IN THE
INDIANA COURT OF APPEALS

Cause No. 71A04-1504-CR-00166

PURVI PATEL,	)	
	)	Appeal from the St. Joseph Superior Court
Appellant	)	
v.	)	Cause No. 71D08-1307-FA-000017
	)	
STATE OF INDIANA,	)	Hon. Elizabeth C. Hurley, Judge
	)	
Appellee	)	

BRIEF OF AMICI CURIAE NATIONAL ASIAN PACIFIC AMERICAN WOMEN'S FORUM AND CENTER ON REPRODUCTIVE RIGHTS AND JUSTICE AT THE UNIVERSITY OF CALIFORNIA, BERKELEY, SCHOOL OF LAW, ET AL

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INTERESTS OF AMICI CURIAE

Amici are organizations and individuals who work to protect and promote the reproductive health, rights, and justice of people and communities throughout the United States. Please see Appendix A for Statements of Interest.

STATEMENT OF THE CASE

Amici accept and adopt the Statement of the Case found in Appellant's brief and base these arguments thereon.

STATEMENT OF THE FACTS

Amici accept and adopt the Statement of Facts found in Appellant's brief and base these arguments thereon.

SUMMARY OF ARGUMENTS

Amici urge the Court to overturn Ms. Patel's conviction, because it is common for pregnant people in the United States, and around the world, to use medication to self-induce abortions. When someone needs to end a pregnancy, legal restrictions, practical barriers, and cultural preferences may make clinic-based care unattainable or untenable, thereby leaving self-induction the only accessible or acceptable option. If the Court upholds this conviction, and allows prosecutors to link self-induced abortions with feticide, it will have cascading repercussions for all pregnant people, particularly those from marginalized communities.

We are confident Ms. Patel's defense counsel and other *amici* will make insightful and effective arguments about the facts of her case and the contradictory nature of the charges against her. Nonetheless, the very basis of the charges and conviction at issue – that a pregnant person's actions or inactions resulting in pregnancy loss can constitute crimes – is inherently

problematic. We urge the court to overturn this, and any, effort to convict a person for ending a pregnancy without medical supervision.

ARGUMENT

I. The Court should not make it a crime for a pregnant person to end her own pregnancy without medical supervision.

Pregnant people in the U.S. sometimes end their own pregnancies without medical supervision because, for many, it is the only method acceptable or available to them. The Court should not make it a crime[1] for a person to use medication to induce her own abortion, because doing so will cut off the rights of an untold number of people. By allowing the State to create criminal liability for self-induced abortions, equating self-administered medication abortion to feticide, the Court ignores the conditions that render this method of abortion a necessity for many people and will disproportionately harm vulnerable and marginalized populations.

A. Abortion self-induction with medication is safe, effective, and common in the United States

It is very common for pregnant people in the U.S. to receive medication abortion care through medical facilities.[2] And, there is growing evidence that pregnant people in the U.S. are self-inducing abortions using an FDA-approved medication called Misoprostol ("Miso") at home

[1] As other *amici* artfully point out, neither Indiana's statutory nor common law contemplate such prosecutions, so by

[2] In 2011, 23 percent of all non-hospital abortions and 36 percent of abortions before nine weeks' gestation were medication abortions. *See* Rachel K. Jones and Jenna Jerman, *Abortion incidence and service availability in the United States*, Perspectives on Sexual and Reproductive Health, 2014, Volume 46, Number 1 (March 2014).

without medical supervision, "primarily among immigrants from countries where such use is common practice."[3]

When a pregnant person in the U.S. receives medication for abortion from a medical clinic, she takes two different types of medication. The first medication, mifepristone (brand name Mifeprex), is ingested in the clinic pursuant to FDA guidelines.[4] To complete the abortion,[5] the protocol endorsed by the American College of Obstetricians and Gynecologists[6] recommends that the pregnant person take the second medication, Miso, at home.

When a pregnant person ends a pregnancy using medication without medical supervision, she generally takes only one of the drugs in this two-part regimen, Miso, because mifepristone is expensive and must be distributed at a licensed medical office.[7] However, ingesting Miso without mifepristone can safely induce an abortion[8] and is 85 percent effective.[9] Miso essentially causes the uterus to contract and empty.[10] The side effects of Miso are generally minimal and similar to those associated with spontaneous miscarriage.[11] In fact, the risk of a pregnant person

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[3] Francine Coeytaux, Leila Hessini, Amy Allina, *Bold Action to Meet Women's Needs: Putting Abortion Pills in U.S. Women's Hands*, Women's Health Issues (September 2015), available at http://www.whijournal.com/article/S1049-3867(15)00129-2/pdf.

[4] Maureen Paul, Steve Lichtenberg, Lynn Borgatta, David A. Grimes, Phillip G. Stubblefield, *Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care*, 114 (2009).

[5] *Id.*

[6] ACOG, Medical Management of First-Trimester Abortion, ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists, No. 143 (March 2014).

[7] Mifeprex Prescriber's Agreement (2005).

[8] Guttmacher Institute, *Induced Abortion in the United States* (July 2014), available at http://www.guttmacher.org/pubs/fb_induced_abortion.html [hereinafter Guttmacher, *Induced Abortion*]

[9] Kulier, R., Kapp, N., Gulmezoglu, A.M., Hofmeyr, G.J., Cheng, L., and Campana, A. *Medical methods for first trimester abortion. Cochrane Database of Systematic Reviews* (2011), at 11.

[10] *Id.*

[11] *Id.*

"being harmed by using misoprostol for abortion is very low and easily mitigated. Indeed, the greatest risk is that the misoprostol is not effective and the pregnancy continues."[12]

Pregnant people throughout much of the world, including in the U.S., often ingest Miso without medical supervision.[13] Although Miso is currently available in the U.S. for medication abortions only with a prescription as part of a two-drug regimen, it is readily available over the counter elsewhere in the world and is commonly used to induce abortion outside of clinical settings.[14]

Regardless of whether a pregnant person in the U.S. has a medication abortion with or without medical supervision, the pregnant person generally takes Miso at home, not in a medical clinic.[15]

B. Countless conditions may push a pregnant person away from clinical abortion care or pull her toward self-directed care.

If the Court criminalizes abortion self-induction, it will be ignoring the myriad reasons that may push a pregnant person away from clinical abortion care or pull her toward self-directed care – conditions that ought to be taken into account. Some pregnant people cannot reach clinics due to excessive and egregious legal restrictions on abortion providers that have decimated reproductive health services. Low-income people run up against insurmountable practical obstacles that make clinic-based abortion care impossible to afford. For some, self-directed care is preferred in order to abide by a value system or to avoid interaction with a distrusted medical

[12] Coeytaux, *supra* note 3, at 2.
[13] *Id.*
[14] *Id.;* Consorcio Latinoamericano Contra el Aborto Inseguro (CLACAI) and Ipas, *Misoprostol and Medical Abortion in Latin America and the Caribbean* (2010).
[15] The only legal reason a pregnant person having a medication abortion in a medical clinic would not take Miso at home is if the state overrides the medical community's recommended protocols. Guttmacher, *Induced Abortion, supra* note 8.

system. Finally, cultural confusion and linguistic barriers dissuade some immigrants from seeking or finding abortion care in a clinical setting.

Pregnant people self-induce abortion when legal restrictions and practical barriers push clinic-based abortion care out of reach.

Ever-tightening restrictions on abortion providers and access have made clinic-based abortion care an unattainable option for many in the U.S. In 2015 alone, states have enacted 51 abortion restrictions.[16] Recently enacted restrictions include pre-viability bans, limits on medication abortion, targeted regulations of abortion providers (TRAP), and insurance coverage limitations.[17] The majority of pregnant people in the U.S. now live in states that have restrictive abortion laws and have severely limited access to clinic-based abortions due to clinics closing as a direct result of these laws.[18]

Indiana has some of the strictest abortion regulations in the nation, including mandatory delays and counseling requirements designed to discourage pregnant people from obtaining abortions.[19] The state also prohibits the use of telemedicine to provide medication abortions. Additionally, a pregnant person must undergo an ultrasound and be offered the option to view the image before receiving abortion care.[20]

The practical implications of abortion restrictions prompt some pregnant people, who would prefer clinic-based abortion care, to end their own pregnancies because they cannot access

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[16] Elizabeth Nash, Rachel Benson Gold, Gwendolyn Rathbun and Yana Vierboom, Guttmacher Instutute, *Laws Affecting Reproductive Health and Rights: State Trends at Midyear* (July 2015), available at http://www.guttmacher.org/statecenter/updates/2015/statetrends22015.html.

[17] Heather D. Boonstra and Elizabeth Nash, Guttmacher Institute, *A Surge of State Abortion Restrictions Puts Providers - and the Women They Serve - in the Crosshairs,* 17 Policy Review 1 (Winter 2014).

[18] Guttmacher Institute, *State Facts about Abortion: Indiana* (2014), available at https://www.guttmacher.org/pubs/sfaa/indiana.html [hereinafter Guttmacher, *State Facts*].

[19] State of Indiana, *Indiana Informed Consent Brochure* (2014), available at http://www.in.gov/isdh/files/Abortion_Informed_Consent_Brochure.pdf

[20] Guttmacher, *Induced Abortion*, *supra* note 8.

providers. In Indiana, where 93 percent of counties had no abortion clinic, and 61 percent of Indiana women lived in counties without an abortion clinic,[21] the distance between a pregnant person and the nearest provider often presents an insurmountable obstacle due to the logistical demands and combined costs of securing travel, accommodations, childcare, and time off work – that is, assuming she can afford the procedure itself.[22] Other laws, such as those requiring counseling, parental consent, and ultrasounds, extract heavy emotional tolls from pregnant people in what can already be an emotionally jarring process.

Clinic-based care can be prohibitively expensive for those who do not have health insurance coverage for abortion.

For poor and low-income people who are uninsured or whose insurance does not cover abortion, the out-of-pocket costs can be prohibitively expensive. The average cost of a first-trimester abortion[23] is equivalent to nearly a quarter of the monthly average per capita income in Indiana.[24] Second-trimester abortions can cost two or three times as much; and this does not account for the attendant costs of transportation, housing, and child care. Pregnant people may have to carry their pregnancies longer than they want in order to pull together the necessary funds for abortions, which then increases the cost and complexity of the procedure, further entrenching pregnant people and their families in poverty.[25]

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[21] Guttmacher, *State Facts*, *supra* note 18.

[22] Guttmacher, *Induced Abortion, supra* note 8; Rachel K. Jones, Ushma Upadhyay, and Tracy A. Weitz, Guttmacher Institute, *At What Cost? Payment for Abortion Care by U.S. Women, Women's Health Issues* (2013), at 2, available at https://www.guttmacher.org/pubs/journals/j.whi.2013.03.001.pdf

[23] Jones, *supra* note 22 (In 2011-2012, the average cost of a non-hospital abortion with local anesthesia at 10 weeks of gestation was $480, and the average amount for medication abortion before 10 weeks was $504.)

[24] U.S. Census Bureau, *Indiana QuickFacts*, available at http://quickfacts.census.gov/qfd/states/18000.html.

[25] Jill E. Adams and Jessica Arons, *A Travesty of Justice: Revisiting Harris v. McRae*, 21 Wm & Mary J. Women and Law 5 (2014).

Medicaid provides health coverage to 11 million non-elderly low-income parents, other caretaker relatives, pregnant women, and non-disabled adults.[26] The Hyde Amendment, an appropriations rider passed by Congress annually since 1976, bans federal Medicaid funds from covering abortions except in few select cases.[27] The Supreme Court upheld the Hyde Amendment in the split decision *Harris v. McRae*[28], in which the narrow majority found that the government does not have an obligation to "subsidize abortions," and that the difficulties indigent women encounter in seeking abortions are not caused by the government, but rather by their own poverty.[29] Thirty-three states, including Indiana, have adopted the Hyde Amendment standard and refused to apply state Medicaid funds to cover abortion care with the same narrow exceptions.[30]

The Hyde Amendment paved the way for subsequent restrictions in other federal health insurance programs, which have led to the denial of abortion coverage for military personnel, Peace Corp volunteers, Native Americans, federal employees, and people incarcerated in federal prisons.[31] It has also been applied to the Affordable Care Act ("ACA") and requires pregnant people who purchase private insurance through the state exchanges with ACA assistance to pay additional premiums for abortion care.[32]

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[26] Centers for Medicare & Medicaid Services, *Medicaid and CHIP Enrollment Data by Population*, available at http://www.medicaid.gov/medicaid-chip-program-information/by-population/by-population.html

[27] Adams, *supra* note 25, at page 11; Jessica Arons and Madina Agénor, Center for American Progress, *Separate and Unequal: The Hyde Amendment and Women of Color* (2010), at 7.

[28] *Harris v. McRae* (1980) 448 U.S. 297.

[29] *Id.*; Adams *supra* note 25, at 12.

[30] Adams *supra* note 25, at 7.

[31] *Id.,* at 13.

[32] *Id.;* Arons, *supra* note 27, at 4.

Indiana also has restrictions on private insurance coverage of abortion – forbidding companies from covering abortion except in cases of rape, incest, or severe risk to life.[33] This policy, when paired with other state and federal funding rules, essentially requires nearly all pregnant people to pay for the abortions they need out of their own pockets.

Strongly held values or deep-seated distrust may lead a person to end her own pregnancy at home without medical supervision.

A pregnant person may prefer to end her pregnancy in the comfort of her own home and in the safety of her chosen company. Self-directed care may be a requirement of her belief system or an expression of her values. This choice is an expression of autonomy and a form of empowerment that ought to be respected – not criminalized. Medical empowerment includes the ability of individuals to make choices and undertake actions related to their health that are in harmony with their values.[34] A familiar form of medical empowerment is self-medication, or taking over-the-counter drugs like ibuprofen to treat minor ailments.[35]

In the context of abortion, empowerment can take shape in the pregnant person's choice of location, company, and method. A pregnant person may prefer to have an abortion in the privacy and comfort of her own home, rather than in the impersonal and public setting of a

[33] Because of these restrictions, poor pregnant people cannot rely on their public insurance to cover abortions, which may be the determinative factor in whether and when they can obtain an abortion. Guttmacher, *Induced Abortion*, *supra* note 8; *see also* Adams, *supra* note 25; Arons, *supra* note 27, at 4.

[34] RM Josée LaFrance and Lyne Mailhot, *Empowerment: A Concept Well-Suited for Midwifery*, 4 Canada Journal of Midwifery Research and Practice 2 (2005).

[35] Survey by StrategyOne, for Consumer Healthcare Products Association, *Your Health at Hand*, Slide entitled "Empowerment" (2010), available at http://www.yourhealthathand.org/pillars/empowerment (finding 93 percent of U.S. adults preferred using self-treatments before seeking professional care and concludes over-the-counter medications "empower consumers to make informed choices every day and take better care of themselves and their families by giving them more control over their own care.")

hospital or clinic.[36] She may want to be surrounded by her spouse, family, or friends, rather than strangers. Additionally, she may want to self-medicate using Miso, vitamins, herbs, or natural remedies, because she views these methods as more natural or less physically invasive than surgical abortion.[37]

As with other forms of self-directed care, these choices align a person's actions with her values – because self-directed care is parcel to their belief system and consistent with their orientation toward health. By imposing sanctions[38] on these people, states violate their rights to autonomy and bodily integrity, coercing their healthcare decisions and forcing them to act in ways that are incompatible with their strongly held beliefs.

The decision to self-administer medication abortion may stem from a distrust of the conventional U.S. healthcare system, which has a long history of abuses targeting people of color, immigrants, and indigent people. The medical system and the U.S. government have a long history of abuses targeting people of color, immigrants, and indigent people. As a result, pregnant people in these communities often have a deep-seated distrust of medical providers, especially as related to reproductive health care. Additionally, many diaspora communities[39] bring with them a similar distrust, rooted in abuses by medical communities in their native

[36] Daniel Grossman, Kelsey Holt, Melanie Peña, Diana Lara, Maggie Veatch, Denisse Córdova, Marji Gold, Beverly Winikoff, Kelly Blanchard, *Self-Induction of Abortion Among Women in the United States*, Reproductive Health Matters (2010), at 142.
[37] *Id.*
[38] Such sanctions are also legally questionable. As other *amici* explain, Indiana's criminal statutes that address fetal death do not explicitly nor by intention cover crimes by a pregnant person against their own fetuses.
[39] While virtually all Americans have immigrant roots, diasporas are created by a forced or induced historical emigration from an original homeland. The Migration Policy Institute has identified 15 distinct diaspora communities in the U.S. *See* Migration Policy Institute, *Select Diaspora Populations in the United States* (July 2014), available at http://www.migrationpolicy.org/research/select-diaspora-populations-united-states.

countries.[40] Two examples of medical abuse are sterilization and pharmaceutical testing. In the last century, Native-American, Mexican-American, African-American, and Puerto-Rican women, as well as Japanese women in U.S. internment camps,[41] endured widespread coercive or forced sterilization by the government and private doctors.[42] Women who did not speak English were asked or coerced into signing English-only forms during labor and childbirth that authorized sterilization, while others were given hysterectomies without their knowledge.[43] Sterilization abuses have been disproportionately showered upon poor women and women of color due to racist and classist attitudes regarding overpopulation and family size.[44] The pharmaceutical industry tested early versions of long-acting reversible contraception methods (or LARCs) on African-American, low-income, and rural women fifty years ago.[45] According to

[40] For example, mass sterilizations abroad, especially in India, have led to negative perceptions of medical professionals among diaspora communities in the U.S. (Filipa Ioannou, *India's Ugly History of Coerced Sterilization*, Slate (November 12, 14), available at http://www.slate.com/blogs/xx_factor/2014/11/12/sterilization_in_india_11_women_die_in_a_state_sponsored_attempt_at_family.html

[41] Nancy Ordover, *American Eugenics: Race, Queer Anatomy, and the Science of Nationalism*, Minneapolis: University of Minnesota Press (2003).

[42] Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutiérrez, *Undivided Rights: Women of Color Organize for Reproductive Justice*, South End Press (November 1, 2004), at 9.

[43] *Id.,* at 10

[44] Elena Gutiérrez, *Fertile Matters: The Politics of Mexican-Origin Women's Reproduction*, University of Texas Press (2009) at 38-39 (notes federally funded Indian Health Service (IHS) clinics pressured Native American women into undergoing sterilization, sometimes threatening the loss of public benefits); Nicole M. Jackson, *A Black Woman's Choice: Depo-Provera and Reproductive Rights*, Journal of Research on Women and Gender Vol. 3, at 4-5, 28, available at https://digital.library.txstate.edu/bitstream/handle/10877/4449/JacksonNicole.pdf?sequence=1 (estimates between 100,000 and 150,000 poor women in the U.S. were sterilized every year in the 1960s and 1970s using federal funds, and that 43 percent of women sterilized in federally funded family planning programs were African-American); Arons, *supra* note 27, at 20-21 (explains that in the 1960s and 1970s, Medicaid physicians delivered babies and performed abortions for African-American women only if they consented to being sterilized, and, in Puerto Rico, about one-third of never-married women between ages 20 and 49 were sterilized by 1965).

[45] Committee on Women, Population and the Environment, *Sex, Lies & Birth Control: What you Need to Know About Your Birth Control Campaign*, Reproductive Justice Briefing Book, at 18, available at http://www.protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf.

allegations made by participants, these trials occurred without warning about side effects or information about the experimental nature of the drugs.[46]

Even today, critics allege that women who are poor, young, and of color are targeted and sometimes coerced into using LARC.[47] Additionally, judges will sometimes mandate LARC use as a condition of a defendant's punishment.[48] This distrust has motivated some members of these communities to avoid the medical system and take healthcare into their own hands.[49]

Immigrants may lean toward abortion self-induction due to culture and customs, unfamiliarity with U.S. systems, and barriers to high-quality health care.

Some immigrants, like native-born residents, do not know that abortion is legal in the U.S., or are unaware of the intricacies of that legality.[50] They may come from countries where abortion provision is completely outlawed, making self-induction common course as the only option, and assume that is the case in their new country as well.[51] Beyond the confusing matrix of state and federal laws implicating abortion, immigrants often have challenges navigating other unfamiliar and complicated systems, such as healthcare and insurance, leading to misunderstandings, frustrations, and substandard quality of care.[52]

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[46] Jackson, *supra* note 44, at 4, 5, 28.

[47] Anu Manchikanti Gomez, Liza Fuentes, and Amy Allina, *Women or LARC First? Reproductive Autonomy and the Promotion of Long-Acting Reversible Contraceptive Methods*, Perspectives on Sexual and Reproductive Health, Volume 46, Issue 3 (Sept. 2014), at 171.

[48] Committee on Women, Population and the Environment, *supra* note 49, at 18.

[49] Arons, *supra* note 27, at 16.

[50] *See, e.g.,* Bessett, Danielle, Caitlin Gerdts, Lisa L. Littman, Megan L. Kavanaugh, and Alison Norris, *Does state-level context matter for individuals' knowledge about abortion, legality and health? Challenging the 'red states v. blue states' hypothesis*. Culture, Health & Sexuality 17, no. 6 (2015): 733-746; National Latina Institute for Reproductive Health, *Latina Immigrants and Abortion* (July 2005), available at http://latinainstitute.org/sites/default/files/Latina_Immigrants_and_Abortion_Final.pdf.

[51] Sjaak van der Geest and Anita Hardon, *Self-Medication in Developing Countries*, 7 Journal of Social and Administrative Pharmacy 4, 199 (1990).

[52] Quyen Ngo-Metzger, Michael P. Massagli, *Linguistic and Cultural Barriers to Care*, Journal of General Internal Medicine Vol. 18 (2003).

Immigrants must contend with language barriers and a lack of qualified interpreters in the U.S. healthcare system.[53] Western medicine does not typically integrate traditional treatments such as herbs, acupuncture, and massage, which are important in many other countries and which immigrants bring with them to the U.S.[54]

Some immigrants also bring with them a custom of self-directed care and a cultural appreciation for at-home care over hospitals and clinics. Home births are common and encouraged in regions in all stages of economic development, from Tibet to France.[55] Self-administered medication abortions are also common and occur in most regions of the world.[56] When people emigrate to the U.S. from other parts of the world, particularly the Global South, where self-administered medication is common for economic and cultural reasons and where Miso is available as a well-known abortifacient, it is understandable that, once in the U.S., they would seek out Miso and use it to self-medicate when they need abortions.[57]

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[53] *Id.* (concluding patients who use family members as interpreters forgo privacy, may limit their disclosures, and risk mistranslation issues. Patients are unaccustomed to the policies and procedures of domestic facilities and doctors often do not write down instructions and other materials for immigrants, which could help them to understand what is happening and take control of their healthcare.)

[54] Ngo-Metzger, *supra* note 52; National Asian Pacific American Women's Forum, *APA Women and Abortion: A Fact Sheet* (March 2005), available at https://napawf.org/wp-content/uploads/2009/working/pdfs/Abortion_FactSheet.pdf. Some immigrants have reported facing negative responses from doctors for their uses of traditional medicines, which may lead to rifts between doctors and patients.

[55] Lisa Selin Davis, *Parenting, Birth and Maternal Health Around the World*, available at http://www.parenting.com/article/birth-maternal-health; Katrin Bennhold and Catherine Saint Louis, New York Times, *British Regulator Urges Home Birth over Hospitals for Uncomplicated Pregnancies* (Dec. 3, 2014), available at http://www.nytimes.com/2014/12/04/world/british-regulator-urges-home-births-over-hospitals-for-uncomplicated-pregnancies.html?_r=0.

[56] Beverly Winikoff and Wendy Sheldon, Guttmacher Institute, *Use of Medicines Changing the Face of Abortion*, 38 International Perspectives on Sexual and Reproductive Health 3 (Sept. 2012), available at https://www.guttmacher.org/pubs/journals/3816412.html#10a; Guttmacher Institute, F*acts on Abortion in Latin America and the Caribbean* (Jan. 2012), available at https://www.guttmacher.org/pubs/IB_AWW-Latin-America.pdf.

[57] *See McCormack v. Hiedeman*, 694 F.3d 1004 (9th Cir. 2012), holding it is an undue burden to expect pregnant people to understand all of the statutory regulations on abortions.

Pregnant people choose to self-induce abortion because they lack legal, practical, or financial resources to access clinic-based abortion care; because they distrust the medical community due to long histories of abuse; because they value self-directed care, or because they are unfamiliar with the U.S. medical system or laws regarding abortion. Regardless of their reasons for using medication abortion without medical supervision, pregnant people should not be prosecuted for their method of abortion.

C. Criminalizing abortion self-induction has the same effect as prohibiting abortion outright when it is the only available or acceptable method.

The Supreme Court of the United States has declared[58] and repeatedly affirmed[59] a constitutionally protected right to choose abortion. International instruments[60] and foreign courts of law[61] have also recognized abortion as a human right. For many people, legal restrictions, practical barriers, preferences, and culture combine to make self-induction the only available or acceptable method of exercising the right to choose abortion. Criminalizing self-induction, therefore, is tantamount to prohibiting exercise of the right.

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[58] *Roe v. Wade*, 410 U.S. 113 (1973).

[59] *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976); *Planned Parenthood of Kansas City, Missouri, Inc. v. Ashcroft*, 462 U.S. 476 (1983); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *Stenberg v. Carhart,* 530 U.S. 914 (2000); *Gonzales v. Planned Parenthood,* 550 U.S. 124 (2007); *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320 (2006).

[60] A number of treaties explicitly or implicitly support the right to abortion. Most notably, the *Convention on the Elimination of All Forms of Discrimination Against Women*, explicitly provides for the right of women to decide freely and responsibly the number and spacing of their children. CEDAW adopted Dec. 18, 1979, G.A. Res. 34/189, UN GAOR (34th Sess.), Supp. No. 46, U.N. Doc. A/34/46, U.N.T.S. 13 (entered into force Sept. 3, 1981); *See also* Sarah A. Huff, *The Abortion Crisis in Peru: Finding a Woman's Right to Obtain Safe and Legal Abortion in the Convention on the Elimination of All Forms of Discrimination Against Women*, 30 B.C.INT'L & COMP. L. REV. 237, 238 (2007).

[61] *See, e.g., K.L. v Peru*, U.N. Doc No. CCPR/C/85/D/1153/2003 (2005); *Paulina Ramírez v. Mexico*, Inter-American Commission on Human Rights Report No 21/07 (2007).

II. The criminalization of abortion self-induction will generate cascading negative repercussions for pregnant people, especially those from marginalized communities.

If the Court allows the State to criminalize abortion self-induction, more people will be forced to carry pregnancies to term. Criminalization will also prompt unwarranted scrutiny of all pregnant people, including those suffering from unintended pregnancy loss. If the Court creates a new category of feticide for self-induced abortions, it will result in constant policing of pregnant people who experience pregnancy loss. These negative repercussions will be felt the most by communities of color, immigrants, and low-income people, who already live under State surveillance and, because of their poverty, are more likely to have poor birth outcomes.

A. If abortion self-induction becomes a crime, more people will be forced to carry pregnancies to term, driving families further into poverty.

When a person is living paycheck to paycheck, denying coverage for an abortion can push her deeper into poverty.[62] A recent study suggests 40% of people seeking an abortion needed one because they did not feel financially prepared to have a baby.[63] Respondents in the study cited general financial concerns ranging from "It all boils down to money" to "can't afford to support a child" to "I didn't have money to buy a baby spoon."[64] Pregnant people often seek abortion because they are unemployed, underemployed, uninsured, could not get or did not want

[62] Reproductive Health Technologies Project, *Two Sides of the Same Coin: Integrating Economic and Reproductive Justice* (2015), at 14.
[63] Antonia M. Biggs, Heather Gould, and Diana Greene Foster, *Understanding why women seek abortions in the US*, BMC Women's Health40, 13:29 (2013), at 5.
[64] *Id.*

public assistance.[65] In other words, pregnant people often seek abortion because they cannot afford to have a child.

The inability to access abortion exacerbates poverty. When a pregnant person is unable to exercise her fundamental right to abortion and is forced to carry a pregnancy to term, she is three times more likely to be living below the federal poverty level two years later than a similarly financially situated person who was able to have an abortion.[66] As such, denying a pregnant person access to the only available abortion option is likely to drive many individuals and families further into poverty.

B. Prosecutions like Ms. Patel's will prompt unwarranted scrutiny of all pregnant people, including those suffering from unintended pregnancy loss.

By upholding Ms. Patel's conviction and criminalizing abortion self-induction, the Court will prompt increased suspicion and surveillance of all pregnant people, ultimately ensnaring untold numbers of them – including those suffering from unintended pregnancy loss – in the criminal justice system.

The more pregnant people we put under a microscope, the more prosecutions for pregnancy loss – intended and unintended – there will be.[67] Nearly one-third of pregnancies end in miscarriage, and the but-for cause is often difficult or impossible to ascertain. Thus, pregnant people under surveillance will have the Herculean task of guaranteeing healthy birth outcomes and, in failing to do so, risk being prosecuted for all sorts of actions and omissions that might

[65] Reproductive Health Technologies Project, *supra* note 61, at 14.
[66] *Id.*
[67] In Indiana, Bei Bei Shuai, a Chinese immigrant, was charged with murder and attempted feticide after attempting suicide while she was pregnant. *Bei Bei Shuai v. State*, 966 N.E.2d 619 (Ind. Ct. App. 2012). *See, e.g., State of Mississippi v. Nina Buckhalter*, 119 So. 3d 1015, 1019 (Miss. 2013); *Gibbs v. State*, 2010-IA-00819-SCT (Miss. 2011); *State v. Aiwohi*,123 P.3d 1210, 1225 (Haw. 2005).

possibly have contributed to a negative outcome, based on the false presumption that they wanted the pregnancy to end. It paints a frightening picture of the future for pregnant people and those who love them. Courts in other states have sounded sirens warning [68] of just such a slippery slope leading to the hyper-vigilance and oppression of pregnant people.

For example, in ruling that prosecutors may not pursue criminal charges against someone for deciding to continue a pregnancy while struggling with drug addiction, the Kentucky Supreme Court foreshadows the dangerous potential expansion of such a prosecutorial practice. The opinion in *Cochran v. Commonwealth*[69] concludes that allowing such scrutiny of pregnant people would give prosecutors an unlimited power to create an indefinite number of new crimes based on habits, conditions, actions, and inactions of pregnant people. In a world where pregnant people are under constant surveillance, everything from falling down stairs,[70] to walking on icy surfaces, to not taking prenatal vitamins could result in criminal sanctions if the pregnant person then suffers pregnancy loss. This constant policing of pregnant people is not good public policy and ultimately does not help pregnant people or their families.

C. Increased scrutiny of pregnant people's behavior will disproportionately impact immigrants, low-income individuals, and people of color.

Constant policing of pregnant people's behavior will have the greatest impact on low-income communities, immigrants, and communities of color for various reasons. As discussed

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[68] *See, e.g.*, *State v Wade*, 232 S.W.3d 663, 666 (Mo 2007) ("the logic of allowing such prosecutions would be extended to cases involving smoking, alcohol ingestion, the failure to wear seatbelts, and any other conduct that might cause harm to a mother's unborn child."); *Reinesto v Super Ct*, 894 P2d 733, 736-37 (Ariz App 1995) (citing factors that may impact health at birth, including poor nutrition, vitamin and iron deficiencies, poor prenatal care, insufficient or excessive weight gain, and ingesting caffeine).

[69] *Cochran v. Commonwealth*, 315 SW3d 325, 328 (Ky 2010).

[70] Amie Newman, *Pregnant? Don't Fall Down the Stairs*, RH Reality Check (February 15, 2010), available at http://rhrealitycheck.org/article/2010/02/15/pregnant-dont-fall-down-stairs/.

earlier, people belonging to these communities may be more likely to need or prefer self-induced abortions. Additionally, their communities are more likely to be subject to surveillance by the police and have more interaction with other government authorities. These factors guarantee that prosecutions for abortion self-induction, and negative pregnancy outcomes generally, will be felt most by members of low-income, racial minority, and immigrant communities.

Pregnant people who are poor, immigrant, or of color may be more likely to end their own pregnancies without medical supervision.

For the reasons explored elsewhere in this brief, self-induction may be the only method of abortion available to members of marginalized communities due to legal restrictions, practical barriers, and financial constraints that render clinic-based abortion care out of reach. Self-induced abortion is a common practice in many countries, and new Americans coming from these places may default to this familiar method in the face of unfamiliarity with the U.S. medical system or the laws regulating abortion. Self-induction may also be a preferred method of abortion for those who value self-directed care, wish to avoid interaction with the conventional medical system, or experience language barriers to high quality health care. Higher rates of abortion self-induction among these groups will trigger heightened surveillance of their members and lead to more arrests.

When pregnant people live under constant surveillance, poor birth outcomes may draw undue suspicions.

If police and prosecutors are encouraged to persecute people for self-induced abortions, it will undoubtedly increase the State's surveillance into all aspects of pregnant people's behavior, particularly if they suffer a pregnancy loss. Increased scrutiny of pregnancy loss will target poor

communities simply because they have higher rates of infant mortality and other negative birth outcomes – even though such losses are the result of socioeconomic factors and systemic problems that are largely outside of their control. Upholding Ms. Patel's conviction will open the door to similar prosecutions, which will effectively punish the poor, who are disproportionately immigrants and people of color, for their poverty and the limiting circumstances it causes.

Birth outcomes correlate with insurance coverage, which, in turn, correlates with income level, immigration status, and race. According to a 2013 report from the United States Census Bureau, the national poverty rate was 23.5 percent for the Latina population, 27.2 percent for the African-American population, and 10.5 percent for the Asian-American and Pacific-Islander (API) population, with some API populations experiencing poverty at a rate of 27 percent.[71] By comparison, the national poverty rate for the non-Hispanic Caucasian population was 9.6 percent. Women were more likely to live in poverty than men and foreign-born individuals were more likely to live in poverty than U.S.-born individuals.[72]

The statistics for health insurance coverage also revealed stark differences between the Caucasian population and populations of color. Latinas, Asian Americans, Native Hawaiians, and Pacific Islanders are more likely to be uninsured than non-Hispanic whites.[73] Among women of reproductive age, 40 percent of noncitizen immigrants are uninsured, as opposed to 18 percent

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[71] Ishimatsu, Josh, *Spotlight on Asian American and Pacific Islander Poverty A Demographic Profile*, National Coalition for Asian Pacific American Community Development (2013), available at: http://nationalcapacd.org/sites/default/files/u12/aapi_poverty_report-web_compressed.pdf

[72] *Id.*

[73] Asian Pacific Islander American Health Forum, *Health Care Access*, website (last checked September 29, 2015), available at http://www.apiahf.org/policy-and-advocacy/focus-areas/health-care-access

of naturalized citizens and 15 percent of native-born women. For women of reproductive age living in poverty, 53 percent of noncitizen immigrant women do not have health insurance.

Lawfully present immigrants are often ineligible for health insurance because of length of residency requirements, and undocumented immigrants are completely barred from public coverage. The ACA prohibits undocumented immigrants from purchasing any coverage through its health insurance marketplaces, even with their own money, and the Deferred Action for Childhood Arrivals Program (DACA) similarly does not provide immigrants with a way to obtain private or public health insurance under the ACA. DACA essentially provides immigrants with a way to stay in the country legally, but treats them as undocumented immigrants for purposes of public health insurance.

In Indiana, poverty is widespread, with 43.2 percent of its families living asset-poor.[74] Because the health and probability for survival of fetuses and infants are closely connected to the pregnant person's socioeconomic circumstances, prosecutions for pregnancy loss essentially result in punishment of the poor for being poor.

Poverty and a lack of health insurance coverage means these populations are more likely to have inadequate prenatal care and suffer worse birth outcomes partially as a result.[75] The lack of quality healthcare, specifically prenatal care, contributes to African-American and Latina

[74] Ed Bierschenk, *Indiana ranks low among states' anti-poverty programs*, NWI Times (June 8, 2014), available at http://www.nwitimes.com/special-section/one-region-one-vision/indiana-ranks-low-among-states-anti-poverty-programs/article_229bc323-b1f0-577b-ab06-1416b03ac1e1.html

[75] *See, e.g.,* Marian F. MacDorman and T.J. Mathews, *Understanding Racial and Ethnic Disparities in U.S. Infant Mortality Rates*, Center for Disease Control and Prevention, National Center for Health Statistics Data Brief No. 74 (Sept. 2011).

populations having higher rates of preterm birth than Caucasians.[76] Babies born to mothers in these populations, as well as to Asian-American and Pacific-Islander mothers, tend to suffer from low birthweight more than those born to Caucasians.[77] Infant mortality rates are also higher among these groups and are inextricably linked to preterm birth rates.[78] Additionally, African-American women are more likely to die during pregnancy and birth, account for a majority of new HIV infections, and are more likely to delay receiving prenatal care or fail to receive it at all.[79]

Negative pregnancy outcomes in these communities result from a multiplicity of socioeconomic factors, including housing and food insecurity, work conditions, and racism, as well as systems structured to provide inadequate or inequitable care, information, and resources.[80] The Court should not authorize further surveillance of pregnant people's behavior, because in doing so, pregnant people from marginalized communities who experience unintended pregnancy loss will get swept up in the system.

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[76] The Center on Disease Control reports preterm birth rates for Caucasians was10.17 percent in 2013, 16.27 percent for African Americans, and 11.31 percent for Hispanics. The CDC also notes that birthweights, which are closely related to gestational age and can predict long term and short term life outcomes, are also lower for African Americans and Hispanics. While 6.98 percent of white infants suffered from low birthweight in 2013, 13.08 percent of black infants, 8.3 percent of Asian Americans and Pacific Islanders, and 7.09 percent of Hispanic infants had low birthweight. Joyce A. Martin, Brady E. Hamilton, Michelle J.K. Osterman, Sally C. Curtin, T.J. Mathews, Center for Disease Control and Prevention, 64 National Vital Statistics Reports 1, *Birth: Final Data for 2013* (page 8-9) (Jan. 15, 2015).

[77] *Id.*

[78] MacDorman, *supra* note 75.

[79] Janine A. Clayton, Claudette E. Brooks, and Susan G. Kornstein, *Office of Research on Women's Health, National Institutes of Health, Women of Color Health Data Book*, 4th ed. (Oct. 2014), at 29, 31.

[80] African-American women in California have a maternal death rate that is four times higher than any other maternal death rate. A report from the California Department of Public Health points to social stressors such as racism, low levels of social support, lower socioeconomic status, chronic exposure to environmental hazards or fragmentation of, or difficulty accessing, health care as contributing to these high mortality rates. California Department of Public Health, *The California Pregnancy Associated Mortality Review, Report from 2002 and 2003 Maternal Death Reviews* (2011), available at http://www.cdph.ca.gov/data/statistics/Documents/MO-CA-PAMR-MaternalDeathReview-2002-03.pdf

Low-income communities have more interaction with the police and other government authorities, which increases the chances of scrutiny into their pregnancy losses.

Because low-income individuals receive more government assistance than wealthier individuals,[81] they must also interact more with government agencies (e.g., social workers, welfare offices, public health officials) and be subjected to more observation and evaluation. Public assistance recipients may be required to undergo drug testing,[82] interviews to determine eligibility,[83] or mandatory home visits.[84]

The heightened interaction with authorities and corresponding inspection into every aspect of the lives of low-income individuals mean that their pregnancies are also easily subject to surveillance. Wealthier people who have abortions, miscarriages, or stillbirths can buffer themselves from observation or judgment, such as by having physicians or midwives tend to them at home or in a private clinic. They may also benefit from cultural perceptions of wealthier people as more responsible parents, casting aside potential doubts about their intentions, actions, or inactions resulting in the loss. By contrast, low-income people may experience pregnancy loss and abortion in a more "public" arena, given proximity to neighbors in multiple-family housing units, the prevalence of police in their neighborhoods, the regular interactions with

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[81] Ishimatsu, *supra* note 71.
[82] *See, e.g.,* National Conference of State Legislatures, *Drug Testing for Welfare Recipients and Public Assistance* (July 27, 2015), available at http://www.ncsl.org/research/human-services/drug-testing-and-public-assistance.aspx#quick (list of states with legislation requiring drug testing of public assistance recipients).
[83] *Id.*
[84] *Id.*

government agents who may notice the flatness of a previously pregnant belly and report their suspicions.[85]

Racial bias and over-policing in communities of color may increase the likelihood of arrest for pregnant people of color.

Studies have shown that pregnant people of color are more frequently targeted for arrests and forced interventions. For instance, in a trend that is evident throughout the nation, between 1973 and 2005, approximately 15 percent of Florida's population was African-American, but 75 percent of its pregnancy-related criminal cases were brought against African Americans, while only 22 percent were brought against Caucasians who represent 60 percent of the overall population.[86] It is reasonable to expect that since more people of color are arrested for pregnancy-related reasons generally, more pregnant people of color will be arrested for pregnancy loss that is suspected to be self-induced abortion.

CONCLUSION

All pregnant people deserve the social, financial, political, and legal conditions required to make genuine choices about reproduction – including whether to have an abortion and which method to use. Unfortunately, we do not yet live in a world where this is true. For many, the only way to exercise their fundamental right to abortion is to muster the ingenuity and courage required to take care of their own needs without medical supervision. We urge the Court not to

[85] *See, e.g.,* Roberts, Dorothy, *Shattered Bonds: The Color of Child Welfare,* Basic Civitas Books (2002, reprinted 2013) (discussing the disparate impact increased surveillance has on communities of color).

[86] Lynn M. Paltrow and Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health*, Journal of Health Politics, Policy and Law, Vol. 38, No. 2, (April 2013).

punish these people by criminalizing the only method of abortion available to the thousands of pregnant people who cannot otherwise afford, access, or navigate clinic-based care. Instead, we ask the Court to respect this fundamental right that everyone deserves to hold equally and to allow those who must rely on themselves to end a pregnancy to ensure that they may do so with dignity, free from threat of persecution.

For the reasons discussed in this brief, Ms. Patel ought to be exonerated for the benefit of all pregnant people in Indiana, as well as those who love and rely on them.

Respectfully submitted,

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Laura Paul, Attorney No. 24342-32
407 Fulton Street
Indianapolis, IN 46202
Telephone: 317-292-3910
Fax: 317-454-0772
email: laura@laurapaul.net

_____
Jill E. Adams, Attorney No. 5255-95-TA
Executive Director
Center on Reproductive Rights and Justice
University of California, Berkeley School of Law
2850 Telegraph Avenue, Suite 500
Berkeley, CA 94705-7220

_____
Melissa A. Mikesell, Attorney No. 5285-95-TA
Affiliated Attorney
Center on Reproductive Rights and Justice
University of California, Berkeley School of Law
2850 Telegraph Avenue, Suite 500
Berkeley, CA 94705-7220

APPENDIX A: LIST OF *AMICI*

Amicus curiae **National Asian Pacific American Women's Forum (NAPAWF)** is dedicated to building a movement for social justice and human rights for Asian American and Pacific Islander (AAPI) women and girls. NAPAWF's founding vision includes strengthening communities by addressing concerns related to access to quality health care, immigrant and refugee rights, civil rights, violence against women, and economic empowerment. NAPAWF conducts its health care agenda through a reproductive justice lens, recognizing the many ways in which health care for women is impacted by socio-economic factors including but not limited to race, immigration status, and poverty.

Amicus curiae **The Center on Reproductive Rights and Justice at the University of California, Berkeley, School of Law (CRRJ)** seeks to realize reproductive rights and advance reproductive justice by furthering scholarship, bolstering law and policy advocacy efforts, and influencing legal and social science discourse through innovative research, teaching, and convenings. CRRJ maintains that all people deserve the social, economic, political, and legal conditions, capital, and control necessary to make genuine choices about reproduction – decisions that must be respected, supported, and treated with dignity.

Amicus curiae **ACCESS Women's Health Justice** removes barriers to sexual and reproductive health care and builds the power of Californian's to demand health, justice and dignity. It's programs include: a bilingual Healthline that connects women and girls throughout California to information, referrals and advocacy on sexual and reproductive health issues, upstream and downstream policy advocacy within the reproductive justice movement and policy debates, and engaging with communities to build support for women seeking reproductive healthcare, including abortion.

Amicus curiae **Advocates for Youth** partners with youth leaders, adult allies, and youth-serving organizations to advocate for policies and champion programs that recognize young people's rights to honest sexual health information; accessible, confidential, and affordable sexual health services; and the resources and opportunities necessary to create sexual health equity for all youth. Advocates believes that all pregnant people should be supported- rather than stigmatized - by both government and culture. Young people who face prejudice and discrimination by virtue of their identity, life experience, or family circumstances disproportionately experience unintended pregnancy and negative health outcomes. The historical and cultural context of reproductive and sexual rights, especially for women of color and low-income women, is one of persistent inequality. Despite legal and cultural barriers, hundreds of thousands of women seek out abortion care each year, with young women, low-income women, and women of color most strongly affected by restrictions. To protect women's health and lives, the courts and country must strive for laws that support reproductive health care, as well as work for cultural changes to underpin the legal and policy work to ensure abortion care is available and affordable.

Amicus curiae **Backline** promotes unconditional and judgment-free support for the full spectrum of decisions, feelings, and experiences with pregnancy, parenting, abortion, and adoption. Through direct service and social change strategies, Backline is building a world where all

people can make the reproductive decisions that are best for their lives, without coercion or limitation, and where the dignity of lived experiences is affirmed and honored.

Amicus curiae **Black Women for Wellness** is committed to the health and well-being of Black women and girls through health education, empowerment and advocacy. We are a woman-centered grassroots community-based organization, seeking to enhance the health and well-being of Black women. Our efforts in providing information, education and advocacy are all about eliminating health disparities, building community, and empowering women.

Amicus curiae **California Latinas for Reproductive Justice** is a statewide organization committed to honoring the experiences of Latinas to uphold our dignity, our bodies, sexuality, and families. We build Latinas' power and cultivate leadership through community education, policy advocacy, and community-informed research to achieve reproductive justice. We do our work using reproductive justice framework that emphasizes the intersection with other social, economic and community-based issues that promote the social justice and human rights of Latina women and girls and the Latino/a community as a whole. In other words, we recognize that Latinas' access to culturally and linguistically appropriate health care, a living wage job, quality education, freedom from discrimination and violence, among many other issues that affect Latinas' daily lives, have a profound effect on Latinas' reproductive and sexual health, as well as our right to self-determination in all aspects of our lives.

Amicus curiae **California Women's Law Center ("CWLC")** is a statewide, non-profit law and policy center dedicated to advancing the civil rights of women and girls through impact litigation, advocacy, and education. CWLC's issue priorities include gender discrimination, reproductive justice, violence against women, and women's health. Since its inception in 1989, CWLC has placed an emphasis on eliminating all forms of gender discrimination.

Amicus curiae **Forward Together** works nationally to change culture and shift policy so that all families can thrive. Our mission is to ensure that women, youth and families have the power and resources they need to reach their full potential. We believe that punishing the decisions that pregnant women make who have limited access to the full range of reproductive options - including abortion - only further criminalizes communities with limited access.

Amicus curiae **Healthy and Free Tennessee** works to protect the reproductive freedom and sexual health of all people and therefore strongly decry the extreme sentencing of Purvi Patel, one that is in direct violation of her civil rights and sets an unjust precedent in women being criminalized for the outcomes of their pregnancies.

Amicus curiae **IndyFeminists** is a collaborative group of proactive, experienced activists that works to bring positive change to Indiana. We use the framework of reproductive justice to seek equality for all women. Reproductive justice includes concepts of not only abortion rights, but the rights of pregnant persons to maintain their constitutional rights and not have them violated due to their pregnancy status. Reproductive justice also includes understanding the ways in which intersecting identities can lead to additional oppression – for instance, a pregnant person of color may find their rights doubly infringed upon due to discrimination in the justice system. Indy Feminists seeks to address all of these issues in order to secure and protect the rights of

people to choose when to parent,how to parent, and to have a safe environment in which to raise their children.

Amicus curiae **In Our Own Voice: National Black Women's Reproductive Justice Agenda** is a national organization representing over 50,000 Black women throughout the United States. We were founded by six women representing themselves and five strategic partner organizations, including Black Women for Wellness, Black Women's Health Imperative, New Voices Pittsburgh, SisterLove, Inc., and SPARK Reproductive Justice Now. Because our work in reproductive rights, health and justice focuses on abortion rights and access for Black women and other women of color, we are particularly concerned about the prosecution of Purvi Patel. Women have the right to terminate an unintended and unwanted pregnancy without fearing criminal prosecution by the state. This right is constitutionally guaranteed under the 1973 Supreme Court decision in Roe v. Wade. Although guaranteed that right, low-income and women of color have suffered because of the lack of access to abortion health services. The lack of access can sometimes force women to seek other ways to exercise a legal right. Prosecution of these women can only lead to a chilling effect that will force women to be afraid of seeking needed health care services. In Our Own Voice: National Black Women's Reproductive Justice Agenda urges the courts to understand the circumstances of low-income, women of color and immigrant women lives as they seek to exercise their rights to reproductive health and justice

Amicus curiae **Ipas**, founded in 1973, is a global nongovernmental organization that supports the right of each woman to control her own sexuality, fertility, health, and well-being. We work to ensure that women can obtain safe, respectful, and comprehensive abortion care, including counseling and contraception to prevent future unintended pregnancies. At Ipas, we believe that: every woman has a right to safe reproductive health choices, including safe abortion care; no woman should have to risk her life, her health, her fertility, her well-being, or the well-being of her family because she lacks reproductive health care; women everywhere must have the opportunity to determine their futures, care for their families and manage their fertility.

Amicus curiae **Law Students for Reproductive Justice (LSRJ),** a non-profit organization with over 100 chapters on law schools and thousands of alumni from across the country, trains and mobilizes law students and new lawyers to foster legal expertise and support for the realization of reproductive justice. LSRJ works to ensure that all people can exercise the rights and access the resources they need to thrive and to decide whether, when, and how to have and parent children with dignity, free from discrimination, coercion, or violence.

Amicus curiae **Legal Voice** is a non-profit public interest organization that works in the Pacific Northwest to advance the legal rights of women through public impact litigation, legislation, and legal rights education. Since its founding in 1978 (as the Northwest Women's Law Center), Legal Voice has been dedicated to protecting and expanding women's legal rights. Toward that end, Legal Voice has advocated for legislation protecting pregnant persons' rights, including their rights to make decisions about their pregnancies, to be protected from workplace discrimination, and to be free from shackling if they are incarcerated and pregnant or in labor. In addition, Legal Voice has participated as counsel and as amicus curiae in the Pacific Northwest and across the country in numerous cases involving the rights of pregnant women. Legal Voice opposes, and has successfully challenged, prosecutions of pregnant women for their pregnancy

outcomes and works to end punitive measures that undermine the humanity and legal rights of all pregnant women.

Amicus curiae **National Latina Institute for Reproductive Health ("NLIRH")** is the only national reproductive justice organization dedicated to building Latina power to advance health, dignity, and justice for 26 million Latinas, their families, and communities in the United States through leadership development, community mobilization, policy advocacy, and strategic communications. Latinas face a unique and complex array of barriers to accessing reproductive health and rights, including economic inequality, xenophobia, and racial and ethnic discrimination. These circumstances make it especially difficult for Latinas to access basic healthcare, including reproductive healthcare.

Amicus curiae **National Women's Health Network ("NWHN")** improves the health of women by influencing public policy and providing health information to support decision-making by individual consumers. Founded in 1975 to give women a greater voice within the health care system, NWHN aspires to a health care system that is guided by social justice and reflects the needs of diverse women. NWHN is committed to advancing women's health by ensuring that women have self-determination in all aspects of their reproductive and sexual health; challenging the inappropriate medicalization of women's lives; and establishing universal access to healthcare that meets the needs of diverse women. The core values that guide NWHN's work include its belief that the government has an obligation to safeguard the health of all people; that it values women's descriptions of their own experiences and believes health policy should reflect the diversity of those experiences; and that it believes evidence rather than profit should determine what services and information are available to inform women's health decision-making and practices. NWHN is a membership-based organization supported by 8,000 individuals and organizations nationwide.

Amicus curiae **New Voices for Reproductive Justice** was founded in 2004 with the vision to achieve the complete health and well-being of Black women and girls, our families and communities. New Voices has served and represented the interests of over 20,000 Black women and girls and women of color in Pennsylvania, Ohio and nationally. Through leadership development, policy advocacy, and community organizing, New Voices amplifies the voices of Black women and girls and women of color to advance Reproductive Justice, access to quality and culturally appropriate health care, and Human Rights.

Amicus curiae **The Religious Coalition for Reproductive Choice** is the leading national multi-faith organization whose supporters are called by our faiths to build a just and righteous society by advancing reproductive health, rights and justice for all. We mobilize faith leaders in support of sexual and reproductive health and justice, focusing on contraception, abortion, and sexuality education.

Amicus curiae **The Reproductive Health Technologies Project** is a national nonprofit advocacy organization that works to promote access to existing and emerging reproductive health technologies so all people have meaningful choices when it comes to maintaining their reproductive health and planning their families. In particular, RHTP was formed in order to help introduce medication abortion (a.k.a., "the abortion pill") to the U.S market. Given that history,

we remain committed to ensuring that women who choose abortion have as many options for ending their pregnancy safely as modern medicine provides and we oppose efforts to criminalize pregnant women for their medical decisions – including ending a pregnancy without clinical supervision – or their pregnancy outcomes.

Amicus curiae **Reproductive Justice Clinic at NYU School of Law** is dedicated to protecting the civil and constitutional rights relating to reproduction, especially the rights of the most vulnerable -- those of child-bearing capacity. The Clinic is also dedicated to promoting the learning, research and policy advocacy needed to establish sound, sensible and fair policies to ensure good reproductive health care is in reality available to all. The Clinic trains law students and attorneys in constitutional and procedural law and policy and provides pro bono legal services to those who most need it to obtain reproductive justice. The Clinic operates under the direction of Professor Sarah E. Burns.

Amicus curiae **SisterLove, Inc.** is on a mission to eradicate the impact of HIV and sexual and reproductive oppression upon all women and their communities in the US and around the world. We are a community-based organization engaged in direct community health services and advocacy, including sexual health screening and linkage to clinical care, primarily for low-income, under-insured, African American women and girls in Atlanta, Georgia - a region impacted by disproportionately high rates of HIV incidence, unplanned pregnancy, and maternal mortality. Aware of the reality that numerous women and girls in Atlanta lack the health coverage necessary to exercise full control over their sexual health and family planning, our organization is interested in this litigation based on our opposition to widening the scope of laws that have the effect of criminalizing unintended outcomes of pregnancy, laws which we know will impact the women and girls that we serve on a daily basis in our medically underserved community.

Amicus curiae **SisterReach** is a grassroots Reproductive Justice organization focused on empowering and mobilizing women and girls in the community around their reproductive and sexual health to make informed decisions about themselves, therefore to become advocates for themselves. We do our work by a three-pronged strategy of reproductive and sexual health education, policy and advocacy on the behalf of women and girls of color, poor and rural women and their families. SisterReach considers punitive measures taken against pregnant mothers a Human Rights violation not only for the mother struggling with drug dependence, but her family as well. SisterReach considers a violation of these rights an act of violence from both the medical community and the government and are committed to ensuring that low income families, in particular, are not further marginalized by punitive measures which have proven to be detrimental to the health and well-being of families.

Amicus curiae **SisterSong Women of Color Reproductive Justice Collective ("SisterSong")** is a national organization of Indigenous women and women of color and allied organizations and individuals working for Reproductive Justice. Its core principals are threefold: it believes that every woman has the human right to choose if and when she will have a baby and the conditions under which she will give birth; the human right to decide if she will not have a baby and her options for preventing or ending a pregnancy; and the human right to parent the children she already has with the necessary social supports to do so. Through advocacy, mentoring, and

support, SisterSong raises the voices of women of color impacted by human rights violations on the national, state, and local levels.

Amicus curiae **Southern Center for Human Rights (SCHR)** provides legal representation to people facing the death penalty, challenges human rights violations in prisons and jails, seeks through litigation and advocacy to improve legal representation for poor people accused of crimes, and advocates for criminal justice system reforms on behalf of those affected by the system in the Southern United States. SCHR represents individuals facing the death penalty at all stages of litigation, consults with lawyers throughout the country on capital cases, and works with other organizations and individuals in efforts to end the use of the death penalty; brings impact litigation to challenge unconstitutional conditions and practices in prisons and jails and inadequate systems for providing legal representation for poor people accused of crimes; publishes reports and articles on these and other issues including judicial independence and the need for more humane and constructive responses to crime; and advocates for positive (and against negative) criminal justice policies and legislation.

Amicus curiae **Southwest Women's Law Center (SWLC)** was founded in 2005 to fill a critical gap in advocacy on behalf of low-income women and their families in New Mexico. SWLC works at the intersection of gender discrimination and poverty by engaging in outreach, education and advocacy and by addressing the systemic causes of disproportionate poverty among women and children in our state. Our mission is to create opportunities for women and girls to realize their full economic and personal potential by: (1) eliminating gender bias; (2) eliminating discrimination and harassment; (3) lifting women and their families out of poverty; (4) ensuring that all women have access to quality, affordable healthcare, and (5) by ensuring that all women have full control over their reproductive lives through access to comprehensive reproductive health services and information.

Amicus curiae **Surge Northwest** is a nonprofit organization based in Seattle, Washington, that works to advance racial and reproductive justice through community mobilization, education, and policy advocacy. The organization's priorities include working to ensure reproductive health and justice for imprisoned people, as well as ensuring that all people have access to health care. Surge Northwest is particularly concerned that criminalization and incarceration are far too often used to respond to what are, in fact, public health concerns, to the detriment of communities of color and poor people. Surge Northwest supports sound, evidence-based public policies that promote health and reproductive justice.

Amicus curiae **Tewa Women United (TWU)** is a collective intertribal women's voice in the Tewa homelands of Northern New Mexico. TWU was started in 1989 as a support group for women concerned with various issues including alcoholism, suicide, and domestic and sexual violence. The mission of TWU is to provide safe spaces of Indigenous women to uncover the power, strength and skills they possess to become positive forces for social change in their families and communities. Through critical analysis and embracing and re-affirming of Indigenous cultural identity, TWU helps women transform and empower one another. TWU has developed and helped develop multi-disciplinary teams to address sexual violence in Native communities in New Mexico and is part of coalitions on local, city, state and national level to address violence against native women and girls.

Amicus curiae **Third Wave Fund,** a hosted project at Proteus Fund, is the only national foundation that supports and strengthens youth-led gender justice activism— focusing on efforts that advance the political power, well-being, and self-determination of communities of color and low-income communities in the US. We partner with institutions and individual donors to invest resources in under-funded regions and social justice youth movements. Over our twenty year history, we have awarded more than $3.2 million dollars in grants, provided mentorship and technical support to dozens of organizations and leaders, and helped gender justice groups generate sustainable revenue streams.

Amicus curiae **URGE: Unite for Reproductive & Gender Equity** envisions a world where all people have agency over their own bodies and relationships, and the power, knowledge, and tools to exercise that agency. URGE builds this vision by engaging young people in creating and leading the way to sexual and reproductive justice for all. URGE believes that young people should be able to parent or end a pregnancy when they choose. We believe that a person who is pregnant knows best how to take care of themselves or seek the care they need to end a pregnancy and should not fear incarceration because of the choices they make.

Amicus curiae **WV FREE** is a non-profit organization that seeks legal protection at state and national levels guaranteeing the right to decide whether, when and how to have children; the human right to bodily integrity and control over one's body; the ability to parent children in health and safe environments; to broaden the base of active, vocal and community support for and understanding of reproductive rights, health and justice in West Virginia; and to ensure accessibility to and affordability of reproductive health care for all West Virginians, including the right to abortion, birth control, adoption, prenatal care, sexuality education, birth options as chosen by women, prevention of sexually transmitted infections, with a special focus on teens and low-income, rural women and women of color.

Amicus curiae **Young Women United** is a community organizing and policy organization led by and for young women of color in New Mexico. They work to build communities where all people have access to the information, education and resources they need to make real decisions about their own bodies and lives. They understand women of color and low income women are the most impacted when reproductive healthcare is criminalized. Young Women United stands in support of Purvi Patel and the thousands of women and people who make the decision to have an abortion and seek the healthcare their families need.