Session 304 | Why Reproductive Justice Matters for APIs: Learning from History to Change the Future

Recent years have presented many new challenges to reproductive healthcare access--from the seating of Justice Amy Coney Barrett to the Supreme Court, fears of Roe being overturned, decreased healthcare access due to COVID-19, and relentless restrictions by state legislatures. Those fears are being realized today in Texas via SB 8, and in the Supreme Court, which just heard oral argument in Dobbs v. Jackson’s Women’s Health. AAPIs are often overlooked in the central reproductive justice narrative but are deeply affected by these issues, especially those who are low-income, immigrants, LGBTQ, or young. Furthermore, AAPIs are actively engaged on these issues—leading change in this field, advocating for visibility, and building power for all AAPIs.

Our breadth of experts will situate this discussion within the history of the lack of reproductive autonomy in the AAPI community. We will then turn to current societal issues, like reproductive health being a taboo topic in the AAPI community, lack of birth control in certain communities, and how that infiltrates into social, economic, and healthcare needs. We will describe recent legislative trends and attempts to control reproductive rights across this country, including restrictions on reproductive healthcare, the criminalization of pregnancy and policing of parents through the so-called “child welfare” system--or more accurately called the family regulation system--and draw connections from historical oppression to the power dynamics that continue to challenge our community’s access to healthcare and justice today.

Moderator:
Peggy Li, Director of Chapters, American Constitution Society

Speakers:
Rosann Mariappuram, Executive Director, Jane’s Due Process
Jenny Ma, Senior Staff Attorney, Center for Reproductive Rights
Samantha Lee, Staff Attorney, National Advocates for Pregnant Women
Emily Sun, Legal Fellow, Her Justice
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INTERSECTIONALITY: Mapping the Movements of a Theory

Devon Carbado
Kimberlé W. Crenshaw
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Barbara Tomlinson

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EDITORIAL INTRODUCTION

INTERSECTIONALITY

*Mapping the Movements of a Theory*

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Very few theories have generated the kind of interdisciplinary and global engagement that marks the intellectual history of intersectionality. Yet, there has been very little effort to reflect upon precisely how intersectionality has moved across time, disciplines, issues, and geographic and national boundaries. Our failure to attend to intersectionality’s movement has limited our ability to see the theory in places in which it is already doing work and to imagine other places to which the theory might be taken. Addressing these questions, this special issue reflects upon the genesis of intersectionality, engages some of the debates about its scope and theoretical capacity, marks some of its disciplinary and global travels, and explores the future trajectory of the theory. To do so, the volume includes academics from across the disciplines and from outside of the United States. Their respective contributions help us to understand how intersectionality has moved and to broaden our sense of where the theory might still go.

Rooted in Black feminism and Critical Race Theory, intersectionality is a method and a disposition, a heuristic and analytic tool. In the 1989 landmark essay “Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics,” Kimberlé Crenshaw introduced the term to address the marginalization of Black women within not only antidiscrimination law but also in feminist and antiracist theory and politics. Two years later, Crenshaw (1991) further elaborated the framework in “Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color.”
There, she employed intersectionality to highlight the ways in which social movement organization and advocacy around violence against women elided the vulnerabilities of women of color, particularly those from immigrant and socially disadvantaged communities.

In both “Demarginalizing” and “Mapping,” Crenshaw staged a two-pronged intervention. She exposed and sought to dismantle the instantiations of marginalization that operated within institutionalized discourses that legitimized existing power relations (e.g., law); and at the same time, she placed into sharp relief how discourses of resistance (e.g., feminism and antiracism) could themselves function as sites that produced and legitimized marginalization. As a concrete example, Crenshaw described the subtle ways in which the law has historically defined the contours of sex and race discrimination through prototypical representatives, i.e., white women and African American men, respectively. She then demonstrated how this antidiscrimination approach narrowed the scope of institutional transformation, truncated both the understanding of and advocacy around racism and patriarchy, and undermined possibilities for sustaining meaningful solidarity by placing resistance movements at odds with each other.

Since the publications of “Demarginalizing” and “Mapping,” scholars and activists have broadened intersectionality to engage a range of issues, social identities, power dynamics, legal and political systems, and discursive structures in the United States and beyond. This engagement has facilitated intersectionality’s movement within and across disciplines, pushing against and transcending boundaries, while building interdisciplinary bridges, and prompting a number of theoretical and normative debates. These movements of intersectionality have left behind a lively and provocative travelogue characterized by adaptation, redirection, and contestation. While no single volume could fully capture this travelogue, the essays that constitute this special issue provide a useful window into how intersectionality has moved and the many different places to which it has travelled. As a prelude to introducing these essays, we highlight six important themes that flow from mapping the movements of intersectionality.

First, paying attention to the movement of intersectionality helps to make clear that the theory is never done, nor exhausted by its prior articulations or movements; it is always already an analysis-in-progress. Put another way, there is potentially always another set of concerns to which the theory can be directed, other places to which the theory might be moved, and other structures of power it can be deployed to examine. This is why Crenshaw (1989) described her intervention in “Demarginalizing the Intersection” as “provisional,” “one way” to approach the problem of intersectionality. Any analysis must necessarily limit itself to specific structures of power. For example, intersectionality’s initial emergence as a product of the juridical erasure of Black women’s subjectivity in antidiscrimination law did not interrogate Black men’s intersectional marginalization vis-à-vis the criminal justice system. All intersectional moves are necessarily particularized and therefore provisional and incomplete. This is the sense in which a particularized intersectional analysis or formation is always a work-in-progress, functioning as a condition of possibility for agents to move intersectionality to other social contexts and group formations.

Understanding intersectionality as a work-in-progress suggests that it makes little sense to frame the concept as a contained entity. Nor is it productive to anthropomorphize the concept as its own agent replete with specific interests and tasks that reflect its capacity and fundamental orientation. An alternative approach to knowing what intersectionality is is to assess what intersectionality does as a starting point for thinking about what else the framework might be mobilized to do.
work-in-progress understanding of intersectionality invites us to do just that—that is, to see the theory in places in which it is already doing work and to imagine other kinds of work that agents might employ intersectionality to perform.

A second theme that builds on the first is that there is no a priori place for intersectionality in either its discipline of origin, or more broadly in the academy itself. Agents of its movement have sought to adapt, refine, and articulate intersectional projects across multiple disciplines as well as within arenas outside academia altogether. This collection represents only a subset of the disciplines and subfields that have seeded intersectional projects and methods, ranging from law, sociology, and education to history, psychology, and political science.

Third, the movement of intersectionality has not been limited to interdisciplinary travel within the United States, but has encompassed international travel as well. Various academics, advocates, and policy makers have taken up, redeployed, and debated intersectionality within institutional settings and discourses that attend to the global dimensions of history and power. These international engagements with intersectionality highlight a fourth dimension of intersectionality’s movement: an undercurrent of anxiety around the continuing salience of Black women in a theory that reaches beyond their specific intersectional realities. The notion seems to be that Black women are too different to stand in for a generalizable theory about power and marginalization. The travels of intersectionality belie that concern. Actors of different genders, ethnicities, and sexual orientations have moved intersectionality to engage an ever-widening range of experiences and structures of power. At the same time, the generative power of the continued interrogation of Black women’s experiences both domestically and internationally is far from exhausted, as contributors to this volume also demonstrate.

The final theme we want to mark is the social movement dimensions of intersectionality. Of course, not all who deploy intersectionality perceive themselves to be part of a social movement. The point is that the multiple contexts in which intersectionality is doing work evidences—more than any abstract articulation of the theory—the social change dimension of the concept.

The foregoing themes do not represent the only ways in which intersectionality has moved. We focus on them because they capture important dimensions of the intellectual and political history of intersectionality and thus function as a useful point of departure for introducing the essays that constitute this special issue. In the remainder of this introduction we describe these essays and discuss the extent to which they reflect the various themes highlighted herein.

INTERSECTIONALITY MOVES AS A WORK-IN-PROGRESS

No particular application of intersectionality can, in a definitive sense, grasp the range of intersectional powers and problems that plague society. This work-in-progress understanding of intersectionality suggests that we should endeavor, on an ongoing basis, to move intersectionality to unexplored places. This is precisely what Dorothy Roberts and Sujatha Jesudason do in their essay, “Movement Intersectionality: The Case of Race, Gender, Disability, and Genetic Technologies.” More particularly, Roberts and Jesudason describe a set of valuable lessons in applying insights from intersectionality theory to radical coalition-building and political change. They illustrate that intersectional analysis can identify and emphasize commonalities and create solidarity between political groups. The authors describe their experiences as leaders of the social justice organization Generations Ahead,
employing intersectionality to forge alliances between formerly adverse groups to achieve real political accomplishments. According to Roberts and Jesudason, identifying categorical differences can enhance the potential to build coalitions between movements by acknowledging differences while promoting commonalities. This can lead to mutual acknowledgement of how structures of oppression are related and, therefore, how struggles are linked. They argue that an intersectional lens can reveal, on a given issue and between separate identity groups, perspectives of both privilege and victimhood, and thereby create a connection around shared experiences of discrimination, marginalization, and privilege. Crucially, Roberts and Jesudason’s argument suggests that intersectional interventions can facilitate cross-movement building.

Sumi Cho’s contribution to this collection, “Post-Intersectionality: The Curious Reception of Intersectionality in Legal Scholarship,” more directly advances an argument based on the work-in-progress conceptualization of intersectionality. Cho’s essay highlights the temporality of intersectionality’s mobility. She challenges the assumption that simply because intersectional analysis has not yet entered a particular arena, that it cannot enter that arena productively. Schematically, one criticism that Cho examines is the contention that intersectionality cannot do X because it has not heretofore done X. More specifically, the argument claims that because intersectionality originated in an article on race and gender issues (specifically, the Black female experience), it cannot engage experiences outside of that subjectivity. Cho contests this claim both descriptively by arguing that it is not true that intersectionality has focused solely on Black women’s experiences, and theoretically by arguing that there is no reason intersectionality cannot engage other categories of power and experience, such as sexuality. According to Cho, “race and gender intersectionality merely provided a jumping off point to illustrate the larger point of how identity categories constitute and require political coalitions.” In other words, intersectionality is not fixed to any particular social position. The theory can and does move.

Cho’s article is particularly important in setting the stage for articulating the interface between race and sexuality. Scholars, advocates, and activists have brought intersectional prisms to bear in analyzing the diverging trajectories of equality demands vis-à-vis the constitutional law doctrines that govern race and sexuality. This interface warrants deft analysis in the wake of the Roberts Court’s dismantling of race based jurisprudence (e.g., restricting racial remediation under the Voting Rights Act), while simultaneously opening up constitutional protections against some practices that reflect historic biases against LBTQ communities. Equally salient is the problematic assertions that “gay is the new black,” and the ongoing discussions within racial justice movements about the place of sexuality in antiracist politics and vice versa. These developments cry out for intersectional interrogations, not with the goal of finishing an incomplete project but to broaden the range of work that a variety of agents mobilize intersectionality to perform.

Alfredo Artiles’ contribution, “Untangling the Racialization of Disabilities: An Intersectionality Critique Across Disability Models,” broadens the reach of intersectionality in precisely the way that Cho’s essay suggests. Artiles argues that special education scholarship recognizes the importance of the “racialization of disability,” but that scholars have been slow to frame this racialization as an intersectional project. In explaining the benefits and problems of various models examining disability, Artiles deploys intersectional analysis to reframe problems to make new solutions imaginable. Importantly, Artiles shows how scholars can mobilize intersectionality to go beyond the recognition that disability is racialized to theorize how this racialization is produced.
Intersectionality moves not only in relation to shifting subjects, but it moves more broadly as a prism linking and engaging scholarly subfields, research methodologies, and topical inquiries. Although intersectional projects that foreground categories and their dynamic relationship to power are most readily identified as prototypically intersectional, Leslie McCall and Averil Y. Clarke remind readers that the terrain upon which the prism works need not be so constrained. In “Intersectionality and Social Explanation in Social Science Research,” McCall and Clarke identify aspects of intersectional research that they believe can further develop social explanation in social science research. Focusing on the process of developing social science research, they argue that scholars can and should draw from a wide range of empirical research that is not necessarily defined as intersectional, but which nevertheless enables an intersectional analysis. Illustrating their points by focusing on three areas—fertility, marital homogamy, and classical liberalism—they examine how intersectional prisms constructed over the course of the research cycle can generate new insights from data that are not initially framed through an intersectional prism. They also identify challenges associated with constructing intersectional research within particular subfields and propose ways of facilitating communication across disciplinary and subdisciplinary divides.

Moving to an intra-disciplinary interrogation of social psychology, Philip Atiba Goff and Kimberly Barsamian Khan reveal how disciplinary conventions that have historically inhibited intersectional knowledge in law are resonant within contemporary research paradigms pertaining to race and gender bias. In “Sexist Racism and Racist Sexism: How Psychological Science Impedes Intersectional Thinking,” the authors argue that social psychology has tended to discount the ways in which race and gender mutually construct each other. Because of this omission, social psychology posits prototypical targets of racism and sexism as Black men and White women, respectively. Goff and Khan’s argument parallels the critique of antidiscrimination law that was articulated in “Demarginalizing”—namely, that the prototypical subjects of antidiscrimination protection were Black men (with respect to racism) and White women (with respect to sexism). Drawing examples from experimental social psychology, Goff and Kahn identify how specific methodologies and habits of thought in the sampling, operationalization, and interpretation of data function to marginalize Black women. They draw attention to the potential distortions that nonintersectional methodologies engender, and suggest ways to rethink conventional methods more broadly in order to address the biases embedded within standard research practice.

Intersectionality’s domestic life as a prism attuned to localized patterns of thought and action has not impeded its movement into global spheres and international discourses. Intersectionality has moved internationally both as a means to frame dynamics that have been historically distinct within other domestic spheres and also as a way to contest material and political realities that are, by some measures, part of global and transhistorical relations of power. One manifestation of this international movement is the feminist engagement with intersectional discourse in Europe. Although intellectual and political projects have long sought to map the interface between systems of power and their attendant subjects, intersection-
ality has emerged within European contexts as a useful tool for articulating these interactions. Yet despite its uptake within feminist discourses, intersectionality frequently has been framed as a North American import that does not reflect the significant differences in the historic context, the disciplinary practices, and discursive traditions between the United States and Europe. One important difference that is often cited in this regard pertains to the relative salience of class over race in Europe, and the minimal traction that analogies to race provide for feminists there.

Sirma Bilge’s contribution interrogates efforts on the part of some European feminists to distance intersectionality from its association with race in the United States. In “Intersectionality Undone: Saving Intersectionality from Feminist Intersectionality Studies,” Bilge explores the discourse around intersectionality that has emerged in several European conferences and texts to highlight argumentative rhetorics that she maintains have neutralized the political potential of intersectionality. These moves include explicit arguments that intersectionality is a feminist project (as distinct from a racial project), a claim that effectively “whiten[s] intersectionality.” Bilge also links the development of intersectionality in Europe to a specifically disciplinary academic feminism that has depoliticized the theory, and to prevailing neoliberal cultures that aim to commodify and manage “diversity.” To challenge these developments, Bilge revisits intersectionality’s grounding as a counter-hegemonic and transformative intervention in knowledge production, activism, pedagogy, and non-oppressive coalitions.

Intersectionality’s movement in the international arena draws attention to how contextual differences generate alternative engagements with the theory. Caribbean feminists, for example, have deployed intersectionality to delve into historical relations and nation-building outside the metropole. In so doing, they draw attention to alternative ways of conceptualizing intersectional subjects that place some of the more limited conceptualizations of intersectional work in sharp relief. Tracy Robinson shows, for example, that the hierarchies to which intersectionality attends are considerably more robust than the formal regimes of race, gender, and class power that are embodied by the legally imposed classifications of certain subjects. In “The Properties of Citizens: A Caribbean Grammar of Conjugal Categories,” Robinson argues that intersectionality proves productive “for thinking about how conjugality comes into being as a regulatory regime of race, class, and heteropatriarchy.” Robinson addresses the continuum of conjugal relationships in the Caribbean to show how hierarchies of conjugality were shaped by the intersection of various influences, including “postcolonial family law reforms, censuses, social science research, population policies, national culture, and everyday interactions.” Through this matrix of influences, marriage was the idealized hetero-patriarchal institution, while common-law marriage (heterosexual cohabitating unions without legal sanction) occupied the middle of the continuum, and visiting relationships (unions without legal sanction and in which partners do not live together) occupied the far end. In revealing how such regimes are intersectionally constituted, Robinson mobilizes intersectionality to capture dynamics of power beyond the more narrow terrain of articulating identities. Robinson’s contribution provides a provocative counterpoint to claims that race or some other marker of social marginalization is inoperative simply because the processes of categorization are not formally articulated as such. More broadly, her analysis demonstrates both the importance of understanding colonial legacies through an intersectional prism, and the importance of understanding how intersectionality moves beyond the metropole.
INTERSECTIONAL MOVES ENGAGE BLACK WOMEN

Despite an enormous range of intersectional research addressing concerns of many racial and ethnic groups, genders, sexual orientations, nationalities, disabilities, and so forth, some scholars have criticized intersectionality for focusing “too much” on Black women. Among such critics are those who de-racialize intersectionality as well as those who comfortably work within a paradigm that is sensitive to race but worry that antiracism has been “too concerned” with Blacks. Such arguments imply either that Black women no longer face problems of structural power, or that their subjectivity is too particular to be productive in broader efforts to understand and counter contemporary manifestations of subordination. Three articles in this issue demonstrate that the underlying assumptions of this critique are thoroughly contestable.

In “Public Tales Wag the Dog: Telling Stories about Structural Racism in the Post-Civil Rights Era,” Tricia Rose focuses on the case of Kelley Williams-Bolar, an African American single mother from Ohio who was arrested in 2011, charged with a felony, and jailed for sending her two daughters to a predominantly White suburban public school in violation of the township’s residency requirements. In examining the public and legal discourse surrounding the case, Rose draws out the intersectional dimensions of the narrative that framed Williams-Bolar as the embodiment of the single Black mother on welfare. Rose names the intersections of gender, economic privilege, spatial containment, systemic educational inequality, and racialized criminalization as the “invisible intersections of colorblind racism.” It is through these converging narratives that Williams-Bolar’s protective investment in her children is recast as a symbol of criminalized Black motherhood. Importantly, the backdrop against which Williams-Bolar is framed reflects myriad disadvantages that touch multiple populations. Yet, the potential coalition that might otherwise arise from this convergence of interests is aborted by the unyielding stigma attached to Williams-Bolar, a multiply-marginalized subject. Rose draws attention to how untested intersections invisibly construct the stifling terms of social life and also defeat the possibilities of emerging coalitions of resistance. She concludes with an argument about the role of mass media in mobilizing a powerful counter-narrative.

The theme of intersectionality in relation to social control is further amplified in Priscilla Ocen’s “Unshackling Intersectionality.” Ocen casts her gaze at prisons, an institutional and social embodiment of racialized punishment that has drawn substantial attention from scholars and advocates over the last decade. Although existing scholarship has understood incarceration as a system of racial control, Ocen charts new territory by deploying intersectionality to draw attention to Black women’s vulnerability to the criminal justice system. Ocen argues that “prison operates to discipline, police, and punish deviant gender identity performance in ways that are deeply raced, classed, and animated by heteronormativity.” Ocen describes how the intersection of race, class, and gender render Black women particularly vulnerable to harassment and violence—including being shackled during childbirth—once they are incarcerated. Moreover, negative constructs of Black women, such as the term “welfare queen” and the claim that Black women’s households are criminogenic, have legitimated the view “of Black women as pathways to disorder and criminality.” As such, according to Ocen, intersectional prisms on incarceration need not be limited to the specific contours of Black women’s vulnerability, but should seek to understand how the convergence of gender, race, and class has constituted fertile ground upon which incarceration became a mass project. “Incarceration became a response to manage Black inequality that was allegedly caused by Black familial pathologies.”
Thus, the framing of Black women as non-normative women is a critical site for disrupting the patriarchal underbelly of mass incarceration that entraps both Black men and women. Ocen’s essay, together with Rose’s, cautions against imperatives to “get beyond” Black women’s experiences. Their work reveals not only how crucial intersectionality is to engendering our understanding of race and criminal justice, but how the marginalization of Black women within the media as well as within social justice discourses leads to an under-theorization of the contours of social control.

Further elaborating intersectionality moves, Devon W. Carbado and Mitu Gulati uncover a further iteration of intersectionality, namely “intra-intersectional” discrimination. To illustrate this intra-intersectional distinction, Carbado and Gulati explore the vulnerability of professional Black women to workplace discrimination in “The Intersectional Fifth Black Woman.” Carbado and Gulati employ a narrative of a hypothetical “fifth” Black woman named Tyisha, one of five Black women who interview for an associate position at a law firm. Four of the Black women get hired, but Tyisha does not. Carbado and Gulati discuss how certain performative dynamics perceived by the firm—specifically one’s demeanor and other characteristics such as name, accent, hair, political identity, social identity, marital status, residence, and religious affiliation—caused Tyisha to be a victim of discrimination while the other four Black women were not. Specifically, all of the five Black women are ostensibly in the same intersectional group (Black women); however, because Tyisha’s performative identity has a stronger “Black racial signification” than the other four Black women, she is not hired based on negative racialized gender perceptions held by the firm. Naming this phenomena “intra-intersectional discrimination,” Carbado and Gulati expand their notion of a “performative conceptualization of race” to encompass its intersectional expressions. Like Rose and Ocen, Carbado and Gulati employ intersectionality not to move beyond Black women’s experiences, but to better understand them.

**INTERSECTIONALITY MOVES TO ENGAGE BLACK MEN**

In “Black Male Exceptionalism?: The Problems and Potential of Black Male-Focused Interventions,” Paul Butler challenges a widespread thesis that Black males are more marginalized than Black women and, therefore, deserve more of our attention and aid in countering racial subordination. Butler defines “Black male exceptionalism” as the notion that African American males are at the bottom of almost every index of inequality—exceptionally burdened and marginalized—and therefore should be treated as a distinct group in fashioning racial justice strategies. According to Butler, numerous organizations ranging from traditional civil rights groups like the NAACP to local governments have responded favorably to Black male exceptionalism by structuring how civil rights interventions are framed and how they are funded. Butler contends that the metaphor of “endangered species” is problematic in that it is aggrandizing, victimizing and evokes the notion of animal conservation. Interrogating the claim of Black male exceptionalism through an intersectional lens, Butler questions whether the ideological “monopoly” it holds on racial justice issues is justified. Butler argues that the deep disparities in resourcing social justice interventions for Black men and Black women are not justified and contends that the needs and interests of Black women are as important as those of Black men. He concludes by urging proponents to embrace gender equity as a value in antiracist discourses, beginning with the presumption that Black women should enjoy equal time and equal funding.
The intersectional politics of racial solidarity is also a central theme of Luke Charles Harris’s contribution, “The Sounds of Silence: Taking Stock of a Political Travesty.” In his critical examination of the nomination of Justice Clarence Thomas to the U.S. Supreme Court, Harris presents a clear example of how an uncritical embrace of the endangered Black male narrative can legitimize Black men’s claims of racial injustice and discredit similar claims on the part of Black women. This displacement not only contributes to an intraracial discourse that legitimizes certain injustices that are visited upon Black women, but it may also generate consent within the Black community to conservative social policies that are frequently packaged together with such rhetorics.

According to Harris, Clarence Thomas deployed the trope of the endangered Black male to garner support for his nomination and to deflect attention away from Anita Hill’s allegation of sexual harassment. More specifically, Thomas claimed that Senate hearings on his nomination, against the backdrop of Hill’s allegations, were a form of “high-tech lynching.” Through this deployment of this symbol of racial terrorism, Anita Hill became embattled within the Black community as a race traitor, while Justice Thomas garnered widespread support as a Black man in trouble. “Lost in the bluster of Thomas’ use of the metaphor was the reality that no Black man had ever been lynched at the behest of an aggrieved Black woman.” Harris makes clear that “Anita Hill had become persona non grata for many Blacks because they felt that even if her allegations were true she should not have sought to bring a brother down.” Black women were expected “to put loyalty to their race first and foremost, even in cases where they may have been subjected to unprofessional or predatory conduct by Black men.” These demands of solidarity, however, were gendered and unidimensional, a dynamic that Harris elaborates in the subsequent re-enactment of Black women’s marginality in Black political rhetoric. Harris does not offer the Clarence Thomas confirmation hearings to question the historical functions of solidarity, nor does he suggest a fundamental indeterminacy around the political and social interests of the Black community. Instead, Harris challenges us to reimagine a Black political sphere that acknowledges and honors the linked fate of Black men and women.

Together, Harris’s and Butler’s contribution reveal the work intersectionality can perform in engaging the contemporary contours of Black political discourse as well as Black male subjectivity. An underlying theme of both is that intra-racial political discourse that is silent about or in fact receptive to the marginalization of Black women unduly limits the scope of Black politics and undermines the realizability of a politics that centers the well-being of women as well as men.

**INTERSECTIONALITY AS A SOCIAL MOVEMENT**

The last theme might be framed as the link that draws the collection full circle, connecting the first article that shows how intersectionality was deployed to highlight unexpected coalitions to the last article that imports intersectional analysis to interrogate rhetorics of solidarity that are presumed but not realized. Beyond its role as a thematic book-end, our deployment of intersectionality’s engagement with social movement, however, is a theme that appears throughout the collection. When Kimberlé Crenshaw drew upon Black feminist multiplicitous conceptions of power and identity as the analytic lens for intersectionality, she used it to demonstrate the limitations of the single-axis frameworks that dominated antidiscrimination regimes and antiracist and feminist discourses. Yet, consistent with the practical dimensions...
of Critical Race Theory within which intersectionality was situated, the goal was not simply to understand social relations of power, nor to limit intersectionality’s gaze to the relations that were interrogated therein, but to bring the often hidden dynamics forward in order to transform them. Understood in this way, intersectionality, like Critical Race Theory more generally, is a concept animated by the imperative of social change. In various ways, each of the essays in this volume demonstrates this dimension of the theory. They do so by interrogating the inter-locking ways in which social structures produce and entrench power and marginalization, and by drawing attention to the ways that existing paradigms that produce knowledge and politics often function to normalize these dynamics. Our contributors provide a conceptual template—and in some instances, a set of practices—that respond to this dynamic view of power and facilitate more productive efforts to transform these structures.

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We began this introduction with the claim that intersectionality is a method and a disposition, a heuristic and analytic tool. Mapping intersectionality’s movements reveals at least this much. More fundamentally, articulating how intersectionality has moved—and the places to which it has travelled—makes clear that intersectionality is what intersectionality does. Conceptualizing intersectionality in terms of what agents mobilize it to do invites us to look for places in which intersectionality is doing work as a starting point for understanding the work that the theory potentially can—but has not yet been mobilized to—do. In this respect, the essays that constitute this volume are as much a signification of how scholars across the disciplines, inside and outside of the United States, have moved intersectionality as they are a signification on the uncharted terrains to which intersectionality might still move.

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NOTE
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Recent Developments

Hitting the Ceiling:

An Examination of Barriers to Success for Asian American Women

Peggy Li†

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I. INTRODUCTION

Some say that we live in a “post-racial society,” where race and gender are not barriers to success. These individuals often use the election of President Barack Obama, the first African American president, as a sign of our post-racial era. The “success” of Asian Americans is also touted as an example of our race-neutral society. But this model minority myth that Asian Americans have assimilated and found success in the United States has been shown to be in error.\(^1\) The term “model minority” ignores the past and present discrimination experienced by Asian Americans and legitimizes the oppression of other communities of color.\(^2\) The model minority myth also ignores the existence of a bamboo ceiling that prevents Asian Americans from advancing to high-ranking, leadership positions.\(^3\)

Asian American women face additional barriers as a result of being both Asian American and female. While research is available on the experiences of women, Asian Americans, and people of color, very little research has been done on the unique experiences of Asian American women. For example, the literature on the glass ceiling focuses solely on gender, while the literature on the bamboo ceiling focuses on race and national origin.\(^4\) This necessarily excludes the experiences of Asian American women since the discrimination faced by Asian American women is wholly different from and more than the sum of the

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2. See id. at 1258-60.
discrimination faced by white women and Asian American men. The experiences of people of color generally or other women of color specifically, while helpful in recognizing common themes of oppression, are unable to fully explain the experiences of Asian American women. Intersectionality, the study of individuals who occupy multiple socially constructed categories, such as race, gender, and sexual orientation, has the potential to shed light on the experiences of Asian American women. Research on intersectionality should be expanded to analyze the experiences of Asian American women. As such, a discussion of Asian American women must take into account their unique history in the United States.

This paper aims to fill the void in legal research on the experiences of Asian American women. This paper is limited in scope and focuses specifically on the experiences of middle-class, educated, Asian American women. It also focuses on societal forces that create barriers to success for Asian American women, such as stereotyping. Asian Americans are not a monolithic group. They are from different countries with distinct histories, and differing languages, cultures, cuisines, and religions. Nevertheless, our dominant society often mistakes all Asian Americans as being members of a monolithic group. For that reason, this paper focuses specifically on external forces creating barriers to success. It will not discuss internal cultural forces that may also create barriers to success for Asian Americans. Part II discusses the exclusion of Asian American women from the theories of the “glass ceiling” and the “bamboo ceiling.” Part III describes the study of intersectionality, its limitations, and potential for understanding and eradicating the barriers to success for Asian American women. To fully understand the barriers to success for Asian American women, Part IV will examine the history of exclusion and stereotypes of Asian American women; this Part will also discuss the model minority myth and how Asian American women fit into this narrative. Part V will examine how these stereotypes contribute to discrimination against Asian American women in the workplace. This paper concludes with a discussion on ways to acknowledge the experiences of Asian American women and remove these barriers to success.

II. THE GLASS CEILING, THE BAMBOO CEILING, AND THEIR EXCLUSION OF ASIAN AMERICAN WOMEN

Researchers have documented professional “ceilings” that prevent women and people of color from attaining higher levels of professional success. While the demographics of previously white male dominated professions show a

significant increase in the number of women and minorities employed, the
demographics of higher-level management present a different picture—one that
reflects a cap on how high women and minorities can advance in their careers.6
This “ceiling” effect has been well documented for women and Asian
Americans, but research has severely overlooked the experiences of Asian
American women. By focusing only on the experiences of women and Asian
Americans, Asian American women, who are subjected to different stereotypes
that lie at the intersection of race, national origin, and sex, are left out.7

A. The Glass Ceiling

Women have made great strides in the last fifty years. Nevertheless, it is
still rare to see women in the highest ranks of employment.8 In 2010, women
made up 47 percent of the total U.S. labor force,9 yet comprised only 10 percent
of senior managers in Fortune 500 companies, less than 4 percent of the upper
ranks of CEOs, presidents, and executive vice presidents, and less than 3 percent
of the top corporate earners.10 This lack of progress can be attributed to the glass
ceiling.

The glass ceiling is a metaphor that refers to the “artificial barriers to the
advancement of women and minorities.”11 It is an invisible barrier based on
attitudinal or organizational bias and discrimination that prevents minorities and
women from rising up the corporate ladder and into high-level management
positions, despite their qualifications.12 A glass ceiling inequality represents a
gender or racial difference that cannot be explained through other job-relevant
characteristics of the employee; this inequality is more pronounced at higher
levels of earning and authority.13 It also represents a gender or racial inequality
in the chances for advancement into higher levels of employment.14 This
inequality increases over the course of a career. While the glass ceiling has been used to describe the experiences of both women and minorities, at least one study states that the glass ceiling, as described above, is a “phenomenon of gender stratification” and not race. Furthermore, much of the literature on the glass ceiling uses examples involving women with no mention of race. There is little discussion on the experiences of people of color and almost no discussion of women of color.

The glass ceiling is difficult to identify since bias and discrimination are so deeply embedded in the organizational structure of a business. Indeed, “[e]ven the women who feel [the glass ceiling’s] impact are often hard-pressed to know what hit them.” These barriers appear in common or mundane work practices and in cultural norms that seem unbiased, but put women at a disadvantage in moving up the corporate ladder. The glass ceiling is manifested in multiple ways: informal recruitment practices that fail to recruit women, lack of opportunities for training and mentorship, exclusion from informal networks, menial assignments rather than challenging assignments that would progress women’s careers, wage gaps between men and women despite comparable work, and placement in jobs with very few advancement opportunities. For example, a company’s norm of routinely cancelling or setting up last-minute meetings and expecting their employees to be available at all times, a seemingly innocuous practice, disproportionately affects women since women oftentimes bear more responsibility for the home and childrearing, and therefore have more demands on their non-working time. As a result, women who work set hours are excluded from informal networks and miss out on important conversations; they are also perceived as less committed to their job than their male counterparts.

In addition, most organizations have been created by men and are based on male experiences. Because of this predominantly male culture and environment, women are judged on traits stereotypically associated with men, such as toughness and aggressiveness. This results in women being viewed as ineffective leaders when using more feminine managerial styles, or criticized for not being feminine enough when displaying more masculine management styles. Women are placed in a double bind: if they do not speak up, they lose opportunities or are unable to defend themselves; if they do speak up, they are

15.  Id. at 661.
16.  Id. at 671.
18.  Id. at 127.
19.  Id. at 128.
20.  See Ragins et al., supra note 12, at 29-33, 35. See also Cotter et al., supra note 11, at 673.
21.  Meyerson & Fletcher, supra note 4, at 129.
22.  Id.
23.  Id.
24.  Id.
seen as “control freaks.” In contrast, men who speak up are seen as passionate. Stereotypes based on gender are so deeply embedded into workplace norms that they appear innocuous, yet these stereotypes create a barrier, or a “ceiling,” on advancement for women.

B. The Bamboo Ceiling

The “bamboo ceiling” is a term that has been recently used to describe a similar barrier to advancement for Asian Americans. Despite increased visibility on college campuses and in elite professions, Asian Americans are rarely seen in high-ranking positions. As of 2010, Asian Americans made up 4.8 percent of the total population but held only 2.1 percent of corporate board of director seats in Fortune 500 companies. Whites, on the other hand, made up 72 percent of the total population and held over 90 percent of corporate board of director seats. Similarly, despite being well represented in the workforce, Asian Americans lack proportional representation in higher-level management positions. While Asian Americans make up more than 11 percent of professionals, they comprise only about 5 percent of first/mid-level officials and managers, and 4 percent of executive/senior level officials and managers. In contrast, whites make up nearly 75 percent of professionals, almost 80 percent of first/mid-level officials and managers, and about 88 percent of executive/senior level officials and managers. Unlike Asian Americans, whites are over-represented in higher-level management positions in proportion to their representation in the workforce.

This data suggests that Asian Americans are not being promoted at the same rate as other minority groups. For example, in 2012, 20 percent of U.S. law firm associates were minorities, yet minorities made up only 6 percent of partners. Asian Americans make up nearly half of all minority associates, yet

26. See Meyerson & Fletcher, supra note 4, at 129.
27. Id.
28. See generally Bigelow, supra note 3, at 2-3, 10.
30. Id. at 9 app.2.
31. Id. at 2 fig.2.
32. Id. at 9 app.2.
34. EEOC 2011, supra note 33.
35. Id.
36. Id.
37. Bigelow, supra note 3, at 3.
38. Id. at 4.
have the “lowest conversion rate from associate to partner of any minority group.” 40

Asian Americans receive “the lowest return on education (i.e. worst salaries) of all ethnic groups.” 41

Yet, Asian Americans are perceived to be model minorities: overly competent, hardworking, educated, intelligent, and ambitious. 42 They are viewed as a large middle-class group that has achieved “economic success without using government programs or welfare.” 43 Despite this perception, Asian Americans do suffer from discrimination—a discrimination that is different from that suffered by other disempowered groups. 44 They are perceived to be competent, yet lacking warmth and social skills. 45 Asian Americans are also not historically seen as leaders. 46 These positive and negative stereotypes contribute to why Asian Americans are not adequately represented in executive-level positions. 47

Like women, Asian Americans also hit a “ceiling” when seeking promotions to leadership or executive positions. For example, in U.S. law firms, the bamboo ceiling prevents Asian American associates from advancing to partner. 48 White partners favor the promotion of white associates. 49 Because whites make up the majority of partners in U.S. law firms, they continue to favor and promote members of their ingroup (whites) over competing outgroups (non-whites), thereby maintaining their high status and privilege. 50 Corporate recruitment practices, which include informal referrals, a lack of Asian Americans engaging in these referrals, and a lack of record-keeping, also reinforce exclusionary outcomes for Asian Americans. 51

C. The Exclusion of Asian American Women

The “glass ceiling” and “bamboo ceiling” are insufficient proxies for understanding the experiences of Asian American women. The concept of the glass ceiling focuses on the experiences of women irrespective of race. The glass ceiling is a concept that is commonly discussed in regards to or as an area of

39.  Id. at 5.
40.  Id. at 10. See also Virginia W. Wei, Asian Women and Employment Discrimination: Using Intersectionality Theory to Address Title VII Claims Based on Combined Factors of Race, Gender and National Origin, 37 B.C. L. REV. 771, 798 (1996); Lydia Lum, Stepping Forward, DIVERSE EDUC., August 25, 2005, http://diverseeducation.com/article/4560/ [hereinafter Lum, Stepping Forward] (reporting that Asian Pacific Americans make up about 50 percent of undergraduate students at the University of California, Irvine).
42.  Id. at 10.
43.  Chang, supra note 1, at 1247.
44.  Bigelow, supra note 3, at 12.
45.  Lum, Stepping Forward, supra note 40.
47.  See Bigelow, supra note 3, at 4-5.
48.  Id. at 26.
49.  Id.
50.  Chiu, supra note 46, at 1090.
concern for the feminist movement. The feminist movement presents a monolithic woman’s experience that is explained independent of race, class, sexual orientation, and national origin. The agenda of the women’s rights movement has been shaped largely by white, middle-class women. Similarly, the bamboo ceiling addresses barriers to success for Asian Americans as a monolithic group, regardless of gender. In fighting for the rights of Asian Americans, women’s issues are seen as secondary. For example, domestic violence and trafficking of Asian American women take a back seat to “more pressing” issues facing the Asian American community, as determined by male community leaders. By using a single-axis analysis where race and gender are mutually exclusive, the “glass ceiling” and “bamboo ceiling” exclude and delegitimize the experiences of Asian American women. The experiences of Asian American women must be analyzed in a way that allows for the interaction of multiple axes of oppression. The barriers Asian American women face are not only distinct, but also more than the sum of the discrimination faced by women and Asian Americans.

Just as the Women’s Rights Movement encouraged African American women to set aside the color of their skin to fight for women’s rights, and the Civil Rights Movement encouraged African American women to set aside their gender to fight for the rights of African Americans, the glass ceiling and bamboo ceiling encourage Asian American women to set aside their intersectional identities for the advancement of the rights of women and Asian Americans. Dominant members of progressive social organizations tend to “monopolize the political apparatuses of these movements and create hegemonic agendas that reflect their own self-interests and that fail to respond to the needs of less visible and less powerful populations within these ‘communities.’” Under this analysis, the Women’s Rights Movement and the Asian American Movement favor the interests of the dominant members of these movements: white women


52. Perez, supra note 5, at 236.
53. Id. at 212.
54. Id.
55. Id.
56. See Crenshaw, Demarginalizing the Intersection of Race and Sex, supra note 5, at 153-54. See also Darren Lenard Hutchinson, Ignoring the Sexualization of Race: Heteronormativity, Critical Race Theory and Anti-Racist Politics, 47 BUFF. L. REV. 1, 2-5 (1999).
57. Hutchinson, supra note 56, at 5.
and Asian American men, respectively. This mirrors larger social inequalities, whereby men are given more power than women and whites are given more power than non-whites. As a result, the experiences of Asian American women are excluded from the fight for equality and opportunity. We therefore cannot rely on the glass ceiling and the bamboo ceiling to acknowledge and reflect the experiences of Asian American women—we must use a more holistic and inclusive analysis.

III. USING INTERSECTIONALITY TO ACKNOWLEDGE THE EXPERIENCES OF ASIAN AMERICAN WOMEN

To comprehend the experiences of Asian American women and create appropriate strategies for counteracting their oppression, we must look at how race, gender, and national origin interact to create unique obstacles, stereotypes, and stigmas for Asian American women. Intersectionality provides a framework to analyze the experiences of Asian American women. Intersectionality looks at the intersection between multiple categories of socially constructed identities, such as race, color, gender, sexual orientation, and class, and considers their effects on the everyday lives of people who sit at the crossroads of these multiple intersections. It rejects the notion that these socially constructed identities are mutually exclusive, since these identities often work together to “limit access to social goods such as employment, fair immigration, healthcare, child care, or education.” For example, “women of color are frequently the product of intersecting patterns of racism and sexism . . . . Because of their intersectional identity as both women and of color within discourses that are shaped to respond to one or the other, women of color are marginalized within both.” Women of color identify with both women and people of color, yet are constantly asked to “choose sides,” to put aside their “woman-ness” to fight for the rights of people of color, or to put aside the color of their skin to fight for the rights of women. An example of this can be seen in the criticism Alice Walker received for her portrayal of domestic violence in African American families in The Color

58. Id.
59. See generally Peggy McIntosh, White Privilege: Unpacking the Invisible Knapsack, in RACE, CLASS, AND GENDER IN THE UNITED STATES (7th ed. 2007).
61. Intersectionality, supra note 60.
62. Crenshaw, Mapping the Margins, supra note 60, at 1243-44 (emphasis in original).
63. See, e.g., id. at 1252-53, 1258 (noting that in regards to violence against women, while “race-based priorities function to obscure the problem of violence suffered by women of color; feminist concerns often suppress minority experiences as well.”).
Purple.\textsuperscript{64} Many in the African American community were angered by Walker’s narrative because it reinforced negative stereotypes of African American families as unstable, and African American men as aggressive and violent.\textsuperscript{65} By choosing to portray this scene, Walker refused to give up her woman-ness for the sake of her blackness and vice versa.

“Asian American women continue to be largely unseen and unheard” in the study of intersectionality.\textsuperscript{66} Current research on intersectionality emphasizes the experience of African American women or women of color generally.\textsuperscript{67} While Asian American women likely benefit from the work that has been done on intersectionality, since many of the struggles affecting African American women parallel those of Asian American women, “the different social histories of Asian and black women in America have created distinctions in their experiences.”\textsuperscript{68}

Asian American women and other women of color all experience marginalization generally; in addition, Asian American women also experience discrimination specific to Asian Americans based on their unique history in the United States.\textsuperscript{69} Therefore the discrimination faced by African American women cannot alone explain the experiences of Asian American women.\textsuperscript{70} To best utilize intersectionality, research must be conducted to fully incorporate the experiences of Asian American women, taking into account their history, the stereotypes they face, and how they fit within the model minority myth. This research must also examine the ways discrimination against Asian American women manifests in our courts. Only by fully acknowledging these experiences will we gain a more holistic understanding of the barriers to success for Asian American women.

\textbf{IV. UNDERSTANDING THE ORIGINS AND PERPETUATION OF DISCRIMINATION AGAINST ASIAN AMERICAN WOMEN}

While there are similarities between the oppression of Asian American women and other women of color, Asian American women face a distinct set of barriers as a result of their history in the United States. This history shaped the perception of Asian American women as outsiders, ultra-feminine lotus blossoms, dragon ladies, and model minorities. These stereotypes, both positive and negative, have contributed to discrimination against Asian American women. The following section provides factors that must be considered in order

\begin{itemize}
  \item\textsuperscript{64} Id. at 1256.
  \item\textsuperscript{65} Id.
  \item\textsuperscript{66} Perez, supra note 5, at 213.
  \item\textsuperscript{67} See Wei, supra note 40, at 772 ("[I]ntersectionality theory[] began largely with black women’s experiences.").
  \item\textsuperscript{68} Id.
  \item\textsuperscript{69} Id. at 773.
  \item\textsuperscript{70} See Chang, supra note 1, at 1265, 1266-67. See also Derald Wing Sue et al., Racial Microaggressions and the Asian American Experience, S. ASIAN AM. J. PSYCHOL. 88, 89 (2009).
\end{itemize}
to have a holistic understanding of the barriers to success for Asian American women.

A. The History of Exclusion of Asian American Women

The first settlers and leaders of this country envisioned America as a country for “pious, God-fearing, white Christians.”71 It was not envisioned to be a place for a multiracial or multicultural society.72 In order to maintain America’s racial purity and homogeneity, outsiders, such as Asian Americans, were discriminated against and subject to strict exclusionary policies.73 From the outset, Asian Americans were seen as members of an inferior race,74 and were denied citizenship and the rights typically associated with citizenship.75 The Naturalization Act of 1790 permitted only “free white persons” to naturalize in the United States.76 Nevertheless, Asian men were allowed to immigrate to the United States for the limited purpose of serving as cheap labor.77 In the early 1800s, Asian immigrants began arriving in America: Chinese immigrants worked on the sugar plantations in Hawaii and in the mines and on the railroad in California during the Gold Rush.78 Asian immigrants also worked as factory operatives, cannery workers, and farm laborers.79 Asians were seen as replacements for black workers and were used by whites to discipline black laborers; for example, a railway company displaced black workers by hiring Filipinos to work as attendants, cooks, and busboys, thereby relegating blacks to porter positions and denying them the mobility to obtain easier and better-paying jobs.80

During this time (and until the 1920s), very few Asian women came to the United States.81 American employers preferred a “bachelor society” of single Asian men and thus only recruited single male workers.82 In addition, Asian laborers found it more economical to have their families stay in Asia.83 Many also considered the United States unsafe for women and children.84 As a result, there was a gross gender imbalance among Asians in the United States,85 which

71. Chiu, supra note 46, at 1058.
72. Id.
73. Id. at 1058-59.
74. Wei, supra note 40, at 787.
75. Chiu, supra note 46, at 1060-61.
76. Hutchinson, supra note 56, at 90.
77. Id.
78. Chiu, supra note 46, at 1059.
79. Wei, supra note 40, at 787.
80. Id. at 788 n.187.
81. Id. at 792.
82. Cho, supra note 7, at 183.
83. Wei, supra note 40, at 793.
84. Id.
85. Id. See also Cho, supra note 7, at 183.
led to the importation of Asian women as prostitutes.\textsuperscript{86}

Asian women were allowed to enter the United States, to meet the demand for sex from both white men, who saw them as mysterious and exotic, and Asian men.\textsuperscript{87} As a result, during the nineteenth century, sexual stereotypes about Asian women emerged. Asian women were seen as both “lotus blossoms”—passive, domesticated, and feminine—and “dragon ladies”—demonically aggressive, conniving, and predatory.\textsuperscript{88} Many Chinese prostitutes in California were indentured servants; their degradation was used as a justification for restricting and excluding Chinese immigrants.\textsuperscript{89} In 1875, the U.S. further stifled the growth of Asian communities through the Page Law, which was aimed at restricting the entrance of prostitutes from China and Japan.\textsuperscript{90} The Page Law nearly ended all Chinese female immigration to the United States.

The 1790 Naturalization Act restricted naturalization to “free white” aliens.\textsuperscript{92} After the Civil War, Congress debated eliminating racial restrictions to naturalization, but decided against it because of concerns about granting citizenship to Chinese immigrants.\textsuperscript{93} Chinese immigrants were “thought to lack the capacity to engage in republican forms of government, and thus, allowing them to naturalize would threaten the survival of American democracy.”\textsuperscript{94} The 1790 Naturalization Act was therefore amended to allow the naturalization of only persons of African descent.\textsuperscript{95} In 1882, the Chinese Exclusion Act suspended immigration of Chinese laborers for ten years and barred any court from allowing Chinese immigrants to naturalize.\textsuperscript{96}

Asians were not only denied citizenship, they were also denied the rights, privileges, and protections typically associated with it.\textsuperscript{97} For example, Asians were prohibited from testifying against white men in court,\textsuperscript{98} unable to obtain gainful employment,\textsuperscript{99} excluded from white public classrooms,\textsuperscript{100} excluded from owning property,\textsuperscript{101} and segregated into ethnic ghettos.\textsuperscript{102}

\begin{thebibliography}{99}
\bibitem{86} Cho, \textit{supra} note 7, at 184.
\bibitem{87} Hutchinson, \textit{supra} note 56, at 93-94; Perez, \textit{supra} note 5, at 217.
\bibitem{88} Cho, \textit{supra} note 7, at 184-85; Hutchinson, \textit{supra} note 56, at 94.
\bibitem{89} Cho, \textit{supra} note 7, at 184.
\bibitem{91} Id. at 410-11.
\bibitem{92} Id. at 412-13. “White persons” was later defined as the common white man. \textit{US v. Thind}, 261 U.S. 204 (1923); Chiu, \textit{supra} note 46, at 1061.
\bibitem{93} Volpp, \textit{supra} note 90, at 412.
\bibitem{94} Id.
\bibitem{95} Id. at 413.
\bibitem{96} Id. at 465, 413.
\bibitem{97} Chiu, \textit{supra} note 46, at 1060-61.
\bibitem{98} People v. Hall, 4 Cal. 399, 405 (1854).
\bibitem{99} Chiu, \textit{supra} note 46, at 1063.
\bibitem{100} Id. at 1064.
\bibitem{101} Id. (“[L]egislation . . . made it unlawful for ‘aliens ineligible to citizenship’ to own real property and prohibited such aliens from leasing agricultural land for a term of more than

Electronic copy available at: https://ssrn.com/abstract=2318802
Anti-Asian animus can be seen in Justice Harlan’s dissent to *Plessy v. Ferguson*. In *Plessy*, Justice Harlan argued that separation on the basis of race was inconsistent with the Constitution; he then compared African Americans with Asians, “a race so different from our own that we do not permit those belonging to it to become citizens of the United States. Persons belonging to [the Chinese race] are, with few exceptions, absolutely excluded from our country.”

This pattern of exclusion continued well into the modern era. Racial biases towards Asians can also be seen with the internment of Japanese Americans during World War II. After the bombing of Pearl Harbor, Executive Order 9066 allowed the Secretary of War to intern both U.S. citizens of Japanese descent and Japanese aliens for the sake of “security.” Despite attempts to challenge its constitutionality, the Supreme Court stated that the hardship of internment is a circumstance of war, and that concerns for the presence of disloyal members in society allowed for the exclusion of Japanese Americans.

Just like their male counterparts, Asian American women suffered as a result of exclusionary immigration policies and a lack of citizenship. Asian American women arguably faced more discrimination because they were brought into the U.S. as indentured prostitutes, perceived as sexual objects, excluded from entering the U.S. years before the Chinese Exclusion Act, and later faced additional difficulties entering the United States. For example, while most Chinese women were admitted to the U.S. as dependents of men, when Chinese women did enter the U.S. on their own, they were unable to bring their husbands as dependents. Thus, the status and admissibility of Chinese women often depended on men. In addition, Asian American women in the U.S. had to be strong, both physically and emotionally. In Hawaii, Asian American women earned money by working in the fields and cooking and cleaning for others; they also raised their own families and tended to household chores in the evenings while the men relaxed. This history shapes contemporary perceptions and stereotypes of Asian American women.
B. Perceptions and Stereotypes of Asian American Women

The perception of Asian women in the nineteenth century as sexual objects, and the perception of Asian Americans in the twentieth century as model minorities permeate our conception of Asian American women today. Generally, Asian Americans are perceived to be overly competent, yet not warm, sociable, aggressive, or assertive.113 Because of their distinct physical features, Asian Americans are unable to blend into the melting pot; their physical features are markers of their foreignness.114 This explains why Asian Americans often get asked, “where are you from?” followed by, “where are you really from?”115 They are also often the recipients of comments such as, “you speak English so well,” or are complimented for not having an accent.116 Asians are thus seen as perpetual foreigners and distinctively “not American.”117

While Asian America women share some of the same stereotypes as Asian American men, Asian American women face additional discrimination as a result of their sexualization.118 Stereotypes of Asian American women are rooted in the nineteenth-century images of Chinese prostitutes and “slave girls.”119 These women were seen as “meek, shy, passive, childlike, innocent and naïve,” yet surprising in [their] sexual prowess and desire to please [their] male master.”120 Recent images of Asian women paint them as sexual servants to soldiers overseas in Asia.121 Asian women are seen as embodying feminine ideals and “set[ting] the bar [for] . . . femininity.”122 Myths about their subservience and sexual prowess have ignited Western fetishes for Asian women.123 Asian women are “fetishized as the embodiment of perfect womanhood and genuine exotic femininity.”124 This western male fantasy is elaborated in Tony Rivers’ article in Gentleman’s Quarterly entitled “Oriental Girls”:

When you get home from another hard day on the planet, she comes into existence, removes your clothes, bathes you and walks naked on your back to

113. Id. at 799; Bigelow, supra note 3, at 9.
114. See Wei, supra note 40, at 800-01.
115. See id.; Chiu, supra note 46, at 1070.
116. Id. See also Chiu, supra note 46, at 1070.
117. See Chiu, supra note 46, at 1070.
118. Wei, supra note 40, at 801.
119. Id.
120. Perez, supra note 5, at 218.
121. Wei, supra note 40, at 801.
123. Perez, supra note 5, at 217.
relax you . . . . She’s fun you see, and so uncomplicated. She doesn’t go to assertiveness-training classes, insist on being treated like a person, fret about career moves, wield her orgasm as a non-negotiable demand . . . . She’s there when you need shore leave from those angry feminist seas. She’s a handy victim of love or a symbol of the rape of third world nations, a real trouper. 

In addition, white men have touted Asian American women’s femininity and passivity as a response to the non-femininity of American women who have left their place in the home to pursue a career and independence. White women’s gains in career, income, and personal autonomy have ignited a backlash against them in American society; they are perceived as abandoning their roles as mothers and wives. In contrast, Asian American women are seen as docile, devoted, traditional, and as deriving joy from serving their men, thereby replacing white career women as “true” women.

These stereotypes are also reflected in mass media. Popular culture and mass media reinforce stereotypical images of Asian American women through one-dimensional, simplistic, and inaccurate portrayals. Often, these characters reinforce two stereotypical images of Asian American women: the “Lotus Blossom Baby” and the “Dragon Lady.” The “Lotus Blossom Baby” is shy and diminutive, while the “Dragon Lady” is devious and wicked. For example, Anna May Wong, the first Chinese-American actress to gain prominence in cinema, was type-cast into roles that sexualized Asian American women, such as “Mongolian Slave Girl” in The Thief of Bagdad (1924). There were very few roles available to Asian Americans at that time, and the roles Wong acquired were stereotypical and demeaning. This led Wong to flee to Europe in 1928. During her time away from Hollywood, images of Asian women in Hollywood did not experience much change. In 1932, Wong returned to Hollywood as an archetypal China Doll/Dragon Lady in Shanghai Express (1932).

Today, despite Asian American women’s significant progress in film and television, there are few Asian American actresses and few roles that truly reflect

126. Cho, supra note 7, at 192; Chiu, supra note 46, at 1086-87.
127. Id. at 1086.
128. Id. at 1086-87.
129. Wei, supra note 40, at 801. See also Perez, supra note 5, at 218-19 (discussing portrayals of Asian American women in film).
130. Id. at 800.
131. Id. at 802.
133. See id.
134. Id.
135. Id.
the experiences of Asian American women. While Asians make up about 5 percent of the U.S. population, they occupy only 3 percent of total characters, and only 1 percent of regular or opening credits in the media. Like Anna May Wong, most Asian American women have played stereotypical Asian American characters, such as the sexualized female. This creates a limitation on the number and quality of roles available for Asian American women, which allows for the perpetuation of negative stereotypes. For example, in Charlie’s Angels (2000), Lucy Liu, dressed in tight, revealing clothing, plays a strong, beautiful agent. Similarly, Li Gong plays a beautiful, exotic, and dangerous wife of an arms and drug trafficker in Miami Vice (2006). Also, in The Scorpion King (2002), Kelly Hu plays a scantily clad, beautiful sorceress. While all of these characters are strong and intelligent, they are nevertheless sexualized and exoticized. Since mainstream media offers few Asian American female characters outside of these stereotypes, these negative stereotypes are reinforced, making it difficult for Asian American women to be accepted as ordinary, as opposed to exotic.

The few Asian female characters that were produced by Asian American women are fascinating and provide a more realistic portrait of the experiences of Asian American women. These characters can be found in works such as Amy Tan’s The Joy Luck Club (1989), and Maxine Hong Kingston’s The Woman Warrior: Memoirs of a Childhood Among Ghosts (1976). Nevertheless, these realistic, complex female characters are few and far between, and thus remain virtually unknown in mainstream American consciousness, while negative stereotypes continue to persist.

C. The Model Minority Myth and How Asian American Women Fit Into This Myth

In addition to the ultra-feminine sexualized stereotype of Asian American women, Asian American women are also perceived through the model minority

138. Id.
139. Id.
140. Id.
141. Id.
143. Sexploitation of the Asian American Female Body, supra note 137.
144. Wei, supra note 40, at 802.
145. See id.
146. Id. at 802-03.
147. Id. at 803; Chiu, supra note 46, at 1072.
The model minority myth focuses on Asian Americans’ educational achievement, economic success, and assimilation into American culture, and characterizes Asian Americans as hardworking, intelligent, and successful. More accurately, this myth refers to the way Asian Americans have “assimilated and adhered to American society’s ‘prescribed mode of behavior for minority assimilation; through hard work, education, quietly remaining in the background, inaction in the face of injustice, and blind faith to the American dream of equality and opportunity for all.’” This misleading portrait furthers the oppression of Asian Americans by denying the existence of present-day discrimination and ignoring the effects of past discrimination. It ignores income disparities within the Asian American community and the absence of Asian Americans in high-ranking executive positions, which is especially striking given the high representation of Asian Americans in universities and professional positions. This perception of Asian American success allows the public, our government, and our judiciary to ignore or marginalize the needs of Asian Americans, for example, by denying funding to social services for Asian Americans. As a result, much-needed funding and attention to issues affecting many Southeast Asian communities, which have poverty rates at least three times the national average, are denied. When Asian Americans do discuss the oppression they face, these complaints are seen as unwarranted given their “success” as a model minority. Asian Americans are not seen as victims of racism.

Within these “positive stereotypes,” the model minority myth also evokes negative stereotypes about Asian Americans. For example, Asian Americans are perceived as passive, lacking social skills, apolitical, submissive, and lacking the aggressiveness required for high-ranking managerial positions. These perceptions of Asian Americans as hardworking, intelligent, ambitious, and achievement-oriented work alongside negative stereotypes of Asian Americans as shy, quiet, polite, and cold to prevent them from breaking the bamboo ceiling and advancing into executive positions.

The model minority myth, created during the Civil Rights Movement to provide a counter example to politically active African Americans, is used to
legitimize the oppression of other minority groups and to blame them for “not being successful like Asian Americans.” The myth reinforces and furthers the belief in America’s system of meritocracy in which “any group can be successful if they work hard enough or possess the right values.”

A color-blind meritocratic system minimizes the effects of oppression and discrimination on minority groups. The model minority myth implies that other minorities have not adopted the “American cultural characteristics of self-sufficiency, individuality, and hard work,” which have been adopted by Asian Americans and are the reason for their success. It is used not only to blame minorities for their oppression, but also to campaign for the government to stop providing social services for “undeserving,” “lazy” minorities. The model minority myth is also used to campaign against affirmative action. This creates resentment and tension between minority groups, which may lead to violence and anger, and prevent minority groups from working together.

Asian American women are caught between two restrictive stereotypes, the sexualized ultra-feminine and the model minority. The model minority traits of passivity and submissiveness are reinforced, intensified, and gendered by the stereotype of Asian American women as obedient, servile, passive, feminine, reserved, humble, and demure. An example of a sexualized, racialized stereotype of Asian American women can be seen in Year of the Dragon (1985). In this film, Tracy Tzu, a Connie Chung inspired character, is a professional newscaster. She represents the “upwardly-mobile professional female variant of the model minority.” The “plot . . . undermines the image of gender and racial liberation” through the incorporation of a submissive, passive Asian woman. Despite her public success, Tracy Tzu is “privately dominated” by a “white, ethnic, working-class police detective” who “domesticates” her by taking control of her career. Despite initially resisting, Tzu eventually gives in,
not only to the detective’s verbal and physical abuse, but also to rape. This film demonstrates how the stereotype of a model minority woman and a sexualized, submissive lotus blossom interact to subjugate and legitimize the domination of Asian American women. The perception of Asian American women as privately compliant, catering, and predisposed to submit to the “assertion of white male desire,” while displaying a hyper-competent, professional exterior puts women at an increased risk of sexual harassment. This stereotype reinforces a belief that Asian American women will be receptive to a harasser’s aggressive sexual advances regardless of how competent, professional, or independent they may seem.

V. STEREOTYPES ABOUT ASIAN AMERICAN WOMEN HAVE CONTRIBUTED TO DISCRIMINATION AND SEXUAL HARASSMENT AGAINST ASIAN AMERICAN WOMEN IN THE WORKPLACE

Stereotypes about Asian American women manifest themselves in discriminatory conduct and sexual harassment against Asian American women in the workplace. The objectification of Asian American women and stereotypes that they are submissive, politically passive, exotic, and compliant makes them susceptible to racialized sexual harassment. This perception makes many believe that it is “okay” to sexually harass and discriminate against Asian American women. In Sumi K. Cho’s article, Converging Stereotypes in Racialized Sexual Harassment: Where the Model Minority Meets Suzie Wong, Cho discusses two cases of racialized sexual harassment involving Asian American women: a hostile work environment case and a quid pro quo case. In both cases, the injuries suffered by the women are a result of the “synergy of race and gender,” rather than race and gender independently.

Asian American women also suffer from unconscious racism in the workplace. For example, minority female attorneys are often mistaken for secretaries or paralegals. They are often excluded from networking opportunities, denied desirable assignments, and denied promotions. Asian American female attorneys, while perceived as being “hard-working, obedient, and compliant,” are also seen as sexually available and too passive for...
HITTING THE CEILING

litigation. These stereotypes create barriers to advancement for Asian American women. For example, minority male partners at law firms outnumber minority female partners more than two to one, despite there being more minority female associates than minority male associates.

A. Proving Unlawful Discrimination

Title VII makes it unlawful for an employer

(1) to fail or refuse to hire or to discharge any individual, or otherwise to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex, or national origin; or

(2) to limit, segregate, or classify his employees or applicants for employment in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual’s race, color, religion, sex, or national origin.

To prove unlawful discrimination, an employee plaintiff must generally show that the employer intended to discriminate; the employer took actions that adversely affected the employee’s employment; and the adverse actions were causally linked to the employer’s intent to discriminate. Under the McDonnell Douglas burden-shifting test for employment discrimination, an employee must first establish a prima facie case of discrimination, which creates a rebuttable presumption that the employer unlawfully discriminated. The employer must then rebut this presumption by establishing a legitimate, non-discriminatory reason for the adverse employment decision. If the employer is able to show a legitimate, non-discriminatory reason, the burden shifts back to the employee to show that the employer’s reason was pretext, and that the real reason for the adverse employment decision was discrimination.

Asian American women experience discrimination not as Asian Americans or as women, but as Asian American women. Therefore, laws addressing employment discrimination must take into account the unique intersecting identities of Asian American women. Courts have been inconsistent with their analysis of cases involving individuals who fit in multiple socially constructed

183. Id. at 9.
184. Id. at 11.
188. Id.
189. Id. at 804-05.
While some courts separate an individual’s claim into discrete unrelated categories, such as “race” and “gender,” others examine discrimination in a more holistic matter by looking at both “race and gender.”

Asian American women face an intersection of at least three forms of illegal discrimination: race, gender, and national origin. When employment discrimination is discussed through a single-axis analysis that compartmentalizes discrimination into discrete categories, the experiences of Asian American women and other individuals who fit in more than one protected category are overlooked. This “marginalizes those who are multiply-burdened and obscures claims that cannot be understood as resulting from discrete sources of discrimination.” Without a more holistic approach, the manner in which Asian American women are subordinated cannot be addressed.

B. Examining the Discrimination Claims Brought By African American Women Is Helpful for Understanding the Claims Brought By Asian American Women Since Both Are Discriminated Against for Their Race and Gender

In discussing employment discrimination against Asian American women, it is helpful to look at similar claims brought by African American women since both groups of women face similar difficulties in bringing claims based on the intersection of their race and gender. In DeGraffenreid v. General Motors, African American women alleged that their employer’s “last-hired-first-fired” policy discriminated against them and perpetuated past acts of discrimination against African American women. After deciding that African American women are not a special protected class under Title VII, the court broke down the Plaintiffs’ claims and analyzed the race and sex discrimination claims separately. With regard to the sex-based discrimination claim, the court granted summary judgment to General Motors, noting that General Motors had hired female employees before the Civil Rights Act of 1964, thereby indicating that their layoff policies did not perpetuate past discrimination against women. The court failed to address the fact that General Motors had employed

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190. See Wei, supra note 40, at 780-85.
191. Id.
192. Id. at 773.
193. See id. at 775, 780-85.
194. Crenshaw, Demarginalizing the Intersection of Race and Sex, supra note 5, at 140.
195. See id.
196. Wei, supra note 40, at 780.
199. Id. at 145.
200. Id. at 144.
only one black female prior to 1970. The court then dismissed Plaintiffs’ race discrimination claim so that it could be consolidated with another race discrimination claim. In this case, the court refused to recognize the distinct discrimination faced by African American women. Rather, it defined the discrimination faced by African American women in terms of the experience of white women and African American men. As a result, African American women can succeed on a discrimination claim only if they can fit their experiences into discrete protected categories.

In contrast, the court in Jeffries v. Harris County Community Action Association agreed with Plaintiff that, “discrimination against black females can exist even in the absence of discrimination against black men or white women.” There, an African American woman alleged that her employer discriminated against her on the basis of race and sex by failing to promote her and terminating her employment. Unlike the court in DeGraffenreid, the court in Jeffries looked at whether the employer discriminated against Plaintiff on the basis of race, sex, and race and sex. The court found that Plaintiff failed to prove race discrimination since the individual who actually received the promotion was also African American. The court remanded Plaintiff’s sex discrimination claim, ordering the district court to make further findings of fact and conclusions of law.

With regard to the sex and race claim, the court agreed with Plaintiff that “discrimination against black females can exist even in the absence of discrimination against black men or white women.” The court stated that the “or” in Title VII prohibits discrimination based on any or all of the protected classifications. In doing so, the court recognized that if black men and white women were considered to be in the same protected class as black females, no remedy would exist for discrimination directed only at black women. The court therefore held that in Title VII cases alleging discrimination against black females, “the fact that black males and white females are not subject to discrimination is irrelevant and must not form any part of the basis for a finding that the employer did not discriminate against the black female plaintiff.” It further concluded that the recognition of African American women as a distinct protected subgroup is the only way to remedy discrimination against African

201. DeGraffenreid, 558 F.2d at 482.
204. Id. at 1028.
205. Id. at 1030-34.
206. Id. at 1030.
207. Id. at 1031-32.
208. Id. at 1032.
209. Jeffries, 615 F.2d at 1032.
210. Id. at 1032-33.
211. Id. at 1034.
American women. The cases above demonstrate the inconsistent approach taken by courts in response to employment discrimination claims made by African American women. In these cases, African American women claimed that they were discriminated against as a result of both their race and sex. As such, these cases provide guidance for Asian American women who are discriminated against for their race, sex, and national origin.

C. Asian American Women Have Had Difficulty Bringing Forth Discrimination Claims Based on Their Intersectional Identities

Like African American women, Asian American women have experienced difficulties bringing forth employment discrimination claims based on the intersection of more than one protected category. For example, in Lim v. Citizens Savings & Loan Association, Plaintiff brought a claim alleging that her employer discriminated against her on the basis of race and sex by failing to promote her and discharging her. Plaintiff also attempted to file a class action suit on behalf of female and Asian employees charging discriminatory practices. The court refused to certify the class, citing statistics that indicated that the percentage of women and Asians employed by Defendant was comparable to relevant labor pools. The court also granted Defendant’s motion for summary judgment on Plaintiff’s individual claim, stating that Plaintiff either failed to prove a prima facie case for discrimination, or that Defendant rebutted her showing with several legitimate reasons for its decisions so that “no genuine issue of material fact as to discrimination remains.”

In Chaddah v. Harris Bank Glencoe-Northbrook, N.A., Plaintiff, an Asian American woman, claimed that she was harassed, denied a transfer, and discharged because of her age, race, and color. In addition to being denied a transfer, Plaintiff claimed that she was harassed by bank employees who ridiculed her English pronunciations, told her that foreigners should not work at the bank if they could not use proper English, and told her that she would “fit right in” with the women in China who worked in the fields barefoot. Plaintiff ultimately resigned from the bank. The court dismissed Plaintiff’s constructive discharge claim and held that Plaintiff failed to show that a reasonable person

212. Id.
213. See Wei, supra note 40, at 780.
215. Id.
216. Id. at 813.
217. Id. at 806.
218. Id. at 813-14 (quoting FED. R. CIV. P. 56).
220. Id. at *2-3.
221. Id. at *2.
under her circumstances would have resigned. The court held that Plaintiff failed to show that younger, white women promoted before her were less qualified than she or that there were few or no Asian bank officers. The court highlighted the fact that “Plaintiff offer[ed] no statistical evidence that other persons in her age category or of her racial background suffered similar discrimination.” The court’s analysis separated Plaintiff’s claims and looked at each individually rather than in combination, which resulted in the dismissal of Plaintiff’s cause of action.

In contrast, the court in Lam v. University of Hawai‘i looked at whether discrimination occurred on the basis of a combination of race and sex. Plaintiff, a Vietnamese woman, twice applied to be the Director of the University of Hawai‘i’s Richardson School of Law’s Pacific Asian Legal Studies (PALS) Program and was rejected both times. During the school’s first hiring search, Plaintiff was one of ten finalists recommended by an appointments committee for full-faculty review. The chairman of the appointments committee had previously had a “run-in” with Plaintiff, and Plaintiff was concerned about how this would affect her candidacy. During a debate regarding Plaintiff’s application, the chairman stated that Plaintiff was “not collegial, was a poor scholar, . . . had poor administrative ability,” and “was unfit to teach anywhere on the University of Hawai‘i campus.” The faculty failed to reach a consensus about who should be appointed, and the search was cancelled.

In response, Plaintiff filed a discrimination complaint with the University, which resulted in a report “detailing confidentiality breaches and procedural violations” in the committee’s search for a new director. University EEO officers spoke with law school faculty and recommended the use of rating sheets and of a clear definition for the PALS program and the director position. When the university reopened its search for a PALS director, Plaintiff reapplied. The new committee disregarded the EEO’s recommendations for screening out potential bias. The final list of candidates consisted entirely, or almost entirely, of persons of U.S. origin, which was in stark contrast to the

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222. Id. at *3.
223. Id. at *5-6.
224. Id. at *5-6.
226. Lam v. Univ. of Haw., 40 F.3d 1551, 1562 (9th Cir. 1994).
227. Id. at 1554.
228. Id. at 1555-56.
229. Id. at 1556.
230. Id. at 1556.
231. Id. at 1557.
232. Lam, 40 F.3d at 1557.
233. Id.
234. Id.
235. Id. at 1558.
substantial number of non-white and foreign-born finalists in the first search. 236
The committee offered the position to a white candidate who declined the offer; as a result, the faculty once again cancelled the search.237

At trial, the Ninth Circuit rejected the district court’s justification for granting summary judgment to Defendants, stating that Defendants’ favorable consideration of an Asian man and a white woman did not demonstrate a lack of discrimination against an Asian woman.238 The Ninth Circuit further noted that the district court

seemed to view racism and sexism as separate and distinct elements amenable to almost mathematical treatment, so that evaluating discrimination against an Asian woman became a simple matter of performing two separate tasks: looking for racism “alone” and looking for sexism “alone,” with Asian men and white women as the corresponding model victims. 239

The court found this perception of employment discrimination to be misconceived, since the attempt to bisect an individual’s identity into discrete categories often distorts or ignores the particular nature of their experience. 240 “When a plaintiff is claiming race and sex bias, it is necessary to determine whether the employer discriminates on the basis of that combination of factors, not just whether it discriminates against people of the same race or of the same sex.”241

Currently, some courts have embraced an intersectional approach, 242 while others have dissected a claimant’s claims into discrete protected categories. 243 Because Asian American women are subjected to stereotypes not shared by Asian men or white women, 244 courts must examine employment discrimination claims holistically, taking into account the history of oppression, stereotypes, and prejudices pertaining to Asian American women specifically. 245 Frameworks, like intersectionality, which integrate multiple factors, such as race and gender, should be utilized to “account for the multi-dimensional character of harassment that occurs and is challenged across races, social classes, and borders.”246 Such a holistic approach not only acknowledges the experiences of Asian American women, but also provides justice for litigants.

236. Id.
237. Id. at 1558.
238. Lam, 40 F.3d at 1561.
239. Id.
240. Id. at 1561-62.
241. Id. at 1562.
242. See id.; Jeffries, 615 F.2d at 1025.
244. Lam, 40 F.3d at 1562.
246. Cho, supra note 7, at 209.
VI. PATHWAYS TO REMOVING BARRIERS TO SUCCESS

Asian American women face barriers to success that are similar to those faced by Asian American men, white women, and other women of color, but these barriers are wholly different because of Asian American women’s unique history in the United States and their perceived characteristics. Because Asian American women are subjected to a different set of assumptions and stereotypes, theories such as the glass ceiling and bamboo ceiling are insufficient to describe the barriers they face. To address barriers to success for Asian American women, a holistic approach must be used. Intersectionality is a well-suited theory to provide this holistic approach since it focuses on the experiences of individuals who fit in more than one protected category. Intersectionality will demonstrate that the discrimination faced by Asian American women is not the same as the discrimination faced by women or Asian American men, and thus is deserving of its own analysis. Asian American women are discriminated against because of their race, sex, and national origin, therefore an understanding of their experiences that ignores how these axes of oppression intersect is incomplete and fails to provide the justice Title VII requires. By examining the history, stereotypes, and experiences of Asian American women, intersectionality can acknowledge the specific experiences of Asian American women and create opportunities for their professional advancement.

Expanding the theory of intersectionality to incorporate the experiences of Asian American women may remove some of the barriers to success for Asian American women by increasing their access to the courts. It will allow courts to analyze discrimination cases based on a combination of factors, rather than mutually exclusive factors. Increasing Asian American women’s ability to find justice in employment discrimination cases will not only send a message to employers that discrimination against Asian American women as a discrete category will not be tolerated, but will also lead to a heightened awareness of the ways implicit biases affect employment decisions.

The knowledge gained from intersectional analysis should be provided to businesses so they can structure their employment policies in ways that do not disparately impact Asian American women. Many businesses are devoted to diversity, but are unaware of how stereotyping and implicit bias affect everyday employment decisions to the detriment of Asian American women. An awareness of the stereotypes of Asian American women will help businesses acknowledge their implicit biases, and will make them more attuned to business practices, conduct, and behavior that may prohibit Asian American women from entering the workforce or obtaining high-ranking positions.

247. See generally Perez, supra note 5, at 211-13; Lam, 40 F.3d at 1561-62; Wei, supra note 40, at 771.
248. See Intersectionality, supra note 60, at 3. See generally Crenshaw, Demarginalizing the Intersection of Race and Sex, supra note 5; Crenshaw, Mapping the Margins, supra note 60.
be shared with businesses through trainings on implicit bias\textsuperscript{249} and intersectionality;\textsuperscript{250} by requiring management to explore the Project Implicit website\textsuperscript{251} and take the Implicit Association Test, which demonstrates the divergence between the conscious and unconscious mind;\textsuperscript{252} or by seeking a private consultation to understand how implicit biases against Asian American women occur in the employer’s specific workplace.\textsuperscript{253} An understanding of implicit bias and intersectionality can assist businesses in recruiting a representative class of Asian American women and avoiding future liability.

Also, in studying the barriers to success for Asian American women, the theory of intersectionality can help shed light on harmful stereotypes surrounding Asian American women, and how these stereotypes are perpetuated through the media to reinforce the oppression of Asian American women. When images of Asian American women are available in the media, they tend to portray negative, unrealistic stereotypes. To remove these denigrating stereotypes, and acknowledge the true experiences of Asian American women, we need more positive, realistic images of Asian American women in the media. This involves having more Asian Americans in mass media, playing multi-dimensional, realistic, humanized roles. This increased visibility will change the public perception of Asian American women and hopefully ensure that negative stereotypes do not prevent these women from reaching the upper echelons of management. Increasing the visibility of Asian American women also requires having more Asian American women in executive positions. By increasing the visibility of Asian American women, we can begin to chip away at the stereotypes that prevent Asian American women from moving forward in society.

\textbf{VII. CONCLUSION}

This paper discusses the failure of the bamboo and glass ceiling theories to adequately represent the experiences of Asian American women in the workplace. It argues that intersectionality has great potential to explain and


acknowledge the experiences of Asian American women, and should thus be expanded to examine the unique position of Asian American women who face discrimination on the basis of multiple categories of identity. To accomplish this, intersectionality must look at the history of Asian American women in the United States, the stereotypes that emerged from this dark history and how these stereotypes permeate our current perceptions of Asian American women, and the effects of the model minority myth. Intersectionality must also look at how these stereotypes manifest in the workplace and prevent Asian American women from advancing to the highest ranks of employment. Intersectionality is a persuasive theory that has the ability to help remove barriers to economic, social, financial, and political success, and to create opportunities for Asian American women.

This paper is limited in its scope in that it focuses on the experiences of educated, middle-class Asian American women. Future research should examine the experiences of Asian Americans with varying levels of education and wealth. This paper is also limited in that it focuses on the external societal forces, rather than the internal cultural forces, that create barriers to success. In the future, research should examine how cultural forces interact with societal forces to produce barriers to success for Asian American women. This research will require examining the cultural forces unique to each discrete Asian American community.

This paper provides an introduction to and overview of the individual factors contributing to the barriers to success for Asian American women. It is clear that there is much more research that needs to be done to better understand the experiences of Asian American women. This research will not only chip away at the ceiling that prevents Asian American women from achieving success, but will also create opportunities for Asian American women to rise above and beyond this ceiling.
A New Vision

for advancing our movement

for reproductive health, reproductive rights and reproductive justice.

“Reproductive Justice is important because it tells us the truth about our bodies, our lives, our families, our world.”
We believe reproductive justice is the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives.

For reproductive justice to become a reality, we must undergo a radical transformation; change must be made on the individual, community, institutional, and societal levels to end all forms of oppression so that women and girls are able to thrive, to gain self-determination, to exercise control over our bodies, and to have a full range of reproductive choices. The control and exploitation of women and girls through our bodies, sexuality, and reproduction is a strategic pathway to regulating entire populations that is implemented by families, communities, institutions, and society. Thus, the regulation of reproduction and exploitation of women’s bodies and labor is both a tool and a result of systems of oppression based on race, class, gender, sexuality, ability, age and immigration status. This is reproductive oppression as we use the term.

In this paper, we discuss the three main frameworks for addressing reproductive oppression, the historical context for the development of these frameworks, and the creation of a women-of-color-led reproductive justice movement. We outline our vision, the Reproductive Justice Agenda, as well as our actions to translate this vision, so that we may continue moving forward to gain reproductive justice.

Reproductive Health, Reproductive Rights, Reproductive Justice

Because reproductive oppression affects women’s lives in multiple ways, a multi-dimensional approach is needed to fight this exploitation and advance the well-being of women and girls. There are three main frameworks for fighting reproductive oppression: [1] Reproductive Health, [2] Reproductive Rights, and [3] Reproductive Justice. Although the frameworks are distinct, together they provide a complementary and comprehensive solution. The Reproductive Health framework emphasizes the very necessary reproductive health services that women need. The Reproductive Rights framework is based on universal legal protections for women, and sees these protections as rights. Issues that were historically seen as private issues in the lives of women and girls have been made public and mainstream. And the Reproductive Justice framework stipulates that reproductive oppression is a result of the intersections of multiple oppressions and is inherently connected to the struggle for social justice and human rights. This paper focuses on the Reproductive Justice framework but will touch upon the Reproductive Health and Reproductive Rights frameworks to provide context.

The terms reproductive health, reproductive rights and reproductive justice are used interchangeably though they are rooted in different analyses, strategies, and constituencies, as we show below. Our intention is to articulate and clarify the main differences so we can ensure that our strategies are aligned with our problem definition and analysis, gain more precision about where our change efforts are situated, and work together more innovatively and synergistically at the nexus points. Consequently, all three frameworks are imperative; by itself, a single one cannot achieve the goal of ending reproductive oppression. Ultimately, as in any movement, all three components of service, advocacy and organizing are crucial to advancing the movement.
The Reproductive Health framework is a service delivery model for addressing the reproductive health needs of women. The central theme of this framework is that health disparities and inequalities can be ameliorated by the creation and development of comprehensive health care clinics and agencies that will ensure women have access to a full range of reproductive health services and are empowered to understand their health care needs. The focus is on providing services for historically marginalized communities through the creation of reproductive health clinics that provide low or no-cost care as well as culturally competent services. The problem in under-served communities is a lack of access not only to reproductive health services, but also to all health care. For many women, reproductive health care is their first and perhaps only encounter with the health care system.

Analysis of the Problem
The lack of access to reproductive health services for women, and health care in general, is seen as a lack of information, a lack of accurate health data, or a lack of available services.

Strategy
Based on this analysis, strategies for change tend to focus on improving and expanding services, research, and access, particularly prevention and cultural competency in communities of color. Work in Reproductive Health often consists of providing health services and public health education with an emphasis on reproductive tract infection (RTI) and sexually transmitted disease (STD) prevention. It also includes comprehensive sex education, access to effective contraception, abortion services and counseling, family planning, HIV/AIDS prevention and treatment, and cancer prevention and treatment.

Constituents
Patients in need of services and/or education.

Key Players Are Providers
Those who work as, or are allied with, medical professionals, community and public health educators, health researchers, and health service providers.

Challenges and Limitations
As services and education are offered on an individual level, the root causes of health disparities are not addressed. In addition, the focus on individual women can be resource-intensive without leading to long-term change. Finally, this model is limited by inherent access issues because different women have different levels of access to these services and education.

Reproduction encompasses both the biological and social processes related to conception, birth, nurturing and raising of children as participants in society.

Social reproduction is the reproduction of society, which includes the reproduction of roles such as race, class, gender roles, etc.
Historical Context

The fight for women’s liberation has been inextricably linked to control over reproduction, nevertheless birth control has also been used as a tool of women’s oppression. For example, in the early 20th century, the eugenics movement began to promote policies that restricted reproduction of society’s most marginalized communities, and adopted access to birth control to achieve population control. Thus birth control was used to exert further control over individuals and communities who were already facing multiple oppressions. As movements for women’s rights have evolved, the dialogue concerning reproduction control has also changed dramatically over time, resulting in the creation of the Reproductive Health, Reproductive Rights, and Reproductive Justice frameworks.

Though highly problematic from an anti-racist and anti-imperialist perspective, population control discourse was politically successful in increasing the visibility and acceptance of birth control in the first half of the 20th century. At the same time, African American women who made connections between race, class, and gender joined the fight for birth control in the 1920s as much from Black women’s experience as enslaved breeders for the accumulation of wealth of White slave-owners as for realization of gender empowerment. In the 1960s, the federal government began funding family planning both in the United States and internationally as part of a strategy for population control, rather than women’s empowerment. Population control has been defined as externally imposed efforts by governments, corporations or private agencies to control (by increasing or limiting) population growth, usually by controlling women’s reproduction and fertility. Other forms of population control include immigration restrictions, selective population movement or dispersal, incarceration, and various forms of discrimination.

As an outgrowth of the civil rights and women’s liberation movements, the women’s health movement of the 1970s established women-centered health clinics throughout the country to provide access to family planning and reproductive health services. There was a strong focus on abortion rights, culminating with the landmark 1973 decision in Roe v. Wade that legalized abortion nationwide. The Roe v. Wade decision struck down state laws that had previously outlawed abortion, making the procedure more accessible and safe, and set a precedent for numerous other subsequent cases. Explaining the link between social and economic participation and reproduction, the Supreme Court noted in 1992 that “the ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives (Planned Parenthood of Southeastern Pennsylvania v. Casey, 1992).”

The Reproductive Rights framework came to champion women’s entitlement to a full range of rights related to reproduction, reproductive freedom, and reproductive health. However, by the 1990s, there was wide recognition by women’s advocates that an approach combining resistance to population control and advocacy for abortion rights was too narrow to achieve the larger goal of women’s empowerment.

Oppression and Reproduction

Both the Reproductive Health and Reproductive Rights frameworks largely focus on individual rights and solutions, rather than structural societal changes. Many of the most oppressed women at the margins of the movements for reproductive autonomy have championed the need for greater analysis of oppression in discussions of reproduction. The existing discourse and focus of the reproductive health and rights agenda rarely includes an analysis of the effect of intersecting forms of oppression. When racial analysis has been inserted into mainstream discourse, it has often used a Black and White framework, without integrating the racial oppression experienced by Asian and Pacific Islander (API), Latina, Indigenous, or Arab American and Middle Eastern women. The focus on and orientation towards individual rights and individual responsibility, as they relate to articulation of reproductive health and women’s choice, reinforce the broader systems of political, economic, and cultural hegemony that privilege and maintain racial stratification in the United States, primarily through White supremacy.

“If I could describe myself in one word, it would be courageous.”

ACRJ YOUTH ACTIVIST

Reproductive oppression is the controlling and exploiting of women and girls through our bodies, sexuality and reproduction (both biological and social) by families, communities, institutions and society.

2 Ross L. “Revisions to the ACRJ Reproductive Justice paper.” E-mail to the author. 3 August 2005.
Examples of reproductive injustice abound in the United States and in the world. The control of Black women’s fertility during slavery as well as via current welfare reform policies is key to racial stigmatization and economic oppression of the Black community. Historical sterilization abuse in Native American communities was a part of a genocidal strategy of decimation. Similarly, women with disabilities have been targeted for coerced sterilization and fertility control, and Puerto Rican women were also sterilized in large numbers. Additionally, contraceptives such as Depo Provera and Norplant, which are potentially dangerous if used over the long term, are systematically pushed on poor and young women of color in the United States with an eye to limiting their reproductive lives. In each case, an imperialist agenda to secure land, resources, and women’s labor has led to control over the bodies of women of color.

Repeatedly, economic, social, and institutional policies have severely affected women’s choice to determine their reproduction. The regulation and control of API women and girls’ bodies, sexuality and reproduction have played a key role in colonization and racial oppression, and in controlling API communities in the U.S. Historically, the nation’s immigrant exclusion laws targeted people from Asia and served as a form of population control. As early as 1870, in an attempt to limit the size of the Asian population in California, the state legislature passed a law that prohibited the immigration of Asian women, and in 1875 the United States Congress passed the Page Law to forbid entry of mostly “Chinese, Japanese and Mongolian” women. Current policies restricting immigration and access to social services also significantly prevent API women from truly being able to make reproductive choices. For example, limited English-speaking API women accessing welfare payments often do not have a complete picture of their rights and status, and are unable to advocate for themselves and navigate the complex system because of the lack of sufficient interpreters. Moreover, though the use of DDT is banned in the continental U.S., over the past 40 years U.S. corporations have dumped vast amounts of agricultural chemicals including DDT in Hawaii, and mounting evidence suggests that these pesticides play a role in breast cancer development. Today, native Hawaiians have one of the highest breast cancer rates in the world. 4

Women of color, including API women, do not face oppression purely due to their gender, but instead experience oppression in many forms. The long history of colonization and Western imperialism have institutionalized racism, xenophobia, heterosexism, and class oppression in this society, so that policies supposedly designed to serve all women often function to perpetuate injustice for women of color. For instance, immigrant or refugee API women with limited English proficiency have little power to negotiate interactions with reproductive health providers.

In addition to race and class discrimination, many API queer women and transgendered people face homophobia that deters them from accessing reproductive care. Reproductive health programs and service providers often focus on women as individuals and may adopt a paternalistic approach that oppresses and regulates women’s reproduction. Although there is, currently, a movement to incorporate cultural competence and language access in health services, these interventions usually do not address power differential in the patient-provider relationship. They do not empower API women to be partners with medical practitioners. Also they usually do not incorporate or respect traditional health practices that API women value such as homeopathic medicine, herbal healing, or acupuncture. Without an intersectional analysis of the impact of multiple forms of oppression, the reproductive health and rights movements’ focus on individual health and choice poses challenges and limitations as a framework to achieve reproductive justice for API women.

As Dorothy Roberts eloquently stated, “Reproduction is not just a matter of individual choice. Reproductive health policy affects the status of entire groups. It reflects which people are valued in our society; who is deemed worthy to bear children and capable of making decisions for themselves. Reproductive decisions are made within a social context, including inequalities of wealth and power.” 5 The focus on individualism neglects the broader societal context in which API women live.

API women’s reproductive options and ability to control their reproductive lives are limited in many ways. For refugee women who have survived war in their home countries, their oppression is often enacted on their bodies. During war, a woman’s body is treated synonymously to the land: as a battleground where women...
and resources are exploited, and as a site where victors establish dominance by reproducing themselves in the population through women’s bodies, as well as reproducing their values, culture, religion, language, and traditions. Secondly, in addition to being more susceptible to HIV/AIDS, RTIs, STDs and other health risks and having limited accessibility to health care, women trafficked from poor countries such as Thailand, Cambodia, and the Philippines are more vulnerable to physical abuse, suffer a range of mental and emotional trauma, lack access to language tools and legal help, and are trapped in a state of powerlessness. These are two of many concrete examples of how reproductive justice is central to API women’s struggle for self-determination.

In focusing on a narrow abortion agenda, or even a broader reproductive health agenda, the Reproductive Health and Reproductive Rights frameworks may neglect critical circumstances that many API women face. API women experiencing poverty, linguistic isolation, domestic violence, human trafficking, and harsh working conditions are focused on survival and do not have the luxury of “choice” because many options are not available to them. In addition, the focus on individualism does not speak to the experiences of API women. Numerous cultures across Asia promote societal, community, and family decision-making that is incompatible with individualistic reproductive rights. API women often have to navigate social taboos and traditions within their own cultures in making reproductive decisions, so that “choice” is not necessarily theirs to make.

**CREATION OF THE WOMEN OF COLOR REPRODUCTIVE JUSTICE MOVEMENT**

In resistance to reproductive oppression, women of color in the United States and internationally have long advocated for a broader reproductive justice analysis that addresses race, class, gender, sexuality, ability, age, and immigration status.

In many countries, the term “sexual health and rights” is used to describe an analogous constellation of reproductive justice issues. Issues of sexual health and rights include: sexual violence against women; comprehensive sex education; marriage rights, including same-sex marriage; and sexual torture during war. Current government policies throughout the world attempt to control sexual relations among people. Sexual health and rights advocates proclaim that humans are sexual by nature and thereby make the connection between sexual rights and human rights. According to the Platform for Action of the World Conference on Women in Beijing, “the human rights of women include their right to have control over and decide freely and responsibly matters related to their sexuality.” Activists call for government to ensure that “public and economic policies, and public services and education, prevent discrimination and abuse in relations to sexuality and promote sexual health and rights.”

Although some historians have tended to erase the contributions of women of color, we have been actively organizing for reproductive justice for countless years. In the past two decades, this race and ethnicity-based organizing has gained visibility and increasing success. The National Black Women’s Health Project was formed in 1984 as the first women-of-color reproductive health organization, building a foundation for women-of-color organizations representing the major ethnic groups. The Mother’s Milk Project on the Akwesasne Reservation in New York was founded in 1985, followed by the National Latina Health Organization in 1986. The Native American Women’s Health Education and Resource Center was launched in 1988, and Asian Pacific Islanders for Choice (forerunner to ACRJ) in 1989. Since then, women of color have organized numerous conferences, established myriad organizations, collaborated with each other, and formed alliances with civil rights and women’s rights organizations.

> “When I think about how others struggled to give us rights and privileges now, it means a lot to me and I’m very thankful.”  

ACRJ Youth Activist

In November 1994, a Black women’s caucus first coined the term “reproductive justice,” naming themselves Women of African Descent for Reproductive Justice at the Illinois Pro-Choice Alliance Conference. According to Loretta Ross, one of the caucus participants, “We were dissatisfied with the pro-choice language, feeling that it did not adequately encompass our twinned goals: To protect the right to have – and to not have – children. Nor did the language of choice accurately portray the many barriers African American women faced when trying to make reproductive decisions. Perhaps because we were just returning from the International Conference on Population and Development in Cairo, Egypt in 1994, we began exploring the use of the human rights framework in our reproductive rights activism in the United States, as many grassroots activists do globally. We sought a way to partner reproductive rights to social justice and came up with the term ‘reproductive justice’.”

A few years later, the SisterSong Women of Color Reproductive Health Collective was formed by 16 women of color organizations in 1997, with a focus on grassroots mobilization and public policy. SisterSong began popularizing the term reproductive justice based on the human rights framework. In April 2004, SisterSong coordinated women-of-color groups to mobilize thousands of women in a “Women of Color for Reproductive Justice” contingent as part of the March for Women’s Lives in Washington, DC. And in October 2004, the groundbreaking book *Undivided Rights* (South End Press) provided a comprehensive history of women-of-color organizing around reproductive health, reproductive rights, and reproductive justice issues, documenting the vital contributions of women of color which hitherto had been largely unreported.
At ACRJ we work towards a vision of the world where Asian women and girls have self-determination, power and resources to make their own decisions. Our vision requires that women, girls and their communities have all they need to thrive, creating the environment for personal, collective, and societal transformation.

To advance our work we use three main strategies: Analysis, Organizing, and Movement Building. Through our Reproductive Justice Analysis work, we host discussion and strategy sessions to deepen and broaden our analysis. We write and disseminate articles to build the base of the movement, and have developed a Reproductive Justice Agenda that informs and directs our work. Our Reproductive Justice Agenda illustrates our vision, solutions, and guiding principles for attacking the root causes of reproductive oppression (see Table 1). In this Agenda we articulate our analysis based on the lived experiences, issues, and research carried out for and by Asian women and girls to develop a model that addresses the nexus of systems of oppression based on gender, race, class, sexuality, ability, age and immigration status.

Secondly, in our Organizing we use popular education and community-based participatory research to develop the leadership of Asian women and girls to plan and lead campaigns to achieve specific and measurable gains at the local and state level. For instance, we worked in collaboration with environmental justice groups to shut down a toxic medical waste incinerator here in Oakland, California, and have been working to pass and enforce state legislation that ensures comprehensive sex education in public high schools. And finally, in our commitment to advancing a Reproductive Justice Movement, we build and strengthen women of color and mainstream alliances for reproductive justice. We believe that organized communities, particularly the most marginalized groups mentioned above, are key agents of change, and focus on improving social conditions and changing power and access to resources on all levels. Table 1 summarizes our approach.

Table 1. ACRJ’s Reproductive Justice Agenda
ACRJ’s Reproductive Justice Agenda (RJA) places reproductive justice at the center of the most critical social and economic justice issues facing our communities, such as ending violence against women, workers rights, environmental justice, queer rights, immigrant rights, and educational justice, which have major implications for Asian women. For example, under conditions of reproductive justice, we will live in homes free from sexual and physical violence; we will live and work without fear of sexual harassment; we will have safe work and home environments protected from corporate exploitation and environmental toxins; we will be free from hatred due to sexual identity; we will be valued for all the forms of work we do; we will earn equitable and livable wages; we will eat healthy and affordable food; and we will have comprehensive health care for ourselves and our families. Moreover, the government and private institutions will support our decisions whether or not to have a child and we will receive the necessary support for our choices. In addition we will receive an education that honors and teaches the contributions of women, people of color, working class communities, and queer and transgendered communities.

As illustrated in the RJA, women’s bodies, reproduction and sexuality are often used as the excuse and the target for unequal treatment in the attempt to control our communities. We believe that by challenging patriarchal social relations and addressing the intersection of racism, sexism, xenophobia, homophobia, and class oppression within a women-of-color context, we will be able to build the collective social, economic, and political power of all women and girls to make decisions that protect and contribute to our reproductive health and overall well-being. From this vision, we have developed key strategies and projects that enable ACRJ to have an impact on the grassroots, community, statewide, and national levels. From the perspective of a Reproductive Justice framework, the key problem is a lack of power, resources and control. At ACRJ we organize to gain power, resources, and self-determination in overcoming the multiple oppressions of race, class, gender, sexuality, ability, age and immigration status.

### Translating Vision into Action: ACRJ’s Impact

Efforts to advance reproductive justice cannot be achieved by vision and analysis alone. In our work with Asian women and girls in California, we have translated our vision for reproductive justice into specific gains at the local and state levels, which include the following:

**Developing New Leaders** In line with our vision, we believe those who are directly impacted by reproductive oppression must be at the forefront of leading and making change. Since 1998, ACRJ has instituted a youth organizing program involving over 250 low-income, young Asian women across California. These young women receive intensive leadership development, popular education and organizing trainings to become effective leaders and powerful organizers for reproductive justice and social justice. The development of a cadre of underserved girls from immigrant and refugee families, comprehensively trained on essential issues of reproductive health and their connection to poverty, education, and employment represents a real first not only for the local community, but also for this portion of the national Asian population.

**Campaigning and Advancing the Reproductive Justice of Asian Women and Girls** By organizing for specific gains, youth activists have won campaigns protecting the reproductive health of Asian women. For example, the Healthy Communities Campaign, in collaboration with environmental justice groups, increased the visibility of reproductive health issues related to toxic emissions and culminated in victory when one of the most toxic medical waste incinerators in the nation was forced to close in 2002.
Educating Community Leaders  ACRJ youth organizers created the Reproductive Freedom Tour of Oakland and Guidebook to educate researchers, community members, and policy makers on the issues impacting their community. The tour focuses on reproductive and social justice issues such as welfare, educational justice and gentrification.

Addressing the Language Needs of Immigrant and Refugee Asian Communities  ACRJ youth leaders conducted surveys in Mien, Cambodian, Cantonese, and English to assess the impact of welfare reform and the true needs of community members, and discovered the biggest barrier facing immigrant women was the lack of interpreters at the Department of Social Services. This effort culminated in the first-ever Southeast Asian community forum in which ACRJ members educated staff at the Department of Social Services about the need for appropriate interpreters and translation for clients.

Advocating for Comprehensive Sexuality Education in California Public Schools  Over the past few years, ACRJ has partnered with the ACLU of Northern California to pass and enforce SB 71, which simplifies sex education guidelines and ensures that public school sexuality education is comprehensive, accurate and free of bias. ACRJ has been conducting youth and adult trainings across California to ensure that communities are aware of the new law and have the tools to hold schools accountable as needed.

Researching Toxins in Personal Care Products  Asian women and girls are affected by personal care product chemicals in a myriad of ways – through personal use promoted by marketing trends, through occupational exposures that are facilitated by poverty and immigrant status, and through hazardous exposures and the lack of access to health care. In response to the wide body of evidence that shows the health hazards of beauty products, ACRJ has established POLISH, the Participatory Research, Organizing, and Leadership Initiative for Safety and Health. POLISH participants are currently researching the degree to which Asian women and girls and the many Asian women who are nail salon workers are exposed to toxic chemicals through both personal use and professional occupation. The results will fill major gaps in information, and the project will increase Asian girls’ and women’s capacity to identify reproductive justice problems and intervene in their community’s health status.

The ultimate goal of our work is to build self-determination for individuals and communities. For Reproductive Justice to be real, change needs to be made at all levels of society. We believe that translating the vision of our Reproductive Justice Agenda into action will bring about change on the individual, community, institutional, and societal levels in order to transform our world:

1. An individual woman or girl will acquire skills as well as demonstrate leadership and commitment to furthering reproductive justice;
2. A community will change its attitudes and behaviors to support women and girls as community leaders;
3. An institution, such as a church, school/school district, business/workplace, or legislative body, will make changes to stop reproductive oppression and protect reproductive justice for women and girls; and
4. Women and girls will gain complete self-determination and all forms of oppression are ended.

“Reproductive Justice means learning about your body, your talents, your strengths, and empowering yourself.”

ACRJ YOUTH ACTIVIST
Where Do We Go From Here?

We are currently in a time of increasing instability, violence and consolidation of state and corporate power in the United States and around the world. These conditions provide fertile ground for an escalated assault on women’s reproductive justice. The war against Iraq, vacancies on the Supreme Court, cuts to public assistance, the continued erosion of abortion access and reproductive health care, the passage of anti-immigrant and anti-youth legislation, and weakening environmental policies that allow toxins to contaminate our bodies and food supplies exemplify the strength and comprehensiveness of these attacks on the self-determination of women and our communities.

Moreover, mainstream reproductive rights leaders acknowledge that the movement is shrinking. By integrating the reproductive justice needs of our communities at local, state, national and international levels, we will be able to activate and mobilize larger constituencies. If our movement is fresh and relevant, it will flourish rather than diminish.

By organizing our communities, we create spaces for women and girls to be active and full agents of change in their lives. Reproductive Justice empowers women and girls to fully come into their strong, talented selves by creating environments in which they feel loved, safe, powerful, and confident. Reproductive Justice builds community among women and girls and creates opportunities for rich discussion where they can work out the conflicting messages they get about complex issues such as identity, sexuality and power.

We need a movement with a vision of addressing women wholly and comprehensively so that we do not single out pieces of a woman’s body but see their bodies as whole. Similarly, we cannot focus solely on one aspect of a woman’s life, whether at work, at school, at home, or on the streets. We need to understand how reproductive oppression may exist in all arenas of her life, and recognize that she may have to walk through all of these arenas in a single day.

Reproductive Justice aims to invigorate the movement by:

- Addressing the needs and issues of a diverse group of women while acknowledging the layers of oppression that our communities face, particularly those with little access to power and resources;
- Encouraging women and girls to be active agents of change and realize their full potential;
- Creating opportunities for new leaders to emerge within our communities and increase the sustainability of our movement;
- Integrating the needs of grassroots communities into policy and advocacy efforts;
- Infusing the movement with creativity, innovation, and vision;
- Providing opportunities to work at the intersection of many social justice issues while forging cross-sector relationships; and
- Connecting the local to the global by integrating the human rights framework.

Reproductive Justice calls for integrated analysis, holistic vision and comprehensive strategies that push against the structural and societal conditions that control our communities by regulating our bodies, sexuality, and reproduction. This is the time to come together across separate identities, issue areas, and change efforts to achieve the vision where all women, girls and communities will truly transform our world.

“It is time to speak your Truth. Create your community. And do not look outside yourself for the leader. We are the ones we have been waiting for”

Hopi Elder
Help Us Advance Reproductive Justice

Here are several ways you can help build a shared vision of reproductive justice to guide substantive work in our communities and beyond. These suggestions serve simply as starting points to inspire your own activism and as opportunities for advancing our movement.

Reproductive Rights and Parental Consent Laws

Few would disagree that it is better when young people communicate with their parents in deciding whether or not to have an abortion. By mandating parental notification, however, some teenagers may choose to have unsafe and illegal abortions, delay seeking medical care, or travel out of state if they are forced to either face a judge or unsupportive parents, thus greatly increasing their physical and emotional health risks.

What You Can Do

• Organize and educate women, girls, and their families not only about access to abortion for young women, but also its connection to other reproductive justice and social justice issues.
• Strengthen alliances and coalitions with social justice groups who traditionally do not work in reproductive justice but whose constituencies are or will be deeply impacted by the issue. By working with community and in coalition, build a strong base with long-term capacity, leadership and electoral power.
• In partnership with state coalitions such as the Campaign for Teen Safety in California (www.no proposition73.org), advocate for upholding reproductive rights for women of all ages and preserving safety for teenagers.
• Ensure the health care system provides resources, information, and quality care to women and teenagers about their reproductive choices.

Queer & Transgender Rights and Health Care Bias

For queer women and transgendered individuals, accessing health care is often limited by bias and discrimination in the medical community, delayed medical care, and a lack of research on health care needs and risks. Queer women and transgendered people must have the ability to exercise self-determination over their identity and their sexual lives as well as full civil rights, free from discrimination and harassment.

What You Can Do

• Organize efforts to incorporate queer and trans-friendly health care programs into mainstream hospitals and clinics, public agencies and community organizations in order to create a safer and more responsive environment.
• Support enforcement of California’s new law that bans denial of insurance coverage based on transgender status and adds gender and gender identity to existing anti-discrimination provisions in state laws regulating insurance companies and health care plans (AB 1586).
• Advocate for Marriage Equality, the legal recognition of same-sex marriage which affords full federal and state benefits.
• Oppose any federal and state efforts that write discrimination into the constitution.

Educational Justice and Comprehensive Sexuality Education

Medically accurate, age-appropriate, comprehensive sexuality education is essential for the healthy development of young people and their relationships with each other. Research shows that by combining an abstinence message with information about condoms and contraception as well as communication and refusal skills, comprehensive sex education is effective at improving young peoples’ understanding of themselves and their health, and preventing teen pregnancy and STI transmission.

What You Can Do

• Mobilize parents, family members, and community members in your neighborhood to research and develop a “Report Card” that assesses the state of sexuality education in your local school district.
• Hold school boards and school administrators accountable to providing comprehensive sex education in public schools.
• Support state and federal legislation that mandates, enforces, and provides resources for comprehensive sexuality education, such as the federal Responsible Education About Life Act (REAL Act, SB 368) and the Family Life Education Act (HR 768).

Environmental Justice and Personal Care Products

Women and girls are exposed to hazardous chemicals on a consumer level through their personal care products, and on an occupational level through work in the beauty care industry. Lacking FDA regulation, only 11% of over 10,500 ingredients in personal care products have been tested for safety thus far. Some of the toxins in beauty products are endocrine disruptors, which interfere with the normal functioning of hormones, and all are associated with reproductive, developmental and other health problems.

What You Can Do

• Pressure the Food and Drug Administration to regulate personal care products, and the personal care products industry to manufacture products without toxins. For instance, the Campaign for Safe Cosmetics works to mandate the phasing out of chemicals that are known or suspected to cause cancer, genetic mutation or reproductive harm (www.safecosmetics.org). African American Women Evolving’s Healthy Vagina Campaign informs women of the potential risks associated with douching and advocates for stricter regulation of companies that manufacture feminine hygiene products (www.aawonline.org/TheHVCPartlyHurt.pdf).
• Organize and educate women consumers and workers about the health hazards of toxins in personal care products.
• Support enforcement of California’s new law that calls for full disclosure of ingredients known to cause cancer or birth defects and investigation of the health impacts of these chemicals (SB 484).
• Advocate for legislative proposals that will ban these toxic chemicals entirely in cosmetics and other personal care products.

Workers Rights and Undocumented Women Laborers

Undocumented women laborers in the electronics industry, garment industry, and domestic services industry are burdened with low wages, little (if any) access to health care and substandard working conditions. Moreover, these immigrant and refugee workers are vulnerable to abuse and exploitation from employers who would deny them the few rights they might have.

What You Can Do

• Develop efforts to establish workers centers or worker cooperatives in your local community that provide a safe and central place for workers to receive training, support, referrals, and resources.
• Encourage unions to be increasingly supportive of their growing immigrant base and more active in fighting for immigrant and refugee workers rights.

• Join an organization that leads campaigns to protect the rights of undocumented women workers, such as CAAAV Organizing Asian Communities, which organizes across immigrant, working-class, and poor Asian communities (www.caaav.org), Sweatshop Watch, which works to eliminate exploitation and inhumane conditions that characterize sweatshops (www.sweatshopwatch.org), and Asian Immigrant Women Advocates, which empowers low-income, immigrant women workers to make change in their workplaces, communities and broader society (www.aiwa.org).
• Support legislative efforts to advance workers rights for undocumented women laborers.

Ending Violence Against Women and Human Trafficking

The lucrative industry of trafficking women and children for the purposes of manual and/or sexual labor is finally being revealed as the crisis it is. The fight against trafficking, and consequent indentured servitude and prostitution, involves empowering those whose age, gender, poverty, and national origin make them a target for exploitation as well as addressing the structural causes which allow it to flourish.

What You Can Do

• Expose the hidden industry of human trafficking through increased awareness, knowledge, and research.
• Join campaigns that work to fight trafficking, such as GABRIELA Network’s Purple Rose Campaign, which works to create an international movement against the sex trafficking of Filipina women and their children (www.gabnet.org).
• Organize a coalition of service providers, public health workers, trafficked women and girls, and community members to inform, educate and mobilize people in your area.
• Lobby for local, state, and federal regulations and enforcement that prevent women and girls from being trafficked and prosecute traffickers, including implementation of two California laws (AB 22 and SB 180).

Immigrant Rights and Exclusion & Discrimination

Xenophobic laws and attitudes in the United States mean that immigrant activists and communities are continually fighting a reactionary battle. The specter of immigration raids, vigilante groups, detentions, deportations and family separations can prevent women and families from seeking needed social services to ensure that their communities continue to grow and thrive.

What You Can Do

• Support immigrant and refugee leaders to lead national debates and counter xenophobic public attitudes.
• Build the base of immigrants, refugees and allies who organize on the local and national levels to protect and expand the rights of immigrants, regardless of immigration status.
• Sign up for the Immigrant Rights News sponsored by the National Network for Immigrant and Refugee Rights, which works to promote a just immigration and refugee policy and defend and expand the immigrant and refugee rights in the U.S. (www.nnirr.org).
• Fight legislative and ballot proposals that aim to perpetuate discrimination and exclusion against immigrant communities.
• Support comprehensive immigration reform that will reunite families, protect workers, and bring stability to the lives of immigrants and refugees, such as the Save America Comprehensive Immigration Act of 2005 (HR 2092).

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Doing Collectively What We Cannot Do Individually

The SisterSong Women of Color Reproductive Health Collective is made up of local, regional and national grassroots organizations and individuals representing the primary ethnic populations/indigenous nations in the country: Native American/Indigenous, Latina, Black/African American, Asian/Pacific Islander, and Middle Eastern/Arab American. The Collective was formed with the shared recognition that as women of color we have the right and responsibility to represent ourselves and our communities.

SisterSong is committed to educating women of color on Reproductive and Sexual Health and Rights, and working towards the access of health services, information and resources that are culturally and linguistically appropriate through the integration of the disciplines of community organizing, Self-Help and human rights education.

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Women of Color and the Struggle for Reproductive Justice

IF/WHEN/HOW ISSUE BRIEF
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INTRODUCTION

If/When/How recognizes that most law school courses are not applying an intersectional, reproductive justice lens to complex issues. To address this gap, our issue briefs and primers are designed to illustrate how law and policies disparately impact individuals and communities. If/When/How is committed to transforming legal education by providing students, instructors, and practitioners with the tools and support they need to utilize an intersectional approach.

If/When/How, formerly Law Students for Reproductive Justice, trains, networks, and mobilizes law students and legal professionals to work within and beyond the legal system to champion reproductive justice. We work in partnership with local organizations and national movements to ensure all people have the ability to decide if, when, and how to create and sustain a family.

BLACK AMERICAN

Due to continuing institutionalized racism and a history of reproductive oppression, many African-Americans today have limited access to adequate reproductive healthcare, higher rates of reproductive health issues, and are disproportionately impacted by restrictions on family health services. Low-income people are especially likely to lack control over their reproductive choices, and in 2014, 26.2 percent of blacks and 23.6 percent of Hispanics were poor, compared to 10.1 percent of non-Hispanic whites. Gerald R. Ford School of Public Policy National Poverty Center, Poverty in the United States, http://www.npc.umich.edu/poverty/ (last accessed April 3, 2017).

Pregnancy:

• 67% of African-Americans’ pregnancies are unintended, compared to 40% for non-Hispanic white people.

• Rates of ectopic pregnancies – pregnancies in which the fertilized egg implants outside the uterus-- in African-Americans have declined more slowly than the national rate. African Americans have three times the risk of death from ectopic pregnancies over non-Hispanic white people.

• African-Americans also face higher rates of uterine fibroids and hysterectomies.

Maternal Mortality:

• Maternal mortality rates are over three times higher among African-Americans, at 21.5%, compared to non-Hispanic white people at 6.7%, and 9.2% of other races. The rate of infant mortality in the African-American community is more than twice the national rate.

Infant Mortality:

• Preterm delivery and low birth weight are the leading reasons that the U.S. claims one of the worst infant survival rates in the industrialized world, falling behind dozens of other countries.

• Greater education for women is the single biggest factor in reducing the rate of death among children under the age of five.

  o Among white people with a college degree or higher education, infant mortality is about four deaths per 1,000 births.

  o Among African-Americans with the same level of education, infant mortality is about ten per 1,000 births. African-American mothers with a college degree have worse birth outcomes than white mothers without a high school education. This disparity cannot be adequately explained by factors such as genetics, smoking during pregnancy, or receipt of prenatal care.

Chronic Stress:

• Studies have suggested that the reproductive health of African-Americans is negatively impacted by chronic stress and lack of social support. Black women living with stressors associated with segregation, poverty, and racial discrimination face one of the highest maternal mortality rates in the world. Viewing this through the lens of racial justice, remedies to these issues require critical self-examination by healthcare professionals and social institutions, and involve community building, urban renewal, and a greater recognition of racism as a public health issue.

1 If/When/How uses the term “Black American” for purposes of inclusivity; however, the term “African American” is used to be congruent with cited sources.
Sexually Transmitted Infections (“STIs”)
• African-Americans are the racial/ethnic group most affected by HIV in the United States.18
  • The number of HIV diagnoses among African-American women has declined in recent years; however, it is still high compared to women of other races/ethnicities.19
• By the end of 2012, approximately 496,500 African-Americans were living with HIV, representing 41% of all Americans living with the virus.20
• In 2013, 3,742 African-Americans died of HIV/AIDS, comprising 54% of the total deaths attributed to the disease that year.21
• In 2014, 44% of new HIV diagnoses in the U.S. were among African-Americans, who comprise only 12% of the U.S. population.22
  ◦ Of this set, approximately 73% were men and 26% were women.23

Abortion:
• Studies conducted by the Guttmacher Institute show that African-American women account for 30% of all abortions, a percentage four times the rate of abortions among white women.24
• On average, 41 in 1,000 pregnancies among African-American women between the ages of fifteen and nineteen are terminated, compared to ten in 1,000 among white women and twenty in 1,000 among Latinx-Americans.25
• The fact that African-Americans have the highest abortion rate is interconnected with the reality that they disproportionately lack access to sex education, healthcare, and reliable contraceptives and are disproportionately victims of domestic violence and sexual abuse. This results in a higher number of unintended pregnancies.

History of Reproductive Control and Oppression:
African-Americans’ struggle for reproductive justice has focused on challenging coercive government policies that have compelled or punished their childbearing throughout U.S. history. Control of African-Americans’ reproductive choices dates back to 18th and 19th-century efforts to increase the slave population through procreative exploitation of enslaved women and continues today in the form of discriminatory welfare policies, abortion restrictions that target African-Americans, and criminal prosecutions of pregnant and child-rearing women. Here are just a few examples:
• Banks’ Administrator v. Marksberry (1823) affirmed slave masters’ ownership of African-American women, their offspring, and their future descendants.29
• The eugenics movement of the late 19th and early 20th centuries sought to curtail birth rates among people of color, deeming them genetically “inferior” and “unfit.”30
• Throughout the 1960s and ’70s in the U.S. South and West, federally funded welfare state programs underwrote the coercive sterilization of thousands of poor African-American women.31 Under threat of termination of welfare benefits or denial of medical care, many African-American women were forced into consenting to sterilization procedures.32
• In the U.S. North, teaching hospitals also performed unnecessary hysterectomies on poor African-American women as practice for their medical residents.33 African-American women were subjected to invasive medical procedures without their consent.34
• Racially-motivated control of reproduction also manifested in stringent immigration policies, mandatory sterilization, and anti-miscegenation laws prohibiting marriage between white people and people of color.35

So-Called “Race Selection” Abortion Bans:
A recent trend in anti-abortion legislation that targets African-Americans is the criminalization of abortion where the pregnancy is terminated because of the race (or sex) of the fetus.36 In 2011, Arizona became the first state in the country to pass legislation that made it a felony for a doctor to perform an abortion due to the fetus’ sex or race.37
• Seeing an opportunity to disingenuously use race and sex discrimination as a means to outlaw abortion, the Susan B. Anthony and Frederick Douglass Prenatal Nondiscrimination Act (“Prenatal Non-Discrimination Act” or “PRENDA”) was introduced in the House of Representatives in 2011.38 The Act purported to prohibit abortion based on the race or sex of the fetus. The bill failed; however states continue to maintain state PRENDA legislation.40
• Many states also began enacting legislation that purported to criminalize sex or race-selective abortions.41 As of March 2016, seven states (AZ, KS, MN, NC, ND, OK, PA, SD) ban abortions for reason of sex selection at some point in pregnancy.

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2 Latinx is the gender-neutral alternative to Latino and Latina, pronounced “La-TEEN-ex.”
In Illinois, enforcement is permanently enjoined by court order; however there is no policy in effect. In Arizona, there is no policy in effect. North Dakota is the only state that prohibits abortions when the fetus may have a genetic anomaly. Minnesota and Oklahoma require counseling on perinatal hospice services if a pregnant person seeks an abortion due to a deadly fetal abnormality; Arizona requires the same counseling in the same instance, as well as counseling on outcomes for those living with the condition that the fetus is diagnosed with if the abortion is sought for a non-deadly fetal condition. Kansas requires counseling before all abortions.

In 2010, the Radiance Foundation launched a billboard campaign, “Too Many Aborted,” which accused African-American women of committing genocide against their own people by deciding not to carry pregnancies to term. As part of the campaign, 172 billboards went up in Georgia, Arkansas, Wisconsin, Texas, New York, Florida, Illinois and California. These billboards equated abortion with genocide and slavery, targeted and shamed African-American women, degraded the African-American womb, and discredited African-American motherhood. Some billboards used pictures of President Obama with the caption, “Every 21 minutes, our next possible leader is aborted,” co-opting the image of a pro-choice president.

To combat this hateful campaign, reproductive justice advocates from across the country came together to form the Trust Black Women Partnership. Together, they successfully mounted campaigns to remove the harmful, racist billboards and highlight the hypocrisy of anti-abortion activists behind the billboards who are otherwise unconcerned with poverty and lack of access to healthcare, particularly reproductive healthcare, in the African-American community.

Black American Women and the Prison Industrial Complex:
With the beginning of the Black Lives Matter movement in July 2013, many activists argue that the movement fails to acknowledge the policing and brutalization of black women and gender-variant people. Further, there has been concern that pregnant people who are heavily policed may avoid prenatal care in order to avoid being reported or interacting with law enforcement. For more information on reproductive justice and the Prison Industrial Complex, see If/When/How’s Reproductive Justice in the Prison System and Regulation of Pregnancy Issue Briefs.

NATIVE AMERICAN AND ALASKA NATIVE (INDIGENOUS)

The federal government directly regulates and restricts reservation-based Native Americans’ reproductive health choices through Indian Health Services (“IHS”), the sole source of health information and services for many Native Americans living on reservations. Isolation, lack of public transportation to urban centers, and concentrated poverty make it difficult for reservations to recruit doctors and for women to access resources besides what is provided by the limited federal healthcare service budget.

Coercive Sterilization & Contraception:
Native Americans have faced extensive reproductive control and coercion by the federal government:

• During the 1970s, IHS coercively sterilized an estimated 25,000 Native American women without their informed consent. Threats that the women would die or lose welfare benefits if they had more children accompanied “consent” documents offered only in English, rather than in the women’s native languages. The procedures were administered with inadequate waiting periods and on minors without their parent’s consent.

• IHS used Depo-Provera, a contraceptive injection, on many indigenous people with disabilities in the 1980s in Phoenix and Oklahoma City despite the fact that the FDA had not yet approved its use at the time.

Sexual Violence:

• One in three Native American women has been raped or has experienced attempted rape in her lifetime—a rate more than twice the national average.

• Until 2013, IHS did not provide access to emergency contraception except in cases of sexual assault. After years of pressure, the IHS finally agreed to change its practice by making Plan B emergency contraception available over-the-counter, although many argue that IHS is out of compliance with this directive.

• Non-Native men are most often the perpetrators of sexual violence against Native women. Until recently, non-Native people were immune from prosecution in tribal courts, and federal attorneys—often the only lawyers who
can try non-Natives who commit crimes on reservations—often do not prosecute the perpetrators. For these reasons and others, many Native women do not report their assault to authorities.

On May 16th, 2012, the House of Representatives declined a Senate measure that would have extended the power of tribal courts to try non-Natives and instead passed a Republican bill reauthorizing a version of the Violence Against Women Act that excludes Native American women on reservations from protection.

However, in March 2013, Congress passed the Violence Against Women Reauthorization Act of 2013 (“VAWA 2013”), which gave tribes authority to “exercise special domestic violence criminal jurisdiction” (“SDVCJ”) over certain defendants, regardless of their Native or non-Native status, with sentencing of up to nine years. The new law also authorized a voluntary “Pilot Project” to allow certain tribes to begin exercising SDVCJ sooner.

- Covered offenses are determined by tribal law; however, tribes’ criminal jurisdiction over non-Natives is limited to domestic violence, dating violence, and criminal violations of protection orders.
- Crimes committed by a person who lacks sufficient ties to the tribe, such as living or working on a reservation, and child or elder abuse that does not involve the violation of a protection order is not covered under VAWA 2013.

Sex Work:
Indigenous people are overrepresented in sex work. Indigenous activists have argued that racism, colonialism, and capitalism all contribute to a coercive cycle of oppression that keeps indigenous women in sex work that is not their ideal or chosen profession. While trafficking is a colonialist invention in indigenous populations, modern sex work activists have argued that decriminalization and protection for sex workers, some of whom choose the work, is warranted.

Abortion:
- In accordance with the Hyde Amendment’s funding restrictions, IHS cannot provide abortion services to indigenous people except in the case of rape, incest, or life endangerment. However, according to a study on Native American women’s abortion rights, 85% of the IHS Service Units contacted were not in compliance with this policy.
- In Mississippi and South Dakota, states with large Native American populations, IHS does not provide federal financial aid for abortion in cases of rape or incest, services guaranteed under federal policy and required by the Department of Health and Human Services.
- Pregnancy termination poses additional barriers to Native women, such as traveling from a rural area, income level, car access, employment, and resources to get to a large urban area.

Two Spirit Identity:
Although there is no proper way to define two-spirit authentically within the context of Western language, two-spirit is a non-binary gender identity traditionally honored by indigenous communities prior to colonization. Native communities see two-spirit, a modern umbrella term that describes a wide variety of gender non-conformity derived from an Ojibwe phrase, as a movement to return to a tradition that did not historically adhere to the gender binary.

ASIAN-AMERICAN AND PACIFIC ISLANDER

Stereotyped as the “healthy minority,” healthcare providers, lawmakers, and the general public often underestimate and ignore the health concerns of Asian-American and Pacific Islanders (“API”). The research that does focus on APIs tends to group them into one group that fails to take into account the diverse cultural and linguistic differences among thirty separate subgroups. As a result, APIs continue to suffer from significant health disparities that could be prevented or treated with early detection and cultural competency, leading to poorer health outcomes than the general population.

- Sexuality is often treated as taboo in API culture, which can restrict young API women’s understanding of sexual health and access to reproductive health facilities and technologies.

Pregnancy:
- In California, rates of prenatal care during the first or second trimester are significantly lower among Cambodian, Filipino, Indian, Korean, Laotian, Thai, and Vietnamese people as compared to non-Hispanic whites between 1999 and 2001. In 2009, 31.5% of API parents in Pennsylvania did not receive prenatal care in the first trimester, a marked increase from 21.7% in 2005 and almost double the rate of the white population (16.2%). However on a national level, prenatal care rates are on the rise, including APIs at 76.8% in 2010.
• Laotian-Americans have the highest teen birth rate of any racial or ethnic group in California at 18% and are less likely than non-Hispanic white teen parents to receive prenatal care, relying on MediCal at a rate of 90%.94
• APIs are twice as likely to die from pregnancy-related causes than the national average, such as embolism and pregnancy-related hypertension.96

Health Disparities:
• Vietnamese-Americans have the highest cervical cancer rate of any racial group, five times the rate of non-Hispanic white people.96
• More than one in five Asian-American women of child-bearing age does not have health insurance.97

Many APIs, particularly those who work in low-wage sectors such as the restaurant and textile industries, do not receive employer-based health insurance. 49% of South East Asian Americans and 48% of Korean-Americans do not have health insurance through their employers.98

• In 2007, 59% of nail technicians were women of color, a majority of which were APIs, who are disproportionately put at risk for exposure to toxic chemicals linked to cancer, miscarriages, and infertility.99
• In 2013, 37.6% of APIs over the age of forty did not get routine mammograms, and 32% did not get routine Pap smears.100 This is, in part, due to language barriers, which exposes the need for interpretative services and culturally appropriate resources and care.101
• U.S.-born APIs have a higher lifetime rate of suicidal thoughts, at 15.9%, compared to the general U.S. population, at 13.5%.102
• High healthcare costs are the most significant contributor to health inequalities for women of color.103

Abortion:
• Seeking to exploit “son preference” found in some Asian cultures, some U.S. clinics specializing in sex selection abortion have intentionally advertised their services in ethnic media outlets such as Chinese and Indian language newspapers and magazines.105
• PRENDA sought to ban race and sex-selection abortions by imprisoning physicians for up to five years and requiring them to report patients who requested the procedure.106
  o While purporting to target biases that favor male children, which are more prevalent in countries like India and China, in reality, PRENDA would create an environment in the U.S. in which APIs would be singled out to have their reproductive choices and motives scrutinized.107
  o Rather than helping API communities tackle the gender biases that are the root cause of sex-selection abortions, PRENDA would limit access to abortions on the basis of race for APIs, and instill fear in those who are undocumented that their immigration statuses may be reported by hospitals.108 PRENDA would further marginalize a community that already faces greater difficulty than their white counterparts in obtaining adequate reproductive health services.109
  o Hypocritically, the sponsors of PRENDA that framed it as “woman-positive legislation” have a history of supporting the defunding of family planning, allowing providers to refuse abortion care even when a woman’s life is in danger, and failing to support the Children’s Health Insurance Program Reauthorization Act.110

PRENDA was defeated in the House of Representatives on May 30, 2012.111 However, it was reintroduced on April 13, 2016 by Representative Trent Franks (R-AZ) to the Subcommittee on the Constitution and Civil Justice,112 modeled after legislation that is currently enacted in eight states, most recently in Indiana.113 The bill did not move out of committee for a vote, and has not been reintroduced in Congress.114

Sexually Transmitted Infections (STI):
The number of HIV diagnoses amongst Asian-Americans has increased in recent years, primarily due to population growth.115
• In 2011, APIs made up 5% of the American population,116 and accounted for only 2% of HIV infections in the United States.117 Between 2010 and 2014, the population of APIs grew by 11%, and HIV diagnoses in the API population grew by 36%.118
• It is estimated that more than one in five Asian-Americans living with HIV do not know their HIV status.119
LATINX AND HISPANIC

In addition to sharing many of the problems accessing reproductive health care and education with many other groups of women of color, Latinxs' reproductive choices are also limited in a manner that reflects national xenophobia. Undocumented people in particular are targeted by policies driven by anti-immigration sentiments, are excluded from healthcare coverage, and are subject to inspection for their reproductive choices.

Pregnancy:

- Compared to non-Hispanic white people, Latinx have higher rates of:
  - Unintended pregnancy (45.3% compared to 36.6% for non-Hispanic white people).\(^\text{121}\)
  - Teen pregnancy (more than two times higher).\(^\text{122}\)
  - Teen pregnancy is generally viewed as a negative phenomenon-- lower incidences are seen as a success.\(^\text{123}\) However, this viewpoint lacks respect for young people’s reproductive choice to become teen mothers and is often associated with racial portrayals of young women of color as needing to be controlled and shamed for being irresponsible rather than supported and protected from discrimination.\(^\text{124}\)
  - Latinx teen parents are disadvantaged by lack of social support and an educational system that seeks to hide pregnant teens\(^\text{125}\) and devalues their education with a separate, substandard curriculum devoid of honors classes\(^\text{126}\) and focused on teaching parenting skills exclusively.\(^\text{127}\)
  - Due to structural discrimination, Latinx parents have less to gain than their white counterparts by delaying childbirth because many opportunities, such as attending college, are out of reach.\(^\text{128}\) Even if Latinxs wait until their mid-twenties to have children, they will not earn significantly more and are no less likely to be on public assistance.\(^\text{129}\)

- More than 25% of Latinxs do not receive prenatal care during the first trimester\(^\text{130}\) due to a lack of healthcare coverage and a shortage of information and care that is linguistically and culturally appropriate.\(^\text{131}\)

Anti-Immigrant Bias:

In 2017, many Latinxs undocumented immigrants report fear of deportation and general anxiety living under an anti-immigrant presidency.\(^\text{132}\)

- In Los Angeles, increased fear of deportation by law enforcement has reduced crime reporting by Latinxs undocumented residents. Reports of sexual assault have gone down by 25%. Reports of domestic violence have fallen by 10%.\(^\text{133}\)
- Latinxs are often fearful of attending their reproductive care medical appointments, for fear of immigration enforcement officials waiting for them near their clinic locations.\(^\text{134}\)
- Latinxs are increasingly under attack by anti-immigration forces, which stereotype Latina women as reproducing for the sake of creating “anchor babies” –children born on U.S. soil and therefore possessing U.S. citizenship –to act as “anchors” to bring over other family members.\(^\text{135}\)
- Environmental injustices are perpetrated against immigrant communities and communities of color, including unequal enforcement of environmental regulations, discriminatory land use and zoning, and unequal responses to environmental complaints.\(^\text{136}\)
  - Overpopulation is a complex phenomenon happening on a global scale and can be addressed by increasing access to education, economic opportunity, and family planning. Likewise, immigration is driven not just by the policies of individual countries, but also social and economic instability and transnational business practices.\(^\text{137}\)
  - The greatest cause behind pollution is large corporations, not new populations of people, who often live in poverty and consume less resources than those who do not.\(^\text{138}\)

Detention and Deportation:

The Aderholt Amendment was passed in 2014 as a part of the Department of Homeland Security (“DHS”) Appropriations Act.\(^\text{139}\) This act attacks the reproductive rights of women in detention centers facing deportation by restricting federal funding for abortion services while they are detained. Women in detention centers already face notably high levels of sexual assault and limited medical care. For more information regarding reproductive justice in

\(^3\) Latinx is a modern term used to challenge the gender designations “Latino” and “Latina” in Spanish language. See, eg Raquel Reichard, Why We Say Latinx: Trans & Gender Non-Conforming People Explain (Aug. 29, 2015) http://www.latina.com/lifestyle/our-issues/why-we-say-latinx-trans-gender-non-conforming-people-explain
detention and deportation centers, see the National Women’s Law Center fact sheet on Immigrant Women in Detention.  

**Lack of Health Insurance:**
- Latinxs have the highest uninsured rate among U.S. women, magnifying the impact of other inequities faced in their struggle for reproductive justice.  
- Undocumented residents were explicitly excluded from the Patient Protection and Affordable Care Act’s (“ACA”) mandate for health coverage and barred from health insurance exchanges, cost-sharing subsidies, and participation in temporary high-risk pools. Even legal residents are excluded from Medicaid coverage for five years after entering the U.S. For five years after entry, the children of legal immigrants are also excluded from State Children’s Health Insurance Plan (“CHIP”), which is supposed to give children health coverage if their families’ income is too high to qualify for Medicaid, but too low to afford private insurance.  
  - Only New York has elected to extend Medicaid to undocumented pregnant people, and a few states have given CHIP coverage to undocumented children.  
  - In June 2015, Governor Jerry Brown (CA-D) signed a state budget that funds a healthcare plan for an estimated 170,000 undocumented children under the age of nineteen; the plan is expected to begin in 2016. However, while MediCal for undocumented adults was included in original legislation, it was dropped after the state estimated the cost at upwards of $1 billion.  

**Sexually Transmitted Infections (STIs):**
- In 2014, Latinxs made up 17% of the U.S. population but accounted for 23% of the country’s HIV infections.  
- Latinxs have a high incidence of syphilis, at a rate of 8.4 cases per 100,000 live births in 2010, 3.1 times the rate of non-Hispanic white people.  
- According to data from the Center for Disease Control and Prevention in 2009, Latinxs have the highest rate of cervical cancer, almost twice that of non-Hispanic white people.  

**Abortion:**
- While Hispanic women generally have lower abortion rates than white women or black women, studies have shown that below the poverty line, they have slightly higher rates than both black and white women.  
- The 2016 Supreme Court case *Whole Woman’s Health v. Hellerstedt* ruled that Texas cannot place restrictions on the delivery of abortion services that create an undue burden on women seeking abortions. This case was considered a victory for many Hispanic women, who comprise 38% of the Texas population, 2.5 million women of which are of reproductive age. This Supreme Court decision reaffirms a woman’s constitutional right to access abortion legally, and marks the most monumental abortion-rights decision since *Planned Parenthood v. Casey* in 1992.  

**MIDDLE EASTERN AND ARAB AMERICAN**

**Immigration:**
- In 2016, the US accepted refugees from Syria and Iraq. However, the largest number of refugees in 2016 came from the Democratic Republic of the Congo, and the largest number of refugees from 2006-2016 came from Burma.  
- Anti-immigrant sentiment, especially against refugees fleeing the Syrian civil war, are spurred by dangerous stereotypes about Middle Eastern people. These sentiments found a louder voice with the election of Donald Trump for US president in 2016.  
- A “travel ban” for people from six Muslim-majority countries, initially an executive order, was partially upheld by the Supreme Court. Travelers from Libya, Sudan, Somalia, Yemen, Iran, and Syria must have a “bona fide relationship” to someone in the US to enter; refugees are also banned for 120 days.  

**Islamophobia:**
- A significant amount of US anti-Muslim sentiment emerged after the terrorist attacks of September 11, 2001, and is based on painting Islam as an extremist religion that oppresses women. While traditional clothing, such as the burka or the hijab, are used as examples of “oppressive control,” many Muslim women view wearing these items as a choice or as a reflection of their commitment to their religion.  
- Since Trump was elected president in 2016, the number of anti-Muslim hate groups
The number of reported hate crimes against Muslims increased by 67%. Arab Americans:

- The United States census does not count Arabs as an ethnic or racial group, though there has been advocacy to change this process.
- There are an estimated 3.5 million Arab-Americans across the US, with a highly diverse population in both country of origin and religion. There is no dominant view, therefore, of reproductive wellness, abortion rights, or sexuality within the diffuse community.
- However, the two most dominant Arab American religions are Christianity, especially Catholicism, and Islam, in which abortion is not typically allowed.

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1 See e.g., Dorothy Roberts, *Killing the Black Body* (1998).
10 *When the Bough Breaks*, supra note 8.
11 Id.
12 Id.
15 Id. at S2-68.
17 Lu et al. supra note 16. at S2-71.
19 Id.
20 Id.
21 Id.
23 Id.
28 Banke’ Adm’t v. Marksberry, 13 Ky. 275 (1823).
31 Id. at 1134.
33 See e.g., Rebecca Skloot, THE IMMORTAL LIFE OF HENRIETTA LACKS (2010).
39 E.g. ARIZ. REV. STAT. § 13-3603.02 (2011).
41 State Policies in Brief, supra note 36.
42 Id.
43 Id.
44 Id.
45 Id.
52 Andrea Ritchie, Beyond Saying Her Name, THE FEMINIST WIRE (May 20, 2015), http://www.thefeministwire.com/2015/05/beyond-saying-her-name/.
58 Broken promises: Reservations Lack Basic Care, MSNBC (June 14, 2009), http://www.msnbc.msn.com/id/31210909/ns/health-healthcare//broken-promises-reservations-lack-basic-care/#T-IqCeXRmg.
59 Jane Lawrence, The Indian Health Service and the Sterilization of Native American Women, 24.3 AM. INDIAN QUARTERLY 400, 406 http://faculty.utep.edu/LinkClick.aspx?link=lawrence.pdf&tabid=19689&mid=71730.
60 Id.
61 Id. at 407.
64 Id.


3 H.R. 4924 supra note 11.

4 A White Paper on Supporting Healthy Pregnancies, Parenting, and Young Latinas’ Sexual Health, supra note 118 at 6.

5 Id. at 7.

6 Id. at 6.

7 Removing Stigma, supra note 119 at 3.

8 Id.


11 Immigrant Communities In Fear as Trump Ups ICE Raids Targeting Sanctuary Cities, (March 28, 2017) DEMOCRACY NOW!, HTTPS://WWW.DEMOCRACYNOW.ORG/2017/3/28/IMMIGRANT_COMMUNITIES_IN_FEAR_AS_TRUMP.


14 Jessica Arons and Madina Agénor, supra note 2 at 23.


16 Id.


19 A White Paper on Supporting Healthy Pregnancies, Parenting, and Young Latinas’ Sexual Health, supra note 118.


22 If.

Tracy Seipel, Half of California’s undocumented immigrants could qualify for Medi-Cal, supra note 140.


Health Disparities in HIV/AIDS, Viral Hepatitis, STDs, and TB, supra note 142.


Id.

Id.


Id.


Id.


The Page Act of 1875 (Immigration Act)

FORTY-THIRD CONGRESS. SESS. II. CH. 141. 1875.

CHAP. 141.-An act supplementary to the acts in relation to immigration.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That in determining whether the immigration of any subject of China, Japan, or any Oriental country, to the United States, is free and voluntary, as provided by section two thousand one hundred and sixty-two of the Revised Code, title "Immigration," it shall be the duty of the consul-general or consul of the United States residing at the port from which it is proposed to convey such subjects, in any vessels enrolled or licensed in the United States, or any port within the same, before delivering to the masters of any such vessels the permit or certificate provided for in such section, to ascertain whether such immigrant has entered into a contract or agreement for a term of service within the United States, for lewd and immoral purposes; and if there be such contract or agreement, the said consul-general or consul shall not deliver the required permit or certificate.

SEC. 2. That if any citizen of the United States, or other person amenable to the laws of the United States shall take, or cause to be taken or transported, to or from the United States any subject of China, Japan, or any Oriental country, without their free and voluntary consent, for the purpose of holding them to a term of service, such citizen or other person shall be liable to be indicted therefore, and, on conviction of such offense, shall be punished by a fine not exceeding two thousand dollars and be imprisoned not exceeding one year; and all contracts and agreements for a term of service of such persons in the United States, whether made in advance or in pursuance of such illegal importation, and whether such importation shall have been in American or other vessels, are hereby declared void.

SEC. 3. That the importation into the United States of women for the purposes of prostitution is hereby forbidden; and all contracts and agreements in relation thereto, made in advance or in pursuance of such illegal importation and purposes, are hereby declared void; and whoever shall knowingly and willfully import, or cause any importation of, women into the United States for the purposes of prostitution, or shall knowingly or willfully hold, or attempt to hold, any woman to such purposes, in pursuance of such illegal importation and contract or agreement, shall be deemed guilty of a felony, and, on conviction thereof, shall be imprisoned not exceeding five years and pay a fine not exceeding five thousand dollars.

SEC. 4. That if any person shall knowingly and willfully contract, or attempt to contract, in advance or in pursuance of such illegal importation, to supply to another the labor of any coolie or other person brought into the United States in violation of section two thousand one hundred and fifty-eight of the Revised Statutes, or of any other section of the laws prohibiting the cooly-trade or of this act, such person shall be deemed guilty of
a felony, and, upon conviction thereof, in any United States court, shall be fined in a sum not exceeding five hundred dollars and imprisoned for a term not exceeding one year.

SEC. 5. That it shall be unlawful for aliens of the following classes to immigrate into the United States, namely, persons who are undergoing a sentence for conviction in their own country of felonious crimes other than political or growing out of or the result of such political offenses, or whose sentence has been remitted on condition of their emigration, and women "imported for the purposes of prostitution." Every vessel arriving in the United States may be inspected under the direction of the collector of the port at which it arrives, if he shall have reason to believe that any such obnoxious persons are on board; and the officer making such inspection shall certify the result thereof to the master or other person in charge of such vessel, designating in such certificate the person or persons, if any there be, ascertained by him to be of either of the classes whose importation is hereby forbidden. When such inspection is required by the collector as aforesaid, it shall be unlawful without his permission, for any alien to leave any such vessel arriving in the United States from a foreign country until the inspection shall have been had and the result certified as herein provided; and at no time thereafter shall any alien certified to by the inspecting officer as being of either of the classes whose immigration is forbidden by this section, be allowed to land in the United States, except in obedience to a judicial process issued pursuant to law. If any person shall feel aggrieved by the certificate of such inspecting officer stating him or her to be within either of the classes whose immigration is forbidden by this section, and shall apply for release or other remedy to any proper court or judge, then it shall be the duty of the collector at said port of entry to detain said vessel until a hearing and determination of the matter are had, to the end that if the said inspector shall be found to be in accordance with this section and sustained, the obnoxious person or persons shall be returned on board of said vessel, and shall not thereafter be permitted to land, unless the master, owner or consignee of the vessel shall give bond and security, to be approved by the court or judge hearing the cause, in the sum of five hundred dollars for each such person permitted to land, conditioned for the return of such person, within six months from the date thereof, to the country whence his or her emigration shall have taken place, or unless the vessel bringing such obnoxious person or persons shall be forfeited, in which event the proceeds of such forfeiture shall be paid over to the collector of the port of arrival, and applied by him, as far as necessary, to the return of such person or persons to his or her own country within the said period of six months. And for all violations of this act, the vessel, by the acts, omissions, or connivance of the owners, master, or other custodian, or the consignees of which the same are committed, shall be liable to forfeiture, and may be proceeded against as in cases of frauds against the revenue laws, for which forfeiture is prescribed by existing law.

Approved March 3, 1875.
In the Supreme Court of the United States

THOMAS E. DOBBS, M.D., IN HIS OFFICIAL CAPACITY AS STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, ET AL., PETITIONERS,

v.

JACKSON WOMEN’S HEALTH ORGANIZATION, ON BEHALF OF ITSELF AND ITS PATIENTS, ET AL., RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF AMICI NATIONAL ASIAN PACIFIC AMERICAN WOMEN’S FORUM, ASIAN AMERICANS ADVANCING JUSTICE | AAJC, AND ORGANIZATIONS REPRESENTING THE INTERESTS OF ASIAN AMERICAN AND PACIFIC ISLANDER WOMEN IN SUPPORT OF RESPONDENTS

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The National Asian Pacific American Women’s Forum, Asian Americans Advancing Justice | AAJC, and the interested parties listed in the Appendix attached hereto (“Amici”), submit this brief in support of Respondents Jackson Women’s Health Organization, on behalf of itself and its patients, and Sacheen Carr-Ellis, M.D., M.P.H., on behalf of herself and her patients.

INTEREST OF AMICI CURIAE

Amici curiae are community-based, advocacy, and social services organizations that work with and on behalf of the Asian American and Pacific Islander community as well as bar associations that represent the interests of Asian American and Pacific Islander women.

The National Asian Pacific American Women’s Forum (“NAPAWF”) is the only national, multi-issue Asian American and Pacific Islander (“AAPI”) women’s organization in the country. NAPAWF’s mission is to advance social justice and human rights for AAPI women and girls. NAPAWF approaches all of its work through a reproductive justice framework that seeks for all members of the AAPI community to have the economic, social, and political power to make their own decisions regarding their bodies, families,

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1 Pursuant to SUP. CT. R. 37.3(a), Amici certify that the parties have filed blanket consents to amicus briefs in this case. Pursuant to SUP. CT. R. 37.6, Amici certify that no counsel for any party authored this brief in whole or in part, no party or party’s counsel made a monetary contribution to fund its preparation or submission, and no person other than Amici or their counsel made such a monetary contribution.
and communities. Their work includes advocating for the reproductive health care needs of AAPI women and ensuring AAPI women’s access to reproductive health care services, including abortion.

Asian Americans Advancing Justice | AAJC (“Advancing Justice | AAJC”) is a national nonprofit organization that works to advance and protect civil and human rights for Asian Americans and to promote an equitable society for all. Advancing Justice | AAJC is a leading expert on issues of importance to the Asian American community. Advancing Justice | AAJC works to promote justice and bring national and local constituencies together through community outreach, advocacy, and litigation.

SUMMARY OF ARGUMENT

*Amici* submit this brief in support of Respondents on behalf of Asian American and Pacific Islander (“AAPI”) women.²

Access to abortion care is critical to protecting both the emotional well-being and financial independence of AAPI women and families. However, AAPI women face significant language, economic, and immigration-related barriers to obtaining abortions. Further, AAPI women also face undue scrutiny into the reasons for obtaining abortions due to racial and cultural stereotypes and discrimination. These barriers would

² When referring to AAPI women, *Amici* acknowledge that AAPI transgender and non-binary child-bearing individuals rely on abortion care, and such individuals also may be harmed or prejudiced to the same extent as AAPI women.
become even more profound if Mississippi’s pre-viability abortion ban is upheld due to laws that unfairly target pregnant AAPI women for criminal prosecution. Overturning Casey and Roe would allow states across the nation to enforce pre-viability abortion bans, including sex-selective abortion bans that are based on racial stereotypes and harm AAPI women by encouraging racial profiling. Given the grave and disparate effect a pre-viability ban on abortion would have on AAPI women, the judgment of the Fifth Circuit should be affirmed.

ARGUMENT

I. AAPI WOMEN ALREADY FACE SIGNIFICANT BARRIERS TO OBTAINING ABORTIONS.

In 2019, there were an estimated 12.7 million AAPI women—about 11.9 million Asian American women and almost 803,000 Native Hawaiian and Other Pacific Islander (“NHPI”) women—living in the United States. These women represent nearly 3.9

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percent of the U.S. population. Id. In addition to being the fastest-growing racial group in the country, AAPIs also are projected to embody 14 percent of the U.S. population by 2065.\(^5\)

As with many underserved communities of color, access to abortion care is critical to protecting both the emotional and physical well-being and financial independence of AAPI women and families. Yet persons of color seeking abortions throughout the United States confront an increasing number of structural and state-imposed obstacles unique to their communities. These impediments fall hard on AAPI women, who often confront additional language, economic, and immigration obstacles that substantially impede their access to abortions.

A. AAPI Women Face Substantial Language Barriers in Accessing Abortions.

AAPI women face substantial language barriers to accessing quality healthcare in general, and reproductive healthcare in particular. Over one-third of Asian Americans report limited English proficiency (“LEP”).\(^6\) Additionally, 52 percent of Asian

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\(^5\) Id.

American immigrants and approximately 45 percent of foreign-born Pacific Islanders are LEP.\textsuperscript{7} LEP individuals generally are more likely “to encounter problems in obtaining [preventative and medical] health services” and “bear added burdens” for communication with health care providers.\textsuperscript{8} Recent studies also suggest that LEP increases the odds of negative health service use outcomes.\textsuperscript{9}

Language access is even more complicated for AAPIs than other communities because AAPI individuals speak over 100 distinct languages or dialects.\textsuperscript{10} This great language diversity “poses a significant challenge to accommodating [AAPI’s] linguistic needs.”\textsuperscript{11}

The inability to clearly and comfortably communicate in English prevents many AAPI women from both “discuss[ing] medical problems with a physician or nurse and . . . complet[ing] an insurance

\textsuperscript{7} Inside the Numbers: How Immigration Shapes Asian American and Pacific Islander Communities, ASIAN AMERICANS ADVANCING JUSTICE, 14 (June 12, 2019).

\textsuperscript{8} Jang, supra note 6.

\textsuperscript{9} Id. (indicators for negative health service use outcomes include, for example, no usual place for care, no regular check-up, unmet needs for medical care, and communication problems in healthcare settings.

\textsuperscript{10} Id. (also noting for comparison that, while AAPI with LEP speak more than 100 languages or dialects, 99 percent of Hispanics with LEP speak Spanish).

\textsuperscript{11} Id.
application.” Language challenges lead to much lower reproductive health usage by AAPI women than other women. For instance, Asian American women have one of the lowest rates of cervical cancer screening due to language barriers, the cost of pap smears, and lack of insurance.

B. AAPI Women Face Economic Barriers to Obtaining Abortions.

AAPI women also face manifold economic barriers to accessing abortion care. The Asian

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14 Id.

15 Economic factors pose barriers to abortion access for a variety of reasons. The Court in June Medical Services L.L.C. v. Russo identified travel as one such barrier: “[B]oth experts and laypersons testified that the burdens of this increased travel
American “model minority myth” obscures vast economic disparities within the AAPI community and it perpetuates a harmful stereotype that “Asian-Americans are among the most prosperous, well-educated, and successful ethnic groups in America.” The myth belies the reality of vast, varying economic, educational, and employment realities among AAPI individuals, which comprise over fifty ethnic subgroups that speak more than 100 languages and dialects.

In fact, AAPIs collectively have the greatest socio-economic disparities within a racial group in the United States. For example, among Asian Americans, six percent of Filipino Americans live below the poverty line, compared to 26 percent of Hmong Americans. While, among NHPIs, about 49 percent would fall disproportionately on poor women, who are least able to absorb them.” 140 S. Ct. 2103, 2130 (2020).


of Marshallese Americans live below the poverty line, contrasted with five percent of Fijian Americans.\textsuperscript{19} Regarding education outcomes, roughly 73 percent of Taiwanese Americans hold a bachelor’s degree, compared to only 12 percent of Laotian Americans.\textsuperscript{20} Similarly, while almost 18 percent of NHPI adults hold a bachelor’s degree, only three percent of Marshallese Americans do.\textsuperscript{21}

Such disparity is particularly significant in pay equity rates among AAPI women. On average, AAPI women working full-time are paid 85 cents for every dollar paid to their white male counterparts.\textsuperscript{22} Disaggregated data from 2015 and 2019 reveals that many AAPI women experience far greater wage gaps than the general population. AAPI wage gaps are particularly pronounced for Southeast Asian and Pacific Islander women. For example, Burmese women earn only 53 cents for every dollar earned by their white male counterparts, and Vietnamese, Laotian, and Samoan American women earn only 61

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\textsuperscript{20} Asian American Report at 31.

\textsuperscript{21} NHPI Report at 11.

\textsuperscript{22} NAPAWF at 1.
Because of the wage gap, AAPI women typically lose $400,000 over a 40-year career.\textsuperscript{24}

Coupled with the financial challenges AAPI women face, the employment realities of AAPI women further complicate access to abortion care. An estimated 27 percent of working AAPI women are essential workers, and nearly half a million AAPI women work in service industries that offer low wages.\textsuperscript{25} In many of these industries, paid time off is atypical, and therefore, time off means lost wages.\textsuperscript{26} Without paid family and medical leave, AAPI women, like many women, must tend to caregiving and other unpaid healthcare obligations, such as reproductive

\textsuperscript{23} Id. (citation omitted); see also Miriam Yeung, Overcoming the “Model Minority” Myth: AAPI Women Are Not Paid Equally, American Association of University Women (Mar. 15, 2016), https://ww3.aauw.org/article/overcoming-the-model-minority-myth-aapi-women-are-not-paid-equally/ (additionally finding that Native Hawaiian women are paid only 66 cents for every dollar a white man is paid, and for Bhutanese American women, only 38 cents).


\textsuperscript{25} Bleiweis, supra note 4.

\textsuperscript{26} Id. (“In 2019, more than 1.4 million AAPI women in the labor force worked in jobs that had median hourly earnings below $15 an hour.”), See also, Jasmine Tucker, Asian American and Pacific Islander Women Lose $10,000 Annually to the Wage Gap, National Women’s Law Center (March 2021), https://nwlc.org/wp-content/uploads/2020/01/AAPI-EPD-2021-v1.pdf (finding that AAPI women are overrepresented in both the frontline and low-wage workforces).
health care, by decreasing work hours, leading to decreased earnings or lost employment.27 Indeed, the majority of people who decide to end a pregnancy in the United States are patients who already have children and must therefore provide childcare while seeking an abortion.28 But, even more crucially, the inability to take time off work inherently restricts access to health care. Yet, seeking timely care is especially crucial for abortion care.

Considering the substantial number of AAPI women working in service industries, the COVID-19 pandemic dealt a serious blow to AAPI women’s employment. Indeed, AAPI women endured the highest long-term unemployment rate among minority women since the onset of the COVID-19 pandemic.29 Additionally, “Asian women experienced a larger drop in their employment [17 percent] during this time than did both women and men overall, who experienced a 15.2 percent drop and a 12.3 percent

27 Bleiweis, supra note 4.

28 Induced Abortion in the United States, Guttmacher Institute (Sept. 2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-statesnoting that in 2014, 59% of abortions were obtained by patients who had at least one birth); Jemma Jerman, et al., Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States, Perspectives on Sexual and Reproductive Health (June 2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5953191/.

29 Id. (“44 percent of Asian women over the age of 16 who lost their jobs during the pandemic were out of work for at least six months as of December 2020—the highest rate among women of any racial group.”).
drop, respectively.” 30 NHPI women’s employment numbers likewise dropped by over 35,000 (from an estimated total of 302,000 in 2019 to 265,000 in 2020). 31

Ability and cost barriers to seeking and obtaining quality healthcare, including an abortion, are substantial for AAPI women. If states ban abortion, people with financial means may be able to travel across (likely multiple) state lines to obtain an abortion, while those without means would be forced to either attempt to terminate their own pregnancies outside of the formal medical system or to carry their pregnancies to term. Those AAPI women that face the economic disparities described above are less likely to be able to access the resources for travel, childcare, lodging, and related costs necessary for an out-of-state trip. Their economic disparities, combined with language-related and immigration-related challenges (see Section I.C, infra) limit many AAPI women’s ability to access and pay for reproductive healthcare, including abortion care. 32 Reproductive justice is critical to protecting and supporting the financial independence and agency of AAPI women.

30 Id.

31 Id.

32 See, e.g., Carolyn Y. Fang, et al., supra note 13 (finding that Asian American women have one of the lowest rates of cervical cancer screening due to the cost of pap smears, lack of insurance, and limited English proficiency).
C. Immigration Related Challenges Impose Significant Barriers to AAPI Women’s Access to Abortion Care.

Immigration related challenges impose additional burdens on AAPI immigrant women seeking access to abortions. Immigration accounts for the significant growth in the AAPI population; nearly two-thirds of AAPIs are foreign-born compared to 14 percent of all Americans and 17 percent of U.S. adults.\textsuperscript{33} AAPIs also represent the fastest-growing racial or ethnic group in the U.S.\textsuperscript{34} In 2020, 24 million Americans identified as Asian American as opposed to 17.3 million in 2010, representing a 38.6 percent increase.\textsuperscript{35} The NHPI population grew to almost 1.6 million in 2020 compared to over 1.2 million in 2010, representing a 29.5 percent increase during the last decade.\textsuperscript{36} More than 20 million people of Asian descent live in the U.S., and almost all trace their


\textsuperscript{34} \textit{Id.} (noting that over the past twenty years, the single-race, non-Hispanic segment of the U.S. Asian population grew by 81 percent).


\textsuperscript{36} \textit{Id.}
roots to at least 19 countries in East and Southeast Asia and the Indian Subcontinent.37

AAPI immigrant women face systemic barriers to obtaining health coverage and care based on their immigration status. For example, immigrants are ineligible for Medicaid during the first five years of legal residency.38 Moreover, only 16 states and the District of Columbia have enacted laws permitting undocumented immigrants to obtain driver's licenses,39 which can limit immigrant women's ability to travel and access abortion care. These barriers can result in serious consequences for the reproductive healthcare of AAPI women, as illustrated by the fact that “foreign-born . . . women are less likely to receive

37 See Abby Budiman, et al, supra note 33. While disaggregating data about these origin groups is difficult, it is important, as “the 19 largest Asian origin groups in the U.S. differ significantly by income, education and other characteristics. These differences highlight the wide diversity of the nation’s Asian population and provide a counterpoint to the “model minority” myth and the description of the group as monolithic.” Id.


[sexual and reproductive health]-related cancer screenings than their U.S.-born counterparts.”

In addition, many AAPI immigrant women fear that seeking healthcare (and signing up for healthcare benefits including Medicaid) may lead to significant immigration consequences and harsh penalties. Such a fear is understandable considering that certain states afford law enforcement considerable discretion in targeting foreign-born individuals for anti-immigration purposes. The pervasive fear of immigration consequences and distrust of government authorities leads to reluctance in seeking out needed health care services.

The reduction in social service usage following the Trump administration’s expansion of the “public charge” rule bears out this reality. In September 2018, the Trump administration announced regulations redefining a “public charge” as inter alia a non-citizen

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41 See, e.g., S.B. 1070, 49th Leg., 2d Reg. Sess. (Ariz. 2010) (requiring immigration status checks during law enforcement stops or where reasonable suspicion exists that the person is an “alien who is unlawfully present”); S.B. No. 4, 85th Leg., Reg. Sess. (Tex. 2017) (effectively banning sanctuary cities in Texas); H.B. 452 (Ga. 2017) and O.C.G.A. § 1-3-4 (empowers the Georgia Bureau of Investigation to create a system compliant with federal law that would post certain information about undocumented individuals released from federal custody within Georgia on the internet).
who receives one or more specified public benefits for more than an aggregate twelve months in any thirty-six month period. Receipt of public benefits became a heavily weighted negative factor in immigration officials’ assessment of whether an immigrant would become a public charge and should be denied permanent residency. Recent data suggests confusion and fear concerning the public charge rule changes “led to thousands of eligible, low-income children failing to receive safety-net support” during the COVID-19 crisis.


The same pattern exists in the context of reproductive health. Many immigrants do not seek out needed healthcare services, including abortions, due to fear of immigration consequences tied to the public charge rule, among other state and federal laws.\textsuperscript{44} Allowing states to ban pre-viability abortions would likely exacerbate this fear.

D. \textbf{Sex Selective Abortion Bans Unfairly Target and Harm AAPI Women}

Sex-selective or gender-selective abortion is the practice of terminating a pregnancy based upon the predicted sex of the infant.\textsuperscript{45} Over the last decade, a wave of states have enacted legislation targeting sex-selective abortions. These bans often are referred to

\begin{itemize}
\item \textsuperscript{44} Anna North, \textit{Immigrants are skipping reproductive health care because they're afraid of being deported}, VOX (July 22, 2019), https://www.vox.com/2019/7/22/20698285/immigration-ice-raids-cities-pregnancy-abortion-health (representative of Physicians for Reproductive Health attributing some of the decline of undocumented immigrant birthrates to concerns of deportation).
\end{itemize}
as “a wolf in sheep’s clothing,” because they derive in large part from racist stereotypes about AAPI women and have a disparate impact on AAPI women. Such bans are yet another barrier AAPI women face when accessing abortions.

1. Sex-selective abortion bans are rooted in racist and xenophobic stereotypes about AAPI women.

Sex-selective abortion bans (“SSABs”) have historical roots in the stereotype that AAPI women prefer sons to daughters, and therefore, are more likely to abort female fetuses. Yet, in reality, Asian Americans give birth to more girls on average than white Americans.

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Still, proponents of SSABs perpetuate false stereotypes and make misguided arguments that Asian women moving to the United States bring “cultural biases against having girl children” and choose to abort female fetuses. Further, legislators proposing SSABs use racially-charged language that is harmful and offensive. For example, when arguing for South Dakota’s ban, State Representative Don Haggar stated,

There are cultures that look at a sex-selection abortion as being culturally okay. And I will suggest to you that we are embracing individuals from some of those cultures in this country, or in this state. And I think that’s a good thing that we invite them to come, but I think it’s also important that we send a message that this is a state that values life, regardless of its sex.

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parents actually have more daughters than white Americans do”); See also J. Pieklo, Report Debunks Conservative Case for Sex-Selection Abortion Bans, RH REALITY CHECK (June 4, 2014), rhrealitycheck.org/article/2014/06/04/report-debunks-conservative-case-sex-selection-abortion-bans.

49 M. Redden, A New Study Demolishes the Racist Myths Behind Sex-Selective Abortion Bans Surprise! The ‘Pro-Women’ Bans Are Just Another Way to Block Abortion Rights, MOTHER JONES (June 4, 2014), m.motherjones.com/politics/2014/06/study-sex-selective-abortion-bans-racist-asian-americans.

50 Seema Mohapatra, False Framings: The Co-opting of Sex-selection by the Anti-Abortion Movement, JOURNAL OF LAW, MEDICINE & ETHICS 270, 271 (2015),
Likewise, South Dakota State Representative Stace Nelson, speaking in favor of the bill said, “Many of you know I spent 18 years in Asia, and sadly I can tell you that the rest of the world does not value the lives of women as much as I value the lives of my daughters.”\footnote{Sharon H. Chang, \textit{Raising Mixed Race: Multiracial Asian Children in a Post-Racial World} (2015). See also M. Redden, GOP Lawmaker: We Need to Ban Sex-Selective Abortions Because of Asian Immigrants, \textit{Mother Jones} (Feb. 25, 2014), \url{https://www.motherjones.com/politics/2014/02/south-dakota-stace-nelson-ban-sex-based-abortions-because-asian-immigrants/}.} This rhetoric imputes a perceived cultural preference for sons in Asian countries to AAPIs living in the United States today. It is no coincidence that South Dakota is among the states experiencing the fastest growth of the AAPI community in the United States (it is among the top three states with the largest Asian American population and among the top ten states for NHPI populations).\footnote{See Race and Ethnicity in the United States: 2010 Census and 2020 Census, Census.Gov (2021), \url{https://www.census.gov/library/visualizations/interactive/race-and-ethnicity-in-the-united-state-2010-and-2020-census.html}.}

Lawmakers enacting SSABs often claim that “abortions based on son preference are widespread in the United States.”\footnote{See International Human Rights Clinic at the University of Chicago Law School, National Asian Pacific American Women’s Forum, and Advancing New Standards in Reproductive Health,}
false premise, legislators cite to one small, problematic study that interviewed a selective group of 65 South Asian women to purportedly show the prevalence of sex selective abortion bans.\textsuperscript{54} In reality, this study was not a random sample of South Asian women, as these 65 women were interviewed because they sought sex selection technologies in order to have a son.\textsuperscript{55}

Nevertheless, the legislative histories of several SSABs reveal that lawmakers rely on this flawed study to claim that widespread sex selection occurs in the United States.\textsuperscript{56} For example, the legislative history in the Florida House of Representatives misrepresents this study as

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\textsuperscript{54} S. Puri, et al., \textit{There Is Such a Thing as Too Many Daughters, but Not Too Many Sons: a Qualitative Study of Son Preference and Fetal Sex Selection Among Indian Immigrants in the United States}, \textit{Social Science and Medicine} 71, no. 7, 1170-1172 (2011).

\textsuperscript{55} S. Puri, et al., \textit{supra} note 54. International Human Rights Clinic, \textit{supra} note 48.

representative of most South Asian women in the United States.\textsuperscript{57} In reality, most abortions in the United States, approximately 92 percent, take place in the first trimester of pregnancy before fetal sex is usually determined.\textsuperscript{58} The continued use of misleading studies perpetuates the false narrative that SSABs are necessary to control a widespread problem of sex-selective abortions among the AAPI community in the United States—a problem that simply is nonexistent.

Since 2011, at least 11 states\textsuperscript{59} have enacted SSABs to prohibit abortions (including pre-viability abortions) where the provider knows, or suspects, the patient is seeking the abortion because of the fetus’ sex.\textsuperscript{60} SSABs are the second-most proposed abortion ban in the country, and they specifically target AAPI

\begin{itemize}
\item \textsuperscript{57} Id.
\item \textsuperscript{59} Abortion Bans in Cases of Sex or Race Selection or Genetic Anomaly, GUTTMACHER INSTITUTE (Aug. 1, 2021), https://www.guttmacher.org/state-policy/explore/abortion-bans-cases-sex-or-race-selection-or-genetic-anomaly (As of August 1, 2021, Arizona, Arkansas, Kansas, Mississippi, Missouri, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Dakota, and Tennessee have banned abortions for reason of sex selection at some point in pregnancy. Other states, including Illinois, Indiana, and Kentucky, have attempted to enact SSAB legislation, but the laws have been either temporarily or permanently enjoined by court order.).
\item \textsuperscript{60} Id.
\end{itemize}
women.\textsuperscript{61} The bans primarily have been passed in states with fast-growing AAPI populations;\textsuperscript{62} for example, among states that have implemented or sought to implement SSABs, North Dakota, South Dakota, North Carolina, Indiana, and Kentucky also are among the top ten states with the fastest growing Asian American populations. Similarly, North Dakota, Arkansas, Indiana, Oklahoma, South Dakota, and Kentucky are among the top ten states with the fast growing NHPI populations.\textsuperscript{63} SSABs have also been proposed at the federal level by at least seven Congresses during the past decade.\textsuperscript{64}


\textsuperscript{62} Abby Budiman and Neil G. Ruiz, \textit{Asian Americans are the fastest-growing racial or ethnic group in the U.S.}, Pew Research Center (Apr. 9, 2021), https://www.pewresearch.org/fact-tank/2021/04/09/asian-americans-are-the-fastest-growing-racial-or-ethnic-group-in-the-u-s/ (showing that all states that have passed SSABs as of August 1, 2021 experienced a 50 percent to 200 percent+ increase in the population of Asian Americans from 2000-2019).


2. SSABs encourage racial profiling of AAPIs by providers.

By stigmatizing certain reasons to have an abortion, SSABs force health care providers to police and racially profile the motivations of their own patients. They require providers to actively inquire into the reason a pregnant person is seeking abortion care. Pregnant persons choose to end their pregnancies for a multitude of complex reasons. Forcing doctors to deduce one “true” reason or the “real” intent of an individual’s decision to access abortion care encourages racial profiling of AAPI patients. SSABs interfere with the trust between doctors and AAPI patients, which is critical for open and honest doctor-patient relationships.\(^65\)

For example, Missouri bans abortion if it is sought for reasons related to the race or sex of the fetus, and a physician who provides such an abortion is subject to civil penalties.\(^66\) Thus, when a doctor treats a patient seeking abortion care in Missouri, the doctor must, under penalty of law, ask a series of questions probing why the patient wants the abortion, including if it is because of the fetus’ gender.\(^67\)

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\(^{66}\) Mo. Stat. § 188.038.

\(^{67}\) Safia Samee Ali, *Sex-selective abortions: Reproductive rights are being pitted against gender equality*, NBC NEWS (Oct. 27
In Tennessee, the SSAB prohibits doctors from providing abortion care where the provider “knows” their patient is seeking to end their pregnancy “because of” the sex of the fetus. Yet, the law offers no explanation, definition, or guidance regarding the meaning of the terms “knows” or “because of” in this context. The vagueness in some SSAB laws, as in Tennessee, requires providers to employ their own subjective, and likely inconsistent, interpretations of the law.

SSABs thus force a doctor to scrutinize a patient’s intent behind their decision to end a pregnancy. Confronted with threats of severe punishment by some SSABs, a doctor is incentivized to adopt an aggressive reading of the statutes. In doing so, doctors also may take into account the State-sanctioned racist stereotype behind SSABs: that AAPI women are more inclined to engage in sex-selective abortions.


69 Id. § 40-35-111(b)(3) (For example, in Tennessee, any provider who violates the Act faces harsh criminal sanctions, including being charged with a Class C felony punishable by up to 15 years’ imprisonment and/or a fine of up to $10,000.).
abortions. This tendency imposes one more barrier on AAPI women accessing abortion care.

II. **OVERTURNING ROE WOULD EXACERBATE THE MYRIAD BARRIERS AAPI WOMEN ALREADY FACE IN ACCESSING ABORTION.**

If Mississippi’s pre-viability abortion ban is upheld, the outcome would effectively overturn Roe. This disastrous consequence would exacerbate the discrimination AAPI women already face on a daily basis. As set forth above, AAPI women encounter language, economic, immigration, and racially motivated barriers that hinder their access to reproductive and abortion care. Confronted with the risks of carrying unwanted pregnancies to term and inability to access abortion providers, some pregnant persons may seek to end their own pregnancies without medical supervision. Those who are suspected of doing so may find their actions criminalized more generally. Ultimately, if Roe is overturned, the impact would fall hard on AAPI women, particularly in the at least twenty-two states that likely will completely ban legal abortion.

A. **AAPI Women Will More Likely Face Criminal Penalties for Abortion.**

If Roe is overturned, pregnant AAPI women are more likely to become targets of criminal prosecution as a result of racial profiling. For example, in the last decade, two AAPI women in Indiana were prosecuted for murder due to pregnancy losses. Both Bei Bei Shuai and Purvi Patel were prosecuted under a 1979
fetal homicide law that was intended to protect pregnant people from third-party violence.

In December 2010 Ms. Shuai, a pregnant Chinese immigrant, consumed rat poison in an attempt to end her life while suffering from major depressive disorder. In December 2010 Ms. Shuai, a pregnant Chinese immigrant, consumed rat poison in an attempt to end her life while suffering from major depressive disorder.70 Subsequently, she was rushed to a hospital where doctors delivered her baby via caesarian section. Unfortunately, Ms. Shuai’s baby died four days later. Ms. Shuai held her baby for five hours prior to the baby’s death, “begging for her own life to be taken so that her child’s might be spared.”71 Indiana charged Ms. Shuai with murder for the death of her baby and with attempted feticide because she could have miscarried, even though she did not.72 Ms. Shuai served over a year in jail before pleading to lesser charges.73

Ms. Patel, an Indian American woman, is widely reported to be the first woman in the country convicted of charges that she allegedly ended her own


71 Id.


pregnancy.\textsuperscript{74} In July 2013, Ms. Patel went to an Indiana hospital seeking emergency care for uninterrupted vaginal bleeding after she experienced a pregnancy loss.\textsuperscript{75} Ms. Patel informed the hospital that her fetus was born stillborn, and not knowing what else to do, she put the body in a bag and left it in a dumpster. Police officers discovered text messages in which Ms. Patel told a friend she ordered abortion inducing pills from a pharmacy in Hong Kong and took the medication. While there were no abortion-related medications in her system, the police assumed she lost her fetus through a self-managed abortion.\textsuperscript{76}

Beginning with the initial investigation, the police focused on Ms. Patel’s race and the race of her fetus’ father. In the hospital, an officer interrogated Ms. Patel about the father’s race repeatedly asking “[w]as he Indian, too?” As one journalist noted, “[t]he officer’s implication that Patel’s race and the race of the fetus’ father had some effect on the outcome of her pregnancy reflects the anti-Asian rhetoric that is increasingly prevalent in the debate about abortion


\textsuperscript{76} \textit{Id.}
Ms. Patel was sentenced to 20 years in prison under Indiana’s feticide statute. While her sentence, ultimately, was overturned on appeal, the charges offer a startling window into how easily the justice system may racially profile and criminalize the actions of a woman.

As several news outlets noted, “it is no coincidence” that both women prosecuted under Indiana’s feticide law are of Asian descent. Low-income women and women of color, including AAPI women, are more likely to be punished for the outcome of their pregnancies than their white counterparts. Further, when such women are punished, they are


more likely to be charged with felonies. Journalists posited that the use of feticide laws to criminalize Asian Americans was due, in part, to lawmakers’ second-hand stories of alleged infanticide in India and sex-selective abortions in China.

Ms. Shuai’s and Ms. Patel’s stories stand in stark contrast with Alicia Keir, a white Indiana woman who — in a courtroom less than 70 miles from where Ms. Patel was unjustly convicted — was sentenced to one day in prison, but avoided any actual jail time, after pleading guilty to involuntary manslaughter in the death of her newborn daughter.

Ms. Shuai’s and Ms. Patel’s cases highlight some of the myriad ways AAPI women’s reproductive autonomy is restricted and their family planning decisions policed. Prosecutorial overreach in misapplying feticide laws to people suspected of terminating their own pregnancies is just one more effort to limit reproductive autonomy, and these efforts result in disproportionately harsher treatment of women of color, including AAPI women, than white

80 Id.
81 Yeung, supra note 77.
AAPI women who miscarry or experience a stillbirth, even due to non-abortion related causes, may find themselves facing murder charges as a result of racial profiling.

B. If *Roe* Is Overturned, At Least Twenty-Two States Would Move to Ban Abortion, Which Would Harm AAPI Women.

Upholding Mississippi’s pre-viability ban, thus essentially overturning *Roe* and its progeny, would have far-reaching negative consequences for AAPI women. If *Roe* is overturned, access to legal abortion would quickly cease to exist in at least 22 states. Each of these states has existing laws that severely restrict the right to abortion and either would impose an outright ban on abortion or would effectively ban access to legal abortion care. In seven states, the legislatures explicitly have expressed their intent to limit abortion to the greatest possible extent. Nine states enacted abortion bans, prior to *Roe*, which could

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83 Paltrow, *supra* note 79.


86 *Id.* (Arkansas, Kansas, Kentucky, Louisiana, Montana, North Dakota, and Ohio).
be revived in the absence of Roe.\textsuperscript{87} Nine states have enacted unconstitutional post-Roe restrictions, which, while currently blocked by the courts, could be enforced if pre-viability abortion bans are upheld by this Court.\textsuperscript{88} Ten states also have enacted so-called “trigger” laws that are intended to ban abortion if Roe is overturned.\textsuperscript{89}

This erosion of reproductive justice and access to legal abortion would harm millions of AAPI women. As discussed above, Asian Americans, Native Hawaiians, and Pacific Islanders are among the fastest-growing populations nationwide.\textsuperscript{90} Of the at least 22 states that would move to ban legal abortion if Mississippi’s 15 week pre-viability ban is upheld, many have large or significantly growing AAPI populations. In fact, in 2020, approximately 44,931 Asian Americans and 3,235 NHPIs lived in Mississippi, the state directly at issue in this litigation.\textsuperscript{91}

\textsuperscript{87} Id. (Alabama, Arizona, Arkansas, Michigan, Mississippi, New Mexico, Oklahoma, West Virginia, Wisconsin).

\textsuperscript{88} Id. (Alabama, Arkansas, Georgia, Iowa, Kentucky, Louisiana, Mississippi, North Dakota, Utah).

\textsuperscript{89} Id. (Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Montana, North Dakota, South Dakota, Tennessee, Utah).

\textsuperscript{90} See Percentage of Population and Percent Change by Race, supra note 35.

\textsuperscript{91} See Race and Ethnicity in the United States, supra note 52. See also Why the Census Matters For Asian American, Native Hawaiian, and Pacific Islander Communities: Mississippi, Asian
Several of the states seeking to ban legal abortion have experienced the largest growth in AAPI population. In Arkansas and Georgia, the AAPI population grew 138 percent since 2000. In Arizona, it grew 157 percent in that same time period. In addition, since 2000, the AAPI population in Louisiana grew 50 percent, 91 percent in Minnesota, and 154 percent in North Carolina. In Wisconsin, the AAPI population grew 82 percent since 2000. The AAPI population has more than doubled since


2000 in Utah, with a growth rate of 128 percent.\textsuperscript{96} Given the rapid growth of the AAPI population in these states and their concomitant pre-existing abortion barriers, upholding a pre-viability abortion ban would foreclose millions of AAPI women's ability to exercise their constitutional right to abortion care.

Circumstances in Texas since Senate Bill 8 (S.B. 8) went into effect demonstrate the harms that result from bans on pre-viability abortion. S.B. 8 breaks with all underpinnings of our judicial system by deputizing private individuals to control and police abortion access in Texas and by outlawing abortion once embryonic or fetal cardiac activity can be detected,\textsuperscript{97} which can be as early as six weeks,\textsuperscript{98} months before viability.

Texas has the third-highest number of AAPIs in the country.\textsuperscript{99} In the case challenging S.B. 8, Plaintiffs found that at the time their complaint was


\textsuperscript{97} S.B. 8, 87 Leg. (Tx. 2021), https://legiscan.com/TX/text/SB8/id/2395961.

\textsuperscript{98} See Shannon Najmabadi, Gov. Greg Abbott signs into law one of nation’s strictest abortion measures, banning procedure as early as six weeks into a pregnancy, THE TEXAS TRIBUNE (May 19, 2021), https://www.texastribune.org/2021/05/18/texas-heartbeat-bill-abortion-law/.

filed, “approximately 85 to 90% of people who obtain abortions in Texas are at least six weeks into pregnancy.” Immediately after the law went into effect, the number of abortions in Texas plummeted. The drastic erosion of abortion access for all Texans also means drastic erosion of abortion access for AAPIs in Texas.

S.B. 8 is also significant because in some states where the state legislature has proven to be hostile to abortion, lawmakers already have signaled interest in passing their own version of S.B. 8, many of them

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with a high and/or growing AAPI population, mentioned above. This overlap would further create a hostile environment where AAPI women find themselves faced with multiple barriers.

CONCLUSION

For the foregoing reasons, the judgment of the Fifth Circuit should be affirmed.

Respectfully submitted,

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September 20, 2021
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Additional Interested Parties (Amici):

American Citizens for Justice, Inc

Apna Ghar, Inc.

Asian & Pacific Islander American Health Forum (APIAHF)

Asian American Bar Association of New York

Asian American Bar Association of the Greater Bay Area

Asian American Organizing Project

Asian Americans Advancing Justice - Asian Law Caucus

Asian Americans Advancing Justice - Los Angeles

Asian Americans Advancing Justice | Chicago

Asian Pacific American Bar Association of Los Angeles County

Asian Pacific American Bar Association of Pennsylvania

Asian Pacific American Bar Association of Silicon Valley (APABA Silicon Valley)

Asian Pacific American Bar Association of South Florida

Asian Pacific Community in Action
Asian/Pacific Islander Domestic Violence Resource Project

AZ AANHPI for Equity

Empowering Pacific Islander Communities (EPIC)

KAN-WIN

Korean American Lawyers Association of Greater New York

National Council of Asian Pacific Americans

National Queer Asian Pacific Islander Alliance (NQAPIA)

New Mexico Asian Family Center

OPAWL - Building AAPI Feminist Leadership in Ohio

Rising Voices, a project of Tides Advocacy

South Asian Bar Association of North America (SABA-NA)

South Asian Bar Association of San Diego

South Asian Public Health Association (SAPHA)

Thai American Bar Association
The U.S Supreme Court decided *June Medical Services v. Russo* on June 29th, 2020, invalidating a Louisiana abortion restriction that would have shuttered most of the state’s remaining clinics. In doing so it preserved its landmark opinion from four years earlier that struck down an identical Texas law—at least for now.

In the prior Texas case, *Whole Woman’s Health v. Hellerstedt* ("WWH"), a five-justice majority emphatically rejected restrictions that impose burdens on access to abortion that outweigh benefits. Five justices in *June Medical Services* ("JMS") agreed that WWH controlled and rendered the Louisiana law unconstitutional, while one of them, Chief Justice Roberts, disagreed about the application of the legal test that courts should use to evaluate abortion restrictions going forward.

In JMS, Justice Breyer wrote a four-justice plurality opinion striking down the Louisiana law while fully upholding WWH and its strong "undue burden" legal standard which considers a law’s lack of benefits alongside the burdens it imposes on abortion access. Chief Justice Roberts voted to strike down the law under stare decisis, since WWH had rejected an identical Texas statute and he agreed it controlled the result. But he would have adopted an undue burden test that does not balance benefits against burdens and instead considers whether an abortion restriction has a legitimate purpose and is reasonably related to that goal as a threshold requirement, before consideration of the restriction’s burdens. In short:

- *Whole Woman’s Health* requires a court to assess a law’s benefits, if any, along with its burdens; when burdens outweigh benefits the law is unconstitutional.

- In *June Medical Services*, four justices voted to fully uphold WWH and its controlling undue burden legal standard that considers benefits alongside burdens.
Prior to *WWH*, many but not all lower courts had correctly applied *Casey* to examine whether restrictions conferred sufficient benefits as part of their undue burden analysis. States meanwhile enacted an onslaught of laws that they claimed had benefits, but in fact only harmed people seeking abortion, with low-income people, people of color, young people, immigrants, people in rural areas, and others with resource constraints suffering the most. In addition to striking a blow against restrictions that burden access but confer minimal or no benefits, *WWH* reaffirmed that the real-world impacts of abortion restrictions—particularly on marginalized communities—matter in the undue burden analysis.

- Chief Justice Roberts provided a fifth vote agreeing that *WWH* controls, but criticized the plurality’s affirmation of the undue burden standard; he would not balance benefits against burdens.
- All five justices agreed that the law imposed unconstitutional burdens on abortion access in Louisiana.
- Lower courts may wrongly choose to follow Chief Justice Roberts’ concurrence even while it did not overrule *WWH* or its legal standard which remain binding law.

**The Undue Burden Legal Standard—*Casey* to *Whole Woman’s Health***

The undue burden test from *Planned Parenthood v. Casey* (1992) is the legal standard that courts use to determine whether an abortion restriction violates the Constitution. In hearing a challenge to a Pennsylvania statute with multiple provisions, the *Casey* Court adopted the undue burden standard to distinguish permissible restrictions from those that are unconstitutional. It held that the undue burden test renders laws unconstitutional if they lack sufficient benefits or impermissibly impede access to abortion.1

Almost 25 years later in *WWH* (2016), the Court applied *Casey*’s undue burden test to strike down two Texas restrictions including a mandate that doctors who provide abortions obtain admitting privileges at a local hospital. Texas claimed that the restriction advanced its interest in women’s health by making abortion safer, but trial evidence showed that it conferred no health or safety benefits. At the same time, evidence showed that it would cause most of Texas’ clinics to close and devastate access in the state. In striking down the Texas admitting privileges law, the Supreme Court affirmed that “The rule announced in *Casey*... requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer.”2 In other words, under *Casey*, even laws that advance the asserted state interest need to offer benefits sufficient to justify the burdens they place on people seeking abortion. Unless benefits outweigh burdens, the law is unconstitutional.

Under *WWH*’s binding precedent, lower courts across the country struck down abortion restrictions that imposed burdens that outweighed their benefits. While access remains severely restricted in many states, and marginalized people are the most impacted, courts following *WWH* rejected laws ranging from Target Regulation of Abortion Provider (TRAP) restrictions to bans on types of abortion procedures.

**June Medical Services—What it Means for Undue Burden**

*JMS* challenged a Louisiana admitting privileges law that was identical to the Texas law struck down in *WWH*. After a trial demonstrated that the law lacked meaningful health or safety benefits but would close almost all of the clinics and drastically reduce access in the state, a Louisiana federal district court found it unconstitutional in April 2017.3 Louisiana...
The plurality affirmed *WHWH’s* application of the undue burden standard: it reiterated that courts must “weigh the law’s asserted benefits against the burdens” and “consider the burdens a law imposes on abortion access together with the benefits those laws confer.”

The Supreme Court agreed to hear the case in October 2019 (after having stepped in to keep the law blocked in the meantime) and issued a decision on June 29th, 2020. Justice Breyer’s plurality opinion (joined by Justices Ginsburg, Kagan, and Sotomayor) affirmed *WHWH’s* application of the undue burden standard: it reiterated that courts must “weigh the law’s asserted benefits against the burdens” and “consider the burdens a law imposes on abortion access together with the benefits those laws confer.”

Utilizing that test, the plurality found that the Louisiana facts were a “mirror” of those it had already analyzed in *WHWH*. In particular, wait times and travel distances would increase; patients would face overcrowding; and the burdens would fall disproportionately on poor people. At the same time, the facts demonstrated that abortion in Louisiana is very safe and admitting privileges would do nothing to make it safer. The Fifth Circuit had been wrong to overturn the District Court’s factual findings which were supported by “ample” credible lay and expert testimony. The law would make abortion more difficult to access, conferred few or no benefits, and was an unconstitutional undue burden.

**The Concurrence – Rejects a Balancing of Benefits with Burdens**

Chief Justice Roberts, writing only for himself, agreed with the plurality that the Louisiana law was an unconstitutional undue burden. In his view, the Louisiana and Texas laws were identical in all pertinent respects, as were the evidentiary records for the two cases. Stare decisis – the legal principle that tells courts to decide similar cases the same way – compelled him to adhere to *WHWH* as binding precedent and reach the same outcome, even though he still believed *WHWH* was wrongly decided.

In addition to agreeing that stare decisis controlled, Justice Roberts concurred with the plurality on multiple key specifics. Like Justice Breyer, he stressed that courts of appeal must defer to credible district court fact finding. He furthermore agreed that the Louisiana law would increase wait times and travel distances; lead to overcrowding; and impose logistical burdens on patients who struggled to afford them. And he agreed that doctors were unlikely to obtain privileges because abortion was very safe and rarely led to hospital admissions, a common requirement for privileges to be granted.

However, Justice Roberts disagreed with the plurality about how to apply the undue burden test. He wrote that *WHWH* had determined the Texas law imposed unconstitutional burdens; because the Louisiana law’s burdens were equivalent, stare decisis rendered it unconstitutional. Although Justice Roberts noted that benefits are relevant under Casey because there is a “threshold” requirement that restrictions must be “reasonably related” to a “legitimate state purpose,” he rejected any balancing of benefits as part of the undue burden test.
**WWH Remains Controlling Precedent - One is Not Enough**

*WWH* applied *Casey’s* undue burden standard to balance burdens against benefits, affirming the approach of lower courts that had interpreted it correctly, and reining in those that had gone off course. *WWH* made clear that a law is unconstitutional if evidence-based benefits do not outweigh burdens.

Four Justices in the *JMS* plurality voted to strike down the Louisiana law and explicitly affirmed that an abortion restriction’s lack of benefits must be balanced against its burdens. Four others – Justices Alito, Gorsuch, Kavanaugh, and Thomas – would have upheld the law and wrote dissenting opinions, which by definition cannot change precedent. Chief Justice Roberts agreed that *WWH* was controlling precedent, and joined the plurality in striking down the law. But he alone called for a different application of the undue burden standard. Although he would still consider lack of benefits as a threshold inquiry before assessing a law’s burdens, he would not weigh benefits against burdens to determine whether a burden is “undue.”

Chief Justice Roberts’ single vote does not create a common denominator on how to apply undue burden, but instead disagrees with four other justices who explicitly affirmed the balancing from *WWH*. His concurrence cannot change the legal standard. It does no more than express his diverging view of the test, while *WWH* remains controlling precedent, unless or until the Court votes to overturn it.

Still, states seeking to defend abortion restrictions have seized on the Roberts concurrence to claim that a law’s lack of benefits cannot be weighed against its burdens. While some lower courts have properly rejected those arguments, at least one court has relied on the concurrence to sow confusion over what standard applies and cast doubt on decisions that blocked restrictions under *WWH*. This ignores that five justices in *JMS*, including Justice Roberts, agreed that *WWH* has continued stare decisis effect, which neither a single vote, nor a lower court, can change. Only the Supreme Court can overturn its own precedent. *JMS* narrowly preserved the balancing test that powerfully rejects laws that impose burdens that outweigh benefits, at least for now.

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**Endnotes**

6. Id. at 2120.
7. Id. at 2113.
8. Id. at 2132.
9. Id. at 2133 (Roberts, C. J., concurring in the judgment).
10. Id. at 2141.
11. Id. at 2140.
12. Id. at 2138.

Photograph on page one: Rally while the Supreme Court hears oral arguments in *June Medical Services v. Russo*. Credit: Alyssa Schuker.

EXECUTIVE SUMMARY

National Advocates for Pregnant Women’s one-of-a-kind study identifies hundreds of criminal and civil cases involving the arrests, detentions and equivalent deprivations of pregnant women’s physical liberty that occurred between 1973 and 2005, after the decision in Roe v. Wade was issued. In each of the 413 cases, pregnancy was a necessary element and the consequences included: arrests; incarceration; increases in prison or jail sentences; detentions in hospitals, mental institutions and drug treatment programs; and forced medical interventions, including surgery. Data showed that state authorities have used post-Roe measures including feticide laws and anti-abortion laws recognizing separate rights for fertilized, eggs, embryos and fetuses as the basis for depriving pregnant women – whether they were seeking to end a pregnancy or go to term – of their physical liberty. The findings make clear that if so-called “personhood” measures are enacted, not only will more women who have abortions be arrested, such measures would create the legal basis for depriving all pregnant women of their status as full persons under the law.

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OVERVIEW

The new National Advocates for Pregnant Women study published in the peer-reviewed Journal of Health Politics, Policy, and Law, and authored by Lynn M. Paltrow and Jeanne Flavin, reveals a disturbing range of punitive state actions directed at pregnant women. The study found:

- Arrests and incarceration of women because they ended a pregnancy or expressed an intention to end a pregnancy;
- Arrests and incarceration of women who carried their pregnancies to term and gave birth to healthy babies;
- Arrests and detentions of women who suffered unintentional pregnancy losses, both early and late in their pregnancies;
• Arrests and detentions of women who could not guarantee a healthy birth outcome;
• Forced medical interventions such as blood transfusions, vaginal exams, and cesarean surgery on pregnant women;

Pregnancy was a necessary element in all of the cases reviewed in the study. The data revealed that pregnant women were denied a range of fundamental rights normally associated with constitutional personhood, including the right to life, physical liberty, bodily integrity, due process of law, equal protection, and religious liberty, based solely on their pregnancy status. (See summaries at p. 5).

FINDINGS

Analysis of the legal claims used to justify the arrests of pregnant women found that such actions relied on the same arguments underlying so called “personhood” measures – that state actors should be empowered to treat fertilized eggs, embryos, and fetuses as completely and legally separate from the pregnant woman. Specifically, police, prosecutors, and judges in the U.S. have relied directly and indirectly on:

• Feticide statutes that create separate rights for the unborn and which were passed under the guise of protecting pregnant women and the eggs, embryos, and fetuses they carry and sustain from third-party violence;
• State abortion laws that include language similar to so called “personhood” measures;
• Misinterpretation of Roe v. Wade as holding what personhood measures propose – that fetuses may be treated as separate legal persons.

This study is the only comprehensive documentation and examination of cases in which a woman’s pregnancy was a necessary factor leading to attempted and actual deprivations of pregnant women’s liberty in its most concrete sense: physical liberty.

National Advocates for Pregnant Women reports:

• 413 cases in 44 states, the District of Columbia and federal jurisdictions from 1973-2005, a number that is likely a substantial undercount and does not include more than 250 known cases that have occurred since 2005;
• Cases occurred in every region of the country and to women of all races;
• The women subjected to deprivations of physical liberty were overwhelmingly economically disadvantaged;
• African American women were found to be significantly more likely to be arrested, reported to state authorities by hospital staff, and subjected to felony charges;
• Although every pregnancy in this study involved a man, in 77% of the cases, the father or the woman’s male partner was not even mentioned in any case document;
• One in ten cases mentioned violence against women.
The study found in a majority of cases, no adverse pregnancy outcome was reported and that where an adverse outcome was alleged, state authorities were typically not required to provide expert testimony or scientific evidence to prove that the pregnant woman’s actions, inactions, or circumstances would or in fact did cause the alleged harm.

The study documented cases in which fear of arrests and forced interventions deterred women from seeking help for themselves and in some cases for their newborns. These findings are consistent with the medical and public health consensus that punitive measures, and the legal arguments supporting them, will undermine rather than further state interests in child, fetal, and maternal health.

This study found that far from protecting patient privacy and confidentiality, professionals in the health care system were often the people gathering information from pregnant women and new mothers and disclosing it to police, prosecutors, and court officials.

- In 112 cases, the disclosure of information to the police or other state authority that led to the arrest, detention, or forced intervention was made by health care or other “helping” professionals;
- In some states, the majority of cases came from just one or a few hospitals.

This study also found that:

- Medical misinformation and ignorance about science and evidence-based research, particularly regarding drug use and pregnant women, played a major role in fueling the arrests, detentions, and forced interventions of pregnant women;
- In nearly one in five cases, not adhering strictly to medical advice was cited as a factor in justifying the arrest, detention, or forced medical interventions;
- In nearly one in five cases authorities viewed a woman’s history of prenatal care as a consideration in their decision to arrest or otherwise deprive the pregnant woman of her liberty.
- Thirty of the cases involved efforts to force women to undergo medical interventions including forced surgery and/or examinations that could include internal vaginal exams.

**CONCLUSION**

This study provides a basis for building a shared public health and political agenda that includes all pregnant women. The public debate and public policies overwhelmingly focus on the issue of abortion and interference with one kind of right – reproductive rights. However, this study confirms that if passed, personhood measures would: 1) provide the basis for arresting pregnant women who have abortions; and 2) provide state actors with the authority to subject all pregnant women to surveillance, arrest,
incarceration and other deprivations of liberty whether women were seeking to end a pregnancy or not. Furthermore, the study demonstrates that there is no way to add fertilized eggs, embryos, and fetuses to state constitutions or to the United States Constitution without removing all pregnant women from the community of constitutional persons. These measures create a “Jane Crow” system of law, establishing a second class status for all pregnant women and disproportionately punishing African American and low-income women.

RECOMMENDATIONS

Based on its findings, National Advocates for Pregnant Women offers five policy recommendations:

1. “Personhood” measures that treat fertilized eggs, embryos and fetuses as completely separate legal persons will deprive pregnant women of their status as constitutional persons and should be rejected.

2. There should be a moratorium on new feticide laws and anti-abortion measures that recognize separate legal status for eggs, embryos and fetuses. There should be a fair and open inquiry into whether feticide laws passed with the promise of protecting pregnant women and fetuses have actually reduced violence against pregnant women.

3. Health care providers should provide pregnant women the confidentiality, respect, and dignity afforded other patients and, as suggested by the ACOG Committee on Health Care for Underserved Women, challenge the state reporting laws that undermine maternal, fetal and child health (http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Substance_Abuse_Reporting_and_Pregnancy_The_Role_of_the_Obstetrician_Gynecologist).

4. Legislators should adopt policies that promote women’s health and remove barriers to family planning and contraceptive services, abortion services, birthing options, and effective and humane drug treatment. Legislators should also address the stark racial and economic inequalities that exist in the U.S. that are perpetuated by the war on drugs and our system of mass incarceration.

5. Legislative authorities should confirm that upon becoming pregnant, women retain their civil and human rights through all stages of pregnancy, labor, and delivery.
SAMPLE CASE SUMMARIES (1973-2013)

LOCKED-UP IN JAILS AND PRISONS

• A pregnant woman accidentally falls down a flight of stairs and is arrested on charges of attempted feticide;
• A woman who obtained the contraceptive Depo Provera later experiences a miscarriage. She is held in jail for year on murder charges;
• A woman is arrested under the state’s feticide law because she exercised her right to medical decision making and delayed having cesarean surgery – the state claimed this decision caused one of her twins to experience a stillbirth;
• Prosecutors use the fact that a woman had an abortion in the past to show it is likely that the woman had demonstrated a disregard for life and in fact murdered her boyfriend;
• A pregnant woman about to be released from prison is re-incarcerated when the judge learns she is pregnant and HIV positive;
• A pregnant woman who is awaiting sentencing that mandates probation is held in jail to prevent her from having an abortion;
• A pregnant woman who attempts suicide survives, but because she lost the pregnancy she is arrested on charges of murder;
• A woman is convicted of homicide by child abuse after she suffers a stillbirth and tests positive for an illegal drug. All agree she had no intention of losing the pregnancy. She serves 8 years in prison before a court decides she received ineffective assistance of counsel in which her trial attorney failed to call experts who would have testified about “recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor;”
• A woman refuses fetal monitoring and cesarean surgery at which point medical staff call the police. She is charged with attempted homicide of her fetus based on the claim that her use of alcohol during pregnancy could have caused her fetus to be stillborn.

LOCKED-UP IN MENTAL HOSPITALS

• A woman goes to her nearby hospital voluntarily seeking help for her opiate addiction. Despite the fact that her addiction posed no significant risk to the health of the fetus, she is reported to the state, sheriffs take her into custody and she is sent to a locked psychiatric ward away from her husband and son and where she receives no prenatal care;
• A woman is held in a locked psychiatric facility because she did not obtain a recommended follow-up gestational diabetes test. The facility never administers the test;
• A woman about to be released from a mental hospital because she has been determined to be sane is, nevertheless, kept in the institution through a civil child welfare proceeding in which the state argued that she should remain
institutionalized because the state alleged she would not properly care for the fetus still inside of her.

DEPRIVED OF LIBERTY & SUBJECT TO MEDICAL INTERVENTIONS INCLUDING SURGERY

• A woman wishes to avoid unnecessary surgery if she can. She seeks to deliver vaginally but is denied access to any hospital unless she agrees to give up her right to medical decision-making and schedules cesarean surgery. Her attempt to labor and delivery at home is discovered and she is taken into custody by a sheriff while in active labor, transported against her will to the hospital with her legs strapped together, and forced to have the surgery;
• Despite knowing that forced cesarean surgery could kill her, a court orders a pregnant woman to undergo that surgery – and both she and the baby die;
• A hospital obtains a court order forcing a woman to undergo cesarean surgery. Her opposition is so strong that hospital staff ties her down with leather wrist and ankle cuffs while she screams for help.
Medical and Public Health Group Statements
Opposing Prosecution and Punishment of Pregnant Women
Revised June 2021

American Medical Association

“Pregnant women will be likely to avoid seeking prenatal or open medical care for fear that their physician's knowledge of substance abuse or other potentially harmful behavior could result in a jail sentence rather than proper medical treatment.” Report of American Medical Association Board of Trustees, Legal Interventions During Pregnancy: Court-Ordered Medical Treatments and Legal Penalties for Potentially Harmful Behavior by Pregnant Women, JAMA Vol. 264, No. 20 p.2667 (1990).

“Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances. The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision. … Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate. Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.” American Medical Association, Policy Statement H-420.969, Legal Interventions During Pregnancy (last modified 2018).

“Our AMA: (1) opposes the criminalization of self-induced abortion as it increases patients’ medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-induced abortion.” American Medical Association, Policy Statement- H. 5980, Oppose the Criminalization of Self-Induced Abortion (2018).

“Our AMA will oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and advocate for appropriate medical evaluation prior to the removal of a child, which takes into account the desire to preserve the individual’s family structure, the patient’s treatment status, and current impairment status when substance use is suspected.”

“Transplacental drug transfer should not be subject to criminal sanctions or civil liability… In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible … Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation.” American Medical Association, Policy Statement H-420.962, *Perinatal Addiction - Issues in Care and Prevention* (last modified 2019).

“It is the policy of the AMA to reconfirm its position that drug addiction is a disease amenable to treatment rather than a criminal activity; …and there is a pressing need for adequate maternal drug treatment and family supportive child protective services; to oppose legislation which criminalizes maternal drug addiction or requires physicians to function as agents of law enforcement - gathering evidence for prosecution rather than provider of treatment;and to provide concentrated lobbying efforts to encourage legislature funding for maternal drug addiction treatment rather than prosecution, and to encourage state and specialty medical societies to do the same.” American Medical Association, Policy Statement H-420.970, *Treatment Versus Criminalization – Physician Role in Drug Addiction During Pregnancy* (last modified 2020).

**American College of Obstetricians and Gynecologists**

“Confidentiality and trust are at the core of the patient–practitioner relationship. Policies and practices that criminalize individuals during pregnancy and the postpartum period create fear of punishment that compromises this relationship and prevents many pregnant people from seeking vital health services. Criminalization of pregnant people violates the pillars of medical ethics including patient autonomy (bodily autonomy despite the potential life within the pregnant person, the right to refuse care), justice (gendered discrimination), beneficence, and non-maleficence. The American College of Obstetricians and Gynecologists (ACOG) opposes any policies or practices that seek to criminalize individuals for conduct alleged to be harmful to their pregnancy. … Criminalization of pregnant people for actions allegedly aimed at harming their fetus poses serious threats to people’s health and the health system itself. Threatening patients with criminal punishment erodes trust in the medical system, making people less likely to seek help when they need it. Criminalization makes people less safe and harms the confidential patient–practitioner relationship by creating uncertainty as to whether law enforcement will become involved. In the worst circumstances, this leads people to be treated as suspects instead of patients, subject to bedside interrogations and legal scrutiny. Harm reduction strategies should be implemented in order to reduce negative consequences and support agency and autonomy in the decision making of pregnant

“Pregnancy is not an exception to the principle that a decisionally capable patient has the right to refuse treatment, even treatment needed to maintain life. Therefore, a decisionally capable pregnant woman’s decision to refuse recommended medical or surgical interventions should be respected. … The College opposes the use of coerced medical interventions for pregnant women, including the use of the courts to mandate medical interventions for unwilling patients. … The College strongly discourages medical institutions from pursuing court-ordered interventions or taking action against obstetrician–gynecologists who refuse to perform them.” American College of Obstetricians and Gynecologists Committee on Ethics, Committee Opinion 664, Refusal of Medically Recommended Treatment During Pregnancy (2016; reaffirmed 2019).

“The American College of Obstetricians and Gynecologists (ACOG) opposes the prosecution of a pregnant woman for conduct alleged to have harmed her fetus, including the criminalization of self-induced abortion…Obstetrician-gynecologists should protect patient autonomy, confidentiality, and the integrity of the parent-physician relationship with regard to self-induced abortion attempts and should advocate against mandated reporting.” American College of Obstetricians and Gynecologists, Position Statement: Decriminalization of Self-Induced Abortion (2017).

“Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing. These approaches treat addiction as a moral failing. Addiction is a chronic, relapsing biological and behavioral disorder with genetic components. The disease of substance addiction is subject to medical and behavioral management in the same fashion as hypertension and diabetes.”

“The use of the legal system to address perinatal alcohol and substance abuse is inappropriate. Obstetrician–gynecologists should be aware of the reporting requirements related to alcohol and drug abuse within their states. In states that mandate reporting, policy makers, legislators, and physicians should work together to retract punitive legislation and identify and implement evidence-based strategies outside the legal system to address the needs of women with addictions.” American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, Committee Opinion 473, Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist (2011, reaffirmed 2014).

“[I]t is important to advocate for this often-marginalized group of patients, particularly in terms of working to improve availability of treatment and to ensure that pregnant women with opioid use disorder who seek prenatal care are not criminalized.” American College of Obstetricians and Gynecologists Committee on Obstetric Practice, Committee Opinion 711, Opioid Use and Opioid Use Disorder in Pregnancy (2017).
“… Laws should not interfere with the ability of physicians to determine appropriate treatment options and have open, honest, and confidential communications with their patients. Nor should laws interfere with the patient’s right to be counseled by a physician according to the best currently available medical evidence and the physician’s professional medical judgment. ACOG strongly opposes any governmental interference that threatens communication between patients and their physicians or causes a physician to compromise his or her medical judgment about what information or treatment is in the best interest of the patient.” American College of Obstetricians and Gynecologists, Statement of Policy: Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship (2013; reaffirmed 2019).

**National Perinatal Association**

“Treating this personal and public health issue (perinatal substance use) as a criminal issue—or a deficiency in parenting that warrants child welfare intervention-results in pregnant and parenting people avoiding prenatal and obstetric care and putting the health of themselves and their infants at increased risk… The threats of discrimination, incarceration, loss of parental rights, and loss of personal autonomy are powerful deterrents to seeking appropriate prenatal care. Perinatal providers promote better practices when they adopt language, attitudes, and behaviors that reduce stigma and promote honest and open communication about perinatal substance use.” National Perinatal Association, Position Statement, *Perinatal Substance Use* (2017).

“The National Perinatal Association opposes any legal measures that involve the criminal justice system for drug use during pregnancy. Any statute which criminalizes substance use during pregnancy is inherently discriminatory in addition to being counterproductive to the goal of improving maternal and neonatal outcomes. Criminalization and incarceration are ineffective and harmful to the health of the pregnant person and their infant.” National Perinatal Association, Position Statement, *Perinatal Substance Use* (2017).

“As clinicians, mental health, and community care providers, it is imperative that we understand the nature of perinatal substance use disorders and provide interventions and care that preserve the parent-infant dyad, promote parenting potential, and support the baby’s health and development.” National Perinatal Association, Position Statement, *Perinatal Substance Use* (2017).

“The National Perinatal Association opposes legislation that defines personhood as beginning at or after viability…The NPA encourages its members to oppose any legislation defining fetal personhood at conception and encourages its members to support legislators in favor of leaving this discussion to the medical sphere.” National Perinatal Association, Position Statement, *Supporting the Legal Autonomy of Pregnant Women* (2013).
“…The standard of care for treating pregnant women with substance use disorder is often medication-assisted treatment (MAT). Voluntary treatment leads to better pregnancy outcomes and shorter hospital stays for newborns. Pregnant women should not fear telling their health care providers about drug use, so they can best prepare for the treatment that will help both the mother and the newborn.” National Perinatal Association, Position Statement, *Perinatal Health Care Access and Disparities* (2019).

**American Academy of Family Physicians**

“[T]he AAFP supports public and individual education about the risks of any substance use and abuse during pregnancy. The AAFP opposes imprisonment or other criminal sanctions of pregnant woman solely for substance abuse during pregnancy, but encourages facilitated access to an established drug and alcohol rehabilitation program for such women.” American Academy of Family Physicians, Policy, Substance Abuse and Addiction, section entitled “Pregnant Women, Substance Use and Abuse by” (2003, 2019 COD).

**American Society of Addiction Medicine**

“It is inappropriate to reflexively move from the possibility to an alleged certainty of defective parenting or danger to the child simply because of evidence of substance use . . . Sanctions against parents under child protective services interventions should be made only when there is objective evidence of danger, not simply evidence of substance use.” American Society of Addiction Medicine, *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids* (2017).

“State and local governments should avoid any measures defining alcohol or other drug use during pregnancy as ‘child abuse or maltreatment,’ and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health care services for these women.” American Society of Addiction Medicine, *Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids* (2017).

Obstetric care providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, either suspected or confirmed.” American Society of Addiction Medicine, *Public Policy Statement on Opioid Use and Opioid Use Disorder in Pregnancy: A Joint Opinion of the American College of Obstetricians and Gynecologists; Committee on Obstetric Practice and the American Society of Addiction Medicine* (2017).
American Public Health Association

“Any personhood initiative that allows the state or other actors to claim rights of the fetus as independent of pregnant women has the potential to deprive women of access to comprehensive reproductive health care—including abortion services, assisted reproductive technologies, and autonomy in pregnancy and childbirth decisions—as well as their rights to life, liberty, and privacy...[T]his policy urges federal and state legislatures, law enforcement and judiciary bodies, election commissions, and health care providers to renounce any and all personhood claims or misapplications of child welfare laws that recognize fetuses as persons and infringe on women's reproductive, constitutional, and human rights....Extension of rights to a fetus through such personhood bills would affect not only women who seek to terminate a pregnancy but also women who wish to carry a pregnancy to term...[A]ny codified personhood effort would inexorably contribute to negative public health outcomes for women...” American Public Health Association, Policy Statement No. 20139, Renouncing the Adoption or Misapplication of Laws to Recognize Fetuses as Independent of Pregnant Women (2013).

American Nurses Association

“ANA opposes laws that may result in punitive legal actions and result in incarceration of pregnant women because of substance use disorder.” American Nurses Association, Position Statement, Non-punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders (2017).

"ANA supports the fact that substance use disorders are diseases that require treatment, not incarceration." American Nurses Association, Position Statement, Non-punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders (2017).

"Criminalization of pregnant women with substance use disorder often results in more harm than good. The threat of criminal prosecution prevents many pregnant women from seeking prenatal care and treatment for their substance problems (Schempf & Strobino, 2009). Prisons are not prepared to provide for the specialized needs of pregnant women (Cardaci, 2013; Skerker, Dickey, Schonberg, Macdonald, & Venters, 2015)." American Nurses Association, Position Statement, Non-punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders (2017).

"Contrary to claims that prosecution and incarceration will deter pregnant women from substance use, the greater result is that fear of detection and punishment poses a significant barrier to treatment (Stone, 2015)." American Nurses Association, Position Statement, Non-punitive Treatment for Pregnant and Breast-feeding Women with Substance Use Disorders (2017).
Association of Women’s Health, Obstetric and Neonatal Nurses

“The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) opposes laws and other reporting requirements that result in incarceration or other punitive legal actions against women because of a substance abuse disorder in pregnancy. AWHONN does not support laws that single out pregnant women or that create penalties for them that differ from other individuals with substance use disorders. The threat of incarceration has been shown to be an ineffective strategy for reducing the incidence of substance abuse, while medication and behavioral therapies serve as important elements of an over-all therapeutic process.” Association of Women’s Health, Obstetric and Neonatal Nurses, *Criminalization of Pregnant Women with Substance Use Disorders* (2015).

“The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) believes that any woman’s reproductive health care decisions are best made by the informed woman in consultation with her health care provider. AWHONN believes these personal and private decisions are best made within a health care system whose providers respect the woman’s right to make her own decisions according to her personal values and preferences and to do so confidentially.” Association of Women’s Health, Obstetric and Neonatal Nurses Position Statement, *Health Care Decision Making for Reproductive Care* (2016).

“Laws that criminalize drug use during pregnancy have the potential to deter women from seeking prenatal and maternity care that can provide access to appropriate counseling, referral, and monitoring. Seeking health care for marijuana use during pregnancy should not expose a woman to legal or civil penalties such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing (Association of Women’s Health, Obstetric and Neonatal Nurses, 2015).” Association of Women’s Health, Obstetric and Neonatal Nurses Position Statement, *Marijuana Use During Pregnancy* (2018).

“The Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) opposes laws and other reporting requirements that result in incarceration or other punitive legal actions against women because of a substance use disorder (SUD) in pregnancy and the postpartum period.” Association of Women’s Health, Obstetric and Neonatal Nurses Position Statement, *Optimizing Outcomes for Women’s Health, Obstetric and Neonatal Nurses* (2019).

**American College of Nurse Midwives**

“ACNM supports a health care system in which individuals with SUD in pregnancy are treated with compassion, not punishment. Patients should not be deterred from seeking care during pregnancy due to fear of prosecution. Optimal care for patients with addiction occurs within a multidisciplinary environment in which holistic care is provided that considers the context of social environment and...
unique health risks. In the health policy and legislative arena, efforts should be directed toward comprehensive approaches to promoting addiction recovery.” American College of Nurse-Midwives Position Statement, *Substance Use Disorders in Pregnancy* (updated 2018).

“‘It is the position of the American College of Nurse-Midwives (ACNM) that: Physiologic vaginal birth is the optimal mode of birth for most women and babies. Cesarean birth is valued as a surgical procedure when there are maternal, fetal, or obstetric indications . . . Women have the right to accurate, balanced and complete information regarding the risks, benefits and potential harms of both vaginal and cesarean birth.’” American College of Nurse Midwives Position Statement, *Elective Primary Cesarean Birth* (updated 2016).

“‘It is the position of the American College of Nurse-Midwives (ACNM) that: Women who have experienced cesarean births have the right to safe and accessible options for subsequent births. Women should receive evidence-based information to guide their decision making when they consider labor after cesarean versus elective repeat cesarean.’” American College of Nurse Midwives Position Statement, *Vaginal Birth After Cesarean Delivery* (Revised and reapproved 2017).

**American Academy of Pediatrics**

“The American Academy of Pediatrics (AAP) first published recommendations on substance-exposed infants in 1990 and reaffirmed its position in 1995 that ‘punitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health’ and argued that ‘the public must be assured of nonpunitive access to comprehensive care that meets the needs of the substance-abusing pregnant woman and her infant.’ . . . The AAP reaffirms its position that punitive measures taken toward pregnant women are not in the best interest of the health of the mother-infant dyad . . . The existing literature supports the position that punitive approaches to substance use in pregnancy are ineffective and may have detrimental effects on both maternal and child health . . . [T]he AAP supports an approach toward substance use in pregnancy that focuses on a public health approach of primary prevention, improving access to treatment, and promoting the provider-patient relationship rather than punitive measures through the criminal justice system.”” American Academy of Pediatrics, Committee on Substance Use and Prevention, Policy Statement, *A Public Health Response to Opioid Use in Pregnancy* (2017).

**March of Dimes**

“The March of Dimes opposes policies and programs that impose punitive measures on pregnant women who use or abuse drugs . . . The March of Dimes believes that targeting women who used or abused drugs during pregnancy for criminal prosecution or forced treatment is inappropriate and
will drive women away from treatment vital both for them and the child.” March of Dimes, Fact Sheet, Policies and Programs to Address Drug-Exposed Newborns (2014).

**American Psychological Association**

“Punitive approaches result in women being significantly less likely to seek substance use treatment and prenatal care due to fear of prosecution and fear of the removal of children from their custody (Faherty et al., 2019). This places both the mother and her children at greater risk of harm…Legislatures should decriminalize substance use during pregnancy and support more funding and programs that offer specialized substance use treatment to pregnant women and girls.” American Psychological Association, Pregnant and Postpartum Adolescent Girls and Women with Substance-Related Disorders (updated 2020).

“…[T]he American Psychological Association [a]ffirms its view that alcohol and drug abuse by pregnant women is a public health problem and that laws, regulations and policies that treat chemical dependency primarily as a criminal justice matter requiring punitive sanctions are inappropriate…[The APA a]ffirms the use of health care strategies to foster the welfare of chemically dependent women and their children by expanding access to prenatal care and to reproductive health care generally. . .” American Psychological Association, Policy, Resolution on Substance Abuse by Pregnant Women (1991).

**American Psychiatric Association**

“The use of the legal system to address perinatal alcohol, tobacco, and other substance use disorders is inappropriate. APA opposes civil charges and criminal prosecution of pregnant and postpartum women based on substance use during pregnancy. Substance use during pregnancy should not be considered child abuse or neglect leading to civil charges. Legislation that mandates reporting of substance use by pregnant or newly delivered women by healthcare providers must be repealed.” American Psychiatric Association, Position Statement, Assuring the Appropriate Care of Pregnant and Newly-Delivered Women with Substance Use Disorders (2019).

“Several state governments have prosecuted and incarcerated women for using substances during their pregnancy under the grounds of “prenatal child abuse.” This legal approach has no proven benefits for maternal or infant health. Furthermore, it likely confers additional harms to both women and their infants by interfering with their willingness to seek obstetric care and substance use treatment, increasing the rate of maternal-child separation, and broadly increasing stigma related to this issue. A public health response, rather than a punitive legal approach to substance use during pregnancy is critical. This should include universal evidence-based screening and voluntary maternal drug testing with informed consent, improved access to substance use treatment, and comprehensive care approaches that include behavioral therapy, appropriate social services, and

“The American Psychiatric Association opposes all constitutional amendments, legislation, and regulations curtailing family planning and abortion services to any segment of the population. The American Psychiatric Association (APA) supports the following: 1. Abortion is a medical procedure for which physicians should respect the patient’s right to freedom of choice… 2. Freedom to act to interrupt pregnancy must be considered a mental health imperative with major social and mental health implications.” American Psychiatric Association, Position Statement, *Abortion and Women’s Reproductive Health Care Rights* (2020).

**The Society for Maternal-Fetal Medicine**

“Abortion is one of the most regulated medical procedures in the United States. Restrictive regulations and legislation at both the state and federal levels have made access to reproductive health services increasingly difficult. When unnecessary policies and regulations are placed on abortion care and health care providers, there are adverse effects on those who need access to abortion services. These regulations and policies compromise the patient and health care provider relationship and interfere with individual reproductive decision-making, restricting access to medically accurate practices and procedures.” The Society for Maternal-Fetal Medicine, Position Statement, *Access to Abortion Services* (2020).

**National Organization on Fetal Alcohol Syndrome**

“NOFAS opposes any law or policy that would impose a criminal penalty on pregnant women for drinking alcohol. Alcohol use during pregnancy is a serious problem, yet criminalization is not a solution. Criminalizing alcohol use during pregnancy interferes with the private patient/doctor relationship and intrudes on the rights of women. Such laws could result in pregnant women choosing not to disclose their alcohol use to medical and allied health providers out of fear of criminal sanction. As a result, women with alcohol dependence or an alcohol use disorder could go unidentified and untreated. Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors and should be treated accordingly.” National Organization on Fetal Alcohol Syndrome, Position Statement, *NOFAS Opposes Criminalizing Alcohol Use by Pregnant Women* (2014).

“NOFAS opposes any law or policy that would impose a criminal penalty on a pregnant woman suffering with an addiction to alcohol or drugs. . . . Incarceration is not a solution to their underlying healthcare need. This so-called “crackdown” may result in pregnant women choosing not to discuss their alcohol or drug use, even with medical providers, out of fear of criminal sanction. As a result, women with an alcohol or substance use disorder could go unidentified and untreated. This
could have the unintended result of increasing the exposure and severity of substance use by pregnant women.” National Organization on Fetal Alcohol Syndrome, Position Statement, NOFAS Opposes New Policy to Prosecute Expectant Mothers for Using Alcohol or Drugs (2018).
[*30] There is no such thing as a "crack" or "meth baby" n1 and no state has a statute that makes it a crime for a drug-using pregnant woman to continue her pregnancy to term, to give birth, or to suffer a miscarriage or stillbirth. Nevertheless, some pregnant women and new mothers are still being arrested in the United States when they give birth or suffer a stillbirth and test positive for an illegal drug or alcohol. These prosecutions not only lack legal foundation, they also lack medical and scientific foundation. In other words, they are based on junk law and junk science.

It outlined the statutory and constitutional arguments that could be used to challenge the prosecution of pregnant women who continued to term in spite of a drug problem. These arguments remain valid today, and with the exception of the Supreme Court of South Carolina, have been used successfully to get charges dismissed and convictions overturned in scores of cases in dozens of states. Additional arguments, including Fourth Amendment claims, have also been successful and international human rights principles weigh strongly against such prosecutions.

Nevertheless, there are many cases in which women have plead guilty to non-existent crimes and are serving significant sentences because they continued or tried to continue a pregnancy to term in spite of a drug problem. The vast majority of these cases are based on the claim that use of any amount of an illegal drug creates such unique risks or actually causes such significant harms, that judicially creating new pregnancy-related crimes is justified.

In 2008, an unlikely source made clear that failing to challenge the science behind these prosecutions could constitute ineffective assistance of counsel. A unanimous South Carolina Supreme Court overturned Ms. Regina McKnight's conviction for homicide by child abuse based on the claim that her use of cocaine during pregnancy caused her to suffer a stillbirth. This ruling is particularly poignant since it comes from the only court in the country to have authorized such prosecutions in the first place.

In a powerful example of judicial activism, in 1997 the Supreme Court of South Carolina in a 3-2 decision rewrote the state's child abuse law, holding that it could be applied to a woman who gave birth to a healthy newborn who tested positive for cocaine. The court held that under law unique to South Carolina, the word "child" included viable fetuses. In 2003, in another 3-2 decision, the Supreme Court of South Carolina upheld the application of the state's homicide laws to pregnant women, ruling that a pregnant woman who unintentionally heightens the risk of a stillbirth can be found guilty of depraved heart homicide. The Supreme Court of South Carolina is the only one in the nation to reinterpret state child abuse and homicide laws to make them applicable to pregnant women in relationship to the fetuses they carry.

Nevertheless, as a result of ongoing post-conviction relief efforts, the very same court was finally persuaded that the conviction was based on "out-dated" and inaccurate science. The court ruled that Regina McKnight had not received a fair trial and that her trial counsel was ineffective in her preparation of McKnight's defense through expert testimony and cross-examination. Specifically, the court found that the research the state relied on was "outdated" and that trial counsel failed to call experts who would have testified about "recent studies showing that cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor."

Media Hype and Enduring Myths Are Not the Same as Science

Prosecutors, public defenders, judges, and even some health care providers still believe that a pregnant woman who uses any amount of an illegal drug will inevitably harm or even kill her fetus. This is not surprising based on the extraordinary misinformation that appeared so frequently in popular media.

For nearly two decades, popular media was full of highly prejudicial and often inaccurate information about the effects of in utero cocaine exposure. In 1986, when crack cocaine began to attract substantial media attention, "six of the nation's largest and most prestigious news magazines and newspapers had run more than one thousand stories about crack cocaine. Time and Newsweek each ran five crack crisis' cover stories. ... [T]hree major network television stations ran 74 stories about crack cocaine in six months. ... Fifteen million Americans watched CBS' prime-time documentary '48 Hours on Crack Street.." This hype, which built on pre-existing cultural and racial stereo-types about Black motherhood in particular, went largely unchallenged.

But media hype is not the same as science. That is why in 2004, 30 leading doctors and researchers in the field of prenatal exposure to illegal drugs signed an open letter regarding the "crack baby" myth. Virtually every expert in the field joined this letter explaining:
Throughout almost 20 years of research, none of us has identified a recognizable condition, syndrome or disorder that should be termed "crack baby." Some of our published research finds subtle effects of prenatal cocaine exposure in selected developmental domains, while other of our research publications do not. This is in contrast to Fetal Alcohol Syndrome, which has a narrow and specific set of criteria for diagnosis.

The term "crack-addicted baby" is no less defensible. Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. By definition, babies cannot be "addicted" to crack or anything else. In utero physiologic dependence on opiates (not addiction), known as Neonatal Narcotic Abstinence Syndrome, is readily diagnosed, but no such symptoms have been found to occur following prenatal cocaine exposure.  

Today courts and leading federal government agencies confirm that "the phenomena of 'crack babies' ... is essentially a myth." As the National Institute for Drug Abuse has reported, "Many recall that 'crack babies,' or babies born to mothers who used crack cocaine while pregnant, were at one time written off by many as a lost generation. ... It was later found that this was a gross exaggeration." As the U.S. Sentencing Commission concluded, "research indicates that the negative effects from prenatal exposure to cocaine, in fact, are significantly less severe than previously believed." And finally, in 2009, the New York Times tried to set the record straight in a story entitled The Epidemic That Wasn't. In this story leading researchers, including Dr. Deborah Frank who is also featured in an online video entitled Prenatal Drug Exposure: Award-Winning Pediatrician Discusses What the Science Tells Us, explain that while researchers have found some effects of prenatal exposure to cocaine, those "effects are less severe than those of alcohol and are comparable to those of tobacco -- two legal substances that are used much more often by pregnant women, despite health warnings."  

The newer hype about so-called "meth babies" is similarly unjustified. In 2005, a national expert panel reviewed published studies concerning the developmental effects of methamphetamine and related drugs and concluded that "the data regarding illicit methamphetamine are insufficient to draw conclusions concerning developmental toxicity in humans." In that same year more than 90 leading medical doctors, scientists, psychological researchers, and treatment specialists released an open letter requesting that "policies addressing prenatal exposure to methamphetamines and media coverage of this issue be based on science, not presumption or prejudice." These experts warned that terms such as "meth babies" lack medical and scientific validity and should not be used.

Although research on the medical and developmental effects of prenatal methamphetamine exposure is still in its early stages, our experience with almost 20 years of research on the chemically related drug, cocaine, has not identified a recognizable condition, syndrome or disorder that should be termed "crack baby" nor found the degree of harm reported in the media and then used to justify numerous punitive legislative proposals.

The term "meth-addicted baby" is no less defensible. Addiction is a technical term that refers to compulsive behavior that continues in spite of adverse consequences. By definition, babies cannot be "addicted" to methamphetamines or anything else.

In 2006, the American College of Obstetrics and Gynecology created a special information sheet about methamphetamine use in pregnancy, noting that "the effects of maternal methamphetamine use cannot be separated from other factors" and that there "is no syndrome or disorder that can specifically be identified for babies who were exposed in utero to methamphetamine." Most recently, a peer-reviewed research article concerning stillbirths concluded that "despite widespread reports linking methamphetamine use during pregnancy with preterm birth and growth restriction, evidence confirming its association with an increased risk of stillbirth remains lacking." Prenatal exposure to opiates, most commonly heroin and oxycodone, is not associated with fetal malformations.
Moreover, there is no scientific evidence that growth and development are compromised by exposure to opiates themselves. Some newborns exposed prenatally to opiates experience an abstinence (withdrawal) syndrome at birth. Withdrawal symptoms may also occur when adults with opioid addictions abstain from opiate use. In pregnant women, withdrawal symptoms are known to cause uterine contractions, miscarriage or early labor, but these symptoms can be prevented through methadone maintenance treatment, the medically approved treatment for opiate addiction that is particularly recommended during pregnancy. The U.S. Department of Health and Human Services advises:

If you're pregnant and using drugs such as heroin or abusing opioid prescription pain killers, it's important that you get help for yourself and your unborn baby. Methadone maintenance treatment can help you stop using those drugs. It is safe for the baby, keeps you free of withdrawal, and gives you a chance to take care of yourself.

For those newborns that do experience withdrawal, identification of such infants by trained caregivers is not difficult, and safe and effective treatment can be instituted.

While research demonstrates that some drugs such as alcohol can cause harm to fetuses, whether drug or alcohol use caused a particular harm or even unique risks of harm in any given pregnancy is a scientific question that requires careful examination. For example, although alcohol can unquestionably have teratogenic effects, much remains unknown about the specific effects, if any, that any individual pregnant woman's pattern of alcohol use may have in any particular pregnancy. While many medical experts, particularly in the United States, recommend as a precautionary matter abstaining from alcohol altogether during pregnancy, there is in fact no medical certainty regarding the level of alcohol consumption during a particular pregnancy that will result in negative fetal outcomes. Even the exact mechanism that establishes a causative link between alcohol ingestion and manifestation of harmful fetal symptoms has yet to be definitively established.

Moreover, the difficulty of isolating the influence of alcohol from that of other factors, such as poverty, poor nutrition, or smoking, on fetal outcomes or infant health renders inferences about causation based on in utero exposure to alcohol alone unreliable. As researchers explain, "defining the factors that place certain women at risk of giving birth to an alcohol-affected child is a key research issue. Risk factors include maternal age, socioeconomic status, ethnicity, genetic factors, and maternal alcohol metabolism, among others." Researchers note that "further research is needed to evaluate the relative contributions of the various risk factors for FAS [fetal alcohol syndrome]."

The principal import of existing research is not that drug and alcohol use during pregnancy is "safe," but rather that no scientific or legal basis exists for concluding that exposure to these substances will inevitably cause harm or that the risks presented by use of these substances are any greater than those associated with many other conditions and activities common in the lives of all people, including pregnant women.

In spite of scientific fact, prosecutors continue to use medical misinformation to justify new arrests of pregnant women and to ask courts to radically rewrite state law to permit the prosecution of pregnant women. It is time for criminal defense attorneys to zealously challenge the junk science at the heart of these prosecutions.

Using Daubert as a Guide To Zealous Advocacy For Pregnant Women

The landmark case of Daubert v. Merrell Dow Pharmaceuticals established the federal standard for admission of scientific expert testimony. That case and its history also provide a surprisingly useful guide for attorneys who want to ensure that pregnant women get fair trials. That case reminds us that even when a pregnant woman takes a drug and her child is born with severe "deformities," it does not mean that there is, in fact, a connection between the drug and the harm the child suffered.

In Daubert, two minors brought suit against Merrell Dow Pharmaceuticals, claiming that they suffered limb reduction birth defects "because their mothers had taken Bendectin, a drug prescribed for morning sickness to about
17.5 million pregnant women in the United States between 1957 and 1982.” Merrell Dow was vigorously defended, and after extensive discovery, the company moved for summary judgment, contending that Bendectin does not cause birth defects in humans and that the plaintiffs would be unable to come forward with any admissible evidence to establish that it did. Applying the Frye standard, the district court granted the motion for summary judgment, concluding that the scientific evidence was not admissible because the principle upon which it was based was not "sufficiently established to have general acceptance in the field to which it belongs." The minors appealed, and the U.S. Supreme Court granted certiorari.

The Court held that the Frye test was superseded by the adoption of the Federal Rules of Evidence, specifically Rule 702. The Court observed that nothing in the text of Rule 702 establishes "general acceptance" as an absolute prerequisite to admissibility. The Court then identified things that trial judges could and should look for to help them determine whether the evidence proposed is scientifically valid and therefore reliable as required by Rule 702: (1) whether the theory or technique at issue can be tested; (2) whether the scientific method at issue has been subjected to peer review and publication; (3) for a technique, the trial court should consider the proffered technique's known or potential rate of error; and (4) the degree to which the new theory has gained acceptance in the scientific community may be pertinent, but such acceptance is not required. The court must also ascertain whether the expert's testimony will assist in understanding the evidence or determining the fact in issue.

With the new standards set, the highest Court sent the case down to the appellate court to apply those standards. The pharmaceutical company argued that even under the new, seemingly more liberal standard, the proffered evidence of causation was not admissible.

On remand, the Ninth Circuit explained:

[S]omething doesn't become "scientific knowledge" just because it's uttered by a scientist; nor can an expert's self-serving assertion that his conclusions were "derived by the scientific method" be deemed conclusive... As we read the Supreme Court's teaching in Daubert, therefore, though we are largely untrained in science and certainly no match for any of the witnesses whose testimony we are reviewing, it is our responsibility to determine whether those experts' proposed testimony amounts to "scientific knowledge," constitutes "good science," and was "derived by the scientific method."

This means that the "expert's bald assurance of validity is not enough. Rather, the party presenting the expert must show that the expert's findings are based on sound science, and this will require some objective, independent validation of the expert's methodology."

On remand, the Ninth Circuit explored, in depth, the limits of scientific evidence concerning the causes of birth defects in general, and the specific evidence that the plaintiffs offered that their birth defects were caused by the drug Bendectin. The court noted on the issue of birth defects in general:

For the most part, we don't know how birth defects come about. We do know they occur in 2-3 percent of births, whether or not the expectant mother has taken Bendectin. Limb defects are even rarer, occurring in fewer than one birth out of every 1000. But scientists simply do not know how teratogens (chemicals known to cause limb reduction defects) do their damage.

In terms of causation, or the "biological chain of events that leads from an expectant mother's ingestion of a teratogenic substance to the stunted development of a baby's limbs," the court cautioned that "[n]o doubt, someday we will have this knowledge, ... in the current state of scientific knowledge, however, we are ignorant."

The court recognized that in some cases, such evidentiary problems could be overcome, and looked specifically at the proffered evidence linking Bendectin to the pregnancy outcomes in that case. Considering whether the testimony reflected "scientific knowledge," was "derived by the scientific method" and "amounted to good science," the court
concluded that the plaintiffs' evidence was not admissible as expert scientific testimony.  

Factors that led to this holding included: that only one of the plaintiff's experts had done original research; that none of the experts based his testimony on preexisting or independent research; and that the proffered analysis and conclusion had not been subjected to normal scientific scrutiny through peer review and publication. The court specifically rejected the testimony of Dr. Palmer, who was the only expert willing to testify that Bendectin caused the limb defects in each of the children.

In support of this conclusion, Dr. Palmer asserts only that Bendectin is a teratogen and that he has examined the plaintiffs' medical records, which apparently reveal the timing of their mothers' ingestion of the drug. Dr. Palmer offers no tested or testable theory to explain how, from this limited information, he was able to eliminate all other potential causes of birth defects, nor does he explain how he alone can state as a fact that Bendectin caused plaintiffs' injuries.

The court concluded that "[t]he record in this case categorically refutes the notion that anyone can tell what caused the birth defects in any given case," and that Dr. Palmer's testimony was "rendered inadmissible by the total lack of scientific basis for his conclusions."

As a result of the ruling, the children and families never even went to trial. The pharmaceutical company was safe from civil suit and financial liability. Daubert does not stand alone in applying stringent standards for the admission of expert testimony about causation in civil actions seeking to hold someone accountable for bad birth outcomes. Indeed, there are more than a dozen published decisions about Bendectin, with most delving into and turning on the admissibility of expert evidence about whether Bendectin caused a birth defect. Civil actions alleging that a birth defect was caused by a drug or pesticide are vigorously, and often successfully, defended by challenging the admissibility of expert evidence.

In another example, New York plaintiffs alleged that Malathion, a pesticide sprayed by a county agency, caused birth defects. The defendant challenged the expert evidence about causation, and the trial court conducted a hearing to determine whether it was generally accepted in the medical and scientific communities that Malathion caused birth defects. Finding that no scientific organizations or peer-reviewed articles accepted a relationship between Malathion and birth defects and that the plaintiff's proposed expert relied on "fundamentally speculative" methodology, the court concluded that the expert's testimony was not admissible. Because the plaintiff presented no other evidence on the issue of causation, the lower court granted summary judgment for the defendant, and the appellate division affirmed.

Consider Scientific Evidence, Not Junk Science

When those accused of causing harm to newborns are pregnant women rather than pharmaceutical companies and what is at stake is a mother's liberty and not just money, the standards for expert evidence often do not even come into play. In many cases, the delivering doctor or the local medical examiner is allowed to testify as to causation of a stillbirth, birth defect, or the creation of risk of harm. Yet, the "average medical doctor is not a trained researcher" and is not necessarily qualified to address as a matter of science whether a particular drug has caused a particular risk or outcome.

On the subject of pregnant women, however, pretty much everyone seems to be considered an expert. A good example of this comes from the Starks case in Oklahoma. Julie Starks, a pregnant woman, was arrested in a trailer that was allegedly being used, or that had once been used, to manufacture methamphetamine. In addition to being arrested and charged with manufacturing methamphetamine, the state began proceedings in the family court to declare her "unborn" child dependent. The family court took emergency custody of Starks' fetus and also raised Starks' bail for the criminal charges in order to prevent her release from jail. Despite the lack of a positive drug test and a recent evaluation by a treatment provider concluding that Starks was not using drugs, the state alleged that Starks used drugs.
The state's case, however, focused on the claim that while pregnant, she had been in a location that exposed her unborn child to dangerous "fumes that permeate in the air."\(^{58}\)

In describing how Starks' fetus was endangered, the state argued:

"It does not take a rocket scientist, so to speak, to figure out that these kinds of chemicals would be harmful to not only the mother but the unborn child. The child breathes the same thing as the mother does. That child, because it's unborn cannot leave that residence. It's helpless. It can't do a thing. As investigator Stinnett says, it can't even cry.\(^{59}\)

Indeed, as these exchanges from hearings in the case make clear, the state was allowed to use law enforcement officials to give opinions on medical and scientific facts:

**State Q:** Sergeant Stinnett, do you need to have a medical degree in order to advise a pregnant woman not to step out in front of a car coming down the highway?

**A:** I don't, no, sir.

**Q:** Do you think you need a medical degree that would enable you to have an opinion that a pregnant woman should not have been in the environment that you were in [when you arrested her] on August 23rd of 1999?

**A:** I don't believe I need a medical degree for that, no.\(^{60}\)

And similarly:

**State Q:** Okay. Let me ask you, Deputy [Dunlap], was there anything unusual that you noticed about Ms. Starks?

**A:** She appeared to be pregnant.

**Q:** And were you able to verify whether or not she was?

**A:** She said she was pregnant.

**Q:** Okay. And do you have an opinion as to whether or not she and her child's safety were placed in danger by being in that lab?

**A:** I felt it was ..

**Q:** Deputy, you have a little boy, do you not?

**A:** That is correct.

**Q:** And he is, if I remember correctly, not very old?

**A:** He is about a half-year old.

**Q:** Six months old. When your wife was seven months pregnant, would you have wanted her to be in a methamphetamine lab?
In other words, as the *Starks* case [*36] and these exchanges demonstrate, if a pharmaceutical company’s pocket book is at stake, a high standard for the admission of expert testimony is applied. But if a pregnant woman’s liberty is at stake, it is often true that no standard is applied at all. Sometimes, defense attorneys, who themselves may believe the medical misinformation, fail to challenge the scientific grounds for the case, fail to ask for *Daubert* hearings (or their state equivalent), fail to challenge the expertise of the state’s witnesses, fail to vigorously cross-examine those witnesses who are allowed to testify, or fail to call their own experts. Courts should act as gatekeepers regardless of whether defense attorneys challenge the admissibility of scientific evidence, but too often do not. Moreover, even when counsel does object to the admission of junk science and unqualified witnesses, their motions are sometimes overruled. Similarly, when defense attorneys request *Daubert* hearings and funding for experts, courts may deny those motions and refuse to authorize expenditures for experts for indigent defendants. And prosecutors arguably violate ethical principles by proceeding with cases that they know or should know are based on junk science and made-up law. Defendants who are pregnant or parenting, however, deserve to have the junk science challenged.

Like the research available about Bendectin at the time of *Daubert*, the research about cocaine, methamphetamine, and other illegal drugs fails to establish, as a matter of science, a causal link between exposure to those drug and stillbirths, a wide range of alleged harms, or even unique risks substantially different from exposures to legal substances and a wide variety of life circumstances experienced by pregnant women. As the American College of Obstetricians and Gynecologists ethics statement on this issue provides:

[P]regnant women should not be punished for adverse perinatal outcomes. The relationship between maternal behavior and perinatal outcome is not fully understood, and punitive approaches threaten to dissuade pregnant women from seeking health care and ultimately undermine the health of pregnant women and their fetuses.  

Other advocates have argued that *Daubert* has not been adequately incorporated into criminal defense practice. This omission, however, is especially dangerous in cases involving pregnant women because pregnant women charged with crimes are not like other defendants. As the Illinois Court of Appeals noted when refusing to create a tort of prenatal maternal negligence:

The relationship between a pregnant woman and her fetus is unlike the relationship between any other plaintiff and defendant. No other plaintiff depends exclusively on any other defendant for everything necessary for life itself. No other defendant must go through biological changes of the most profound type, possibly at the risk of her own life, in order to bring forth an adversary into the world. It is, after all, the whole life of the pregnant woman which impacts on the development of the fetus. As opposed to the third-party defendant, it is the mother’s every waking and sleeping moment which, for better or worse, shapes the prenatal environment which forms the world for the developing fetus. That this is so is not a pregnant woman’s fault: it is a fact of life.

Because pregnancy and pregnancy loss occur inside a woman’s body, the state can, in effect, make out virtually every element of a circumstantial case of guilt by simply producing evidence of a positive drug test, a stillbirth or some alleged harm, and the fact of cocaine use or any other unwise or unpopular behavior. This makes it especially important for trial counsel to attack the state’s case for causation. In other words, in these kinds of prosecutions, ceding the issue of causation is not an option.

In a prescient passage, the *Stallman* court warned of the role prejudice and presumption, rather than probative scientific facts, could play in cases involving pregnant women.

If a legally cognizable duty on the part of mothers were recognized, then a judicially defined standard of
conduct would have to be met. It must be asked, by what judicially defined standard would a mother have her every act or omission while pregnant subjected to state scrutiny? By what objective standard could a jury be guided in determining whether a pregnant woman did all that was necessary in order not to breach a legal duty to not interfere with her fetus' separate and independent right to be born whole? In what way would prejudicial and stereotypical beliefs about the reproductive abilities of women be kept from interfering with a jury's determination of whether a particular woman was negligent at any point during her pregnancy? n66

This is just one reason why, even if a causal link between a drug and harm could be established, these cases should never come to trial. n67 But if a motion to dismiss fails, and the case does proceed to trial, effective defense attorneys must challenge the qualifications of the state's experts and the scientific claims on which the prosecutions are based. Moreover, effective representation requires the introduction of scientific evidence to counteract the numerous prejudicial and stereotypical beliefs about pregnancy and addiction that are bound to influence the judge and jury.

On the basis of popular literature, warning labels, and general confidence in the advances of modern medicine, many people wrongly believe that women have a high degree of control over their pregnancy outcomes. For example, the best selling pregnancy advice book What to Expect When You're Expecting n68 warns women to avoid contact with anyone who is smoking, changing a cat litter box, consuming unpasteurized cheese or undercooked meat, gardening without gloves, inhaling when handling household cleaning products, and ingesting caffeine, thereby creating the illusion that women who conform to all proscriptions can guarantee a healthy pregnancy outcome.

The longstanding and constant medical reality, however, is that as many as 20-30 percent of all pregnancies will end in miscarriage or stillbirth. In fact, stillbirth is one of the most common adverse outcomes of pregnancy, n69 and it occurs despite the best intentions and numerous precautions [*37] taken by individual women. As the president of the March of Dimes noted in a letter to the Wall Street Journal:

No one would deny parents play a significant role in the health and well-being of their child, both before and after birth. But ... every day in America women who did everything "right" during pregnancy -- that is, they got good prenatal care, they were married to the father of the child, they neither smoked nor drank nor abused drugs -- nevertheless give birth to babies with birth defects or low birth weight. ... Scientific progress in understanding the causes of some birth defects inclines people to overestimate what is known, but the truth is that more than 60 percent of all birth defects are of unknown origin. n70

Conclusion

The decision in the McKnight case, a growing body of helpful popular and scientific, peer-reviewed literature, as well as an increasing number of real experts who may be available to testify on a pro bono basis should all encourage defense counsel not to accept the junk science behind the prosecutions of pregnant women. Model briefs and motions, evidence-based research, and contact information for some of the leading experts are available from National Advocates for Pregnant Women.

Pregnant women charged with non-existent crimes may not have the financial resources available that pharmaceutical companies have. They, however, are no less entitled to a zealous defense.

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FOOTNOTE-1:


n3 Some more recent examples of successful efforts to get charges dismissed or convictions overturned are: State v. Geiser, 763 N.W.2d 469 (N.D. 2009) (reversing conviction for endangerment of a child based upon suffering a stillbirth and testing positive for methamphetamine and holding that “pregnant woman cannot be charged for a crime allegedly committed against her unborn child” because the plain meaning of the word “child” does not include a fetus); State v. Wade, 232 S.W.3d 663 (Mo. Ct. App. 2007) (affirming the dismissal of child endangerment charge based on allegation that child tested positive for methamphetamine and marijuana at birth and stating that “[t]he plain language of the child endangerment statute does not proscribe conduct harmful to fetuses, and Section 1.205.4 clearly prohibits any cause of action against a mother for improper prenatal care”); State v. Martinez, 137 P.3d 1195 (N.M. Ct. App. 2006) (refusing to apply child abuse statutes to punish a woman for continuing her pregnancy to term in spite of a cocaine addiction); Kilmon v. State, 905 A.2d 306 (Md. 2006) (holding that the reckless endangerment statute does not apply to the context of pregnancy); Ward v. State, 188 S.W.3d 874 (Tex. App. 2006) (reversing the convictions of Tracy Ward and Rhonda Smith, who had both been convicted of delivery of a controlled substance to a “child” for their alleged in utero transfer of drug metabolites to their fetuses, holding that the plain language of the statute made clear that the state legislature did not intend the drug delivery statute to apply to the context of pregnancy); State v. Aiwohi, 123 P.3d 1210 (Haw. 2005) (holding that according to the plain language of the Hawai’i manslaughter statute, the definition of person did not include fetus); State v. Dunn, 916 P.2d 952 (Wash. Ct. App. 1996) (holding that the legislature did not intend to include fetuses within the scope of the term “child” which was defined “as a person under 18 years of age”); Reinstein v. Superior Court, 894 P.2d 733 (Ariz. Ct. App. 1995) (dismissing child abuse charges filed against a woman for heroin use during pregnancy and holding that the ordinary meaning of “child” excludes fetuses, and to conclude otherwise would offend due process notions of fairness and render statute impermissibly vague); Collins v. State. 890 S.W.2d 893 (Tex. Ann. 1994) (charges brought for substance abuse during pregnancy dismissed because application of the statute to prenatal conduct violates federal due process guarantees); Ex Parte Lovill, 287 S.W.3d 65 (Tex. App. 2008), rev’d on other grounds, No. PD-0401-09 (Tex. Ct. Crim. App. Dec. 16, 2009) (finding that the decision to revoke a woman’s probation because she was pregnant constituted impermissible sex discrimination, and remanding habeas claim to trial court for determination of whether the discrimination could survive Equal Protection review).


n8 Whitner, 492 S.E.2d at 777.

n9 State v. McKnight, 576 S.E.2d 168 (2003).


n27 See generally METHADONE TREATMENT FOR PREGNANT WOMEN, supra note 26.

n29 See, e.g., Grace Chang, *Alcohol-Screening Instruments for Pregnant Women*, 25 ALCOHOL RESEARCH & HEALTH 204 (2001). Alcohol, (ethanol) intake during pregnancy, however, has also been shown to have a beneficial effect on women and fetal health by preventing preterm labor, which poses high risks of infant morbidity. Until the recent development of alternative pharmacological agents offering lower risks and greater benefits, alcohol was routinely used in some circumstances to prevent preterm labor in order to promote optimal fetal development in utero. See also Marc J.N.C. Keirse, *The History of Tocolysis*, 110 BR. J. OBSTETRICS & GYNECOLOGY 94, 95 (2003) (describing history of use and research on ethanol as a tocolytic agent for preterm labor as recently as 1981 and citing reports that "for ethanol to be effective you needed to achieve blood levels between 1.2 and 1.8 g/l. However, this caused depression and incontinence in women"); Nancy D. Berkman et al., *Tocolytic Treatment for the Management of Preterm Labor: A Review of the Evidence*, 188 AM. J. OBSTETRICS GYNECOLOGY 1648, 1649 (2003) (noting ethanol as among "five classes of tocolytic agents currently used to treat women in preterm labor," although ethanol has been surpassed in usage by new treatments that are more effective and have fewer harmful side effects). Uncertainty about the optimal and, of course, harmful, dosage and timing of ethanol infusion merely highlights the difficulty of charging women without medical expertise with such knowledge for the purposes of imposing criminal liability.
See, e.g., Elizabeth M. Armstrong & Ernest L. Abel, *Fetal Alcohol Syndrome: The Origins of a Moral Panic*, 35 *ALCOHOL & ALCOHOLISM* 276, 277 (2000) (comparing warning of the United States Surgeon General in 1981 that "women who are pregnant (or considering pregnancy) not to drink alcoholic beverages and to be aware of the alcoholic content of foods and drugs" to 1996 guidelines of the British Royal College of Obstetricians and Gynecologists recommending that "women should be careful about alcohol consumption in pregnancy and limit this to no more than one standard drink per day") (citations omitted).


See, e.g., Armstrong, *supra* note 31, at 2028 (noting possibility that effect of enzyme deficiencies that prevent breakdown of alcohol -- rather than effect of alcohol itself -- may explain why similar patterns of alcohol consumption do not necessarily correlate with the same incidence of fetal symptoms).


Armstrong & Abel, *supra* note 30 (disproportionate incidence of symptoms associated with fetal alcohol syndrome among poor women may result from their simultaneous experience with "smoking and poor diet, [which] exacerbate the effects of alcohol") (citation omitted); Nesrin Bingol et al., *The Influence of Socioeconomic Factors on the Occurrence of Fetal Alcohol Syndrome*, 6 *ADVANCES IN ALCOHOL & SUBSTANCE ABUSE* 105 (1987) (demonstrating that differences in infant health are attributable to differences in economic status).


n37 Daubert v. Merrell Dow Pharmaceuticals, 43 F.3d 1311, 1313 (9th Cir. 1995).

n38 Id.


n40 Id. at 593.

n41 Id. This list of factors is not exhaustive.

n42 Id.

n43 Daubert v. Merrell Dow Pharmaceuticals, 43 F.3d 1311, 1315-16 (9th Cir. 1995) (emphasis added).

n44 Id. at 1316.

n45 Id. at 1313 (internal citations omitted).

n46 Id. at 1313-14.
n47  *Id.* at 1315.

n48  *Id.* at 1317-18.

n49  *Id.* at 1319.

n50  *Id.* at 1320 n.20.

n51  *Id.* at 1321 n.18.

n52  *See, e.g.,* Merrell Dow Pharmaceuticals v. Havner, 953 S.W.2d 706, 709-10 (Tex. 1997) (discussing the numerous federal and state Bendectin cases).


n55  *Id.*

n57 See In re Unborn Child of Starks, 18 P.3d 342 (Okla. 2001); Order, In re Unborn Child of Starks, No. 93,606 (Okla. Sept. 23, 1999) ("petitioner's confinement ... is inefficacious and unenforceable as an unauthorized application of judicial force").


n60 Id. at 284.

n61 Id. at 333-34.


n66 Id. at 360.

n67 Sample motions to dismiss are available from National Advocates for Pregnant Women.

n68 ARLENE EISENBERG, HEIDI E. MURKOFF, & SANDEE E. HATHAWAY, WHAT TO EXPECT WHEN YOU'RE EXPECTING 54-57 (2d ed. 1996).


BY THE EDITORIAL BOARD DEC. 28 2018

Katherin Shuffield was five months pregnant when she was shot in 2008. She survived, but she lost the twins she was carrying. The gunman, Brian Kendrick, was charged with murdering them.

Bei Bei Shuai was eight months pregnant and depressed when she tried to kill herself in 2010. She was rushed to the hospital and survived, but her baby died a few days later. Ms. Shuai was charged with murder.

Both cases are tragedies. But are Ms. Shuai and the man who shot Ms. Shuffield really both murderers?

Ms. Shuai is one of several hundred pregnant women who have faced criminal charges since 1973 for acts seen as endangering their pregnancies, according to National Advocates for Pregnant Women, which has completed the only peer-reviewed study of arrests and forced interventions on pregnant women in the United States. In many cases, the laws under which these women were charged were ostensibly written to protect them. Ms. Shuai, for instance, was charged under a law that was stiffened after the attack on Ms. Shuffield.
These criminal statutes are results of a tried-and-true playbook, part of a strategic campaign to establish fetal rights, reverse Roe v. Wade and recriminalize abortion. The sequence begins with anti-abortion groups seizing upon a tragic case in which a woman loses her pregnancy because of someone else’s actions. Public outcry then helps to strengthen a state feticide law that recognizes such lost pregnancies as murder or manslaughter. It’s a backdoor way of legally defining when life begins.

Here’s what that playbook looked like in Indiana, the first state to convict a pregnant woman of feticide:
Feticide laws redefine when life begins

In March, Indiana expanded its feticide law, originally passed in 1979, to include previable fetuses — those that would not survive outside of the womb. Indiana Right to Life applauded the passage of the bill, S.B. 203. The group’s president, Mike Fichter, called for “doubling down” on efforts to “dismantle Roe” and said, “The recognition of the worth of a
child killed during a felony further places Roe v. Wade on a collision course with law and history.”

Much like Mr. Fichter’s statement, many feticide laws use carefully chosen language to legitimize fetal rights, providing grounds for the state to intervene and control pregnant women for the sake of the fetus.

Twenty-nine states now have feticide laws that recognize the ending of any stage of pregnancy, from fertilization onward, as equivalent to murder, except in cases of legal abortion.

Nine states recognize feticide only in later periods of a fetus’s development, such as when it could survive outside the womb. In 2004, Congress passed the first federal statute to give victim status to fertilized eggs, embryos and fetuses, in cases of violence crime against pregnant women.

These laws have meant that pregnant women who were addicted to drugs, were suicidal, were in car accidents, fell down stairs, delivered at home, refused C-sections or went about their lives in ways that were perceived to harm their pregnancies have been detained and jailed for a variety of crimes, including murder, manslaughter, neglect, criminal recklessness and chemical endangerment.

Feticide laws embolden prosecutors

The reason lawmakers often make an exception to prevent pregnant women themselves from being charged under fetal protection laws is to win broader support for the measures.
Staunch conservatives can pass laws that are said to protect “unborn life” while more centrist lawmakers can think they’re protecting pregnant women from legal overreach.

But such laws nevertheless often put the rights of pregnant women at risk. Take Texas, for instance: In 2003, three weeks after an expansive fetal protection act passed, the Potter County district attorney, Rebecca King, used the law to begin pursuing pregnant women who used narcotics, even though this was clearly not the Legislature’s intent.
Laci Peterson, at eight months pregnant, is murdered in California, 2002

prompting Texas legislators to support passage of the Prenatal Protection Act. Prosecutors interpret the law to mean that physicians must report to authorities women who use illegal drugs while pregnant. This legislation is used to

...arrest

at least 50 women in Potter County, Tex., for drug use during pregnancy. 2003

...convict

...convict

Tracy Ward for using cocaine while pregnant. 2004

She appeals and is successful because the court agrees that pregnant women cannot be charged under Texas law. 2006

Despite this, authorities in Texas have arrested or taken action against at least 17 pregnant women since then.
Women of color and the poor are immediately targeted

In reality, women charged with pregnancy-related crimes are often poor and nonwhite, without adequate access to education, health care and job opportunities. About seven out of 10 women charged cannot afford a lawyer to defend them, according to National Advocates for Pregnant Women.

Black women made up 52 percent of the cases recorded from 1973 to 2005 by National Advocates for Pregnant Women. Many of these women were arrested during the crack epidemic of the 1980s and 1990s.

The punitive response to pregnant black women who used cocaine set a standard for treating addiction while pregnant as a criminal matter, rather than a public health concern. In recent years, the opioid epidemic — and the spike in methamphetamine addiction before it — has begun to change the racial makeup of those arrested, since white Americans more often use both drugs.

All of this is avoidable

Eight of the 12 states that do not have feticide laws instead require harsher punishment for crimes against pregnant women than against other victims. These states preserve women’s rights by considering harm to a fetus as harm to the pregnant woman.

In Colorado, after the murder of a pregnant woman, state legislators chose not to adopt a law that would treat the fetus as a victim separate from the pregnant woman, the approach sought by anti-abortion groups. Instead, they passed a bill in 2003 that punishes anyone who injures a woman in a way that harms her pregnancy, while simultaneously declining to recognize fetal personhood. This crime of “unlawful termination of a pregnancy” carries a maximum punishment of 32 years in prison.

Since then, Colorado voters and legislators have rejected fetal homicide bills multiple times, arguing that the law already provides justice and recognition for the loss of a fetus while affirming a woman’s right to determine her own pregnancy and health care.
Anti-abortion activists have patiently been working to pass fetal protection laws not only in hopes of establishing that a fetus is a person entitled to full rights, but also to create a vehicle for overturning Roe v. Wade. Many of these activists are hoping that the new conservative majority on the Supreme Court is prepared to take that step.
Alabama, which has prosecuted more pregnant women in the name of fetal protection than almost any other state in the nation, last month became the only state to amend its Constitution to give “unborn children” the right to life, a guarantee that conflicts with the legal protections enshrined in Roe.

Alabama and other states would better serve the interests of children by putting less energy into manufacturing legal fights and more into ensuring the dignity and protection of women.

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The Rising Trend Of Criminalizing Pregnancy Is Turning Everyone Into Suspects
By Galina Varchena, Amber Khan & Farah Diaz-Tello
Aug. 16, 2018

The rights of pregnant people are under attack both in the statehouses and from the federal government. With Brett Kavanaugh's nomination to the U.S. Supreme Court, combined with increasingly strict TRAP statutes across the country, we could be facing a full Roe repeal or at least a severe crippling of abortion protections. But there is also a more insidious trend: the criminalization of pregnancy.

The trend of criminalizing pregnancy takes two forms. Either prosecutors and judges contort existing laws in ways they were never intended, or legislators propose and pass new laws that target pregnant people. Prosecutions of miscarriage, stillbirth, abortion, and drug use during pregnancy — even when the drugs are prescribed and when the drugs do not harm the fetus — have become widespread.

As these cases continue to trickle in across the country, it becomes overwhelmingly clear that a person’s human rights are devalued and violated upon becoming pregnant. In Virginia, Katherine Dellis was sentenced to five months in jail in February 2017. Her crime? Suffering a stillbirth and disposing of the remains before seeking emergency medical help.

After her stillbirth, Dellis was convicted of concealing a dead body. Virginia Attorney General Mark Herring issued an opinion clarifying that the law is not intended to apply to someone who has a miscarriage or a stillbirth and doesn’t head straight to a funeral home. “Virginia law does not criminalize women who have a miscarriage,” he said in a statement. But the opinion came too late for Dellis; a panel of the Virginia Appeals Court had already ruled against her.
Appeals Court Judge Theresa M. Chafin had concluded that "the legislature intended that a fetus be treated the same as a dead body." Her ruling was so broad that, if it were to set a legal precedent, it would mean anyone who had a miscarriage at any stage in her pregnancy might find herself under threat of a felony conviction unless the miscarriage was immediately reported to the police.

On June 1, Virginia Gov. Ralph Northam pardoned Dellis, but Virginia isn’t alone in depriving pregnant people of their rights. The volume of examples from around the country is staggering. In 2013, Lynn M. Paltrow and Jeanne Flavin from National Advocates for Pregnant Women released a study in which they cited 413 examples from 1973 to 2005 where a person’s pregnancy contributed to the deprivation of their physical liberty. And in recent years, there have been many new instances across the country.

In 2017, Amnesty International published a report documenting the “patchwork” of laws across the U.S. that are used to prosecute people when they become pregnant, concluding that “the existence and enforcement of pregnancy criminalization laws are violating of pregnant women’s human rights.” A recent case that raised public outrage was the prosecution of Purvi Patel, an Indiana woman imprisoned for three years after allegedly ending her pregnancy before she was finally freed by an appellate court. Although she was the first woman in the U.S. charged with homicide offenses for ending her own pregnancy, she is far from the only woman prosecuted for pregnancy outcomes, both intentional and unintentional. Women of color and low-income women are disproportionately affected, though no pregnant person is safe.

Many other women across America have stories similar to Patel’s. For example, an Arkansas woman was convicted of concealing a birth after delivering a stillborn fetus in the middle of the night at home. She safeguarded the remains for several hours and then brought them to the hospital the next morning. The Arkansas Court of Appeals overturned her conviction, but the DA in her county has chosen to re-prosecute her. Her trial is scheduled for this fall.

In rural Pennsylvania, Jennifer Whalen was sentenced to nine to 18 months in jail for helping her 16-year-old daughter safely self-manage an abortion
with pills. Met with barriers of distance, cost, and unnecessary regulations intended to make abortions in clinics hard to access, Whalen researched misoprostol and mifepristone, the drugs that doctors prescribe, and purchased them online. She hadn’t known that buying the pills was illegal.

The future of reproductive rights across the country is under immediate threat — and this threat goes beyond Roe.

Also consider the story of Bei Bei Shuai, a Chinese immigrant in Indiana who attempted suicide during her pregnancy. She survived her suicide attempt, only to be devastated by her daughter’s death just days after her emergency cesarean delivery. Shuai faced murder and attempted feticide charges, which were eventually pleaded down to criminal recklessness.

Every story is different, but the common thread that unites these prosecutions is the refusal to see pregnant people as not only the masters of their own bodies, but also as full citizens worthy of constitutional protection. Ironically, the push to punish only serves to strip pregnant people of their own rights and human dignity by reducing them to potential suspects and threats to their own pregnancies.

A recent resolution by the American Medical Association House of Delegates points to the public health policy implications of these prosecutions. The physicians raised concerns that criminalization would increase health risks and stop patients from seeking care. The resolution also pointed out the race disparities in prosecutions for pregnancy outcomes, which is of particular concern because women of color are more likely to experience miscarriages and other complications of pregnancy.

As executive director of the National Advocates for Pregnant Women, Lynn Paltrow, cautioned in a New York Times interview in 2012, “there is no way to treat fertilized eggs, embryos and fetuses as separate constitutional
persons without subtracting pregnant women from the community of constitutional persons.”

With Kavanaugh’s confirmation vote looming, the future of reproductive rights across the country is under immediate threat — and this threat goes beyond Roe. Federal protections are at risk, and we urge legislators and prosecutors across America and at all levels of government to treat pregnant people as human beings first, deserving of the respect of their full dignity and autonomy.

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*This op-ed solely reflects the views of the authors, and is part of a larger, feminist discourse.*


July 22, 2016.

Synopsis

Background: Defendant was convicted in the Superior Court, St. Joseph County, Elizabeth C. Hurley, J., of class A felony neglect of a dependent and feticide. Defendant appealed.

Holdings: The Court of Appeals, Crone, J., held that:

[1] sufficient evidence existed that defendant was subjectively aware that her infant was born alive, as required to support neglect conviction;

[2] sufficient evidence existed that defendant endangered infant by failing to provide medical care immediately after birth, as required to establish conviction for neglect of a dependent as a class D felony;

[3] insufficient evidence existed that defendant's failure to provide medical care for infant resulted in infant's death, as required to support conviction as a class A felony;

[4] illegal abortions were not governed by feticide statute; and

[5] feticide statute did not apply to pregnant women who have abortions.

Vacated and remanded with instructions.

West Headnotes (26)

[1] Criminal Law ⇔ Inferences or deductions from evidence

Criminal Law ⇔ Evidence considered; conflicting evidence

When reviewing the sufficiency of the evidence to support a conviction, the Court of Appeals considers only the provocative evidence and reasonable inferences supporting the verdict.


The Court of Appeals does not reweigh the evidence or judge the credibility of the witnesses, and the Court respects the jury's exclusive province to weigh conflicting evidence.

[3] Criminal Law ⇔ Evidence considered; conflicting evidence

When confronted with conflicting evidence, the Court of Appeals considers it most favorably to the jury's verdict.

[4] Criminal Law ⇔ Sufficiency to support conviction in general

To sustain a conviction under a sufficiency of the evidence challenge, there must be sufficient evidence on each material element of the offense.


Criminal Law ⇔ Inferences or hypotheses from evidence

The Court of Appeals will affirm a conviction unless no reasonable factfinder could find the elements of the crime proven beyond a reasonable doubt, but the evidence need not overcome every reasonable hypothesis of innocence.
[6] **Criminal Law** ⇐ Verdict unsupported by evidence or contrary to evidence

**Criminal Law** ⇐ Reasonable doubt

While the Court of Appeals seldom reverses a conviction for insufficient evidence, in every case where that issue is raised on appeal, the Court has an affirmative duty to make certain that the proof at trial was, in fact, sufficient to support the judgment beyond a reasonable doubt.

[7] **Criminal Law** ⇐ Inferences from evidence

The evidence is sufficient to support a conviction if an inference may reasonably be drawn from it to support the verdict.

[8] **Criminal Law** ⇐ Inferences from evidence

A reasonable inference of guilt must be more than a mere suspicion, conjecture, conclusion, guess, opportunity, or scintilla.

[9] **Infants** ⇐ Intent, state of mind, and motive

Sufficient evidence existed that defendant was subjectively aware that her infant was born alive, as element required to support conviction for class A felony neglect of a dependent; there was evidence that the infant took at least one breath and that its heart was beating after delivery and continued to beat until all of its blood had drained out of its body, an obstetrician/gynecologist testified that the infant was approximately 30 weeks gestation, defendant told police that she tried to open the infant's mouth, and defendant gave false statements to her friend and others regarding her pregnancy, delivery, and disposal of infant. *West's A.I.C. 35–41–2–2(b), 35–46–1–4(b)(3).*

1 Cases that cite this headnote

[10] **Infants** ⇐ Deprivation of services

Sufficient evidence existed that defendant endangered her infant by failing to provide medical care, as required to establish conviction for neglect of a dependent as a class D felony; infant was significantly premature and weighed less than two pounds and was bleeding from its severed umbilical cord, and defendant failed to provide infant with any medical care after birth. *West's A.I.C. 35–41–2–2(b), 35–46–1–4(a)(1).*

1 Cases that cite this headnote


In a prosecution for neglect of a dependent, when there are symptoms from which the average layperson would have detected a serious problem necessitating medical attention, it is reasonable for the jury to infer that the defendant knowingly neglected the dependent. *West's A.I.C. 35–41–2–2(b), 35–46–1–4(b)(3).*

1 Cases that cite this headnote

[12] **Infants** ⇐ Necessity of expert testimony

Insufficient evidence existed that defendant's failure to provide medical care for her premature infant immediately after birth resulted in the infant's death, as required to support conviction for class A felony neglect of a dependent, absent any medical testimony as to how quickly medical care could have been provided or whether it could have changed the outcome. *West's A.I.C. 35–41–2–2(b), 35–46–1–4(b)(3).*

5 Cases that cite this headnote

[13] **Constitutional Law** ⇐ Relation between allegations and proof; variance

It is a denial of due process of law to convict an accused of a charge not made. *U.S.C.A. Const.Amend. 14.*

[14] **Criminal Law** ⇐ Review De Novo

The interpretation of a statute is a legal question, which is reviewed de novo on appeal.
[15] Statutes ⇒ Language
The first and often last step in interpreting a statute is to examine the language of the statute.

[16] Statutes ⇒ Absence of Ambiguity; Application of Clear or Unambiguous Statute or Language
The court will not interpret a statute that is clear and unambiguous on its face.

[17] Statutes ⇒ Absent terms; silence; omissions
The Court of Appeals’ role on appeal is to interpret and apply the statute, and absent some ambiguity, the Court may not substitute language that is not there.

[18] Statutes ⇒ Intent
Determining legislative intent is foremost in construing any statute and, wherever possible, the court will give deference to that intent.

[19] Statutes ⇒ Language and intent, will, purpose, or policy
Statutes ⇒ Plain Language; Plain, Ordinary, or Common Meaning
The best evidence of legislative intent is the language of the statute itself, and courts strive to give the words in a statute their plain and ordinary meaning.

[20] Statutes ⇒ Policy behind or supporting statute
Statutes ⇒ Statutory scheme in general
Indispensable to ascertaining the legislature's intent is a consideration of the goals sought to be achieved and the reasons and policy underlying a statute; consequently, it is necessary to view a statute within the context of the entire act, rather than in isolation, when construing the statute.

[21] Criminal Law ⇒ Liberal or strict construction; rule of lenity
Penal statutes must be strictly construed against the state.

[22] Criminal Law ⇒ Construction and Operation in General
Criminal statutes cannot be enlarged by construction, implication, or intendment beyond the fair meaning of the language used.

[23] Criminal Law ⇒ Liberal or strict construction; rule of lenity
Even though an act may fall within the spirit of a statute, it will not constitute a crime unless it is also within the words of the statute.

[24] Criminal Law ⇒ Liberal or strict construction; rule of lenity
Criminal statutes must not be construed so narrowly as to exclude cases fairly covered thereby.

[25] Abortion and Birth Control ⇒ Abortion Offenses; Nature and Elements
Homicide ⇒ Unborn children
Illegal abortions are governed by the provisions regulating abortion and not the feticide statute. West's A.I.C. 16–34–2–7, 35–42–1–6.

[26] Homicide ⇒ Unborn children
The statute prohibiting feticide does not apply to pregnant women who have abortions. West’s A.I.C. 35–42–1–6.
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CRONE, Judge.

Case Summary

[1] Thirty-two-year-old Purvi Patel managed her father's restaurant in Mishawaka. A relationship with a restaurant employee resulted in her pregnancy. In June 2013, she purchased mifepristone and misoprostol online from a Hong Kong pharmacy and used those drugs to terminate the pregnancy at home. On the evening of July 13, she delivered a live baby of approximately twenty-five to thirty weeks gestation who died shortly after birth. She drove to the restaurant, put the baby in a nearby dumpster, and drove herself to the emergency room.

*1044 [2] The State charged Patel with class A felony neglect of a dependent, alleging that she failed to provide any medical care to her baby immediately after its birth, which resulted in its death. The State also charged Patel with class B felony feticide, alleging that she knowingly terminated her pregnancy with the intention other than to produce a live birth or to remove a dead fetus. A jury found her guilty as charged. The trial court sentenced Patel to thirty years of imprisonment for neglect of a dependent, with twenty years executed and ten years suspended, and a concurrent executed term of six years for feticide.

[3] On appeal, Patel argues that her neglect of a dependent conviction should be overturned because it is not supported by sufficient evidence. She also argues that her feticide conviction should be overturned because the feticide statute is either inapplicable or unconstitutional as applied to her.

[4] As for the neglect conviction, we hold that the State presented sufficient evidence for a jury to find that Patel was subjectively aware that the baby was born alive and that she knowingly endangered the baby by failing to provide medical care, but that the State failed to prove beyond a reasonable doubt that the baby would not have died but for Patel's failure to provide medical care. Therefore, we vacate Patel's class A felony conviction and remand to the trial court with instructions to enter judgment of conviction for class D felony neglect of a dependent and resentence her accordingly.

[5] As for the feticide conviction, we hold that the legislature did not intend for the feticide statute to apply to illegal abortions or to be used to prosecute women for their own abortions. Therefore, we vacate Patel's feticide conviction.

Facts and Procedural History

[6] Consistent with our well-settled standard of appellate review, we recite the relevant facts most favorable to the jury's verdicts. Patel was born in the United States to immigrants from India in September 1980. She lived in a home in Granger with her parents and paternal grandparents, and she managed Moe's, a restaurant in Mishawaka owned by her father. In approximately August 2012, Patel became involved
in a sexual relationship with a married man\(^2\) and did not use birth control. She did not mention the relationship to her parents, but she did share some details of the relationship via text messages with a friend from Michigan, medical assistant Felicia “Fay” Turnbo. Tr. A at 814.\(^3\)

[7] On April 15, 2013, thirty-two-year-old Patel texted Turnbo, “[C]ramps coming n going, my cycle is changing completely due to all the stress I been under lately so not sure when my period is coming but still feeling the pain[.]” State’s Ex. 47 at 4. On April 19, she stated, “Man I’m cramping again ... my period been so funny the last 2 mths cuz of my stress[...]. I spot n then stop. But cramps come n go ... the cramps r the worst part.” Id.

[8] Just over a month later, on May 21, Patel stated, “I keep cramping bad but then my period won’t start, driving me crazy! [...] It’s been like this for 2 weeks now [...] tired of the pain[.]” Id. Turnbo replied, “U might wanna go to the Dr.[.]” *1045 Id. Patel responded, “[D]on’t like docs lol! I think it’s cuz of all the stress my body been goin thru physically n mentally[.]” Id.

[9] Two weeks later, on June 4, Patel told Turnbo that she had not had an appetite “for a while now” and indicated that she thought that she might be pregnant, but she “hope[d] not!!!!!!!!!!!!!” Id. at 5, 6. Turnbo asked, “Have u missed?” Id. at 6. Patel replied, “I been cramping like crazy tho for weeks now so I’m hoping its cuz of stress[.]” Id. Turnbo responded, “Take a test!!!!!” Id. Patel stated, “Hoping it all just goes away lol[.]” Id.

[10] On June 8, Patel took a pregnancy test. She informed Turnbo that it “didn’t even take a min[ute] for it to show” that she was pregnant and that “[m]y Fam would kill me n him[..]” Id. at 8. Patel stated, “U already know I can’t have it[..]” Id. Turnbo stated, “Now first we gotta get u to a dr. This may b[e] something that ur body is deciding on its own[...]. U can go to the urgent care place even and tell them that u took a test and it shows positive but u r cramping bad and spotting. They will do an ultrasound and let u know then we will go from there[..]” Id. at 8–9. Patel stated, “I rather not even go to a doc ... just wanna get it over with[..]” Id. at 9. Turnbo replied, “I understand that but for ur health u should go to a dr first.” Id.

[11] On June 16, Patel told Turnbo, “Btw I just realized today I’ve missed 2.” Id. at 11. Turnbo replied, “You need to go to Dr. first[..]” Id. Patel stated, “Yeah I think we need to go this week[..]” Id. Instead of going to a doctor, however, Patel performed a “good bit” of online research on medications for terminating pregnancies. Id. at 15. On June 19, Turnbo told Patel that a clinic in South Bend had “the pill for that” and estimated its cost at “between 300–400 or something like that.” Id. at 12. Patel replied, “But it’s only within 60 days ... I might be over that[.]” Id. Later that day, Patel ordered mifepristone and misoprostol\(^4\) online from a Hong Kong pharmacy for $72 and had the package shipped to Moe’s so “no one would know[..]” Id. On June 27, Patel “vent[ed]” to Turnbo that she wanted her boyfriend and “the baby outta [her] life[..]” Id. at 14.

[12] On July 1, Patel told Turnbo, “My package came[..]” Id. On July 3, Patel stated that she would wait until after she returned from a trip to Chicago to take the medications because she “[didn’t] wanna be in pain cramping all weekend while [she had to] meet with vendors[..]” Id. at 15. One week later, on July 10, Patel told Turnbo that, in accordance with her online research, she would take one mifepristone pill that morning and two misoprostol pills one to three days later, and “if it doesn’t work then 2 more [misoprostol] after 4 hrs[..] If this doesn’t work then we will have to take a trip[..]” Id. at 10:34 a.m., Patel told Turnbo that she had taken the mifepristone.

[13] At 5:22 p.m. on July 11, Patel told Turnbo that she had taken two misoprostol pills. Over the next two days, Patel experienced “horrible cramps” and intermittent bleeding. Id. at 17. On the evening of July 12, Patel told Turnbo that she would *1046 take another misoprostol pill the following evening “to give it extra time[..]” Id. at 20. That same evening, Patel visited a webpage entitled “National Abortion Federation: Abortion after Twelve Weeks.” State’s Ex. 50. At 3:44 p.m. on July 13, Patel told Turnbo that she had “[b]een home in bed since” 12:30 p.m. State’s Ex. 47 at 20. At 6:58 p.m., Patel told Turnbo that she was trying to go to the hospital “but [couldn’t] get off the bed to get dressed[..]” Id. at 21. Turnbo promptly replied, “U need to go.” Id. at 7:37 p.m., Turnbo asked Patel, “R u going to go?” Id. at 7:42 p.m., Patel replied, “Want to but can’t drive.” Id.

[14] At 8:11 p.m., Patel told Turnbo, “Just lost the baby[..]” Id. Tens less than three minutes later, Patel stated, “Imma clean up my bathroom floor n then go to Moe[.]” Id. Turnbo asked, “Was it still a clot or starting to form?” Id. Patel replied, “Starting to form a lil[..] More so big clots tho [..]” Id. In fact, Patel had delivered a baby boy measuring thirty-one
centimeters (approximately one foot) long and weighing 660 grams (slightly less than one and a half pounds).

[15] Patel cut the umbilical cord and placed the baby in a plastic shopping bag containing bathroom trash and an airline boarding pass with Patel's name. She was unable to remove "a piece of the cord hanging from [her]" and "kept bleeding thru her clothes[,]" so she drove herself to St. Joseph Regional Medical Center in Mishawaka. Id. at 21, 22. En route, she stopped at Moe's and put the bag containing the baby into a dumpster.

[16] At 9:23 p.m., Patel was admitted to the emergency room ("ER") with "a substantial amount of bleeding" and "an umbilical cord hanging from the vaginal area." Tr. A at 316. She continued to exchange texts with Turnbo throughout the evening. Patel told the ER staff that she had been ten to twelve weeks pregnant, had missed two menstrual periods, and had "just passed clots." Id. at 354. Based on the size of the umbilical cord and a physical examination of Patel, however, OB/GYN Dr. Tracy Byrne estimated that Patel had been twenty-eight to thirty weeks along, and OB/GYN Dr. Kelly McGuiire estimated that she had been at least twenty-five or twenty-six weeks "or beyond." Id. at 521. Both doctors determined that "there had to have been a baby" and questioned Patel, who finally acknowledged that she had given birth to a baby and stated that she had put it in a paper bag and placed it in a dumpster behind a Target store. Id. at 355. Because "[i]t was a warm night and based on the size of the umbilical cord[,]" Dr. McGuiire "thought that [they] could find a baby that was far enough along that could still be alive" and left the hospital to search for it. Id. at 549.

[17] Law enforcement officers were notified and searched a dumpster behind the Target store, to no avail. Patel was asked for more specific information regarding the baby's location, and she ultimately revealed that she had put the baby in a plastic bag and placed it in a dumpster behind to the left of Target," which is near Moe's. Id. at 366. Officers searched dumpsters in that area and finally found the plastic bag containing Patel's baby at 12:06 a.m.

[18] At that point, Dr. McGuiire had been participating in the search for approximately thirty to forty-five minutes. When he was informed that the baby had been found nearby, he went to the scene and removed the baby from the bag, which "was sealed shut from the blood." Id. at 542. "The baby was cold and lifeless" but "was an otherwise normal, healthy appearing baby" with no signs of trauma. Id. at 544. His "rough estimate" was that "the baby was about 30 weeks along[,]" and he would have expected a baby at that developmental *1047 stage to exhibit "movement, possibly crying" upon birth. Id. at 546, 548. He believed that the baby was viable "[d]espite the fact that it was not born in a hospital setting[.]" Id. at 549.

[19] An ultrasound revealed that Patel's uterus was full of blood. She underwent surgery to remove the placenta 5 and was interviewed by police at the hospital. Patel stated that she had always had irregular menstrual cycles and had taken a pregnancy test three weeks ago after missing a couple periods. She stated that she was suffering from cramps in her bedroom and felt a strong urge to urinate, and that "everything came out" on the bathroom floor "like [she] had no control over it" before she reached the toilet. State's Ex. 62 (video of interview). She stated that the baby did not cry after delivery and that she did not attempt CPR because it was not moving. She claimed that she tried to "open the baby's mouth and move it, and it was just a small little limpless body." Id. Patel also claimed that she had taken only pain medication, that the pregnancy was the result of a "random hookup," and that she had been "excited" about having a baby. Id.

[20] A search warrant was obtained for Patel's house. Police found blood on her bedroom floor and bathroom floor as well as on a towel, a bath mat, and a pair of underwear. DNA testing on blood samples taken from the boarding pass and the bath mat indicated that the baby could not be excluded as one of the two contributors to the samples. On Patel's iPad, police found a customer service email from InternationalDrugMart.com, from which a detective was able to order and receive one mifepristone pill and four misoprostol pills without a prescription. State's Exs. 49, 53, 54.

[21] Forensic pathologist Dr. Joseph Prahlow performed an autopsy on Patel's baby, which revealed no external or internal abnormalities. Based on various weights and measurements of the body and organs, as well as an examination of the organs both inside the body and under a microscope, Dr. Prahlow concluded that the baby was of approximately twenty-five weeks gestation, “more likely than not” was born alive, and had breathed after it was born. Tr. B at 411. For purposes of this appeal, Patel has stipulated that the baby was born alive.6 The umbilical cord *1048 showed no abnormalities, and the baby showed no signs of maceration (breaking down of tissue after death in utero) or decomposition. According to Dr. Prahlow, the manner of
death was homicide, and the possible mechanisms of death were “extreme prematurity” coupled with a lack of essential medical care, hypothermia or hyperthermia due to the baby's inability to regulate its body temperature, loss of blood due to the severed umbilical cord, or asphyxia from being placed in a plastic bag or from items inside the bag that could cover its mouth and nose. Tr. A at 1015, 957. Dr. Prahlow was unable “to draw even a very, very small amount [of the baby's blood] into a test tube for toxicology purposes[,]” which he attributed to the umbilical cord being severed and “not clamped off or tied off in any way.” Id. at 929–30. He testified that “[a]s long as the heart is beating and moving blood, then bleeding can occur. Once the heart stops [...] beating, then the blood loss would be very minimal.” Id. at 934.

[22] On July 17, 2013, the State charged Patel with class A felony neglect of a dependent, alleging that she failed to provide any medical care to her baby immediately after its birth, which resulted in its death. In August 2014, the State amended the charging information to add a charge of class B felony feticide, alleging that Patel knowingly terminated her pregnancy with the intention other than to produce a live birth or to remove a dead fetus. A jury trial was held from January 23 to February 3, 2015. The jury found Patel guilty as charged. In March 2015, the trial court sentenced Patel to thirty years of imprisonment for neglect of a dependent, with twenty years executed and ten years suspended, and a concurrent executed term of six years for feticide. Patel now appeals her convictions but does not challenge the appropriateness of her sentence.7 Additional facts will be provided as necessary.

Discussion and Decision

Section 1—The State failed to prove beyond a reasonable doubt that Patel committed class A felony neglect of a dependent.

[23] In July 2013, when the relevant events occurred, the neglect statute read in pertinent part as follows:

(a) A person having the care of a dependent, whether assumed voluntarily or because of a legal obligation, who knowingly or intentionally:

(1) places the dependent in a situation that endangers the dependent's life or health;

... commits neglect of a dependent, a Class D felony.

(b) However, the offense is:

... (3) a Class A felony if it is committed under subsection (a)(1) ... by a person at least eighteen (18) years of age and results in the death of a dependent who is less than fourteen (14) years of age[.]

Ind.Code § 35–46–1–4. A class D felony carries a sentencing range of six months to three years, with an advisory sentence of one and a half years. Ind.Code § 35–50–2–7. A class A felony carries a sentencing range of twenty to fifty years, with an advisory sentence of thirty years. Ind.Code § 35–50–2–4.

[24] The charging information alleged that Patel, who is more than eighteen (18) years old, and having the care of a dependent, *1049 did knowingly place that dependent in a situation that endangered the dependent's life or health by failing to provide any medical care for that dependent immediately after the dependent's birth, resulting in the death of that dependent, who was less than fourteen (14) years old.

Appellant's App. at 201. To establish that Patel knowingly placed her dependent in a dangerous situation, the State was required to prove that she was “aware of a high probability” that she was doing so. Ind.Code § 35–41–2–(b).

Section 1.1—Standard of review

[1] [2] [3] [4] [5] [25] Patel asserts that the State failed to present sufficient evidence to sustain her conviction. “When reviewing the sufficiency of the evidence to support a conviction, we consider only the probative evidence and reasonable inferences supporting the verdict.” Miller v. State, 916 N.E.2d 193, 198 (Ind.Ct.App.2009), trans. denied (2010). “We do not reweigh the evidence or judge the credibility of the witnesses, and we respect the jury's exclusive province to weigh conflicting evidence.” Keller v. State, 987 N.E.2d 1099, 1117 (Ind.Ct.App.2013), trans. denied. Accordingly, when confronted with conflicting evidence, we consider it most favorably to the jury's verdict. See Miller, 916 N.E.2d at 198. “To sustain a conviction under a sufficiency of the evidence challenge, there must be sufficient evidence on each material element of the offense.” Ferrell v. State, 746 N.E.2d 48, 51 (Ind.2001). We will “affirm the conviction unless no
reasonable factfinder could find the elements of the crime proven beyond a reasonable doubt. The evidence need not overcome every reasonable hypothesis of innocence.” *Miller*, 916 N.E.2d at 198–99 (citation omitted).

[6] [7] [8] [26] “Although this standard of review deferential, it is not impossible, nor can it be.” *Galloway v. State*, 938 N.E.2d 699, 709 (Ind.2010). Article 7, Section 6 of the Indiana Constitution guarantees “in all cases an absolute right to one appeal.” “An impossible standard of review under which appellate courts merely ‘rubber stamp’ the fact finder's determinations, no matter how unreasonable, would raise serious constitutional concerns because it would make the right to an appeal illusory.” *Id.* “While we seldom reverse for insufficient evidence, in every case where that issue is raised on appeal we have an affirmative duty to make certain that the proof at trial was, in fact, sufficient to support the judgment beyond a reasonable doubt.” *Bean v. State*, 818 N.E.2d 148, 150 (Ind.Ct.App.2004). “[T]he evidence is sufficient if an inference may reasonably be drawn from it to support the verdict.” *Pickens v. State*, 751 N.E.2d 331, 334 (Ind.Ct.App.2001). “A reasonable inference of guilt must be more than mere suspicion, conjecture, conclusion, guess, opportunity, or scintilla.” *Willis v. State*, 27 N.E.3d 1065, 1068 (Ind.2015) (quoting *Mediate v. State*, 498 N.E.2d 391, 393 (Ind.1986)) (alteration in *Willis* omitted).

Section 1.2—The State presented sufficient evidence for a jury to find that Patel was subjectively aware that the baby was born alive.

[9] [27] Regarding the specific elements of the neglect charge, Patel concedes that she was over eighteen years old and that her baby was less than fourteen years old and born alive and therefore a dependent for purposes of the neglect statute. *See Herron v. State*, 729 N.E.2d 1008, 1010 (Ind.Ct.App.2000) (holding that an unborn child is not a dependent for purposes of the neglect statute), *trans. denied.* Her sufficiency argument proceeds from our supreme court’s holding in *Armour v. State* that “the level of culpability required when a child neglect statute requires knowing behavior is that level *1050* where the accused must have been subjectively aware of a high probability that he placed the dependent in a dangerous situation.” 479 N.E.2d 1294, 1297 (Ind.1985). Thus, Patel contends, the first question that must be answered is whether the State presented sufficient evidence “to support a finding (even by inference) that [she] had actual awareness there was a live infant.” Appellant’s Br. at 18; *see Fout v. State*, 575 N.E.2d 340, 342 (Ind.Ct.App.1991) (“Normally a defendant's subjective awareness requires resort to inferential reasoning to ascertain a mental state.”).

[28] We conclude that it did. The evidence most favorable to the jury's verdict establishes that the baby took at least one breath and that its heart was beating after delivery and continued to beat until all of its blood had drained out of its body. *See Tr.* A at 958, 929–30, 934 (Dr. Prahlow's testimony). It is true, as Patel states, that Dr. Prahlow acknowledged that there was no way to determine how many breaths the baby took. *Id.* at 1017. But Dr. McGuire testified that, based on his observations of the baby and his training and experience, he would have expected it to exhibit “signs of life upon birth” such as “movement, possibly crying.” *Id.* at 548. Patel notes that Dr. McGuire estimated that the baby was of approximately thirty weeks gestation and never opined whether a baby of twenty-five weeks gestation (per Dr. Prahlow's estimate) would exhibit signs of life. It was exclusively within the jury's province to credit Dr. McGuire's testimony regarding the baby's gestational age and attributes based on his observations, training, and experience. *Cf.* *Robinson v. State*, 894 N.E.2d 1038, 1042 (Ind.Ct.App.2008) (affirming class A felony neglect conviction and finding sufficient evidence that baby was born alive based on doctors' testimony “and all of the evidence relied upon by these experts”).

[29] Patel also cites testimony that allegedly proves that the baby would have bled to death in less than a minute through the severed umbilical cord. *9* The State points out that “this would have occurred only after the cord was cut and not *1051* clamped, so it did not necessarily occur in the baby’s first minute of life.” Appellee's Br. at 23 n.9. There is no indication that anyone other than Patel cut the cord, and we agree with the State that “it defies credibility to suppose that [Patel] was oblivious” to a foot-long baby “exiting from her body[.]” *Id.* at 24. In fact, Patel told the police that she tried to open the baby’s mouth, from which the jury could have found that she got a good look at the baby up close. *10* And the jury could have considered Patel's false statements to Turnbo and others regarding her pregnancy, delivery, and disposal of the baby as evidence of guilty knowledge that the baby was born alive. *See Grimes v. State*, 450 N.E.2d 512, 521 (Ind.1983) (“Any testimony tending to show an accused's attempt to conceal implicating evidence or to manufacture exculpatory evidence may be considered by the trier of fact as relevant since revealing a consciousness of
guilt.”). In sum, Patel's argument on this point is an invitation to reweigh evidence, draw inferences, and reassess witness credibility in her favor, which we may not do. The State presented sufficient evidence for a jury to find that Patel was subjectively aware that the baby was born alive.

Section 1.3—The State presented sufficient evidence for a jury to find that Patel endangered her baby by failing to provide medical care.

[10] [11] [30] Next, Patel contends that the State failed to prove beyond a reasonable doubt that she actually endangered the baby by failing to provide any medical care immediately after its birth. “To endanger is to bring into danger.” State v. Downey, 476 N.E.2d 121, 123 (Ind.1985). “The placement must itself expose the dependent to a danger which is actual and appreciable.” Id. “When there are symptoms from which the average layperson would have detected a serious problem necessitating medical attention, it is reasonable *1052 for the jury to infer that the defendant knowingly neglected the dependent.” Mitchell v. State, 726 N.E.2d 1228, 1240 (Ind.2000), abrogated on other grounds by Beattie v. State, 924 N.E.2d 643 (Ind.2010).

[31] More specifically, Patel asserts that

the prosecution needed to prove, as an objective matter, the Information's allegation that by not “providing medical care immediately following the birth of the dependent,” [she] exposed the baby to danger—i.e., enhanced the risk the baby would die. And it had to prove, as a subjective matter, that [she] had actual awareness of that risk.

Appellant's Br. at 22.

[32] The evidence favorable to the jury's verdict was sufficient for a reasonable factfinder to conclude that Patel's failure to provide medical care actually endangered her significantly premature baby, who weighed less than two pounds and was bleeding from its severed umbilical cord. Patel's argument that the State failed to prove that she was actually aware of the danger is yet another invitation to reweigh the evidence, which we must decline. The State presented sufficient evidence for a jury to find that Patel endangered her baby by failing to provide medical care.

Section 1.3—The State failed to prove beyond a reasonable doubt that Patel's failure to provide medical care resulted in the baby's death.

[12] [33] By proving that Patel endangered her baby by failing to provide medical care after its birth, the State established that she committed neglect of a dependent as a class D felony. But to convict Patel of a class A felony, the State also had the burden to prove beyond a reasonable doubt that her failure to provide medical care resulted in the baby's death. We agree with Patel that the State failed to carry this burden.

[34] This Court has not been called upon to interpret the phrase “results in the death of a dependent” for purposes of the neglect statute, but caselaw suggests, and both parties agree, that this language implicates proximate causation. See Abney v. State, 766 N.E.2d 1175, 1177–78 (Ind.2002) (defendant was convicted of operating motor vehicle while intoxicated, a class C felony if it “results in the death of another person”); court held that “the State must prove the defendant's conduct was a proximate cause of the victim's injury or death” and rejected lesser standard of “contributing cause”); Mallory v. State, 563 N.E.2d 640, 643 (Ind.Ct.App.1990) (defendant was convicted of class B felony neglect of a dependent resulting in serious bodily injury, i.e., death; court held that evidence was sufficient to establish that “the death of the dependent arose as a consequence of” defendant's deprivation of support), trans. denied (1991). In the civil context, our supreme court has explained that, “[a]t a minimum, proximate cause requires that the injury would not have occurred but for the defendant's conduct.” Paragon Family Rest. v. Bartolini, 799 N.E.2d 1048, 1054 (Ind.2003). Thus, the State was required to prove beyond a reasonable doubt that the baby's death would not have occurred but for Patel's failure to provide medical care immediately after its birth. See Wayne R. LaFave, Substantive Criminal Law § 6.2(d) (2d ed.) (“Legal or ‘proximate’ cause, at the very least, requires a showing of ‘but for’ causation: but for the omission the victim would not have died. Failure on the part of a parent to *1053 call a doctor for a sick child may often make the parent criminally liable for the child's death; but only if the doctor could have saved it, not if it would have died in spite of medical attention. It is apparent that this is a matter which often is not susceptible of easy proof, and convictions have sometimes been reversed because of what the appellate court viewed as less than adequate proof of causation.”) (footnotes omitted).
[35] In *Bergmann v. State*, 486 N.E.2d 653 (Ind.Ct.App.1985), the defendants' nine-month-old daughter contracted *bacterial meningitis* and died approximately eleven days later. The defendants never sought medical care and were convicted of reckless homicide and class B felony neglect of a dependent. At trial, the State asked the coroner whether, “within the bounds of reasonable medical certainty,” the child would have died if she had been “timely medically treated.” *Id.* at 657. The coroner opined that the child “would have had a very good chance” of surviving if “she had timely treatment”; that she “had no chance of survival without medical treatment”; and that “early treatment in cases of this type provides a 90–95% survival rate.” *Id.* On appeal, the defendants dismissed this opinion as “speculation,” but we stated that it “was probative evidence because it was based upon reasonable medical certainty.” *Id.* And in *Brown v. State*, 770 N.E.2d 275 (Ind.2002), the State elicited testimony from a doctor that the victim's “chances for survival were good had she received prompt medical treatment” after her father fractured her skull with a wooden paddle. *Id.* at 281. The court affirmed the victim's mother's neglect conviction, holding that “overwhelming evidence” proved that the victim “would still be alive had she received [medical treatment] promptly.” *Id.*

[13] [36] Patel observes that the State failed to elicit similar testimony from its medical experts in this case. The State chastises Patel for “deliberately induc[ing] the premature delivery of her baby” with no “medical supervision and in a setting where there would be no [neonatal intensive care unit] or medical help available for the child.” Appellee's Br. at 28, 29. But these considerations are invalid under *Herron*, in which we stated that the plain language of the neglect statute “contemplates only acts that place one who is a dependent at the time of the conduct at issue in a dangerous situation—not acts that place a future dependent in a dangerous situation.” 729 N.E.2d at 1011.13 The State also criticizes Patel for cutting the umbilical cord “without first calling 911 or otherwise seeking medical advice.” Appellee's Br. at 29. However, the State charged Patel with neglect based on her failure to provide medical care, not her affirmative act of cutting the umbilical cord. “It is a denial of due process of law to convict an accused of a charge not made.” *Hazlett v. State*, 229 Ind. 577, 583, 99 N.E.2d 743, 745 (1951).

[37] In an attempt to bridge the evidentiary gap, the State points to Dr. McGuire's testimony that “it was ‘absolutely possible’ that the baby could have survived even though not born in a hospital,” as well as Dr. Byrne's testimony that a baby of twenty-four weeks gestation would “have a better chance of survival with medical intervention”14 and Dr. Prahlow's *1054* testimony that “the baby's lungs were sufficiently developed to be capable of respiration” and that he “found no abnormalities or problems in his examination of the baby.” *Id.* at 29, 30 (quoting Tr. A at 549). However, none of the witnesses testified as to how quickly any medical care could have been provided or whether it could have changed the outcome. At most, the foregoing testimony establishes only a possibility that Patel's baby would not have died but for Patel's failure to provide medical care immediately after its birth.15 As such, it falls short of satisfying the State's burden of proving guilt with respect to this element beyond a reasonable doubt. *See Willis, 27 N.E.3d at 1068* (a reasonable inference of guilt must be more than mere conjecture).

[38] Courts in other states have confronted similar evidentiary shortfalls regarding causation and reached similar conclusions. See, e.g., *Commonwealth v. Pugh*, 462 Mass. 482, 969 N.E.2d 672, 688 (2012) (reversing mother's involuntary manslaughter conviction following unassisted home breech birth: “Speculation that the baby might have survived if the defendant had summoned medical help does not satisfy the Commonwealth's burden of proving causation beyond a reasonable doubt because that the baby *might* have survived with proper care ... engender[ed] considerable doubt as to what actually happened.”) (citation and quotation marks omitted); *State v. Muro*, 269 Neb. 703, 695 N.W.2d 425, 432 (2005) (finding evidence insufficient to support mother's conviction for child abuse resulting in death where medical experts could not say that survival was probable with immediate treatment for victim's skull fracture: “The State proved only the *possibility* of survival with earlier treatment. Such proof is insufficient to satisfy even the lesser civil burden of proof by a preponderance of the evidence.”). In *Ex parte Lucas*, 792 So.2d 1169 (Ala.2000), the Supreme Court of Alabama reversed a mother's murder conviction premised on her failure to provide medical services to her child:

The crucial issue is not whether Lucas had a duty to provide her injured child with medical treatment or whether she breached that duty. The evidence is sufficient to establish that Lucas, as the child's mother, at some point owed a duty to seek medical treatment for her child. The evidence is arguably sufficient to establish that, at some point, Lucas breached her duty by failing to seek medical treatment sooner than she finally sought it. The compelling issue on the merits before this Court, however, is whether the evidence establishes that Lucas's breach of duty caused her son's death. Does the evidence establish *1055* that but
for Lucas's failure to seek prompt medical treatment for her son, her son's life would have been saved or extended? Neither the emergency room pediatrician ... nor the forensic pathologist ... testified that the child would have lived or lived longer if he had received medical treatment promptly after he was battered. They were the State's only medical experts.

Id. at 1171 (citation omitted).

[39] We are faced with a comparable lack of evidence here. Based on the foregoing, we conclude that the State failed to prove beyond a reasonable doubt that Patell's failure to provide medical care resulted in her baby's death. Therefore, we vacate Patell's conviction for class A felony neglect of a dependent and remand to the trial court with instructions to enter judgment of conviction for class D felony neglect of a dependent and resentencce her accordingly.

Section 2—Indiana's feticide statute does not apply to Patell's conduct.

[40] In July 2013, the feticide statute read as follows:

A person who knowingly or intentionally terminates a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus commits feticide, a Class B felony. This section does not apply to an abortion performed in compliance with:

(1) IC 16–34; or

(2) IC 35–1–58.5 (before its repeal).


[41] The charging information alleged in pertinent part,

Between the 9th day of July 2013, and July 13, 2013, ... [Patell] did knowingly terminate a human pregnancy, to-wit: her own pregnancy, by ingesting the medication mifepristone and/or misoprostol, or equivalent medication under generic or alternate brand name, with the intention other than to produce a live birth or to remove a dead fetus, and the conduct of [Patell] was not an abortion performed in compliance with I.C. 16–34. Appellant's App at 219–20.

[42] As a preliminary matter, we address Patell's contention that the feticide statute is inapplicable to her because it requires the death of a fetus. The plain wording of the statute indicates otherwise. See Herron, 729 N.E.2d at 1010 (“[I]t is just as important to recognize what a statute does not say as it is to recognize what it does say. A court may not read into a statute that which is not the expressed intent of the legislature.”). Patell's argument relies primarily on the dictionary definition of feticide, i.e., “the act of causing the death of a fetus.” Merriam–Webster Online Dictionary, http://www.merriam-webster.com/dictionary/feticide (last visited June 30, 2016). But the statute merely defines the crime and labels it feticide, in apparent disregard of that definition. The State correctly observes that “Indiana does not define the crime of feticide as ‘the killing of a fetus’ ” and that “[a] live birth undeniably constitutes a termination of a pregnancy.” Appellee's Br. at 49, 50. “[W]hen a government entity's intent reveals that a word is used in a manner different from its common dictionary definition, the common dictionary definition must be disregarded.” Bd. of Dirs. of Bass Lake Conservancy Dist. v. Brewer, 839 N.E.2d 699, 702 (Ind.2005) (citation and quotation marks omitted). Another panel of this Court has recognized that “the language of the [feticide] statute could lead to many possibly absurd outcomes.” Shual v. State, 966 N.E.2d 619, 629 n.15 (Ind.Ct.App.2012), trans. denied. In this case, the apparently absurd outcome is a *1056 woman being convicted under both the neglect of a dependent statute, which requires a live infant, and the feticide statute, which does not require a dead infant.

Section 2.1—Standard of review

[14] [15] [16] [17] [43] Patell raises several additional challenges to the applicability of the feticide statute, most of which involve statutory interpretation. “The interpretation of a statute is a legal question, which we review de novo.” Ashley v. State, 757 N.E.2d 1037, 1039 (Ind.Ct.App.2001). “The first and often last step in interpreting a statute is to examine the language of the statute. We will not, however, interpret a statute that is clear and unambiguous on its face.” Id. at 1040 (citation omitted). “Our role on appeal is to interpret and apply the statute, and absent some ambiguity, we may not substitute language that is not there.” Id.

best evidence of legislative intent is surely the language of the statute itself, and courts strive to give the words in a statute their plain and ordinary meaning.”  

Prewitt v. State, 878 N.E.2d 184, 186 (Ind.2007). “Indispens[able] to ascertaining the legislature's intent is a consideration of the goals sought to be achieved and the reasons and policy underlying a statute. Consequently, it is necessary to view a statute within the context of the entire act, rather than in isolation, when construing the statute.”  

Alvers, 489 N.E.2d at 88 (citation omitted).

[21] [22] [23] [24] [45] Penal statutes, such as those at issue here, must be strictly construed against the State. Id. at 89. “Criminal statutes cannot be enlarged by construction, implication, or intention beyond the fair meaning of the language used.”  

Herron, 729 N.E.2d at 1010. “Even though an act may fall within the spirit of a statute, it will not constitute a crime unless it is also within the words of the statute.”  

Id. “However, [criminal] statutes must not be construed so narrowly as to exclude cases fairly covered thereby.”  

Alvers, 489 N.E.2d at 89.

Section 2.2—The legislature did not intend for the feticide statute to apply to illegal abortions.

[46] As mentioned above, the feticide statute provides in pertinent part that it “does not apply to an abortion performed in compliance with ... IC 16–34 [.]”  

Ind.Code § 35–42–1–6. Title 35 of the Indiana Code, in which the feticide statute appears, is entitled Criminal Law and Procedure. Title 16 is entitled Health, and Article 16–34 is entitled Abortion. Indiana Code Section 16–18–2–1 defines abortion for purposes of Title 16 as “the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus. The term includes abortions by surgical procedures and by abortion inducing drugs.”  

Indiana Code Section 16–34–2–1(a) provides that “[a]bortion shall in all instances be a criminal act, except when performed under” certain specified circumstances. Patel effectively concedes that the termination of her pregnancy was an abortion that was not performed under those circumstances.  

*1057 [47] Nevertheless, she asserts that the feticide statute “is simply not the law that governs unlawful abortions; rather, unlawful abortions are governed by the Unlawful Abortion Statute,  

Ind.Code § 16–34–2–7, which defines various offenses and sentences for abortions proscribed by law.”  

Appellant's Br. at 30. She claims that this matter was resolved by the Indiana Supreme Court in Baird v. State, 604 N.E.2d 1170 (Ind.1992), cert. denied (1993), in which the defendant strangled his wife, who was six months pregnant. The fetus apparently died in utero. Baird was convicted of murder and feticide. On appeal, he argued that the feticide statute “was enacted to punish those who perform illegal abortions and cannot reasonably be applied to a crime in which the sole act was the killing of a pregnant woman and in which there was no evidence that the defendant intended to harm the fetus.”  

Baird, 604 N.E.2d at 1189. Our supreme court disagreed:

The feticide statute is contained in chapter 1 of article 42, Homicide, and its language exempts legal abortions. The chapter which contains the provisions regulating abortion is I.C. 35–1–58.5. Section 4 of that chapter makes it a Class C felony to knowingly or intentionally perform an abortion not expressly provided for in that chapter (or a Class A misdemeanor for a physician who performs an abortion intentionally or knowingly in violation of section 2(1)(C) or section 2.5 of that chapter). A proper construction of the feticide statute, therefore, requires that it be viewed not as an illegal abortion statute, but as an extension of the laws of homicide to cover the situation in which the victim is not a “human being” as defined by I.C. 35–41–1–14 (an individual who has been born and is alive), but a fetus.  

Id.

[48] Today, the feticide statute is still contained in Chapter 1 of Article 42, Homicide, and its language still exempts legal abortions. But in 1993, after our supreme court decided Baird, our legislature recodified the provisions regulating abortion under Chapter 16–34–2, entitled Requirements for Performance of Abortion; Criminal Penalties. We find this to be a strong indication of legislative intent to draw an even clearer distinction between feticide and illegal abortions.

[49] The successor to Indiana Code Section 35–1–58.5–4,  

Indiana Code Section 16–34–2–7, read as follows in July 2013:

(a) Except as provided in subsections (b) and (c), a person who knowingly or intentionally performs an abortion not expressly provided for in this chapter commits a Class C felony [punishable by two to eight years of imprisonment under Indiana Code Section 35–50–2–6].

(b) A physician who performs an abortion intentionally or knowingly in violation of section 1(a)(1)(C) or 4 of this chapter [requiring written consent of the woman's parent or
guardian] commits a Class A misdemeanor [punishable by up to one year of imprisonment under Indiana Code Section 35–50–3–2].

*1058 (c) A person who knowingly or intentionally performs an abortion in violation of section 1.1 of this chapter [requiring informed consent and fetal ultrasound] commits a Class A infraction [subject to a maximum judgment of $10,000 under Indiana Code Section 34–28–5–4].

(d) A woman upon whom a partial birth abortion is performed may not be prosecuted for violating or conspiring to violate section 1(b) of this chapter.18

Patel observes that if the feticide statute were to apply to unlawful abortions, “each and every one of these would automatically constitute Feticide, a Class B felony, punishable by 6–20 years imprisonment.” Appellant's Br. at 31 (bold emphasis omitted). She argues, “Thus, a prosecutor would have absolute discretion to bring a Feticide charge and secure a sentence of up to 20 years, as compared to an infraction, misdemeanor, or lesser-class felony as set forth in the Unlawful Abortion Statute.” Id.

[25] [50] We cannot conclude that this would be permissible under Baird. We acknowledge that, unlike Patel’s baby, the victim’s fetus in Baird was not delivered alive or as the result of an abortion. But we read our supreme court’s opinion in Baird as standing for the unremarkable proposition that illegal abortions are governed by “the provisions regulating abortion” (now in Title 16), and not the feticide statute (still in Title 35). Since the legislature enacted the feticide statute in 1979, it has been used to prosecute third parties who knowingly terminate pregnancies by using violence against the expectant mother without her consent.19 See, e.g., Shane v. State, 716 N.E.2d 391 (Ind.1999) (shooting); Hicks v. State, 690 N.E.2d 215 (Ind.1997) (shooting); Baird, 604 N.E.2d 1170 (strangulation); Perigo v. State, 541 N.E.2d 936 (Ind.1989) (beating with baseball bat); Abbott v. State, 535 N.E.2d 1169 (Ind.1989) (shooting).20 This is the first case that we are aware of in which the State has used the feticide statute to prosecute a pregnant woman (or anyone else) for performing an illegal abortion, as that term is commonly understood.21 We find this to be an abrupt departure from the *1059 foregoing cases as well as the much more recent Kendrick v. State, in which the State used the feticide statute to prosecute a bank robber who shot a pregnant teller in the abdomen. 947 N.E.2d 509 (Ind.Ct.App.2011), trans. denied, cert. denied (2012). In its appellate brief in Kendrick, the State “ma[de] clear that the victim of feticide is the mother (the one whose pregnancy has been terminated).” Id. at 514 n. 7. The State’s about-face in this proceeding is unsettling, as well as untenable under Baird.

[51] Furthermore, we cannot conclude that the legislature intended for the specific provisions and lesser penalties in Indiana Code Section 16–34–2–7 to be subsumed by the general and more punitive feticide statute. See Riley v. State, 711 N.E.2d 489, 495 (Ind.1999) (“[W]e do not presume that the legislature intended language used in a statute to be applied illogically or to bring about an unjust or absurd result[.]”); Alvers, 489 N.E.2d at 88 (noting that courts may “look beyond the statute’s language to the titles and headings of the statute” to determine legislative intent). We find it significant that although the definition of abortion in Title 16 and the definition of feticide in Title 35 are nearly identical, only the former mentions surgical procedures and abortion-inducing drugs. Also, we find it significant that the feticide statute does not say that it applies to an abortion performed in violation of Chapter 16–34. See Herron, 729 N.E.2d at 1010 (“[I]t is just as important to recognize what a statute does not say as it is to recognize what it does say. A court may not read into a statute that which is not the expressed intent of the legislature.”).

[52] The State directs us to Indiana Code Section 16–34–2–3, which provides in relevant part as follows:

(a) All abortions performed on and after the earlier of the time a fetus is viable or the time the postfertilization age of the fetus is at least twenty (20) weeks shall be:

(1) governed by section 1(a)(3) and 1(b) of this chapter;

(2) performed in a hospital having premature birth intensive care units, unless compliance with this requirement would result in an increased risk to the life or health of the mother; and

(3) performed in the presence of a second physician as provided in subsection (b).

(b) An abortion may be performed after the earlier of the time a fetus is viable or the time the postfertilization age of the fetus is at least twenty (20) weeks only if there is in attendance a physician, other than the physician performing the *1060 abortion, who shall take control of and provide immediate care for a child born alive as a result of the abortion. During the performance of the
abortion, the physician performing the abortion, and after the abortion, the physician required by this subsection to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child. However, this subsection does not apply if compliance would result in an increased risk to the life or health of the mother.

(c) Any fetus born alive shall be treated as a person under the law, and a birth certificate shall be issued certifying the child's birth even though the child may subsequently die, in which event a death certificate shall be issued. Failure to take all reasonable steps, in keeping with good medical practice, to preserve the life and health of the live born person shall subject the responsible persons to Indiana laws governing homicide, manslaughter, and civil liability for wrongful death and medical malpractice.

[53] The State contends that this statute demonstrates that the legislature never intended all abortion attempts to be subject only to the unlawful abortion statute in Title 16. At the very least, under the circumstances of this case it is clear that the legislature did not intend the unlawful abortion statute to be the sole avenue of prosecution. The evidence shows that [Patel's] baby was on or past the age of viability. [Patel] did not induce the termination of her pregnancy in a hospital with a premature birth intensive care unit or in the presence of a second physician who would be available to care for the baby, the baby was born alive, and [Patel] was the sole person responsible for failing to take any, much less all, reasonable steps to attempt to preserve his life and health. As such, she was subject to the Indiana laws governing homicide, which include the feticide statute. Appellee's Br. at 45.

[54] Indiana Code Section 16–34–2–3(c) is the provision in Chapter 16–34–2 that most closely addresses the circumstances of Patel's abortion, i.e., the abortion of a viable fetus that results in a live birth. But the phrases “physician performing the abortion,” “good medical practice,” “medical malpractice,” and “responsible persons,” as well as the wording of the statute as a whole, indicate that the legislature intended for any criminal liability to be imposed on medical personnel, not on women who perform their own abortions, which brings us to Patel's next argument.

Section 2.3—The legislature did not intend for the feticide statute to apply to women who have abortions.

[55] Patel traces the history of abortion legislation in Indiana, noting that “the first abortion statute in 1835 did not punish women who had abortions[,]” Appellant's Br. at 36. In 1881, the legislature enacted a misdemeanor statute that punished *1061 women who had abortions, but it “was only applied to third parties who performed or procured the miscarriage.” Shuai, 966 N.E.2d at 635 (Riley, J., dissenting). Patel also notes that in 1977, four years after the U.S. Supreme Court legalized abortion in Roe v. Wade, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), the legislature repealed the misdemeanor statute and also removed language from a 1973 statute that made it a crime for persons to knowingly aid or abet the performance of an abortion. 1977 Ind. Acts ch. 335, §§ 21, 1.

[56] In a footnote in her brief, Patel asserts that “English common law afforded pregnant women immunity from prosecution for their own abortions” and notes that the Shuai majority rejected a similar assertion regarding the actions of a pregnant woman against her own fetus. Appellant's Br. at 40 n.11 (citing Shuai, 966 N.E.2d at 631). Patel observes that we may decide the issue differently, should we reach it, and claims that “[s]pace limitations preclude offering arguments on that issue beyond the adoption by reference of Judge Riley's analysis” in her Shuai dissent. Id. This tangential reference to common law immunity is insufficient to preserve the issue on appeal, especially since it was not raised before the trial court. See Hape v. State, 903 N.E.2d 977, 997 (Ind.Ct.App.2009) (stating that a party may not raise an argument for the first time on appeal), trans. denied; see also Bigler v. State, 732 N.E.2d 191, 197 (Ind.Ct.App.2000) (“[A] party may not present an argument entirely by incorporating by reference from a source outside the appellate briefs.”), trans. denied. In any event, if common law immunity ever did exist in Indiana, it was eliminated by the passage of the 1881 misdemeanor statute.

[57] That being said, we are persuaded by Patel's argument that the legislature's repeal of the 1881 statute and its amendment of the 1973 statute “evince an unmistakable legislative decision not to prosecute a woman under the abortion laws based on her own abortion.” Appellant's Br. at 37. Moreover, as mentioned above, the legislature has exempted pregnant women from prosecution for having partial birth abortions, which are prohibited in most
two years before it enacted the feticide statute, we conclude that the legislature never intended the feticide statute to apply to pregnant women in the first place and therefore never saw the need to create an exception. Accordingly, we vacate Patel's feticide conviction.

Conclusion

[59] We vacate Patel's convictions for class A felony neglect of a dependent and feticide. We remand to the trial court with instructions to enter judgment of conviction for class D felony neglect of a dependent and resentencing Patel accordingly.

[60] Vacated and remanded.

VAIDIK, C.J., and BAILEY, J., concur.

All Citations

60 N.E.3d 1041

Footnotes

1 We heard oral argument on May 23, 2016. We thank the parties for their presentations.

2 See State's Ex. 47 at 2 (mentioning man's wife).

3 The trial was recorded by two court reporters, and the second reporter started renumbering the transcript at page 1. We refer to the first part of the transcript as "Tr. A" and the second part as "Tr. B."

4 According to OB/GYN Dr. Kelly McGuire, mifepristone, also known as RU–486, is a "progesterone antagonist" most commonly used for "first trimester abortions" and is "approved [...] up until 49 days of gestation [,]” presumably by the FDA. Tr. B at 550. It "attack[s] the placental tissue and by attacking the placental tissue, it indirectly would kill the baby." Id. Misoprostol, also known as cytotec, is "used to cause uterine contractions" and "induce labor[,]” Id. at 551. In response to a question from the State, Dr. McGuire testified that only a doctor may administer or prescribe misoprostol. Id. at 581–82. He was not asked the same question about mifepristone.

5 Pathologist Dr. Bobbie Sutton testified that the placenta weighed 231 grams, which "falls right in that mean placental weight or average placental weight for about 26 to 27 weeks gestational age which is right at about the end of the second to early third trimester." Tr. B at 90.

6 Amici The Innocence Network and Dr. Gregory J. Davis challenge Dr. Prahlow's conclusion that Patel's baby was born alive, focusing primarily on the reliability of the lung flotation test performed during the autopsy. Dr. Prahlow acknowledged that the test is "necessarily unreliable all by itself" but stated that it "can be part of an entire equation that leads to a conclusion that a baby breathed after birth." Tr. A at 947. He testified that the baby's lungs were "spongy,” “felt like they had air in them, just touching them,” and “substantially filled" the "pleural spaces” in the chest cavity, which "is an indication that there is air in the lungs.” Id. at 939. He further testified that “the bronchioles or the air tubes as well as the alveoli, the air [sacs], were consistent microscopically with being aerated as well.” Id. at 948. According to Dr. Prahlow, the baby's lungs also contained "fairly large blood vessels" that were “filled with blood,” which occurs when a baby breathes. Tr. B at 936–97. And finally, he testified that he had “done [his] share of autopsies of “discarded newborn infants [...] over the years” and that this was "the first case" where he “felt confident enough in [his] findings to say [he believed] that this baby was born alive, meaning that it breathed.” Tr. A at 1024. Because Patel does not challenge the admissibility of Dr. Prahlow's testimony and has stipulated that her baby was born alive, the amici's argument is moot.

Indeed, the jury in this case was instructed that “[t]o be guilty of Neglect of a Dependent the conduct alleged must be

Patel asserts that Dr. McGuire testified that “only neonatalogists have the expertise to testify about these first moments following birth of a severely premature infant.” Appellant's Br. at 21 n.5 (citing Tr. A at 510, 564). Dr. McGuire actually stated, “[W]hen we deliver the babies as obstetricians, we deliver the babies and in these premature cases, then we're going to hand them off to a neonatologist for care and then we'll follow along to find out how the babies did[.]” Tr. A at 510. He also stated that a question regarding the treatment “issues” presented by a baby of twenty-four weeks gestation would be “better directed to a neonatologist.” Id. at 564. In any event, Patel did not object to Dr. McGuire's testimony on this basis at trial and therefore has waived any claim of error on appeal. See Lanham v. State, 937 N.E.2d 419, 423 (Ind.Ct.App.2010) (“The failure to object at trial to the admission of evidence results in waiver of that issue on appeal.”).

Dr. Prahlow testified that a baby the size of Patel's would have approximately twenty-five to fifty milliliters of blood in its body (roughly the volume of a shot glass) and that a person could go into shock and die after rapidly losing twenty-five percent of his blood. Tr. A at 932, 992. Patel's counsel questioned Dr. Prahlow about the “rate of blood flow through the umbilical cord[.]” Id. at 976. Counsel stated that he “looked it up in an article called Fetal Circulation.... in a magazine called Prenatal Diagnosis[,]” which purportedly gave a rate of thirty-five milliliters per minute for a fetus of twenty weeks gestation, and asked Dr. Prahlow if that “sound[ed] about right[,]” Id. Dr. Prahlow replied, “I have no reason to doubt that but I'd probably like to look at the article, et cetera.” Id. at 977. Dr. Prahlow ultimately testified that he was not familiar with that publication and did not “have any independent verification” that it was relied on by professionals. Id. at 982. In her brief, Patel cites several facts and figures regarding fetal blood circulation and blood loss that were not presented to the jury at trial. Appellant's Br. at 18–19 n.3. Cf. Jackson v. Virginia, 443 U.S. 307, 318, 99 S.Ct. 2781, 61 L.Ed.2d 560 (1979) (“[T]he critical inquiry on review of the sufficiency of the evidence to support a criminal conviction must not simply to determine whether the jury was properly instructed, but to determine whether the record evidence could reasonably support a finding of guilt beyond a reasonable doubt.”) (emphasis added). The State also relies on extrarecord sources regarding fetal viability in its brief. Appellee's Br. at 28.

For this reason, Patel's reliance on Taylor v. State, 28 N.E.3d 304 (Ind.Ct.App.2015), trans. denied, is misplaced. In Taylor, the State failed to prove that the mother subjectively became aware that her sleeping one-year-old son needed medical care before he died. See id. at 309 (“In this instance, the jury simply was not provided evidence that Taylor inflicted an injury, was present when injury was inflicted, heard the infliction of injury, or saw manifestations of an injury necessitating medical care. Although Taylor conceivably or hypothetically could have seen an injury of such severity that immediate medical care would be warranted, there is no evidence that she did so.”).

Patel claims that she had a “hazy eye” and “staggered into the bathroom” during the birthing process. Appellant's Br. at 19, 20. Yet she fails to acknowledge that she was able to text a running commentary to Turnbo, cut the umbilical cord, attempt to clean the bathroom floor, drive herself to Moe’s, dispose of the baby, and drive herself to the ER. Moreover, Dr. George Drew testified that Patel did not “appear to be in danger of passing out or comatose” when she arrived at the ER. Tr. A at 339. Patel also claims that she “believed she was only 10– to 12–weeks pregnant” and thus “there is no reason to assume that she would have immediately inspected ... what she was sure was a 10– to 12–week–old undeveloped fetus.” Appellant's Br. at 20. Although the jury is always free to disregard a self-serving claim, Patel’s text messages indicating that she would have immediately inspected the uterus, her perusal of a webpage entitled “Abortion after Twelve Weeks,” and her false statements to Turnbo and others provide affirmative evidence to the contrary.

Patel cites no authority for her suggestion that the State was required to prove, for purposes of establishing endangerment, that the medical care would “have made any difference.” Appellant's Br. at 22. Neither the neglect statute nor caselaw imposes such a requirement.

Indeed, the jury in this case was instructed that “[t]o be guilty of Neglect of a Dependent the conduct alleged must be based on acts committed by the Defendant that occurred after the birth of the child.” Appellant's App. at 277 (emphasis added).

The State notes that Dr. Byrne testified that the survival rate for a baby of twenty-four weeks gestation was “much higher” than forty percent, Tr. A at 479, but he clarified that this statistic is for hospital births. Id. at 480. Dr. Byrne also testified that “[s]ometimes babies” of twenty-three to twenty-five weeks gestation “will need help with breathing and they'll need to be ventilated. Sometimes they'll need medication to start out in terms of to boost their heart rate. It all depends.” Id. at 481. The State elicited no testimony regarding how quickly such treatment could have been provided or whether it could have made any difference in this case. By contrast, Patel's expert, forensic pathologist Dr. Shaku Teas, testified that,
In fact, the State failed to establish that Patel's baby would have had even a fifty-percent chance of survival if she had provided medical care immediately after its birth. Cf. Mayhue v. Sparkman, 653 N.E.2d 1384, 1387 (Ind.1995) ("Where a patient's illness or injury already results in a probability of dying greater than 50 percent, an obvious problem appears. No matter how negligent the doctor's performance, it can never be the proximate cause of the patient's death. Since the evidence establishes that it is more likely than not that the medical problem will kill the patient, the disease or injury would always be the cause-in-fact.").

Indiana Code Section 16–18–2–1.6 defines “abortion inducing drug” in pertinent part as “a medicine, drug, or substance prescribed or dispensed with the intent of terminating a clinically diagnosable pregnancy with the knowledge that the termination will, with reasonable likelihood, cause the death of the fetus.”

Because we resolve this issue on other grounds, we need not address Patel’s argument that applying the feticide statute to women who choose abortions would violate the Indiana and U.S. Constitutions, an argument that she raises for the first time in this appeal. We do note, however, that the Indiana Supreme Court recently expressed its “view that judicial intervention to address constitutional claims for the first time at the appellate level is not appropriate, especially ... where for the most part Appellants’ claims are dependent on potentially disputed facts.” Layman v. State, 42 N.E.3d 972, 976 (Ind.2015). Also, in Clinic for Women, Inc. v. Brizzi, 837 N.E.2d 973 (Ind.2005), the court left open the question of whether Article 1, Section 1 of the Indiana Constitution confers the right to an abortion. And in Planned Parenthood of Southeastern Pennsylvania v. Casey, the U.S. Supreme Court confirmed “the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health.” 505 U.S. 833, 846, 112 S.Ct. 2791, 120 L.Ed.2d 674 (1992).

Indiana Code Section 16–34–2–1(b) provides, “A person may not knowingly or intentionally perform a partial birth abortion unless a physician reasonably believes that: (1) performing the partial birth abortion is necessary to save the mother's life; and (2) no other medical procedure is sufficient to save the mother's life.”


In 2009, the legislature enacted a statute authorizing a sentencing enhancement of six to twenty years if the State “can show beyond a reasonable doubt that the person, while committing or attempting to commit murder under IC 35–42–1–1(1) or IC 35–42–1–1(2), caused the termination of a human pregnancy.” Ind.Code § 35–50–2–16(a). “[E]nhancement of the penalty for that crime does not require proof that: (1) the person committing or attempting to commit the murder had knowledge or should have had knowledge that the victim was pregnant; or (2) the defendant intended to cause the termination of a human pregnancy.” Ind.Code § 35–50–2–16(d). This statute is further evidence of the legislature’s intent that feticide be viewed as a crime committed against a pregnant woman and not as a crime committed by a pregnant woman.

In Shuai, 966 N.E.2d 619, the defendant was charged with murder and attempted feticide after she ingested rat poison in an attempt to kill herself and her late-term fetus, which was delivered alive via caesarean section and later died as a result of the poison. On appeal from the denial of her motion to dismiss the charges, Shuai argued that the feticide statute was ambiguous as applied to her and that it did not apply to pregnant women in relation to their own fetuses. The majority explicitly rejected Shuai's first argument and implicitly rejected the second. See id. at 629 (“Nor can we find the feticide statute ambiguous as applied here, as it is undisputed Shuai's pregnancy was terminated when A.S. was born, and the State seems prepared to argue it was Shuai's intent to end her pregnancy when she ingested rat poison.”). The State notes that the legislature has not amended the feticide statute since Shuai was decided and argues that this alleged acquiescence shows that the majority “correctly applied the feticide statute in accord with the legislative intent[,]” i.e., that it may apply “to a woman with regard to her own pregnancy[,]” Appellee's Br. at 35. At its core, Shuai was a case of attempted suicide with the termination of a pregnancy as a collateral consequence. Because the majority did not specifically address whether the feticide statute applies to illegal abortions, we do not find Shuai persuasive or controlling here.
See 1835 Ind. Acts ch. XLVII, § 3 ("That every person who shall wilfully administer to any pregnant woman, any medicine, drug, substance or thing whatever, or shall use or employ any instrument or other means whatever, with intent thereby to procure the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of such woman, shall upon the conviction, be punished by imprisonment in the county jail any term of time not exceeding twelve months, and be fined any sum not exceeding five hundred dollars.").

See 1894 Ind. Acts ch. 651, § 1997 ("Every woman who shall solicit of any person any medicine, drug, or substance or thing whatever, and shall take the same, or shall submit to any operation or other means whatever, with intent thereby to procure a miscarriage, except when by a physician for the purpose of saving the life of mother or child, shall be fined not more than $500 nor less than ten dollars, and imprisoned in the county jail not more than twelve months or less than 30 days, and any person who in any manner whatever unlawfully aids or assists any such woman to be a violation of this section, shall be liable to the same penalty.").
AN ACT

relating to abortion, including abortions after detection of an unborn child's heartbeat; authorizing a private civil right of action.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. This Act shall be known as the Texas Heartbeat Act.

SECTION 2. The legislature finds that the State of Texas never repealed, either expressly or by implication, the state statutes enacted before the ruling in Roe v. Wade, 410 U.S. 113 (1973), that prohibit and criminalize abortion unless the mother's life is in danger.

SECTION 3. Chapter 171, Health and Safety Code, is amended by adding Subchapter H to read as follows:

SUBCHAPTER H. DETECTION OF FETAL HEARTBEAT

Sec. 171.201. DEFINITIONS. In this subchapter:

(1) "Fetal heartbeat" means cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac.

(2) "Gestational age" means the amount of time that has elapsed from the first day of a woman's last menstrual period.

(3) "Gestational sac" means the structure comprising the extraembryonic membranes that envelop the unborn child and that is typically visible by ultrasound after the fourth week of pregnancy.

(4) "Physician" means an individual licensed to practice medicine in this state, including a medical doctor and a doctor of osteopathic medicine.

(5) "Pregnancy" means the human female reproductive condition that:

(A) begins with fertilization;

(B) occurs when the woman is carrying the developing human offspring; and

(C) is calculated from the first day of the woman's last menstrual period.

(6) "Standard medical practice" means the degree of skill, care, and diligence that an obstetrician of ordinary judgment, learning, and skill would employ in like circumstances.

(7) "Unborn child" means a human fetus or embryo in any stage of gestation from fertilization until birth.

Sec. 171.202. LEGISLATIVE FINDINGS. The legislature finds, according to contemporary medical research, that:

(1) fetal heartbeat has become a key medical predictor that an unborn child will reach live birth;

(2) cardiac activity begins at a biologically identifiable moment in time, normally when the fetal heart is formed in the gestational sac;

(3) Texas has compelling interests from the outset of a woman's pregnancy in protecting the health of the woman and the life of the unborn child; and

(4) to make an informed choice about whether to continue her pregnancy, the pregnant woman has a compelling interest in knowing the likelihood of her unborn child surviving to full-term birth based on the presence of cardiac activity.

Sec. 171.203. DETERMINATION OF PRESENCE OF FETAL HEARTBEAT REQUIRED; RECORD. (a) For the purposes of determining the presence of a fetal heartbeat under this section, "standard medical practice" includes employing the appropriate means of detecting the
heartbeat based on the estimated gestational age of the unborn child and the condition of the woman and her pregnancy.

(b) Except as provided by Section 171.205, a physician may not knowingly perform or induce an abortion on a pregnant woman unless the physician has determined, in accordance with this section, whether the woman's unborn child has a detectable fetal heartbeat.

(c) In making a determination under Subsection (b), the physician must use a test that is:
   (1) consistent with the physician's good faith and reasonable understanding of standard medical practice; and
   (2) appropriate for the estimated gestational age of the unborn child and the condition of the pregnant woman and her pregnancy.

(d) A physician making a determination under Subsection (b) shall record in the pregnant woman's medical record:
   (1) the estimated gestational age of the unborn child;
   (2) the method used to estimate the gestational age; and
   (3) the test used for detecting a fetal heartbeat, including the date, time, and results of the test.

Sec. 171.204. PROHIBITED ABORTION OF UNBORN CHILD WITH DETECTABLE FETAL HEARTBEAT; EFFECT. (a) Except as provided by Section 171.205, a physician may not knowingly perform or induce an abortion on the unborn child as required by Section 171.203 or failed to perform a test to detect a fetal heartbeat.

(b) A physician who performs an abortion under circumstances described by Subsection (a) shall make written notations in the pregnant woman's medical record:
   (1) the physician's belief that a medical emergency necessitated the abortion; and
   (2) the medical condition of the pregnant woman that prevented compliance with this subchapter.

(c) A physician performing or inducing an abortion under this section shall maintain in the physician's practice records a copy of the notations made under Subsection (b).

Sec. 171.206. CONSTRUCTION OF SUBCHAPTER. (a) This subchapter does not create or recognize a right to abortion before a fetal heartbeat is detected.

(b) This subchapter may not be construed to:
   (1) authorize the initiation of a cause of action against or the prosecution of a woman on whom an abortion is performed or induced or attempted to be performed or induced in violation of this subchapter;
   (2) wholly or partly repeal, either expressly or by implication, any other statute that regulates or prohibits abortion, including Chapter 6-1/2, Title 71, Revised Statutes; or
   (3) restrict a political subdivision from regulating or prohibiting abortion in a manner that is at least as stringent as the laws of this state.

Sec. 171.207. LIMITATIONS ON PUBLIC ENFORCEMENT.
(a) Notwithstanding Section 171.005 or any other law, the requirements of this subchapter shall be enforced exclusively through the private civil actions described in Section 171.208. No enforcement of this subchapter, and no enforcement of Chapters 19 and 22, Penal Code, in response to violations of this subchapter, may be taken or threatened by this state, a political subdivision, a district or county attorney, or an executive or administrative officer or employee of this state or a political subdivision against any person, except as provided in Section 171.208.

(b) Subsection (a) may not be construed to:

1. Legalize the conduct prohibited by this subchapter or by Chapter 6-1/2, Title 71, Revised Statutes;
2. Limit in any way or affect the availability of a remedy established by Section 171.208; or
3. Limit the enforceability of any other laws that regulate or prohibit abortion.

Sec. 171.208. CIVIL LIABILITY FOR VIOLATION OR AIDING OR ABETTING VIOLATION. (a) Any person, other than an officer or employee of a state or local governmental entity in this state, may bring a civil action against any person who:

1. Performs or induces an abortion in violation of this subchapter;
2. Knowingly engages in conduct that aids or abets the performance or inducement of an abortion, including paying for or reimbursing the costs of an abortion through insurance or otherwise, if the abortion is performed or induced in violation of this subchapter, regardless of whether the person knew or should have known that the abortion would be performed or induced in violation of this subchapter; or
3. Intends to engage in the conduct described by Subdivision (1) or (2).

(b) If a claimant prevails in an action brought under this section, the court shall award:

1. Injunctive relief sufficient to prevent the defendant from violating this subchapter or engaging in acts that aid or abet violations of this subchapter;
2. Statutory damages in an amount of not less than $10,000 for each abortion that the defendant performed or induced in violation of this subchapter, and for each abortion performed or induced in violation of this subchapter that the defendant aided or abetted; and
3. Costs and attorney’s fees.

(c) Notwithstanding Subsection (b), a court may not award relief under this section in response to a violation of Subsection (a)(1) or (2) if the defendant demonstrates that the defendant previously paid the full amount of statutory damages under Subsection (b)(2) in a previous action for that particular abortion performed or induced in violation of this subchapter, or for the particular conduct that aided or abetted an abortion performed or induced in violation of this subchapter.

(d) Notwithstanding Chapter 16, Civil Practice and Remedies Code, or any other law, a person may bring an action under this section not later than the fourth anniversary of the date the cause of action accrues.

(e) Notwithstanding any other law, the following are not a defense to an action brought under this section:

1. Ignorance or mistake of law;
2. A defendant’s belief that the requirements of this subchapter are unconstitutional or were unconstitutional;
3. A defendant’s reliance on any court decision that has been overruled on appeal or by a subsequent court, even if that court decision had not been overruled when the defendant engaged in conduct that violates this subchapter;
4. A defendant’s reliance on any state or federal court decision that is not binding on the court in which the action
has been brought:

(5) non-mutual issue preclusion or non-mutual claim preclusion;
(6) the consent of the unborn child's mother to the abortion; or
(7) any claim that the enforcement of this subchapter or the imposition of civil liability against the defendant will violate the constitutional rights of third parties, except as provided by Section 171.209.

(f) It is an affirmative defense if:

(1) a person sued under Subsection (a)(2) reasonably believed, after conducting a reasonable investigation, that the physician performing or inducing the abortion had complied or would comply with this subchapter; or
(2) a person sued under Subsection (a)(3) reasonably believed, after conducting a reasonable investigation, that the physician performing or inducing the abortion will comply with this subchapter.

(f-1) The defendant has the burden of proving an affirmative defense under Subsection (f)(1) or (2) by a preponderance of the evidence.

(g) This section may not be construed to impose liability on any speech or conduct protected by the First Amendment of the United States Constitution, as made applicable to the states through the United States Supreme Court's interpretation of the Fourteenth Amendment of the United States Constitution, or by Section 8, Article I, Texas Constitution.

(h) Notwithstanding any other law, this state, a state official, or a district or county attorney may not intervene in an action brought under this section. This subsection does not prohibit a person described by this subsection from filing an amicus curiae brief in the action.

(i) Notwithstanding any other law, a court may not award costs or attorney's fees under the Texas Rules of Civil Procedure or any other rule adopted by the supreme court under Section 22.004, Government Code, to a defendant in an action brought under this section.

(j) Notwithstanding any other law, a civil action under this section may not be brought by a person who impregnated the abortion patient through an act of rape, sexual assault, incest, or any other act prohibited by Sections 22.011, 22.021, or 25.02, Penal Code.

Sec. 171.209. CIVIL LIABILITY: UNDUE BURDEN DEFENSE LIMITATIONS. (a) A defendant against whom an action is brought under Section 171.208 does not have standing to assert the rights of women seeking an abortion as a defense to liability under that section unless:

(1) the United States Supreme Court holds that the courts of this state must confer standing on that defendant to assert the third-party rights of women seeking an abortion in state court as a matter of federal constitutional law; or
(2) the defendant has standing to assert the rights of women seeking an abortion under the tests for third-party standing established by the United States Supreme Court.

(b) A defendant in an action brought under Section 171.208 may assert an affirmative defense to liability under this section if:

(1) the defendant has standing to assert the third-party rights of a woman or group of women seeking an abortion in accordance with Subsection (a); and
(2) the defendant demonstrates that the relief sought by the claimant will impose an undue burden on that woman or that group of women seeking an abortion.

(c) A court may not find an undue burden under Subsection (b) unless the defendant introduces evidence proving that:

(1) an award of relief will prevent a woman or a group
of women from obtaining an abortion; or

(2) an award of relief will place a substantial obstacle in the path of a woman or a group of women who are seeking an abortion.

(d) A defendant may not establish an undue burden under this section by:

(1) merely demonstrating that an award of relief will prevent women from obtaining support or assistance, financial or otherwise, from others in their effort to obtain an abortion; or

(2) arguing or attempting to demonstrate that an award of relief against other defendants or other potential defendants will impose an undue burden on women seeking an abortion.

(e) The affirmative defense under Subsection (b) is not available if the United States Supreme Court overrules Roe v. Wade, 410 U.S. 113 (1973) or Planned Parenthood v. Casey, 505 U.S. 833 (1992), regardless of whether the conduct on which the cause of action is based under Section 171.208 occurred before the Supreme Court overruled either of those decisions.

(f) Nothing in this section shall in any way limit or preclude a defendant from asserting the defendant's personal constitutional rights as a defense to liability under Section 171.208, and a court may not award relief under Section 171.208 if the conduct for which the defendant has been sued was an exercise of state or federal constitutional rights that personally belong to the defendant.

Sec. 171.210. CIVIL LIABILITY: VENUE.

(a) Notwithstanding any other law, including Section 15.002, Civil Practice and Remedies Code, a civil action brought under Section 171.208 shall be brought in:

(1) the county in which all or a substantial part of the events or omissions giving rise to the claim occurred;

(2) the county of residence for any one of the natural person defendants at the time the cause of action accrued;

(3) the county of the principal office in this state of any one of the defendants that is not a natural person; or

(4) the county of residence for the claimant if the claimant is a natural person residing in this state.

(b) If a civil action is brought under Section 171.208 in any one of the venues described by Subsection (a), the action may not be transferred to a different venue without the written consent of all parties.

Sec. 171.211. SOVEREIGN, GOVERNMENTAL, AND OFFICIAL IMMUNITY PRESERVED.

(a) This section prevails over any conflicting law, including:

(1) the Uniform Declaratory Judgments Act; and

(2) Chapter 37, Civil Practice and Remedies Code.

(b) This state has sovereign immunity, a political subdivision has governmental immunity, and each officer and employee of this state or a political subdivision has official immunity in any action, claim, or counterclaim or any type of legal or equitable action that challenges the validity of any provision or application of this chapter, on constitutional grounds or otherwise.

(c) A provision of state law may not be construed to waive or abrogate an immunity described by Subsection (b) unless it expressly waives immunity under this section.

Sec. 171.212. SEVERABILITY.

(a) Mindful of Leavitt v. Jane L.

the severability of a state statute regulating abortion the United States Supreme Court held that an explicit statement of legislative intent is controlling, it is the intent of the legislature that every provision, section, subsection, sentence, clause, phrase, or word in this chapter, and every application of the provisions in this chapter, are severable from each other.

(b) If any application of any provision in this chapter to
any person, group of persons, or circumstances is found by a court to be invalid or unconstitutional, the remaining applications of that provision to all other persons and circumstances shall be severed and may not be affected. All constitutionally valid applications of this chapter shall be severed from any applications that a court finds to be invalid, leaving the valid applications in force, because it is the legislature's intent and priority that the valid applications be allowed to stand alone. Even if a reviewing court finds a provision of this chapter to impose an undue burden in a large or substantial fraction of relevant cases, the applications that do not present an undue burden shall be severed from the remaining applications and shall remain in force, and shall be treated as if the legislature had enacted a statute limited to the persons, group of persons, or circumstances for which the statute's application does not present an undue burden.

(b-1) If any court declares or finds a provision of this chapter facially unconstitutional, when discrete applications of that provision can be enforced against a person, group of persons, or circumstances without violating the United States Constitution and Texas Constitution, those applications shall be severed from all remaining applications of the provision, and the provision shall be interpreted as if the legislature had enacted a provision limited to the persons, group of persons, or circumstances for which the provision's application will not violate the United States Constitution and Texas Constitution.

(c) The legislature further declares that it would have enacted this chapter, and each provision, section, subsection, sentence, clause, phrase, or word, and all constitutional applications of this chapter, irrespective of the fact that any provision, section, subsection, sentence, clause, phrase, or word, or applications of this chapter, were to be declared unconstitutional or to represent an undue burden.

(d) If any provision of this chapter is found by any court to be unconstitutionally vague, then the applications of that provision that do not present constitutional vagueness problems shall be severed and remain in force.

(e) No court may decline to enforce the severability requirements of Subsections (a), (b), (b-1), (c), and (d) on the ground that severance would rewrite the statute or involve the court in legislative or lawmaking activity. A court that declines to enforce or enjoins a state official from enforcing a statutory provision does not rewrite a statute, as the statute continues to contain the same words as before the court's decision. A judicial injunction or declaration of unconstitutionality:

(1) is nothing more than an edict prohibiting enforcement that may subsequently be vacated by a later court if that court has a different understanding of the requirements of the Texas Constitution or United States Constitution;

(2) is not a formal amendment of the language in a statute; and

(3) no more rewrites a statute than a decision by the executive not to enforce a duly enacted statute in a limited and defined set of circumstances.

SECTION 4. Chapter 30, Civil Practice and Remedies Code, is amended by adding Section 30.022 to read as follows:

Sec. 30.022. AWARDS OF ATTORNEY’S FEES IN ACTIONS CHALLENGING ABORTION LAWS. (a) Notwithstanding any other law, any person, including an entity, attorney, or law firm, who seeks declaratory or injunctive relief to prevent this state, a political subdivision, any governmental entity or public official in this state, or any person in this state from enforcing any statute, ordinance, rule, regulation, or any other type of law that regulates or restricts abortion or that limits taxpayer funding for individuals or entities that perform or promote abortions, in any state or federal court, or that represents any litigant seeking
such relief in any state or federal court, is jointly and severally liable to pay the costs and attorney's fees of the prevailing party.

(b) For purposes of this section, a party is considered a prevailing party if a state or federal court:
   (1) dismisses any claim or cause of action brought against the party that seeks the declaratory or injunctive relief described by Subsection (a), regardless of the reason for the dismissal; or
   (2) enters judgment in the party's favor on any such claim or cause of action.

(c) Regardless of whether a prevailing party sought to recover costs or attorney's fees in the underlying action, a prevailing party under this section may bring a civil action to recover costs and attorney's fees against a person, including an entity, attorney, or law firm, that sought declaratory or injunctive relief described by Subsection (a) not later than the third anniversary of the date on which, as applicable:
   (1) the dismissal or judgment described by Subsection (b) becomes final on the conclusion of appellate review; or
   (2) the time for seeking appellate review expires.

(d) It is not a defense to an action brought under Subsection (c) that:
   (1) a prevailing party under this section failed to seek recovery of costs or attorney's fees in the underlying action;
   (2) the court in the underlying action declined to recognize or enforce the requirements of this section; or
   (3) the court in the underlying action held that any provisions of this section are invalid, unconstitutional, or preempted by federal law, notwithstanding the doctrines of issue or claim preclusion.

SECTION 5. Subchapter C, Chapter 311, Government Code, is amended by adding Section 311.036 to read as follows:

Sec. 311.036. CONSTRUCTION OF ABORTION STATUTES. (a) A statute that regulates or prohibits abortion may not be construed to repeal any other statute that regulates or prohibits abortion, either wholly or partly, unless the repealing statute explicitly states that it is repealing the other statute.

(b) A statute may not be construed to restrict a political subdivision from regulating or prohibiting abortion in a manner that is at least as stringent as the laws of this state unless the statute explicitly states that political subdivisions are prohibited from regulating or prohibiting abortion in the manner described by the statute.

(c) Every statute that regulates or prohibits abortion is severable in each of its applications to every person and circumstance. If any statute that regulates or prohibits abortion is found by any court to be unconstitutional, either on its face or as applied, then all applications of that statute that do not violate the United States Constitution and Texas Constitution shall be severed from the unconstitutional applications and shall remain enforceable, notwithstanding any other law, and the statute shall be interpreted as if containing language limiting the statute's application to the persons, group of persons, or circumstances for which the statute's application will not violate the United States Constitution and Texas Constitution.

SECTION 6. Section 171.005, Health and Safety Code, is amended to read as follows:

Sec. 171.005. COMMISSION [DEPARTMENT] TO ENFORCE; EXCEPTION. The commission [department] shall enforce this chapter except for Subchapter H, which shall be enforced exclusively through the private civil enforcement actions described by Section 171.208 and may not be enforced by the commission.

SECTION 7. Subchapter A, Chapter 171, Health and Safety Code, is amended by adding Section 171.008 to read as follows:

Sec. 171.008. REQUIRED DOCUMENTATION. (a) If an abortion
is performed or induced on a pregnant woman because of a medical emergency, the physician who performs or induces the abortion shall execute a written document that certifies the abortion is necessary due to a medical emergency and specifies the woman's medical condition requiring the abortion.

(b) A physician shall:
(1) place the document described by Subsection (a) in the pregnant woman's medical record; and
(2) maintain a copy of the document described by Subsection (a) in the physician's practice records.

(c) A physician who performs or induces an abortion on a pregnant woman shall:
(1) if the abortion is performed or induced to preserve the health of the pregnant woman, execute a written document that:
   (A) specifies the medical condition the abortion is asserted to address; and
   (B) provides the medical rationale for the physician's conclusion that the abortion is necessary to address the medical condition; or
   (2) for an abortion other than an abortion described by Subdivision (1), specify in a written document that maternal health is not a purpose of the abortion.

(d) The physician shall maintain a copy of a document described by Subsection (c) in the physician's practice records.

SECTION 8. Section 171.012(a), Health and Safety Code, is amended to read as follows:
(a) Consent to an abortion is voluntary and informed only if:
   (1) the physician who is to perform or induce the abortion informs the pregnant woman on whom the abortion is to be performed or induced of:
      (A) the physician's name;
      (B) the particular medical risks associated with the particular abortion procedure to be employed, including, when medically accurate:
         (i) the risks of infection and hemorrhage;
         (ii) the potential danger to a subsequent pregnancy and of infertility; and
         (iii) the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer;
      (C) the probable gestational age of the unborn child at the time the abortion is to be performed or induced; and
      (D) the medical risks associated with carrying the child to term;
   (2) the physician who is to perform or induce the abortion or the physician's agent informs the pregnant woman that:
      (A) medical assistance benefits may be available for prenatal care, childbirth, and neonatal care;
      (B) the father is liable for assistance in the support of the child without regard to whether the father has offered to pay for the abortion; and
      (C) public and private agencies provide pregnancy prevention counseling and medical referrals for obtaining pregnancy prevention medications or devices, including emergency contraception for victims of rape or incest;
   (3) the physician who is to perform or induce the abortion or the physician's agent:
      (A) provides the pregnant woman with the printed materials described by Section 171.014; and
      (B) informs the pregnant woman that those materials:
         (i) have been provided by the commission
Department of State Health Services;

(ii) are accessible on an Internet website sponsored by the commission; [department;]

(iii) describe the unborn child and list agencies that offer alternatives to abortion; and

(iv) include a list of agencies that offer sonogram services at no cost to the pregnant woman;

(4) before any sedative or anesthesia is administered to the pregnant woman and at least 24 hours before the abortion or at least two hours before the abortion if the pregnant woman waives this requirement by certifying that she currently lives 100 miles or more from the nearest abortion provider that is a facility licensed under Chapter 245 or a facility that performs more than 50 abortions in any 12-month period:

(A) the physician who is to perform or induce the abortion or an agent of the physician who is also a sonographer certified by a national registry of medical sonographers performs a sonogram on the pregnant woman on whom the abortion is to be performed or induced;

(B) the physician who is to perform or induce the abortion displays the sonogram images in a quality consistent with current medical practice in a manner that the pregnant woman may view them;

(C) the physician who is to perform or induce the abortion provides, in a manner understandable to a layperson, a verbal explanation of the results of the sonogram images, including a medical description of the dimensions of the embryo or fetus, the presence of cardiac activity, and the presence of external members and internal organs; and

(D) the physician who is to perform or induce the abortion or an agent of the physician who is also a sonographer certified by a national registry of medical sonographers makes audible the heart auscultation for the pregnant woman to hear, if present, in a quality consistent with current medical practice and provides, in a manner understandable to a layperson, a simultaneous verbal explanation of the heart auscultation;

(5) before receiving a sonogram under Subdivision (4)(A) and before the abortion is performed or induced and before any sedative or anesthesia is administered, the pregnant woman completes and certifies with her signature an election form that states as follows:

"ABORTION AND SONOGRAM ELECTION

(1) THE INFORMATION AND PRINTED MATERIALS DESCRIBED BY SECTIONS 171.012(a)(1)-(3), TEXAS HEALTH AND SAFETY CODE, HAVE BEEN PROVIDED AND EXPLAINED TO ME.

(2) I UNDERSTAND THE NATURE AND CONSEQUENCES OF AN ABORTION.

(3) TEXAS LAW REQUIRES THAT I RECEIVE A SONOGRAM PRIOR TO RECEIVING AN ABORTION.

(4) I UNDERSTAND THAT I HAVE THE OPTION TO VIEW THE SONOGRAM IMAGES.

(5) I UNDERSTAND THAT I HAVE THE OPTION TO HEAR THE HEARTBEAT.

(6) I UNDERSTAND THAT I AM REQUIRED BY LAW TO HEAR AN EXPLANATION OF THE SONOGRAM IMAGES UNLESS I CERTIFY IN WRITING TO ONE OF THE FOLLOWING:

___ I AM PREGNANT AS A RESULT OF A SEXUAL ASSAULT, INCEST, OR OTHER VIOLATION OF THE TEXAS PENAL CODE THAT HAS BEEN REPORTED TO LAW ENFORCEMENT AUTHORITIES OR THAT HAS NOT BEEN REPORTED BECAUSE I REASONABLY BELIEVE THAT DOING SO WOULD PUT ME AT RISK OF RETALIATION RESULTING IN SERIOUS BODILY INJURY.

___ I AM A MINOR AND OBTAINING AN ABORTION IN ACCORDANCE WITH JUDICIAL BYPASS PROCEDURES UNDER CHAPTER 33, TEXAS FAMILY CODE.

___ MY UNBORN CHILD [FETUS] HAS AN IRREVERSIBLE MEDICAL
CONDITION OR ABNORMALITY, AS IDENTIFIED BY RELIABLE DIAGNOSTIC PROCEDURES AND DOCUMENTED IN MY MEDICAL FILE.

(7) I AM MAKING THIS ELECTION OF MY OWN FREE WILL AND WITHOUT COERCION.

(8) FOR A WOMAN WHO LIVES 100 MILES OR MORE FROM THE NEAREST ABORTION PROVIDER THAT IS A FACILITY LICENSED UNDER CHAPTER 245, TEXAS HEALTH AND SAFETY CODE, OR A FACILITY THAT PERFORMS MORE THAN 50 ABORTIONS IN ANY 12-MONTH PERIOD ONLY:

I CERTIFY THAT, BECAUSE I CURRENTLY LIVE 100 MILES OR MORE FROM THE NEAREST ABORTION PROVIDER THAT IS A FACILITY LICENSED UNDER CHAPTER 245 OR A FACILITY THAT PERFORMS MORE THAN 50 ABORTIONS IN ANY 12-MONTH PERIOD, I WAIVE THE REQUIREMENT TO WAIT 24 HOURS AFTER THE SONOGRAM IS PERFORMED BEFORE RECEIVING THE ABORTION PROCEDURE. MY PLACE OF RESIDENCE IS:__________.

SIGNATURE ______________________________ DATE";

(6) before the abortion is performed or induced, the physician who is to perform or induce the abortion receives a copy of the signed, written certification required by Subdivision (5); and

(7) the pregnant woman is provided the name of each person who provides or explains the information required under this subsection.

SECTION 9. Section 245.011(c), Health and Safety Code, is amended to read as follows:

(c) The report must include:

(1) whether the abortion facility at which the abortion is performed is licensed under this chapter;

(2) the patient's year of birth, race, marital status, and state and county of residence;

(3) the type of abortion procedure;

(4) the date the abortion was performed;

(5) whether the patient survived the abortion, and if the patient did not survive, the cause of death;

(6) the probable post-fertilization age of the unborn child based on the best medical judgment of the attending physician at the time of the procedure;

(7) the date, if known, of the patient's last menstrual cycle;

(8) the number of previous live births of the patient;

[and]

(9) the number of previous induced abortions of the patient;

(10) whether the abortion was performed or induced because of a medical emergency and any medical condition of the pregnant woman that required the abortion; and

(11) the information required under Sections 171.008(a) and (c).

SECTION 10. Every provision in this Act and every application of the provision in this Act are severable from each other. If any provision or application of any provision in this Act to any person, group of persons, or circumstance is held by a court to be invalid, the invalidity does not affect the other provisions or applications of this Act.

SECTION 11. The change in law made by this Act applies only to an abortion performed or induced on or after the effective date of this Act.

SECTION 12. This Act takes effect September 1, 2021.
I hereby certify that S.B. No. 8 passed the Senate on March 30, 2021, by the following vote: Yeas 19, Nays 12; and that the Senate concurred in House amendments on May 13, 2021, by the following vote: Yeas 18, Nays 12.

__________________________
Secretary of the Senate

I hereby certify that S.B. No. 8 passed the House, with amendments, on May 6, 2021, by the following vote: Yeas 83, Nays 64, one present not voting.

__________________________
Chief Clerk of the House

Approved:

__________________________
Date

__________________________
Governor
The Health Equity and Access under the Law (HEAL) for Immigrant Families Act
117th Congress

What is the Problem?
For decades, health care and immigration policy in the United States has limited immigrant access to affordable, comprehensive health insurance. Harmful policies and rhetoric on immigrants’ rights, and the health, safety, and wellbeing of immigrants and their families have contributed to long-term health disparities. The unjustifiable five-year waiting period on Medicaid and CHIP enrollment—in place since 1996—in addition to other longstanding restrictions mean that immigrants must navigate a complicated patchwork of care that often forces them to pay out-of-pocket for basic health services. Furthermore, targeted threats on immigrants’ access to health care, such as the previous administration's unlawful attempt at expanding the “public charge” rule,¹ have instilled fear in immigrant communities when seeking care.

The spread of COVID-19 has also laid bare the many ways our country has failed our most marginalized communities, including cruel and unnecessary policy barriers that prevent immigrants from accessing affordable and timely health care. Immigrants make up nearly a fifth of all essential workers in the United States, and more than two-thirds of all undocumented immigrant workers serve in these frontline jobs.² Instead of focusing on how to support essential workers and people impacted by COVID-19, anti-immigrant policymakers are focusing on preventing access to critical health care services, including testing, treatments, and vaccines, for immigrant communities. We put all of society at risk when we fail to ensure equitable access to health care for all families, including immigrants of all statuses.

These restrictions are harmful for immigrants’ health and interfere with their basic right to protect their own and their families’ well-being. These barriers translate directly to immigrants being uninsured: the 14.6 million noncitizen immigrants of reproductive age in the United States in 2019 were three times more likely to be uninsured than naturalized citizen immigrants or U.S.-born people (36% vs. 12% and 12%, respectively). For noncitizen immigrants who are also low income, the proportion of people uninsured grows to half.³ Obtaining health care is not a reality if it is not affordable.

Legal and policy barriers to federal health programs disproportionately harm Black, Indigenous, Latinx, Asian, Pacific Islander, and other Immigrants of Color, and contribute to persistent inequities in the prevention, diagnosis, and treatment of health conditions. Many immigrant communities of color face compounding barriers and discrimination from health care providers and systems when accessing care based on sexual orientation, gender identity, income, ethnicity, disability, primary language, and immigration status. Black immigrant women often cite cost as a major barrier to health care, with many

¹ The Trump-era public charge regulations are permanently blocked nationwide. On March 9, 2021, the Biden Administration began to halt the government’s defense in lawsuits challenging the Trump-era public charge regulations. As a result, the government’s appeals were dismissed, meaning the final judgment entered in the Northern District of Illinois on Nov 2, 2020, which vacated the public charge rule nationwide, is now in effect. Protecting Immigrant Families, Victory! The Trump Administration’s public charge rule is permanently blocked, nationwide, https://protectingimmigrantfamilies.org/.
³ Guttmacher Institute, Uninsured Rate for People of Reproductive Age Ticked Up Between 2016 and 2019, April 2, 2021, https://www.guttmacher.org/article/2021/04/uninsured-rate-people-reproductive-age-ticked-between-2016-and-2019. Note: Low-income people are those in families with incomes under the federal poverty level ($21,330 for a family of three in 2019). Data include some information on undocumented immigrants, although that information is generally acknowledged to be a considerable undercount of that population group.
who are undocumented forgoing doctors’ visits altogether due not only to the financial burden, but additionally experiencing consistent racial bias by medical practitioners and racism in health care. The financial burden is often exacerbated for people living with a disability, who are also more likely to live in poverty than those without disabilities.

These onerous barriers additionally limit access to contraceptive care, maternity care, and other preventive sexual and reproductive health care services for immigrant communities. Half of noncitizen immigrant women of reproductive age who would otherwise qualify for Medicaid are uninsured. Even for those immigrants who qualify for Medicaid during pregnancy, many are limited in coverage to only labor and delivery costs, leaving them unable to afford crucial prenatal care. Research also shows that immigrant women are less likely to receive other preventive services, such as Pap tests, hepatitis B vaccinations and mammograms. This gap in access exacerbates the risk of negative pregnancy related and other reproductive and sexual health outcomes. Restrictions on sexual and reproductive health and rights affect everyone, including LGBTQ immigrants—especially those that are transgender, nonbinary, and gender diverse—who face specific stigma and discrimination in accessing reproductive health services and barriers, due to anti-LGBTQ laws, policies, and gender norms.

Now more than ever, the basic human needs and rights of the nation’s immigrants must be elevated in policymaking.

What does the HEAL for Immigrant Families Act do?
The Health Equity & Access under the Law (HEAL) for Immigrant Families Act of 2021 removes political interference and restores coverage so immigrants in the United States can participate in the health care programs their billions of tax dollars support. By ensuring that all immigrants can access affordable coverage for which they are otherwise eligible, this bill will allow immigrant women and their families to receive the health care they need, and create healthier communities and a stronger economy. Specifically, the bill:

- **Restores enrollment to full-benefit Medicaid and the Children’s Health Insurance Program (CHIP) to all federally authorized immigrants who are otherwise eligible.** The bill removes the discriminatory legal barriers to health coverage for immigrants imposed by the Personal Responsibility and Work Opportunity and Reconciliation Act (PRWORA). Specifically, the bill eliminates that 1996 law’s restrictive five-year waiting period and outdated list of “qualified” immigrants for Medicaid and CHIP eligibility. Through these changes, the bill ensures all individuals granted federally authorized presence, including Deferred Action for Childhood Arrivals (DACA) recipients, are eligible for federally funded health care programs.

- **Removes the unjustifiable exclusion of undocumented immigrants from accessing health insurance coverage on the Affordable Care Act’s Health Insurance Exchanges.** The bill would allow all individuals’ immediate eligibility to purchase qualified health insurance coverage, obtain premium tax credits and cost-sharing reductions, and enroll in the Basic Health Program, in accordance with

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6 Supra, note 1.

7 Guttmacher Institute, Immigrant Women’s Access to Sexual and Reproductive Health Coverage and Care in the United States, November 26, 2018.

existing income eligibility requirements. This access would be available for everyone, regardless of their documentation or status.

- **Ensures access to public and affordable health coverage for Deferred Action for Childhood Arrivals (DACA) recipients**, and ensures that those who will gain new forms of administrative relief via a deferred action program will not be similarly excluded from the health care programs their tax dollars support.

**Why should you support the HEAL for Immigrant Families Act?**

- **Health should not depend on immigration status.** Every individual deserves to be healthy and to obtain **affordable** health care with dignity, regardless of how long they have been in the US or the status they have been granted.

- **This is important for women and families.** When women are healthy, their entire family benefits. Immigrant women are often the decision-makers regarding health care for their families and the backbones of their communities.

- **Under current law, immigrants must navigate a complicated patchwork of care that often forces them to pay out-of-pocket for health care, particularly if a community health center or employer-sponsored health insurance is not available to them.** **Obtaining health care is not a reality for immigrant communities if it is not affordable.**

- **Viruses do not discriminate based on race, ethnicity, or national origin—but people and policies do.** The pandemic has made it clear that every person should be able to get affordable health care no matter how long they have been in the U.S. or the status they have been granted, especially now.

- **From threats to health care and nutrition to affordable housing, to separating families at the border and mass deportation, the Trump administration spent four years relentlessly working to strip away agency and dignity from immigrant families.** As we move forward under a new administration, we need **bold and impactful legislation** that expands access to the basic care that immigrant families need and deserve.

**How can you support the HEAL for Immigrant Families Act?**

- **To cosponsor**, contact:
  
  o **House:** Jazmine Garcia Delgadillo ([Jazmine.GarciaDelgadillo@mail.house.gov](mailto:Jazmine.GarciaDelgadillo@mail.house.gov)) with Rep. Pramila Jayapal or or Miranda Hernandez ([Miranda.Hernandez@mail.house.gov](mailto:Miranda.Hernandez@mail.house.gov)) with Rep. Nanette Barragán
  
  o **Senate:** Kimberly Miller-Tolbert ([kimberly_miller-tolbert@booker.senate.gov](mailto:kimberly_miller-tolbert@booker.senate.gov)) with Senator Booker’s office

- **HEAL is endorsed by over 250 national and state organizations.** To **endorse** as an organization, please visit [http://bit.ly/endorseheal2021](http://bit.ly/endorseheal2021)

- For more information, please visit [www.napawf.org/heal](http://www.napawf.org/heal) or contact Jennifer Wang, National Asian Pacific American Women’s Forum, at [jwang@napawf.org](mailto:jwang@napawf.org), or Candace Gibson, National Latina Institute for Reproductive Justice, at [candace@latinainstitute.org](mailto:candace@latinainstitute.org)
Asian Americans and Pacific Islanders (AAPIs) form a growing and diverse share of the United States population and are the fastest growing immigrant community in the country. Asian Americans are also the largest growing group of undocumented immigrants, with one in seven Asian Americans being undocumented. However, current policies severely limit the ability of recent AAPI immigrants and their families to obtain affordable health insurance, which leads to higher rates of uninsurance and negative health outcomes for these populations, further exacerbating the growing inequities in access to health services.

The AAPI immigrant community, particularly AAPI immigrant women, a significant proportion of whom work in front-line health and essential services workforces, have also faced a disproportionate burden of the negative health and economic effects of the COVID-19 pandemic. From March 2020 through February 2021, immigrant women experienced the largest unemployment rates of any group in the United States, including U.S.-born men, U.S.-born women, and immigrant men, resulting in a loss of health coverage that was previously tied to employment.

These factors together call for the need to protect, legitimize, and advance the rights of AAPI women. Ensuring equitable access to health care is one of the most important steps in this direction. The Health Equity and Access under the Law (HEAL) for Immigrant Families Act of 2021 could significantly reduce inequities and improve health outcomes for AAPI immigrants by removing barriers to obtaining public health insurance coverage for eligible federally authorized immigrants and their families, allowing undocumented immigrants to purchase health insurance through the Affordable Care Act’s (ACA) health insurance exchanges, and ensuring that Deferred Action for Childhood Arrivals (DACA) recipients are eligible for these programs.

Access to Health Care is a Top Priority for AAPI Women

Based on NAPAWF’s survey of over 3,537 adult AAPI women across the nation on a fully representative sample, the largest nationwide poll ever conducted among AAPI women in the U.S., the number one concern and voting issue for AAPI women voters in 2020 was health care.

- 3 of the 4 top issues for AAPI women—both overall and among almost every demographic group—center on health care, with protections for those with pre-existing conditions and ensuring everyone has access being the top two.
- Ensuring women have the authority to make decisions about their bodies and having access to affordable birth control are among the top tier issue priorities for AAPI women.

8-in-10 AAPI women believe that having control over their reproduction produces more positive family outcomes.

- The top issues that AAPI women want to see the federal government address include but are not limited to: COVID-19 and rising health care costs.
Current Barriers to Affordable Health Insurance Coverage for AAPI Immigrant Women

In addition to race and national origin-based discrimination, which have seen a rise over the last few years fueled by the previous administration, AAPI immigrants also face major barriers to accessing basic and necessary public programs to which their tax dollars contribute, such as Medicaid and the Children Health Insurance Program (CHIP) and other means-tested benefits programs. Currently, lawfully residing immigrants who are otherwise eligible must wait at least five years in order to access Medicaid or CHIP benefits as a result of the Personal Responsibility and Work Opportunity and Reconciliation Act (PRWORA) of 1996.

Additionally, the categories of immigrants who are considered to be “lawfully residing” is both restrictive and outdated. The situation is even more grim for undocumented immigrants, who are not only ineligible for public benefits, but are not even permitted to purchase subsidized health insurance through the ACA marketplace.

As a result, newly-arriving immigrants, especially those who are in financially vulnerable positions, are left with few options to access health services unless they pay costly out-of-pocket fees. Newly arriving immigrants, especially immigrant women, experience much higher rates of uninsurance than U.S.-born whites. Based on NAPAWF’s analysis of data collected in the Medical Expenditures Panel Survey (MEPS), close to 17 percent of Asian, Native Hawaiian, and Pacific Islander women who had immigrated to the U.S. less than five years ago reported being uninsured as of December 31, 2019. This uninsurance rate is almost 10 percentage points higher than the uninsurance rate for U.S.-born whites in the same time period, and it is estimated that the COVID-19 pandemic significantly increased uninsurance rates among noncitizens in the year 2020 due to an increase in unemployment rates. Medicaid coverage could significantly reduce the aforementioned uninsurance rates among newly arriving immigrant women, but the current five-year waiting period prevents that from happening for many.

Under the CHIP Reauthorization Act of 2009, states were given the option to remove the five-year waiting period for lawfully residing pregnant women and children. However, this policy excludes immigrant women who are not pregnant, including those of reproductive age, as well as all other federally authorized immigrants. Additionally, 21 states have chosen not to exercise this option.

As a result of these policy barriers, AAPI immigrants who are not U.S. citizens are significantly more likely to lack any form of health insurance as compared to U.S. citizens, and researchers have noted that this lack of insurance is a critical reason for disparities in health care access and utilization between immigrants and U.S.-born individuals. On the other hand, health insurance coverage through Medicaid increases the utilization of preventive services, improves health outcomes, and helps reduce financial strain. Studies have found that expanding Medicaid eligibility significantly improves mental health outcomes for parents who are low-income, improves the utilization of medical services among children, and leads to increased early diagnosis of chronic conditions such as diabetes, which has higher prevalence in the AAPI population as compared to the white population and is one of the leading causes of death among AAPIs. Therefore, a more comprehensive, inclusive, and uniform law needs to be enacted at the federal level in order to improve health care access and outcomes for AAPI immigrants and their families, reduce rates of uninsurance in the U.S., and pave the way for a more equitable society.
HEAL for Immigrant Families Act of 2021
The HEAL for Immigrant Families Act of 2021 removes unnecessary and unethical barriers to accessing health insurance coverage for all immigrants and their families and allows otherwise eligible individuals to enroll in Medicaid, CHIP, or purchase subsidized insurance plans off the ACA exchanges. The key provisions of this bill include:

• **Restores enrollment to full-benefit Medicaid and the CHIP to all federally authorized immigrants who are otherwise eligible.** The bill removes the discriminatory legal barriers to health coverage for immigrants imposed by PRWORA. Specifically, the bill eliminates that 1996 law’s restrictive five-year waiting period and outdated list of “qualified” immigrants for Medicaid and CHIP eligibility. Through these changes, the bill ensures all individuals granted federally authorized presence, including DACA recipients, are eligible for federally funded health care programs.

• **Removes the unjustifiable exclusion of undocumented immigrants from accessing health insurance coverage on the ACA’s Health Insurance Exchanges.** The bill would allow all individuals’ immediate eligibility to purchase qualified health insurance coverage, obtain premium tax credits and cost-sharing reductions, and enroll in the Basic Health Program, in accordance with existing income eligibility requirements. This access would be available for everyone, regardless of their documentation or status.

• **Ensures access to public and affordable health coverage for DACA recipients, and ensures that those who will gain new forms of administrative relief via a deferred action program will not be similarly excluded from the health care programs their tax dollars support.**

An overwhelming majority of Americans believe that the right to access care should not depend on an individual’s income, race, gender, or country of origin.14 The HEAL for Immigrant Families Act of 2021 is a significant step towards universal coverage, reducing disparities in health care utilization and outcomes, and building a healthier and more equitable U.S. society.

For more information and to find out about ways to support this legislation, please visit [www.napawf.org/heal](http://www.napawf.org/heal) or contact Jennifer Wang, National Asian Pacific American Women’s Forum, at [jwang@napawf.org](mailto:jwang@napawf.org).
Endnotes
1  Pew Research Center, “Asian Americans are the fastest-growing racial or ethnic group in the U.S.” (April 2021). https://www.pewresearch.org/fact-tank/2021/04/09/asian-americans-are-the-fastest-growing-racial-or-ethnic-group-in-the-u-s/
13 Asian Health Coalition, “Chronic & Infectious Diseases Prevention Programs” https://www.asian-health.org/chronic-infectious-diseases