

**Legal Retrogression and the Harms of Louisiana's Near Total Abortion Bans:
A Report to the Human Rights Committee 139 Session (09 Oct 2023 - 03 Nov 2023), United States**
Jointly submitted on September 12, 2023

Human Rights Committee Secretariat
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The undersigned reproductive rights, reproductive justice, and human rights organizations¹ respectfully submit this report to the Human Rights Committee ahead of the fifth periodic report of the United States of America at the Committee's 139th session in October 2023.

Our joint submission represents early findings from fact-finding research undertaken in 2023 by the undersigned organizations in the southern U.S. state of Louisiana, where abortion is prohibited at all stages of pregnancy with few exceptions. The documented experiences of health care providers, patients, and community-based organizations capture the array of harms that Louisiana's abortion bans have caused its residents in violation of their rights to life, equality, privacy, information, and to be free from torture and ill-treatment.

In its List of Issues, issued in 2019 prior to the *Dobbs v. Jackson Women's Health Organization* (hereinafter *Dobbs*) ruling overturning the federal protection of the right to abortion, the Human Rights Committee requested information from the U.S. government on how state laws restricting abortion impact women's access to reproductive health and abortion care.¹ In its report to the Committee, the U.S. not only did not provide the requested information but altogether failed to recognize the human right to abortion in and of itself and as fundamental to the full realization of human rights. Our joint submission highlights multiple human rights violations following swift action by U.S. states to enforce existing abortion bans and enact new ones after the *Dobbs* decision. We intend to aid the Committee in evaluating U.S. progress on the implementation of the ICCPR since its last periodic review, and to recommend priorities for the Committee's upcoming review in October 2023.

We respectfully urge the Human Rights Committee to condemn the retrogression of abortion rights in the U.S. post-*Dobbs*, including the multiple bans in Louisiana, as a violation of the rights to life, equality and

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non-discrimination, privacy, information, and freedom from torture and ill-treatment during its upcoming review of the U.S. and to recommend that the U.S. government:

- a. Enact positive measures to ensure that people with the capacity to become pregnant have meaningful access to abortion and other reproductive healthcare information and services, such as the Women’s Health Protection Act, federal legislation currently pending in the U.S. Congress which establishes a statutory right for healthcare professionals to provide abortion care and the right of their patients to receive care;
- b. Repeal harmful legislation that creates barriers to abortion access, in particular for Black, Indigenous, and other people of color, people with limited financial resources, and people with disabilities, including the Hyde Amendment which restricts federal funding for abortion care except in very limited circumstances under Medicaid, a joint federal and state program that provides public health insurance for low-income families in the U.S.;
- c. Integrate the World Health Organization’s newly issued Abortion Care Guideline, which makes evidence-based law and policy recommendations to States, including that they fully decriminalize abortionⁱⁱ and refrain from enacting laws that restrict abortion by grounds, and ensure that the U.S. Federal Drug Administration maintains authority to approve medication abortion;
- d. Enact laws and policies that protect people seeking or accessing abortion from prosecution under state laws;
- e. Protect medical professionals who provide abortion and other reproductive healthcare services by prohibiting their civil or criminal liability, disbarment, loss of license, or other retribution or reprimanding measures as a result of abortion bans, and by promoting the adoption of “shield laws” that create protections from civil actions of another state for individuals who obtain, provide, recommend, or assist others in obtaining abortion services;
- f. Adopt laws and policies to protect clinicians and clinics from violence for the provision of abortion and other reproductive healthcare services; and
- g. Use the U.S. government’s oversight authority to monitor the impact of abortion bans on the provision of reproductive health care and on health inequities, and the effectiveness of legislative measures such as federal guidance on Emergency Medical Treatment and Active Labor Act (EMTALA) that is aimed to secure access to abortion in life-threatening situations even in states where abortion is banned.

Respectfully,
Center for Reproductive Rights
Lift Louisiana

ⁱⁱ The WHO defines this as “removing abortion from all penal/criminal laws, not applying other criminal offences (e.g., murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.” See *infra* note 98.

Physicians for Human Rights
RH Impact

TABLE OF CONTENTS

- I. After *Roe* Fell: Retrogression of the Right to Abortion
- II. Louisiana’s Abortion Legal Landscape
- III. Abortion Access
 - a. Louisiana’s trigger bans deny pregnant people the ability to exercise their right to abortion and leave them no option but to travel or to self-manage their own abortion, if they’re able, to access essential reproductive health care
 - b. Louisiana’s trigger bans deter providers from legally providing abortion care to patients in all cases, including where patients face risks to their lives and health
 - c. Louisiana’s trigger bans contribute to a maternal health care crisis in the state
 - d. Louisiana’s trigger bans threaten the doctor-patient relationship and undermine patients’ rights to privacy and information
 - e. Pregnant people who experience multiple forms of discrimination are disparately impacted by Louisiana’s trigger bans
 - f. The delay and denial of abortion care causes pregnant people physical, mental, and legal harm
- IV. International Human Rights Standards
- V. World Health Organization Recommendations
- VI. Suggested Recommendations

Appendix A: UN Statements and Concluding Observations

I. After *Roe* Fell: Retrogression of the Right to Abortion

On June 24, 2022, the United States Supreme Court issued its ruling in *Dobbs* eliminating a pregnant person’s federal constitutional right to decide to end their pregnancy.² The ruling overturned *Roe v. Wade*, which for nearly 50 years had recognized the right to abortion as a fundamental liberty protected by the United States (U.S.) Constitution.³ In the absence of federal protection, emboldened state legislatures across the country moved to ban or severely restrict abortion access. In the year following the ruling, fourteen (14) states have outlawed abortion while abortion is at risk of being severely limited in another twenty-six (26) states and three territories.⁴ Removing a long-held constitutional right to abortion marks a major retrogression in the U.S. and establishes it as an outlier – running counter to the global trend to liberalize abortion laws.⁵ This submission focuses on the southern U.S. state of Louisiana where the undersigned have undertaken human rights fact-finding research to document the harmful impact of the state’s action to swiftly prohibit abortion after the *Dobbs* ruling.

Immediately following the *Dobbs* ruling, large swaths of the U.S. became “abortion deserts” where access to abortion care is either illegal or severely restricted. An estimated 36 million women of reproductive age live in states where abortion has or is likely to be banned.⁶ Included in that number are nearly 3 million women with disabilities, 12.5 million women with low financial resources, 1.3 million transgender adults, 1.2 million LGBTQ nonbinary adults, and 15 million women of color.⁷ The majority of “abortion desert” states are concentrated in the South and Midwest regions where over 25 million women of reproductive age, or two in five nationally, currently live, many of them women of color.⁸ People living in these states have less access to healthcare and worse health, including reproductive health, outcomes than people living in other regions.⁹ Pregnant people living in these states must instead —if they are even able— travel long distances across multiple state lines to “abortion havens” where legislatures have enacted measures to protect abortion.¹⁰

Moreover, anti-abortion states have moved to impede this inter-state movement by introducing legislation designed to restrict travel.¹¹ Such is the case in Idaho where the Governor recently signed a law criminally prohibiting people from helping minors travel to a neighboring state to receive abortion care.¹² Such laws draw upon a method used in Texas’ 2021 S.B. 8 abortion ban, which encouraged residents of the state to sue anyone who “aided or abetted” someone in accessing an abortion, including outside the state.¹³ In these circumstances, pregnant people who are delayed or denied abortion care may seek medication abortion via telemedicine, in which care is provided virtually; however, states have likewise imposed barriers to both medication abortion and telemedicine for abortion care.¹⁴

As noted *infra* in Appendix A, multiple UN human rights bodies and special procedures have expressed their concern with the *Dobbs* decision and the abortion restrictions that followed and called on the U.S. government to remove barriers to safe, legal abortions. For a more complete accounting of abortion retrogression in the U.S. and its impact on people’s rights to reproductive freedom and bodily autonomy, see *Retrogression in U.S. Reproductive Rights and the Ongoing Fight for Reproductive Autonomy – A Report for the Human Rights Committee*.

II. Louisiana’s Abortion Landscape

Louisiana is one of the 16 states that make up the U.S.’ Southern region. It is home to nearly 4.7 million residents.¹⁵ Louisiana has a majority rural landscape and much of its population is concentrated in its urban centers.¹⁶ A third of its population (31%) identifies as Black, compared to 14% nationally, and it ranks highest in the nation in percentage of households living below the federal poverty level.¹⁷ In fact, Louisiana’s Black population is nearly three times as likely as its white population to live below the federal poverty level.¹⁸

In the year since *Dobbs*, every licensed “abortion clinic” in Louisiana has either closed or stopped providing abortion care to pregnant people except in limited circumstances.¹⁹ Louisiana has three “trigger bans” on abortion, each of which purported to go into effect immediately upon the overruling of *Roe v. Wade*.²⁰ Louisiana’s first trigger ban, enacted in 2006 and amended in 2022, essentially criminalizes all abortions regardless of gestational age.²¹ It establishes that “no person may knowingly administer to, prescribe for, or procure for, or sell to any pregnant woman any medicine, drug, or other substance” or “knowingly use or employ any instrument or procedure upon a pregnant woman” with the “specific intent of causing or abetting the termination of the life of an unborn human being.”²² The ban makes narrow exceptions, including to prevent the death of the pregnant person,²³ but does not make exceptions for pregnancies that result from rape or incest.²⁴

On June 21, 2022 —likely emboldened by a leaked draft of *Dobbs*— the Governor signed into law two additional trigger bans, with increased civil and criminal penalties for doctors who provide abortion care, subjecting them to up to fifteen (15) years imprisonment and \$200,000 for any violation.²⁵ The second and third trigger bans contain limited exceptions, such as when a patient experiences an ectopic pregnancy or when the patient’s fetus is “medically futile,” which is not a medical term.²⁶ Notably, it explicitly states that a pregnant person’s emotional, psychological, or mental condition cannot be considered when determining whether they are experiencing a qualifying “medical emergency” or “serious health risk.”²⁷ Louisiana’s Department of Health subsequently issued an emergency declaration on August 1, 2022.²⁸ The most recent iteration contains 25 “medically futile” conditions and only allows abortion care for a fatal condition not explicitly named on the list if it can be certified by two physicians licensed in Louisiana.²⁹ Obstetrics and gynecology (OBGYN) and maternal-fetal medicine physicians have noted, however, that this list is unhelpful as it is not exhaustive. Further, requiring two physicians to sign off where a pregnant person presents with an unenumerated fatal fetal condition is not always feasible, especially in rural areas, and puts an enormous burden on the pregnant person.

Following a challenge to the trigger bans, a state trial court temporarily blocked Louisiana from enforcing its three bans.³⁰ The temporary relief was suspended, however, on July 29, 2022.³¹ The legal challenge is ongoing, but the bans remain in effect – tying the hands of clinicians who cannot provide patients with abortion care and denying pregnant people in Louisiana access to essential health care and the right to exercise their human rights.³²

Louisiana also has other laws that severely restrict abortion access even when a pregnant person’s life is at risk or when a fetus is deemed to be “medically futile.” These include gestational bans at twenty weeks post fertilization and post-viability,³³ a ban on medication abortion, a requirement that patients seeking abortion care undergo a mandatory 72-hour waiting period, biased counseling, and an ultrasound before receiving care,³⁴ as well as a requirement that minors have the consent of a parent, legal guardian, or a judge in their parish.³⁵

Louisiana also bans public funding for abortion care unless “medically necessary to prevent the death of the mother,” “necessary to save the life of the mother,” the pregnancy resulted from rape, or the pregnancy resulted from incest.³⁶ Additionally, Louisiana bans private health insurance coverage of abortion, which unlike the public funding ban, fails to provide any carve outs for medical exceptions, rape, or incest.³⁷

III. Abortion Access

To better understand and illustrate the harmful impact of Louisiana’s near-total bans, the submitting organizations undertook human rights fact-finding research in the state beginning in May 2023 (the research remains ongoing at the time of this submission). The research methodology involves over 30 individual interviews with a range of practicing clinicians throughout the state, as well as focus group sessions with community-based organizations (hereinafter CBO) and individual interviews with people with the capacity to become pregnant.³⁸ Preliminary findings from the research, described below, underscore the harm that people in Louisiana are experiencing in a post-*Dobbs* landscape.

a. Louisiana’s trigger bans deny pregnant people the ability to exercise their right to abortion and leave them no option but to travel or to self-manage their own abortion, if they are able, to access essential reproductive healthcare

The near-total bans on abortion in Louisiana endanger the life and health of pregnant people seeking abortions and of pregnant people experiencing pregnancy complications. Under the bans, pregnant people seeking abortions are forced to travel long distances across multiple state lines to access care in “haven states,” where abortion is legally protected.³⁹ This is an increase in distance of 1,720 percent.⁴⁰ Closing off health care options for pregnant people and pushing them to travel to other states to receive care causes them stress, suffering and additional financial burdens during a time that may already be laden with anxiety. It also requires them to find—if they are able—the emotional and material support they need to make such a trip including, but not limited to, taking time off work, finding childcare, and booking their travel and accommodation while receiving care.⁴¹ As one CBO lamented, “[w]e are no longer able to assist folks in receiving care in the state.” Instead, they partner with clinics outside the state and help pregnant people navigate “flights, travel, [and] childcare.” Another organization characterized it as a kind of “secret society to find other resources for a pregnant person” whose in-state access to care is severely restricted under Louisiana’s laws. For some, gathering the financial resources needed to travel may take weeks, if it ever happens. All the while, their pregnancy progresses, and they run up against gestational bans barring abortion care altogether.

Abortion bans in states like Louisiana and its neighboring states of Texas, Oklahoma, Arkansas, Missouri, and Mississippi have contributed to a strain on abortion care systems in haven states, like Illinois, where both medication and surgical abortions at one clinic rose by 54 percent in the last year alone.⁴² The surge in out-of-state patients results in longer waiting periods for all patients seeking care.⁴³ This is true for both in-state patients and patients who manage to travel from states like Louisiana where they were denied abortion care.

Those patients who are unable to travel are forced to continue their pregnancy when they otherwise would choose to terminate it. Louisiana’s abortion laws effectively make legal abortion care unavailable to anyone unable to travel out of state. As one maternal fetal medicine physician shared:

[T]here are patients floating around out there that I'm literally like, I know you didn't want to be pregnant. I know you wish you could have terminated the pregnancy, and you're still pregnant, and you're complicated for one reason or another. I know you are at a high risk of dying or having a bad health outcome. And I'm not going to sleep well until you're six months postpartum because you are at extremely high risk of having problems. But you didn't quite make the cutoff for us to be able to offer it, and you just couldn't get out of state, right?

One CBO reflected that:

...[P]eople are not going to be able to access the care that they want and they're going to be circumstanced into growing their families or reproducing in a way that they didn't consent to or choose for themselves, and so we're trying to think about that means for making Louisiana a healthy and sustainable place because we already know it is hard here for people [who] choose to have children because of the multiple and intersecting crises that we are faced with...

b. Louisiana's trigger bans deter providers from legally providing abortion care to patients in all cases, including where patients face risks to their lives and health

Trigger bans like Louisiana's impede clinicians from fulfilling their ethical and professional responsibilities to their patients; they also cruelly and unnecessarily endanger the lives of pregnant people.⁴⁴ Louisiana's trigger bans do not use clear medical terminology when they describe limited, legal exceptions to their enforcement. A preliminary finding from our research is particularly illustrative of this dilemma and the subsequent impact on pregnant people:

One patient I took care of last fall, a couple of months after *Roe* was overturned. She lives in a small town a couple of hours away. She's very sick. She had heart problems and kidney failure and was on dialysis and got pregnant. And she was seeing a doc[tor] there who had told her how risky the pregnancy was. And both the cardiologist and the nephrologist would not write in the chart that they thought that the patient was at risk of dying because they knew what the implications of that would be, and they didn't want their name on the chart. So, she didn't get to me until she was about 16 weeks, and she had wanted to terminate the whole time and just didn't have the resources available. So, she ended up hospitalized and got transferred to us, and we took care of her and were able to provide those services once we had the right people on board.

In the face of such confusion, providers face “dual loyalty”: they struggle to meet their ethical obligations to provide the appropriate standard of care to their patients while facing threat of legal and professional harms for providing such care.⁴⁵ This is the experience of providers in similarly situated states. In a recent national survey of OBGYNs who provide abortion care, the majority (68 percent) said that the U.S. Supreme Court's overturning of *Roe* undermined their ability to manage pregnancy-related emergencies.⁴⁶

Predictably, cases of pregnant women being denied abortion care in states with total bans or severe restrictions after experiencing a life-endangering pregnancy complication, including for non-viable pregnancies, have been documented in the year since *Roe* was overturned, including in Louisiana.⁴⁷

Clinicians in Louisiana have little to no guidance on when they can legally provide their patients with abortion care. As discussed *supra*, Section II, in August 2022, the Department of Health issued an emergency list of medical conditions that would warrant abortion care, but the list did not resolve the lack of clarity.⁴⁸ After clinicians request greater clarity on what kinds of conditions would qualify a pregnant person to receive legal abortion care, the Department of Health balked and instead referred providers to the state's Attorney General.⁴⁹ Providers are wary of asking the Attorney General for guidance, however, as this office had issued letters to abortion clinics the day *Roe* was overturned threatening legal action should they provide abortion care contrary to the state's trigger ban.⁵⁰ Against a backdrop of surveillance, legal uncertainty, and criminalization, providers in Louisiana are forced to weigh providing their patients with abortion care against the real threat that doing so will leave them vulnerable to civil and criminal penalties of up to 15 years in prison or steep fines.

c. Louisiana's trigger bans contribute to a maternal health care crisis in the state

Providers in Louisiana have raised concerns that the state's trigger bans impact the standard of care in maternal health. Many of them have started delaying their patient's first pre-natal appointment based on the fact that miscarriages are most likely to happen in the first twelve (12) weeks of pregnancy.⁵¹ Delaying the first pre-natal appointment shields providers from being investigated for or charged with providing abortion care to a pregnant person who experiences a miscarriage.⁵² Under Louisiana's trigger bans, pregnancy complications like miscarriage may lead providers to be overly cautious in their care out of concern, for example, that the pregnant person's life is not sufficiently at risk as required under the state law's exceptions.⁵³ As a result of the state's trigger bans, clinicians must weigh whether their medical judgement will lead to scrutiny and be deemed sound.

The U.S. has the highest maternal mortality ratio in the 'developed' world and, within the U.S., Louisiana has one of the highest maternal mortality rates.⁵⁴ Regardless of income or education, Black women are more than three times more likely to die than white women are, and American Indian and Alaskan Native women are twice as likely as white women to die.⁵⁵

For every maternal death in the U.S., about 100 women will experience maternal morbidity—a life-threatening pregnancy complication—and survive.⁵⁶ Maternal morbidity can include traumatic injuries and illnesses that result in short or long-term disability.⁵⁷ A month after Louisiana's trigger bans took effect, a pregnant woman's water broke at 16-weeks and her doctor recommended that she seek an abortion.⁵⁸ The hospital's legal department, however, intervened and she was instead forced to labor and deliver her pregnancy. Afterward, she experienced substantial hemorrhaging, one of the leading drivers of maternal mortality in Louisiana.⁵⁹ She survived, but her experience illustrates how restricting care options for providers and patients alike can cause maternal morbidity and could lead to more preventable maternal deaths in Louisiana. As one physician shared:

[M]y concern is that we have horrendous maternal mortality rates to begin [with], and... a third of our parishes are [obstetric care] deserts. And I sit on the [redacted], which means I review every death of a pregnant or

postpartum woman. And it's horrendous. It's horrible, like the worst several hours of any day. And I know because ... when you're in the emergency department, you see the downstream effects of a whole lot of things. Any barrier in access to a woman at the most vulnerable time of her life, which it truly is for most, means more people suffer and more people die. It's just plain and simple.

d. Louisiana's trigger bans threaten the doctor-patient relationship and undermine patients' rights to privacy and information

In addition to undermining the provision of care, Louisiana's trigger bans undermine providers' ability to provide—and patient's ability to access—accurate information from their trusted healthcare providers about safe, legal abortion. This is reflected in national survey results showing that in states where abortion is banned, a third of providers do not offer patients information about abortion or referrals to other providers who could provide care.⁶⁰ This situation contributes to an erosion of trust in the doctor/patient relationship wherein providers withhold comprehensive, accurate, and evidence-based information on abortion services fearing that providing such information will violate their state's abortion laws. As one provider interviewed shared, “I know part of what is going to cause them the most harm is if the laws make them distrust us,” while another noted “[a]s a provider, I am supposed to counsel my patients on risks and benefits, alternatives, and help them navigate through making a decision. And I can't do that... because it's not allowable and I can go to jail.” Access to this information is critical to patients exercising their reproductive rights.⁶¹ This is a particular concern for pregnant people who already face discriminatory barriers to accessing abortion care, including Black, Indigenous, and other people of color.

Before *Dobbs*, Louisiana enacted a law that requires physicians to report to the state's Department of Health every instance where they provide “any post-abortion care.”⁶² This is required even when the person has received abortion care legally pursuant to the state's abortion laws.⁶³ These reports could lead the state's Department of Health to investigate the healthcare provider as well as the patient under the suspicion that they sought care after unlawfully accessing an abortion.⁶⁴

In a context where abortion providers are being scrutinized and pregnant people are being surveilled with an eye toward prosecution, providers are taking extra precautions to protect their patients' privacy. The Health Information Portability Accountability Act (HIPAA), a federal law that protects a patient's personal health information, was enacted over a quarter century ago and lawmakers, providers, and patients are concerned that its protections may not be robust enough to fully defend patient privacy if and when police departments investigate their health care history.⁶⁵ Their concerns are in direct response to the overturning of *Roe v. Wade* and the surge of trigger bans like the one enforced in Louisiana.

Nationally, clinics and providers are also considering how to protect patient-doctor privacy, including by using encrypted messaging apps or foregoing computers altogether in hopes of avoiding a digital paper trail.⁶⁶ Patients, too, are reconsidering services that track their fertility and are being counseled to use private messaging apps to communicate about their plans to seek an abortion, if they communicate them at all, and to use incognito browsing to search online for abortion resources.⁶⁷ Collectively, these measures further burden the doctor-patient relationship.

e. Pregnant people who experience multiple forms of discrimination are disparately impacted by Louisiana’s trigger bans

While Louisiana’s abortion laws apply to everyone equally, their impact does not. They fall hardest on people who already face multiple and intersecting forms of discrimination in accessing healthcare: Black, Indigenous, and other people of color, people with disabilities, people in rural areas, young people, undocumented people, LGBTQ+ people, and people with limited financial resources.⁶⁸ As one CBO noted: “the number of those [impacted who] are Black...Indigenous...low income is going to be higher than other, more affluent people who have access to choice regardless of the bans.” These communities already experience poor maternal and reproductive health outcomes and are subjected to structural racial bias and discrimination within and beyond Louisiana’s health care system and are the least likely to overcome the many barriers put in place by the state to limit abortion access.⁶⁹ Another CBO shared about the disproportionate impact on Black and Brown communities due to the lack “of access [to] healthcare, access [to] reproductive health in communities where they have OB deserts.”

Before the trigger bans went into effect, 94 percent of parishes in Louisiana had no abortion clinics, leaving pregnant people in rural areas without ready access to care.⁷⁰ 72 percent of women in Louisiana lived in those parishes without abortion access.⁷¹ Following the trigger bans going into effect, the remaining three abortion clinics in the state shuttered.⁷² This has exacerbated what was already an untenable situation in which 26.6 percent of parishes in the state were also categorized as “maternity care deserts.”⁷³ The dearth of maternal, abortion, and other reproductive healthcare providers in Louisiana is particularly harmful to care access among Black and Indigenous pregnant people who, as discussed above, have disproportionately higher rates of maternal mortality in the state.⁷⁴ As one CBO noted, “Louisiana was already experiencing a maternal mortality crisis before [*Dobbs*]” that “disproportionately affect[ed] [B]lack parenting.” They continued, “the loss of abortion access” in the state exacerbates that crisis.

Disparities in income are pronounced in Louisiana and make surmounting the numerous barriers to abortion care impossible for many. This is especially true for Louisiana’s Black residents who make up the majority of pregnant people who access abortion.⁷⁵ That is in part because more than a third of Louisiana’s Black residents live below the poverty level and only 38 percent live in households with an income greater than 250 percent of the federal poverty level compared to 65 percent of white Louisiana residents.⁷⁶ As one provider stressed:

I just would want to highlight... the racial disparities that come with this, and especially in Louisiana, where the south has the majority of the [B]lack people that live in this country... The rates of poverty go hand in hand with that. And when... you have people that are experiencing extreme poverty, changes in their jobs, we also have to bring in global warming and changes in their environment, which means more hurricanes and natural disasters which people are experiencing and still recovering from... These are the lived realities of people. And this is what our patients tell us every day, right. Whether it’s that hurricane or it’s this job or it’s this amount of money that they’re trying to get by on it and just have food on the table.

Likewise, LGBTQ+ people of color in Louisiana have higher poverty rates than white LGBTQ+ residents and nationally, people with disabilities are more likely to live in poverty and to work in low-wage, part-

time or service positions.⁷⁷ Access to care for marginalized communities is not only predicated on income disparities. Nearly 10 percent of Louisianans are uninsured while nearly a third are covered by Medicaid/Child Health Insurance Program, an income-dependent public insurance program that since 1976 has not covered abortion care except in the limited cases of rape, incest, or life endangerment.⁷⁸ 62 percent of the Insurance Program's non-elderly enrollees are people of color.⁷⁹

Immigration status can often result in additional barriers to abortion access. Approximately four percent of Louisiana's residents are immigrants and another four percent are native-born U.S. citizens with at least one immigrant parent.⁸⁰ Immigrants in the U.S. are more likely to be uninsured.⁸¹ They are also more likely than citizens to report not having a reliable source of medical care, not having seen a healthcare provider in the last year, and foregoing healthcare in the last year because of its cost.⁸² People with disabilities living in rural Louisiana have identified similar barriers to accessing health care including, a lack of transportation, lack of locally accessible specialized care, insurance coverage limits, and high out-of-pocket costs.⁸³

f. The delay and denial of abortion care causes pregnant people physical, mental, and legal harm

Louisiana's trigger bans nowhere contemplate the physical and mental trauma that pregnant people face when they seek and are denied abortion care. Even before *Roe* was overturned and Louisiana's trigger bans went into effect, the American Psychological Association reiterated that "people who are denied abortions are more likely to experience higher levels of anxiety, lower life satisfaction and lower self-esteem with those who are able to obtain abortions."⁸⁴ This has been borne out in a longitudinal study examining the harm of denying pregnant people access to abortion.⁸⁵

When pregnant people are neither able to access abortion care in their state nor to travel to a state where abortion is legal, they may self-manage their abortion. In guidelines recently published by the World Health Organization, it recommended that self-managed abortion should be available as an option to pregnant people, including by modifying restrictions on abortion medications, and should not be criminalized or restricted for non-clinical reasons, including a pregnant person's age.⁸⁶

As highlighted above, states have moved to limit access to medication abortion.⁸⁷ They have also targeted Black pregnant people. Research shows that 59 percent of people arrested or detained for self-managing an abortion or being suspected of having done so in the U.S. are Black.⁸⁸ This, in addition to state laws that criminalize pregnant people for their pregnancy outcomes when they suffer miscarriages and stillbirths, poses a particular threat to pregnant people of color who are subject to heightened surveillance and disproportionately targeted by the criminal justice system.⁸⁹

IV. International Human Rights Standards

Treaty monitoring bodies have long affirmed that abortion care is part of the continuum of reproductive health care and as such must be available, accessible, affordable, and of good quality.⁹⁰ They have also consistently found that restrictive abortion laws violate a range of human rights, including the rights to health, life, privacy, freedom from discrimination, and freedom from torture and ill-treatment.⁹¹ This Committee has recognized the central importance of personal autonomy to living a life with dignity.⁹² In so doing, it reaffirmed that abortion access is critical to a person's ability to enjoy their right to life and

that States must not impose criminal sanctions against women and girls accessing abortion or against health care providers who provide them abortion care.⁹³

In response to these human rights violations, U.N. treaty monitoring bodies, including this Committee, have found that States should, at a minimum, ensure certain legal grounds for abortion, i.e., when a pregnant person's life or health is at risk, in cases of rape and incest, and in cases of severe or fatal fetal impairments.⁹⁴ It is important to recognize that no human rights body —international or regional— has ever found legal provisions allowing abortion on request to be inconsistent with or in violation of a state's human rights obligations.

Moreover, human rights bodies in recent years have articulated state obligations to ensure access to abortion without reference to the minimum requirements of grounds-based laws and by noting how abortion regulations should not force persons to undergo unsafe abortions, consistent with the WHO's recent guidance showing evidence of how grounds-based laws lead to unsafe abortion (*see infra*, section V). In particular, in its General Comment No. 36 on the right to life, this Committee while articulating the minimum exceptions-based framework that states have an obligation to meet, also articulated the obligation that “States parties may not regulate pregnancy or abortion in all other cases in a manner that runs contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions.”⁹⁵ Both the Committee on the Elimination of Discrimination against Women (hereinafter CEDAW Committee) and the Committee on Economic, Social and Cultural Rights (hereinafter CESCR Committee) have also called on states to ensure access to safe abortion without specifying an exceptions-based minimum standard. The CEDAW Committee's General Recommendation No. 30 notes that states must “[e]nsure that sexual and reproductive health care includes access to sexual and reproductive health and rights information;... safe abortion services; post-abortion care;...”⁹⁶ The CESCR Committee has said that preventing unsafe abortions requires States to liberalize restrictive abortion laws, and to eliminate laws and policies that undermine autonomy and the right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health, for example by ending criminalization of abortion or removing restrictive abortion laws.⁹⁷

In addition, grounds-based legal frameworks do not provide sufficient guarantee of effective access to abortion services in practice, even when the grounds have been met. According to the WHO, the evidence shows that grounds-based laws contribute to delayed abortion for a number of reasons, including overly restrictive or inconsistent interpretations of grounds; disagreement among medical professionals about the satisfaction of a legal ground; women having to wait for their eligibility to be determined; and women having their claim that the pregnancy resulted from rape questioned or disbelieved.⁹⁸ Such laws are also subject to misinterpretation, which can lead to the denial of abortion.⁹⁹ In some cases, providers wait for “a health condition to deteriorate sufficiently to ensure that a woman satisfie[s] a ‘risk to life’ ground.”¹⁰⁰ The WHO abortion guideline notes that “grounds-based laws may contribute to an increase in the incidence of unsafe abortion, with people who do not satisfy a ground resorting to unlawful abortion.”¹⁰¹

Human rights bodies have unambiguously and repeatedly affirmed that people who are denied access to abortion care due to prohibitions on abortion may endure severe anguish, and mental and physical suffering reaching the minimum level of severity necessary to engage the absolute prohibition of torture and other ill-treatment.¹⁰² Moreover, in every case heard by this Committee on the denial of abortion access, it has found a violation of the right to be free from torture or cruel, inhuman or degrading treatment or punishment.¹⁰³

This Committee and others have long called on states to instead liberalize their abortion laws, remove existing barriers to effective access to safe and legal abortion, and in light of the non-retrogression principle, to refrain from introducing new barriers to abortion.¹⁰⁴ They have also called on States to repeal or reform discriminatory laws and policies that undermine people’s access to sexual and reproductive healthcare, including laws that criminalize or restrict abortion, require third-party authorizations, biased counseling, and mandatory waiting periods in order to ensure nondiscriminatory access to care.¹⁰⁵

Treaty monitoring bodies have consistently emphasized that access to information is critical to abortion access, and that states have a positive obligation to ensure such access to information.¹⁰⁶ They have recognized the right of providers to provide care to their patients and called on States to refrain from placing criminal sanctions on providers who provide information on abortion.¹⁰⁷ They have also called on States to remove other information barriers to care, including biased counseling, and to ensure that providers can share information to their patients that is science- and evidence-based.¹⁰⁸

Acknowledging that persons are impacted by intersecting forms of discrimination in the context of sexual and reproductive health, treaty monitoring bodies have recommended that States put a particular focus on the sexual and reproductive health needs of people belonging to these groups, including low-income people, persons with disabilities, migrants, indigenous or other racial and ethnic minorities, adolescents, and LGBTQ+ people.¹⁰⁹ Additionally, the CEDAW Committee has found that criminalization of abortion, denial or delay of safe abortion and post-abortion care, and forced continuation of pregnancy are all forms of gender discrimination and constitute gender-based violence.¹¹⁰

V. WHO Recommendations

The WHO’s Abortion Care Guideline (2022) sets forth recommendations on clinical, systems, and law and policy approach to abortion care. It is the WHO’s definitive guidance to states and other stakeholders on the issue of the provision of abortion care. The Guideline and its recommendations are grounded in public health evidence and in human rights standards, noting specifically that “as a standard approach to human rights-based health care, all norms, standards and clinical practice related to abortion should promote and protect: individuals’ health and human rights; informed and voluntary decision-making; autonomy in decision-making; non-discrimination (including intersectional discrimination) and equality; confidentiality and privacy; adequate referral mechanisms; the continuum of care.”¹¹¹

Equality and non-discrimination are at the heart of the guideline noting that the regulation of abortion should have the objective of “meeting the particular needs of marginalized persons,” “must consider the needs of all individuals,” and “should not lead to discrimination.”¹¹² The Guideline takes special note of women with few financial resources, young people, women with disabilities, migrant women, transgender and non-binary persons, and women from ethnic and racial minorities.¹¹³ Where abortion is highly restricted these communities, it underscores, are robbed of the choice to seek and obtain an abortion denied their human right to abortion.

To respect, protect, and fulfill the human right to abortion, the WHO Guideline makes seven law and policy recommendations based in human rights and public health evidence. Among these is the full decriminalization of abortion, which entails “removing abortion from all penal/criminal laws, not applying other criminal offences (e.g., murder, manslaughter) to abortion, and ensuring there are no criminal

penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.”¹¹⁴ The WHO also recommends that abortion be available on the request of the woman, girl, or other pregnant person and not restricted by grounds (i.e., the life or health of the pregnant person).¹¹⁵ It further recommends against prohibitions based on gestational age limits, mandatory waiting periods, third-party authorization, and regulations limiting who can provide abortion care that contravene WHO guidance.¹¹⁶ Lastly, the Guideline urges that laws and policies that protect against barriers to care created by conscientious objection should be enacted.¹¹⁷

The WHO Guideline further reiterates the safety and efficacy of medication abortion – it is on the WHO’s essential medicines list and human rights bodies have long recognized states’ obligation to ensure its availability and accessibility.¹¹⁸ Noting its safety, it recognizes that medication abortion can be self-administered at home and should not be considered “a last resort option,” but rather should be employed to meet the circumstances and preferences of the pregnant person.¹¹⁹ It further recommends “the option of telemedicine as an alternative to in-person interactions” with healthcare providers for the provision of counseling, instructions for the administration of medicines, and follow-up post-abortion care.¹²⁰

VI. Suggested Recommendations

We respectfully urge the Human Rights Committee to strongly condemn the major retrogression of abortion rights in the United States and express concern about its impact on pregnant people’s rights to life, equality and non-discrimination, privacy, information, and to be free from torture and ill-treatment, especially as it relates to pregnant people of color in the U.S. who experience multiple and intersecting forms of discrimination in exercising their right to reproductive freedom and bodily autonomy.

We further urge the Human Rights Committee to recommend to the United States government:

- a. Enact positive measures to ensure that people with the capacity to become pregnant have meaningful access to abortion and other reproductive healthcare information and services, such as the Women’s Health Protection Act, federal legislation currently pending in the U.S. Congress which establishes a statutory right for healthcare professionals to provide abortion care and the right of their patients to receive care;
- b. Repeal harmful legislation that creates barriers to abortion access, in particular for Black, Indigenous, and other people of color, people with limited financial resources, and people with disabilities, including the Hyde Amendment which restricts federal funding for abortion care except in very limited circumstances under Medicaid, a joint federal and state program that provides public health insurance for low-income families in the U.S.;
- c. Integrate the WHO’s newly issued Abortion Care Guideline, which makes evidence-based law and policy recommendations to States, including that they fully decriminalize abortionⁱⁱⁱ and refrain from enacting laws that restrict abortion by grounds, including by ensuring that the U.S. Federal Drug Administration maintains authority to approve medication abortion;

ⁱⁱⁱ The WHO defines this as “removing abortion from all penal/criminal laws, not applying other criminal offences (e.g., murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors.” *See supra* note 98.

- d. Enact laws and policies that protect people seeking or accessing abortion from prosecution under state laws;
- e. Protect medical professionals who provide abortion and other reproductive healthcare services by prohibiting their civil or criminal liability, disbarment, loss of license, or other retribution or reprimanding measures as a result of abortion bans, including by promoting the adoption of “shield laws” that create protections from civil actions of another state for individuals who obtain, provide, recommend, or assist others in obtaining abortion services;
- f. Adopt laws and policies to protect clinicians and clinics from violence for the provision of abortion and other reproductive healthcare services; and
- g. Use the U.S. government’s oversight authority to monitor the impact of abortion bans on the provision of reproductive health care and on health disparities, and the effectiveness of legislative measures such as federal guidance on Emergency Medical Treatment and Active Labor Act (EMTALA) that is aimed to secure access to abortion in life-threatening situations even in states where abortion is banned.

APPENDIX A

UN Statements and Concluding Observations

U.N. human rights mechanisms and mandate holders have repeatedly expressed their concern about the United States Supreme Court's ruling in *Dobbs* and its adverse effects on pregnant people and reminded the U.S. of its human rights obligations to protect the rights to life, health, equality and non-discrimination, privacy, information, and to be free from torture and ill-treatment.

- Mandate holders submitted an *amicus* brief in *Dobbs* detailing international human rights protections for abortion access and how retrogression in U.S. constitutional protections for abortion would contradict international human rights law.¹²¹
- Following *Dobbs*, mandate holders issued a Press Release denouncing the decision as an erosion of human rights and of democratic values and processes.¹²²
- The CEDAW Committee conveyed its concern with the *Dobbs* ruling, expressing solidarity with women and girls in the U.S. and urging that the government meets its obligations under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).¹²³
- At the conclusion of his country visit to the U.S. in August 2022, the Independent Expert on sexual orientation and gender identity relayed his concern that federal protections based on sexual orientation and gender identity remained vulnerable to erosion and cited *Dobbs*.¹²⁴
- In its concluding observations to the U.S. at the conclusion of its review under the Convention on the Elimination of all Forms of Racial Discrimination in 2022, the Committee on the Elimination of Racial Discrimination noted its concern with *Dobbs*. In particular, the “profound disparate impact on the sexual and reproductive and rights of racial and ethnic minorities.”¹²⁵
- Most recently, in May 2023, ten mandate holders sent a communication to the U.S. expressing their concern about the retrogressive measures that are restricting access to abortion care throughout the country.¹²⁶

¹ Human Rts. Comm., List of issues prior to submission of the fifth periodic report of the United States of America, U.N. Doc. CCPR/C/USA/QPR/5 (April 18, 2019), https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2FC%2FUSA%2FQPR%2F5&Lang=en.

² *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf.

³ *Id.*; *Roe v. Wade*, 410 U.S. 113 (1973).

⁴ This includes Idaho, North Dakota, South Dakota, Missouri, Arkansas, Mississippi, Alabama, among many others. *After Roe Fell: Abortion Laws by State*, Ctr. for Reprod. Rts., <https://reproductiverights.org/maps/abortion-laws-by-state/> (last visited Aug. 9, 2023).

⁵ *In Historic Victory, Argentina Legalizes Abortion*, Ctr. for Reprod. Rts. (Jan. 15, 2021), <https://reproductiverights.org/historic-vote-argentina-legalize-abortion/>; Fabiola Sánchez & Megan Janetsky, *Mexico decriminalizes abortion, extending Latin American trend of widening access to the procedure*, AP (Sept. 6, 2023), <https://apnews.com/article/mexico-abortion-decriminalize-d87f6eddbdf68c2e6c8f5700b3afd15de>.

⁶ Katherine Gallagher et al., *State Abortion Bans Harm More than 15 Million Women of Color*, Nat'l P'ship for Women & Families (June 2023), <https://nationalpartnership.org/report/state-abortion-bans-harm-woc/>.

⁷ *Id.*

⁸ Geoff Mulvihill et al., *A Year After Fall of Roe v. Wade, 25 Million Women Live in States with Abortion Bans or Restrictions*, AP (June 22, 2023), <https://apnews.com/article/abortion-dobbs-anniversary-state-laws-51c2a83899f133556e715342abfcface> (finding that in addition to the 25 million women who live in states where there are more restrictions on abortion access today than pre-Jackson Women's Health Organization, another 5.5 million live in states where laws prohibiting or restricting abortion are under being litigated).

⁹ Rachel Treisman, *States with the toughest abortion laws have the weakest maternal supports, data shows*, NPR (Aug. 18, 2022), <https://www.npr.org/2022/08/18/1111344810/abortion-ban-states-social-safety-net-health-outcomes>; see also David C. Radley et al., *2023 Scorecard on State Health System Performance*, The Commonwealth Fund (June 22, 2023), <https://www.commonwealthfund.org/publications/scorecard/2023/jun/2023-scorecard-state-health-system-performance>.

¹⁰ Many of these “abortion havens” —including California, Connecticut, New Jersey, and New York— have enacted interstate shield laws. “Interstate shield legislation shields ‘access state’ providers, patients, and people assisting in abortion provision by protecting against investigations, extradition, health care professional penalties, and judgments in out-of-state lawsuits.” *2022 State Legislative Wrap-Up, State Policy Report: An overview of the state landscape*, Ctr. for Reprod. Rts. (Dec. 21, 2022), <https://reproductiverights.org/2022-state-legislative-wrap-up/#:~:text=During%202022%2C%20states%20considered%20more.and%20the%20District%20of%20Columbia.&text=%E2%80%9CWithout%20proactive%20legislation%2C%20access%20to.abortion%20care%20access%20has%20become.%E2%80%9D>.

¹¹ Piper Hutchinson, *Louisiana AG Landry wants info on out-of-state abortions, gender-affirming care*, Louisiana Illuminator (July 17, 2023), <https://lailluminator.com/2023/07/17/louisiana-ag-jeff-landry-wants-info-on-out-of-state-abortions-gender-affirming-care/>.

¹² Aria Bendix, *Idaho becomes one of the most extreme anti-abortion states with law restricting travel for abortions*, NBC News (April 6, 2023), <https://www.nbcnews.com/health/womens-health/idaho-most-extreme-anti-abortion-state-law-restricts-travel-rcna78225>.

¹³ Tex. Health & Safety Code §§ 171.201-204, 207-211.

¹⁴ Abigail Aiken et al., *Factors associated with use of an Online Telemedicine Service to Access Self-Managed Medical Abortion in the U.S.*, 4 JAMA 1 (May 21, 2021), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780272?widget=personalizedcontent&previousarticle=0> (noting that Louisiana was among the state with the highest rates of request.)

¹⁵ *Louisiana: 2020 Census*, U.S. Census Bureau (Aug. 25, 2021), <https://www.census.gov/library/stories/state-by-state/louisiana-population-change-between-census-decade.html>.

¹⁶ *The Louisiana Health Care Landscape*, KFF (June 8, 2016), [https://www.kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/#:~:text=In%20particular%2C%20compared%20to%20the.12%25%20nationally\).&text=Hispanics%20account%20for%206%25%20of.identifies%20as%20non%2DHispanic%20White](https://www.kff.org/health-reform/fact-sheet/the-louisiana-health-care-landscape/#:~:text=In%20particular%2C%20compared%20to%20the.12%25%20nationally).&text=Hispanics%20account%20for%206%25%20of.identifies%20as%20non%2DHispanic%20White).

¹⁷ *Louisiana: 2020 Census*, *supra* note 15; *Poverty in Louisiana, America's Health Rankings* https://www.americashealthrankings.org/explore/measures/household_poverty/LA (last visited Aug. 17, 2023).

¹⁸ *The Louisiana Health Care Landscape*, *supra* note 16.

¹⁹ Josie Abugov, *A year after Roe v. Wade overturned, abortion rights advocacy groups keep fighting*, Louisiana Illuminator (June 26, 2023), <https://lailluminator.com/2023/06/26/a-year-after-roe-v-wade-overturned-abortion-rights-advocacy-groups-keep-fighting/>.

²⁰ La. Stat. Ann. §40:1061; La. Stat. Ann. §§14:87.7, 14:87.8.

²¹ La. Stat. Ann. §40:1061; 2006 La. Act 467, §1; 2022 La. Act 545; 2022 La. Act 548. Numerous other states, including Alabama, Arkansas, Kentucky, Missouri, Oklahoma, South Dakota, Texas, and Utah, moved to immediately ban abortion under trigger bans. *13 States Have Abortion Trigger Bans - Here's What Happens When Roe Is Overturned*, Guttmacher Inst. (June

6, 2022), <https://www.guttmacher.org/article/2022/06/13-states-have-abortion-trigger-bans-heres-what-happens-when-roe-overturned>.

²² La. Stat. Ann. §40:1061(C).

²³ *Id.* at §40:1061(F).

²⁴ *See id.* at §40:1061.

²⁵ La. Stat. Ann. §§14:87.7, 14:87.8.

²⁶ La. Stat. Ann. § 14:87.1(1)(b)(iii). Act 545 defines a "medically futile" pregnancy as one where "'in reasonable medical judgment as certified by two physicians, the unborn child has a profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth.'" La. Stat. Ann. §14:87.1(19)(a).

²⁷ La. Stat. Ann. §§ 14:87.1(18), 14:87.1 (26).

²⁸ Dr. Courtney N. Phillips, *List of Conditions that shall deem an unborn child "Medically Futile"*, La. Dep't of Health: Off. of Pub. Health (Aug. 1, 2022), https://ldh.la.gov/assets/oph/Rulemaking/er/LDH_ER_List_of_Conditions_that_Shall_Deem_an_Unborn_Child_Medically_Futile_CLV_Signed_and_Dated_1_August_2022.pdf (list of conditions that would make a fetus "medically futile").

²⁹ *Id.*

³⁰ *June Med. Servs. v. Landry*, No. C-720988, 2022 WL 2902418 (La. East Baton Rouge Par. Civ. Dist. Ct. July 21, 2022) (granting preliminary injunction).

³¹ *June Med. Servs. v. Landry*, No. 2022 CW 0806 (La. App. 1 Cir. July 29, 2022) (suspending preliminary injunction).

³² *June Med. Servs. v. Landry*, No. C-720988, La. East Baton Rouge Par. Civ. Dist. Ct.

³³ La. Stat. Ann. §§ 40:1061.1.2(E)–(G), 40:1061.13.

³⁴ La. Stat. Ann. §14:87.9 (criminalizing medication abortion); La. Stat. Ann. §§ 40:1061(C) (prohibiting medication abortion), 40:1061.10 (requiring a 72-hour waiting period, an ultrasound, and biased counseling), 40:1061.16 (requiring biased counseling and a related 72-hour waiting period), 40:161.17 (requiring biased counseling and a related 72-hour waiting period), 40:1061.11.1 (requiring biased counseling).

³⁵ La. Stat. Ann. §§40:1061.14, 40:1061.21 (A) (5) (c).

³⁶ The person seeking an abortion must either report the rape or incest to law enforcement, or the treating physician must certify in writing that in their professional opinion, the pregnant person was "too physically or psychologically incapacitated to report" the rape or incest. In addition, the pregnant person must certify that the pregnancy resulted from rape or incest, and this certificate must be witnessed by the treating physician. La. Stat. Ann. §§40:1061.6 (A) (1), 40:1061.6(B), 40:1061.18(A), 40:1061.18(B).

³⁷ La. Stat. Ann. § 22:1014. *See also Regulating Insurance Coverage of Abortion*, Guttmacher Institute (Aug.31, 2023), <https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion#:~:text=Several%20states%20have%20restricted%20abortion,state%2Dlevel%20health%20insurance%20exchange>

³⁸ The research methodology was approved by PHR's Ethics Review Board in order to ensure compliance with U.S. requirements for human subject research. The research teams obtained informed oral consent from all interview subjects, and all interviews were conducted using a range of security precautions and protections. Subjects are only described in a manner that does not identify them or to provide any identifying characteristics.

³⁹ Nancy Davis was 10 weeks pregnant when her fetus was diagnosed with acrania, a rare and fatal condition in which the fetus does not develop a skull. Ms. Davis was told the diagnosis meant that she would be able to access abortion care in the state based on a state list of conditions that constituted a "medically futile" fetus. She was referred to a nearby abortion clinic only to learn later that it had shut down. When Ms. Davis sought abortion care at Women's Hospital, she was told that in order to comply with the state's trigger ban she would need to carry her pregnancy to term or travel to Florida where abortion was then legal up to 15 weeks of gestation. Ms. Davis was ultimately forced to travel to New York state, where abortion is legally protected, to access essential care. *See Emily Woodruff, Louisiana Hospital Denies Abortion for Fetus Without a Skull*, NOLA News (Aug. 17, 2022), https://www.nola.com/news/healthcare_hospitals/article_d08b59fe-1e39-11ed-a669-a3570eed885.html; Ava Sasani & Emily Cochrane, *'I'm Carrying this Baby Just to Bury It': The Struggle to Decode Abortion Laws*, The N. Y. Times (Aug. 19, 2022), <https://www.nytimes.com/2022/08/19/us/politics/louisiana-abortion-law.html>; Ramon Antonio Vargas, *Louisiana Woman Carrying Unviable Fetus Forced to Travel to New York for Abortion*, The Guardian (Sept. 14, 2022), <https://www.theguardian.com/us-news/2022/sep/14/louisiana-woman-skull-less-fetus-new-york-abortion>.

⁴⁰ *Id.*

⁴¹ *If Roe v. Wade is Overturned: New Interactive Map Shows How Far People Seeking Abortion in the 26 States Certain or Likely to Ban the Procedure Will Need to Travel to get the Care they Need*, Guttmacher Inst. (Oct. 28, 2021),

<https://www.guttmacher.org/news-release/2021/if-roe-v-wade-overtured-new-interactive-map-shows-how-far-people-seeking-abortion>.

⁴² Kaitlin Washburn, *Planned Parenthood of Illinois Reports Spike in Abortion Patients Since Roe v. Wade Overtured*, WBEZ Chicago (June 13, 2023), <https://www.wbez.org/stories/illinois-sees-spike-in-abortions-since-roe-v-wade-overtured/c34edc98-9efa-42bb-acc1-5ac460015948>.

⁴³ Elvia Malagón, *Illinois Abortion Providers See Demand, Wait Times Rise a Month After Supreme Court Struck Down Roe v. Wade*, Chicago Sun Times (July 23, 2022), <https://chicago.suntimes.com/2022/7/23/23271342/abortion-demand-midwest-access-coalition-supreme-court-dobbs-jackson-reproductive-rights-roe-wade>.

⁴⁴ *Zurawski v. Texas*, No. D-1-GN-23-000968, 2023 WL 4995462 (Tex. Dist. Ct. Aug. 4, 2023).

⁴⁵ See Physicians for Human Rts. & the Sch. of Pub. Health and Primary Health Care Univ. of Cape Town, *Dual Loyalty & Human Rights In Health Professional Practice: Proposed Guidelines & Institutional Mechanisms* 11-13 (2002), <https://phr.org/wp-content/uploads/2003/03/dualloyalties-2002-report.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/#:~:text=Nationally%2C%20one%20in%20five%20office,in%20ten%20OBGYNs%20\(40%25\)](https://www.kff.org/womens-health-policy/report/a-national-survey-of-obgyns-experiences-after-dobbs/#:~:text=Nationally%2C%20one%20in%20five%20office,in%20ten%20OBGYNs%20(40%25)).

⁴⁷ In testimony in support of a bill that would have provided legal and medical clarity to the trigger ban, the bill's sponsor told of a pregnant woman who had been diagnosed with a molar pregnancy – where cells grow inside the uterus and can lead to cancer, hemorrhaging, and other complications. Notwithstanding the medical risks a molar pregnancy diagnosis carries, the woman's providers told her they could not provide her with abortion care until “her vitals crashed”, fearing that they would run afoul of the state's trigger ban. Rosemary Westwood, *House Republicans defeat bills to clarify pregnancy care under Louisiana abortion ban*, WWNO (May 16, 2023), <https://www.wwno.org/public-health/2023-05-16/house-republicans-defeat-bills-to-clarify-pregnancy-care-under-louisiana-abortion-ban>; see also Woodruff, *supra* note 39; Sasani & Cochrane, *supra* 39; Vargas, *supra* note 39.

⁴⁸ Phillips, *supra* note 28.

⁴⁹ Julie O'Donoghue, *Louisiana Health Department Declines to Answer Doctor's Questions on Abortion Law*, Louisiana Illuminator (Nov. 1, 2022), <https://lailluminator.com/2022/11/01/louisiana-health-department-declines-to-answer-doctors-questions-on-abortion-law/>.

⁵⁰ *Id.*

⁵¹ Rosemary Westwood, *Bleeding and In Pain, She Couldn't Get 2 Louisiana ERs to Answer: Is it a Miscarriage?*, NPR (Dec. 29, 2022), <https://www.npr.org/sections/health-shots/2022/12/29/1143823727/bleeding-and-in-pain-she-couldnt-get-2-louisiana-ers-to-answer-is-it-a-miscarria>.

⁵² *Id.*

⁵³ Kaitlyn Joshua of Baton Rouge, Louisiana, was six weeks pregnant when she learned her OB/GYN was delaying prenatal appointments to 12 weeks. After experiencing abdominal pain and heavy bleeding at around 10 weeks Ms. Joshua visited the emergency room at Women's Hospital and was told her fetus had stopped growing and had a faint heartbeat. When she asked the doctors to confirm what she knew to be true, that she was suffering a miscarriage, they equivocated and recommended she go home and keep monitoring her symptoms. When Ms. Joshua's symptoms worsened, she visited a second hospital, this one further away. The doctors there also refused to confirm that Ms. Joshua was suffering a miscarriage and denied her care. Ms. Joshua, a Black woman and mother of a four-year old, was ultimately forced to pass her pregnancy at home over the course of multiple weeks. *Id.*

⁵⁴ Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2021*, Ctrs. for Disease Control & Prevention (Mar. 2023), <https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf>; Laura G. Fleszar et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Groups in the United States*, 330 JAMA 52 (2023), <https://jamanetwork.com/journals/jama/article-abstract/2806661>; Munira Z. Gunja et al., *The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison*, The Commonwealth Fund (Dec. 1, 2022), <https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison>.

⁵⁵ *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths*, Ctrs. for Disease Control & Prevention (Sept. 5, 2019), <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>.

⁵⁶ *What Explains the United States' Dismal Maternal Mortality Rates?*, Wilson Ctr. (Nov. 19, 2015), <https://www.wilsoncenter.org/event/what-explains-the-united-states-dismal-maternal-mortality-rates#:~:text=More%20women%20are%20having%20children,believed%20to%20be%20a%20contributor>.

⁵⁷ So O'Neil et al., *The High Costs of Maternal Morbidity Show Why We Need Greater Investment in Maternal Health*, The Commonwealth Fund (Nov. 12, 2021), <https://www.commonwealthfund.org/publications/issue-briefs/2021/nov/high-costs->

[maternal-morbidity-need-investment-maternal-health#:~:text=The%20most%20severe%20consequence%20of.the%20worst%20among%20developed%20countries.](#)

⁵⁸ Emily Woodruff, *'It's a Minefield': Louisiana's Abortion Laws Leave Doctors Fearful of Violations*, Nola (July 22, 2022), https://www.nola.com/news/healthcare_hospitals/article_c48759b2-0905-11ed-82cb-3769ba1e2b5a.html.

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