

Retrogression in U.S. Reproductive Rights: The Ongoing Fight for Reproductive Autonomy

A Report for the Human Rights Committee

Submitted on September 12, 2023 by the following reproductive rights, health, and justice organizations:

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I. Introduction

The coalition of reproductive rights, health, and justice organizations named above respectfully submits this report to the Human Rights Committee (CCPR) in preparation for its fifth periodic review of the United States of America (hereafter “U.S.” or “United States”). **This report describes a subset of the human rights abuses presently occurring in the U.S. with regard to sexual and reproductive health and rights (SRHR), in violation of U.S. commitments to uphold rights to non-discrimination, gender equality, life, privacy, freedom from torture, cruel, inhuman or degrading treatment or punishment, and to equal protection (articles 2, 3, 6, 7, 17, and 26) under the International Covenant on Civil and Political Rights (ICCPR).**ⁱ

Drawing on the experiences and expertise of individuals and organizations across the U.S. who have been affected or directly harmed by U.S. laws, policies, and practices that infringe on reproductive rights, this coalition report details long-standing inequities and more recent retrogressions. In particular, this report addresses the impact of the Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization* (hereafter “*Dobbs*”) and what taking away a fundamental right to reproductive autonomy and decision-making during pregnancy has meant for both abortion access and maternal health.

The revocation of constitutional rights and subsequent actions by anti-abortion state lawmakers have widened the gap between the U.S. legal framework and human rights standards. This report describes the escalation of obstacles, risks, and cruel outcomes that pregnant people and their healthcare providers now face when seeking or providing care. It also shines a light on the lengths that state officials have gone to scare, disempower, and punish people who facilitate access to abortion care, including individuals who have sought access to justice in lawsuits challenging abortion bans.

This report further demonstrates how abortion care is an essential aspect of maternal healthcare, and that the U.S. approach to maternity care was already rife with inequities and failing to meet human rights standards regarding the accessibility, availability, acceptability, and quality of health services, goods, and facilities. It highlights the systemic racism and intersectional discrimination that drives racial and ethnic inequities in U.S. maternal health, resulting in the highest maternal mortality ratio among wealthy countries. Finally, it addresses how disrespect and abuse or ill treatment in facility-based maternity care settings contributes to adverse outcomes, and how those issues intersect with the marginalization of community-based midwifery care, and the exclusion of people of color from the healthcare workforce.

This report fills gaps in the U.S. government’s report and responds to the Committee’s prior concluding observations and recommendations to the United States. It is intended to assist the Committee in evaluating U.S. progress on implementation of the ICCPR since the last periodic

ⁱ The regression of sexual and reproductive health and rights in the U.S. has been so severe, that the violations described in this report may also implicate or raise concerns about self-determination (article 1), liberty (article 9), incarceration (article 10), liberty of movement (article 12), notice (article 15), freedom of thought (article 18), freedom of expression (article 19), family (article 23), public participation (article 25), and the right of minorities to maintain their own culture (article 27). The panoply of rights implicated underscores how central reproductive autonomy is to the full realization of civil and political rights.

review, and to recommend priorities for the Committee’s interactive dialogue with the U.S. government in Geneva in October 2023.

We urge the Human Rights Committee to condemn violations of reproductive rights during its upcoming periodic review of the United States and to recommend that the U.S. government:

- 1) Halt retrogression of the right to abortion and bring U.S. law, policy, and practice in line with the 2022 WHO Abortion Care Guideline
- 2) Take proactive steps to ensure individuals can access comprehensive reproductive healthcare in their own communities
- 3) Abolish laws that impair an individual’s right to make and act on decisions about their body, sexuality, and reproduction
- 4) Remove legal and practical barriers to community-based midwifery
- 5) Strengthen legal protections for the right to life and non-discrimination and ensure that the U.S. legal framework provides remedies for violations of reproductive autonomy

II. Issue and Testimonials

On two of the most critical indicators of sexual and reproductive health and rights—reducing maternal mortality and the liberalization of abortion laws—the U.S. is a global outlier. Decades of rising maternal mortality rates and a severe regression in legal protections for abortion reflect the alarming truth that many pregnant people in the U.S. do not have the freedom to protect and direct their own lives. The lack of legal protections for reproductive autonomy reflects a widening gap between U.S. law and human rights standards, and forcefully communicates disturbing messages about who the U.S. is willing to recognize and respect. As marginalized groups and individuals in the U.S. know from experience, the mere existence of legal rights is often not sufficient to ensure justice—but their absence can be catastrophic. The following sections describe (1) the legal landscape of U.S. reproductive rights; (2) the state of abortion access and the impact of retrogression; and (3) the state of maternal health and the violations that are normalized when the rights of pregnant, birthing, and postpartum people are neglected, suspended, or outright denied.

1) The U.S. legal framework fails to protect reproductive health and autonomy

a) The rollback of reproductive rights escalated by the U.S. Supreme Court violates principles of non-retrogression and has far reaching consequences for civil and political rights

On June 24, 2022, the U.S. Supreme Court issued a decision in *Dobbs v. Jackson Women’s Health Organization*, reversing nearly 50 years of precedent and concluding that there is no federal constitutional right to abortion.¹ The *Dobbs* decision overruled *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey* and, for the first time in U.S. history, took away a right grounded in personal liberty. The ruling allows anti-abortion politicians to seek to ban or further restrict abortion in individual states and emboldens their push for a nationwide ban.² The Supreme Court’s decision to destroy federal protection for abortion access in the

U.S.—despite evidence of the harm—reflects a callous disregard for the lives of people who can become pregnant.³

The *Dobbs* decision is wrong. It is causing profound harm to individuals and their communities and weakens the power of U.S. law to uphold the nation’s international and domestic human rights obligations. The reasoning in *Dobbs* undermines the very purpose of the Fourteenth Amendment to the U.S. Constitution and threatens many other rights that are embedded in decades of settled precedent.

The Fourteenth Amendment states: “*No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.*”⁴ Ratified in 1868 following the American Civil War, and alongside other amendments of its era, it was meant to address the lasting brutality of slavery and the denial of Black people’s humanity by the framers of the original U.S. Constitution.⁵ Prior to adoption of the Fourteenth Amendment, States had viciously denied enslaved people fundamental aspects of liberty, bodily integrity, and dignity, including through state-sanctioned sexual violence and rape, coerced pregnancy and childbearing, and forced separation of families. To begin to repair that damage, the Fourteenth Amendment guaranteed a right of liberty against state control. That liberty guarantee must include the right of each individual—not the government—to decide whether and when to become pregnant and give birth to a child, and to create and raise a family.⁶

Instead of considering what the Fourteenth Amendment’s promise of liberty means for the lives of women and all who can become pregnant, the *Dobbs* decision sets forth a radically narrow interpretation of the U.S. Constitution that reinforces the historical subordination of marginalized people.⁷ It first notes that the word “abortion” is not in the Constitution’s text. It then states that to decide whether the right to liberty encompasses a right to abortion, the Court must determine if such a right is “deeply rooted in this Nation’s history and tradition.” When applying this method in prior cases—for example, to determine that the right to marry someone of the same sex was “deeply rooted”—the Court had asked about marriage broadly and considered present-day justifications for limiting who can exercise rights. In *Dobbs*, however, the Court significantly narrows the inquiry—stating that to be “deeply rooted,” a fundamental right must have been *positively* endorsed or recognized in 1868, the year the Fourteenth Amendment was adopted. The Court then selectively surveys the history and traditions of the largely wealthy, white, men who shaped the laws at that time—with no acknowledgment of the sexist, racist, and nativist impulses many of those early laws reflect.⁸ Using this flawed historical approach to find that there was no positive right to abortion established in 1868, the Court concludes the Fourteenth Amendment’s liberty guarantee cannot encompass a right to abortion.

Dobbs’ approach rejects extending rights where they were previously denied. Instead, it tethers the scope of rights to a time when the government codified and brutally enforced shameful social inequalities. Because the U.S. *has* a deeply rooted history and tradition of sexism, racism, and other forms of discrimination, women, LGBTQ+ people, people of color, and other marginalized groups will never be able to achieve full and equal rights under a legal framework that preserves and idealizes unjust and exclusionary rules of the past.⁹ As Justices Breyer, Sotomayor, and

Kagan note in dissent, “*When the majority says we must read our foundational charter as viewed at the time of ratification (except that we may also check it against the Dark Ages), it consigns women to second-class citizenship.*”¹⁰

The *Dobbs* Court’s interpretation of the U.S. Constitution widens the gap between U.S. domestic law and international human rights law and violates human rights principles of non-retrogression. As the dissent in *Dobbs* powerfully explains, the right to reproductive autonomy is deeply grounded in the U.S. Constitution and must be extended to cover historically marginalized groups. *Roe* was correct to hold in 1973 that decisions about pregnancy and childbearing rise to the level of constitutional importance, and that the right to abortion is part of the liberty guaranteed by the Fourteenth Amendment.¹¹ And for nearly 50 years after *Roe*, numerous Supreme Court cases correctly built on *Roe* to recognize a variety of rights to make personal decisions about family, relationships, and bodily autonomy. In overturning a fundamental right to abortion, the Supreme Court threatens many of these related rights—including the right to contraception, the right to marriage equality for same-sex and inter-racial couples, and the right to engage in private sexual conduct.¹² The rollback of abortion rights is not only disastrous for pregnant people and those who care for them, but also a warning about the potential for retrogression in other areas of human rights.

b) Restrictions on abortion are incompatible with non-discrimination, gender equality, and maternal health

The *Dobbs* decision is especially devastating to reproductive autonomy because it removed a floor of protection that was insufficient to begin with. *Roe* provided some protection for decision-making during pregnancy, but it also left many people behind. Decades of court decisions and state and federal legislation targeting abortion imposed a web of unnecessary hurdles and financial costs that many people found impossible to overcome. Even before the *Dobbs* decision was issued, reproductive rights, health, and justice advocates could predict the harms that have since materialized—including preventable pregnancy complications and criminalization—because these were harms that many people of color, people with disabilities, immigrants, youth, LGBTQ+ people, and those living in poverty were already facing.¹³

And still, reliance on the right to abortion has been essential to advancing gender equality in the United States. Access to abortion has enabled generations of women to have more control over their lives and futures and to help realize many other rights—better enabling them to pursue personal, educational, and employment opportunities and life goals.¹⁴ The ability to decide if and when to carry a pregnancy has been essential to countering the long history of discrimination that has limited women’s legal, social, and economic progress.¹⁵ For people of color who experience intersectional discrimination on the basis of race, class, and gender, the fight for equality is far from finished, and bodily autonomy is central to that struggle.¹⁶ The same can be said for women with disabilities, and many other pregnant people who experience multiple and intersecting forms of discrimination on the basis of marginalized identities. Taking away an individual’s right to make their own decisions about pregnancy turns back the clock on incremental—but essential—progress and limits the ability of women and other people who can become pregnant to participate fully and equally in society.¹⁷

Finally, *Dobbs* is a blow to sexual and reproductive health and rights broadly, including maternal health, assisted reproduction,¹⁸ contraception, gender affirming care,¹⁹ and more. At its core, the

right to abortion is the right to make personal healthcare decisions that impact one's life, health, and future.²⁰ *Roe* was a floor of legal protection for pregnancy-related decision-making and a moderate restraint on reproductive oppression—a building block for a future where U.S. law might affirmatively and comprehensively protect reproductive autonomy.²¹ By eliminating the right to abortion, the U.S. now forces people to be pregnant and birth in a country that normalizes preventable pregnancy-related deaths and injuries, non-consented care, and mistreatment in the healthcare system; obstructs meaningful options for where, how, and with whom individuals experience birth; and provides little or no legal recourse for these violations.²² If the government can decide that an individual must not end their pregnancy, what other decisions about pregnancy can be overruled and taken from them?

2) Retrogression on abortion rights is escalating discrimination, gender inequality, privacy violations, preventable deaths and illnesses, and is subjecting some pregnant people to torture and cruel treatment

a) *Dobbs* is deepening inequities in abortion access

In the U.S., an individual's reproductive rights and reproductive health outcomes depend heavily on where they live, how much money they have, and whether they face discrimination while seeking to act on their healthcare decisions. This has always been true and has become even more apparent since *Dobbs*, in which the Court claimed that abortion access and regulations should be decided by state-level political processes. But fundamental rights should not be up for debate.

Moreover, attacks on voting rights and democratic norms have made it even more difficult for those who support abortion rights to see their values and priorities represented in the political process.²³ The majority of women age 18-49 in the U.S. believe abortion is a personal choice, did not want *Roe* overturned, and oppose the criminalization of abortion.²⁴ In August 2022, voters in the state of Kansas successfully rejected a state constitutional amendment that would have allowed for a state-wide abortion ban. This resounding vote by the people of Kansas allowed clinics to stay open and provide care to people traveling from across the South and Midwest. As of November 2022, Kansas was home to the closest abortion clinics for 2.7 million people — a 2,039 percent increase from March 1, 2022.²⁵

Nevertheless, in the aftermath of *Dobbs*, fourteen states enforce total or near-total abortion bans, all of which include criminal penalties.²⁶ Many other states are politically hostile to abortion and severely restrict access or have attempted to ban it.²⁷ Abortion bans and restrictions have hit the South and Midwest the hardest. Tens of millions of people in the U.S. now live in states with little or no access to comprehensive abortion care, including many women of reproductive age.²⁸ In states where abortion is legal but neighboring states have banned it, there has been an increase in the number of abortions provided.²⁹

Abortion restrictions disproportionately impact pregnant people who are already facing systemic discrimination, including people of color, low-income people, young people, immigrants, and people with disabilities.³⁰ The majority of abortions in the U.S. are sought by women of color³¹ and about three-fourths are sought by patients who are poor or have low incomes.³² Poverty is deeply intertwined with other forms of discrimination and economic inequality that people of color, immigrants, LGBTQ+ people, people with disabilities, and women and children suffer disproportionately³³

Many people seeking abortion care have to cross multiple states to reach a clinic, sometimes traveling 300 kilometers or more.³⁴ The U.S. is a large country without sufficient public transportation systems and a 6 hour drive in a personal vehicle can take over 19 hours on multiple buses.³⁵ In some cases, it may require airline travel and overnight lodging. In states with complete bans or six-week abortion bans, travel times increased, on average, by more than 4 hours.³⁶ In Texas, the average travel time increased from about 15 minutes to an average of eight hours.³⁷ Travel barriers can be particularly challenging for people with caregiving responsibilities, a disability or illness, immigrants, young people, and individuals experiencing abuse from partners who control their movements and finances. They also raise the cost of obtaining an abortion and can push people farther into pregnancy.

Along with increased travel distances and costs, longer clinic wait times, and a confusing landscape of care, people seeking and providing abortions now face an increased threat of criminalization and surveillance. Some states and localities even seek to restrict abortion access in neighboring states where abortion remains legal. States and localities are proposing or enacting new laws, or threatening to enforce existing laws, to prosecute or impose heavy fines on people who help anyone in a state where abortion is banned access an abortion anywhere—including targeting local roads on which people may drive out of state to access abortion.³⁸ Other laws try to prohibit even wholly out-of-state activity.³⁹ These norm-breaking—and dangerous—legal tactics aim to isolate people seeking abortion, and create chaos for health care providers, pregnant people, and their families and communities.

For more information about the impact of Dobbs on people with disabilities, please see the shadow report submitted to the Human Rights Committee by Women Enabled International and the U.S. Gender and Disability Justice Alliance.

b) Abortion providers are navigating chaotic and challenging conditions as they try to maintain abortion access

In the United States, abortion care is provided institutionally by private physicians' offices, hospitals, and abortion clinics. Although independent abortion care providers represent about 24% of all facilities offering abortion care, they provide 55 percent of all abortion procedures nationwide, with hospitals providing just 3% of abortion care.⁴⁰ All of these medical providers are necessary to ensure access to reproductive healthcare, including abortion.

In 2022, at least forty-two independent abortion clinics closed across the U.S.⁴¹ Even in states where abortion remains legal, there are a limited number of providers willing to provide care in the hostile conditions U.S. politicians have enabled. These human rights defenders struggle to absorb the influx of out-of-state patients while also meeting the health care needs of people in their own communities.⁴²

Kwajelyn Jackson, Executive Director of Feminist Women's Health Center, an independent abortion clinic in the state of Georgia (in the Southern United States), describes what it has been like to try to help people seeking abortion as the laws in her state, and those surrounding it, change:

"Abortion care has been difficult to access in Georgia and across the South for a very long time. But in the year since the Supreme Court's callous decision, we have watched people experience harm and disregard even greater than we had anticipated. As Southern

*and Midwestern states watched in horror as their rights to healthcare were stripped away overnight, for a brief moment, about 3 weeks, Georgia remained a buoy in the Southeast. Our staff received hundreds of desperate phone calls from people who felt scared and angry and abandoned by their states. But on July 20, 2022, when Georgia's 6-week ban took effect, compassion and care were once again taken from thousands of people in desperate situations. We had to call patients with already scheduled appointments and disappoint them again. Forcing them to start this complicated and increasingly dangerous process all over again, start pulling together even more money, take more time off work, and potentially risk harm to their health or safety. Our patients have already had to navigate all of these challenges and more for many years, but now have an even shorter window of time to reach needed and necessary care. And still, surrounded by states with zero access to abortion and no exceptions, Georgia has tried to be a beacon. We see as many patients as we can, as early in their pregnancies as we can, and it breaks our hearts each time we have to turn someone away."*⁴³

When abortion providers are criminalized and clinics are forced to close, entire communities lose centers of care and expertise. Not only do people lose abortion services, but they may also lose access to trusted healthcare providers who do wellness checks, prescribe birth control, diagnose and treat sexually transmitted infections, provide gender-affirming care, midwifery, comprehensive pregnancy care, or offer other forms of primary or preventative healthcare. Moreover, as the following sections demonstrate, abortion restrictions that force experts in routine reproductive healthcare to close their clinics or leave the state also prevent pregnant people from receiving appropriate care in emergencies—including in hospitals.

c) Exceptions to abortion bans are not preventing human rights violations

Although the abortion bans in effect since *Dobbs* typically include some exceptions, these exceptions do not adequately protect human rights and fail to provide even the limited protections they purport to include. Twenty-two states with abortion restrictions have an exception for the life of the pregnant person, 16 states have a health exception, 8 states have an exception for rape and incest, and 7 states have explicit exceptions for a fatal “fetal anomaly.”⁴⁴ Many state legislatures have passed multiple abortion bans and restrictions, with conflicting definitions and requirements. These laws’ attempts to define “exceptions” are too vague and inconsistent with medical terminology. As a result, providers are caught between their duty to provide quality care to patients and the risk that they might face fines, jail time, and loss of their professional licenses for doing so. Thus, even when exceptions for the life or health of the pregnant person are included in state laws prohibiting abortion, these laws are still commonly referred to in the U.S. as “bans” because, in practice, that is how they function.

i. Even with exceptions, abortion bans restrain healthcare providers from offering information and the standard of care to all patients

In late 2022, researchers posing as prospective patients contacted 34 hospitals in Oklahoma and asked them about their policies for emergency obstetric care. Oklahoma prohibits abortion, except when “necessary to preserve” the life of a pregnant person. Some of the hospitals contacted provided factually incorrect information. One hospital representative told the caller that the pregnant patient’s body would be used as an “incubator” to carry the baby as long as

possible. None provided clear information about obstetric emergencies that supported a clinician’s ability to protect their patients. As this research in Oklahoma demonstrates, narrow exceptions to abortion bans such as “only to save the life” of the pregnant person stoke uncertainty and fear for pregnant people, health care providers, and hospital decision-makers.⁴⁵

In a national survey of U.S. OBGYNs conducted in 2023, 68% said the *Dobbs* ruling has worsened their ability to manage pregnancy-related emergencies and the majority believed it had worsened pregnancy-related mortality, as well as racial and ethnic inequities in maternal health. More than half of OBGYNs in states with gestational limits or abortion bans are concerned about their own legal risk when making decisions about patient care and the necessity of abortion. In states where abortion is banned, half of OBGYNs said they have had patients in their practice who were unable to obtain an abortion they sought and 30% do not provide their patients with any information about abortion or offer referrals to another clinician.⁴⁶

Many OBGYNs in states with abortion bans are moving to other states because they can no longer adequately treat pregnant patients without great legal risk, exacerbating the shortage of maternity healthcare providers and forcing pregnant people to travel further and wait longer periods to see a physician.⁴⁷

For more information about the impact of Dobbs on abortion providers, please see two other joint shadow reports submitted to the Human Rights Committee by (1) Lift Louisiana, RH Impact, Center for Reproductive Rights and Physicians for Human Rights; and (2) Ipas, RH Impact, Global Justice Center, and Obstetricians for Reproductive Justice.

Although maternal mortality data is not yet published for 2022 and 2023, many people expect rates to rise as a result of *Dobbs*.⁴⁸ In the years before *Dobbs*, U.S. data trends show that—compared to states where abortion is accessible—states that have banned, are planning to ban, or have otherwise restricted abortion have fewer maternity care providers and higher rates of maternal and infant mortality.⁴⁹ And, although people may safely end their own pregnancies outside the medical system (“self-managed abortion”), not everyone will be able to access the information, medications, and support they need to do so.⁵⁰ The World Health Organization’s Abortion Care Guideline confirms this, noting that between 4.7% and 13.2% of global maternal deaths are attributed to unsafe abortions.⁵¹ The proportion of unsafe abortions is significantly higher in countries with highly restrictive abortion laws than in those with less restrictive laws.

ii. The experiences of pregnant people in Texas demonstrate that abortion bans and restrictions threaten pregnant people’s right to life and freedom from torture, cruel, inhuman or degrading treatment or punishment

In a lawsuit filed by the Center for Reproductive Rights this year against the state of Texas, *Zurawski v. State of Texas*, doctors and patients describe the confusion, fear, pain, and suffering they have endured because of the state’s abortion ban—despite its exception for “medical emergencies.”⁵² The OBGYN plaintiffs in the *Zurawski* case argue that Texas’ abortion bans interfere with their ability to provide pregnant people with the standard of medical care. Physicians who provide abortion care that does not meet the state’s confusing “medical emergency” exception face fines of at least \$100,000, up to 99 years in prison, and loss of their state medical license. The patient plaintiffs in the case describe how Texas’ abortion bans have caused them preventable physical and psychological harm.⁵³

Amanda Zurawski nearly died because of a delay in care caused by Texas' abortion bans:

Amanda underwent a year and a half of fertility treatment to become pregnant. Seventeen weeks into the pregnancy that she wanted so much, she was diagnosed with weak cervical tissue and her water broke. There was no chance that her fetus would survive at this stage of pregnancy. Amanda went to a hospital and was told that she could not have an abortion—the standard of care in her situation—because she did not have an acute infection. Birth might take hours, days, or weeks. She was advised to stay within 15 mins of a hospital and decided not to risk traveling 11 hours to the closest state where she could get an appointment. Two days later, she was septic (suffering a life-threatening reaction to infection), and the hospital agreed to induce labor and provide the abortion she needed to save her life. Amanda gave birth and her baby, Willow, did not survive. Amanda's condition continued to deteriorate and she spent three days in the intensive care unit (ICU). Her family members flew to Texas, fearing it would be the last time they saw her. Amanda survived, with her life and body forever changed. The infections caused severe scar tissue to form on her uterus and fallopian tubes, requiring additional medical procedures. One of Amanda's fallopian tubes is now permanently closed, threatening her fertility.⁵⁴

Kiersten Hogan was denied treatment, detained in a hospital, and threatened with criminal penalties when her water broke early:

Kiersten was in an abusive relationship when she discovered her pregnancy, but after multiple miscarriages, she thought this might be her only chance to become a mother. She left the relationship, moved, and found a new job. Then her water broke early. Emergency responders took her to a nearby hospital where she was told she must wait until she got sicker or went into labor. Hospital staff informed her that if she tried to leave, she could be arrested for trying to kill her baby. Nurses watched her use the bathroom to make sure she didn't push and reminded her repeatedly that she was alone and unmarried, but did not tell her much about her fetus' chance of survival. Even though she declined religious counseling, the hospital told her it would be good for her and sent a religious person to "guide" her. After four days, Kiersten gave birth to a stillborn son. She named him Eamon Blake. Less than 24 hours afterwards "they came in with a wheelchair and all my belongings, and sent me home with papers saying that I was cleared to return to work the next day – as if nothing had happened." In Kiersten's own words: "I was made to feel less than human. Texas law caused me to be detained against my will for five days and treated like a criminal, all during the most traumatic and heartbreaking experience of my life. This shouldn't happen to anyone no matter who they are or where they live. So much was taken away from me."⁵⁵

Kylie Beaton was forced to have a cesarian section and watch her baby die:

Kylie is the mother of a four-year-old daughter and underwent fertility treatment to become pregnant again. During an anatomy scan 20 weeks into her pregnancy, Kylie's obstetrician diagnosed the fetus with alobar holoprosencephaly, a condition where the brain does not develop as it typically does. A specialist explained to Kylie that the baby would die shortly after birth and that the fetus' head would be larger than expected for its

gestational age. Before Texas' law changed, doctors would have been able to perform an abortion. Kylie and her husband looked for care in other states and made an appointment. But because her fetus' head was a size typically seen later in pregnancy, Kylie was also affected by gestational restrictions in other states and had to cancel her appointment. After searching for care across the country, Kylie realized she would be forced to continue the pregnancy. At 28 weeks, the fetus was the size of a full-term baby and Kylie begged her doctors to induce her so she could have a vaginal birth. Her doctors said they could not because of Texas' abortion law. At 35 weeks, Kylie was in severe pain and had an emergency cesarian surgery, involving a large incision. She named her baby Grant. For the next four days, Kylie watched her son slowly die. He cried and could not eat. He could not be held upright or sit in a car seat because doing so would put too much pressure on his head. On the fourth day, Kylie took Grant home and she and her husband held him for the next several hours as his breathing became labored and he grew cold. He passed that night. Kylie has been recovering from the preventable surgery and coping with grief. She is 33 years old and will have to wait at least a year before trying to become pregnant again. Her daughter still asks about Grant.⁵⁶

Samantha Casiano was forced to continue her pregnancy after a fetal diagnosis of anencephaly:

Samantha was 20 weeks pregnant when her fetus was diagnosed with anencephaly.⁵⁷ Samantha was devastated. Her doctor told her that she had no options and gave her a prescription for an anti-depressant and a list of funeral homes. Knowing that her baby would not live, Samantha "wanted to be able to put her daughter to rest earlier" and spare them both additional suffering. Samantha and her partner called abortion clinics in other states and quickly realized that it would be financially impossible to make the trip. They were already raising five children in a mobile home. To travel out of state for abortion care, Samantha would need somewhere to stay, a car, and a way to pay for the procedure, none of which she had. Her family only has one car that her partner uses to drive an hour and half to work every day. And she could not miss work or find childcare for her children. She also feared she or her partner would be breaking the law if they tried to leave the state for an abortion. As months passed, Samantha endured the growing physical demands of pregnancy, along with the emotional toll of carrying a fetus that she knew would be stillborn or die shortly after birth. She had to repeatedly tell people who congratulated her that her baby would not survive and she worried about how she would afford the inevitable funeral. Samantha eventually gave birth to a daughter, who she named Halo. Halo lived for four hours, gasping for air and eventually turning cold in Samantha's arms.⁵⁸ Samantha later testified in court "I just kept telling myself and my baby that I'm so sorry that this has happened to you. I felt so bad. She had no mercy. There was no mercy there for her."⁵⁹

These women have each personally suffered extensive harm because of Texas's abortion laws and have sought clarification of the medical exception through the courts. In doing so, they have also made others more aware of the damage abortion bans are causing. Texas has responded to these efforts with radical callousness. Not only has the state denied the women access to healthcare, but it is intent on punishing them for seeking access to justice too. In a brief requesting that the judge dismiss the case, attorneys for Texas accuse the plaintiffs of participating in "splashy news conferences" and argue that Texas courts are not the proper venue

for them to “tell their stories.”⁶⁰ They attacked the plaintiff’s legal right to sue (“standing”), claiming that repetition of the harm is only hypothetical because some of the women—whose fertility is now compromised due to being denied abortions— are unlikely to become pregnant again. They have also complained about an online fundraiser for Samantha, the low-income mom who could not afford her daughter’s funeral.⁶¹

When the judge allowed the case to continue to a hearing, attorneys for the state aggressively cross-examined the patient plaintiffs in court, stating that all these tragedies were in the past, blaming the patient’s doctors, and even badgering Samantha about her history of depression and use of anti-depressants.⁶² Samantha became physically ill while testifying in court, and Amanda remarked to the press afterwards, “I survived sepsis and I don’t think today was much less traumatic than that.”⁶³

This cruel, inhuman and degrading treatment is not limited to Texas. Pregnant people are experiencing similar devastating harms to their health and loss of human rights in states across the U.S. that have banned abortion.

d) Abortion bans and restrictions cause harm every day, and not just in emergencies

For many people, and for many different reasons, abortion is essential. For every instance where someone is denied abortion care in an emergency, there are many more individuals who simply decide that abortion is right for them but face overwhelming barriers to acting on that decision. The obstacles and stigma that abortion bans and restrictions perpetuate routinely undermine the equality, privacy, and well-being of all these individuals.

The largest study of women’s experiences with abortion and unwanted pregnancy in the U.S.—“The Turnaway Study”—found that women who wanted an abortion and were denied one were more likely to experience death, serious pregnancy complications, poor health, and chronic pain.⁶⁴ They were also more likely to experience household poverty, stay tethered to an abusive partner, and the children they already had showed worse child development compared to the children of women who obtained abortion care.⁶⁵ People of color and other populations that are already facing social, economic, and health inequities cannot afford the many ways that denial of abortion access amplifies their marginalization.⁶⁶

Government sanctioned stigmatization of reproductive health also contributes to an environment in which patients and their healthcare providers are routinely exposed to privacy violations and harassment at work, on their way to health appointments, in their communities, and in online spaces where they seek or share information.⁶⁷ Laws that restrict abortion access send the message that abortion is distinct from “normal” healthcare, and that people who seek to end a pregnancy deserve to suffer in the process.⁶⁸ Even when patients are ultimately able to overcome these obstacles and obtain an abortion, lawmakers have ensured that they will face some harm while navigating a process designed to punish and condemn their decision.⁶⁹ By targeting people who seek abortion care, people who provide it, and those who facilitate access for others, abortion bans are isolating pregnant people, cultivating a climate of fear around reproductive health, and chilling the networks on which that pregnant people rely for information and support.

Finally, laws that criminalize abortion further normalize the idea that pregnant people’s most fundamental rights can be modified or suspended, and they extend the reach of a criminal justice

system that is already notorious for discrimination against people of color. The criminalization of reproductive healthcare also amplifies concerns about the way that healthcare sites can facilitate surveillance and control, making it difficult for marginalized communities to access quality care and trust healthcare providers who may be encouraged to police and punish them.

For a detailed discussion of the criminalization of abortion, please see the joint shadow report submitted to the Human Rights Committee by the Human Rights and Gender Justice Clinic, CUNY School of Law, Pregnancy Justice, and If/When/How: Lawyering for Reproductive Justice.

3) The U.S. is forcing people to continue pregnancies amidst a maternal health crisis

a) Maternal mortality and morbidity are already unacceptably high and disproportionately harm Black and Indigenous people

The U.S. has the highest maternal mortality ratio among wealthy countries.⁷⁰ While maternal mortality is declining in most countries, it is rising in the U.S. and disproportionately threatens the lives of women of color.⁷¹ Regardless of income or education, Black and Indigenous women are 2-3 times more likely to die of pregnancy-related causes than white women are, and recent data⁷² indicates that Native Hawaiians and other Pacific Islander people have the highest rates of all.⁷³ The majority of these deaths are preventable.⁷⁴

Maternal mortality is the extreme end of a spectrum of harms that people in the U.S. face during pregnancy, birth, and postpartum. For every maternal death in the U.S., many more people will experience a life-threatening pregnancy complication and survive.⁷⁵ Maternal morbidity can include traumatic injuries and illnesses that result in short or long-term disability.⁷⁶ Like maternal mortality, maternal morbidity has been rising in the U.S. and disproportionately affects women of color, particularly Black and Hispanic women.⁷⁷

Maternal health outcomes are both a form and a symptom of discrimination in the United States.⁷⁸ They expose the country's complacency with gender inequality and systemic racism, and its unwillingness to repair a broken healthcare system. For decades, the U.S. has failed to adequately intervene in pregnancy-related deaths, normalizing gender stereotypes that objectify women as vessels for reproduction, meant to suffer and sacrifice through pregnancy. And by tolerating racial and ethnic disparities in who survives the effort to carry a pregnancy or build a family, the U.S. reinforces white supremacy, making clear whose lives matter most.⁷⁹

b) Many people lack available, accessible, acceptable, quality healthcare—before, during, and after pregnancy

To obtain healthcare, pregnant people in the U.S. must navigate expensive, complex, and fragmented healthcare delivery and payment systems.⁸⁰ By placing many of the burdens of healthcare access and coordination on patients, the U.S. healthcare system exacerbates inequities and barriers to care.⁸¹ And while public insurance (Medicaid) is available to many low-income people during pregnancy, many providers do not accept it and in some states, the coverage ends just 60 days after the pregnancy does⁸²—despite a growing proportion of maternal deaths occurring during the first year postpartum.⁸³

Moreover, the U.S. healthcare system segregates many women of color by poverty, location, or insurance status.⁸⁴ Nearly half of all U.S. counties lack an obstetric provider and hospitals that provide critical maternity and emergency care to rural areas, Native Americans, and communities of color are closing across the country.⁸⁵ The hospitals that primarily serve Black patients provide lower quality care and have worse maternal health outcomes.⁸⁶ Indian Health Service hospitals—which are responsible for providing federal health services to American Indians and Alaska Natives—have also been found to provide low quality labor and delivery care, including failure to follow national clinical guidelines and best practices.⁸⁷ Physicians and nurses of color are significantly underrepresented in the healthcare workforce, and many women of color never have an opportunity to be cared for by someone who shares their racial or cultural background.⁸⁸

c) Mistreatment in U.S. maternity care settings is normalized

The devaluation of women and people of color increases the risk of abuse and neglect in maternity care facilities.⁸⁹ Because discrimination is both normalized and denied in the U.S., government actors, healthcare professionals, and sometimes even patients themselves overlook or accept many instances of mistreatment and violence in maternity care.⁹⁰ Women in hospital labor and delivery units are routinely objectified, treated as bodies from which babies will be extracted, rather than respected as the authority and ultimate decision-maker in the physiological process of birth their body is undergoing.⁹¹ For pregnant people of color, the risks of objectification and violence are heightened.⁹²

Women of color's pregnancy and birth experiences too often include being humiliated, verbally abused, coerced, threatened, restricted to a hospital bed during labor, forced to birth without a companion, treated as teaching aids for medical students, racially profiled for drug testing and referral to child welfare authorities, forced into procedures, denied information and the opportunity to give or refuse consent, denied care and pain medication, and having police or hospital security called on them for acts of self-advocacy.⁹³

A survey of U.S. maternity care patients found that nearly 1 in 5 women participating, and 1 in 3 women of color, reported being mistreated.⁹⁴ That nearly half of patients surveyed also held back from asking questions or sharing concerns further highlights the pervasive disempowerment of pregnant and birthing people that characterizes U.S. maternity care.⁹⁵

d) Criminalization of midwifery care undermines reproductive health and autonomy

An individual's power to decide where, how, and with whom they experience pregnancy care and childbirth is a critical exercise of bodily autonomy. All pregnancies and all birth settings come with risks and benefits that the pregnant or birthing person must have the opportunity to learn about and weigh for themselves.⁹⁶ For some people, birthing in community settings with a midwife is a way to ensure they experience birth in a place that feels comfortable and safe to them, and allows them to more easily incorporate family members, loved ones, and cultural or religious practices. For people who have experienced traumatic births in facility-based birth settings, planning a birth at home or in a birth center with a trusted midwife may also help heal or mitigate trauma.

Midwives provide skilled, compassionate care for people during pregnancy, birth, and postpartum.⁹⁷ The midwifery model of care approaches birth as a natural process, rather than a pathology, and upholds the birthing person's right to make informed, autonomous decisions.⁹⁸

Unlike many other wealthy nations where midwives provide maternal healthcare for most people giving birth, the U.S. has marginalized midwifery care by imposing medically unnecessary legal and financial barriers and has created a patchwork of laws that vary from state to state.⁹⁹ Restrictive licensure requirements and regulations can make it difficult or impossible for midwives to practice in their communities. For many pregnant people, these restrictions make birthing with a surgeon in the nearest hospital (which may be far) their only option.

Legal restrictions on midwifery are rooted in racism and economic competition.¹⁰⁰ The initial campaigns to limit who could practice midwifery and what midwifery could entail relied on racist propaganda targeting Black, Indigenous, and immigrant midwives.¹⁰¹ According to legal scholar Michelle Goodwin, “[s]killed Black midwives represented both real competition for white men who sought to enter the practice of child delivery, and a threat to how obstetricians viewed themselves.”¹⁰² To eliminate competition from midwives, “[s]uccessful racist and misogynistic smear campaigns, cleverly designed for political persuasion and to achieve legal reform, described Black midwives as unhygienic, barbarous, ineffective, non-scientific, dangerous, and unprofessional.”¹⁰³ Seeking financial gains, recognition, and a monopoly, “[g]ynecologists pushed women out of the field of reproductive health by lobbying state legislatures to ban midwifery [...]. Doing so not only undercut women’s reproductive health, but also drove qualified Black women out of medical services.”¹⁰⁴

e) Criminalization of midwives disproportionately harms Black and Indigenous communities

Despite a long “history and tradition” of midwifery, communities of color in the U.S. have been denied the right to continue much needed, culturally affirming maternal healthcare practices because of laws and policies that restrict many midwives from lawfully providing services. These restrictions harm midwives, midwifery students, and pregnant people seeking care. In many states, Black and Indigenous midwives with a demonstrated record of providing respectful, life-saving healthcare have seen midwifery laws change over the course of their career, and now face punishment if they continue to serve their communities. Women of color who wish to learn midwifery skills face numerous barriers to entering the profession. And as pandemics, climate disasters, and other emergencies strain health and hospital systems, millions of people continue to need safe places to birth and access pregnancy-related care.¹⁰⁵

Jamarah Amani’s path to midwifery demonstrates how unnecessary restrictions on midwifery care negatively impact Black midwives and Black birthing people:

Jamarah was living in the state of Georgia when her interest in midwifery began. Her first midwifery teacher was an elder midwife who was carrying on the traditions of prior generations—specifically, the traditions of Black women known as “grand midwives,” who had once provided the majority of maternal healthcare in the Southern U.S. Jamarah’s mentor was deeply knowledgeable about pregnancy and childbirth, and highly respected by the families she served—but she was also practicing under threat of criminalization. In Georgia, the only individuals who can obtain a midwifery license are advanced practice registered nurses who specialize in reproductive health (certified nurse midwives) and are trained to work in hospitals. It wasn’t always that way. Jamarah’s mentor had seen these laws evolve and narrow over the course of her own career and advised Jamarah to continue learning in a state with less restrictive laws,

where Jamarah could become licensed and would be free to practice openly. Jamarah moved to the neighboring state of Florida where she attended direct-entry (non-nursing) midwifery school, obtained a midwifery license, and built a career providing respectful, culturally competent care, primarily to Black families. Jamarah's midwifery services reach some of the most vulnerable pregnant people, including girls and low-income families she connects with through a mobile clinic. She is a recognized leader in the field of midwifery and birth justice. And still, she is not permitted to provide her services in Georgia. The inequity of this legal framework has real consequences for Jamarah, and her clients. For example, during Hurricane Irma, Jamarah and her family were forced to evacuate. Like many Floridians, they fled north, to Georgia. One of Jamarah's clients was also temporarily in Georgia because of the storm and was due to give birth any day. Jamarah had to inform her client that, in addition to the many other distressing conditions she was navigating, she might not have continuity of care from her preferred provider or access to a birth center because Jamarah was prohibited from assisting her in that state. Georgia has a shortage of maternity care providers and some of the highest maternal mortality rates in the country, yet it refuses to allow certain types of skilled midwives to practice within its jurisdiction.¹⁰⁶

In Hawai'i,ⁱⁱ a recent change in the state's midwifery licensure law is threatening access to maternal healthcare, with particularly devastating implications for Native Hawaiians. In 2019, Hawai'i passed Act 32, which requires midwives in the state to be licensed and sets forth requirements that exclude most midwives trained in a traditional apprenticeship model.¹⁰⁷ The formal education programs that meet Act 32's standards are not located in the state, and none of the midwives currently licensed under Act 32 appear to identify themselves as Native Hawaiian. While Act 32 contains some language referencing possible exceptions for Native Hawaiian cultural practices, the extent to which these exceptions include midwifery, rather than other healing practices that can be incorporated into midwifery, is unclear. A Native Hawaiian midwife who attempted to follow the process described in the law for an exception was denied recognition. Moreover, Act 32 prohibits those without a midwifery license from using the title "midwife," and practicing without a required license is a crime.¹⁰⁸ When Act 32's exemption for "birth attendants" to practice midwifery without a license expired on July 1, 2023, many families, midwives, and midwifery students were thrown into a state of uncertainty and fear.

An investigation by the Center for Reproductive Rights found that Native Hawaiian and Black families in Hawai'i have inadequate access to respectful maternity care and that the recent criminalization of traditional midwives will exacerbate this reality.¹⁰⁹ In interviews with the Center, pregnant and postpartum women described the difficulty of finding available obstetricians and reaching care at health clinics and hospitals. For families that live in rural areas, the distance to a hospital can be hours by car or even an airplane flight away. Many of the pregnant people interviewed see community-based midwives as complementary to other types of healthcare and want the option of reaching out to traditional midwives for advice, culturally tailored care, and support with home births:

ⁱⁱ The state of Hawai'i includes a group of volcanic islands in the Pacific Ocean, more than 3,000km from the U.S. mainland.

One mother (A.O.) described having to temporarily relocate to another island five weeks before her due date in order to be close to the hospital, a situation that separated her from her child and husband, and left her feeling isolated, stressed, and unable to advocate for herself during the birth and postpartum. When another mother, M.M. gave birth in a hospital, an obstetrician told her she needed to be induced because “she can’t just keep a bed.” The healthcare practice that M.M. received services from has since announced that they are discontinuing obstetrics services, leaving her with few alternatives. Other individuals described having to hide their interest in accessing midwifery care or having a home birth from obstetricians who refuse to work with such patients. For example, D.D. was made to sign a contract saying that she would give birth in a hospital and after birthing at home instead, her obstetrician called to tell her that she could never be seen at that health center again. Several mothers reported other coercive or punitive measures, including obstetricians threatening to report Black and brown women to child welfare authorities if they miss prenatal appointments, are deemed “difficult” for asserting their rights to bodily autonomy and informed consent, or if they birth at home.

Several individuals described how access to a traditional midwife made them feel safe and supported as they navigated pregnancy, birth, and the postpartum period. For some, this was in contrast to mistreatment they had experienced in more medicalized birth settings. For others, it was simply an empowering option that they chose again and again because it worked well for them and they didn’t need the emergency care and interventions provided by surgeons and hospitals.

Women who had previously received care from midwives now criminalized by Act 32 described learning valuable information about their health and bodies that will benefit them for years to come. M.M. noted that under the care of her midwife, “you really learn how to care for yourself and your baby, and how to take on that responsibility.” G.G. appreciated that her traditional Native Hawaiian midwife provided traditional massage and advice on diet and exercise that included traditional cultural foods. She reflected that her midwife gave her the kind of care she wanted, “she also stopped doing something if I asked her to,” and “she was there whenever I needed her.” S.K. also noted that her midwife was attentive while also respecting her autonomy. She “kept me as much in control as you can be in that situation.” S.D. appreciated that her traditional midwife was experienced with birth, knew when to advise S.D. to go to the hospital, and provided the support she needed to have the birth experience S.D. desired. D.D. shared how important it was that her traditional Native Hawaiian midwife came to her, despite a long, somewhat dangerous drive, so that D.D. could labor safely at home with her family and receive compassionate postpartum care there as well. And S.K. found it helpful that her midwife engaged her partner and family members in supporting her pregnancy and preparing for the birth, including teaching them about the process and ceremony, and about food medicines her husband could gather.

Many of the individuals interviewed view birth as a moment of great cultural significance and traditional midwifery care as key to revitalizing both culture and health. Mothers spoke of the harmful impact that the U.S. takeover of the Hawaiian kingdom and repression of Native Hawaiian cultural practices has had on Native Hawaiians’ health and well-being and saw culturally aligned, traditional midwifery care as key to self-determination. This sentiment was

shared by other women of color who found culturally affirming traditional midwifery care to be essential for similar reasons related to mitigating discrimination and amplifying the joys of cultural connection.

As midwifery student W.W. observes, “how we come into this world is the beginning and start of how we live a culture.” W.W. lives on her ancestral land, where her ancestors were also born. W.W. believes that by imposing a ban on traditional midwifery practices, the government is violating her right to “do as we did on our own land before we were even a part of the U.S. If I am blessed to have a great-grandchild, I should be able to help birth my great-grandchild on our property.” Traditional Native Hawaiian midwife L.T. explained that midwives are restoring traditions by helping families prepare for and safely practice traditional pregnancy and birth customs. L.T. noted that by effectively allowing only midwives trained outside Hawaii to practice, Act 32 threatens to regulate traditional Native Hawaiian midwifery out of existence. For D.D., Act 32 represents another Native Hawaiian practice “being stripped away... [our] language was revitalized, but it’ll never be back to where it was before; hula [Hawaiian dance] was once stripped away; land has been stripped away; now it’s reproductive rights. When it’s gone, it’ll be much harder to bring back.” S.K. likened the criminalization of traditional midwives to burning down a library: “knowledge is erased when you criminalize what they are doing.” And D.A. described her resolve and her exhaustion with resistance: “with our language, we fought hard to get that back; we fight for the aina/land back, the wai/water back; but where is the fighting when it comes to our wahine/women and birth practices? That should be at the forefront.”

Traditional midwives are caught between a desire to address the unmet needs of their communities and a legal framework that prohibits them from doing so:

Ki‘inaniokalani Kaho‘ohanohano (“Ki‘i”) trained as a midwife, has practiced as a midwife, is known to her community as a midwife, and before Act 32, was able to lawfully identify herself as a midwife. Families that have worked with Ki‘i describe her as knowledgeable, and the care she provided them as transformative. But on July 1, 2023, when Act 32’s “birth attendant” exception expired, Ki‘i was put in the heartbreaking situation of having to turn families away. Then, on August 8, 2023, a wildfire swept through Lahaina, Maui, destroying the historic town, displacing thousands, and killing and injuring over 100 people, with many still missing.¹¹⁰ In the aftermath, community members—including unlicensed midwives—have stepped up to assist those most affected by the fire. Ki‘i has been helping to distribute supplies and information to families, and has been offering the traditional healing practices that she is legally permitted to share, including Lomi Lomi (massage), free to pregnant people on Maui. In the midst of trauma and crisis, when it is apparent that her midwifery skills are also urgently needed, Ki‘i has had to consider Act 32’s restrictions and guess at how much support for pregnant people the government might consider too much. Grieving the loss of her own loved ones and the devastation to her community, Ki‘i wonders, “why do we need permission to help our people and get them what they need?”

Pregnant people are also suffering:

D.D is due to give birth in September and feels stuck. “It’s really tough to not know what will happen—I just only want a home birth, but I’m afraid to get (my midwife) in trouble, and for myself to get in trouble too. Women should give birth in the spaces and places that they feel most comfortable—I just don’t understand why that would be decided by the law, or anybody else for that matter.” Another pregnant woman reported that if Act 32 prevents her chosen midwife from assisting her, she will likely birth alone.

e) The ICCPR and international human rights law prohibit the sexual and reproductive health and rights violations that people in the U.S. are experiencing

i. Prior Guidance and Concluding Observations from the Human Rights Committee

In General Comment No. 36 the Human Rights Committee notes that the right to life “should not be interpreted narrowly.”¹¹¹ “It concerns the entitlement of individuals to be free from acts and omissions that are intended or may be expected to cause their unnatural or premature death, as well as to enjoy a life with dignity.”¹¹² The Committee further notes that the duty to protect life implies obligations to address conditions that threaten a right to life with dignity, such as taking measures to ensure access to healthcare and reduce maternal mortality.¹¹³ General Comment No. 36 makes clear that States parties may not regulate abortion in ways that result in violations of the right to life, or any other rights under the Covenant. Abortion restrictions must not jeopardize the lives of women and girls, “subject them to physical or mental pain or suffering,” “discriminate against them,” or “interfere with their privacy.”

Further, States parties “must *provide* safe, legal, and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or where the pregnancy is not viable.” In all other cases, States parties may not regulate pregnancy or abortion in ways that lead pregnant people to resort to unsafe abortions. They should not apply criminal sanctions to people who have abortions or medical providers who assist them. Additionally, States parties “should *remove* existing barriers to effective access” to safe and legal abortion, and “should *not introduce* new barriers.” Finally, States parties should prevent stigmatization of individuals who seek abortion and ensure access to quality healthcare during and after pregnancy.¹¹⁴

In multiple decisions—*K.L. v. Peru* (2005), *Mellet v. Ireland* (2016) and *Whelan v. Ireland* (2017)—the Committee confirmed that laws prohibiting and criminalizing abortion give rise to human rights violations, including violations of articles 2, 7, 17, 24, and 26.¹¹⁵ In *Mellet*, the Committee noted that the State had subjected Mellet to mental and physical suffering by prohibiting her from receiving medical treatment in her country of residence, forcing her to travel to receive care away from her support systems.¹¹⁶ The Committee also noted that the State’s failure to account for Mellet’s medical needs and socio-economic status, and provide necessary services amounted to discriminatory treatment.¹¹⁷

In its **2014 concluding observations** on the fourth periodic report of the U.S., the Committee addressed several rights violations that involve an individual’s right to access healthcare, receive

dignified, non-coercive treatment in healthcare settings, and make decisions about their own bodies and lives.¹¹⁸ In particular, the Committee recommended that the U.S. “facilitate access to adequate healthcare, including reproductive healthcare services” for immigrants and expressed concern about non-consensual and coercive practices in mental health services, concluding that the U.S. should promote (psychiatric) care “aimed at preserving the dignity of patients, both adults and minors.”¹¹⁹ In its 2006 concluding observations on the third periodic report of the U.S., the Committee recognized that shackling people during labor raised concerns under article 7 and recommended the prohibition of such practices.¹²⁰ The Committee has also expressed concerns about other U.S. policy choices, such as voting restrictions and tendencies toward excessive surveillance and criminalization, that have indeed created the enabling conditions for all kinds of rights violations, including recent violations of sexual and reproductive health and rights.¹²¹

In preparation for this review, the Committee included in its **list of issues** a robust set of questions about reproductive rights. The Committee requested information about “measures undertaken by the State party to address maternal mortality and morbidity, and in particular to address persistent racial disparities in maternal health outcomes.” It also requested that the U.S. explain how numerous policies impact people’s Covenant rights to non-discrimination, gender equality, life, freedom from torture, cruel, inhuman or degrading treatment or punishment, and to equal protection (articles 2,3,6,7, and 26). Specific measures cited by the Committee include restrictions on access to reproductive healthcare rooted in “conscience-based objections,” newly created barriers to abortion, the criminalization of pregnant women who use drugs, the “global gag rule,” the practice of shackling detained women during birth, and the availability of abortion services in immigration detention facilities.

These observations and concerns remain painfully relevant in 2023 as pregnant people in the U.S. experience preventable suffering due to government actions that constrain their reproductive agency and options. Rising maternal mortality and morbidity, abortion bans, restricted access to midwives, ill treatment in maternity care hospitals, and the criminalization of reproductive healthcare and outcomes all reflect the lack of progress toward implementation of U.S. obligations under ICCPR. Indeed, far from promoting access to healthcare “aimed at preserving the dignity of patients,” some of the United States’ most powerful decision-makers have weaponized healthcare access as a method of contesting the dignity and humanity of marginalized groups, including women, LGBTQ+ people, people of color, people with disabilities, youth, and people living in poverty.¹²²

ii. Other UN Human Rights Bodies’ Recommendations

One year ago, the Committee on the Elimination of Racial Discrimination (CERD) expressed concern about “the limited availability of culturally sensitive and respectful maternal healthcare, including midwifery care for low-income, rural, and people of African descent and Indigenous communities,” and racial/ethnic inequities in maternal mortality and morbidity. CERD wrote that “in this context,” the impact of *Dobbs* was particularly concerning.¹²³ CERD recommended that the U.S. take further steps to eliminate maternal health inequities using an intersectional and culturally respectful approach, including midwifery care; adopt “all necessary measures” to address the disparate impact of *Dobbs*; “provide safe, legal, and effective access to abortion” in line with international human rights obligations and the WHO Abortion Care Guidelines; and “take all necessary measures to mitigate the risks faced by women seeking an abortion and by

health providers assisting them, and to ensure that they are not subjected to criminal penalties.”¹²⁴

In the wake of the *Dobbs* decision, experts across the human rights community have reacted with alarm and condemnation.¹²⁵ On the same day the decision was issued, UN Special Procedures mandate holders denounced it as “shocking and dangerous.” In a public statement, they observed that “[t]he Supreme Court has completely disregarded the United States’ binding legal obligations under international human rights law, including those stemming from its ratification of the International Covenant on Civil and Political Rights, which protects a woman’s right to life from the harmful impact of abortion restrictions” and noted that the Court “was duly reminded of this binding obligation and others in a detailed amicus brief submitted by international independent human rights experts.” The amicus brief they refer to thoroughly sets forth the relevant international human rights law on abortion, illustrating for the U.S. Supreme Court that reproductive rights violations have been recognized by UN bodies and UN Special Procedures mandate holders for many years, including, for example, the Human Rights Committee (HRC), the Committee on the Elimination of Racial Discrimination (CERD), the Committee Against Torture (CAT), the Committee on Economic, Social, and Cultural Rights (CESCR), the Committee on the Elimination of Discrimination Against Women (CEDAW), the Committee on the Rights of Persons with Disabilities (CRPD), and the Committee on the Rights of the Child (CRC).¹²⁶ The Committee on the Elimination of Discrimination Against Women also issued a statement of concern shortly after the *Dobbs* decision.¹²⁷ A year later, ten UN mandate holders sent a communication to the U.S. government providing an overview of relevant international human rights law and urging the U.S. to halt violations of human rights stemming from the *Dobbs* decision.¹²⁸

Beyond these recent statements, over the last ten years the U.S. has received recommendations to improve maternal health, ensure abortion access, and/or address racial and economic disparities in SRHR during the 2020 Universal Periodic Review and at the conclusion of country visits from the UN Working Group on Arbitrary Detention, the UN Special Rapporteur on Extreme Poverty, the UN Working Group of Experts on People of African Descent, and the UN Working Group on Discrimination Against Women in Law and Practice.¹²⁹

iii. World Health Organization Recommendations

In outlining states’ core obligations in General Comment 22, to ensure the satisfaction of minimum essential levels of the right to sexual and reproductive health, the CESCR Committee notes that states “should be guided by . . . the most current international guidelines established by United Nations agencies, in particular WHO.”¹³⁰ **In its most recent Abortion Care Guideline, the World Health Organization (WHO) makes several law and policy related recommendations, including the full decriminalization of abortion¹³¹ and advises against laws and other regulations that restrict abortion by grounds.¹³²** The WHO recommends that abortion be available on the request of the woman, girl or other pregnant person.¹³³ It further recommends against gestational age limits,¹³⁴ mandatory waiting periods for abortion¹³⁵ and third-party authorization.¹³⁶ The WHO includes abortion medication on its essential medicines list and notes that these medicines can expand abortion access within the healthcare system and can be safely self-administered as well.¹³⁷ The WHO provides strong public health evidence to support its law and policy recommendations and consistently refers to discrimination, including based on race and ethnicity, as playing a part in hindering access to abortion services.¹³⁸

f) U.S. Government Response

The **United States’ fifth periodic report to the UN Human Rights Committee**, submitted by the Trump Administration in January 2021, **contains alarming and harmful statements about human rights generally, and reproductive rights specifically**. The report incorrectly asserts that “there is no international right to abortion” and rejects the guidance provided in General Comment No. 36, claiming that “any issues concerning access to abortion... are outside the scope of Article 6.”¹³⁹ We object to this characterization of international human rights law and affirm the Committee’s conclusion that abortion access is essential to realization of the right to life.

Fortunately, the actions taken by the Biden Administration since submission of that report have demonstrated a much greater appreciation for the rights of pregnant people to life, privacy, gender equality, non-discrimination, and freedom from torture, cruel, inhuman or degrading treatment or punishment. **We acknowledge and appreciate the steps taken by the Biden Administration to improve maternal health, address reproductive health inequities, protect patient privacy, and preserve access to abortion.** In particular, we are encouraged by the U.S. government’s efforts to: protect access to medication abortion in the wake of litigation against the Food and Drug Administration (“FDA”); lift the Veterans Affairs (“VA”) total ban on abortion and abortion counseling, allowing the VA to provide abortions in cases of rape, incest, and health or life endangerment of the pregnant person; strengthen privacy protections under the Health Insurance Portability and Accountability Act (“HIPAA”) for patients receiving reproductive healthcare; finalize the 1557 rule, implementing the Affordable Care Act (“ACA”) provision that protects against discrimination in healthcare on the basis of race, color, national origin, sex, age or disability; improve access to high quality maternal healthcare through implementation of the White House Blueprint for Addressing the Maternal Health Crisis;¹⁴⁰ encourage state governments to extend public health insurance to cover individuals for a full year after their pregnancy ends; and increase access to contraception by approving a daily oral contraceptive for use without a prescription.

We also note the continued lack of access to abortion care in the U.S. and the alarming rates of maternal mortality. We must draw attention to fundamental inadequacies in the U.S. legal framework that impede the enjoyment of reproductive rights as human rights, including a disregard for human rights law by some state governments, and lack of domestic protections for reproductive autonomy, the right to life, and freedom from discriminatory impacts. Furthermore, we note the judiciary’s role in limiting access to necessary reproductive care, which further contributes to the denial of bodily autonomy and human rights violations.

g) Suggested Questions for the U.S.

- 1) Does the U.S. government repudiate the previous Administration’s disavowal of human rights protections for sexual and reproductive health and rights contained in the fifth periodic report it submitted, and instead reaffirm the United States’ commitment to upholding and protecting sexual and reproductive rights as human rights?
- 2) What is the U.S. doing to address its long-term problems with preventable maternal deaths and illnesses and ensure that maternal mortality and morbidity rates do not increase further as people in states that have banned abortion are denied lifesaving care?

- 3) What is the U.S. doing to provide remedies for people who have already suffered health harms and violations of human rights, including cruel, inhuman and degrading treatment in states like Texas because of abortion bans?
- 4) Given the prevalence of poor maternal health outcomes in the U.S., discrimination in the healthcare system, provider shortages, and the lack of respectful, nondiscriminatory maternity care, what is the U.S. doing to ensure that all communities in the U.S. have access to midwifery care (at home and in community, not just in hospital settings), and that Black and Indigenous midwives in particular are able to practice and pass on traditions that protect the health of their communities?
- 5) In light of ongoing concerns about health equity throughout Hawai‘i, further exacerbated by the wildfire disaster in Maui, will Hawai‘i reconsider its ban on traditional midwives, which took effect on July 1, 2023 and made it illegal for traditional midwives to provide care they had lawfully provided for over 20 years?

h) Suggested Recommendations to the U.S.

- 1) Take immediate steps to halt retrogression in abortion rights and access and bring U.S. law, policy, and practice in line with the 2022 WHO Abortion Care Guideline, including by ensuring access to abortion with no restriction as to reason, no waiting periods, no third-party authorization, and no gestational limits; and by protecting and expanding access to medication abortion.
- 2) Use all available means to ensure that all people in the U.S. can access comprehensive, culturally acceptable, quality reproductive health services, goods, and facilities in their own communities, free from criminalization, violence, harassment, coercion, and other forms of discrimination.
- 3) Decriminalize abortion in line with WHO Guidance. Review and abolish criminal and civil laws that impair the right to make and act on decisions about one’s own body, sexuality and reproduction—including decisions about pregnancy, where, how, and with whom to birth, contraception, assisted reproduction, abortion care, and access to reproductive health services, goods, facilities, and information.¹⁴¹
- 4) Remove discriminatory legal and practical barriers to community-based midwifery care, including and especially those that inhibit Black and Indigenous communities from preserving culturally significant midwifery traditions or participating in the healthcare workforce, and promote pregnancy care that preserves the dignity and autonomy of patients in all healthcare settings.
- 5) Strengthen legal protections for the right to life and non-discrimination, including intersectional discrimination, and ensure that both individuals and communities are afforded remedies and resources that address the harm caused by preventable maternal mortality and morbidity, abortion restrictions, and other violations of their reproductive autonomy.

¹ *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf.

² For nearly five decades, as *Roe v. Wade* was repeatedly affirmed as the law of the land, politicians could not enforce bans on abortion before a fetus was viable.

³ Ctr. for Reprod. Rts., *Legal Analysis: What Dobbs Got Wrong* (2023), <https://reproductiverights.org/wp-content/uploads/2023/03/Legal-Analysis-What-Dobbs-Got-Wrong-3.15.23.pdf> [hereinafter *Legal Analysis*].

⁴ U.S. Const. amend. XIV.

⁵ The Thirteenth Amendment to the U.S. Constitution abolishes slavery and the Fifteenth Amendment states that “[t]he right of citizens of the United States to vote shall not be denied or abridged by the United States or by any State on account of race, color, or previous condition of servitude.” U.S. Const. amend. XIII, XV.

⁶ *Legal Analysis*, *supra* note 3, at 5.

⁷ *Legal Analysis*, *supra* note 3, at 3.

⁸ *Id.* at 4; Ctr. for Reprod. Rts., *Dobbs’ Destructive Originalism* 3 (2023), <https://reproductiverights.org/wp-content/uploads/2023/06/Dobbs-Destructive-Originalism-6.22.23.pdf> [hereinafter *Dobbs’ Destructive Originalism*].

⁹ *Legal Analysis*, *supra* note 3; *Dobbs’ Destructive Originalism*, *supra* note 8.

¹⁰ *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228, 2325 (2022) (Breyer, Sotomayor, and Kagan JJ., dissenting).

¹¹ *Id.* at 2317-2323; Ctr. for Reprod. Rts., *The Constitutional Right to Reproductive Autonomy: Realizing the Promise of the 14th Amendment* 1-2 (2022), <https://reproductiverights.org/wp-content/uploads/2022/07/Final-14th-Amendment-Report-7.26.22.pdf> [hereinafter *The Constitutional Right to Reproductive Autonomy*].

¹² Ctr. for Reprod. Rts. et al., *Systematic Racism and Reproductive Injustice in the United States: A Report for the UN Committee on the Elimination of Racial Discrimination* 20 (2022), <https://reproductiverights.org/wp-content/uploads/2022/08/2022-CERD-Report-Systemic-Racism-and-Reproductive-Injustice.pdf> [hereinafter *Systematic Racism and Reproductive Injustice*]; see also *Legal Analysis*, *supra* note 3.

¹³ *Systematic Racism and Reproductive Injustice*, *supra* note 12, at 17-20.

¹⁴ U.N., *USA: UN experts denounce Supreme Court decision to strike down Roe v. Wade, urge action to mitigate consequences*, U. N. Human Rts. Office of the High Commissioner (Jun. 24, 2022), <https://www.ohchr.org/en/press-releases/2022/06/usa-un-experts-denounce-supreme-court-decision-strike-down-roe-v-wade-urge>.

¹⁵ See *Abortion and Gender Equality: Spotlight on Dobbs v. Jackson Women’s Health*, Ctr. for Reprod. Rts. (Nov. 9, 2021), <https://reproductiverights.org/supreme-court-case-mississippi-abortion-ban-gender-equality/>.

¹⁶ Kimberlé Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 *Standard L. Rev.* 1241 (1991), <https://www.jstor.org/stable/1229039?origin=crossref>.

¹⁷ *Queering Reproductive Health, Rights & Justice*, Nat’l LGBTQ Task Force, <https://www.thetaskforce.org/reproductive-justice/> (last visited Sept. 5, 2023).

¹⁸ The fallout from *Dobbs* has been felt beyond abortion. Abortion bans and their definitions of conception, life, and pregnancy have made fertility care providers and their patients uncertain about the legal landscape in which they operate. *Lawmakers v. The Scientific Realities of Human Reproduction*, 387 *The New England J. of Medicine* 367-368 (2022), <https://www.nejm.org/doi/full/10.1056/NEJMe2208288>; Julianna Goldman, *Why many IVF patients worry about the antiabortion movement*, *The Washington Post* (July 29, 2023), <https://www.washingtonpost.com/wellness/2023/07/29/dobbs-abortion-ivf-embryos-impact/>. Some have raised questions regarding their ability to perform or receive assisted reproduction (“AR”) services, including in vitro fertilization (“IVF”), discard embryos, and make key decisions about their reproductive healthcare. *But see* Kerry Lynn Macintosh, *Dobbs, Abortion Laws, and In Vitro Fertilization*, 26 *J. of Healthcare Law and Policy* 1 (2023). They are right to worry. States that have enacted abortion bans have been emboldened to push for the enactment of personhood bills establishing that life begins at fertilization. Ala. H.B. 454, 2023 Regular Session §§ 14-16 (2023), <https://www.legislature.state.al.us/pdf/SearchableInstruments/2023RS/HB454-int.pdf>; Ark. H.B. 1174, 94th Gen. Assembly, Regular Session §§ 27-32 (2023), <https://www.arkleg.state.ar.us/Home/FTPDocument?path=%2FBills%2F2023R%2FPublic%2FHB1174.pdf>. These bills could affect the provision of AR services, particularly IVF. For instance, the Arkansas House of Representatives introduced a bill that would have amended the state’s Criminal Code to define a person as including an “unborn child” at any stage of development, including from fertilization until birth. *Id.* Worryingly, the amended definition would also remove the requirement that the “unborn child” be in utero. Although the bill was ultimately not enacted, it reveals how *Dobbs*’ effects can spill over into other spheres, creating new threats for other reproductive healthcare and rights beyond abortion. It also signals that these legislative efforts are just beginning, and we can expect further threats to the reproductive rights of the 9.7 million women in the United States for whom it is difficult or impossible to get pregnant or carry a pregnancy to term, and who may need to access assisted reproduction services like IVF.

Impaired fecundity, Ctrs. for Disease Control and Prevention, https://www.cdc.gov/nchs/nsfg/key_statistics/i-keystat.htm#impaired (last visited August 7, 2023).

¹⁹21 states currently ban gender-affirming care. *Anti-Transgender Medical Care Bans*, Equal. Fed'n, <https://www.equalityfederation.org/tracker/anti-transgender-medical-care-bans> (last visited Sept. 5, 2023); *Map: Attacks on Gender Affirming Care by State*, Human Rts. Campaign, <https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map> (last visited Sept 5, 2023); see also Irin Carmon, *The Shared Anti-Trans and Anti-Abortion Playbook*, N.Y. Magazine (April 4, 2023), <https://nymag.com/intelligencer/2023/04/anti-trans-anti-abortion-activism-playbook.html>.

²⁰ *Constitutional Protection for the Right to Abortion: From Roe to Casey to Whole Woman's Health*, Ctr. for Reprod. Rts., <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/factsheets/Constitutional-Protection-for-the-Right-to-Abortion-Fact-Sheet2.pdf> (last visited Sept. 5, 2023).

²¹ *Id.*

²² Individuals can use medical malpractice lawsuits and various complaint systems to address violations of informed consent, discrimination, and poor-quality care, but these avenues have not been sufficient to remedy harms or deter mistreatment in maternity care settings.

²³ For example, in Ohio, a measure which would have made it more difficult to change the state's constitution was recently introduced. This was done in anticipation of an effort to enshrine the right to abortion in Ohio's constitution. Julia Carr Smyth & Samantha Hendrickson, *Voters in Ohio reject GOP-backed proposal that would have made it tougher to protect abortion rights*, AP (Aug. 9, 2023), <https://apnews.com/article/ohio-abortion-rights-constitutional-amendment-special-election-227cde039f8d51723612878525164f1a>. See generally *The Impact of Voter Suppression on Communities of Color*, Brennan Ctr. for Justice (Jan. 10, 2022), <https://www.brennancenter.org/our-work/research-reports/impact-voter-suppression-communities-color>.

²⁴ Samantha Artiga et al., *What are the Implications of the Overturning of Roe v. Wade for Racial Disparities?*, KFF (Jul. 15, 2022), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-are-the-implications-of-the-overturning-of-roe-v-wade-for-racial-disparities/>.

²⁵ Caitlin Myers et al., *Abortion Access Dashboard*, Middlebury College, <https://experience.arcgis.com/experience/6e360741bfd84db79d5db774a1147815/page/Page/?views=October> (last visited Sept. 8, 2023).

²⁶ *After Roe Fell: Abortion Laws by State*, Ctr. for Reprod. Rts., <https://reproductiverights.org/maps/abortion-laws-by-state/> (last visited Sept. 5, 2023).

²⁷ *Id.*

²⁸ Artiga et al., *supra* note 24.

²⁹ Soc'y of Fam. Plan., *#WeCount Report* (2022), https://societyfp.org/wp-content/uploads/2022/10/SFPWeCountReport_AprtoAug2022_ReleaseOct2022-1.pdf. The Society for Family Planning, as well as the Guttmacher Institute, have been collecting information regarding the number of abortions being performed in the United States after *Dobbs*. Even though they have diverging conclusions, they both represent important resources to keep track of *Dobbs*' effects, including the increasing number of abortions being provided in abortion access states that border abortion ban states. To see how they differ, see *How We Collect the Data*, Guttmacher Inst., <https://www.guttmacher.org/monthly-abortion-provision-study> (last visited Sept. 8, 2023) (describing the differences between #WeCount and the Monthly Abortion Provision Study).

³⁰ See 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 (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, Nat'l Latina Inst. for Reprod. Health, *Latina immigrant women's access to abortion: Insights from interviews with Latina Grasstops Leaders*, 1-4 (2010), <https://nciwr.files.wordpress.com/2011/01/nlirh-research-brief-sept2010-final1.pdf>; Nat'l 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>.

³¹ Artiga et al., *supra* note 24.

³² Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst. (May 2016), <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014> (see Table 1).

³³ M.V. Lee Badgett et al., *LGBTQ Poverty in the United States*, Williams Inst. (Feb. 2023), <https://williamsinstitute.law.ucla.edu/publications/lgbt-poverty-us/>.

³⁴ Selena Simmons-Duffin & Shelly Cheng, *How many miles do you have to travel to get abortion care? One professor maps it*, NPR (June 21, 2023), <https://www.npr.org/sections/health-shots/2023/06/21/1183248911/abortion-access-distance-to-care-travel-miles>.

³⁵ Nigel Chiwaya et al., *Where is abortion legal? See how far you'd have to travel for care*, NBC News (June 24, 2022), <https://www.nbcnews.com/data-graphics/live-state-set-ban-abortions-see-how-far-you-d-n1296555>.

³⁶ Cameron Scott, *Model Shows Where Women Lost Access to Abortion After Dobbs*, Univ. of Cal. San Francisco (Nov. 1, 2022), <https://www.ucsf.edu/news/2022/10/424121/model-shows-where-women-lost-access-abortion-after-dobbs>; Benjamin Rader et al., *Estimated Travel Time and Spatial Access to Abortion Facilities in the US Before and After the Dobbs v Jackson Women's Health Decision*, 328 JAMA 2041 (2022), <https://jamanetwork.com/journals/jama/fullarticle/2798215>.

³⁷ *Id.*

³⁸ See, e.g., Amy Yurkanin, *Alabama Can Prosecute Those Who Help Women Travel for Abortion*, Attorney General Says, AL.com (Aug. 30, 2023), <https://www.al.com/news/2023/08/alabama-can-prosecute-those-who-help-women-travel-for-abortion-attorney-general-says.html>; Caroline Kitchener, *Highways are the Next Antiabortion Target. One Texas town is Resisting.*, The Washington Post (Sept. 1, 2023), <https://www.washingtonpost.com/politics/2023/09/01/texas-abortion-highways/>.

³⁹ See, e.g., Caroline Kitchener & Devlin Barrett, *Antiabortion Lawmakers Want to Block Patients from Crossing State Lines*, The Washington Post (Jun. 30, 2022), <https://www.washingtonpost.com/politics/2022/06/29/abortion-state-lines>.

⁴⁰ Abortion Care Network, *Communities Need Clinics: A New Landscape of Independent Abortion Clinics in the United States* 3 (2022), <https://abortioncarenetwork.org/wp-content/uploads/2022/12/communities-need-clinics-2022.pdf>.

⁴¹ *Id.* at 11.

⁴² See, e.g., Rebecca Greenberg, *Queens abortion clinic sees uptick in out-of-state patients*, NY1 (Sep. 6, 2023), <https://ny1.com/nyc/queens/news/2022/09/08/queens-abortion-clinic-sees-uptick-in-out-of-state-patients> (describing how a New York abortion clinic has seen an increase in out-of-state patients).

⁴³ Email Interview with Kwajelyn Jackson, Executive Director, Feminist Women's Health Center (Aug. 1, 2023).

⁴⁴ Mabel Felix et al., *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF (May 18, 2023), <https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortion-bans-implications-for-the-provision-of-abortion-services/>.

⁴⁵ *New Study Finds Oklahoma Hospitals Unable to Provide Clear and Accurate Information on Emergency Obstetric Care*, Ctr. for Reprod. Rts. (April 25, 2023), <https://reproductiverights.org/oklahoma-hospitals-abortion-study/>; Physicians for Human Rts., The Okla. Call for Reprod. Justice & Ctr. for Reprod. Rts., *No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post-Roe Oklahoma* (2023), https://reproductiverights.org/wp-content/uploads/2023/04/OklahomaAbortionBanReport_Full_SinglePages-NEW-4-27-23.pdf.

⁴⁶ Brittni Frederiksen et al., *A National Survey of OBGYNs' Experiences After Dobbs*, KFF (June 21, 2023), <https://www.kff.org/womens-health-policy/report/a-national-survey-of-obgyns-experiences-after-dobbs/>; see also Daniel Grossman et al., *Advancing New Standards for Reprod. Health, Care Post-Roe: Documenting cases of poor-quality care since the Dobbs decision, Preliminary findings* (2023), <https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf>.

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- ⁵¹ World Health Org., *Abortion Care Guideline 26* (2022), <https://www.who.int/publications/i/item/9789240039483>.
- ⁵² *Zurawski v. Texas*, No. D-1-GN-23-000968, 2023 WL 4995462 (Tex. Dist. Ct. Aug. 4, 2023).
- ⁵³ *Texas Abortion Ban Emergency Exceptions Case: Zurawski v. State of Texas*, Ctr. for Reprod. Rts., <https://reproductiverights.org/case/zurawski-v-texas-abortion-emergency-exceptions/zurawski-v-texas/> (last visited Sept. 5, 2023).
- ⁵⁴ Plaintiffs' First Amended Verified Petition for Declaratory Judgment and Application for Temporary and Permanent Injunction at 5-9, *Zurawski v. Texas*, No. D-1-GN-23-000968 (Tex. Dist. Ct. May 22, 2023), <https://reproductiverights.org/wp-content/uploads/2023/05/2023.05.22-Zurawski-v.-Texas-1st-Am.-Ver.-Pet.-FINAL.pdf>.
- ⁵⁵ *Plaintiff's Stories: Zurawski v. State of Texas*, Ctr. for Reprod. Rts. (May 22, 2023), <https://reproductiverights.org/zurawski-v-texas-plaintiffs-stories-remarks-2/>.
- ⁵⁶ Plaintiffs' First Amended Verified Petition, *supra* note 54, at 22-26.
- ⁵⁷ Anencephaly is a condition in which a baby is born without parts of the brain and skull. *Facts about Anencephaly*, Ctrs. for Disease Control & Prevention, <https://www.cdc.gov/ncbddd/birthdefects/anencephaly.html#:~:text=Anencephaly%20is%20a%20serious%20birth,part%20of%20the%20neural%20tube> (last visited Sept. 5, 2023).
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- ⁶⁰ Defendant's Amended Plea to the Jurisdiction and Response to Plaintiff's Application for Temporary Injunction at 3, *Zurawski v. Texas*, No. D-1-GN-23-000968 (Tex. Dist. Ct. July 14, 2023), https://reproductiverights.org/wp-content/uploads/2023/07/20230712_Ds-PTJ_AMND-Apndx_Final.pdf.
- ⁶¹ *Id.*
- ⁶² *Texas Women Give Gripping Testimony Against State in Abortion Hearing*, Ctr. for Reprod. Rts. (July 20, 2023), <https://reproductiverights.org/texas-women-give-gripping-testimony-against-state-in-abortion-hearing/>.
- ⁶³ Simmons-Duffin, *supra* note 59.
- ⁶⁴ *The Turnaway Study*, Advancing New Standards in Reprod. Health, <https://www.ansirh.org/research/ongoing/turnaway-study> (last visited Sept. 5, 2023).
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⁶⁸ See *Abortion is Health Care*, Nat'l Health Law Program, <https://healthlaw.org/abortion-is-health-care/> (last visited Sept. 5, 2023).

⁶⁹ See Carol Sanger, *About Abortion: Terminating Pregnancy in Twenty-First-Century America* 23 (2017) (describing abortion regulation as the civil law equivalent of what legal sociologist Malcolm Feely identified in the criminal context as “process as punishment,” i.e., the “real costs” incurred before the ruling — lost wages from missed work, attorney’s fees, and wasted time, etc.).

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¹⁰⁷ Haw. Rev. Stat. Ann. §§457J-5,8.

¹⁰⁸ *Id.* at §457J-5.

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¹¹¹ Human Rts. Comm., General comment No. 36 Art. 6: right to life, ¶3, U.N. Doc. CCPR/C/GC/36 (2018).

¹¹² *Id.*

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¹¹⁴ *Id.* at ¶8(emphasis added).

¹¹⁵ *K.L. v. Peru*, Human Rts. Comm., Commc'n No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).; *Mellet v. Ireland*, Human Rts. Comm., Commc'n No. 2324/2013, U.N. Doc. CCPR/C/116/D/2324/2013 (2016); *Whelan v. Ireland*, Human Rts. Comm., Commc'n No. 2425/2014, U.N. Doc. CCPR/C/119/D/2425/2014 (2017).

¹¹⁶ *Mellet v. Ireland*, *supra* note 115, at ¶7.4.

¹¹⁷ *Id.* at ¶7.11.

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¹¹⁹ *Id.* at ¶¶15, 18.

¹²⁰ Human Rts. Comm., Concluding observations of the Human Rights Committee United States of America, ¶33, U.N. Doc CCPR/C/USA/CO/3/Rev.1 (2006).

¹²¹ HRC Concluding Observations (2014), *supra* note 118, at ¶¶6, 12, 19, 22.

¹²² This is also evident in the United States' history of refusing to extend public health insurance (Medicaid) to everyone who needs it (including immigrants and postpartum people recovering from pregnancy) and state bans on gender-affirming health care that have utilized abortion bans as a blueprint for legislation that harms and stigmatizes the LGBTQ community.

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¹³² World Health Org., *supra* note 51.

¹³³ *Id.* at §2.2.2 (pp. 26–27).

¹³⁴ *Id.* at §2.2.3 (pp. 28–29).

¹³⁵ *Id.* at §3.3.1 (pp. 41–42).

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