THE SIA LEGAL TEAM
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CUNY SCHOOL OF LAW

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Dear Professor Alston:

We welcome your upcoming visit to the United States in service of your mandate as the Special Rapporteur on extreme poverty. We submit this letter to encourage you to consider the intersection between gender, race and poverty, and to examine the ways punitive government policies around reproduction exacerbate poverty and violate other fundamental rights of women living in poverty including - social security, health, autonomy and security of the person, freedom from torture and ill-treatment and non-discrimination based on sex.

This visit comes at a moment of widening economic inequality and deterioration of social safety nets, threats to fragile gains in access to healthcare, attacks on access to reproductive health care, and renewed commitment to use of criminalization to address social problems. These forces have unique and pernicious impacts on poor women, who are discriminated against and targeted because of their reproductive decision-making.

This letter raises three issues that converge to affect the reproductive lives of women living in extreme poverty: limits on cash assistance for children born into families already receiving public benefits, prohibition on public insurance (Medicaid) coverage of most abortions, and criminalization of self-induced abortion.

Poverty and Pregnancy in the US

In the United States, women are disproportionately affected by poverty. Women are 38% more likely than men to experience poverty, with more than one in eight women (16.3 million) living in poverty, and nearly 1 in 17 living in extreme poverty (below 50% of the federal poverty threshold) last year.[1] These disparities are even more stark for women of color. In 2016, 21.4% of Black women, 22.8% of Native American women, 18.7% of Latinas, and 10.7% of Asian-American women lived in poverty, compared to 9.7% of white women.[2]

Poverty among women reflects a persistent gender pay gap and segregation into lower paying "pink collar" jobs, but is also profoundly affected by pregnancy and parenting.[3] The lack of job protection for pregnant workers and lack of affordable childcare hinder women's ability to retain and advance in employment.[4] Women are also more likely to bear the economic costs of raising children: eight out of ten custodial single parents are mothers.[5] Families with children headed by a single woman are twice as likely to experience poverty as families headed by a single man, and more than five times as likely as a family headed by a married couple.[6]

These effects are compounded by the fact that poverty is associated with unintended pregnancy: women who live below the federal poverty line are twice as likely to experience an unexpected pregnancy as those at or above 200% of the federal poverty line, and those pregnancies were six and a half times more likely to end in a birth than an abortion.[7] The disparities along racial lines apply to unintended pregnancy as well, with Black and Latina women approximately twice as likely to have unintended pregnancies as white women.[8]

Because more women live in poverty, women are disproportionately impacted by the inadequacy of public assistance. For instance, in 2016, the purchasing power of cash assistance benefits in 35 states was 20% below the 1996 level.[9] Women are also targets of unique provisions that exclude reproductive health care in government health care coverage and target women for decreased benefits based on their childbearing decisions.

Women in poverty deciding how to handle an unintended pregnancy face overlapping sets of policies that place them in an untenable situation. Limits on public benefits mean that they cannot give birth without driving their family deeper into poverty. The programs they rely on for healthcare do not cover abortions, meaning they must pay out of pocket. And if they are unable to pay and take matters into their own hands, they risk jail. The image that coalesces is a punitive system which simultaneously seeks to coerce women's childbearing decisions based on discriminatory notions about which women should have children and punish women living in poverty for continuing (through decreased benefits) or ending pregnancies (through criminalization of self-induced abortions). All while abdicating state responsibility to provide basic subsistence benefits and non-discriminatory health care.

Welfare Family Caps

"Family Cap" laws are state welfare policies that impose limits on benefits or reduce cash grant rates for families on public assistance who have additional children.[10] These caps are authorized by a federal program, Temporary Aid for Needy Families (TANF).[11] TANF itself is problematic because rather than providing funds based on actual need, TANF authorizes federal "block grants" to states[12] creating a financial incentive for states to reduce the number of people receiving cash assistance, rather than ensure that all persons in need of benefits receive them. States calculate a cash assistance grant according to a household's income and the number of family members, with broad discretion in how funds are distributed.[13] Between 1992-2003, twenty-four states passed Family Caps in an attempt to control childbearing among welfare recipients.[14] More recently, several states have repealed Family Caps recognizing that they do not have the intended effect of decreasing pregnancy and instead serve only to punish people in poverty for their reproductive decisions, thrusting them deeper into poverty and significantly increasing child poverty levels. Currently, seventeen states have Family Caps.[15]

Most TANF recipients are already living in dire poverty, and families receiving benefits calculated based on their family size frequently cannot take care of their daily needs.[16] By providing families with *less* than this amount to penalize childbearing, Family Caps take away benefits from women and families who can least afford it. Perversely, Family Caps deepen child

poverty by prohibiting additional cash assistance for children born into families already recognized as vulnerable.[17] Moreover, other children in the household are harmed because they are forced to share resources calculated to provide basic subsistence for a smaller family.[18] The natural result is that family cap laws increase the deep poverty rate of children with single mothers by about 13.1%.[19]

Comments by lawmakers adopting these policies suggest Family Caps were designed to discriminate against women of color and improperly seek to coerce the reproductive decisions of women receiving TANF benefits. Family caps are premised on racist stereotypes and moral judgments about women who have children outside of marriage. The first welfare program, known as Aid to Dependent Children, was designed to provide support to single mothers (generally presumed to be widows). Black women were systematically excluded from this program and others until the 1960s, when welfare rights reformers agitated to ensure benefits for Black families.[20] In response, states cut welfare programs, espousing rhetoric that blamed poverty on irresponsible reproduction by unwed mothers.[21] When the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) created TANF, its introduction stated that public assistance law should promote the "very important government interest" of preventing out-of-wedlock pregnancies.[22]

While current-day welfare policies are facially race-neutral, they continue a legacy of early 20th century government-sponsored efforts to sterilize Black, Latina, and Native American women.[23] The connection between eugenic sterilization and current welfare policy is often overt: politicians continue to push for sterilization as a requirement for women to receive benefits.[24]

One indication of the punitive intent of these laws is that many states with Family Caps exempt women pregnant by rape or incest, but require proof of the rape or incest from law enforcement or medical personnel.[25] In addition to reinforcing the idea that women lie about rape, these exemptions create a distinction between "innocent" and "irresponsible" pregnancies, and force women to undergo the trauma of proving that pregnancy was forced on them.

The premise underlying Family Caps is that women have additional children to receive additional aid. This overlooks the reality that the costs associated with having a child far exceed the median benefit increase of $78.00/month.[26] Pregnant women faced with the prospect of having to provide for an additional child without any increase in resources may feel that they have no other option than to end an otherwise welcome pregnancy.[27] Unfortunately, their ability to make this decision is further constrained by policies that put abortion care out of reach for women living in poverty.

Prohibitions on Medicaid Funding for Abortion

Federal restrictions on funding for abortion coverage limit access to abortion services for women in poverty, making the fundamental right to decide whether to continue a pregnancy and the spacing of children into a privilege for those who can afford it. These prohibitions limit

women's ability to plan family size, forcing them to choose between carrying a pregnancy they did not plan or having an abortion they cannot afford. Ironically, a woman seeking an abortion because she cannot afford to raise a child may find herself pushed deeper into poverty by the abortion's cost.

A significant barrier to abortion access for women living in poverty is a policy known as the Hyde Amendment, which was implemented in 1977 and renewed annually thereafter. It prohibits Medicaid[28] coverage for abortions for social or economic reasons unless the woman can prove that she was sexually assaulted or that she will die without an abortion.[29]

States may use their own Medicaid funds to cover abortion care, but currently only 17 states have a policy or case law requiring it,[30] and only 15 appear to actually be doing so.[31] As of September 26, 2017, Illinois became the 18th state to authorize Medicaid coverage for abortions, but implementation has not yet begun.[32] Access to abortion care for Medicaid recipients is therefore dependent on where they live, and more than half of Medicaid-enrolled women of reproductive age (7.4 million) live in the states where funding is restricted.[33] Three-fourths of abortion patients in 2014 were low-income.[34] And prohibitions on coverage for abortions disproportionately burden women of color: in 2014, 30% of Black and 24% of Latina women of reproductive age were enrolled in Medicaid, compared to 14% of white women.[35]

Ironically, this means that abortion care is not covered for the women who most need it and can least afford it. And, the expense women are forced to bear can be substantial, with a median cost starting at $500 early in pregnancy and increasing to $1350 by mid-gestation.[36] This does not reflect collateral costs such as transportation, lost wages, child care, and lodging.[37] Women are often forced to forego necessities such as rent, bills, or food, and some must resort to pawning household goods, theft, or commercial sex.[38] Difficulty securing funds may cause women to delay the procedure, increasing the cost and health risks.[39] While complications are rare, the risk increases as pregnancy progresses.[40]

Because Medicaid provides healthcare to people without the means to afford it, prohibitions on coverage have the purpose and effect of making abortion inaccessible, taking away needed health care and the reproductive autonomy of women living in poverty. Indeed, the policy's sponsor, Rep. Henry Hyde stated, *"I would certainly like to prevent, if I could legally, anybody having an abortion: a rich woman, a middle class woman, or a poor woman. Unfortunately, the only vehicle available is the… Medicaid bill."*[41] The result is "a two-tier system of abortion rights that protect[s] the affluent but allow[s] the government to interfere with the reproductive decisions of the poor."[42]

But making abortions unaffordable does not stop women from needing them. Many women who are unable to afford abortions may take their health care into their own hands by self-inducing abortions. And in so doing, they may find themselves ensnared in a system that increasingly seeks to punish women who end their own pregnancies.

Criminalization of Women for Self-Inducing Abortions

The current political hostility towards abortion rights in the United States has left many women in poverty with no practical option for ending untimely pregnancies but to do so themselves. Criminalizing self-induced abortion turns a constitutionally protected human right into a crime, unjustly penalizing women and exacerbating poverty through the stigma and unemployability resulting from criminal prosecution.

The US Supreme Court recognized the right to end a pregnancy in the 1973 decision *Roe v. Wade.*[43] Subsequent US jurisprudence forbids a state from enacting limitations on abortion with the "purpose or effect of placing a substantial obstacle (an 'undue burden') in the path of a woman seeking an abortion for a non-viable fetus."[44] Despite this protection, "for women in large swaths of the United States, access to abortion services is more limited now than at any time since *Roe v. Wade*."[45] States have enacted more than 300 new legal restrictions on access to abortion care since 2011,[46] leading to clinic closures, and leaving many women, especially those in rural areas and without access to transportation, with no provider nearby.

Fortunately, the advent of new reproductive technologies makes the possibility of safe self-managed abortion accessible for more women. Abortion with pills is considered an extremely safe means of ending a pregnancy in the first ten weeks.[47] A growing body of evidence suggests that these medications can be safely taken with minimal medical supervision,[48] and public health researchers have been exploring ways to improve abortion access in restrictive settings and supplant ineffective or dangerous means by disseminating information about how women can safely end a pregnancy on their own.[49]

But women who self-induce abortions — whether due to lack of access, traditional or cultural practice, or personal preference — find themselves at risk of arrest and prosecution.[50] Seven states have laws explicitly criminalizing self-managed abortion that pre-date *Roe v. Wade,* some of which have been enforced in recent years.[51] In other states, politically-motivated prosecutors have misused laws purporting to protect pregnant women (through criminalization of unauthorized abortion providers or third-party harm to fetuses) to charge them with felonies.[52]

Women in poverty are disproportionately affected by criminalization because they are subject to greater surveillance and suspicion due to their interactions with social workers, welfare offices, and public health officials.[53] Criminal convictions — or even investigations that come to public light — exacerbate poverty by forcing women to bear the cost of defending against criminal charges.[54] Criminal convictions can bar women from certain jobs and the arrest and stigma of public prosecution alone can making it difficult to find employment.[55] This type of criminalization has a racially disproportionate effect: between 1973 and 2005 approximately 15% of Florida's population was African American, but 75% of its pregnancy-related criminal cases were brought against African Americans. By contrast, only 22% of cases were brought against whites, who represented 60% of the overall population.[56]

Critically, criminalization endangers the health of women in poverty by driving them away from healthcare in the event of a complication from a self-induced abortion. Many of the women

who have been arrested in recent years came to the attention of law enforcement when they sought emergency medical care.[57] Even women experiencing spontaneous miscarriages may be deterred from health care to avoid the risk of encountering health care providers who might report them to authorities on suspicion of self-inducing the pregnancy loss.[58]

Criminalization has never been an effective deterrent to abortions; to the contrary, prior to the decriminalization of abortion heralded by *Roe v. Wade*, women risked and often lost their lives to end pregnancies.[59] Criminalization inserts fear of arrest into reproductive health care, and prevents the expansion of safe, lower-cost, self-managed abortion options that could be a lifeline to women living in poverty.

Caught in the Crosshairs: Jennie McCormack

The cruel convergence of poverty, restrictions on abortion, and criminalization are evident in the 2011 arrest of Jennie McCormack. A single mother raising three, Ms. McCormack was unemployed and raising her children on approximately $250 per month in child support when she discovered she was pregnant. Had she been receiving public assistance, she would have come up against Idaho's "flat cap" policy, which gives families the same size grant regardless of how many children are in the family. But knowing that she was unable to provide for another child, Ms. McCormack sought an abortion.

The nearest abortion provider was hours away in Utah, and the procedure cost much more than she could afford. Neither Idaho nor Utah provide Medicaid coverage for abortion. Unable to surmount the obstacles of cost, distance, and the need for childcare, she found a website through which a physician outside the US would prescribe abortion pills.[60] She obtained pills through the mail and safely ended her pregnancy.

However, after confiding in a friend, she was reported to police. Ms. McCormack was arrested and indicted based on a law penalizing self-induced abortion as a felony. The state eventually dropped the charges due to lack of evidence, but the damage was done: Ms. McCormack lost her job and was ostracized by her community.[61]

She subsequently challenged the constitutionality of the statute under which she was charged, and a federal appeals court struck down the state's criminal abortion statute because it requires women to "police" their abortion providers (in this case an internet doctor/provider).[62] In rendering its decision, the court acknowledged that many of the restrictions that the Supreme Court has permitted have particularly harsh effects on women living in poverty.[63]

Further Information and Recommendations

We are pleased to provide, along with this submission, a list of organizations and individuals from whom the Special Rapporteur can learn more about the policies described above. They can provide more specific recommendations to alleviate the harmful effects on women in poverty, including:

- **Abolish welfare family caps.** States with family caps should be encouraged to voluntarily abandon these policies. Additionally, the federal authorizing statute (TANF) could be amended to require that states allocate funds to families according to their need, rather than in a manner calculated to coerce reproductive decision-making.

- **Ensure Medicaid coverage for all abortions.** Legislators should be encouraged to either let the Hyde Amendment lapse, or enact other legislative or regulatory measures that ensure that women enrolled in Medicaid are not forced to pay out-of-pocket for health care they cannot afford.

- **Halt criminalization of self-induced abortion.** States should repeal laws explicitly criminalizing self-induced abortion, and clarify (through amendment or authoritative interpretation) that laws such as feticide or criminal abortion laws are not intended to punish women who self-induce abortions.

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[1] Center for Poverty Research University of California, Davis, *How Does Gender Relate to Poverty Status*? (2015) https://poverty.ucdavis.edu/faq/how-does-gender-relate-poverty-status

[2] Kayla Patrick, National Women's Law Center, *National Snapshot: Poverty Among Women & Families, 2016* (Sept. 2017. http://bit.ly/2g8JP2k.

[3] Alexandra Cawthorne, Center for American Progress, *The Straight Facts on Women in Poverty,* (Oct. 8, 2008), http://ampr.gs/2yjhwZG.

[4] *Id.*

[5] *Id.*

[6] Patrick, *supra* note 2.

[7] Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008-2011*, 374 New Eng. J. of Med.843, 846 tbl. 1 (2016).

[8] Guttmacher Institute, *Evidence You Can Use: Medicaid Funding of Abortion*, Dec. 21, 2016, at 2 (Dec. 2016) http://bit.ly/2xJPMwB. In 2011, black and Hispanic women had unintended pregnancy rates of 79 and 58 per 1000 women, respectively, while white women had a rate of 33 per 1000.

[9] Center on Budget and Policy Priorities, *TANF Benefits Have Fallen by More Than 20 Percent in Most States and Continue to Erode, October 17, 2016, http://bit.ly/2yWrEER.*

[10] National Conference of State Legislatures, Welfare Reform: Family Cap Policies, Jan. 31, 2011. http://bit.ly/2kdn29Y

[11] Rebecca J. Smith, *Family Caps in Welfare Reform: Their coercive effects and damaging consequences*, 29 Harv. J.L. & Gender 151, 192 (2006).

[12] Michael Hiltzik, *Block grants are just budget cuts in disguise — and the targets are antipoverty programs*, Los Angeles Times (Mar. 25, 2016) http://lat.ms/2x8X4us.

[13] *See*, e.g., Christopher Dinkel, *Welfare Family Caps and the Zero-Grant Situation*, 96 Cornell L. Rev. 365-396, 375 (2011).

[14] The Center on Reproductive Rights and Justice, University of California Berkeley Law, *Bringing Families out of 'Cap'tivity: The path toward abolishing welfare family caps* (2016) at 1, http://bit.ly/2fE5X3M.

[15] *Id.*

[16] *Id.* at 6-7.

[17] Christopher Dinkel, *Welfare Family Caps and the Zero-Grant Situation*, 96 Cornell L. Rev. 365-396, 367 (2011).

[18] *Id.*

[19] Signe-Mary McKernan & Caroline Ratcliffe, The Urban Institute, *The Effect of Specific Welfare Policies on Poverty*, April 2006, http://urbn.is/2klr2pb, at 19.

[20] Dorothy E. Roberts, Welfare and the Problem of Black Citizenship, 105 Yale Law Journal 1563, 1570-71 (1996).
[21] Rebecca J. Smith, *Family Caps in Welfare Reform: Their coercive effects and damaging consequences*, 29 Harv. J.L. & Gender 151, 155 (2006).
[22] Diana Romero & Madina Agenor, *US Fertility Prevention as Poverty Prevention: An empirical question and social justice issue*, Women's Health Issues, 355-364, 365 (2009).
[23] *Id.* at 360-36.
[24] Smith, *supra* note 11 at 163.
[25] *Id.* at 166-167.
[26] *Id.* at 158.
[27] Romero & Agenor, *supra* note 22 at 357. (A national study of fertility behaviors before and after welfare reform in the 1990s found that poor women went from being 2.8 times as likely to have an abortion as non-poor women, to 4.3 times as likely. Taking into consideration that contraceptive usage and pregnancy rates among both poor and non-poor women remained the same in these time frames, the study results suggested that poverty policies may have influenced increased abortion rates among women living in poverty.)
[28] Medicaid provides health coverage to low-income people and is one of the largest payers for health care in the United States. Medicaid, About Us, www.Medicaid.gov/about-us/index.html.
[29] "No Taxpayer Funding for Abortion and Abortion Insurance Full Disclosure Act of 2017," H.R.7 -- 115th Congress (2017-2018) http://bit.ly/2hKAktY. Since its enactment, the Hyde Amendment restrictions have been expanded to other forms of federally funded health care, including that of federal government employees and their dependents, military servicewomen and veterans, Peace Corps volunteers, federal prison inmates, immigrant detainees, Medicare, Children's Health Insurance Program (CHIP), and Indian Health Service beneficiaries. *See*, Brooke McGee, *Pregnancy as Punishment for Low-Income Sexual Assault Victims: An Analysis of South Dakota's Denial of Medicaid-Funded Abortion for Rape and Incest Victims and Why the Hyde Amendment Must be Repealed*, 27 Geo. Mason U. Civ. Rts. L.J. 77, 89 (2016).
[30] Guttmacher Institute, Medicaid Funding of Abortion, *supra* note 8.
[31] *Id.*
[32] John O'Connor and Sophia Tareen, *Illinois Governor Agrees to Allow Medicaid Coverage for Abortions,* Time (Sept. 28, 2017) http://ti.me/2klexd2.
[33] Guttmacher Institute, Medicaid Funding of Abortion, *supra* note 8.
[34] Guttmacher Institute, Fact Sheet: Induced Abortion in the U.S, January 2017, http://bit.ly/2g9zzqx.
[35] Guttmacher Institute, Medicaid Funding of Abortion, *supra* note 8.
[36] *Id.*
[37] For more detailed information about out-of-pocket costs of abortion please see Ibis Reproductive Health, *Research Brief: The Impact of Out-of-Pocket Costs on Abortion Care Access*, September 2016, http://bit.ly/2fIVOCZ.
[38] Center for Reproductive Rights, *Whose Choice: How the Hyde Amendment Harms Poor Women,* 28, Sept. 13, 2010. http://bit.ly/2yia3u6.
[39] *Id.* at 24-27. See also Guttmacher Institute, Medicaid Funding of Abortion, *supra* note 8.
[40] *Id.* at 3, *citing* Zane S et al*., Abortion-related mortality in the United States: 1998-2010*, *Obstetrics & Gynecology*, 2015, 126(2): 258-265.
[41] Jill E. Adams & Melissa Mikesell, *And Damned if They Don't: Prototype Theories to End Punitive Policies Against Pregnant People Living in Poverty*, 18 Geo. J. Gender & L. 283, 306 (2017), *citing* 123 CONG. REC. 19, 700 (1977).
[42] Jill E. Adams & Jessica Arons, *A Travesty of Justice: Revisiting Harris v. McRae*, 21 Wm. & Mary J. Women & L. 5, 6 (2014).
[43] 410 U.S. 113 (1973).
[44] *See, e.g., Planned Parenthood of Southeastern Pennsylvania v Casey*, 505 U.S. 833 (1992) and *Whole Women's Health v. Hellerstedt*, 579 U.S. ___ (2016).
[45] Adams & Mikesell, *supra* note 41 at 317.
[46] Guttmacher Institute, Laws Affecting Reproductive Health and Rights: State Trends at Midyear, 2016, July 21, 2016, http://bit.ly/2q0OXe8.
[47] Andrea Rowan, *Prosecuting Women for Self-Inducing Abortion: Counterproductive and Lacking Compassion,* Guttmacher Policy Review, Vol. 18, No. 3, Summer 2015, http://bit.ly/2yIE8yM at 71.

[48] Abigail Aiken et al., *Self-Reported Outcomes and Adverse Events After Medical Abortion Through Online Telemedicine: Population Based Study in the Republic of Ireland and Northern Ireland*, 357 BMJ j2011 (2017) (finding that "self-sourced medical abortion using online telemedicine can be highly effective and outcomes compare favourably with in clinic protocols").
[49] *E.g.,* Francine Coeytaux et al., *Facilitating Women's Access to Misoprostol Through Community-Based Advocacy in Kenya and Tanzania*, 125 Int. J. Gynecology & Obstetrics 53 (2014).
[50] Farah Diaz-Tello, Cynthia Soohoo, *Criminalization of Women Who Self-Induce Abortions in the United States*, submitted to UN Working Group on Discrimination Against Women in Law and Practice, June 2017 at 7 [hereinafter "Submission on Criminalization of Self-Induced Abortion"].
[51] *Id.* at 8-10.
[52] *Id.* at 10-19.
[53] Adams & Mikesell, *supra* note 41 at 323.
[54] Even if women qualify and opt for free legal representation, they still must take time off from work and bear other costs associated with defending against criminal charges.
[55] Karen Dolan, Institute for Policy Studies, *The Poor Get Prison: The Alarming Spread of the Criminalization of Poverty*, (March 18, 2015) at 12. http://bit.ly/2xUlZji.
[56] Adams & Mikesell, *supra* note 41 at 342.
[57] Submission on Criminalization of Self-Induced Abortion, *supra* note 50 at 7.
[58] Rowan, *supra* note 47 at 74.
[59] William Cates, Jr., David A. Grimes, *The Public Health Impact of Legal Abortion: 30 Years Later*, Perspectives on Sexual and Reproductive Health, Jan/Feb 2003, at 25, 27 ("The number of abortion-related deaths per million live births fell from nearly 40 in 1970 to eight in 1976.").
[60] Adams & Mikesell, *supra* note 41 at 319.
[61] *Id.*
[62] *Id.*
[63] *McCormack v. Hiedeman*, 694 F.3d 1004, 1018 (9th. Cir.2012) ("While the Supreme Court has permitted many restrictions that make obtaining an abortion more difficult, particularly for low-income women seeking abortion care, it has not authorized the criminal prosecution of women seeking abortion care. Imposing criminal liability upon women for their providers' purported failure to comply with state abortion regulations places a substantial obstacle in the path of women seeking an abortion.").