
5. The Committee on Economic, Social and Cultural Rights has noted the importance of avoiding retrogressive measures in the area of sexual and reproductive health and rights, including the imposition of barriers to sexual and reproductive health information, goods, and services.

II. U.S. Legal Framework

6. In the United States, the constitutional right to abortion is well established. The right was established by the U.S. Supreme Court in 1973 in *Roe v. Wade*,¹ and the Court has repeatedly affirmed the right, including most recently in *Whole Woman's Health v. Hellerstedt*.²
7. Nevertheless, twenty-one states severely restrict access to reproductive health care, and a number of state legislatures are enacting increasingly extreme and unconstitutional abortion bans and restrictions in an effort to ask the Supreme Court to overturn or decimate *Roe v. Wade*.³ These state laws are the subject of ongoing litigation and most have been enjoined by the courts.
8. The U.S. Constitution does not explicitly protect the right to health. Healthcare in the United States is available through a patchwork of private and public coverage.
9. Because the U.S. has a federalist form of government, both federal and state laws regulate health care access. Numerous federal and state statutes in the U.S. address various aspects of non-discrimination, physical access, affordability, and coverage of healthcare, including sexual and reproductive healthcare.

10. The U.S. has ratified international instruments that commit the United States to ensuring sexual and reproductive rights, including the International Covenant on Civil Political Rights (ICCPR), the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), and the Convention Against Torture. The U.S. has signed but not ratified the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

11. At the conclusion of the its Second UPR, the U.S. supported, at least in part, several recommendations related to and implicating reproductive health, rights, and justice, including:

- a. Ensure that the United States international aid allows access to sexual and reproductive health services for women victims of sexual violence in conflict situations⁴
- b. Take affirmative steps to ensure that individuals' religious refusals are regulated to conform with international human rights standards that protect sexual and reproductive rights and the rights to equality and nondiscrimination on the basis of sex, gender, sexual orientation or gender identity⁵
- c. While recognizing economic, social and cultural measures, strengthen efforts in ensuring equal access to health-care and social services⁶
- d. Continue efforts regarding access to the right to health⁷
- e. Ensure equal access to equality maternal health and related services as an integral part of the realization of women's rights⁸
- f. Further efforts in this positive direction with a view to strengthen national health-care programmes so that health care is easily accessible, available and affordable for all⁹

12. Since the United States' Second UPR, a number of human rights mechanisms have noted specific concerns with reproductive health, rights, and justice issues in the United States:

- a. In 2016, the **UN Working Group on Discrimination Against Women in Law and Practice** recommended that the U.S. ensure that women be able to exercise their existing constitutional right under *Roe v. Wade*; repeal the Hyde Amendment; combat the stigma attached to reproductive and sexual health care; address racial disparities in maternal health;¹⁰ and reconcile conscience-based refusals to provide reproductive health care in the U.S. with international human rights standards.¹¹ The Working Group also expressed concern that "immigrant women and girls face severe barriers in accessing sexual and reproductive health services,"¹² and women in U.S. immigration detention face a lack of appropriate health care services.¹³
- b. In 2016, the **UN Working Group of Experts on People of African Descent** noted that racial discrimination has a negative impact on Black women's ability to maintain good

health and recommended that the U.S. prioritize policies and programs to reduce maternal mortality for Black women.¹⁴

- c. In 2017, the **UN Working Group on Arbitrary Detention** expressed concern about civil detentions of pregnant women in the United States who used or were suspected to have used criminalized drugs, noting that “[t]his form of deprivation of liberty is gendered and discriminatory in its reach and application.”¹⁵
- d. In 2018, **UN Special Rapporteur on Extreme Poverty** noted concern that the U.S. has the highest maternal mortality rate among wealthy countries, and that Black women are three to four times more likely to die from child birth;¹⁶ low-income women in the U.S. face legal and practical obstacles to exercising their constitutional, privacy-derived right to access abortion services, trapping many women in cycles of poverty;¹⁷ women immigrants experience higher poverty rates and have less access to social protection benefits;¹⁸ and people in poverty in the U.S., and in particular pregnant women, are disproportionately criminalized and subjected to interrogations that strip them of privacy rights.¹⁹
- e. In 2018, a **number of Special Procedures** jointly issued a communication to the U.S. expressing “grave concern at the risks to the life, health, liberty, safety, wellbeing and other human rights of pregnant migrant women, associated with their detention in ICE custody.”²⁰
- f. In April 2019, the **Human Rights Committee** included the issue of reproductive health and rights, including access to abortion, in the List of Issues Prior to Reporting for its next review of U.S. compliance with the ICCPR.²¹

III. Promotion and Protection of Human Rights on the Ground

A. Limits on Access to Health Care, including Reproductive Health Care, and Health Care Information

13. **Health Care Coverage.** Enacted in 2010, the Affordable Care Act (ACA) provided health care coverage for approximately 20 million uninsured Americans, including by (1) expanding eligibility for Medicaid (public health insurance program for low-income individuals and families, including pregnant women, children and families, individuals with disabilities, and seniors) and (2) expanding the ability to purchase private health insurance by creating state health care exchanges, providing tax subsidies, and prohibiting predatory insurance practices.²² However, since the United States’ last UPR, there have been repeated attacks on the ACA, including efforts to restrict Medicaid access and coverage. For example, the federal government has cut funding to assist consumers in enrolling in health plans and has encouraged consumers to enroll in plans that do not meet the stringent coverage requirements of the ACA.²³ The federal

government has approved applications by states to impose work requirements as a prerequisite for individuals to receive Medicaid health insurance.²⁴ Separately, several states are seeking federal approval to prevent health care providers who also provide abortion services from participating in the Medicaid family planning program entirely.²⁵

14. **Non-Discrimination.** The ACA includes an important provision that prohibits discrimination in health care, but non-discrimination protections for women, pregnant people, LGBTQI+ people, and people with limited English proficiency are being weakened by the Administration. Section 1557 of the ACA prohibits discrimination based on sex by health care programs that receive federal funding and by plans on ACA state exchanges.²⁶ Current Department of Health and Human Services (HHS) regulations define sex-based discrimination to include discrimination on the basis of pregnancy status (including termination of pregnancy), sex stereotyping, and gender identity.²⁷ The Administration recently proposed a regulation that would eliminate that definition and roll back protections from discrimination in healthcare settings for women, pregnant people, and LGBTQI+ people.²⁸ The rule also proposes to eliminate requirements that provide individuals with limited English proficiency with necessary language services.²⁹ The proposed changes will not go into effect until HHS issues a finalized version of the rule.

15. **Contraceptive Coverage.** All ACA-compliant health care plans must provide coverage for contraception at no cost to plan beneficiaries.³⁰ The required benefit recognizes that contraceptive care is essential preventive health care and that women pay a disproportionate amount of health care costs. However, new federal regulations drastically expand the number of plan sponsors who can opt out of the mandate based on religious or moral objection, without requiring an alternative manner to make coverage available.³¹

16. The Administration has issued regulations that will undermine Title X, the nation's family planning program that serves low-income, uninsured, and underinsured individuals. Nearly 4 million low-income individuals rely on the federal Title X family planning program for comprehensive family planning and related reproductive health care services.³² Title X services include family planning and contraceptive services, breast and cervical cancer screenings, and STD screenings,³³ but Title X is prohibited by statute from funding abortion care.³⁴ In 2019, new regulations were issued that, among other things, make providers ineligible for Title X funds if they separately provide abortions at the same location, or if they refer patients for abortion services.³⁵ Planned Parenthood, a nationwide provider serving 40 percent of all Title X patients, announced its withdrawal from the Title X program, rather than comply with the restrictive regulations, and has already been forced to close several clinics as a result.³⁶ Maine Family Planning, which is the only Title X recipient in the state, also decided to withdraw from the program.³⁷ In total, the gag rule may force providers that serve nearly half of all Title X patients out of the program, making it difficult or impossible for many low-income individuals to obtain contraceptive coverage and other critical healthcare services.³⁸ Those who continue to receive coverage from providers remaining in the Title X program will not receive complete and unbiased health information.³⁹

B. Discriminatory Access to Health Care for Immigrant Women

17. Existing health laws and newly proposed changes to immigration policy result in a two-tiered system of health care access in the United States that denies essential health care to immigrant women and their families.

18. Federal policies have excluded immigrants from government health insurance programs since 1996.⁴⁰ These policies exclude both undocumented immigrants as well as immigrants who have been deemed “lawfully present” in the U.S. for less than five years. Immigrant women of reproductive age are disproportionately uninsured and face particularly high barriers to affordable health care.⁴¹ Restricted access to health insurance has greatly impacted the ability of low-income immigrant women to access maternity care, family planning, and other reproductive health care services.⁴²

19. In August 2019, the Administration issued a new federal regulation that intensifies the longstanding pattern of exclusion by broadening the “public charge” test that has been a part of federal immigration law for decades.⁴³ Under current law, if U.S. immigration deems a person likely to become a “public charge,” that person can be refused admission to the U.S., or if they are in the U.S., deny their ability to adjust to Permanent Resident Status (otherwise known as green card holders). The new regulation expands the public charge definition to include an immigrant who simply “receives one or more public benefits,” including benefits that address basic needs.⁴⁴ This could force immigrant families to choose between future permanent legal status and healthy food, safe housing, and health care, leading to devastating impacts on immigrant women’s health.⁴⁵ The regulation is set to take effect on October 15, 2019, and has already generated substantial fear within immigrant communities, creating a chilling effect, which has impacted immigrants’ decisions to seek care and led some families to stop participating in programs that help them meet their basic needs.⁴⁶ A number of state and local jurisdictions and advocacy organizations have challenged the rule in court.⁴⁷

20. Additional information about the human rights violations experienced by people detained in immigration detention facilities is provided in Sections D & F, below.

C. Refusal to Provide Reproductive Health Care Based on One’s Religious or Moral Beliefs

21. In recent years, the United States has undertaken a vast expansion of laws and regulations that permit health care workers to deny care based on their religious and moral beliefs. An array of federal and state laws permit individual and institutional health care providers to opt out of providing critical health services, including abortion (46 states), contraception (12 states), and sterilization (18 states).⁴⁸ In some states, the right to deny care is afforded not only to those directly involved in health care services but also to ancillary health care personnel, such as pharmacists (12 states).⁴⁹

22. In most cases, these laws extend beyond individual providers to also allow religiously affiliated health care institutions (e.g., hospitals and clinics) to refuse to provide reproductive health care based on religious or moral beliefs. Forty-four states extend such refusal rights to

health care institutions and corporations.⁵⁰ At the federal level, the 1973 Church Amendments (42 U.S.C. § 300a-7) were the first to prohibit the federal government from requiring individuals or facilities receiving public funds to provide abortion or sterilization services. Over the past four decades, federal lawmakers have passed additional laws to allow an increasingly wide range of health care professionals and institutions to refuse to provide needed, and even life-saving, health care services.⁵¹

23. The Administration has issued new regulations that allow virtually any employer, insurance provider, or university to deny employees, insurance holders, students, and their dependents contraceptive coverage required under the ACA based on religious or moral objections, without requiring them to make any alternative arrangements to ensure that insurance holders receive coverage.⁵² The regulations newly grant religious refusal rights to all employers, including publicly traded corporations, and further permit opt-outs on non-religious moral grounds for closely held corporations and non-profits. These regulations have been temporarily enjoined as a result of two federal lawsuits.⁵³

24. In January 2018, HHS announced a new division of HHS's Office of Civil Rights (OCR), which focuses exclusively on religious and moral exemption claims.⁵⁴ In so doing, the Administration is positioning providers who oppose their patients' exercise of sexual and reproductive rights as the victims of civil rights abuses, effectively encouraging health care providers and institutions to discriminate against patients seeking reproductive health care services.⁵⁵

25. In May 2019, HHS finalized a new regulation that vastly expands the scope of health care workers who may claim a religious exemption under existing law.⁵⁶ The new rule would permit health care workers with only a tangential connection to the objected-to procedure to refuse to provide their services, for example, permitting a receptionist to refuse to schedule an abortion or an ambulance driver to transport a woman experiencing an ectopic pregnancy to the hospital.⁵⁷ The rule does not contain any provision to ensure that patients who are refused care are referred elsewhere or offered other care options, and it incentivizes facilities to cease offering contraception, abortion, and LGBTQI+-focused care for fear of losing federal funding. The rule is temporarily enjoined nationwide as a result of several ongoing lawsuits.⁵⁸

26. When implemented without balancing, religious and moral refusal laws can be—and have been—exploited to limit access or deny care, particularly in the field of reproductive health care.⁵⁹ Refused services include access to safe pregnancy termination, miscarriage management, and contraception, which are all necessary to ensure health and wellbeing.⁶⁰

D. Attacks on Access to Abortion

27. Abortion access is under attack in the United States, and people seeking or providing this health care face a growing number of obstacles that threaten their rights to life, privacy, bodily integrity, health, equality, freedom from discrimination, and freedom from cruel, inhuman and degrading treatment. Although the U.S. Supreme Court has repeatedly affirmed the constitutional right to abortion established in *Roe v. Wade*,⁶¹ including most recently in *Whole Woman's Health*

v. Hellerstedt,⁶² states are enacting increasingly extreme and unconstitutional abortion bans and restrictions in an effort to ask the Supreme Court to overturn or decimate *Roe*.⁶³

28. Thus far in 2019, states have enacted forty-six laws restricting abortion access.⁶⁴ These include unconstitutional pre-viability bans on abortion,⁶⁵ such as laws banning abortion around 6 weeks of pregnancy.⁶⁶ For example, in May 2019, the Alabama governor signed a bill into law that bans most abortions and creates criminal penalties for doctors.⁶⁷ States have also outlawed the procedure that is the standard of care for abortion after approximately 15 weeks of pregnancy.⁶⁸ States have enacted bans on abortion for specific reason, including fetal diagnosis.⁶⁹

29. In addition, states have enacted and expanded regulations that target abortion providers with medically unjustified regulations which subject people seeking abortion to mandatory delays, multiple clinic visits, and medically inaccurate information.⁷⁰ While not directly prohibiting abortion, these targeted regulations are designed to impose barriers making it difficult or impossible for clinics to provide care and for people to access it.

30. The result is a patchwork of access to abortion care across the United States, with six states having only one abortion provider.⁷¹ As detailed in the Abortion Care Network's most recent *Communities Need Clinics* report, abortion clinics are closing at an alarming rate and the number of independent clinics has been reduced by nearly 28 percent since 2012.⁷² As clinics close, patients are increasingly forced to travel farther, find overnight lodging, take additional time away from work, and find childcare — increasing both medical and personal out-of-pocket costs.⁷³ Restrictions on abortion access particularly impact marginalized communities, including immigrants, low-income women, women of color, LGBTQI+ persons, persons living in rural areas, and persons with disabilities.⁷⁴

31. Abortion access is also unavailable to millions of low-income and poor people because of cost. First enacted in 1976, the Hyde Amendment bans federal programs like Medicaid (which provides health insurance to people with low-incomes) from covering abortion care, except in the limited cases of rape, incest, or life endangerment.⁷⁵ Since 1976, Congress has expanded the reach of the Hyde Amendment's abortion coverage bans and federal funding bans. Over half of the 7.5 million women potentially affected by the Hyde Amendment are women of color.⁷⁶ Restrictions on publicly financed health care coverage for abortion also has a disproportionate impact on people with disabilities.⁷⁷ In addition, the Administration has issued two proposed regulations that would push abortion coverage further out of reach for women by making it more onerous for health insurance issuers to provide abortion coverage under their plans.⁷⁸ For more information on the barriers women, girls, and nonbinary persons with disabilities face when accessing sexual and reproductive health information, goods, and services, see joint submission by Women Enabled International and the Lurie Institute for Disability Policy at Brandeis University.

32. Today, because of growing restrictions on clinic-based abortion care, the intimidation and harassment that people seeking abortion care face at clinics, and the increased availability of medication abortion as a safe and effective method to terminate a pregnancy,⁷⁹ more people may be choosing to have self-managed abortions. As detailed in joint submission *Criminalization &*

Civil Punishment of Pregnancy and Pregnancy Outcomes, they face increased threat of being criminally prosecuted.

33. The federal government attempts to block adolescent girls in immigration detention from accessing abortion. 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 director issued a directive prohibiting federally funded shelters from taking "any action that facilitates" abortions without the ORR director's approval.⁸⁰ The policy came to light in 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.⁸¹ 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.⁸²

34. Similar stories have since arisen, including a young woman who took medication abortion and was forcibly sent to the emergency room before completing her abortion,⁸³ and visits by government officials to federally funded shelters to dissuade young women from obtaining abortion care.⁸⁴ 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.⁸⁵ Following the government's appeal, in June 2019, the federal court of appeals affirmed both class certification and the injunction barring ORR from obstructing unaccompanied minor's access to abortion.⁸⁶

35. Health care services for pregnant people in prisons, jails, and immigration detention do not cover abortions, and state policies vary as to whether people will be granted permission to travel to an outside abortion clinic and whether they must pay for the cost of transport.⁸⁷ In recent years, women have sued jails that have denied a medical furlough or transport to clinics to obtain abortions.⁸⁸

E. Racial Disparities in Maternal Mortality and Morbidity

36. In the United States, Black and indigenous women suffer preventable maternal deaths at significantly higher rates than other women. With the highest maternal mortality ratio in the developed world, the U.S. is one of only thirteen countries where maternal mortality is on the rise.⁸⁹ This crisis disproportionately impacts Black women, who are nearly four times more likely than white women to suffer a maternal death,⁹⁰ and twice as likely to suffer maternal morbidity.⁹¹ Indigenous women are two and a half times more likely than white women to die from a maternal death.⁹² Low-income women, and women in poor rural areas are also disproportionately affected.⁹³ The majority of U.S. maternal deaths are preventable.⁹⁴

37. In the U.S., racial and ethnic disparities in health are closely linked to social and economic inequalities, reflecting systemic obstacles to health that harm women of color especially. Factors such as poverty, lack of access to health care, and exposure to racism all undermine health and contribute to the disproportionately high number of maternal deaths among Black and indigenous women.⁹⁵

38. Nevertheless, the U.S. fails to adequately prioritize or monitor maternal deaths. The lack of systematically collected maternal mortality and morbidity data precludes comparisons across states and regions and undermines accountability for preventable maternal deaths and injuries.⁹⁶

39. Maternal health is further undermined by a lack of social supports and basic health care services for those who cannot afford to pay for them. Rather than expanding access to such resources, recent progress is now under attack. In particular, many low-income uninsured people whom the ACA was intended to cover have fallen through the cracks because they live in states that have opted out of Medicaid expansion.⁹⁷ Moreover, many immigrants are excluded from coverage under the ACA.⁹⁸

40. As a result, millions of people lack access to basic primary care and critical sexual and reproductive health care services that support healthy pregnancies and births, exacerbating racial and economic disparities.⁹⁹

F. Mistreatment of Pregnant People in Immigration and Criminal Detention

41. 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.¹⁰⁰ ICE reported that between December 14, 2017 and April 7, 2018, 590 pregnant women were in immigration detention.¹⁰¹

42. 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.¹⁰² According to an ICE spokesperson, 28 women “may have experienced a miscarriage just prior to, or while in ICE custody” between Oct. 1, 2016 and Aug. 31, 2018.¹⁰³

43. One recent investigation found that agencies may be taking infants from migrants, refugees, and people seeking asylum, because the Administration has decided to criminalize their ability to seek asylum, under its “zero-tolerance” policy.¹⁰⁴ Physicians and advocates have detailed instances when people seeking asylum who are in federal custody were forced to hand their newborns over to the state authorities right after birth, with no guarantee of whether they would be able to regain custody.¹⁰⁵

44. Further, common detention practices that may constitute cruel, inhumane, 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 people who are pregnant. Federal law and ICE policies prohibit shackling of pregnant women,¹⁰⁶ but the policies do not appear to be enforced. Since 2017, there have been multiple reports of pregnant women experiencing birth complications exacerbated by a delay in care, and when receiving care, being shackled around hands, legs, and belly when transported between facilities, attending check-up appointments, and within a few hours after giving birth.¹⁰⁷

45. The U.S. does not maintain statistics on how many pregnant people are detained in jails and prisons, but in 2012, the ACLU estimated the number to be 12,000,¹⁰⁸ and it is currently estimated that 1,400 women give birth in custody every year.¹⁰⁹ 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.¹¹⁰ In 24 states, there is no law prohibiting shackling.¹¹¹ In 2017, a lawsuit against the Milwaukee County jail alleged that at least 40 women were forced to give birth in shackles.¹¹² In jurisdictions with prohibitions, officers are often unfamiliar with the law or refuse to comply.¹¹³ In 2015, New York state passed one of the country's strongest anti-shackling laws.¹¹⁴ 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.¹¹⁵

46. There has been a 742 percent increase in incarceration rates for women in prisons in the U.S. over the past three decades, yet there is a lack of data and no national standards regarding the treatment of pregnant people in jails and prisons.¹¹⁶ Pregnant people 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.¹¹⁷ Even in states that prohibit shackling, pregnant women continue to be shackled, subjected to squat and cough strip searches, and denied adequate nutrition.¹¹⁸ Pregnant women also have been placed in solitary confinement.¹¹⁹ 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,¹²⁰ and denied the ability to breast-feed.¹²¹

G. Imposition of Helms Amendment and the Global Gag Rule

47. The United States continues to implement and enforce the Helms Amendment to the Foreign Assistance Act,¹²² 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.¹²³

48. The U.S. has reinstated and dramatically expanded the Mexico City Policy, also known as the “Protecting Life in Global Health Assistance” (PLGHA) policy,¹²⁴ or the Global Gag Rule (GGR), violating the rights of women and girls around the world.

49. Under this new, expansive iteration of the GGR, nongovernmental organizations (NGOs) incorporated outside of the U.S. that wish to receive, or that currently receive, U.S. global assistance funds cannot use those funds, or any funds acquired from any other source, to “perform or actively promote abortion as a method of family planning.”¹²⁵ Furthermore, U.S. NGOs that receive U.S. government funds are required to enforce the policy and cannot provide financial support to foreign NGOs that “perform or actively promote abortions as a method of family planning.”¹²⁶

50. 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,¹²⁷ though he failed to follow this announcement with actual guidance on implementation, thus sowing further confusion.

51. The GGR denies women and girls the right to control their own fertility, makes it more difficult for pregnant people to receive proper prenatal and postnatal maternal care, and leaves communities at risk.¹²⁸ CSOs, integrated health care providers, and small, remote clinics must choose between cutting vital abortion services and finding new sources of funding that are not tied up in the GGR; in many cases, funds cannot be recovered, and they must shut their doors entirely.¹²⁹

52. Previous implementation of the GGR 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.¹³⁰ The current expanded rule has created broad confusion about how it is applied, led to over-implementation driven by organizations’ fear of losing funding, and created a chilling effect on health service delivery and civil society advocacy.¹³¹ 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, which they assert will result in thousands more maternal deaths, unintended pregnancies, and unsafe abortions.¹³²

IV. Suggested Recommendations:

A. Access to Health Care and Health Care Information

1. Guarantee access to health-care services, free from discrimination, and take care to ensure access to care for those who face multiple and intersecting forms of discrimination, including people living in poverty, people of color, immigrants, indigenous people, people with disabilities, women, and LGBTQI+ persons, among others.
2. Rescind the Title X restrictions and guarantee the delivery of high-quality family planning services, including access to care and critical information patients need regarding their healthcare, including pregnancy options.

B. Discrimination Against Immigrant Women

1. Remove the federal five-year waiting period for “lawfully present” immigrant women to qualify for Medicaid and other health insurance programs.
2. Retract new changes to “public charge” designation and ensure that people navigating the immigration system will not be penalized for accessing basic programs that provide for their basic health, nutrition, and housing needs.

3. Ensure access to comprehensive and quality reproductive health care for all, regardless of nationality, and including people in immigration detention facilities.

C. Abortion access

1. Enact federal legislation affirming the constitutional right to abortion and the right to make decisions about one's reproductive life and the right to bodily autonomy without interference by the state.
2. Repeal the Hyde Amendment and ensure abortion access, regardless of ability to pay.
3. State legislatures should refrain from passing laws or promulgating regulations related to abortion provisions that interfere with the right to abortion and people's right to make decisions about their reproductive lives.

D. Racial Disparities in Maternal Mortality and Morbidity

1. Guarantee access to and availability of affordable, accessible, acceptable, and quality comprehensive health-care services, free from racial bias, including expanded access to respectful maternal health services that encompass midwifery, doulas, and culturally competent, community-based models of care.
2. Improve government and health system accountability for preventing maternal deaths and eliminating racial disparities and engage communities in data collection and interpretation related to maternal mortality and morbidity and respectful maternity care.
3. Recognize and provide adequate resources to address the social determinants of health, including adequate housing, transportation, nutritious food, clean water and healthy environments, fair treatment within the criminal justice system, safety and freedom from violence, and equal economic opportunity.

E. Religious Refusals of Services and Care

1. Take measures to ensure that laws permitting refusals of care based on religious and moral beliefs guarantee seamless access to reproductive health care, including abortion and contraception, and that measures are put in place to monitor and prevent abuses.

F. Pregnant People in Detention Facilities

1. Ensure that pregnant individuals are only detained or incarcerated if there are no possible and appropriate alternatives and have access to gender responsive health care, including prenatal, emergency, and abortion care, and that policies and procedures regarding housing, work detail, nutrition, transportation, recreation, visitation, and security searches reflect the needs and rights of pregnant people.

2. Ensure that solitary confinement and use of shackles and other forms of restraints are banned throughout pregnancy and during labor, delivery, and post-partum recovery.
3. Ensure that immigration, law enforcement, and correctional officials are properly trained about the rights of people who are pregnant and are held accountable for rights violations.
4. Revoke the “zero-tolerance” policy and halt criminal immigration prosecutions of asylum-seeking families and family separations occurring at the border, including newborns being removed right after birth in nearby hospitals.

G. Helms Amendment and Global Gag

1. Remove Helms restrictions on U.S. foreign aid coverage of safe and legal abortion services and amend the Foreign Assistance Act to ensure that development assistance funds may be used to provide comprehensive reproductive health care information and services.
2. Revoke the Mexico City Policy, also known as the Global Gag Rule, and enact a federal statute that would prevent any future enactment of the policy.

¹ Roe v. Wade, 410 U.S. 113 (1973).

² Whole Woman’s Health v. Hellerstedt, 136 S. Ct. 2292 (2016).

³ Center for Reproductive Rights, *What If Roe Fell: 2019* 15 (Forthcoming Oct. 2019); *Abortion Policy in the Absence of Roe*, GUTTMACHER INST. (Sept. 1, 2019), <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe>; *State Abortion Policy Landscape: From Hostile to Supportive*, GUTTMACHER INST. (Aug. 29, 2019), <https://www.guttmacher.org/article/2019/08/state-abortion-policy-landscape-hostile-supportive>.

⁴ Human Rights Council, *Report of the Working Group on the Universal Periodic Review: United States of America*, para. 176.100, U.N. Doc. A/HRC/30/12 (2015).

⁵ *Id.* at para. 176.164.

⁶ *Id.* at para. 176.313.

⁷ *Id.* at para. 176.314.

⁸ *Id.* at para. 176.316.

⁹ *Id.* at para. 176.317.

¹⁰ U.N. Working Group on Discrimination Against Women in Law and Practice, *Report of the Mission to the United States of America*, para. 90(g), 90(j), 95(h), 95 (e), U.N. Doc. A/HRC/32/44/Add.2 (June 7, 2016).

¹¹ *Id.* at paras. 71, 95(i).

¹² *Id.* at para. 68.

¹³ *Id.* at para. 80.

¹⁴ Human Rights Council, *Report of the Working Group of Experts on People of African Descent, on its Mission to the United States*, paras. 56, 117, UN Doc. A/HRC/33/61/Add.2 (Aug. 18, 2016).

¹⁵ Working Group on Arbitrary Detention, *Rep. of the Working Group on Arbitrary Detention on its visit to the United States of America*, para. 74, U.N. Doc. A/HRC/36/37/Add.2 (July 17, 2017).

¹⁶ Special Rapporteur on extreme poverty and human rights, *Report of the Mission to the United States of America*, para. 57, U.N. Doc. A/HRC/38/33/Add.1 (May, 4, 2018) (by Philip Alston).

¹⁷ *Id.* at para. 56.

¹⁸ *Id.* at para. 59.

¹⁹ *Id.* at para. 56.

²⁰ UN Human Rights Council, *Communication of Special Procedures to the U.S. on Immigration detention of pregnant women*, 3, Ref. OL USA 8/2018 (May 16, 2018), <https://www.ohchr.org/Documents/Issues/Women/WG/Communications/OL-USA-8-2018.pdf>.

²¹ Human Rights Committee, *List of issues prior to submission of the fifth periodic report of the United States of America*, para. 12, U.N. Doc. CCPR/C/USA/QPR/5 (Apr. 18, 2019).

²² 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>.

²³ 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 Sept. 19, 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).

²⁴ *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAMILY FOUND. (Sept. 18, 2019), <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/> (as of September 2019, six states' work requirement waivers were approved and eight states pending); *Taking Away Medicaid for Not Meeting Work Requirements Harms Women*, CTR. ON BUDGET AND POL'Y PRIORITIES (updated March 14, 2019), <https://www.cbpp.org/sites/default/files/atoms/files/5-10-18health-brief-women.pdf>.

The number of people in the United States without health insurance grew by nearly two million in 2018, the first increase since 2014, which some experts attribute, in part, to the Administration's efforts to undermine the ACA. Edward R. Bercheck et al., U.S. Census Bureau, *Health Insurance Coverage in the United States: 2018 Current Population Reports 2* (2019), <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>; *Statement: Census Bureau Data Highlight Trump's Assault on Americans' Access to Health Care, Says CAP's Ben Olinsky*, CTR. FOR AM. PROGRESS (Sept. 10, 2019), <https://www.americanprogress.org/press/statement/2019/09/10/474368/statement-census-bureau-data-highlight-trumps-assault-americans-access-health-care-says-caps-ben-olinsky/>.

²⁵ MEDICAID.GOV: *Healthy Texas Women Section 1115 Demonstration Waiver Application*, TEX. HEALTH & HUMAN SERV. COMM. (June 28, 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>.

²⁶ Patient Protection and Affordable Care Act, § 1557, 42 U.S.C. § 18116 (2010).

²⁷ 45 CFR § 92.4 (2016).

²⁸ Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27846 (proposed June 14, 2019) (to be codified at 42 C.F.R. pt. 92).

²⁹ *Id.*

³⁰ 45 C.F.R. §147.130 (2011).

³¹ 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/>.

³² U.S. Dep't of Health and Human Servs., *Title X Family Planning Annual Report Summary* (last reviewed Aug. 29, 2019), <https://www.hhs.gov/opa/title-x-family-planning/fp-annual-report/fpar-infographic/index.html>.

³³ *Fact Sheet: Title X*, NAT'L FAMILY PLANNING & REPROD. HEALTH ASS'N (Sept. 2018), <https://www.nationalfamilyplanning.org/file/Title-X-101-2018-.pdf>.

³⁴ Title X of the Public Health Service Act, 42 U.S.C. § 300a-6 (1970).

³⁵ HHS Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714-7720 (Mar. 4, 2019) (codified at 42 C.F.R. pt. 59).

³⁶ Pam Belluck, *Planned Parenthood Refuses Federal Funds Over Abortion Restrictions*, N.Y. TIMES (Aug. 19, 2019), <https://www.nytimes.com/2019/08/19/health/planned-parenthood-title-x.html>.

³⁷ *Press Release: Maine Family Planning Withdraws from Title X Family Planning Program Will Not Comply with Trump-Pence Gag Rule*, MAINE FAMILY PLANNING (July 16, 2019), https://mainefamilyplanning.org/wp-content/uploads/2019/07/PressRelease_TitleXWithdrawal.pdf.

On June 21, the Center for Reproductive Rights and Covington & Burling LLP filed an emergency request in federal court to block the Gag Rule on MFP's behalf. The district court denied the motion for a preliminary, as well as a later motion filed to amend the denial of the injunction and for a stay of the gag rule pending appeal. The rule is in effect as ongoing litigation continues. *Family Planning Association of Maine v. United States Department of Health and Human Servs.*, No. 1:19-cv-00100-LEW, 2019 WL 3774619 (D. Me. August 9, 2019); *Family Planning Association of Maine v. United States Department of Health and Human Servs.*, No. 1:19-cv-00100-LEW, 2019 WL 2866832 (D. Me. July 3, 2019).

³⁸ Brittni Frederiksen et al., *Data Note: Impact of New Title X Regulations on Network Participation*, KAISER FAMILY FOUND. (Sept. 20, 2019), <https://www.kff.org/womens-health-policy/issue-brief/data-note-impact-of-new-title-x-regulations-on-network-participation/>.

³⁹ *See* 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/womens-health-policy/issue-brief/new-title-x-regulations-implications-for-women-and-family-planning-providers/>.

⁴⁰ The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) barred undocumented immigrants, as well as immigrants with legal residence who had resided in the U.S. for under five years, from eligibility for "means tested" public benefits, including Medicaid. 8 U.S.C. §§ 1611 et seq. (1996).

⁴¹ Kinsey Hasstedt et al., *Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States*, GUTTMACHER INST. 2(Nov. 26, 2018), https://www.guttmacher.org/sites/default/files/article_files/attachments/immigrant_womens_access_to_sexual_and_reproductive_health_coverage_and_care_in_the_united_states.pdf.

⁴² *Id.* at 4.

⁴³ Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41292(Aug. 14, 2019) (to be codified at 8 C.F.R. pt. 103, 212-4; 245; 258).

⁴⁴ The government defines public charge as "an alien who receives one or more public benefit for more than 12 months in the aggregate within any 36-month period (such that, for instance, receipt of two public benefits in one month counts as two months)" and receipt of the following programs will be considered a heavily negative factor in an immigration status determination, including Medicaid (with limited exceptions, including coverage of an emergency medical condition, coverage of children under 21 and pregnant women up to 60 days postpartum, and certain disability services related to education); the Supplemental Nutrition Assistance Program (SNAP) (formerly "food stamps"); Federal Public Housing, including Section 8 housing vouchers, and Section 8 Project-based Rental Assistance. Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41292, 41295-41297 (Aug. 14, 2019) (to be codified at 8 C.F.R. pt. 103, 212-4; 245; 258).

⁴⁵ *See* Jeanne Batalova et al., *Millions Will Feel Chilling Effects of U.S. Public-Charge Rule That Is Also Likely to Reshape Legal Immigration*, MIGRATION POL'Y INST. (2019), <https://www.migrationpolicy.org/news/chilling-effects-us-public-charge-rule-commentary>.

⁴⁶ Hamutal Bernstein et al., *Brief: One in Seven Adults in Immigrant Families Reported Avoiding Public Benefit Programs in 2018*, URBAN INST. (May 2019), https://www.urban.org/sites/default/files/publication/100270/one_in_seven_adults_in_immigrant_families_reported_avoiding_publi_7.pdf; see also Joan Alker et al., *Nation's Progress on Children's Health Coverage Reverses Course*, GEORGETOWN UNIV. HEALTH POLICY INST. CTR. FOR CHILDREN AND FAMILIES 9 (Nov. 2018), https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018_Final_asof1128743pm.pdf; 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>.

⁴⁷ See Complaint for Declaratory and Injunctive Relief, State of California et al. v. U.S. Dep't of Homeland Security, No. 3:19-cv-04975 (N.D. Cal. Aug. 16, 2019); Complaint for Declaratory and Injunctive Relief, La Clínica de la Raza et al. v. Trump et al., No. 3:19-cv-04980 (N.D. Cal. Aug. 16, 2019); Complaint for Declaratory and Injunctive Relief, State of Washington et al. v. U.S. Dep't of Homeland Security, No. 4:19-cv-05210 (E.D. Wash. Aug. 14, 2019), ECF No. 1; Complaint for Declaratory and Injunctive Relief, City and County of San Francisco and County of Santa Clara v. U.S. Citizenship and Immigration Services et al., No. 3:19-cv-04717 at 2-3 (N.D. Cal. Aug. 13, 2019).

⁴⁸ *State Laws and Policies: Refusing to Provide Health Services*, GUTTMACHER INST. (Sept. 1, 2019), <https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services>.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ The Coats-Snowe Amendment, 42 U.S.C. § 238n, prohibits governmental entities from withholding funding when doctors, medical students, and health training programs refuse to provide or participate in abortion training, abortion services, or referrals. This law does not require a denial of care to be based on moral or religious beliefs. In 1997, Congress expanded entities eligible for religious refusals beyond healthcare providers, allowing managed care plans operating under the federal Medicaid and Medicare programs to opt-out of providing, reimbursing for, or covering a counseling or referral service to which the plan objects on moral or religious grounds. 42 U.S.C. § 1395w-22(j)(3)(B)(Medicare); 42 U.S.C. § 1396u-2(b)(3)(B)(Medicaid). In addition, the Weldon Amendment prohibits governmental entities and recipients of federal funding from “discriminating” against a broad range of healthcare entities for their refusal to provide, pay for, cover, or refer for abortions. See Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, 125 Stat. 786.

⁵² Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 5736 (Nov. 15, 2018) (to be codified at 45 C.F.R. pt. 147).

⁵³ See *California v. Azar*, No. 18-15144, 2018 WL 6566752, at *2, *17 (9th Cir. Dec. 13, 2018) (upholding the preliminary injunction against the interim final rules, but limiting its scope to the five states — California, Delaware, Maryland, New York, and Virginia— that brought the lawsuit in the California district court); *Commonwealth of Pennsylvania v. Trump, et al.*, 281 F.Supp.3d 553 at 30-31 (E.D. Pa. 2017) (issuing a nation-wide preliminary injunction).

⁵⁴ *HHS Announces New Conscience and Religious Freedom Division*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (Jan. 18, 2018), <https://www.hhs.gov/about/news/2018/01/18/hhs-ocr-announces-new-conscience-and-religious-freedom-division.html>.

⁵⁵ See Dalia Sopher, *HHS Division to Enforce 'Conscience and Religious Freedom' When do a clinician's rights deny those of the patient?*, 118 AM. J. OF NURSING 12 (2018); Robert Pear et al., *Trump Gives Health Workers New Religious Liberty Protections*, N.Y. TIMES (Jan. 18, 2018), <https://www.nytimes.com/2018/01/18/us/health-care-office-abortion-contraception.html>.

⁵⁶ Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 Fed. Reg. 23170 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88).

⁵⁷ *Id.*

⁵⁸ See Katie Keith, *Provider Conscience Rule Delayed Due To Lawsuits*, HEALTH AFFAIRS (July 2, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190702.497856/full/>.

⁵⁹ See Julia Kaye et al., *Health Care Denied- Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives*, AM. CIV. LIBERTIES UNION (2016), <https://www.aclu.org/report/report-health-care-denied>; Nat'l Womens Law Ctr., *Below the Radar: Health Care Provider's Religious Refusals Can Endanger*

Pregnant Women's Lives and Health (2011), <https://nwlc-ci49tixgw51bab.stackpathdns.com/wp-content/uploads/2015/08/nwlcbelowtheradar2011.pdf>.

⁶⁰ Amy Littlefield, *A Miscarrying Woman Nearly Died After a Catholic Hospital Sent Her Home Three Times*, REWIRE (Sept. 25, 2019, 9:37 AM), <https://rewire.news/article/2019/09/25/miscarriage-catholic-hospital/>; Christina Caron, *Michigan Pharmacist Refused to Dispense Miscarriage Medication, Citing Religious Beliefs*, N.Y. TIMES (Oct. 18, 2018), <https://www.nytimes.com/2018/10/18/us/catholic-pharmacist-miscarriage.html>; *Fact Sheet: Pharmacy Refusals 101*, NATL. WOMEN'S LAW CTR. (Dec. 28, 2017), <https://nwlc.org/resources/pharmacy-refusals-101/>; Amy Littlefield, *Catholic Rules Forced This Doctor to Watch Her Patient Sicken—Now, She's Speaking Out*, REWIRE (Sept. 7, 2017 at 11:18 a.m.), <https://rewire.news/article/2017/09/07/catholic-rules-forced-doctor-watch-patient-sicken-now-shes-speaking/>; Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774-8 (Oct. 2008).

⁶¹ *Roe v. Wade*, 410 U.S. 113 (1973).

⁶² *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

⁶³ Center for Reproductive Rights, *What If Roe Fell: 2019* 15 (Forthcoming Oct. 2019).

⁶⁴ This number is current as of July 15, 2019, according to legislation tracking and analysis by the Center for Reproductive Rights.

⁶⁵ Alabama, Arkansas, Georgia, Indiana, Iowa, Kansas, Kentucky, Louisiana, Mississippi, Nebraska, 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. (Sept. 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.

⁶⁶ 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 May 30, 2019) (tracking laws restricting abortion at six weeks gestation and ongoing litigation challenging the restrictions).

⁶⁷ H.B. 314, 2019 Leg., Reg. Sess. (Al. 2019). The American Civil Liberties Union, ACLU of Alabama, and Planned Parenthood Federation of America filed a lawsuit challenging the extreme law, as well as a motion to block Alabama's near-total abortion ban while the legal challenge proceeds. The ban is not scheduled to take effect until November 15. *Complaint, Robinson, et al. v. Marshall, et al.*, No. 2:19-cv-00365 (M.D. Ala. May 24, 2019); see also *Press Release: ACLU files request for preliminary injunction in Alabama abortion ban lawsuit*, AM. CIV. LIBERTIES UNION (June 21, 2019), <https://www.aclu.org/press-releases/aclu-files-request-preliminary-injunction-alabama-abortion-ban-lawsuit>.

⁶⁸ Alabama, Arkansas, Indiana, Kansas, Kentucky, Louisiana, Mississippi, Ohio, 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 most are enjoined. See *Bans on Specific Abortion Methods Used After the First Trimester*, GUTTMACHER INST. (Sept. 1, 2019), <https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester>.

⁶⁹ Arkansas, Indiana, Kentucky, Louisiana, Missouri, North Dakota, Ohio, and Utah have all passed laws prohibiting abortions based on a fetal diagnosis, although the provisions have been challenged and most are enjoined. *Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly*, GUTTMACHER INST. (Sept. 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”).

⁷⁰ For an overview of barriers to access and their impact, see *Targeted Regulation of Abortion Providers*, GUTTMACHER INST. (Sept. 1, 2019), <https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers>; *Counseling and Waiting Periods for Abortion*, GUTTMACHER INST. (Sept. 10, 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).

⁷¹ At minimum six states are down to one clinic — Kentucky, Mississippi, Missouri, North Dakota, South Dakota and West Virginia. 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/2018/09/07/us/abortion-supreme-court-arkansas.html>; see also Alice F Cartwright et al., *Identifying National Availability of Abortion Care and Distance From Major US Cities: Systematic Online Search*, 20 J. MED. INTERNET RES. 186 (2018), <https://www.jmir.org/2018/5/e186/> (finding that abortion facilities are not evenly distributed geographically, many large U.S. cities do not have an abortion facility, and that long distances can push women to seek abortion in later gestations when care is even more limited).

⁷² *Communities Need Clinics*, ABORTION CARE NETWORK 8 (2018), <https://www.abortioncarenetwork.org/wp-content/uploads/2019/01/communities-need-clinics-FINAL-2018.pdf>.

⁷³ Patients are also forced to wait longer to access care, may not be able to access the method of their choice, and as a result may increase patients' clinical risks and cost of care. In some cases, patients may not be able to obtain a wanted abortion at all, which studies have shown may have serious consequences on patients' health and wellbeing. *Id.* at 10; Advancing New Standards in Reproductive Health (ANSIRH), Bixby Center for Global Reproductive Health at the University of California, San Francisco, *Turnaway Study*, <https://www.ansirh.org/research/turnaway-study> (last visited Sept. 23, 2019); National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the U.S.* 77 (2018), <http://nationalacademies.org/hmd/reports/2018/the-safety-and-quality-of-abortion-care-in-the-united-states.aspx>.

⁷⁴ See *Communities Need Clinics*, ABORTION CARE NETWORK 3 (2018), <https://www.abortioncarenetwork.org/wp-content/uploads/2019/01/communities-need-clinics-FINAL-2018.pdf>; see also Alyssa Llamas et al., Jacobs Inst. of Women's Health, Geo. Wash. U., *Public Health Impacts of State-level Abortion Restrictions Overview of Research & Policy in the United States* 1, 18 (Apr. 2018), https://publichealth.gwu.edu/sites/default/files/downloads/projects/JIWH/Impacts_of_State_Abortion_Restrictions.pdf; Erin Durkin, *'Women will die': how new abortion bans will harm the most vulnerable*, THE GUARDIAN (May 19, 2019), <https://www.theguardian.com/us-news/2019/may/19/abortion-ban-alabama-women-of-color-poor>; Liza Fuentes, *Latina immigrant women's access to abortion: Insights from interviews with Latina Grasstops Leaders*, NAT'L LATINA INST. FOR REPROD. HEALTH (Sept. 2010), <https://nciwr.files.wordpress.com/2011/01/nlirh-reserach-brief-sept2010-final1.pdf>; see also National Council on Disability, *The Current State of Health Care for People with Disabilities* 51-52, 54-56 (2009), https://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d.pdf; Megan K. Donovan, *In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact*, GUTTMACHER INST. (Jan. 5, 2017), <https://www.guttmacher.org/gpr/2017/01/real-life-federal-restrictions-abortion-coverage-and-women-they-impact>.

⁷⁵ Alina Salganicoff et al., *The Hyde Amendment and Coverage for Abortion Services*, KAISER FAMILY FOUND. (July 30, 2019), <https://www.kff.org/womens-health-policy/issue-brief/the-hyde-amendment-and-coverage-for-abortion-services/>.

⁷⁶ Megan K. Donovan, *In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact*, 20 GUTTMACHER POL'Y REV. 1, 2 (2017), https://www.guttmacher.org/sites/default/files/article_files/gpr2000116.pdf.

⁷⁷ *Id.* at 3; see also National Council on Disability, *The Current State of Health Care for People with Disabilities* 54-56 (2009), https://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d.pdf.

⁷⁸ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227 (proposed Jan. 24, 2019) (to be codified at 45 C.F.R. pt. 156); Patient Protection and Affordable Care Act; Exchange Program Integrity, 83 Fed. Reg. 56015 (proposed Nov. 9, 2018) (to be codified at 45 C.F.R. pt. 156).

⁷⁹ 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).

⁸⁰ See *Garza v. Hargan*, 304 F.Supp.3d 145, 150 (D.D.C. 2018).

⁸¹ *Id.*

⁸² Garza v. Hargan, 874 F.3d 735, 746 (D.C. Cir. 2017), cert. granted and vacated by 138 S. Ct. 1790 (2018).

⁸³ 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/>.

⁸⁴ 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.”).

⁸⁵ 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).

⁸⁶ J.D. v. Azar, 925 F.3d 1291 (D.C. Cir. 2019) (per curiam), aff’g in part, vacating in part Garza v. Hargan, 304 F.Supp.3d 145 (D.C. Cir. 2018) (affirming the District Court ruling on the class cert decision and portions of the preliminary injunction enjoining obstructions to abortion access and vacating ORR’s disclosure to parents and/or sponsors policy and remanding for further findings).

⁸⁷ 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> [hereinafter Roth, *She Doesn’t Deserve to be Treated Like This*].

⁸⁸ *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).

⁸⁹ The United States has a maternal mortality ratio (MMR) of 14, placing the U.S. behind 45 other countries. WORLD HEALTH ORGANIZATION (WHO) ET AL., ESTIMATES BY WHO, UNICEF, UNFPA, WORLD BANK GROUP AND THE UNITED NATIONS POPULATION DIVISION 99-104 (2019), <https://www.unfpa.org/featured-publication/trends-maternal-mortality-2000-2017>.

⁹⁰ Reproductive Health: Pregnancy Mortality Surveillance System, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html> (last reviewed June 4, 2019); 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).

⁹¹ *Id.*

⁹² Emily E. Petersen et al., *Morbidity and Mortality Weekly Report, Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 10, 2019), <https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm>.

⁹³ See Theresa Chalhoub and Kelly Rimar, *The Health Care System and Racial Disparities in Maternal Mortality*, CTR. FOR AM. PROGRESS 2, 3 (May 10, 2018), <https://www.americanprogress.org/issues/women/reports/2018/05/10/450577/health-care-system-racial-disparities-maternal-mortality/>.

⁹⁴ *Morbidity & Mortality Wkly Rep.: Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017*, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w.

⁹⁵ See Francine Coeytaux et al., *Maternal Mortality in the United States: A Human Rights Failure*, 83 CONTRACEPTION 189-93 (2011); Arline T. Geronimus, *The weathering hypothesis and the health of African-American women and infants: evidence and speculations*, 2 ETHNICITY & DISEASE 207-221 (1992), <https://www.ncbi.nlm.nih.gov/pubmed/1467758> (finding a kind of toxic stress triggers the premature deterioration of

the bodies of Black women as a consequence of repeated exposure racial discrimination and that this effect could lead to poor pregnancy outcomes).

⁹⁶ *MMR Map*, REVIEW TO ACTION <http://www.reviewtoaction.org/content/mmr-map> (last visited Sept. 25, 2019).

⁹⁷ Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAMILY FOUND. (Mar. 21, 2019), <http://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>; see also Hannah Katch et al., *Medicaid Works for Women – But Proposed Cuts Would Have Harsh, Disproportionate Impact*, CTR. ON BUDGET AND POL’Y PRIORITIES (May 11, 2017), <https://www.cbpp.org/research/health/medicaid-works-for-women-but-proposed-cuts-would-have-harsh-disproportionate-impact>.

⁹⁸ Samantha Artiga et al., *Health Coverage and Care for Immigrants*, KAISER FAMILY FOUND. (July 11, 2017), <http://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-immigrants/>.

⁹⁹ See Adam Sonfield, *Why Protecting Medicaid Means Protecting Sexual and Reproductive Health*, GUTTMACHER INST. (Mar. 9, 2017), <https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health>.

¹⁰⁰ 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).

¹⁰¹ 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).

¹⁰² *Id.*; see also 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).

¹⁰³ Tina Vasquez, *ICE Increased Risks for Pregnant Migrants in Detention. What Is the Agency Doing About It?*, REWIRE (Apr. 5, 2019, 1:10 PM), <https://rewire.news/article/2019/04/05/ice-increased-risks-pregnant-migrants-detention/>.

¹⁰⁴ Pregnant migrants who have presented themselves at a port of entry are typically turned over to Immigration and Customs Enforcement (ICE) by Border Patrol agents. It is reported that pregnant asylum seekers entering the United States without authorization face a different reality— because the under the Administration’s zero-tolerance policy, federal attorneys have been directed by the Trump administration to accept all those cases by Customs and Border Protection and prosecute them under the U.S. Marshals Service. Tina Vasquez, *Trump Administration Separates Some Migrant Mothers From Their Newborns Before Returning Them to Detention*, REWIRE (May 28, 2019, 8:32am), <https://rewire.news/article/2019/05/28/trump-administration-separates-pregnant-migrants-newborns-before-returning-detention/>; Tina Vasquez, *Meet the Federal Agency Helping to Criminalize Pregnant Migrants*, REWIRE (May 14, 2019, 12:11pm), <https://rewire.news/article/2019/05/14/meet-the-federal-agency-helping-to-criminalize-pregnant-migrants/>.

¹⁰⁵ Tina Vasquez, *Trump Administration Separates Some Migrant Mothers From Their Newborns Before Returning Them to Detention*, REWIRE (May 28, 2019, 8:32am), <https://rewire.news/article/2019/05/28/trump-administration-separates-pregnant-migrants-newborns-before-returning-detention/>.

¹⁰⁶ 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, 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”); 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).

¹⁰⁷ See Tina Vasquez, *OB-GYN Says U.S. Marshals Service Is Shackling Detained Pregnant Migrants*, REWIRE (May 14, 2019, 12:11pm), <https://rewire.news/article/2019/05/14/ob-gyn-says-u-s-marshals-service-is-shackling-detained-pregnant-migrants/>; 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>; see also Jennifer L. Costello, Acting Inspector General, Memorandum for Kevin K. McAleenan, Acting Secretary for Department of Homeland Security: Management Alert- DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley (Redacted), U.S. DEP’T OF HOMELAND SECURITY (July 2, 2019), https://www.oig.dhs.gov/sites/default/files/assets/2019-07/OIG-19-51-Jul19_.pdf (conducting inspections of five Customs and Border Protection (CBP) facilities in south Texas finding squalid conditions in several detention centers for migrant families and children in Texas, including “serious” overcrowding, minors going without hot meals for days and detainees begging not to be returned to their cells; representing an immediate risk to the health and safety of those detained, and DHS agents and officers).

¹⁰⁸ 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.

¹⁰⁹ See Carolyn Sufrin, *The Shameful Neglect of Pregnant Women Behind Bars*, UC PRESS BLOG (Mar. 15, 2018).

¹¹⁰ 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).

¹¹¹ See Ginette G. Ferszt et al., *Where Does Your State Stand on Shackling of Pregnant Incarcerated Women?*, 22 NURSING FOR WOMEN’S HEALTH 17, 18 (2018), [https://nwhjournal.org/article/S1751-4851\(17\)30335-5/pdf](https://nwhjournal.org/article/S1751-4851(17)30335-5/pdf).

¹¹² 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).

¹¹³ 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).

¹¹⁴ See N.Y. CORRECT. LAW § 611 (McKinney 2016).

¹¹⁵ See 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); 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>.

¹¹⁶ See Carolyn Sufrin et al., *Pregnancy Outcomes in US Prisons, 2016–2017*, 100 AM. J. OF PUB. HEALTH 799 (2019), <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2019.305006>.

¹¹⁷ Roth, *She Doesn’t Deserve to Be Treated Like This* at 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, 1:19 PM), <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).

¹¹⁸ Roth, *She Doesn't Deserve to Be Treated Like This* at 8, 10-11 (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).

¹¹⁹ 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).

¹²⁰ 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).

¹²¹ 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).

¹²² 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).

¹²³ 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>.

¹²⁴ See SEC'Y FOR HEALTH AND HUMAN SERVICES ADMIN.'R OF THE U.S. AGENCY FOR INT'L DEV., *THE MEXICO CITY POLICY—MEMORANDUM FOR THE SECRETARY OF STATE* (2017), <https://www.whitehouse.gov/presidential-actions/presidential-memorandum-regarding-mexico-city-policy>; OFFICE OF THE SPOKESPERSON, U.S. DEPT. OF STATE, *PROTECTING LIFE IN GLOBAL HEALTH ASSISTANCE – FACT SHEET* (2017), <https://www.state.gov/protecting-life-in-global-health-assistance-2/>.

¹²⁵ USAID Standard Provisions for Non-U.S. Nongovernmental Organizations, *Protecting Life in Global Health Assistance* RAA29(a)(I)(1) (May 2017), <https://www.usaid.gov/sites/default/files/documents/1868/303mab.pdf>.

¹²⁶ *Id.* at RAA28(a)(II)(1).

¹²⁷ 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).

¹²⁸ See, e.g., Int'l Women's Health Coalition, *Reality Check: Year One Impact of Trump's Global Gag Rule* (2018), https://iwhc.org/wp-content/uploads/2018/05/GGR-Formatted-Report_FINAL.pdf; Population Action Int'l, *Access Denied: Uganda, Preliminary Impacts of Trump's Expanded Global Gag Rule* 5-9 (2018), https://pai.org/wp-content/uploads/2018/03/Access-Denied_Uganda_March-2018.pdf; Population Action Int'l, *Access Denied: Nigeria, Preliminary Impacts of Trump's Expanded Global Gag Rule* 5-9 (2018), <https://pai.org/wp-content/uploads/2018/03/Access-Denied-Nigeria-2.pdf>; Population Action Int'l, *Access Denied: Nepal, Preliminary Impacts of Trump's Expanded Global Gag Rule* 9-14 (2018), <https://pai.org/wp-content/uploads/2018/09/Access-Denied-Nepal-Brochure-V6.pdf>.

¹²⁹ See, e.g., Melvine Ouyo and Alexa Hamilton, *The Effects of the Global Gag Rule Are Being Felt Everywhere*, *REWIRE NEWS*, (Jul. 2, 2018 10:30 AM), <https://rewire.news/article/2018/07/02/effects-global-gag-rule-felt-everywhere/>; Sara Jerving, *Q&A: 'Global gag rule' hits Kenya's largest reproductive health organization*, *DEVEX*, (Jun. 25, 2018), <https://www.devex.com/news/q-a-global-gag-rule-hits-kenya-s-largest-reproductive-health-organization-92967>.

¹³⁰ 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/>.

¹³¹ *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>; 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.

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