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SEXUAL AND REPRODUCTIVE HEALTH, RIGHTS, AND JUSTICE

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Submitted by: The Center for Reproductive Rights, a global organization founded in 1992 that uses the power of law to advance reproductive rights as fundamental human rights around the world. Within the United States (U.S.), the Center engages in litigation, policy, and advocacy work at the state, national, and international levels. (https://reproductiverights.org/)

Contact Name:
Tanya Karanasios, Interim Vice President, Global Advocacy, Center for Reproductive Rights
Estelle Wagner, Associate Director for Global Advocacy, Center for Reproductive Rights
Tania Agosti, Senior Global Advocacy Adviser, Center for Reproductive Rights

Contact e-mail: tkaranasios@reprorights.org, wagnere@reprorights.org, tagosti@reprorights.org

Co-submitting organizations:
Abortion Care Network
National Asian Pacific American Women's Forum
National Black Midwives Alliance
National Latina Institute for Reproductive Justice
Women Enabled International

I. Summary

1. At the conclusion of its Third UPR, the U.S. received more than a dozen recommendations to improve sexual and reproductive health and rights (SRHR). During that process, the U.S. was given the opportunity to take a position on each recommendation and it "supported," at least in part, several of them, including:

a. Lift funding restrictions on United States foreign assistance to promote women's full access to sexual and reproductive health and rights.[1]
b. Ensure that laws permitting the refusal of care based on religious and moral beliefs do not restrict women's sexual and reproductive health and rights and that measures are put in place to monitor and prevent violations of these rights.[2]
c. Reverse policies inhibiting comprehensive and universal access to voluntary sexual and reproductive health services, especially in emergency situations.[3]
d. Rescind the Title X restrictions to ensure access to comprehensive family planning services for all.[4]
e. Make essential health services accessible to all women and girls, paying special attention to those who face multiple and intersecting forms of discrimination.[5]
f. Ensure universal access to sexual and reproductive health information, education and services for all.[6]

2. Just five years later, the retrogression in sexual and reproductive health and rights (SRHR) is extreme. While human rights advocates in the U.S. have been fighting attacks on SRHR for years, recent, hostile developments in all branches of federal government—the judicial, legislative, and executive branches—have taken the backlash against SRHR to new levels. As legal protection erodes, violations of pregnant people's rights to life, equality, health (including sexual and reproductive health), privacy, information, freedom from discrimination and violence, and freedom from torture, cruel, inhuman and degrading treatment are escalating.[7]

3. This submission focuses on threats to (1) abortion access; (2) maternal health; and (3) foreign assistance for SRHR. Other joint reports submitted by CUNY Human Rights and Gender Justice Clinic, the Global Justice Center, Physicians for Human Rights, and others provide additional detail on SRHR violations.

II. U.S. Legal Framework

4. *Dobbs v. Jackson Women's Health Organization*, reversed nearly 50 years of precedent and concluded that there is no federal constitutional right to abortion.[8] The *Dobbs* decision overruled *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey* and, for the first time in U.S. history, took away a right grounded in personal liberty.

5. In the U.S. both federal and state laws regulate health care access, addressing various aspects of non-discrimination, physical access, affordability, and coverage of healthcare, including sexual and reproductive healthcare. Now that federal constitutional protection for abortion has been revoked, conservative state legislatures are imposing aggressive restrictions on reproductive health care. Currently, abortion is illegal in 12 states and severely restricted in many others.[9] Consequently, people seeking abortion are being

denied care and/or forced to travel long distances to obtain care in states where it remains legal—if they have the means to do so. Patients, their helpers, and their health care providers fear punishment and harassment for acting on their best judgment and doctors are leaving states that do not allow them to provide comprehensive, evidence-based reproductive health care. The impact of these restrictions is not limited to abortion—without a recognized legal right to make decisions about pregnancy and access appropriate medical care, pregnant people in the U.S. are even more vulnerable to coercion and neglect than before, whether they seek contraception, fertility care, abortion, routine or emergency obstetric care, or control over the circumstances in which they give birth.[10]

6. Despite these radical shifts in domestic law and policy, the U.S. has ratified international instruments that commit the United States to ensuring sexual and reproductive health and rights. These include the International Covenant on Civil Political Rights (ICCPR), the International Convention on the Elimination of All Forms of Racial Discrimination (CERD), and the Convention Against Torture. The U.S. has signed but not ratified the Convention on the Rights of Persons with Disabilities (CRPD), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

7. During the most recent reviews of the U.S. by UN treaty monitoring bodies, both the Committee on the Elimination of Racial Discrimination (CERD Committee) and the Human Rights Committee issued strong recommendations affirming U.S. obligations to uphold sexual and reproductive health and rights:

- In 2022, CERD expressed concern about the impact of systemic racism on access to sexual and reproductive health services, including abortion and culturally sensitive, respectful maternal health care. CERD recommended that the U.S. take an intersectional, culturally respectful approach to removing barriers to comprehensive SRHR access, and reducing maternal mortality and morbidity, including through midwifery care. CERD also recommended the U.S. adopt all necessary measures to address the profound disparate impact of *Dobbs* and to "provide safe, legal, and effective access to abortion," ensure that women seeking abortion and providers assisting them are not subjected to criminal penalties, and reference the (2022) WHO abortion care guideline.[11]

- In 2023, the Human Rights Committee issued similar recommendations, including that the U.S. should "remove restrictive and discriminatory legal and practical barriers to midwifery care, including those affecting midwifes in communities of people of African descent and Indigenous peoples." The Human Rights Committee also expressed concern about "restrictions to inter-state travel, bans on medication abortion, and surveillance of women seeking abortion care through their digital data for prosecution purposes." Among other recommendations, the Human Rights Committee urged the U.S. to "put an end to the criminalization of abortion by repealing laws that criminalize abortion, including laws that apply criminal sanctions to women and girls who undergo abortion, to health service providers who assist women and girls to undergo abortion and to persons who assist women and girls to procure an abortion, and consider harmonizing its legal and policy framework with the World Health Organization's Abortion Care Guideline (2022)."[12]

8. On January 20th, and February 4th, President Trump issued Executive Orders with instructions to withdraw the U.S. from the World Health Organization[13] and from the U.N. Human Rights Council[14], respectively, and to withhold committed funds. Executive Orders have also been issued to review membership or withdraw funding from several other UN entities.[15] These Executive Orders demonstrate the Trump administration's disregard for their obligations under international human rights law and undermine efforts to hold them accountable for human rights violations. It also demonstrates the intention to reject evidence- and science-based policy recommendations in favor of ideologically motivated policies.

III. Erosion of Protections and Violations of Human Rights on the Ground

A) Attacks on Abortion Access

i. *Dobbs* is deepening inequities in abortion access

9. The federal protections for abortion under *Roe* and *Casey* were never enough to ensure meaningful access to abortion in the U.S.; although these cases created a minimum level of protection, abortion access was severely limited in many parts of the U.S. even before *Dobbs*. In the aftermath of the *Dobbs* decision, it has become even more clear that a person's right to bodily autonomy and reproductive health depends heavily on where they live, how much money they have, and whether they face discrimination when seeking to access care. The U.S. Supreme Court asserted that abortion is a political issue that should be left to the states to decide[16]—but fundamental rights should not be up for debate. Eviscerating a long-held constitutional right to abortion marks a major retrogression in the U.S. and establishes it as an outlier—running counter to the global trend to liberalize abortion laws.[17]

10. Immediately following the *Dobbs* ruling, legislators in multiple states moved to ban or severely restrict access to abortion, creating "abortion deserts"[18] across large swaths of the U.S. Twelve states are currently enforcing total criminal bans in the United States, an additional four states ban abortion between 18-23 weeks, and 19 states are enforcing a ban between 24-26 weeks.[19] And in many of those states, legislators have gone a step further, enacting laws that purport to criminalize abortion support, further restrict access to medication abortion, and/or increase criminal penalties for abortion care.

11. An estimated 36 million women of reproductive age live in states where abortion has or is likely to be banned.[20] Included in that number are nearly 3 million women with disabilities, 12.5 women with limited financial resources, 1.3 million transgender adults, 1.2 million LGBTQ adults who identify as nonbinary, and 15 million women of color.[21] The majority of "abortion desert" states are concentrated in the South and Midwest regions where over 25 million women of reproductive age, or two in five nationally, currently live, many of them women of color.[22] People living in these states have less access to health care and worse health outcomes, including reproductive health outcomes,

than people living in other regions.[23]

12. Nearly three million women with disabilities live in states that have banned or are likely to ban abortion.[24] Indeed, the states with the highest prevalence of chronic illness and disability are also the states with the most restrictive abortion legislation.[25] People with disabilities are equally likely to become pregnant as people without disabilities, but have a significantly higher risk of almost all adverse maternal outcomes and are eleven times more likely to die during childbirth.[26] This is particularly concerning when vaguely worded medical exceptions for abortion bans force delays and denials of life-saving and health-preserving abortions.[27] Logistical issues like transportation are the most common barriers that people with disabilities face when trying to access reproductive health care[28] and they frequently rely on assistance from others for transportation.[29] This makes pregnant people with disabilities seeking abortion care across state lines particularly reliant on others for access which can compromise their privacy, their ability to access care at all, and even their safety.

13. States that have banned or severely restricted abortion have some of the worst maternal health outcomes in the nation and offer the fewest supports for families.[30] The high maternal mortality rate disproportionately impacts Black and Indigenous communities who consistently face the greatest risks during pregnancy, childbirth, and postpartum due to discrimination and inadequate access to health services.[31] Even before *Dobbs*, the maternal mortality rate was 2.6 times higher for Black women than for white women. Post-*Dobbs,* the mortality rate remains highest for Black and Indigenous women.[32]

14. Pregnant people in states where abortion has been criminalized or restricted must travel 300 kilometers or more across multiple state lines to reach states where they can receive care.[33] For many pregnant people abortion is not only banned in their state, but also in their neighboring states. Travel times increased, on average, by more than four hours.[34] This is especially true in the U.S. Southeast where abortion is largely inaccessible.[35] The U.S. is a large country without sufficient public transportation systems and travel may require overnight lodging. Travel barriers can be particularly challenging for people with caregiving responsibilities, a disability, or illness, immigrants, young people, and individuals experiencing abuse from partners who control their movements and finances. They also raise the cost of obtaining abortion and can push people farther into pregnancy.

15. Instead of supporting pregnant people to exercise their reproductive autonomy, many state legislatures have introduced legislation that would criminalize self-managed abortions and punish pregnant people for seeking abortion care.[36] This is in addition to laws that criminalize pregnant people for their pregnancy outcomes when they suffer miscarriages and stillbirths.[37] These legislative efforts and enacted laws pose a particular threat to women of color, who already experience bias and discrimination in the healthcare system, are subject to heightened surveillance and family separations, and are disproportionately targeted by the criminal justice system.[38]

16. Medication abortion is the U.S.' most common method of abortion, accounting for more than 60% of all abortions, though this is likely an undercount because it does not account for self-managed abortions.[39] In May 2024 the governor of the state of Louisiana signed a bill into law that reclassifies mifepristone and misoprostol—the two drugs used in

medication abortion—as controlled substances and makes possession without a prescription a crime punishable by jail time and fines.[40]

ii. Abortion providers are navigating chaotic and challenging conditions as they try to maintain abortion access, including risk of criminalization

17. Many abortion bans include medical exceptions which use non-medical and vague language. Because of this, physicians do not know whether providing care consistent with their good faith medical judgment will subject them to felony prosecution and jail time.[41] When medical providers have sought clarity from state governments and their own hospitals regarding the applicability and scope of medical exceptions to abortion bans, they have been ignored or given unworkable parameters.[42]

18. In this context, physicians and clinicians are forced to balance the demands of state abortion bans—and their corresponding civil and criminal sanctions—against the risk of civil liability for failing to uphold their ethical obligations to limit harm to patients.[43] This situates medical providers in positions of dual loyalty, "a situation where physicians are unable to fully comply with both the law and their ethical obligations as medical providers."[44] In restrictive and uncertain legal environments, physicians and clinicians do not have the flexibility to determine whether their good faith assessment of medical need, as dictated by their education, experience, and medical ethics, is sufficient to legally provide the medically necessary care to patients. Even when a physician is told by a court that they can provide care, they can still face threats of prosecution or penalties from anti-abortion state governments.[45]

19. In December 2024 the Attorney General of the state of Texas brought a civil suit against a New York state-based doctor for prescribing medication abortion pills to a patient in Texas via telemedicine.[46] And in late January 2025, the state of Louisiana brought criminal charges against the same New York state-based doctor for prescribing abortion pills to a patient in Louisiana also via telemedicine.[47] These lawsuits instill fear in providers who live in states where abortion is legal and who prescribe medication abortion via telemedicine to patients in states where abortion is banned. They also may have a chilling impact on the prescription of medication abortion. All of this even though eight states in the U.S., including New York, have shield laws that protect abortion providers and helpers from civil and criminal consequences stemming from abortion care provided to an out-of-state resident who cannot travel for care.[48]

20. The Freedom of Access to Clinic Entrances Act (FACE Act) is a federal law that prohibits individuals from activities including, but not limited to, physically blocking patients from accessing their doctors.[49] On January 23, 2025, President Trump pardoned 23 individuals who had been convicted under the FACE Act.[50] Some of the offenses committed included breaking into clinics, stealing fetal tissue, and accosting pregnant patients. More recently, the U.S. Department of Justice signaled it will no longer enforce the FACE Act except in “extraordinary circumstances” or where there is “death, bodily harm, or serious property damage.”[51] Against this backdrop, providers and patients alike face heightened physical threats, harassment, and intimidation from protestors at clinics, and providers have stated that they fear for their safety, and the safety of their staff and patients.

iii. Exceptions to abortion bans are not preventing human rights violations

21. Although the abortion bans in effect since *Dobbs* include some narrow exceptions, these exceptions do not protect human rights and fail to ensure care even under the extremely limited circumstances they purport to include. In the 18 states that have abortion bans or early gestational limits between six and 12 weeks, 18 have an exception for the life of the pregnant person, 12 have a health exception, 10 have an exception for rape and incest, and eight have explicit exceptions for a fatal "fetal anomaly."[52] Even where exceptions exist, misinformation and the threat of criminalization are strong enough that pregnant people have died because they either did not seek or were not provided with care.[53]

22. In 2022, researchers posing as prospective patients contacted 34 hospitals in Oklahoma and asked them about their policies for emergency obstetric care. Oklahoma prohibits abortion, except when "necessary to preserve" the life of a pregnant person. Some of the hospitals contacted provided factually incorrect information.[54] None provided clear information about obstetric emergencies that supported a clinician's ability to protect their patients. As this research in Oklahoma demonstrates, narrow exceptions to abortion bans such as "only to save the life" of the pregnant person stoke uncertainty and fear for pregnant people, health care providers, and hospital decision-makers.[55]

23. Fact-finding in Louisiana in 2023 documented the human rights violations pregnant people who seek medical care in the state are experiencing under the state's multiple abortion bans. Abortion is banned in Louisiana except under narrow legal exceptions to save the pregnant person's life or where the pregnant person's fetus is deemed "medically futile."[56] Findings indicated that clinicians are waiting to intervene in pregnancy complications until the patient's condition worsened and could be clearly documented.[57]

24. In a 2023 lawsuit filed by the Center for Reproductive Rights against the state of Texas, *Zurawski v. State of Texas*, doctors and patients described the confusion, fear, pain, and suffering they had endured because of the state's abortion ban—despite its exception for "medical emergencies."[58] The OBGYN plaintiffs in the *Zurawski* case argued that Texas' abortion bans interfered with their ability to provide pregnant people with the standard of medical care. Physicians who provide abortion care that does not meet the state's confusing "medical emergency" exception face fines of at least $100,000, up to 99 years in prison, and loss of their state medical license. The patient plaintiffs in the case described how Texas' abortion bans had caused them preventable physical and psychological harm.[59] On May 31, 2024, the Texas Supreme Court ruled in the case, refusing to clarify the exceptions to the state's abortion bans and rejected claims brought by 20 women who were denied abortions despite dire pregnancy complications.

iv. *Dobbs* has galvanized efforts to grant fetuses and embryos with legal rights—which has negatively affected access to abortion and fertility care and pregnant people

25. States also continue to introduce legislation that would grant legal rights to fetuses and embryos, distinct but interconnected anti-abortion efforts with dire circumstances for

pregnant people and people trying to become pregnant.[60] These kinds of laws undermine people's reproductive autonomy and put providers, pregnant people, and people trying to become pregnant at risk of criminal and civil penalties.[61]

26. On January 20, 2025, the Trump administration issued an Executive Order "Defending Women From Gender Ideology Extremism and Restoring Biological Truth to The Federal Government"[62] seeking to end federal policies and practices that recognize the existence of Transgender, Nonbinary, and Intersex people. The order included inaccurate definitions for "male" and "female" that attempted to normalize the concept of personhood and gender at conception. This action further emboldens those attempting to ban access to sexual and reproductive health care and lays the groundwork to criminalize providers and pregnant people, especially those seeking abortion or experiencing a miscarriage.

27. Laws that criminalize abortion further normalize the idea that pregnant people's fundamental rights can be modified or suspended, and they extend the reach of a criminal justice system that is already notorious for discrimination against people of color. The criminalization of reproductive healthcare also amplifies concerns about the way that healthcare sites can facilitate surveillance and control, making it difficult for marginalized communities to access quality care and trust healthcare providers who may be encouraged to police and punish them.

28. The consequences of these efforts reveal how *Dobbs'* effects can spill over into other spheres, creating new threats for other reproductive healthcare and rights beyond abortion. This was clear after Alabama's Supreme Court ruled, in a case concerning the accidental destruction of cryopreserved embryos, that based on its previous rulings and its state constitution, it was required to hold fertility clinics liable for the loss of embryos under the state's Wrongful Death of a Minor Act.[63] The February 2024 ruling led the state's three largest fertility clinics to immediately halt their provision of IVF and care did not resume until weeks later when the state legislature enacted a law providing clinics immunity from civil and criminal liability.[64] By the end of the year, two of these clinics announced they were permanently closing.[65] This ruling and the many bills that have been introduced post-*Dobbs* that would grant legal rights to embryos signal that these legislative efforts are just beginning, and we can expect further threats to the reproductive rights of the 9.7 million women in the United States for whom it is difficult or impossible to get pregnant or carry a pregnancy to term, and who may need to access assisted reproduction services like IVF.

B) Maternal Health

i. The maternal health crisis is rooted in structural racism

29. The U.S. is entrenched in a maternal health crisis and women of color are bearing the brunt of it. For decades, maternal deaths have been rising.[66] The U.S. maternal mortality ratio is the highest among wealthy nations and particularly high for Black women.[67] While maternal deaths decreased slightly between 2022 and 2023, Black women were left behind. The maternal mortality rate for Black women in 2023 was 50.3 deaths per 100,000 live births—nearly three and a half times the rate for white women.[68]

30. Recent improvements in data collection have revealed additional racial and ethnic disparities. For example, Indigenous people and Native Hawaiian and other Pacific Islanders are also significantly more likely than white women to experience pregnancy-related deaths during pregnancy, birth, or up to one year after the end of their pregnancy.[69] Moreover, as U.S. states have begun to better track and analyze pregnancy-related deaths, Maternal Mortality Review Committees and the CDC have determined that 80% of these deaths are preventable.[70]

31. Adverse maternal health outcomes are not limited to preventable deaths. Rising maternal morbidity (non-fatal health conditions caused or aggravated by pregnancy or childbirth), inadequate access to care, and mistreatment or coercion in health care settings are also threats.[71]

32. Each year, 50,000 or more women in the U.S. experience severe maternal morbidity, a life-threatening event.[72] Access to maternity care is declining across the U.S. and more than 2.2 million women of childbearing age live in maternity care deserts—counties with no obstetric care provider or facility (hospital or birth center).[73] People with disabilities face extraordinary barriers to health care of all kinds, including maternal health care, and are at higher risk for all maternal morbidities.[74] Even when individuals are able to reach maternal health care facilities, the care they receive may not be appropriate for their needs. Birth interventions[75] are routine, despite evidence that routine use of such interventions increases the risk of complications for birthing people and their babies.[76] More than 30% of births in the U.S. involve cesarean surgery.[77] According to the World Health Organization, there is no evidence that mortality rates improve when the cesarean rate rises above 10%.[78] "[W]hen practiced without a woman's consent, caesarian sections may amount to gender-based violence against women and even torture."[79]

33. Mistreatment of patients in U.S. maternity care settings has been normalized and facility-based pregnancy and birth experiences too often include humiliation, verbal abuse, coercion, and threats. Individuals from marginalized communities (such as those experiencing intersectional discrimination on the basis of race and sex, or race, sex, and disability) are at increased risk of abuse and neglect by obstetric care providers. One in six women (of all races and ethnicities) report experiencing mistreatment in maternity care.[80] For women of color, it's nearly one in four.[81] Moreover, abortion restrictions are contributing to a legal and cultural environment where health care providers and others are encouraged to prioritize concerns about the fetus over the pregnant person's autonomy. This increases the risk that pregnant people will be subjected to over-medicalized procedures, which are invasive, unnecessary and deny them choices about the circumstances and manner in which they give birth.[82]

34. A more racially diverse health care workforce that includes a robust cohort of midwives could address many of the challenges that the U.S. faces in terms of providing available, accessible, acceptable, and high-quality maternal health care to all who need it. Unfortunately, the U.S. has few midwives compared to most other high-income countries.[83] The marginalization of midwifery began nearly one hundred years ago when white, male physicians led campaigns to discredit and replace midwives (roles

traditionally held by Black, Indigenous, and immigrant women), and laws were passed to restrict or eliminate their practices.[84]

35. Law and policy barriers undermine access to the midwifery model of care[85] in most parts of the U.S., and Black and Indigenous communities face particularly steep hurdles to accessing and providing midwifery care. For example, in Hawai‘i midwives, students, and pregnant women sued their government to block a licensure law that criminalizes family members and skilled midwives—including Native Hawaiian cultural practitioners—for providing care.[86] And in Georgia, a Southern state where Black midwives have a long history of skillfully caring for families, the law now excludes all trained midwives except those with a nursing degree and masters level midwifery degree.

36. Both the Committee on the Elimination of Racism and the Human Rights Committee have expressed alarm at U.S. failures to safeguard pregnant people's rights to health and ensure access to non-discriminatory maternal health care. They have called on the U.S. to improve maternal health, including by eliminating barriers to midwifery care and taking an intersectional and culturally sensitive approach to policies and programs. Previous UPR reviews have also yielded recommendations to improve maternal health—recommendations which the U.S. accepted.[87]

ii. Policy retrogression threatens efforts to address racial disparities in maternal mortality and morbidity

37. The Trump administration has launched a relentless assault on public health programs and infrastructure that threatens to exacerbate maternal health disparities. President Trump has issued Executive orders and other directives seeking to dismantle efforts that promote diversity, equity, and inclusion in the federal government, as well as in private sector spaces that receive federal funding.[88] Critical research on health disparities was abruptly halted, and federal websites with data and information about women and people of color was abruptly removed, including a data set focused on monitoring health risks during pregnancy. Although some of these efforts are being challenged in court, they have already had a chilling effect that goes beyond the federal government.[89] By abandoning and actively discouraging efforts to target health disparities, acknowledge the impacts of systemic racism, and diversify the healthcare workforce, the Trump administration is deepening the maternal health crisis and undermining efforts to end preventable maternal deaths.

38. Proposed cuts to Medicaid[90] funding threaten the fundamental right to available, accessible, and non-discriminatory healthcare, particularly for pregnant and postpartum individuals.[91] Medicaid, a public health insurance program which covers 41% of births in the U.S., is foundational to ensuring equitable access to essential health services and from the prenatal through the postpartum period. Cutting Medicaid funding would not only violate the United States' commitments to upholding the right to health and life, but it would also exacerbate existing racial and socioeconomic disparities, disproportionately harming Black, Indigenous, disabled and low-income communities, who already face disproportionately high rates of maternal mortality.

39. Reducing Medicaid funding directly undermines the availability of essential health services that are fundamental to improving maternal health outcomes. This impact would be felt most in rural and underserved areas where Medicaid-funded facilities serve as the primary providers of care.[92] Financial constraints on hospitals and providers would result in reduced availability of pregnancy-related care, including labor and delivery services, leading to worse outcomes for parents and newborns. Marginalized communities that already face systemic barriers to respectful and culturally competent pregnancy-related care, would be left with even fewer acceptable options for providers who meet their needs. The Human Rights Committee has long recognized that the right to life entails the State obligation to ensure universal access without discrimination for all individuals—including those from disadvantaged and marginalized groups—to the full range of quality sexual and reproductive health care, including maternal health care.[93]

40. Proposals to include work requirements and restrict eligibility criteria delay access to timely care, as millions of low-income individuals would experience churn, or temporary loss of continuous coverage, and may be at risk of losing coverage entirely.[94] These policies act as barriers and can delay access to prenatal and postpartum care, increasing the risk of preventable complications. Any effort to cut Medicaid funding must be recognized as a violation of international human rights norms and a deliberate rollback of progress towards maternal health equity.[95] The U.S. government must instead prioritize strengthening Medicaid to ensure that maternal health services remain fully available, accessible, acceptable, and of high quality for all who need them.

C) Discriminatory Access to Health Care for Immigrant Women

41. Federal policies have excluded immigrants from government health insurance programs since 1996.[96] These policies exclude both undocumented immigrants as well as immigrants who have been deemed "lawfully present" in the U.S. for less than five years. Immigrant women of reproductive age are disproportionately uninsured and face particularly high barriers to affordable health care.[97] Restricted access to health insurance has greatly impacted the ability of low-income immigrant women to access maternity care, family planning, and other reproductive health care services.[98]

42. In January 2025, the Administration revoked a directive that prevented Immigration and Customs Enforcement (ICE) and Customs and Border Protections (CBP) from conducting immigration enforcement actions near protected areas, such as schools, places of worship, and health care facilities.[99] This action, combined with anti-immigrant rhetoric and increased surveillance of immigrant communities increases fear and will result in immigrants forgoing necessary medical care, such as prenatal visits, newborn appointments, and postpartum checkups. Delaying prenatal care increases the risk of undiagnosed pregnancy complications, while fear of family separation, detention, and deportation may lead women to risk giving birth at home, heightening the risk of severe complications and mortality.

D) The Helms Amendment, the Global Gag Rule and the Dismantling of Foreign Assistance

43. The United States continues to implement and enforce the Helms Amendment to the Foreign Assistance Act[100], a law intended to prohibit foreign aid extended by the United States from being used to pay for the use of abortion "as a method of family planning." In practice, the Helms Amendment is used to justify a complete ban on using federal foreign aid for abortion care.[101]

44. The U.S. has reinstated and dramatically expanded the Mexico City Policy[102], also known as the Global Gag Rule (GGR), which undermines the rights of women and girls around the world. Under this expansive iteration of the GGR, nongovernmental organizations (NGOs) incorporated outside of the U.S. that wish to receive, or that currently receive, U.S. global assistance funds cannot use those funds, or any funds acquired from any other source, to "perform or actively promote abortion as a method of family planning." Furthermore, U.S. NGOs that receive U.S. government funds are required to enforce the policy and cannot provide financial support to foreign NGOs that "perform or actively promote abortions as a method of family planning."

45. The GGR undermines women and girls the right to control their own fertility, makes it more difficult for pregnant people to receive proper prenatal and postnatal maternal care, and leaves communities at risk.[103] The GGR's expansion during the first Trump administration stalled and even reversed progress toward expanded access to modern contraception, impacting reproductive health outcomes, women and girls' ability to make family planning decisions and overall bodily autonomy.[104]

46. The U.S. government has frozen foreign aid[105], halted programs and services around the world[106], and dissolved USAID.[107] The administration's actions are an overstep of presidential powers and represent a radical shift in US foreign policy.[108] Notwithstanding legal challenges, these decisions signal the end of an organization that has brought crucial aid to millions globally, with detrimental impact on SRHR.

47. USAID has played a significant role in improving access to family planning services, supplies, and information in 41 countries, while also integrating these efforts with maternal and child health, HIV programming, and initiatives to combat child marriage and gender-based violence.[109] As a result of the foreign aid freeze, more than 200 health care facilities have shut down or suspended operations in Afghanistan, where midwives are reporting devastating impact on infant and maternal mortality.[110]

IV. Suggested Recommendations

1. **Ensure access to non-discriminatory sexual and reproductive health care for all individuals and communities, paying special attention to those who face intersecting forms of discrimination such as people of color, LGBTQ individuals, or people with disabilities living in poverty or in rural remote areas.**
2. **Immediately halt the retrogression in reproductive rights and ensure access to abortion, in alignment with the WHO Abortion Care Guideline (2022).**

3. **Ensure that pregnant people, their loved ones, and their health care providers are not subject to criminal or civil punishment for seeking, supporting, or providing abortions.**
4. **Adress the high rates of maternal deaths and morbidities, eliminate racial and ethnic inequities in these outcomes, and ensure that maternal health care is available, accessible, acceptable and quality across the territory, without discrimination.**
5. **Ensure that policies and programs to improve maternal health are culturally acceptable and do not criminalize or exclude Black and Indigenous communities or their birth practices.**
6. **Ensure that pregnant people have access to both community-based midwifery care and hospital-based emergency obstetric care and take steps to eliminate all violations of informed consent and bodily autonomy during birth.**
7. **Remove restrictions on U.S. foreign assistance that block access to comprehensive sexual and reproductive health care.**

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[1] U.N. Human Rts. Council, Report of the Working Group on the Universal Periodic Review, United Sates, ¶¶ 26.302-304, ¶¶26.311-312, ¶26.299 (Austria, Canada, Denmark, Netherlands, New Zealand, Norway), U.N. Doc. A/HRC/46/15 (2020).
[2] *Id* at ¶26.301 (Australia).
[3] *Id* at ¶26.302 (Austria).
[4] *Id* at ¶26.304 (Denmark).
[5] *Id* at ¶26.305 (Finland).
[6] *Id* at ¶26.300, ¶¶26.302-304, ¶¶ 26.306-310 (United Kingdom of Great Britain and Northern Ireland, Austria, Canada, France, Luxembourg, Mexico, Iceland, Malaysia, Denmark).
[7] *See e.g., Life of the Mother: How Abortion Bans Lead to Preventable Deaths*, PRO PUBLICA, https://www.propublica.org/series/life-of-the-mother (last visited Apr. 4, 2025); Lucie Arvallo et al., Deepening the Divide: Abortion Bans Further Harm Immigrant Communities, NAT'L LATINA INST. FOR REPROD. JUSTICE & THE CTR. FOR L. AND SOC. POL'Y (Sept. 17, 2024), https://www.latinainstitute.org/wp-content/uploads/2024/09/Deepening-the-Divide-2024-Factsheet_Final_English.pdf; *Freezing of Title X Funds Will Deny Millions Access to Family Planning Services*, CTR. FOR REPROD. RTS. (Apr. 3, 2025), https://reproductiverights.org/trump-title-x-freeze-family-planning/; Kelly Baden et al., *Clear and Growing Evidence that Dobbs is Harming Reproductive Health and Freedom*, Guttmacher Institute, (May 2024), https://www.guttmacher.org/2024/05/clear-and-growing-evidence-dobbs-harming-reproductive-health-and-freedom; Giuliana Grossi, *Infant Mortality Increases Across US Following Dobbs Decision*, AM. J. OF MANAGED CARE (Oct. 25, 2024), https://www.ajmc.com/view/infant-mortality-increases-across-us-following-dobbs-decision.
[8] *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf [hereinafter *Dobbs*].
[9] CTR. FOR REPROD. RTS., *After Roe Fell*, https://reproductiverights.org/maps/abortion-laws-by-state/ (last visited March 27, 2025). Abortion is illegal in Idaho, South Dakota, Indiana, West Virginia, Kentucky, Tennessee, Alabama, Louisiana, Arkansas, Mississippi, Oklahoma, and Texas.
[10] *See e.g., Human Rights Crisis: Abortion in the United States after Dobbs*, HUMAN RTS. WATCH (Apr. 18, 2023, 12:01 AM), https://www.hrw.org/news/2023/04/18/human-rights-crisis-abortion-united-states-after-dobbs; Mara Buchbinder & Erika L. Sabbath, *Reproductive Health Care After* Dobbs*: Rethinking Obstetric Harm in the United States*, 44 MED. ANTHROPOLOGY 6, 6–21 (2024) https://doi.org/10.1080/01459740.2024.2438034.
[11] Comm. on the Elimination of Racial Discrimination, Concluding observations on the combined tenth to twelfth reports of the United States of America ¶35-36, U.N. Doc CERD/C/USA/CO/10-12 (2022). [hereinafter U.N. Doc. CERD/C/USA/CO/10-12].
[12] WORLD HEALTH ORG., ABORTION CARE GUIDELINE (2022), https://www.who.int/publications/i/item/9789240039483. The Abortion Care Guideline is based on an evaluation of public health evidence and human rights standards. This guideline provides the first-ever definition of "decriminalization" in the context of abortion by a UN agency or human rights mechanism: "Decriminalization means removing abortion from all penal/criminal laws, not applying other criminal offences (e.g. murder, manslaughter) to abortion, and ensuring there are no criminal penalties for having, assisting with, providing information about, or providing abortion, for all relevant actors." It notes that "decriminalization would ensure that anyone who has experienced pregnancy loss does not come under suspicion of illegal abortion when they seek care" and that "decriminalization of abortion does not make women, girls or other pregnant persons vulnerable to forced or coerced abortion. Forced or coerced abortion would constitute

serious assault as these are non-consensual interventions." Accordingly, the Guideline recommends: 1) the full decriminalization of abortion and the absence of laws and other regulations that restrict abortion (at §2.2.1, pp. 24-25); 2) that abortion be available on the request of the woman, girl, or other pregnant person (at §2.2.2, pp. 26–29); 3) the absence of gestational age limits (at §2.2.1, pp. 24–25), mandatory waiting periods for abortion (at §3.3.1, pp. 41–42), and third-party authorization requirements (at §3.3.2, pp. 42–44); 4) the option of self-management of medical abortion in whole or in part at gestational ages of less than 12 weeks (at §3.6.2, p. 98); and 5) that regulations on who can provide and manage abortion are consistent with WHO guidance (at §3.3.8, p. 59).

[13] Withdrawing The United States From The World Health Organization, Exec. Order No. 14155, 90 Fed. Reg. 8631 (Jan. 20, 2025).

[14] Withdrawing the United States from and Ending Funding to Certain United Nations Organizations and Reviewing United States Support to All International Organizations, Exec. Order No. 14199, 90 Fed. Reg. 9275 (Feb. 10, 2025).

[15] *Id.*

[16] *Dobbs*, *supra* note 8.

[17] *In Historic Victory, Argentina Legalizes Abortion*, CTR. FOR REPROD. RTS. (Jan. 15, 2021), https://reproductiverights.org/historic-vote-argentina-legalize-abortion/; Fabiola Sánchez & Megan Janetsky, *Mexico decriminalizes abortion, extending Latin American trend of widening access to the procedure*, AP (Sept. 6, 2023), https://apnews.com/article/mexico-abortion-decriminalize-d87f6edbdf68c2e6c8f5700b3afd15de.

[18] *Abortion Deserts*, ADVANCING NEW STANDARDS IN REPROD. HEALTH, https://www.ansirh.org/abortion/restrictions/abortion-deserts (last visited Apr. 4, 2025); *Communities Need Clinics: There Is No Access Without Independent Abortion Providers*, ABORTION CARE NETWORK, https://abortioncarenetwork.org/wp-content/uploads/2024/12/CommunitiesNeedClinics2024_WEB-FINAL.pdf (last visited Apr. 4, 2025).

[19] *After Roe Fell*, Abortion Laws by State, CTR. FOR REPROD. RTS., https://reproductiverights.org/maps/abortion-laws-by-state/; *State Bans on Abortion Throughout Pregnancy*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/state-policies-abortion-bans.

[20] Katherine Gallagher et al., *State Abortion Bans Harm More than 15 Million Women of Color*, NAT'L P'SHIP FOR WOMEN & FAMILIES (June 2023), https://nationalpartnership.org/report/state-abortion-bans-harm-woc/.

[21] *Id*.

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

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

[24] Katherine Gallagher et al., *State Abortion Bans Harm More than 15 Million Women of Color*, NAT'L P'SHIP FOR WOMEN & FAMILIES (June 2023), https://nationalpartnership.org/report/state-abortion-bans-harm-woc/;
See Asha Hassan et al., *Dobbs and disability: Implications of abortion restrictions for people with chronic health conditions*, 58 HEALTH SERV. RSCH. 197–201 (2022).

[26] Jessica Gleason et al., *Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities*, JAMA NETWORK OPEN at 2, 4-6 (Dec. 15, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787181.

[27] *Another Texas Woman Died Because of Abortion Ban: Nevaeh Crain*, NAT'L ABORTION FED'N (Nov. 1, 2024), https://prochoice.org/another-texas-woman-died-because-of-abortion-ban-nevaeh-crain/; *Voices from Abortion Ban States*, CTR. FOR REPROD. RTS., https://reproductiverights.org/exceptions-plaintiffs-voices-abortion-ban-states/ (last visited Apr., 2025).

[28] *See* M. Antonia Biggs et al., *Access to Reproductive Health Services Among People with Disabilities*, JAMA NETWORK OPEN (Nov. 29, 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812360 (reporting 50.7% of people with disabilities experienced logistical barriers to reproductive health care compared to 29.7% of those without disabilities).

[29] *See* Stephen Brumbaugh, U.S. DEP'T OF TRANSP., *Travel Patterns of American Adults with Disabilities* 9 (2018), https://www.bts.gov/sites/bts.dot.gov/files/2022-01/travel-patterns-american-adults-disabilities-updated-01-03-22.pdf.

[30] A study found that states with abortion restrictions have a higher amount of maternity care "deserts" and fewer maternal care providers. Eugene Declercq et al., *The U.S. Maternal Health Divide: The Limited Maternal Health*

Services and Worse Outcomes of States Proposing New Abortion Restrictions, THE COMMONWEALTH FUND (Dec. 14, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes; March of Dimes estimated that 2.2 million women of childbearing age live in maternity care deserts, while 4.7 million women live in counties with limited maternity care access. *Nowhere to Go: Maternity Care Deserts Across the U.S., 2022 Report*, MARCH OF DIMES (Aug. 1, 2023), https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf.

[31] U.N. Doc. CERD/C/USA/CO/10-12, *supra* note 11 at ¶35; Ctr. for Reprod. Rts. et al., *Systematic Racism and Reproductive Injustice in the United States: A Report for the UN Committee on the Elimination of Racial Discrimination*, CTR. FOR REPROD. RTS. (July 15, 2022), https://reproductiverights.org/wp-content/uploads/2022/08/2022-CERD-Report_Systemic-Racism-and-Reproductive-Injustice.pdf; *See also* Kat Stafford, *Why do so many Black women die in pregnancy? One reason: Doctors don't take them seriously*, AP (May 23, 2023), https://projects.apnews.com/features/2023/from-birth-to-death/black-women-maternal-mortality-rate.html; Latoya Hill et al., *Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them*, KFF (Nov. 1, 2022), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/.

[32] Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2021*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Mar. 2023), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf; Laura G. Fleszar et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Groups in the United States*, 330 JAMA 52 (2023), https://jamanetwork.com/journals/jama/article-abstract/2806661.

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

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

[35] In Texas, for example, where abortion is banned, travel time after the ban took effect increased from about 15 minutes to an average of eight hours. In November 2024, Florida, which up to that point had provided critical abortion access to pregnant people in Florida and the greater South, enacted a six-week abortion ban. Since then, pregnant people in Florida seeking an abortion after six weeks need to travel nearly 1,000 kilometers to North Carolina, which has a 72-hour waiting period, or many more kilometers to reach Virginia. *See e.g.,* Cameron Scott, *Model Shows Where Women Lost Access to Abortion After Dobbs*, UNIV. OF CAL. SAN FRANCISCO (Nov. 1, 2022), https://www.ucsf.edu/news/2022/10/424121/model-shows-where-women-lost-access-abortion-afterdobbs; Benjamin Rader et al., *Estimated Travel Time and Spatial Access to Abortion Facilities in the U.S. Before and After the Dobbs v Jackson Women's Health Decision*, 328 JAMA 2041 (2022), https://jamanetwork.com/journals/jama/fullarticle/2798215. Fla. Stat. § 390.0111(1)(d). (Accessed September 9, 2024); Selena Simmons-Duffin & Hilary Fung, How Florida and Arizona Supreme Court rulings change the abortion access map, NPR (April 11, 2024), https://www.npr.org/sections/health-shots/2024/04/11/1243991410/how-florida-and-arizona-supreme-court-rulings-change-the-abortion-access-map.

[36] Brief of Experts, Researchers, and Advocates Opposing the Criminalization of People Who Have Abortions as Amici Curiae in Support of Respondents, Dobbs v. Jackson Women's Health Organization), 597 U.S. ___ (2022) (No. 19-1392), https://www.supremecourt.gov/DocketPDF/19/19-1392/192812/20210917160608544_Brief%20of%20Amici%20Experts%20Researchers%20and%20Advocates.pdf; Shefali Luthra, *Abortion bans don't prosecute pregnant people. That may be about to change*., THE 19TH (Jan. 13, 2023), https://19thnews.org/2023/01/abortion-bans-pregnant-people-prosecution/; Poppy Noor, *Republicans push wave of bills that would bring homicide charges for abortion*, THE GUARDIAN (Mar. 10, 2023), https://www.theguardian.com/us-news/2023/mar/10/republican-wave-state-bills-homicide-charges.

[37] Brief of Experts, Researchers, and Advocates Opposing the Criminalization of People Who Have Abortions as Amici Curiae in Support of Respondents, Dobbs v. Jackson Women's Health Organization), 597 U.S. ___ (2022) (No. 19-1392), https://www.supremecourt.gov/DocketPDF/19/19-1392/192812/20210917160608544_Brief%20of%20Amici%20Experts%20Researchers%20and%20Advocates.pdf; *Confronting Pregnancy Criminalization: A Practical Guide for Healthcare Providers, Lawyers, Medical Examiners, Child Welfare Workers, and Policymakers*, PREGNANCY JUSTICE (June 3, 2022), https://www.pregnancyjusticeus.org/wp-content/uploads/2022/12/202211-PJ-Toolkit-Update-2.pdf; MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD 15 (2020); Human Rts. & Gender Justice Clinic (CUNY School of Law) et al., *Racial Coercion and*

Control Over Reproductive Decision-Making and Families Shadow Report to the UN Committee on the Elimination of Racial Discrimination for the Tenth Periodic Review of the United States, CUNY SCHOOL OF LAW, https://www.law.cuny.edu/wp-content/uploads/page-assets/newsroom_post/racial-coercion-and-control-over-reproductive-decision-making-and-families/US-Racial-Coercion-Control-CERD-Shadow-Report.pdf (last visited Aug. 10, 2023).

[38] Brief of Experts, Researchers, and Advocates Opposing the Criminalization of People Who Have Abortions as Amici Curiae in Support of Respondents, Dobbs v. Jackson Women's Health Organization), 597 U.S. ___ (2022) (No. 19-1392), https://www.supremecourt.gov/DocketPDF/19/19-1392/192812/20210917160608544_Brief%20of%20Amici%20Experts%20Researchers%20and%20Advocates.pdf; *Confronting Pregnancy Criminalization: A Practical Guide for Healthcare Providers, Lawyers, Medical Examiners, Child Welfare Workers, and Policymakers*, PREGNANCY JUSTICE (June 3, 2022), https://www.pregnancyjusticeus.org/wp-content/uploads/2022/12/202211-PJ-Toolkit-Update-2.pdf; MICHELE GOODWIN, POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD 15 (2020); Human Rts. & Gender Justice Clinic (CUNY School of Law) et al., *Racial Coercion and Control Over Reproductive Decision-Making and Families Shadow Report to the UN Committee on the Elimination of Racial Discrimination for the Tenth Periodic Review of the United States*, CUNY School of Law, https://www.law.cuny.edu/wp-content/uploads/page-assets/newsroom_post/racial-coercion-and-control-over-reproductive-decision-making-and-families/US-Racial-Coercion-Control-CERD-Shadow-Report.pdf (last visited Aug. 10, 2023).

[39] *The Availability and Use of Medication Abortion*, Kaiser Family Foundation (March 20, 2024), https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/; S.B. 276, 2024 Leg., Reg. Sess. (La. 2024) (to be codified at La. Stat. Ann. § 40.964). See also La. Stat. Ann. § 40.964.

[41] *See, e.g.,* Caroline Kitchener & Dan Diamond, *Faced with abortion bans, doctors beg hospitals for help with key decisions*, Wash. Post (Nov. 1, 2023), https://www.washingtonpost.com/politics/2023/10/28/abortion-bans-medical-exceptions/.

[42] In the case of Louisiana, for example, which has multiple abortion bans, the Department of Health failed to provide clear answers and instead referred medical providers to the state's Attorney General who had issued a threatening letter to the state's medical society just days after the *Dobbs* ruling. *See* Julie O'Donoghue, *Louisiana health department declines to answer doctors' questions on abortion law*, LOUISIANA ILLUMINATOR (Nov. 1, 2022), https://lailluminator.com/2022/11/01/louisiana-health-department-declines-to-answer-doctors-questions-on-abortion-law/#:~:text=By%3A%20Julie%20O%27Donoghue%20%2D,1%2C%202022%206%3A41%20pm&text=The%20Louisiana%20Department%20of%20Health,at%20risk%20for%20criminal%20charges. (The letter threatened that "any medical provider who would perform or has performed an elective abortion after the Supreme Court's decision in *Dobbs* is jeopardizing his or her liberty and medical license"); @AGLizMurrill, X (formerly TWITTER), (June 29, 2022, 3:46 pm), https://x.com/AGLizMurrill/status/1542233093729312768?s=20.

[43] *See, e.g.,* AM. COLLEGE OF EMERGENCY PHYSICIANS, *Policy Statement Code of Ethics, II.B.1* 6 (2023), https://www.acep.org/siteassets/new-pdfs/policy-statements/code-of-ethics-for-emergency-physicians.pdf. *See also* Lift Louisiana, Physicians for Human Rights, RH Impact, and Center for Reproductive Rights, *Criminalized Care: How Louisiana's Abortion Bans Endanger Patients and Clinicians*, CTR. FOR REPROD. RTS. (March 2024), https://reproductiverights.org/wp-content/uploads/2024/03/Criminalized-Care-Report-Updated-as-of-3-15-24.pdf. Brief for *Amicus Curiae* Physicians for Human Rights in Support of Appellees, State of Texas v. Zurawski (No.23-0629).

[45] In Texas, Ms. Kate Cox, a pregnant woman seeking an emergency abortion, sued the state of Texas to access care. Ms. Cox's doctors confirmed that her fetus had Trisomy 18, a condition causing multiple structural abnormalities, and had no chance of survival. Her doctors warned her that continuing her pregnancy could jeopardize her fertility and health. The lower court affirmed Ms. Cox's right to access urgent abortion care and allowed her physician, Dr. Damla Karsan, to provide her an abortion in Texas without the threat of prosecution under its abortion ban. However, Texas' Attorney General Ken Paxton released a statement that the order "will not insulate hospitals, doctors, or anyone else, from civil and criminal liability for violating Texas' abortion laws." As a result, Ms. Cox was forced to leave the state to receive life-saving abortion care. These threats, including to their professional licensure, can change the way in which doctors treat patients and can lead to delays or refusals of necessary care, as well as the withholding of medical information. *Center Sues Texas on Behalf of Pregnant Woman Seeking an Emergency Abortion to Protect Her Health, Life and Future Fertility*, CTR. FOR REPROD. RTS. (Dec. 5, 2023), https://reproductiverights.org/cox-v-texas-emergency-abortion/; *Texas Judge Grants Temporary Order Allowing Pregnant Woman to Access Abortion Care in the State*, CTR. FOR REPROD. RTS. (Dec. 7, 2023), https://reproductiverights.org/cox-v-texas-tro-abortion-access/; Ava Sasani, *Texas attorney general says he will sue*

doctor who gives abortion to Kate Cox, The Guardian (Dec. 8, 2023), https://www.theguardian.com/us-news/2023/dec/08/ken-paxton-texas-abortion-kate-cox; @TXAG, X (formerly TWITTER) (Dec. 7, 2023, 2:49 pm), https://twitter.com/AGJeffLandry/status/1542233093729312768; J. David Goodman, *Texas Judge Grants Woman's Request for Abortion, in Rare Post-Roe Case*, N.Y. TIMES (Dec. 7, 2023), https://www.nytimes.com/2023/12/07/us/texas-abortion-ruling-exception.html.

[46] Associated Press, *Texas Challenges Shield Laws by Suing New York Doctor who Prescribed Abortion Pills*, NPR (Dec. 13, 2024), https://www.npr.org/2024/12/13/g-s1-38240/texas-abortion-pill-lawsuit-new-york-doctor-challenge-interstate-telemedicine.

[47] Brendan Pierson, *New York Doctor Indicted in Louisiana for Prescribing Abortion Pill Taken by Teen*, REUTERS (Jan. 31, 2025), https://www.reuters.com/legal/new-york-doctor-indicted-louisiana-prescribing-abortion-pill-teen-reports-say-2025-01-31/.

[48] CTR. FOR REPROD. RTS., *After Roe Fell*, https://reproductiverights.org/maps/abortion-laws-by-state/ (last visited April 4, 2025).

[49] 18 U.S.C.A § 248(a).

[50] *President Trump Pardons 23 People who Harassed and Attacked Abortion Patients and Clinics*, CTR. FOR REPROD. RTS., (Jan 24, 2025), https://reproductiverights.org/trump-pardons-23-people-attacked-abortion-patients-clinics/.

[51] U.S. DEP'T OF JUSTICE, OFFICE OF THE ASSOCIATE ATTORNEY GENERAL, *Memorandum for Kathleen Wolfe, Supervisor Official of the Civil Rights Division* (Jan. 24, 2025), https://www.justice.gov/media/1386461/dl.

[52] KFF, *Policy Tracker: Exceptions to state abortion bans and early gestational limits*, https://www.kff.org/womens-health-policy/dashboard/exceptions-in-state-abortion-bans-and-early-gestational-limits/ (last updated Jan. 6, 2025). Most of these health exceptions are for medical emergencies where the abortion is deemed necessary to prevent substantial and irreversible impairment of a major bodily function. In Texas, for example, abortion is banned unless there is a "serious risk of substantial impairment of a major bodily function" of the pregnant person." The rape and incest exceptions typically require the pregnant person to report the assault to law enforcement, as in Florida, Georgia, Idaho, Iowa, Mississippi, South Carolina, and West Virginia, making it unworkable in practice.

[53] *Life of the Mother: How Abortion Bans Lead to Preventable Deaths*, PRO PUBLICA, https://www.propublica.org/series/life-of-the-mother (last visited Apr. 4, 2025).

[54] One hospital representative told the caller that the pregnant patient's body would be used as an "incubator" to carry the baby as long as possible. PHYSICIANS FOR HUM. RTS., OKLA. CALL FOR REPROD. JUST., AND CTR. FOR REPROD. RTS,, NO ONE COULD SAY: ACCESSING EMERGENCY OBSTETRICS INFORMATION AS A PROSPECTIVE PRENATAL PATIENT IN POST-ROE OKLAHOMA 16 (April 2023), https://reproductiverights.org/wp-content/uploads/2023/04/OklahomaAbortionBanReport_Full_SinglePages-NEW-4-27-23.pdf.

[55] *New Study Finds Oklahoma Hospitals Unable to Provide Clear and Accurate Information on Emergency Obstetric Care*, CTR. FOR REPROD. RTS. (April 25, 2023), https://reproductiverights.org/oklahoma-hospitals-abortion-study/; PHYSICIANS FOR HUM. RTS., OKLA. CALL FOR REPROD. JUST., AND CTR. FOR REPROD. RTS,, NO ONE COULD SAY: ACCESSING EMERGENCY OBSTETRICS INFORMATION AS A PROSPECTIVE PRENATAL PATIENT IN POST-ROE OKLAHOMA (April 2023), https://reproductiverights.org/wp-content/uploads/2023/04/OklahomaAbortionBanReport_Full_SinglePages-NEW-4-27-23.pdf..

[56] La. R.S. Secs. 14:87.1(1)(b)(v), 14:87.1(1)(b)(vi).

[57] New "Criminalized Care" Report Shows How Louisiana's Abortion Bans Endanger Patients and Clinicians, CTR. FOR REPROD. RTS. (March 19, 2024) https://reproductiverights.org/new-criminalized-care-report-shows-how-louisianas-abortion-bans-endanger-patients-clinicians/; LIFT LA., PHYSICIANS FOR HUM. RTS., RH IMPACT, AND CTR. FOR REPROD. RTS., CRIMINALIZED CARE: HOW LOUISIANA'S ABORTION BANS ENDANGER PATIENTS AND CLINICIANS (March 2024), https://reproductiverights.org/wp-content/uploads/2024/03/Criminalized-Care-Report-Updated-as-of-3-15-24.pdf.

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

[59] *Texas Abortion Ban Emergency Exceptions Case: Zurawski v. State of Texas*, CTR. FOR REPROD. RTS., https://reproductiverights.org/case/zurawski-v-texas-abortion-emergency-exceptions/zurawski-v-texas/ (last visited March 24,2025).

[60] Laws granting legal rights to fetuses and embryos undermine pregnant people's bodily autonomy and human rights to privacy, life, equality, health, freedom from discrimination and violence, and freedom from torture, cruel, inhuman and degrading treatment, by forcing them to continue pregnancies against their will, in contradiction of human rights standards. It also increases the vulnerability of survivors of intimate partner violence, domestic violence, and sexual assault, exacerbating their trauma and limiting their ability to escape abusive situations. *See, Fetal Personhood Legal Landscape*, PREGNANCY JUST., https://www.pregnancyjusticeus.org/legal-landscape/ (last visited April 4, 2025).

[61] At least 24 states include language granting legal rights to fetuses and embryos in laws regulating or prohibiting abortion care. Post-Dobbs, states have been emboldened to introduce legislation that would establish or strengthen fetal or embryo personhood laws. In the last full state legislative session, seven states introduced but did not pass 13 bills establishing fetal personhood for the purposes of civil law. These included bills that would allow people to bring wrongful death claims on behalf of a fetus. Expanding these claims to fetuses would allow to sue abortion providers or people who help others to access abortion. *See e.g. Fetal Personhood Legal Landscape*, PREGNANCY JUST., https://www.pregnancyjusticeus.org/legal-landscape/ (last reviewed Sept. 24, 2024); CTR. FOR REPROD. RTS., 2024 LEGISLATIVE WRAP UP 27 (Dec. 2024), https://reproductiverights.org/wp-content/uploads/2024/12/CRR_LegislativeWrapUp_2024_Digital.pdfhttps://reproductiverights.org/wp-content/uploads/2024/12/CRR_LegislativeWrapUp_2024_Digital.pdf.

[62] Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, Exec. Order No. 14168, 90 Fed. Reg. 8615 (Jan. 30, 2025).

[63] *LePage v. Center for Reproductive Medicine*, 2024 WL 656591 (Ala. 2024).

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[67] Munira Z. Gunja et al, *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, THE COMMONWEALTH FUND (June 4, 2024) https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison.

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[69] Laura G. Fleszar et al., *Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States*, JAMA 2023; 330(1): 52-61. Doi:10.1001/jama.2023.9043, https://jamanetwork.com/journals/jama/article-abstract/2806661?appId=scweb.; CTRS. FOR DISEASE CONTROL & PREVENTION, PREGNANCY MORTALITY SURVEILLANCE SYSTEM, https://www.cdc.gov/maternal-mortality/php/pregnancy-mortality-surveillance/index.html (last updated Nov. 14, 2024) (See Figure 2. *Pregnancy-related mortality ratio by race-ethnicity: 2017–2019, 2020, and 2021*).

[70] CTRS. FOR DISEASE CONTROL & PREVENTION, PREVENTING PREGNANCY-RELATED DEATHS, https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html (last updated Sept. 15, 2024).

[71] Treaty monitoring bodies have specifically recognized that the disrespect and abuse faced by women in maternal health facilities can amount to ill-treatment. *See e.g.,* M.D.C.P. v. Spain, CEDAW Committee, CEDAW/C/84/D/154/2020, para. 8(b)(i); U.N. Doc. CERD/C/USA/CO/10-12, *supra* note 11 at ¶35.

[72] Eugene Leclerq et al, *Severe Maternal Morbidity in the United States: A Primer*, THE COMMONWEALTH FUND (Oct. 28, 2021) https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer/.

[73] *Nowhere To Go: Maternity Care Deserts Across the U.S. 2020 Report*, MARCH OF DIMES 5 (2020) https://www.marchofdimes.org/sites/default/files/2022-10/2020-Maternity-Care-Report.pdf.

[74] See e.g., Tara Lagu et al., *'I Am Not the Doctor For You': Physicians' Attitudes About Caring For People With Disabilities*, 41 HEALTH AFF. 1387, 1389–90 (2022); Willi Horner-Johnson et al., *Perinatal Health Risks and Outcomes Among U.S. Women With Self-Reported Disability*, 41 HEALTH AFF. 1477, 1481 (2022); Willi Horner-Johnson et al., *Differences in Prenatal Care by Presence and Type of Maternal Disability,* 56 AM. J. PREV. MED. 376, (Mar 2019); Jessica Gleason et al., *Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities*, 4 JAMA NETWORK OPEN (2021) at 2, 4–7, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787181.

[75] Examples of birth interventions include epidural, the use of Pitocin to induce labor, episiotomies, and cesarean surgeries.

[76] Judith A. Lothian, *Healthy Birth Practice #4: Avoid Interventions Unless They Are Medically Necessary*, 28(2) J. PERINATAL EDUC. 94 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4235054/.

[77] Michelle J.K. Osterman, M.H.S., *National Vital Statistics Rapid Release: Changes in Primary and Repeat Cesarean Delivery: United States, 2016-2021*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 2022),

https://www.cdc.gov/nchs/data/vsrr/vsrr021.pdf.

[78] *WHO recommendations: non-clinical interventions to reduce unnecessary caesarean sections*, WORLD HEALTH ORG. (2018) at p.12, https://iris.who.int/bitstream/handle/10665/275377/9789241550338-eng.pdf?sequence=1.

[79] U.N. Gen. Assembly, Special Rapporteur on violence against women, UN. Doc. A/74/137 (2019) para.25 (The WGADWG has similarly recognized that "[…] unnecessary medicalization …[has] functioned as [a] form[]of social control exercised by patriarchal establishments to preserve the gender roles of women in Human Rights Council); *Report of the UN Working Group on the issue of discrimination against women in law and in practice*, UN Doc. A/HRC/32/44 (2016), para. 73.

[80] Saraswathi Vedam, et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD. HEALTH (June 2019), https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2.

[81] *Id.*

[82] For example, CITIZEN, DEMOCRACY AND ACCOUNTABILITY, *Women – Mothers – Bodies: Women's Human Rights in Obstetric Care in Healthcare Facilities in Slovakia* (2015), p.189, https://odz.sk/en/wp-content/uploads/Women-Mothers-Bodies_summ_EN.pdf; *See also*, Amnesty International, *She is not a criminal: the impact of Ireland's Abortion Law* (2015), p. 47; Such treatment is often justified on the basis of the purported interests of the fetus but reinforces the stereotype that women are unable to make rational decisions and reduce them to objects of intervention without agency in Liiri Oja & Alicia Ely Yamin, "'Woman' in the European Human Rights System: How is the Reproductive Rights Jurisprudence of the European Court of Human Rights Constructing Narratives of Women's Citizenship?" (2016) 32(1) *Columbia Journal of Gender and Law*, p. 77.

[83] Munira Z. Gunja et al, *Insights into the U.S. Maternal Mortality Crisis: An International Comparison*, THE COMMONWEALTH FUND (June 4, 2024) https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison.

[84] Ann Ledbetter, *Maternity care in the U.S. is in crisis. It's time to call the midwife*, STAT (Oct. 12, 2022); *See also* NAT'L MUSEUM OF AFR. AM. HIST. & CULTURE, *The Historical Significance of Doulas and Midwives* https://nmaahc.si.edu/explore/stories/historical-significance-doulas-and-midwives.

[85] WORLD HEALTH ORG., *Transitioning to Midwifery Models of Care: Global Position Paper* at xiv (2024), *available at* https://iris.who.int/bitstream/handle/10665/379236/9789240098268-eng.pdf?sequence=1. "In midwifery models of care, midwives provide integrated care, addressing the needs of each individual woman and newborn, within functional and enabling health systems, equipped with necessary resources and streamlined consultation and referral processes. They collaborate within networks of care as part of interdisciplinary teams characterized by equality, trust and respect. This approach guarantees that every woman and newborn receives personalized care, tailored to their health needs."

[86] *See,* Danielle Campoamor, *Hawaii's new law could jail traditional midwives. They are fighting back*, INDEPENDENT (Jun. 15, 2024, 6:30 PM) https://www.independent.co.uk/news/world/americas/hawaii-midwife-sue-court-case-b2563285.html; Kaho'ohanohano v. State, 1CCV-24-0000269 (Feb. 27, 2024) (complaint) https://reproductiverights.org/wp-content/uploads/2024/02/Kahoohanohano-v.-State-of-Hawaii-Complaint-and-Summons-2-27-24.pdf; Kaho'ohanohano v. State, 1CCV-24-0000269 (Jul. 23, 2024) (preliminary injunction) https://reproducti-verights.org/wp-content/uploads/2024/07/PI-Order-July-24-2024-Hawaii.pdf.

[87] U.N. Doc. CERD/C/USA/CO/10-12, *supra* note 11 at ¶35-36. (While the U.S. has taken some steps to implement these recommendations—including improving maternal health data collection, targeting racial disparities, and extending public health insurance to postpartum people—these advances are now threatened by the Trump administration).

[88] Latoya Hill et al, *Elimination of Federal Diversity Initiatives: Implications for Racial Health Equity*, KFF (March 21, 2025) https://www.kff.org/7697897/.

[89] *Id.*

[90] CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID, https://www.medicaid.gov (last visited March 27, 2025). Medicaid is a joint federal and state program that provides health coverage to low-income individuals, including pregnant people, children, people with disabilities, and seniors. It is funded by both federal and state governments but administered by states within federal guidelines. Medicaid covers essential health services, including hospital visits, primary care, prescription drugs, and long-term care. Eligibility and benefits vary by state, though federal law mandates certain minimum standards. The program plays a critical role in maternal and child health, disability care, and long-term services for older adults.

[91] Elizabeth Williams et al, *Putting $880 Billion in Potential Federal Medicaid Cuts in Context of State Budgets and Coverage*, KFF (March 24, 2025) https://www.kff.org/medicaid/issue-brief/putting-880-billion-in-potential-federal-medicaid-cuts-in-context-of-state-budgets-and-coverage/.

[92] Joan Alker et al, *Medicaid's Role in Small Towns and Rural Areas,* Georgetown University Center for Children and Families (January 15, 2025) https://ccf.georgetown.edu/2025/01/15/medicaids-role-in-small-towns-and-rural-areas/; *November 2024 Medicaid & CHIP Enrollment Data Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVS. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights (last visited April 7, 2024).
[93] Human Rights Committee, *General Comment No. 36 on the Right to Life*, para. 45, U.N. Doc. CCPR/C/GC/36 (2018) [hereinafter Human Rights Committee, *Gen. Comment No. 36*].
[94] Bradley Corallo et al, *Medicaid Enrollment Churn and Implications for Continuous Coverage Policies*, KFF (December 14, 2021) https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.
[95] Articulating the principle of non-retrogression, State laws, policies, and practices that introduce new restrictions on the exercise of the right to health or that erect new barriers to individuals' access to health services should be interpreted as failing to comply with international human rights laws and standards. CESCR Committee, *General Comment No. 3 on the nature of states parties' obligations (art. 2, para. 1 of the Covenant)*, U.N. Doc. E/1991/23 (December 14, 1990), para. 9; ESCR Committee, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (art. 12)*, paras 32, 48, 50, U.N. Doc. E/C.12/2000/4 (2000). In the specific context of abortion, see also Human Rights Committee, *Gen. Comment No. 36*, *supra* note 93, para. 8, it specifically recognizes this principle in the context of abortion, noting that States parties should not introduce new barriers that deny effective access by women and girls to safe and legal abortion.
[96] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) barred undocumented immigrants, as well as immigrants with legal residence who had resided in the U.S. for under five years, from eligibility for "means tested" public benefits, including Medicaid. 8 U.S.C. §§ 1611 et seq. (1996).
[97] Kinsey Hasstedt et al., *Immigrant Women's Access to Sexual and Reproductive Health Coverage and Care in the United States*, GUTTMACHER INST. (Nov. 26, 2018) https://www.guttmacher.org/sites/default/files/article_files/attachments/immigrant_womens_access_to_sexual_and_reproductive_health_coverage_and_care_in_the_united_states.pdf.
[98] *Id.* at 4.
[99] U.S. DEP'T OF HOMELAND SEC., Memorandum on Enforcement Actions in or Near Protected Areas, (January 20, 2025) https://www.dhs.gov/publication/enforcement-actions-or-near-protected-areas (last visited April 7, 2025).
[100] Section 104(f)(1) of the Foreign Assistance Act of 1961, P.L. 87-195; 22 U.S.C. 2151b(f)(1), as amended by the Foreign Assistance Act of 1973, P.L. 93-189, (Dec. 17, 1973).
[101] UN Human Rights Council, *Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to the United States of America*, para. 30, U.N. Doc. A/HRC/32/44/Add.2 (Aug. 4,2016); *see also,* Sneha Barot, *Abortion Restrictions in U.S. Foreign Aid: The History and Harms of the Helms Amendment*, Guttmacher Institute (Sept. 13, 2013), https://www.guttmacher.org/gpr/2013/09/abortion-restrictions-usforeign-aid-history-and-harms-helms-amendment.
[102] Presidential Memorandum on The Mexico City Policy, 90 Fed. Reg. 8753 (Feb. 3, 2025), https://www.govinfo.gov/content/pkg/FR-2025-02-03/pdf/2025-02176.pdf.
[103] CTR. FOR REPROD. RTS, *Factsheet: The Global Gag Rule and Human Rights Global-Gag-Rule_Fact-Sheet_1-27-25.pdf* (last visited April 4, 2025).
[104]Patty Skuster et al, *Evidence for Ending the Global Gag Rule: A Multiyear Study in Two Countries*, GUTTMACHER INST. (April, 2024) https://www.guttmacher.org/report/evidence-for-ending-global-gag-rule
[105] Reevaluating and Realigning United States Foreign Aid, Exec. Order No. 14169, 90 Fed. Reg. 8619 (Jan. 30, 2025).
[106] Robbie Gramer et al, *State Department issues immediate, widespread pause on foreign aid*, POLITICO (January 24, 2025) https://www.politico.com/news/2025/01/24/state-department-foreign-aid-pause-00200510
[107] Sean Lyngaas et al, *State Department formally notifies Congress it is effectively dissolving USAID*, CNN (March 28, 2025) https://us.cnn.com/2025/03/28/politics/state-department-formally-notifies-congress-effectively-dissolving-usaid/index.html.
[108] Gleb Tsipurski et al, *Trump is striking at the heart of American government,* THE HILL (February 18, 2025) https://thehill.com/opinion/technology/5149150-trump-executive-overreach-threatens-democracy/
[109] Samira Damavandi et al, *Just the Numbers: The Impact of US International Family Planning Assistance*, GUTTMACHER INST. (February 18, 2025) https://www.guttmacher.org/2025/02/just-numbers-impact-us-international-family-planning-assistance-2024.

[110] Diaa Hadid, *More babies and mothers are dying in Afghanistan after USAID cuts, midwives say*, NPR (March 25, 2025) https://www.npr.org/2025/03/25/nx-s1-5338754/more-babies-and-mothers-are-dying-in-afghanistan-after-usaid-cuts-midwives-say.