STATE OF INDIANA) COUNTY OF ST. JOSEPH)		IN THE ST. JOSEPH SUPERIOR COURT CAUSE NUMBER: 71D08-1307-FA-00017
STATE OF INDIANA	)	
	)	
	)	BRIEF OF *AMICI CURIAE*
v.	)	IN SUPPORT OF PURVI PATEL'S
	)	MOTION TO DISMISS
PURVI PATEL	)	

BRIEF OF *AMICI CURIAE* NATIONAL ADVOCATES FOR PREGNANT WOMEN, HEALTH AND BIOETHICS EXPERTS, REPRODUCTIVE JUSTICE AND WOMEN'S RIGHTS ORGANIZATIONS IN SUPPORT OF PURVI PATEL'S MOTION TO DISMISS

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INTEREST OF *AMICI CURIAE*

Amici are experts in maternal, fetal, and child health, bioethics, and law, who seek to bring to this Court's attention the ways in which the prosecution of Purvi Patel will undermine public health and violate numerous fundamental constitutional rights in the service of no compelling, important, or even rational purpose. While the contradictory charges in this case make it difficult to understand precisely what alleged facts support this prosecution, *Amici* assure the Court that none of the undersigned organizations or individuals believes that knowingly failing to provide care for a newborn – the original charge levied against Ms. Patel – is morally or legally acceptable. But it does not appear from the facts available that "neglect of a dependent" as defined in Indiana law is what this case is about. Rather, as the amended Information against Ms. Patel indicates, the state seeks to use its feticide law to prosecute a woman who either (from the state's account) self-induced an abortion or (from her accounts reported in the press) suffered a stillbirth. As a result, this case presents significant questions of concern to *Amici* and within their areas of expertise, including the health consequences for women and children if pregnancy loss and medical self-help become the subject of criminal investigations, arrest, prosecution, and incarceration. Statements of interest of *amici* are set out in Appendix A.

STATEMENT OF FACTS

Amici adopt the Statement of Facts set out in Ms. Patel's Motion to Dismiss. As that statement demonstrates, what actually happened in this case is not clear. The fact that Ms. Patel is being charged with contradictory crimes is indicative, however, of precisely the concern *amici* address: namely, that women who experience miscarriages and stillbirths, or who have abortions, will be subjected to criminal investigation, arrest, and prosecution. This response is both cruel to the individual woman and threatening to the important state goals of maternal, fetal, and child health.

SUMMARY OF ARGUMENT

The prosecution seeks to establish the principle that by becoming pregnant, women may be subject to criminal charges depending on the circumstances of or outcomes of those pregnancies, including the all too common experiences of stillbirth. In this case, the prosecution seeks to prove that Ms. Patel gave birth to a child who she then neglected. Amended Information Count I; *see also* Ind. Code § 35-46-1-4(b)(3). In direct contradiction of this claim, the state seeks to prove that Ms. Patel did not give birth to a living child, but rather committed the crime of "feticide."[1] Amended Information, Count II. Whether the death was the result of a stillbirth experienced by Ms. Patel, or, as asserted in the Amended Information, the result of Ms. Patel's "knowing[]actions to terminate a pregnancy not performed in accordance with IC 16-34," expanding Indiana's feticide law to permit prosecutions of women in such circumstances harms public health and serves no state interest.

Stillbirths, miscarriages, abortions (including those that are self-induced and do not conform to abortion regulations), and women's mental health during pregnancy are health issues,

[1] This brief addresses only the charge of "feticide" (defined in Ind. Code § 35-42-1-6). *Amici* point out that if the state had sufficient evidence to support the neglect of a dependent charge, the addition of the contradictory "feticide" charge is both constitutionally problematic and nonsensical.

not matters for the criminal justice system. Nor has Indiana passed any legislation that makes clear an intent to send pregnant women and new mothers to jail for experiencing a pregnancy loss or for having an abortion (whether self-induced or not). The ramifications of permitting feticide prosecutions against women in relationship to their own pregnancies are enormous, and include both public health consequences, perpetuation of second-class status for women, and the likelihood that such prosecutions will target poor women and women of color, who are already disproportionately subject to law enforcement surveillance, arrest, and punishment. The threat of such prosecutions creates fear and stigma that deter pregnant women from getting the health care they need, and impedes those who do seek care from speaking honestly with their health care providers. Moreover, the penalties imposed – arrest, imprisonment, and family separation– undermine the health and wellbeing of pregnant women, mothers, and their families.

In recognition of these consequences, every major public health and professional medical organization in the United States opposes the criminal prosecutions of women who become pregnant and whose actions or inactions are believed to have harmed or risked harm to the fertilized eggs, embryos, or fetuses they carry. *Amici* address these consequences in detail below, and emphasize that the health issues addressed in this brief are not mere policy arguments or matters properly left to the legislature. When state action impinges on constitutional rights, it is the independent duty of the courts to consider whether and what recognized state interests justify that infringement. And, if the rights at stake are fundamental, the courts must determine whether the means chosen to advance those interests– in this case criminal investigation, arrest, prosecution, and punishment – actually does so. Because the state action in this case does not meet even minimal standards of rationality, *Amici* urge this Court to dismiss the feticide charge against Ms. Patel.

ARGUMENT

Prosecuting women for feticide in relation to their own pregnancies violates women's constitutional rights to procedural due process, procreative privacy, and equal protection.[2] When the application of a law threatens constitutional rights, courts are called upon to evaluate the state interests involved. *See, e.g., Youngberg v. Romeo*, 457 U.S. 307, 320-321 (1982), *citing Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting) ("In determining whether a substantive right protected by the Due Process Clause has been violated, it is necessary to balance "the liberty of the individual" and "the demands of an organized society"); *Delaware v. Prouse*, 440 U.S. 648, 654 (1979) ("T]he permissibility of a particular law enforcement practice is judged by balancing its intrusion on the individual's Fourth Amendment interests against its promotion of legitimate governmental interests"); *Connick v. Myers*, 461 U.S. 138, 142 (1983) (Our task . . .is to seek "a balance between the interests of the [employee], as a citizen, in commenting upon matters of public concern and the interest of the State, as an employer, in promoting the efficiency of the public services it performs through its employees.") (internal citation omitted). Depending on what right is at stake and the level of scrutiny accorded its imposition, courts must also consider whether and how the law's application serves that interest. *See, e.g., Washington v. Glucksberg*, 521 U.S. 702, 721 (1997) (the "Fourteenth Amendment forbids the government to infringe ... 'fundamental' liberty interests *at all*, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.") (emphasis in original).

There are, however, no compelling, important, or even rational state interests in prosecuting women for feticide in relation to their pregnancies, because every recognized state interest that can be asserted to support such action is undermined, rather than advanced, by

[2] These arguments are raised in Ms. Patel's Motion to Dismiss. *Amici* support those arguments and do not repeat them here.

prosecution.[3] Public health is not served, maternal, fetal, and child health is threatened, and the consequences to individual women and their families have far-reaching effects that ultimately undermine the health and welfare of their communities.

I. Every major health association in the United States opposes prosecuting pregnant women for the circumstances or outcomes of their pregnancies.

For more than two decades, all major U.S. public health and medical organizations have taken an unequivocal stance against criminal responses to a woman's pregnancy and the actions, inactions, or circumstances that may (or may not) affect pregnancy outcome. These organizations developed specific responses in the wake of proposed punitive state actions to address a perceived problem of drug use during pregnancy, and in light of cases where pregnant women were ordered to undergo unconsented medical interventions – including a high profile case in which neither the mother nor the newborn survived the forced surgery.[4] In June 1990, the American Medical Association ("AMA") issued a report, "Legal Interventions During Pregnancy,"[5] in which it assessed the considerations involved in state action against pregnant women. For a number of reasons, the AMA rejected any role for criminal sanctions or civil liability.[6] Similarly, in a series of statements, the American College of Obstetricians and Gynecologists ("ACOG") rejected criminal prosecutions of pregnant women. In its analysis,

[3] While the Indiana Court of Appeals (over a vigorous dissent) allowed a feticide charge to proceed against a woman who tried to commit suicide while she was pregnant, and, later, gave birth to a daughter who died four days after birth, the appellate court did not analyze the constitutional rights at stake, nor did it consider whether any possible state interest was actually served by that prosecution. *Bei Bei Shuai v. Indiana,* 966 N.E.2d 619, 629 (Ind. Ct. App.) *trans. denied*, 967 N.E.2d 1035 (Ind. 2012). As the case was ultimately resolved without a conviction or trial on the feticide charge, the constitutionality of the prosecution was never further litigated. *Amici* contend that, here, a feticide prosecution for what was either an abortion or a stillbirth utterly undermines any asserted state interest, and the profound imposition on fundamental rights cannot be justified.

[4] Helen Cole, for the American Medical Association Board of Trustees, *Legal Interventions During Pregnancy*, 264 JAMA 2663, 2664 (1990) (hereinafter "AMA").

[5] *Id.*

[6] *Id*. at 2670.

"Maternal Decision Making, Ethics, and the Law," the ACOG Committee on Ethics concluded that "pregnant women should not be punished for adverse perinatal outcomes."[7]

Other health care associations share the views of ACOG and the AMA. The American Academy of Pediatrics warns that "punitive measures taken toward pregnant women, such as criminal prosecution and incarceration, have no proven benefits for infant health."[8] Likewise, the American Public Health Association stresses that drug use during pregnancy is a public health concern, and recommends that "no punitive measures should be taken against pregnant women" for illicit drug use.[9] The American Nurses Association notes that "[t]he threat of criminal prosecution is counterproductive in that it prevents many women from seeking prenatal care and treatment."[10] And according to the American Psychological Association, "no punitive action should be taken against women on the basis of behaviors that may harm a developing fetus."[11]

Maternal, fetal, and child health are significant public health concerns. On the world stage, the United Nations member states adopted maternal and child health as Millennium Development Goals.[12] At the national level, the federal Office of Disease Prevention and Health Promotion of the Department of Health and Human Services notes that "[i]mproving the well-

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[7] American College of Obstetricians and Gynecologists, Committee on Ethics, *Maternal Decision Making, Ethics, and the Law*, 106 OBSTETRICS & GYNECOLOGY 1127, 1135 (2005) (hereinafter "ACOG").
[8] American Academy of Pediatrics, Committee on Substance Abuse, *Drug Exposed Infants*, 86 PEDIATRICS 639, 641 (1990).
[9] American Public Health Association, *Illicit Drug Use by Pregnant Women*, Pol'y No. 9020 (1990).
[10] American Nurses Association, *Position Statement on Opposition to Criminal A Prosecution of Women for Use of Drugs While Pregnant and Support for Treatment Services for Alcohol and Drug Dependent Women of Childbearing Age* (Apr. 5, 1991).
[11] American Psychological Association, *Resolution on Substance Abuse by Pregnant Women* (Aug. 1991). *See also* American Psychiatric Association, Position Statement, *Care of Pregnant and Newly Delivered Women Addicts*, APA Document Reference No. 200101 (Mar. 2001) (also opposing criminal prosecution of pregnant women for the use of substances that risk harm to fetuses, urging treatment as the appropriate response).
[12] United Nations, *We Can End Poverty: Millenium Development Goals and Beyond 2015*, Goal 4: Reduce Child Mortality, http://www.un.org/millenniumgoals/childhealth.shtml, Goal 5: Improve Maternal Health, http://www.un.org/millenniumgoals/maternal.shtml (last visited November 5, 2014).

being of mothers, infants, and children is an important public health goal for the United States."[13] Additionally, Indiana's Department of Health has created a division dedicated to improving maternal and child health.[14] As a review of that division's maternal and fetal health campaign illustrates, the array of recommended public health responses to ensure maternal, fetal, and child health does not include arresting, prosecuting and incarcerating pregnant women and mothers.[15]

Positions opposing prosecution are informed by the understanding that punishment of women in relationship to their own pregnancies does not further public health: specifically, criminal investigation, arrest, prosecution, and imprisonment deters pregnant women from getting the health care they need, and is too often selectively applied to those who are already disproportionately targeted by the criminal justice system: poor women and women of color.

II. Permitting criminal penalties for the outcome of women's pregnancies undermines public health.[16]

Responding to physical and mental health aspects of a woman's pregnancy through the criminal justice system undermines public health. The allegations the state makes in its charging Information suggest that this case is really about health issues – pregnancy, labor, childbirth, possible mental health issues, and the growing use of medical self-help (something that is increasing in many contexts). Punishing a woman who either may have suffered a stillbirth or sought an abortion implicates the constitutional rights to privacy, bodily integrity, and equal

[13] Office of Disease Prevention and Health Promotion, *Maternal, Infant, and Child Health*, HealthyPeople.gov, http://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health (last visited Nov. 5, 2014).
[14] Indiana State Department of Health, Maternal and Child Health Division, http://www.state.in.us/isdh/19571.htm (last visited Nov. 5, 2014).
[15] *See* Division of Maternal Health and Children's Special Health Care Services of the Indiana Department of Health, *Five Year Needs Assessment for FY 2011-2015*, *Part Two, Section II*, 162-168 (July 15, 2010) (stating that Indiana's priorities include: increasing access to prenatal care; reducing pre-term labor and childbirth; reducing smoking and alcohol use during pregnancy through treatment programs and public education campaigns; increasing the numbers of new mothers who initiate breastfeeding; ensuring that all newborns are screened at birth for hearing impairments, blood disorders, and other conditions; to reduce the risk of HIV transmission at birth; and more. In this lengthy document, not one stakeholder and not one recommendation indicate that punitive measures against pregnant women should be implemented to protect maternal and fetal health).
[16] *See, e.g.,* ACOG, *supra* note 7, at 1133-34; AMA, *supra* note 4, at 2667-2668.

protection of the laws – in service of no rationale, let alone an important or compelling one. Rather, subjecting women to investigation, arrest, and potentially years in prison based on their actions or inactions during pregnancy or the actual outcome of those pregnancies undermines numerous state interests, including important state interest in maternal, fetal, and child health and the wellbeing of communities.

A. *Pregnancy is a health condition with many potential outcomes and health consequences, few of which are entirely under the control of the pregnant woman.*

Pregnancy is an extremely common experience for women. By age 44, approximately 85% of women in the U.S. will have been pregnant and had at least one birth.[17] Because of cultural expectations about wanted pregnancies and happy outcomes, it is not always acknowledged that pregnancy is a health condition, which brings with it many symptoms, some life altering. The risks pregnancy poses to a woman's health can be profound. For example, a significant number of women who become pregnant experience depression;[18] others will experience gestational diabetes, which, while treatable, carries risks to the fetus and the pregnant woman;[19] others may suffer from hypertension, which, if not treated early, can develop into preeclampsia, a condition dangerous to both pregnant women and fetal health.[20] In sum, pregnancy-related health conditions range from mild discomfort to life-threatening illnesses.

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[17] Centers for Disease Control & Prevention, 55 (No. RR-6) Morbidity and Mortality Weekly Report 2, *Recommendations to Improve Preconception Health and Health Care - United States: A Report of the CDCIATSDR Preconception Care Work Group and the Select Panel on Preconception Care* (Apr. 21, 2006), *available at* http://www.cdc.gov/mmwr/PDF/rr/rr5506.pdf.

[18] *See, e.g.,* David Bornstein, *Treating Depression Before It Becomes Postpartum*, NY Times (Oct. 16, 2014), http://opinionator.blogs.nytimes.com/2014/10/16/treating-depression-before-it-becomes-postpartum/?_php=true&_type=blogs&_r=0 (describing increasing attention to treating depression before and during pregnancy, and some successful programs that have reduced depression for pregnant women).

[19] *See* Eunice Kenney Shriver National Institute of Child Health and Development, *Will Gestational Diabetes Hurt My Baby?,* NIH.gov (updated Sept. 11, 2006) (explaining some of the risks of gestational diabetes to the fetus and to the short and longterm health of the pregnant woman).

[20] American Pregnancy Association, *Gestational Hypertension: Pregnancy-Induced Hypertension* (last updated Jan. 2014), http://americanpregnancy.org/pregnancy-complications/pregnancy-induced-hypertension/.

Disturbingly, women's pregnancy-related mortality has been on the rise in the U.S. in the last several years – including significantly disproportionate maternal mortality for women of color.[21]

At this moment in history, medical science cannot always determine the cause of maternal or fetal health complications during pregnancy.[22] But many life and health conditions over which women may or may not have some degree of control may impact the health of the pregnant woman and her pregnancy outcomes. These include poverty, lack of access to prenatal care, stress, pre-existing health conditions like diabetes or obesity, intimate partner violence, birth spacing, and more.[23] This prosecution presents the radical idea that there is a role for criminal justice authorities in evaluating the cause and consequences of anything deemed "harmful" to a pregnancy, all from the moment a pregnancy begins.

1. Stillbirths are a health issue, and, unfortunately, are also a common but often mysterious pregnancy outcome

Stillbirth[24] is one of the most common adverse pregnancy outcomes.[25] Despite its relative frequency, its causes are not well understood.[26] Indeed, physicians cannot determine the cause of

[21] Amnesty International, *Deadly Delivery: The Maternal Health Crisis in the USA, One-Year Update* 3, 5-7 (2011) (women in the U.S. face a higher risk of dying in childbirth than women in 49 other countries, including all European countries; maternal mortality rate for African American women in the US is 3 to 4 times that of white women at comparable socio-economic levels); *see also* Institute of Medicine, *Report Brief: Preterm Birth, Causes, Consequences, and Prevention* (2006), http://www.iom.edu/~/media/Files/Report%20Files/2006/Preterm-Birth-Causes-Consequences-and-Prevention/Preterm%20Birth%202006%20Report%20Brief.pdf (there are "very troubling and persistent" disparities in pre-term birth, particularly for African American and Latina women).
[22] *See, e.g.,* Donald J. Dudley et al., *A New System for Determining the Causes of Stillbirth*, 116 OBSTETRICS & GYNECOLOGY 254, 258 (August 2010) (a significant proportion of stillbirths, for example, continue to evade scientific understanding of the cause or contributing factors).
[23] *See* N. Tanya Naggahawatte & Robert Goldenberg, *Poverty, Maternal Health, and Adverse Pregnancy Outcomes*, 1136 N.Y. ACAD. SCI. 80, 80-85 (2008).
[24] A stillbirth is the death of a fetus prior to delivery. Generally, the term "miscarriage" describes spontaneous abortion early in pregnancy, while the term "stillbirth" describes antenatal death later in pregnancy. Centers for Disease Control and Prevention, *Stillbirth* (October 28, 2009), http://www.cdc.gov/ncbddd/bd/stillbirths.htm. There is no universally accepted understanding of at what point fetal demise prior to birth is considered a stillbirth as opposed to a miscarriage. *Id*. United States medical researchers commonly draw the line at 20 weeks gestation or a birth weight greater than 350 grams. R.L. Goldenberg et al., *Stillbirth: A Review*, 16 J. OF MATERNAL-FETAL & NEONATAL MEDICINE 79, 80 (2004).
[25] Goldenberg et al., *supra* note 24, at 79.
[26] *Id.* at 90; Ruth C. Fretts, *Etiology and Prevention of Stillbirth*, 193 AM. J. OF OBSTETRICS & GYNECOLOGY 1923 (March 2005).

between 25 and 65 percent of all stillbirths.[27] Later pregnancy losses (after 28 weeks gestation) are even more likely to defy explanation,[28] partly because of limited research into the causes of stillbirth, which itself may be explained by a public perception that adverse pregnancy outcomes are rare. The lack of uniform definitions and problems with data collection further muddy the waters.[29] Identifying a single cause of a stillbirth is extremely difficult, as fetal demise can be very complex, and may result from the cumulative effect of several risk factors, none of which may be obvious.[30]

Prosecuting pregnant women for stillbirth wrongly lays at their feet the blame for this sad outcome. In fact, there are some maternal factors—particularly cigarette smoking – that are associated with stillbirth.[31] But association is not the same as causation, and a statistically notable increase in general risk tells nothing about whether, in a particular case, that risk factor actually caused, or even contributed to, the stillbirth. Numerous other factors may increase a woman's likelihood of suffering a stillbirth. These include genetic predisposition, environmental hazards, intimate partner violence, paternal factors, lack of access to health care, stress, and the fact that many health care providers have not adopted simple monitoring methods shown to help reduce the incidence of stillbirth.[32] Medical science has great difficulty separating these various factors and determining one particular cause of stillbirth.[33] Threatening arrest, investigation, and punishment of women because they experienced a stillbirth will not reduce stillbirths; but those punitive sanctions do deter women from getting prenatal care (as noted above, a risk factor for stillbirth) and increase stress and fear (also a risk factor for negative pregnancy outcomes). Thus,

[27] *Id.* at 1925; *see also* Melissa A. Sims & Kim A. Collins, *Fetal Death: A 10-Year Retrospective Study*, 22 AMERICAN JOURNAL OF FORENSIC MEDICINE & PATHOLOGY 261 (2005).
[28] Fretts, *supra* note 26, at 1925.
[29] *See, e.g.,* Goldenberg et al., *supra* note 24, at 79, 89-90.
[30] Dudley et al., *supra* note 22, at 258.
[31] Goldenberg et al., *supra* note 24, at 82.
[32] *Id*. at 80-88.
[33] Dudley et al., *supra* note 22, at 258.

prosecution undermines, rather than advances, state interests in reducing stillbirths and encouraging knowledge and prevention.

2. Abortion is also a common pregnancy outcome, because women have and always will seek to control their fertility and protect their health

Throughout history women have attempted to control their fertility and its impact on their lives.[34] Whether legal or illegal, women have used contraceptives and obtained abortions; prior to the decision in *Roe v. Wade*, estimates of illegal abortions ranged from 200,000 to 1 million[35] – approximately the same number of women who have abortions in the U.S. today.[36] The movement to make abortion safe and legal was not only a movement against women's subordination. It was also a movement to address the grave public health consequences resulting from restricting access to abortion, which included the deaths of women.[37] The lack of access to safe, legal abortion was a public health crisis,[38] and it was unusual for states to respond by arresting, prosecuting, and jailing the women who had abortions.[39]

It remains the case today that the vast majority of state legislatures have refused to expressly direct their abortion criminalization laws at pregnant women who obtain abortions.[40]

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[34] *Roe v. Wade*, 410 U.S. 113, 130-139 (1973) (in the context of a review of legal and social attitudes toward abortion, indicating that history demonstrates that women had abortions in ancient societies as well as in modern times).

[35] Willard Cates, *Legal Abortion: The Public Health Record,* 215 SCIENCE 1586 (1982).

[36] *See, e.g.,* Guttmacher Institute, *Fact Sheet: Induced Abortion In The United States* (July, 2014), http://www.guttmacher.org/pubs/fb_induced_abortion.html (in 2011, there were 1.06 million abortions in the U.S.); *see also* Amnesty International, *On the Brink of Death: Violence Against Women and the Abortion Ban in El Salvador* 10 (2014) (women will seek abortions regardless of illegality).

[37] Willard Cates et al., *The Public Health Impact of Legal Abortion: 30 Years Later*, 35 PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 25, 26-27 (2003).

[38] ROSALIND POLLACK PETCHESKY, ABORTION & WOMAN'S CHOICE: THE STATE, SEXUALITY, & REPRODUCTIVE FREEDOM, 80 (1984) (prior to 1973, "many physicians acknowledged that abortion was relatively safe and that only its illegality and practice under unhygienic conditions made it dangerous.").

[39] *Roe v. Wade*, 410 U.S. 113, 151 ("[T]he few state courts called upon to interpret their laws in the late 19th and early 20th centuries did focus on the State's interest in protecting the woman's health rather than in preserving the embryo and fetus. Proponents of this view point out that in many States, including Texas, by statute or judicial interpretation, the pregnant woman herself could not be prosecuted for self-abortion or for cooperating in an abortion performed upon her by another.") (footnotes omitted).

[40] *See e.g.,* Alaska Stat. § 11.41.289 (liability for "assault of an unborn child" does not apply to actions "committed by a pregnant woman against herself and her own unborn child"); Ark. Code Ann. §§ 5-61-101(c),

Although a small number of states retain old statutes authorizing criminal liability for women who exercise their right to terminate their pregnancies, *see e.g.* N.Y. Penal Law §§ 125.20, 125.55 (making "self-abortion" a misdemeanor), such statutes directly contradict the decades-old justification for abortion regulations: protecting the woman's health from unqualified or dangerous third parties who perform abortions.

The terrible result of the criminal approach to abortion is on display in those countries where abortion is a crime and women are the targets of arrest and incarceration. We see the dire consequences of this punitive response in countries like El Salvador, where abortion is illegal under all circumstances, and women are investigated, arrested, and jailed for miscarriages.[41] The extreme penalties for pregnancy complications – many unrelated to abortion – have led women,

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5-61-102(c) ("Nothing in this section shall be construed to allow the charging or conviction of a woman with any criminal offense in the death of her own unborn child in utero."); Cal. Penal Code § 187 (stating that liability for murder applies only to the physician); Fla. Stat. § 782.36 ("A patient receiving a partial-birth-abortion procedure may not be prosecuted under this act."); Ga. Code Ann. § 16-12-140(a); *Hillman v. State,* 503 S.E.2d 610 (Ga. Ct. App. 1998) (interpreting Georgia's "criminal abortion" law as not applying to the pregnant woman); 720 Ill. Comp. Stat. 5/9-1.2(b), formerly Ill. Rev. Stat 38,§ 9-1.2 (criminal liability for intentional homicide of an unborn child does not apply to "the pregnant woman whose unborn child is killed"); Kan. Stat. Ann.§ 65-6703(e) ("A woman upon whom an abortion is performed shall not be prosecuted under this section[.]"); Ky. Rev. Stat. Ann. § 507A.010(3) ("Nothing in this chapter shall apply to any acts of a pregnant woman that caused the death of her unborn child."); La. Rev. Stat. Ann. § 14:87 (penalties for criminalized abortions not applicable to pregnant women having abortions); Minn. Stat. § 609.266 (excluding "the pregnant woman" from liability for "crimes against unborn children"); Neb. Rev. Stat. § 28-335 (providing "[n]o civil or criminal penalty . . . against the patient upon whom the abortion is performed"); Ohio Rev. Code Ann. § 2919.1 7(I) (expressly excluding woman from liability for post- viability abortions); 18 Pa. Cons. Stat. Ann. § 2608 (exempting pregnant woman from liability "in regards to crimes against her unborn child"); Tex. Penal Code Ann. § 19.06(1) (exempting the woman from liability for "death of an unborn child"); Utah Code Ann. § 76-5-201(4) (providing woman is not guilty of criminal homicide for death of fetus under certain circumstances), Utah Code Ann. § 76-7-314.5(2) ("A woman is not criminally liable for (a) seeking to obtain, or obtaining, an abortion that is permitted by this part; or (b) a physician's failure to comply [with specified statutes.]"); Vt. Stat. Ann. tit. 13 § 101 ("However, the woman whose miscarriage is caused or attempted shall not be liable to the penalties prescribed by this section."); Wis. Stat. Ann. § 940.13 (providing no fine or imprisonment for woman who obtains an abortion or violates any provision of an abortion statute).

[41] Amnesty International, *On the Brink of Death: Violence Against Women and the Abortion Ban in El Salvador*, 34-35 (2014), http://www.amnesty.org/en/library/asset/AMR29/003/2014/en/b3f73e66-6732-4d4e-ad12-7b5dc04d23bc/amr290032014en.pdf (hereinafter "*On the Brink of Death*") (in a section titled "Harsh Inquires When Women Suffer Miscarriages," describing the results of a study of arrest of women in El Salvador between 2001 and 2007, indicating that some women who suffer miscarriages are reported to the police and interrogated, and some ultimately prosecuted and imprisoned); Center for Reproductive Rights & La Agrupacion Ciudadana, *Marginalized, Persecuted, and Imprisoned: The Effects of El Salvador's Total Criminalization of Abortion* (2014), http://reproductiverights.org/sites/crr.civicactions.net/files/documents/El-Salvador-CriminalizationOfAbortion-Report.pdf.

especially poor women, to avoid medical care for pregnancy complications.[42] Suicide has become the third most common cause of maternal mortality in that country, and half of all teenage girls who committed suicide were pregnant when they took their own lives.[43]

The situation is similarly stark in Nicaragua, which enacted a criminal abortion ban in 2008, that "provides for lengthy sentences for women and girls" who have abortions, as well as their health care providers.[44] As the Nicaraguan experience demonstrates, even the threat of arrest and prosecution – in the absence of actual arrests and prosecutions – deters women from getting the health care they need. As of 2013, there were no reported arrests of either women or medical professionals pursuant to the abortion ban, but the law has nonetheless stopped women from seeking medical care for miscarriage and other pregnancy needs, undermining that country's efforts to reduce maternal mortality.[45]

Criminalizing abortion has similarly deleterious affects around the world – not only preventing women from seeking health care when they need it, but driving them to seek unsafe abortions to avoid criminal prosecution and stigma. In Rio de Janeiro, Brazil, where abortion is a crime except in cases of rape, fetal anencephaly, or where the pregnant woman's life is at risk,

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[42] *On the Brink of Death*, supra note 41.

[43] Nina Lakhani, *El Salvador: Where Women May Be Jailed for Miscarrying*, BBC News, Oct. 17, 2013, http://www.bbc.com/news/magazine-24532694 (describing the same study noted above, finding that more than 100 women were prosecuted and 49 were convicted either of murder or abortion; one of the women described in the article was a 19-year old mother of a four-year old child and the victim of domestic violence, sentenced to 10 years in prison for allegedly inducing an abortion; according to this report, much of the testimony that convicted her came from the abuser).

[44] Amnesty International, *The Total Abortion Ban in Nicaragua: Women's Lives and Health Endangered, Medical Professionals Criminalized* (2009).

[45] *Id.* at 20-21. *See also* Eleanor Klibanoff, *Nicaragua: Abortion Ban and the Right to Chooose*, Pulitzer Center on Crisis Reporting (Aug. 10, 2013), *available at* http://pulitzercenter.org/reporting/central-america-nicaragua-abortion-ban-women-youth-girls-rape-victims-sexual-abuse-pregnancy-maternal-health-illegal-prochoice-activists-puberty-laws-childhood-fear ("'No one has been put in jail,' says Ochoa [producer of a documentary on the abortion ban]. 'But women have died. Women have suffered. Thousands of girls under the age of 14 have suffered from sexual abuse and continue to suffer after giving birth. No one wins under this law.'")

unsafe abortion is the third-leading cause of maternal death.[46] This troubling statistic mirrors the worldwide causes of maternal death:

> Globally, unsafe abortion results in death for approximately 47,000 women and causes disability for an additional 5 million. This accounts for roughly 13% of maternal mortalities, making unsafe abortion the third largest cause of maternal mortality globally. Restrictive abortion regimes are a major contributor to the reliance on unsafe abortions.[47]

Women who are jailed for miscarriages and abortions throughout the world are often also mothers, whose children are left motherless and impoverished.[48] And of course, none of these laws prohibiting abortion actually result in an end to abortion. These laws do, however, ruin the lives of women and their families. It is important to note that the trend worldwide is to move away from criminalizing abortion, in recognition of the public health consequences that accompany such restrictions.[49] If Indiana truly seeks to punish women who have abortions through arrest, prosecution, and incarceration, the health consequences of that approach are so severe that the Legislature – not the courts – must expressly consider and determine whether to enact such an extraordinarily counterproductive (and unconstitutional) law.

3. Self-help for medical care –including abortion – is both common and a health issue, not a matter for criminal intervention

To the extent the charge in this case is directed at terminating a pregnancy out of conformity with Indiana's abortion code, allegedly by self-inducing an abortion, state interests in public health are similarly thwarted when women who seek abortions are prosecuted as criminals. People in the U.S. increasingly resort to self-help for medical information and

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[46] Ellen Mitchell et al., *Brazilian adolescents' knowledge and beliefs about abortion methods: a school-based internet inquiry*, 14 BMC WOMEN'S HEALTH 1-2 (2014), *available at* http://www.biomedcentral.com/1472-6874/14/27.
[47] *On the Brink of Death, supra* note 41, at 22.
[48] *See, e.g.,* Lakhani, *supra* note 43.
[49] *On the Brink of Death, supra* note 41, at 10 ("The legislation introducing the total prohibition on abortion in El Salvador stands in marked contrast to the global trend of the past 20 years towards liberalization of abortion laws.")

treatment,[50] and commonly obtain drugs through sources other than physical pharmacies (such as through the mail and online).[51] Like a self-induced abortion, much of this takes place outside the regulatory scheme governing the medical professions and pharmaceuticals.[52] But the typical response to this phenomenon is not to criminalize people for their attempts to treat their own health conditions.[53] That is because regulation of the medical profession and drugs is done to protect individuals and the public from harm to their health[54] – not to punish people for seeking to obtain health care for themselves.

Similarly, protecting women's health is the primary reason that courts have upheld regulations on the abortion right. *See Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992) (women's health is of paramount concern in abortion regulation); *McCormack v. Hiedeman*, 694 F.3d 1004, 110-1015 (9th Cir. 2012) ("[c]onsistent with this history [of states regulating the conduct of third parties, not women, in their abortion statutes], there is no Supreme Court precedent that recognizes or suggests that third party criminal liability may extend to pregnant women who obtain an abortion in a manner inconsistent with state abortion statutes"). The list of cases in which regulations on abortion have been upheld by reference to a state interest in

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[50] June Forkner-Dunn, *Internet-based Patient Self-care: The Next Generation of Health Care Delivery*, 5 J. MED. INTERNET RES. e8, Intro. (2003).

[51] *See, e.g.,* Grazia Orizio et al., *Quality of Online Pharmacies and Websites Selling Prescription Drugs: A Systematic Review*, 13 J. MED. INTERNET RES. (2011) (as of 2011, exact numbers of online pharmacies and people purchasing prescription drugs online were difficult to obtain, but one survey estimated that at least 4% of Americans had made such purchases, there were between approximately 3,500 and 5,000 such pharmacy sites, and "prescription or over-the-counter drugs" was the fifth most common internet search in the U.S.).

[52] *See, e.g..,* Anupam B. Jena et al., *Prescription Medication Abuse and Illegitimate Internet-Based Pharmacies*, 155 ANNALS OF INTERNAL MEDICINE 848, 849-850 (2011).

[53] *Id*. (recommending improved federal and state regulation and oversight of financial institutions, internet pharmacy sites, and prescribers, as well as physician education, noting that "every patient is susceptible" to obtaining controlled substances through unregulated, possibly illegal online pharmacies. Notably, there is no recommendation that patients, including those who may be abusing controlled substances, be prosecuted).

[54] *See Bennett v. Indiana State Bd. of Registration & Examination in Optometry*, 7 N.E.2d 977, 980 (1937) *citing State ex rel. Burroughs v. Webster et al.*, 50 N.E. 750 (1898) (upholding regulations on optometry against a constitutional challenge, and referencing the state interests in public health as the basis for regulating the practice of medicine: "'The legislature has judged that the safety of the public health requires the guards that are placed around the practice of medicine by this law; and, notwithstanding the questions made by counsel, we are unable to see that the act is not a valid exercise of the police power of the state.'").

protecting women's health is long – but not one of those cases asserts that states may prosecute and punish women who self-induce abortions. *Id.*

In the only case of its kind that has been addressed by a federal circuit court of appeals, the Ninth Circuit Court of Appeals enjoined the prosecution of Jennie McCormack, a pregnant mother of three who lived over a hundred miles away from any abortion provider, and who purchased abortifacient drugs over the internet and took them to terminate her pregnancy. *McCormack*, 694 F.3d at 1007, 1018. Idaho prosecutors charged Ms. McCormack with a violation of an abortion statute, subjecting her to arrest and the potential imposition of criminal penalties. *Id.* at 1008. As the Ninth Circuit Court of Appeals held in its decision affirming a preliminary injunction of the prosecution, not only were abortion statutes never intended to punish women who obtain abortions, but such a prosecution unduly burdens a woman's constitutional right to an abortion, by requiring her to police abortion providers (whether local or online) and their compliance with their regulatory obligations under state law. *Id.* at 1015-1016. The *McCormack* court was careful to point out that part of the reason women may be compelled to engage in self-help to have an abortion is that states like Idaho have adopted numerous restrictions that both stigmatize women seeking abortion and erect imposing barriers to accessing abortions from clinics and health care providers. *Id.* at 1016-1018.

Here, the prosecutor seeks to use a feticide law against a pregnant woman, rather than an abortion criminalization statute or any other law that expressly calls for prosecution and punishment of the pregnant women herself. The same analysis that the Ninth Circuit Court of Appeals applied in McCormack applies here, and militates against a prosecution for self-abortion. Moreover, there are additional public health consequences that flow from such a

prosecution: that the fear of prosecution will deter pregnant women from seeking the health care they need, and the impact of incarceration on the wellbeing of women and their families.

III. Punitive policies are counterproductive to the important goal of promoting maternal, child, and fetal health.

A. *Punishing pregnant women deters them from seeking the health care they need.*

Punishing pregnant women whose actions are believed to threaten fetal health achieves the opposite result.[55] As studies indicate,[56] this kind of prosecution will discourage pregnant women who need health care from seeking it. Instead of getting care for alcoholism, drug addiction, depression, or other important health needs, pregnant women may try to avoid detection by physicians or other health care providers. *See, e.g., Ferguson v. City of Charleston*, 532 U.S. 67, n14 (2001), *citing Whalen v. Roe*, 429 U.S. 589, 599-600 (1977) (recognizing that being reported to the police in the context of prenatal care "may have adverse consequences because it may deter patients from receiving needed medical care"). As a result, physicians, nurses, psychologists and others are less able to provide the kinds of treatment that could address the woman's medical condition and help avert fetal harm.

If this prosecution proceeds, the state will, counter to its own goals, have increased the likelihood that pregnant women who are struggling with mental health problems, who miscarry, or who suffer a stillbirth outside the hospital setting, will be reluctant to go to a hospital, clinic, or physician's office for fear that they will be reported to law enforcement officials.[57] As a result,

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[55] AMA, *supra* note 4, at 2667.

[56] American Academy of Pediatrics, *supra* note 8, at 641; ACOG, *supra* note 7, at 1134; American Psychological Association, *supra* note 11. *See also* American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, *Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician-Gynecologist*, 117 OBSTETRICS & GYNECOLOGY 200 (2011) ("Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties."); M.L. Poland et al., *Punishing pregnant drug users: Enhancing the flight from care*, 31 DRUG ALCOHOL DEPEND 199 (1993).

[57] *See, e.g.,* Martha A. Jessup, *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women*, 33 J. DRUG ISSUES 285 (2003) (finding that women identified fear of punitive actions from helping institutions and individuals as a major barrier to prenatal care); Sarah Roberts, "*You Have to Stop Using Before You*

measures that could protect their health and their pregnancies will not be implemented, and the opportunity to prevent harm will have been lost.

B. *Punishing pregnant women in relation to their own pregnancies separates families and harms children*

Such prosecutions not only increase the risk that women will avoid prenatal care, but also increase the risk to their health and their children's wellbeing when punitive sanctions are employed. The majority of women who seek abortions are already mothers raising their children.[58] Punitive responses to pregnancy outcomes – including self-inducing abortions – means that pregnant women and mothers end up in jail. For incarcerated people throughout the United States, jail and prison often means that the jailed person will lose, or never receive, necessary health care, putting their health and their lives at risk.[59] This is especially true for pregnant women: all the available evidence and anecdotal knowledge demonstrate that jail is no place to have a healthy pregnancy.[60] Besides facing the extremely high risk of sexual assault within prison,[61] pregnant women in jail and prison often lack adequate food and nutrition,[62]

Go to the Doctor": Barriers to Prenatal Care for Women Who Use Drugs During Pregnancy, Presentation at Am. Public Health Ass'n Annual Meeting (Nov. 6, 2007), *available at* http://apha.confex.com/apha/135am/techprogram/paper_149351.htm ("For women who want a healthy baby and want to reduce or stop their drug use, fear of being reported to CPS is an additional barrier to care."); *See also* S. J. Ondersma et al., *Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response*, 5 CHILD MALTREATMENT 93 (2000).

[58] Rachel K. Jones et al., *Characteristics of Abortion Patients, 2008*, Guttmacher Institute, 8 (2010) (overall, 61% of U.S. women obtaining abortions in 2008 were already mothers of at least one child; for women over 35 who accessed abortion, 89% were already mothers raising at least one child).

[59] *See, e.g., Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 888 (E.D. Cal. 2009) (noting that in California prisons, one person was "dying needlessly *every six or seven days*." (emphasis in original); *Estelle v. Gamble*, 429 U.S. 97 (1976) (establishing that prisons have an Eighth Amendment obligation to meet incarcerated people's serious medical needs); *see generally* Margo Schlanger, *Inmate Litigation*, 116 HARV. L. REV. 1555 (2003).

[60] *See* Sara Ainsworth & Rachel Roth, *"If They Hand You a Paper, You Sign It": A Call To End the Sterilization of Women in Prison*, 26 HASTINGS WOMEN'S L.J. 1, _ (forthcoming December 2014).

[61] Paul Guerino & Allen J. Beck, *Sexual Victimization Reported by Adult Correctional Authorities, 2007-2008,* U.S. Department of Justice (2011), *available at* http://www.bjs.gov/content/pub/pdf/svraca0708.pdf.

[62] Robin Levi et al., *Creating the Bad Mother: How the U.S. Approach to Pregnancy in Prisons Violates the Right to be a Mother*, 18 UCLA WOMEN'S L.J. 1, 30-32 (2010) (describing how California prisons provided rotting food or not enough food to pregnant incarcerated people, and denied them legally-mandated nutritional supplements); *see also* Carole Schroeder & Janice Bell, *Doula Birth Support for Incarcerated Pregnant Women*, 22 PUB. HEALTH

access to prenatal care,[63] and, far too often for any civilized nation, give birth alone on the floor of their cells, their pleas for help ignored.[64] Despite a growing movement in state legislatures and in the federal government to ban the practice, the majority of states (including Indiana) still permit corrections officers to shackle pregnant women to their hospital beds during labor and delivery,[65] even though obstetric and medical associations oppose the use of such restraints because they are both inhumane and medically dangerous.[66]

And the negative consequences to children of having an incarcerated parent are increasingly understood. Those consequences include the struggles with education, housing, and basic needs that flow from family disruption,[67] as well as the increased likelihood of foster care and long-term state involvement.[68] But these children are also at risk of harms to their health, including mental health, from both the separation from their parent and the stigma that attaches to the children themselves from having a parent in jail.[69] Even after incarceration, the stigma of

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NURSING 53, 55 (2005) (pregnant women in the King County Jail in Seattle, Washington said they were "constantly hungry").

[63] *See* Rachel Roth, *Obstructing Justice: Prisons as Barriers to Medical Care for Pregnant Women*, 18 UCLA WOMEN'S L.J. 79 (2010).

[64] *Id*. (documenting court decisions and case filings on behalf of numerous pregnant women who gave birth alone, or for whom medical care came to late, and suffered miscarriages and stillbirths). *See also* Diana Claitor & Burke Butler, *Pregnant Women in Texas County Jails Deserve Better Than This*, DALLAS MORNING NEWS (June 26, 2014) http://www.dallasnews.com/opinion/latest-columns/20140626-pregnant-women-in-texas-county-jails-deserve-better-than-this.ece (describing the story of a pregnant woman incarcerated in the Wichita County Jail, was left alone in a "medical segregation cell" where she gave birth on a mat on the floor to a baby whose umbilical cord was wrapped around her neck. The baby died.).

[65] *See, e.g.,* Meredith Derby Berg, *Pregnant Prisoners are Losing Their Shackles*, Boston Globe (April 18, 2014) (noting that Massachusetts would become the 19th state to limit the use of restraints on pregnant and laboring incarcerated women, once its proposed legislation passed).

[66] *See Villegas v. Metro. Gov't of Nashville*, 709 F.3d 563, 574 (6th Cir. 2013) ("The universal consensus from the courts to have addressed this issue as well as the chorus of prominent organizations condemning the practice demonstrates that, without any extenuating circumstances, shackling women during labor runs afoul of the protections of the Eighth Amendment.").

[67] *See* Nancy G. Levigne et al., *Broken Bonds: Understanding and Addressing the Needs of Children of Incarcerated Parents*, Urban Institute (2008) (hereinafter "*Broken Bonds"*); Erik Eckholm, *In Prisoners' Wake, A Tide of Troubled Kids*, NY Times (2009); Sarah Thompson, *Local Children of Incarcerated Parents Suffer Sentences of Their Own*, Times of NW Indiana (Jan. 20, 2011), http://www.nwitimes.com/news/local/illinois/chicago/local-children-of-incarcerated-parents-suffer-sentences-of-their-own/article_c2bc14d0-500d-5ede-9c41-f556c6b0e555.html.

[68] *Broken Bonds, supra* note 67, at 4-5.

[69] *Id.* at 7-9.

conviction lingers in a host of legal and social consequences to the person who has been convicted, making it difficult to get public benefits such as housing and food stamps, to find employment, to pay off court-imposed fines and other sanctions, and to participate in full citizenship.[70] Not just the formerly imprisoned person, but also their children feel the economic and social impact of this ongoing stigma.

In short, a criminal justice response does not stop women from obtaining abortions, whether legally sanctioned or not; does nothing to reduce miscarriage and stillbirth; and in fact worsens public health and family and child wellbeing. Thus, there simply is no state interest furthered by such prosecutions.

IV. Prosecutions of pregnant women are disproportionately leveled at poor women, particularly poor women of color.

Prosecutions of pregnant women are problematic for an additional reason. Coercive or punitive measures against pregnant women in relation to their pregnancies have consistently been implemented in a discriminatory fashion.[71] Whether in the context of a court order to require a cesarean section or a felony prosecution for the use of drugs, the criminal justice system extends its reach overwhelmingly to poor women, especially poor women of color.[72] This reflects the alarming racial disproportionality in the criminal system at every point, from

[70] *See, e.g.,* MARC MAUER AND MEDA CHESNEY-LIND, EDS., INVISIBLE PUNISHMENT: THE COLLATERAL CONSEQUENCES OF MASS IMPRISONMENT (2002).
[71] AMA*, supra* note 4, at 2668; ACOG, *supra* note 7, at 1134-1135; Lynn M. Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States*, *1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL., POL'Y & L. 299, 300–01 (2013) (documenting hundreds of arrests, prosecutions, forced cesarean sections, and other forced medical interventions directed at pregnant women during the period studied, and finding that "low-income women and women of color, especially African American women, are overrepresented among those who have been arrested or subjected to equivalent deprivations of liberty"); Ira J. Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202 (1990); Dwight L. Greene, *Abusive Prosecutors: Gender, Race and Class Discretion and the Prosecution of Drug-Addicted Mothers*, 39 BUFFALO L. REV. 737 (1991); Veronika E.B. Kolder, et al., *Court-ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192 (1987).
[72] *See, e.g.,* Paltrow & Flavin, *supra* note 72.

surveillance to arrest, from trial to conviction, to sentencing, probation, and parole.[73] Indiana courts should not acquiesce to prosecution policies that perpetuate bias and unfairly burden low-income pregnant women and pregnant women of color.

CONCLUSION

Important public health interests in maternal, child and fetal health are undermined when women are prosecuted in relation to their own pregnancies. The "feticide" charge leveled at Ms. Patel is directed at her in relation to her pregnancy, either for self-inducing an abortion or for suffering a stillbirth. Such a charge is wholly unsupportable as a matter of constitutional law, because it does not serve – and in fact runs counter to – any state interest. Accordingly, *amici* respectfully request that this court dismiss the "feticide" charge against Ms. Patel.

Respectfully submitted,

National Advocates for Pregnant Women

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[73] *See generally* MICHELLE ALEXANDER, THE NEW JIM CROW (2010); JEROME G. MILLER, SEARCH AND DESTROY: AFRICAN-AMERICAN MALES IN THE CRIMINAL JUSTICE SYSTEM, Chapt. 2 (1996).

APPENDIX A

Organizations

Abortion Care Network ("ACN") is the leading national organization working to de-stigmatize and normalize the experiences of women who undergo an abortion. ACN offers support and training to the abortion care community, especially to counselors, advocates, clinic administrators and medical support staff, who care directly for women and their families. Founded in 2008 as a successor to the National Coalition of Abortion Providers, ACN has created a network of independent abortion providers, supportive allied organizations, and socially conscious individuals who are deeply invested in creating an environment where women who choose to have an abortion, and those that provide care, are no longer shamed for their choices. ACN reaches millions of women across the country through our members and through on-line venues, and seeks to help its patient-members fulfill all of their reproductive and parenting needs.

Backline promotes unconditional and judgment-free support for the full spectrum of decisions, feelings, and experiences with pregnancy, parenting, abortion, and adoption. Through direct service and social change strategies, Backline is building a world where all people can make the reproductive decisions that are best for their lives, without coercion or limitation, and where the dignity of lived experiences is affirmed and honored.

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

The Carr Center for Reproductive Justice at New York University Law School ("CCRJ") was established to conduct innovative research, provide legal services, promote dialogue and expand the academic discipline on reproductive justice issues. CCRJ's goal is to ensure justice and democracy for all.

Center for Gender and Justice seeks to develop gender-responsive policies and practices for women and girls who are under criminal justice supervision. The Center is committed to research and to the implementation of policies and programs that will encourage positive outcomes for this underserved population.

The **Center on Reproductive Rights and Justice at Berkeley School of Law** ("CRRJ") seeks to realize reproductive rights and advance reproductive justice by furthering scholarship,

bolstering law and policy advocacy efforts, and influencing legal and social science discourse through innovative research, teaching, and convenings. In essence, CRRJ propels policy solutions by connecting people and ideas across the academic-advocate divide. We believe all people deserve the social, economic, political, and legal conditions, capital, and control necessary to make genuine choices about reproduction – decisions that must be respected, supported, and treated with dignity.

Indiana Religious Coalition for Reproductive Justice ("IRCRC") is a coalition of Indiana people of faith working for reproductive health, rights, and justice in Indiana. Reproductive Justice is a movement emerging from women of color working for the equal right to have a baby, to not have a baby, and to raise one's babies in conditions that can sustain new life. This movement recognizes that oppression is worst at the intersection of multiple injustices. IRCRC is an affiliate of the Religious Coalition for Reproductive Choice.

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

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

Justice Now works to promote alternatives to policing and prisons and challenge the prison industrial complex in all its forms. We fulfill our mission by providing legal services and supporting organizing efforts of people in prison that promote health and justice; working with people in prison, their families, and community members on political education and mobilization campaigns; building coalitions to create safety and individual accountability without relying on the punishment system; and training the next generation of activists and lawyers committed to working for social justice.

Law Students for Reproductive Justice ("LRSJ") **Indiana University Maurer School of Law Chapter** is a chapter of LSRJ, a non-profit organization with over 100 chapters in law schools and thousands of alumni from across the country. LSRJ trains and mobilizes law students and new lawyers to foster legal expertise and support for the realization of reproductive justice. LSRJ

works to ensure that all people can exercise the rights and access the resources they need to thrive and to decide whether, when, and how to have and parent children with dignity, free from discrimination, coercion, or violence. As reproductive justice advocates, the Maurer Chapter of LSRJ recognizes the ways that race, class, sex, age, sexual orientation, gender expression and other identities converge to impact agency and autonomy in legal questions surrounding self-determination. We seek to secure the conditions necessary for all people to thrive in their reproductive lives and beyond.

Legal Voice is a non-profit public interest organization that works in the Pacific Northwest to advance the legal rights of women through public impact litigation, legislation, and legal rights education. Since its founding in 1978 (as the Northwest Women's Law Center), Legal Voice has been dedicated to protecting and expanding women's legal rights. Toward that end, Legal Voice has advocated for legislation to advance protections for pregnant women, including laws advancing equal opportunity in the workplace and banning shackling of pregnant and laboring incarcerated women. In addition, Legal Voice has participated as counsel and as amicus curiae in the Pacific Northwest and across the country in numerous cases involving the rights of pregnant women. Legal Voice opposes, and has successfully challenged, prosecutions of pregnant women for their pregnancy outcomes and works to end punitive measures that undermine the humanity and legal rights of all pregnant women.

National Advocates for Pregnant Women ("NAPW") is a non-profit reproductive justice organization that advocates for the human and civil rights, health and welfare of all women, focusing particularly on pregnant and parenting women, and those who are most vulnerable to state control and punishment. Through litigation, representation of leading medical and public health organizations and experts as amicus, and through organizing and public education, NAPW works to ensure that women do not lose their constitutional, civil, and human rights as a result of pregnancy. The organization also conducts research, and has published a peer-reviewed study on prosecutions of and forced medical interventions on pregnant women. NAPW believes that health and welfare problems experienced by women during pregnancy should be addressed as health issues, not as crime, and promotes policies that actually protect maternal, fetal, and child health.

The **National Institute for Reproductive Health** ("NIRH") works in states and localities across the country to promote reproductive rights and expand access to reproductive health care, including abortion; reduce unintended pregnancies; and empower youth to make healthy sexual and reproductive decisions. NIRH develops and implements innovative and proactive approaches to galvanize public support, change policy, and remove barriers to care. By working through a partnership model to support local and state advocacy, NIRH addresses issues of national significance and helps to shift the overall culture.

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

discrimination. These circumstances make it especially difficult for Latinas to access basic health care, including reproductive health care.

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

Physicians for Reproductive Health ("PRH") is a doctor-led national not-for-profit organization that relies upon evidence-based medicine to promote sound reproductive health care policies. Comprised of physicians, PRH brings medical expertise to discussions of public policy on issues affecting reproductive health care and advocates for the provision of comprehensive reproductive health services as part of mainstream medical care.

Positive Women's Network USA ("PWN-USA") envisions a world where women living with HIV can live long, healthy, dignified, and productive lives, free from stigma and discrimination. Our mission is to prepare and involve all women living with HIV, in all our diversity, including gender identity and sexual expression, in all levels of policy and decision-making. In working to ensure the rights and dignity of women with HIV, PWN-USA promotes the realization of reproductive justice, including our right to choose when and how to be sexual and when or whether to have children and the information to make an informed decision.

Individuals

Pippa Abston, MD, PhD, FAAP is a pediatrician and Assistant Professor of Pediatrics practicing in Alabama. She is on the board of Physicians for a National Health Program and is Physician Coordinator for North Alabama Healthcare for All. In her book Who is My Neighbor: A Christian Response to Healthcare Reform, she explains why providing good healthcare to everyone in our country would improve not only the quality of our medical system but our economic health. She is also on the board of the Huntsville Chapter of NAMI, The National Alliance on Mental Illness. In her family, practice and community work, she has witnessed first-hand the effects of addiction as a medical illness and has advocated for better access to effective treatment instead of criminalization of the sick.

Leslie Hartley Gise, MD,* is Clinical Professor of Psychiatry at the John A. Burns School of Medicine, University of Hawai`i. She has extensive experience teaching at the professional level

regarding substance use disorders in women, and she worked at a facility treating drug and alcohol addicted pregnant and parenting women for eight years. She is past President of the North American Society for Psychosocial Obstetrics and Gynecology under ACOG.

Anna Mastroianni, JD, MPH,* has substantial work experience and has produced many influential publications in health law and bioethics, with specific expertise in issues affecting women, reproduction and families. Formerly a practicing attorney in Washington, DC, she is a tenured faculty member of the University of Washington School of Law and has graduate faculty appointments in the School of Public Health and School of Medicine. She is also Affiliate Faculty at the Treuman Katz Center for Pediatric Bioethics at Seattle Children's Hospital. Her work with the Institute of Medicine is considered a seminal analysis of the medical, legal, and ethical challenges surrounding the inclusion of women (particularly pregnant women and women of childbearing potential) in research. She is currently co-investigator on an NIH-funded research project evaluating the legal and ethical issues of including pregnant women in HIV research. In her capacity as Trustee of the Population Council, an international research and services organization based in New York, she oversees domestic and international activities involving health, reproduction, and pregnancy. Professor Mastroianni teaches graduate courses in the Schools of Law, Medicine, and Public Health in family law and health law and publishes and lectures internationally.

Shafia Monroe, MPH, is the founder and president of the International Center for Traditional Childbearing (ICTC) a renowned international non-profit that increases the number of midwives, doulas, and healers of color to empower families to reduce infant and maternal mortality and build capacity in their community. Driven by the high infant mortality rate in the Black community, she advocates, trains and speaks for this health inequity to be addressed as a Human Rights issue, and is community activist devoted to infant mortality prevention, breastfeeding promotion, and increasing the number of midwives of color. Her work, among other things, created the Oregon legislation for Medicaid reimbursement for doulas to help vulnerable populations in 2014.

Daniel R. Neuspiel, MD, MPH,* is Director of Ambulatory Pediatrics at Levine Children's Hospital and Clinical Professor of Pediatrics at University of North Carolina School of Medicine in Charlotte, NC. As a pediatrician, he has cared for hundreds of drug-affected infants and children, has published research on the impact of maternal substance use and abuse on infants, and has lectured widely as an expert on this topic.

Robert Newman, MD, MPH, was until January 2001, President and CEO of Continuum Health Partners, Inc., a $2.2 billion hospital network in New York City. Prior to the creation of Continuum in 1997 he was CEO of the Beth Israel Health Care System for 20 years. He is now President Emeritus of Continuum. For over 40 years Dr. Newman has played a major role in planning and directing some of the largest addiction treatment programs in the world - including the New York City Methadone Maintenance and Ambulatory Detoxification Programs, which in the mid-1970s served some 33,000 patients annually. He has also been a strong addiction treatment advocate in Europe, Australia and Asia. Throughout his career he has championed the right of drug-dependent persons to treatment access and choice of provider, and the right to be

cared for under the same conditions as apply to the management of all other chronic medical conditions.

Sharon Stancliff, MD, FAAFP,* is the Medical Director of the Harm Reduction Coalition. She oversees SKOOP, which provides overdose prevention services both directly in New York City and through education and capacity building nationally and internationally. She has been the Medical Director of a large methadone program and, as a Family Practitioner she has provided prenatal care for many women including those in drug treatment. Dr. Stancliff also consults on drug related problems for the AIDS Institute, New York State Department of Health and for several international organizations.

Mishka Terplan, MD, MPH, FACOG,* is Assistant Professor of Obstetrics, Gynecology & Reproductive Sciences and Epidemiology & Public Health at the University of Maryland School of Medicine and Staff Physician at Mercy Medical Center and Planned Parenthood. He is board certified in both OB/Gyn and Addiction Medicine and has done extensive research related to pregnant women with drug and alcohol problems.

Bruce Trigg, MD was, until 2011, the medical director of the Sexually Transmitted Disease program for Regions 1 and 3 of the New Mexico Department of Health. He also served as medical director of a public health program that offers reproductive and infectious disease programs at the Bernalillo County Metropolitan Detention Center, in Albuquerque, NM. For 20 years Dr. Trigg provided clinical care to patients as part of the Milagro Program, for pregnant women who use drugs, at the University of New Mexico Health Sciences Center. He is currently a Clinical Assistant Professor in the Department of Pediatrics at the University of New Mexico and on the faculty of the Adolescent Reproductive and Sexual Health Education Project (ARSHEP) of Physicians for Reproductive Health; a project cosponsored by the American College of Obstetrics and Gynecology and the Society for Adolescent Health and Medicine. Since 2011, Dr. Trigg has been a clinician in Opioid Treatment Programs in Albuquerque and Santa Fe, NM where he treats patients with methadone and buprenorphine. He has recently consulted on addiction treatment in several Southeast Asian countries. Dr. Trigg graduated from the City College of NY and attended the George Washington University School of Medicine in Washington, DC. He did his residency in pediatrics at the Albert Einstein College of Medicine in New York City and at the University of New Mexico School of Medicine. Dr. Trigg served three years with the US Public Health Service in the Indian Health Service in Native American communities in New Mexico and Arizona.

*** Institutional affiliation is for identification purposes only.**

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been served by United States first class mail, postage prepaid, upon the following counsel of record this __ day of November, 2014.

St. Joseph County Prosecutor's Office
227 W. Jefferson Blvd
South Bend, IN 46601

Jeff Sanford
212 S. Taylor St.
South Bend, IN 46601

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Kathrine Jack