

Criminalization and Punishment of Pregnant People and People Who Facilitate Access to Abortion Care

Report Update April 2026

I. Introduction

1. This report updates “Criminalization and Punishment of Pregnant People and People Who Facilitate Access to Abortion Care,” a report submitted for the Fourth Cycle of the Universal Periodic Review of the United States in April 2025 (“Initial Criminalization Report”). The Initial Criminalization Report described improper prosecution and punishment of people because of pregnancy status or outcomes. It described criminal and civil penalties that specifically target pregnant people who terminate a pregnancy or those who assist them and the growing misuse of other laws to punish people for abortions or pregnancy loss.

2. This updated report (“Updated Report”) includes information about the escalation of criminalization since April 2025 and the impact that criminalization and restrictive abortion laws have on people with disabilities.¹

3. U.N. Treaty bodies have repeatedly condemned the use of criminal laws to address reproductive health issues, and called on the U.S. to stop criminalizing abortion seekers, providers of care, and people who facilitate access to care. *See* Initial Criminalization Report, paras. 4-8.² The overturn of *Roe v. Wade* in 2022 and the policies of the Trump Administration caused a major retrogression in reproductive health and rights, dramatically increasing the use of criminal law to address abortion and adverse pregnancy outcomes. This situation has continued to deteriorate since April 2025.

II. U.S. Criminalization of Abortion Seekers and Providers

4. “Criminalization and Punishment of Pregnant People and People Who Facilitate Access to Abortion Care” focused on the criminalization of pregnant people (as opposed to clinicians) and those who support and help them. From 2022 to 2024, more than 400 people were charged with pregnancy-related crimes, and most of these prosecutions have targeted low-income women in the south.³ Since the Initial Criminalization Report, there has been a continuation and repeated attempts to escalate the criminalization of people who seek abortions – or even experience miscarriages or stillbirths – as well as attacks on provision of abortion care through attempts by state officials to enforce abortion bans extraterritorially and classify abortion medications similarly to narcotics and other controlled substances.

A. Continued Criminalization of Pregnancy Outcomes

5. As discussed in the Initial Criminalization Report, states are increasingly criminalizing people for actions believed to have harmed or created a risk of harm to a pregnancy. In a small handful of states where such prosecutions are frequent, criminal charges proceed pursuant to case law extending the reach of child endangerment crimes to people who use criminalized drugs during pregnancy.⁴ In other states, prosecutors misapply laws never intended to punish pregnancy outcomes. While this trend existed even prior to the *Dobbs* decision,⁵ the increased aura of illegality surrounding abortion and attempts to ascribe “personhood” to fetuses have increased the trend of prosecutors bringing criminal charges under state laws criminalizing abortion and fetal harm laws despite statutory protections for the pregnant individual. As a result, people may be arrested without legal basis, or have charges intended for other purposes (such as antiquated laws punishing out-of-wedlock births, or laws intended to punish desecration of dead bodies⁶) retrofitted to the purpose of punishing abortion. For instance, recently a Kentucky prosecutor charged a woman who allegedly self-managed an abortion with fetal homicide, later dropping the charge and admitting that the law did not apply to acts taken by a pregnant person.⁷ However, the prosecutor still charged the woman with concealing the birth of an infant, abuse of a corpse and tampering with physical evidence.⁸ In Georgia, in defiance of both statutory law and legal precedent, a woman faces potential charges for “malice murder” and offenses related to the possession of medications and controlled substances without prescription due to an alleged attempt to self-manage an abortion using pills.⁹

6. In addition to increasing prosecutions brought by overzealous prosecutors, anti-abortion lawmakers in many states have attempted to pass laws explicitly criminalizing people who have abortions. Currently, in all but one state, criminal abortion laws do not apply to the pregnant person who has an abortion.¹⁰ However, in many states, anti-abortion groups are trying to pass laws styled as “prenatal equal protection acts.” These laws would authorize criminal homicide prosecutions for people who have abortions, based on the notion that abortion seekers and abortion providers should be equally liable for “murder” in the case of an abortion.¹¹ While it is unlikely that bills like prenatal protection acts will pass, these harmful bills signal a shift towards a broader willingness to overtly embrace the criminalization of people who have abortions.

B. Criminalization of Medication Abortion

7. In the current environment where abortion at any stage is banned in 13 states,¹² pregnant people who want or need to terminate their pregnancies are increasingly turning to medication abortion,¹³ which can be prescribed and supervised by a health care provider located in a state where abortion is legal using telehealth, or self-managed. Information about and access to abortion pills is critical to prevent unsafe abortions. Yet states are passing new laws designed to restrict access to abortion pills, as well as information about pills, and seeking to prosecute doctors who prescribe pills.

1. Attempts to Prosecute Abortion Providers Across State Lines For Engaging in Interstate Humanitarian Practice

8. Clinicians across the country are facing the increasing threat of criminal prosecution for the practice of mailing medication abortion pills into states with abortion bans. When the U.S. Supreme Court rescinded constitutional protection for abortion rights, many states responded by imposing criminal penalties on abortion provision. By 2025, eleven¹⁴ of the thirteen states that ban abortion at all stages of pregnancy imposed criminal penalties on clinicians who perform abortions.¹⁵ From a few months in prison to the possibility of a life sentence, penalties for clinicians who assist patients have created a chilling effect, leading “physicians to delay health- or life-preserving care and preventing them from practicing medicine based on accepted standards of care” in ban states.¹⁶ In addition, nine states have laws prohibiting the use of telehealth for medication abortion and/or the mailing of medication abortion drugs.¹⁷ Given that more than 31 million women of reproductive age live in states where abortion is banned or under threat, further restricting patient access to reproductive health care endangers the lives of pregnant individuals.¹⁸ Despite the possibility of punishment, many abortion providers have sought to support people in need by prescribing medications to patients located in states where abortion is unavailable. To protect this practice, in 2023, some states started passing “shield laws” meant to protect providers from prosecution and civil suits as long as they are located in the shielding state and the care they provide is legal in the shielding state regardless of the patient’s location.¹⁹ Providers issuing prescriptions under this model are aware that they are violating the law of the patient’s state, but nevertheless provide care to protect patient health.

9. In December of 2024, Texas became the first state to challenge interstate abortion provision, filing a lawsuit against New York physician Margaret Carpenter, for mailing medication abortion pills into the state.²⁰ In the lawsuit, Texas alleged Dr. Carpenter illegally practiced medicine in Texas without a license and violated the state’s abortion ban and prohibition on telehealth abortion care.²¹ Relying on New York’s shield law, Dr. Carpenter did not respond to the Texas lawsuit and on February 13, 2025, a Texas trial court issued a \$100,000 default judgment against her and enjoined her from prescribing abortion medication to Texas residents.²² To date, New York has refused to enforce the judgment.²³ In January 2025, Dr. Carpenter was indicted by a Louisiana grand jury for violating Louisiana’s abortion laws.²⁴ New York has refused to extradite Dr. Carpenter to Louisiana.²⁵

10. In February of 2026, the Texas attorney general sued Aid Access (an Austrian NGO operated by physicians who prescribe abortion medications to patients in low-access settings), Aid Access’ founder, Dr. Rebecca Gomperts, and California clinician Dr. Remy Coeytaux, under a new state law that prohibits the creation and distribution of abortion-inducing drugs.²⁶ The law, which took effect in December of 2025, allows private citizens to sue anyone who manufactures, distributes, mails, or provides abortion medication to or from Texas – effectively cutting off aid to patients in need.²⁷ Doctors report that if they stop prescribing medication abortion for individuals in ban states, “tens of thousands of patients [will no] longer be able to end early

pregnancies safely at home...” putting patients at greater risk.²⁸ Louisiana has also indicted Dr. Coeytaux for providing abortion pills to a Louisiana resident, but based on California’s shield law, California’s governor has refused to extradite Dr. Coeytaux.²⁹

2. Classification of Abortion Pills as Controlled Substances

11. In October 2024, Louisiana passed Act 246 classifying mifepristone and misoprostol, the two drugs used for medication abortion, as Schedule IV controlled substances³⁰ despite the fact that neither poses a risk of abuse or dependence and both have been listed as essential medications by the World Health Organization (WHO).³¹ Individuals charged with violating Act 246’s possession and distribution restrictions face up to 10 years incarcerated and \$15,000 in fines.³² Similar bills classifying mifepristone and misoprostol as controlled substances are pending in South Carolina³³ and Mississippi,³⁴ and were proposed but so far have failed to pass in Texas,³⁵ Kentucky,³⁶ and Missouri.³⁷

12. In the U.S., the key factors determining whether a drug is labeled a controlled substance and the drug’s classification level are typically abuse rate and medical purpose.³⁸ The greatest restrictions and penalties are imposed on Schedule I (the highest classification) drugs, which have no medical purpose and high potential for severe psychological or physical dependency. Penalties and restrictions incrementally decrease the lower the classification.³⁹ The federal government has not classified mifepristone or misoprostol as a controlled substance.⁴⁰ Louisiana’s classification of the drugs is unusual because state classifications rarely depart so drastically from federal guidance and scientific evidence.⁴¹

13. Neither mifepristone nor misoprostol present any risk of abuse or dependency.⁴² There is no evidence of misuse or addiction potential, and neither medication is classified as a dangerous controlled substance by the federal Drug Enforcement Administration (DEA) or similar organization outside the U.S.⁴³ Both have been approved by the Food and Drug Administration for decades.⁴⁴ Indeed, the World Health Organization lists mifepristone and misoprostol as essential medications⁴⁵ that are safe for self-managing abortions.⁴⁶ The medications also treat an array of serious medical conditions, including postpartum hemorrhage, miscarriage, uterine fibroids, ovarian cancer, and gastric ulcers.⁴⁷

14. Classifying mifepristone and misoprostol as Schedule IV controlled substances mandates heightened prescribing and dispensing protocols that act as barriers for physicians and resource-limited hospitals.⁴⁸ First, prescribers must acquire a Controlled Dangerous Substance license from the Louisiana Board of Pharmacy in addition to a registration license from the DEA.⁴⁹ Physicians prescribing controlled substances are also subject to invasive reporting requirements.⁵⁰ State law enforcement does not need a subpoena to access this database,⁵¹ invading the privacy of patient health information and increasing concerns of criminalization.

15. Additionally, when hospitals are mandated to put mifepristone and misoprostol under lock and key as required by storage and security requirements for controlled substances⁵² access to care is delayed or denied. As a result of the new restrictions, patients in Louisiana reported delays or denials of access to misoprostol in inpatient and outpatient settings, including during the insertion of intrauterine devices, the facilitation of fertility treatment and miscarriage management.⁵³ Access to misoprostol was delayed for patients suffering from postpartum hemorrhage, which accounts for 14% of pregnancy related deaths in the United States.⁵⁴ After Act 246 went into effect, 39% of pharmacies in Orleans Parish and 58% of pharmacies in Jefferson Parish reported that they did not stock misoprostol. Several pharmacies reported placing additional restrictions on dispensing or eliminating stocking the medication because of Act 246.⁵⁵

16. In addition to the dangers presented when doctors cannot readily access medication in healthcare settings, limiting access to mifepristone and misoprostol increases the likelihood that pregnant people will resort to dangerous or ineffective methods when trying to self-manage abortions.⁵⁶ Imposing criminal penalties for possessing mifepristone or misoprostol will make it more difficult for individuals to obtain the drugs, forcing them to use more dangerous or less effective methods as alternatives.⁵⁷ Concern over criminalization could also prevent or delay patients who have taken the drugs and experience complications from seeking medical assistance.⁵⁸

III. Impact of Criminalization and Restrictions of Sexual and Reproductive Health Rights for People with Disabilities⁵⁹

17. People with disabilities are just as likely to become pregnant as non-disabled people, but significantly more likely to experience severe maternal morbidities that can require abortion care, making access to abortion without fear of criminalization critical.⁶⁰ There are 2.67 million disabled women of reproductive age in the United States who reside in states where providing abortion has been criminalized. Furthermore, over 1.8 million disabled women of reproductive age in the U.S. live in extreme states that introduced bills in the 2025 legislative session that would bring homicide charges against pregnant people who have abortions.⁶¹ People with disabilities are disproportionately impacted by the criminal legal system, with sixty-six percent of incarcerated people self-reporting a disability, and an even higher estimated percentage of incarcerated women reporting a disability (seventy-nine percent).⁶²

18. Disabled people experience heightened rates of reproductive coercion and intimate partner violence, in part because reliance on others for daily assistance can compromise privacy and autonomy.⁶³ Because many disabled people face significant transportation and logistical barriers, they often must rely on others to attend in-person medical appointments.⁶⁴ In the context of reproductive care, this reliance can force disclosure of deeply private medical decisions and expose disabled people to interference, pressure, or retaliation— increasing disabled abortion

seekers' risk of criminalization. This reliance on support persons for care access also creates an increased risk of criminalization for people who facilitate access to abortion for people with disabilities.

19. The current legal landscape has deterred people with disabilities from seeking life-saving abortion care because of the threat of criminalization. The U.S. state of Georgia currently bans abortion care after six weeks of gestation unless to prevent the death of the pregnant person.⁶⁵ Candi Miller, a 41-year-old mother of three from Georgia, who had lupus, diabetes, and hypertension, had been warned by her doctors that another pregnancy could be fatal.⁶⁶ When she unexpectedly became pregnant, she ordered abortion pills online to end her pregnancy at home before it caused a life-threatening situation. Georgia's abortion ban meant that she was unable to access in-person abortion care in her home state, despite the health risks that continued pregnancy posed. Candi experienced an incomplete abortion, but fearing the consequences of seeking care because of Georgia's abortion ban, Candi suffered through her pain at home until her husband found her unresponsive in bed several days later. A committee of maternal health experts in Georgia ruled Candi's death a preventable maternal death resulting from the state's abortion ban.

20. Even when people with disabilities attempt to access abortion care in states that legally protect reproductive health services, barriers persist. Most states in the U.S. still allow judges, family members, or guardians to make reproductive health decisions on behalf of a disabled person. For example, only two states explicitly ban the forced sterilization of disabled people.⁶⁷ People with disabilities are also less likely than non-disabled people to have received comprehensive sexual health education.⁶⁸ This is especially pronounced for Black youth, Hispanic or Latino youth, and young people from low-income households.⁶⁹ Negative stereotypes that disabled people are not sexually active or do not have the capacity to understand sexual education undermine the bodily, sexual, and reproductive autonomy of disabled people.⁷⁰

21. People with disabilities are much more likely than non-disabled people to report medical mistreatment when seeking reproductive health care.⁷¹ In one recent study surveying physicians about their treatment of patients with disabilities, every respondent acknowledged that their practice contained physical barriers to care, including inaccessible facilities or equipment.⁷² One study inspecting 2,389 primary care offices found that only 53% met all exterior access criteria, 56% met entrance and interior public-area criteria, and just 34.3% met interior office and restroom accessibility standards.⁷³

IV. Recommendations

22. We urge that the following recommendations be made to the United States:

1. Immediately repeal all federal, state and local laws criminalizing abortion, including the reclassification of misoprostol and mifepristone as controlled substances, and enact

legislation to guarantee access to abortion care in line with the World Health Organization's Abortion Care Guideline (2022). Further, end policies or practices that result in punishment of individuals based on pregnancy outcomes or acts during one's pregnancy through the criminal legal system, family regulation system, immigration system, or civil legal system.

2. Immediately repeal bans on abortion support and prohibit the use of criminal law or private civil causes of action to penalize or harass people who provide abortion care or support abortion seekers by sharing information, providing funding, assisting with inter-state travel, or furnishing the means to self-manage an abortion. Furthermore, recognize sexual and reproductive health providers and sexual and reproductive health rights (SRHR) advocates as human rights defenders. Allow civil society organizations to operate in partnership without surveillance, including around SRHR information and services. Protect these human rights defenders from threats of violence.
3. Repeal laws, policies, or practices that limit or remove legal capacity for persons with disabilities, including those that allow third parties to make decisions about their sexual and reproductive health and rights, bodily autonomy, and sexuality.
4. Strengthen state and federal protections for privacy of patients' medical information, and repeal all laws that require healthcare personnel to report individuals to law enforcement or family regulation authorities on the basis of acts during pregnancy. The State should ensure that the privacy of healthcare information is protected even when it is held by private corporations, and that it is not used as evidence in criminal, family regulation, immigration, or other civil proceedings. Healthcare settings must remain confidential and safe for people seeking care to foster trust in the healthcare system
5. Expand coverage for existing healthcare programs to ensure that all individuals, particularly those from marginalized communities including those of African descent, Indigenous Peoples and people with disabilities have access to intersectional and culturally respectful, affordable and comprehensive healthcare, including mental health care, voluntary drug treatment, and sexual and reproductive health services. This includes ensuring access to contraception, sexual education, and respectful maternal healthcare, as well as integrating community-based midwifery into healthcare systems. Provide guidance and support to sexual and reproductive health providers on how to ensure that sexual and reproductive health facilities and equipment are physically accessible, services and goods are economically accessible, patients are provided with information in accessible formats, and sign language interpreters or other trained support people are provided.
6. Implement comprehensive and targeted policies and programs to eliminate racial, ethnic, disability, and socioeconomic disparities in access to sexual and reproductive health services. This includes enacting policies and programs aimed at removing barriers to accessing services, reducing maternal mortality and morbidity, particularly for marginalized communities, including racial and ethnic minorities, Indigenous peoples, and low-income individuals. Require all sexual and reproductive health providers and staff to undergo training on human rights, particularly gender and disability rights,

including as part of higher education of medical professionals. This training includes:

- a. Information to counter the incorrect assumption that persons with disabilities are asexual or incapable of making healthcare decisions.
- b. Information on the diversity of disability and on providing respectful care to persons with disabilities.

¹ The authors of this report are grateful to Women Enabled International for sharing their information and expertise.

² The Initial Criminalization Report is available at https://www.law.cuny.edu/newsroom_post/hrhj-clinic-report-to-un-highlights-the-misuse-of-laws-to-criminalize-abortion-and-punish-pregnant-people/.

³ See, e.g., *Pregnancy as a Crime: An Interim Update on the First Two Years After Dobbs*, 1-2, Pregnancy Justice (Sep. 2025), <https://www.pregnancyjusticeus.org/wp-content/uploads/2025/09/Pregnancy-as-a-Crime-An-Interim-Update-on-the-First-Two-Years-After-Dobbs.pdf>.

⁴ See, e.g., *State v. Green*, 474 P.3d 886 (Okla. Crim. App. 2020); *Ankrom v. Alabama*; *Kimbrough v. Alabama*, 152 So.3d 397 (Ala. 2013); *Whitner v. State*, 492 S.E.2d 777 (S.C. 1997).

⁵ See, e.g., Diaz-Tello et al., *If/When/How, Roe's Unfinished Promise: Decriminalizing Abortion Once and for All* (2018), https://ifwhenhow.org/wp-content/uploads/2023/06/19_Roes_Unfinished_Promise.pdf.

⁶ See e.g., *After Pregnancy Loss*, Pregnancy Justice (Jan. 2026), <https://www.pregnancyjusticeus.org/wp-content/uploads/2026/01/After-Pregnancy-Loss.pdf>.

⁷ Taylor Six, KY prosecutor explains walking back fetal homicide charge after reading state law, *Lexington Herald Leader* (Feb. 18, 2026), <https://www.kentucky.com/news/local/crime/article314648874.html>.

⁸ *Id.*

⁹ Edward Helmore, Judge sets \$1 bail for Georgia woman charged with murder for taking abortion pills, *The Guardian*, March 24, 2026, <https://www.theguardian.com/us-news/2026/mar/24/georgia-woman-bail-abortion-pills-murder-charge>

¹⁰ As discussed in the original report, only one state, Nevada explicitly criminalizes a pregnant person for having an abortion. N.R.S. §200.220; See Initial Report, para. 14.

¹¹ Shefali Luthra, *State lawmakers are weighing bills that would treat abortion as homicide*, *The 19th** (Apr. 7, 2025), <https://19thnews.org/2025/04/state-bills-abortion-homicide-pregnant-people/>

¹² *State Bans on Abortion Throughout Pregnancy*, Guttmacher (March 10, 2025), <https://www.guttmacher.org/state-policy/explore/state-policies-abortion-bans>.

¹³ According to the Society for Family Planning, “[t]elehealth abortion care (which involves mailing medication abortion pills) increased both in proportion and in absolute numbers [from the first quarter of 2022 to the second quarter of 2025], Society of Family Planning, #WeCount report, April 2022 to June 2025, Dec. 9, 2025, <https://societyfp.org/research/wecount/wecount-june-2025-data/> The data likely underrepresents the total number of medication abortions because it only includes abortions provided by licensed clinicians. *Id.*

¹⁴ Laurie Sobel, Ivette Gomez, and Alina Salganicoff, *The Intersection of State and Federal Policies on Access to Medication Abortion Via Telehealth after Dobbs*, July 24th, 2025, <https://www.kff.org/womens-health-policy/the-intersection-of-state-and-federal-policies-on-access-to-medication-abortion-via-telehealth-after-dobbs/>

¹⁵ Mabel Felix, Laurie Sobel, and Alina Salganicoff, *Criminal Penalties for Physicians in State Abortion Bans*, March 4th, 2025, <https://www.kff.org/womens-health-policy/criminal-penalties-for-physicians-in-state-abortion-bans/>

¹⁶ *Id.*

¹⁷ Laurie Sobel, et al., *The Intersection of State and Federal Policies on Access to Medication Abortion Via Telehealth after Dobbs*.

¹⁸ Ashley Kurzweil and Katherine Gallagher Robbins, *Three Years Post-Dobbs, Abortion Bans & Criminalization Threaten More than 15 Million Women of Color*, National Partnership for Women & Families (June 2025), <https://nationalpartnership.org/report/abortion-bans-and-criminalization-three-years-post-dobbs/>.

¹⁹ Mabel Felix, Laurie Sobel, and Alina Salganicoff, *Criminal Penalties for Physicians in State Abortion Bans*, March 4th, 2025.

²⁰ *Id.*

²¹ *Texas v. Margaret Daley Carpenter*, No. 471-08943-2024 (471st Dist. Ct., Collin Cty., Tex.)

²² Laurie Sobel et al., *The Intersection of State and Federal Policies on Access to Medication Abortion Via Telehealth after Dobbs*.

²³ Maria M. Silva, *Louisiana investing second abortion case against New Paltz doctor*, *Times Union* May 13, 2025, <https://www.timesunion.com/hudsonvalley/news/article/new-paltz-doctor-faces-second-abortion-pill-case-20324962.php>

²⁴ Laurie Sobel et al., *The Intersection of State and Federal Policies on Access to Medication Abortion Via Telehealth after Dobbs*; Rosemary Westwood, *Louisiana Mother, NY Doctor Indicted for Giving Minor Abortion*

Pills, WWNO – New Orleans Public Radio, January 31st, 2025, <https://www.wwno.org/public-health/2025-01-31/louisiana-mother-ny-doctor-indicted-for-giving-minor-abortion-pills>

²⁵ Maria M. Silva, *Louisiana investing second abortion case against New Paltz doctor*.

²⁶ Ayden Runnels and Zariah Carter, *Ken Paxton Suing California Doctor in Second Lawsuit citing Texas Abortion Pill Law*, The Texas Tribune, February 2nd, 2026, <https://www.texastribune.org/2026/02/02/texas-california-abortion-pill-lawsuit-bounty-hunter-law-hb-7/>

²⁷ 2025 Texas House Bill No. 7, Texas Eighty-Ninth Legislature - 2nd Called Session, 2025 Texas House Bill No. 7, Texas Eighty-Ninth Legislature - 2nd Called Session.

²⁸ Rosemary Westwood, *After Historic Indictment, Doctors Will Keep Mailing Abortion Pills over State Lines*, NPR, March 19th, 2025, <https://www.npr.org/sections/shots-health-news/2025/03/19/nx-s1-5312115/margaret-carpenter-indictment-telemedicine-abortion-louisiana-mail-mifepristone-misoprostol>

²⁹ Pam Belluck, *Newsom Says California Will Not Extradite Abortion Provider to Louisiana*, New York Times, Jan. 14, 2026, <https://www.nytimes.com/2026/01/14/us/california-louisiana-extradite-abortion-doctor.html>

³⁰ Drug Scheduling, Drug Enforcement Agency, Available at: <https://www.dea.gov/drug-information/drug-scheduling>. In the United States, the Controlled Substances Act classifies drugs, substances, and other chemicals used to make drugs into five distinct categories or “schedules,” depending on the drug’s accepted medical use and its potential to incur abuse or dependency. Drug Scheduling, Drug Enforcement Agency, Available at: <https://www.dea.gov/drug-information/drug-scheduling>. The key factor in determining the scheduling of the drug is the abuse rate; Schedule I drugs have no medical purpose and high potential for severe psychological or physical dependency, while Schedule VI drugs serve a medical purpose and represent the least potential for abuse. *Id.*

³¹ ACMT Position Statement: Mifepristone and Misoprostol are Not “Controlled Dangerous Substances”, American College of Medical Toxicology, Maryann Mazer-Amirshahi, PharmD, MD, MPH, PhD; Peggy Ye, MD, MPH; Diane P. Calello, MD; Andrew I. Stolbach, MD, MPH, September 30, 2024, Available at: https://www.acmt.net/wp-content/uploads/2024/09/PS_240930_Mifepristone-and-Misoprostol-are-Not-Controlled-Dangerous-Substances.pdf; WHO Model List of Essential Medicines, World Health Organization, Available at: <https://list.essentialmeds.org/>.

³² RS 40: § 969 B(2) Available at: <https://www.legis.la.gov/legis/Law.aspx?d=98883>

³³ South Carolina H. 4760 Available at: https://www.scstatehouse.gov/sess126_2025-2026/bills/4760.htm

³⁴ Bill Criminalizing Mail-Order Abortion Pills as ‘Drug Trafficking’ Heads to Mississippi Governor’s Desk, Heather Harrison; Mississippi Free Press; March 6, 2026; Available at: <https://www.mississippifreepress.org/bill-criminalizing-mail-order-abortion-pills-as-drug-trafficking-heads-to-mississippi-governors-desk/>

³⁵ Texas H.B. 148 status, Available at: <https://www.billtrack50.com/billdetail/1901900>

³⁶ Kentucky S.B. 106 status, Available at: <https://www.billtrack50.com/billdetail/1820684>

³⁷ Missouri S.B. 763 status, Available at: <https://www.billtrack50.com/billdetail/1845298>

³⁸ Drug Scheduling; Drug Enforcement Agency, Available at: <https://www.dea.gov/drug-information/drug-scheduling>

³⁹ A DEA Resource Guide: Federal Trafficking Penalties pg. 36, 37, Available at: <https://www.dea.gov/sites/default/files/2021-12/Trafficking%20Penalties.pdf>

⁴⁰ ACMT Position Statement: Mifepristone and Misoprostol are Not “Controlled Dangerous Substances”, American College of Medical Toxicology, Maryann Mazer-Amirshahi, PharmD, MD, MPH, PhD; Peggy Ye, MD, MPH; Diane P. Calello, MD; Andrew I. Stolbach, MD, MPH, September 30, 2024, Available at: https://www.acmt.net/wp-content/uploads/2024/09/PS_240930_Mifepristone-and-Misoprostol-are-Not-Controlled-Dangerous-Substances.pdf

⁴¹ ACMT Position Statement: Mifepristone and Misoprostol are Not “Controlled Dangerous Substances”, American College of Medical Toxicology, Maryann Mazer-Amirshahi, PharmD, MD, MPH, PhD; Peggy Ye, MD, MPH; Diane P. Calello, MD; Andrew I. Stolbach, MD, MPH, September 30, 2024, Available at: https://www.acmt.net/wp-content/uploads/2024/09/PS_240930_Mifepristone-and-Misoprostol-are-Not-Controlled-Dangerous-Substances.pdf

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⁴³ *Id.*

⁴⁴ Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation, content current as of February 2, 2026, Available at:

<https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation>

⁴⁵ WHO Model List of Essential Medicines, World Health Organization, Available at: <https://list.essentialmeds.org/>

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- ⁵⁰ Prescription Monitoring Program Information; Louisiana Board of Pharmacy; Available at: <https://www.pharmacy.la.gov/page/prescription-monitoring-program-pmp-information>.
- ⁵¹ La. Stat. Ann. § 40:988.
- ⁵² La. Admin. Code tit. 46, § LIII-2717.
- ⁵³ New Orleans Health Department, *Evaluating the Impact of Act 246 of the 2024 Louisiana Legislative Session: The Classification of Misoprostol and Mifepristone as Schedule IV Controlled Dangerous Substances*, September 2025; Available at: <https://nola.gov/getattachment/NEXT/Health-Department/Topics/Data-and-Publications/Act-246-Report-Final-9-30-25.pdf>
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