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In the Supreme Court of the State of Utah

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff, *Plaintiff-Respondent*, v. STATE OF UTAH, et al., *Defendants-Petitioners*.	No. 20220696-SC

Opposition to Petition for Permission to Appeal Interlocutory Order
(*Subject to assignment to the Court of Appeals*)

On petition for permission to appeal
an interlocutory order from the Third Judicial District Court,
Hon. Andrew Stone, No. 220903886

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INTRODUCTION

Petitioners (the "State") seek interlocutory review of a preliminary-injunction order that blocks enforcement of Senate Bill 174 ("the Act," or the "Criminal Abortion Ban"), a law that would ban nearly all abortions in Utah at any stage of pregnancy. In the order at issue, the district court made clear that it was not finally determining the merits, but rather maintaining the status quo while it could consider the serious issues presented in this state constitutional challenge. The State ignores the scope of this narrow holding and the district court's determination that further legal and factual development are warranted, instead urging this Court to accept interlocutory review. However, because the preliminary-injunction order has no chance of "materially affect[ing] the final decision," and review at this juncture would impede, rather than "serve[,] the administration and interests of justice," the petition should be denied. Utah R. App. P. 5(g).

FACTUAL AND PROCEDURAL BACKGROUND

A. The Criminal Abortion Ban

In 2020, the Utah Legislature adopted the Criminal Abortion Ban, which bars abortion at any point in pregnancy, with only three limited exceptions. Those exceptions apply only where (1) abortion is necessary to protect the patient's life or to prevent "a serious risk of substantial and irreversible impairment of a major bodily function of the" patient; (2) two maternal-fetal medicine physicians confirm that a fetus has—in terms left undefined by statute—either a "uniformly diagnosable and uniformly lethal" health condition or a "uniformly diagnosable" brain abnormality that would leave the fetus "to

live in a mentally vegetative state"; or (3) where a patient's pregnancy resulted from rape or incest and her physician confirms that the assault was reported to law enforcement, irrespective of a patient's wishes and other reporting laws. Utah Code Ann. § 76-7a-201.

Instead of making the Criminal Abortion Ban immediately operative, the Legislature provided that the Act would take effect only if a court of binding authority held that a state may prohibit abortion at any point in pregnancy. 2020 Utah Laws Ch. 279, § 4(2). On June 24, 2022, in *Dobbs v. Jackson Women's Health Organization* ("*JWHO*"), the U.S. Supreme Court overruled *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705, 35 L. Ed. 2d 147 (1973), and its progeny. 142 S. Ct. 2228 (2022). In so doing, the U.S. Supreme Court eliminated nearly fifty years of precedent protecting a federal due process right to abortion until viability. It made clear, though, that states, including state courts, remain free to make their own decisions about abortion. *Id.* at 2328.

Based on the *JWHO* decision, on June 24, 2022, the Criminal Abortion Ban took effect, immediately making the performance of abortion in Utah a second-degree felony in nearly all cases. Utah Code Ann. § 76-7a-201(3). Under the Act, abortion providers and other staff who assist in the performance of a prohibited abortion would face a prison term of one to fifteen years per abortion, as well as criminal fines. *Id.* §§ 76-7a-201(3), 76-3-203(2), 76-3-301(1)(a), 76-3-302(1); *see also id.* §§ 76-2-202 (accessory liability), 76-4-201 (conspiracy liability). In addition, licensed abortion clinics and staff would face licensing and other professional penalties. *Id.* § 76-7a-201(4)–(5).[1]

[1] The State describes the Act as requiring that abortions be performed only by a

B. The Initial Litigation

Respondent PPAU is one of only two outpatient abortion providers in Utah. When the Act took effect, PPAU and its staff were forced to immediately stop providing abortions that did not meet the Act's limited exceptions. The day after the Act took effect, PPAU filed a lawsuit against the State in the Third District Court on behalf of itself, its patients, and its staff. It brought seven claims, alleging that the Act violated Utahns' rights to (1) determine their own family composition and to parent; (2) their equal protection rights; (3) their right to the uniform operation of laws; (4) their substantive due process right to bodily integrity; (5) their right to be free from involuntary servitude; (6) their rights of conscience; and (7) their privacy rights. Compl. ¶¶ 60–92.

With notice to defendants and after a hearing with the parties, the district court entered a temporary restraining order on June 27, 2022. The court then issued a preliminary injunction from the bench on July 11, 2022. PI Order 4. In deciding the preliminary-injunction motion, the court had before it declarations from (1) Dr. David Turok, PPAU's director of surgical services and a board-certified obstetrician-gynecologist who provides abortions, attesting to the Act's harmful impact on PPAU, staff, and patients; (2) Colleen Heflin, Ph.D., a sociologist who addressed the Act's heavy impact on Utahns living in low-income households; (3) Lauren Hunt on behalf of the Rape Recovery Center in Utah,

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physician and in a clinic or hospital. *See* Pet. Permission Appeal ("Pet.") 2. However, Utah has long imposed those requirements, which remain enforceable and are not at issue here. Prelim. Inj. Order ("PI Order") 4 n.1; Utah Code Ann. §§ 76-7-302, 302.5.

addressing the Act's impact on sexual assault survivors; and (4) three PPAU patients whose abortion appointments would have to be cancelled without a preliminary injunction. Mot. Prelim. Inj. ("PI Mot.") Ex. A ("Turok Decl."), attached hereto as Attach. 1; Ex. B ("Heflin Decl."), attached hereto as Attach. 2; Ex. D ("Hunt Decl."), attached hereto as Attach. 3; Pl.'s Mot. Submit Decls. Under Pseudonym ("Pseudonym Mot.") Exs. A–C, attached hereto as Attachs. 4–6. The patient declarations provided evidence not only about the Act's harmful impact, but also about the barriers that patients face in bringing their own suits. *See, e.g.*, Pseudonym Mot. Ex. A, ¶ 12; Prelim. Inj. Tr. ("Tr.") 42:24–43:03. The court also relied on an amicus brief from the American College of Obstetricians & Gynecologists, the American Medical Association, and the Society for Maternal-Fetal Medicine ("ACOG Br."), attached hereto as Attach. 7. As the court explained, that brief showed "the ethical difficulties that doctors face and the kind of fundamental changes to the doctor-patient relationship that this [Act] would result in." Tr. 46:10–12.

At the preliminary-injunction stage, the State submitted no written evidence and called no witnesses to rebut PPAU's declarations or to support its contentions that enjoining the Act would harm the State and the public. The State described its interest in the Act as serving "one overriding purpose: the protection of human life, rooted in a moral conviction about the worth of each unborn child." Defs.' Mem. Opp'n. Prelim. Inj. ("Opp'n Mem.") 13; *see also id.* 62–63. Although it challenged PPAU's standing to represent patients' interests, it did not object to PPAU's standing to represent PPAU staff, or to consideration of staff injuries when assessing irreparable harm and the equities.

C. The Preliminary Injunction and Subsequent Proceedings

At the conclusion of the preliminary-injunction hearing on July 11, the district court orally granted the injunction. The court made clear that the injunction was effective immediately, but it asked PPAU to submit "an appropriate order." Tr. 53:20–23. PPAU submitted a proposed written order that same day, to which the State filed no objections.[2]

On July 19, the district court entered its written decision. It "easily conclude[d]" that it had jurisdiction, explaining that "PPAU has demonstrated an injury in its own right and to its patients," and that "enjoining the Act would redress those injuries." PI Order ¶ 8. It also concluded in the alternative that PPAU has "representative standing because it is an appropriate party to litigate this case of significant public import." *Id.*

The district court further concluded that all four preliminary-injunction factors favored PPAU, and in particular that PPAU made a "strong showing" of irreparable harm to itself, its patients, and its staff. *Id.* ¶ 3. In examining the equities, the court acknowledged the State's asserted interest in the Act, but concluded that it was "unclear on this record whether and to what extent the Act will ultimately further" the State's goals. *Id.* ¶ 4. As to the merits, the Court determined, for each of the six claims on which PPAU had sought a preliminary injunction (i.e., all but the involuntary servitude claim), that there are "at least serious issues on the merits that should be the subject of further litigation." *Id.* ¶ 6.

[2] Although the State now argues that the trial court prematurely issued the injunction order, Pet. 4, the State never objected to or sought reconsideration of that order and waited nearly a month before attempting to appeal. The State's procedural objection was, therefore, forfeited. *438 Main St. v. Easy Heat, Inc.*, 2004 UT 72, ¶ 51, 99 P.3d 801.

However, it emphasized that its consideration of the "novel and complicated issues" in the case would "benefit from further development, including through any facts that the parties may wish to introduce in the normal course." *Id.* ¶ 7.

On August 10, nearly a month after the district court first granted the preliminary injunction and weeks after its written order, the State petitioned this Court for permission to appeal the order and moved to stay the injunction, a motion that PPAU opposed.

Meanwhile, in the district court, the State has not moved to dismiss PPAU's claims. It answered the complaint on July 18, 2022, and the court has set a scheduling order under which the parties have already exchanged initial disclosures.

REASONS FOR DENYING THE PETITION

Interlocutory appeal is appropriate only if (1) "the order involves substantial rights and may materially affect the final decision," or (2) "a determination of the correctness of the order before final judgment will better serve the administration and interests of justice." Utah R. App. P. 5(g). A party seeking such review must show why interlocutory review "may materially advance the termination of the litigation." *Id.* 5(c)(1)(D). Because the State has failed to make this showing, review should be denied.

I. INTERLOCUTORY APPEAL IS UNWARRANTED TO REVIEW THE DISTRICT COURT'S STANDING ANALYSIS

The State first seeks this Court's interlocutory review of the district court's conclusion that PPAU has standing to seek a preliminary injunction. It suggests that if this Court disagrees with the district court's determination that PPAU has standing, then the

Court would have to dismiss PPAU's entire case. Pet. 19. That assertion is insufficient to warrant interlocutory review under Rule 5 for at least four reasons.

First, the district court's preliminary ruling as to standing will not affect the final decision in this case. A challenge to standing "is to be evaluated under the standard used . . . at the relevant stage of litigation." *Brown v. Div. of Water Rts. of Dep't of Nat. Res.*, 2010 UT 14, ¶ 15, 228 P.3d 747; *accord S. Utah Wilderness All. v. Kane Cnty. Comm'n*, 2021 UT 7, ¶ 16, 484 P.3d 1146. Accordingly, at the preliminary-injunction stage, the question before the district court was whether PPAU demonstrated a substantial likelihood or serious issue of standing. *See Brown*, 2010 UT 14, ¶ 15; *see also, e.g.*, *Elec. Priv. Info. Ctr. v. Presidential Advisory Comm'n on Election Integrity*, 878 F.3d 371, 377 (D.C. Cir. 2017); *Speech First, Inc. v. Fenves*, 979 F.3d 319, 329–30 (5th Cir. 2020). The district court's order is consistent with that standard: It does not preclude the State from later attempting to introduce evidence challenging PPAU's standing under the applicable legal precedent. And the preliminary injunction, as an interlocutory order, is "by its very nature subject to modification." *Kasco Servs. Corp. v. Benson*, 831 P.2d 86, 88 (Utah 1992) (citing U.C.R.P. 54(b)); *see also Centro de la Familia de Utah v. Carter*, 2004 UT 43, ¶ 5, 94 P.3d 261 (U.C.R.P. 65A "does not direct that findings and conclusions relating to an injunction are binding in a subsequent trial").

Second, the district court's standing decision rests on multiple legal grounds, each of which involves the straightforward application of this Court's existing precedent. Under these circumstances, even if the Court were to find error in *one* of those legal grounds, its

intervention could not possibly change the outcome of the order under review or materially advance the termination of this litigation, as required by Rule 5, because PPAU would still have standing to seek a preliminary injunction and final relief under an alternative standing ground. *See, e.g.*, *Utah Med. Prod., Inc. v. Searcy*, 958 P.2d 228, 233 (Utah 1998) (affirming denial of preliminary injunction where alternative ground supported decision).

Third, even if the Court were to hold that PPAU lacks standing on this record to seek a preliminary injunction, that holding would not end the litigation, as the State claims. An "inability" to meet the preliminary-injunction standard as to standing "requires denial of [a] motion for preliminary injunction, not dismissal of the case." *Food & Water Watch, Inc. v. Vilsack*, 808 F.3d 905, 912 (D.C. Cir. 2015). Accordingly, even if this Court ruled against PPAU on standing, PPAU would be entitled to a remand, where it could attempt to re-plead its complaint to address any perceived shortcomings or to submit further evidence in support of a renewed motion for preliminary injunction or at later stages of litigation. And because PPAU's standing is assessed on a claim-by-claim basis, *see, e.g.*, *Alpine Homes, Inc. v. City of W. Jordan*, 2017 UT 45, ¶ 12, 424 P.3d 95, and PPAU did not move for a preliminary injunction on all of its claims, the interlocutory review sought by the State as to standing would necessarily be incomplete.

Fourth, permitting appeal of the district court's straightforward and correct standing analysis would serve only to encourage piecemeal litigation disfavored under Rule 5. Utah courts are common law courts of general jurisdiction. Utah Const. art. VIII, § 1. Unlike federal courts, their judicial power "is not constitutionally restricted by the language of

Article III of the United States Constitution requiring 'cases' and 'controversies,' since no similar requirement exists in the Utah Constitution." *Gregory v. Shurtleff*, 2013 UT 18, ¶ 12, 299 P.3d 1098. Thus, standing requirements under Utah law are not as rigorous as those in federal courts. *Id.*; *see also, e.g.*, *Laws v. Grayeyes*, 2021 UT 59, ¶ 84, 498 P.3d 410 (Pearce, J., concurring).

PPAU clearly satisfies the traditional test for standing to sue. As the State concedes, the Act will prevent PPAU from serving patients, Opp'n Mem. 18, which alone gives PPAU a personal stake in the suit. *E.g.*, *Utah Chapter of Sierra Club v. Utah Air Quality Bd.*, 2006 UT 73, ¶ 14, 148 P.3d 975. PPAU also faces substantial reputational harms and the threat of criminal and licensing penalties if it provides abortions in violation of the Act. Utah Code Ann. § 76-7a-201(3)–(5); *see also Jenkins v. Swan*, 675 P.2d 1145, 1151 (Utah 1983). As the district court concluded, these established harms are a direct result of the new law, and "a decision . . . enjoining the Act would redress those injuries." PI Order ¶ 8; *see also* Reply Supp. Prelim. Inj. ("PI Reply") 3. That is all that is required to invoke the district court's jurisdiction under "the traditional test" for standing. *Hogs R Us v. Town of Fairfield*, 2009 UT 21, ¶¶ 8–10, 207 P.3d 1221.

The State contends that PPAU lacks a "personal stake" in the case because it does not allege a violation of its own constitutional rights. Pet. 7. But that contention is at odds with Utah precedent allowing associations to sue on behalf of their members to vindicate members' rights, *see id.* 8 (conceding the vitality of this doctrine), and with *Shelledy v. Lore*, 836 P.2d 786, 789 (Utah 1992), which recognized yet another third-party standing

doctrine. Indeed, PPAU satisfies the test for third-party standing articulated in *Shelledy* because (1) the relationship between a medical provider and patient is "substantial," (2) it would be impossible for all of PPAU's patients to bring their own cases challenging the Act, and (3) enforcing the Act against PPAU would result in the "dilution of [patients'] constitutional rights" were third-party standing not permitted. *Id.*[3]

In any event, the district court also correctly concluded that PPAU has standing under the "alternative public-interest doctrine," which does not hinge on whether a litigant has a "personal stake in the controversy." *Gregory*, 2013 UT 18, ¶ 24 (internal quotation omitted). That doctrine allows Utah courts to adjudicate any case of significant public importance where the plaintiff is an appropriate party, as the district court expressly held that PPAU is. *See* PI Order ¶ 8. The recognition of public interest standing is particularly appropriate here, where PPAU asks the courts to consider only "whether [the Act] was passed in accordance with the constitution, since the determination of that question does not require . . . instruct[ing] another branch of government to do anything other than obey" constitutional limits. *Gregory*, 2013 UT 18, ¶ 27 n.14.

[3] Notably, *Shelledy* cited with approval a law review article that endorsed a broad third-party standing test in federal court, including the recognition of such standing for abortion providers suing on behalf of patients. *See* 836 P.2d at 789 (citing *Standing to Assert Constitutional Jus Tertii*, 88 Harv. L. Rev. 423 (1974)). And federal courts have "long permitted abortion providers to invoke the rights of their actual or potential patients in challenges to abortion-related regulations." *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2118, 207 L. Ed. 2d 566 (plurality opinion), *abrogated on other grounds by JWHO*, 142 S. Ct. 2228; *id*. at 2139 n.4 (Roberts, C.J., concurring). The State's view that PPAU lacks standing would lead to the nonsensical conclusion that PPAU could bring its claims in an Article III federal court but not in a state court of equity in Utah.

The State counters that public interest standing is unwarranted because patients could bring their own constitutional challenges. Pet. 9. However, as this Court has explained, public interest standing does not require a plaintiff to be the *most* appropriate plaintiff, but rather *an* appropriate plaintiff. *Gregory*, 2013 UT 18, ¶¶ 14–18. In any event, the State ignores evidence that shows why patients are unlikely to bring their own suits, including because of a lack of knowledge, time, and resources; fear of being in court; and fear for their anonymity. *See generally* Pseudonym Mot., Exs. A–C; *see also* Tr. 46:15–19.

In short, given the ample avenues by which PPAU has shown standing, all of which are based on existing Utah law, this Court's intervention is unwarranted.

II. INTERLOCUTORY APPEAL IS UNWARRANTED TO REVIEW THE DISTRICT COURT'S NARROW MERITS ANALYSIS

The State seeks to appeal from the preliminary-injunction order as to the district court's merits analysis, claiming that "PPAU has no possibility of winning on its claims." Pet. 1. Interlocutory appellate review is unwarranted on this ground as well.

First, the district court's merits review is extremely narrow and preliminary. The district court held only that the six claims on which PPAU sought a preliminary injunction raise "serious issues" warranting further development. PI Order ¶ 6. The court expressly solicited further elaboration of the constitutional history arguments raised by the State, and made clear that the court could benefit from additional evidence in litigation. *Id.* Nothing about the district court's order as to these serious questions will limit the arguments available to the parties at later stages of the litigation or render the final judgment a

foregone conclusion. Accordingly, the preliminary-injunction order will not "materially affect the final decision" so as to justify interlocutory review. Utah R. App. P. 5(g).

Second, any review by this Court as to whether serious legal issues are presented for further litigation could reach only a subset of PPAU's claims, since PPAU did not move for preliminary injunctive relief on all grounds raised in its complaint. As a result, even if this Court is inclined to provide interlocutory guidance as to the merits at some point in this case, its review of the preliminary-injunction order would necessarily result in the kind of "piecemeal appeals"' that are disfavored by this Court. *Copper Hills Custom Homes, LLC v. Countrywide Bank, FSB*, 2018 UT 56, ¶ 11, 428 P.3d 1133 (citation omitted).

Third, this is not a case in which, absent interlocutory review by this Court, the parties and the district court are likely to get bogged down in massive discovery or an extended trial that would burden the orderly administration of the litigation. The parties have already made initial disclosures that suggest fact discovery is likely to be modest, and as is evident from the pending petition to appeal, the State has thus far argued that it can prevail without introducing any evidence at all. In any event, the district court is well-positioned to manage the scope and pace of the litigation, while ensuring that all Utah courts examining this case will have relevant testimony before them when considering the weighty issues and interests at stake. There is, therefore, no reason for this case to be the exception to the general rule against appeal from non-final orders. *See id.*

Fourth, even if this Court could delve into the legal weeds as the State urges, and is willing to do so without a fully developed record, that review would still lead to the

inexorable conclusion that the district court appropriately exercised its discretion when it concluded that PPAU's claims presented serious legal issues for further litigation and thus justified a preliminary injunction. To conclude otherwise, this Court would have to find that the district court was wrong in its assessment that PPAU might prevail on not just one, but all six claims at issue in the underlying order. There is no colorable argument that the Court could do so here.

The gist of the State's argument is that the Utah Constitution cannot protect *any* right that bears on a Utahn's abortion decision because the word "abortion" does not appear in the Utah Constitution—or in the record of the constitutional convention—and because Utah criminalized abortion in the late 1800s. Pet. 12.

However, the State's constricted view of originalism finds no home in this Court's precedent. To be sure, the history on which the State relies is not irrelevant to the meaning of "text [from the late 1800s] as understood when it was adopted." *S. Salt Lake City v. Maese*, 2019 UT 58, ¶ 18, 450 P.3d 1092. But the meaning of a particular right in the Utah Constitution may evolve over time, especially when—as is true with the rights at issue here—the public would have understood the scope of a particular right to be "expanding in use and purpose" at the time the Constitution was enacted. *Patterson v. State*, 2021 UT 52, ¶ 122, 504 P.3d 92; *see id.* ¶¶ 123–35 (considering the evolving scope of the writ of habeas corpus over the nineteenth and twentieth centuries); *see also, e.g.*, PI Mot. 26 (discussing debate over the scope of the equal rights provision at the time of its adoption);

id. 13–14 (discussing the textual indicator in the equal rights provision that it was intended to evolve in scope as civil and political rights and privileges did as well).

Were the State's simplistic view of originalism correct, the Utah Legislature would not be constrained by the Utah Constitution from reenacting laws from the late 1800s prohibiting interracial marriages, Utah Rev. Stat. § 1184 (1898); providing that the testimony of a woman is insufficient, by itself, to establish that an abortion has occurred, *id*. § 4858; criminalizing the employment of women to play music or to dance in almost any place where two or more persons assemble, *id*. §§ 4243–44; authorizing minor children to be bound to apprenticeships, *id*. § 74; and criminalizing the sale of liquor to all Native Americans and any persons cohabiting with a Native American woman, Laws of the State of Utah, ch. 76, § 1 (1896). This Court has never embraced such an extreme and mechanical approach to interpreting the Utah Constitution.

Moreover, as PPAU argued below, some of the constitutional protections on which it relies—which cannot in any event be dismissed as a single "right to abortion"—have been amended recently. Those amendments post-date, for example, the establishment of a federal right to abortion under *Roe v. Wade* in 1973; the Utah legislature's 2009 adoption of the *Roe* framework to prohibit only post-viability abortion, *see* 2009 Utah Laws Ch. 38, § 1 (amending Utah Code Ann. § 76-7-302); and this Court's decision in 2002 that the Utah Constitution independently encompasses a substantive due process right to abortion. *Wood v. Univ. of Utah Med. Center*, 2002 UT 134, ¶ 29, 67 P.3d 436, *overruled on other grounds*,

Waite v. Utah Labor Comm'n, 2017 UT 86, 416 P.3d 635.[4] As the State concedes, an originalist analysis should consider "the shared linguistic, political, and legal presuppositions and understandings" of Utahns at the time of a provision's drafting. Pet. 12 (quoting *Neese v. Utah Bd. of Pardons & Parole*, 2017 UT 89, ¶ 98, 416 P.3d 663). The nature of these presuppositions at the time of constitutional amendments are therefore relevant, and the district court correctly concluded that it would benefit from additional briefing and factual development on them. Tr. 50:6–52:14. A "clear factual record" in that respect will "facilitate[] informed decisions" in this case. *S. Utah Wilderness All.*, 2021 UT 7, ¶ 3 n.2, 484 P.3d 1146 (internal quotation marks omitted).

The State's argument that the challenged claims present no serious issues for review also rests on a blinkered, rigidly formalistic interpretive model at odds with the varied approaches this Court has taken to constitutional interpretation in recent years. Earlier this year, for example, this Court favored a modern understanding of the Uniform Operation Clause over its original understanding. *Salt Lake City Corp. v. Utah Inland Port Auth.*, 2022 UT 27, ¶¶ 11–28, ___P.3d___. And to the extent that the originalist framework is a method of constitutional interpretation rooted in notions of the scope of the judiciary's power, it is noteworthy that Article VIII of the Utah Constitution—which defines the scope

[4] Similarly, although the State relies on language in *In re J.P.*, 648 P.2d 1364 (Utah 1982), regarding *Roe v. Wade*, *see* Pet. 3, that language was dicta that distinguished between the source of "the parental liberty right at issue" in that case with substantive due process rights sounding in "privacy," as in *Roe*. 648 P.2d at 1375; *see also* PI Reply 20. At minimum, the lengths to which the State must go to make its case to this Court confirm that there are serious issues to be resolved in the normal course of litigation.

of judicial power under Utah law—was extensively amended in 1984, at a time when the common understanding of constitutional interpretation allowed for courts to consider policy concerns and approaches by other states.

At bottom, review of the district court's conclusion that PPAU's claims present "serious issues" for litigation would not provide any occasion for this Court to delve into the legal arguments that the State now presses, and if it did, the clear outcome on appeal would be affirmance. Taking a piecemeal appeal just to affirm the district court's commonsense conclusion as to the need for a fully developed record and for further elaboration of the merits would be a waste of judicial resources and should be rejected.

III. INTERLOCUTORY APPEAL IS UNWARRANTED TO REVIEW THE DISTRICT COURT'S WEIGHING OF OTHER FACTORS

The State briefly argues that this Court should review the preliminary-injunction order as to the district court's assessment of irreparable harm and the other injunction factors under Rule 65A, *see* Pet. 18, but it makes no attempt to explain how this assessment could "materially affect the final decision" in this case, as described in Rule 5(g). For good reason. To ultimately obtain a declaration of the Act's invalidity under Utah's Declaratory Judgment Act, PPAU need not show irreparable harm. *See* Utah Code Ann. § 78B-6-408. Nor would such relief require the balancing of the public interest and equities set forth in Rule 65A. *See id.* § 78B-6-406; *see also Birch Creek Irr. v. Prothero*, 858 P.2d 990, 994 (Utah 1993) ("The issues raised on a motion for a preliminary injunction are distinct from those raised when a permanent injunction is sought." (citation omitted)). Accordingly, even

if the district court erred in applying the preliminary-injunction standard to the facts in the record (it did not), granting interlocutory review would not affect the case outcome.

Nor can the State demonstrate that the interests of justice are served by this Court's review as to the balancing of harm, equities, and the public interest. The State's complaints are either based on grounds not presented to the district court or are a result of the State's own failure to introduce supporting evidence. Giving the State multiple bites at appeal here would, far from serving justice, prejudice PPAU and undermine the district court, which of course cannot consider arguments never presented to it.

1. The district court did not, as the State contends, "ignore[]" asserted injuries to the State's interests or otherwise abuse its discretion in considering them. Pet. 19.

Although the State now raises an abstract interest in "preserving . . . the lives of mothers," *id.*, it did not rely on that interest in women's health in the district court. To the contrary, in that court, the State contended that its sole interest in the ban was in protecting fetal life, and it dismissed harm to Utah women seeking abortion as legally irrelevant. Opp'n Mem. 66–67. The State, therefore, forfeited this argument. *438 Main St.*, 2004 UT 72, ¶ 51. Moreover, even if the State had raised this interest below, it could not possibly show that the district court's decision was "clearly erroneous" in crediting the ample, unrebutted evidence submitted by PPAU. *Utah Med. Prod.*, 958 P.2d at 231 (citing U.C.R.P. 52(a)). That evidence shows that the Act poses far greater risks to pregnant people's health and well-being than the status quo, under which safe, legal abortion has been available for nearly fifty years. *See* PI Order ¶ 3; PI Mot. Exs. A–B, D.

Nor did the district court err in assessing the State's asserted interest in fetal life. The court acknowledged that asserted interest but observed that the current record does not demonstrate to what extent the Act would actually further that interest. PI Order ¶¶ 3–4; *see also* Tr. 48:20–21. And while the State contends that abortion is "irreversible," Pet. 19, so is having a child. "[T]he abortion decision is one that simply cannot be postponed, or it will be made by default with far-reaching consequences." *Bellotti v. Baird*, 443 U.S. 622, 643, 99 S. Ct. 3035, 61 L. Ed. 2d 797 (1979). The district court navigated these impacts not by minimizing an interest in fetal life, but by maintaining the status quo, under which Utahns, not the State, can weigh that interest among all others in their decision whether to have an abortion or to carry a pregnancy to term. PI Order ¶ 5.[5]

Finally, the State's interests are not unprotected under the district court's order. The preliminary injunction does not restrict the administration or enforcement of other abortion restrictions that PPAU has not challenged in this litigation—specifically Utah's bar on post-viability abortion and abortion after 18 weeks of pregnancy. PI Order 4 n.1; Utah Code Ann. §§ 76-7-302, 302.5. The State's mandatory counseling and waiting period also remain in effect, both of which permit the State to further its purported interests. *Id.* § 76-7-305.

2. The State argues that evidence of injury to PPAU itself "is far from a strong showing" of irreparable harm. Pet. 18. However, as the State concedes, the district court

[5] The State's contention that the Act represents the "status quo," Pet. 19, is incorrect. The status quo is based on "the reality of the existing status and relationship between the parties" before the dispute began. *Schrier v. Univ. of Co.*, 427 F.3d 1253, 1260 (10th Cir. 2005). Here, that reality included access to safe, legal abortion.

found that PPAU, along with its staff, would "suffer reputational harm or the threat of criminal and licensing penalties." *Id.* (citing PI Order 2); *see also, e.g.*, Utah Code Ann. § 76-7a-201(3)–(5); *id.* § 76-3-203(2), -301(1)(a), -302(1); Turok Decl. ¶¶ 3–4, 54; ACOG Br. 17–21. And under well-established law, "[l]oss of business and goodwill may constitute irreparable harm susceptible to injunction." *Hunsaker v. Kersh*, 1999 UT 106, ¶ 10, 991 P.2d 67; *see also Zagg, Inc. v. Harmer*, 2015 UT App 52, ¶ 8, 345 P.3d 1273; *Sys. Concepts, Inc. v. Dixon*, 669 P.2d 421, 429 (Utah 1983). Given the case law, and the State's failure to introduce any countervailing evidence, the district court did not abuse its discretion or act contrary to the "clear weight of evidence" in holding that PPAU had established irreparable injury. *Sys. Concepts*, 669 P.2d at 425 (internal quotation omitted).

3. The State argues that in assessing irreparable harm and the equities, the district court erred in considering harms to PPAU's patients. Pet. 18–19. That argument does not warrant this Court's review. As an initial matter, the State cannot have it both ways, on one hand dismissing as irrelevant the Act's unrebutted impact on PPAU's patients, while on the other hand, as discussed above, abstractly invoking women's lives to justify enforcement of the Act. Moreover, because PPAU has standing to sue on behalf of its patients, *see supra* Section I, harms to patients are appropriately considered not only with respect to the public interest, but also in assessing irreparable harm and the equities. *See, e.g.*, *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 67–68, 208 L. Ed. 2d 206 (2020) (considering harm to parishioners in case brought by diocese).

The State's related contention that PPAU cannot rely on harm to its staff in showing that the equities favor maintenance of an injunction should likewise be rejected. In the district court, the State never objected to consideration of these harms in assessing the propriety of an injunction, and it has thus forfeited that contention at this stage of the litigation. *See 438 Main St.*, 2004 UT 72, ¶ 51.

CONCLUSION

For all these reasons, the petition for permission to appeal should be denied.[6]

[6] Should this Court be inclined to permit interlocutory appeal, PPAU agrees that the Court should retain that appeal instead of transferring it to the Utah Court of Appeals.

DATED: September 2, 2022

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. This response brief does not exceed 20 pages, excluding any tables or addenda, in compliance with Utah Rule of Appellate Procedure 5(d).

2. This response brief has been prepared in a proportionally spaced typeface using Microsoft Word in 13-point Times New Roman font in compliance with the typeface and type-size requirements of Utah Rule of Appellate Procedure 27(a).

3. This brief contains no non-public information and complies with Utah Rule of Appellate Procedure 21(h).

/s/ Troy L. Booher

CERTIFICATE OF SERVICE

I hereby certify that on September 2, 2022, I caused the foregoing to be served by email on the following:

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Attachment 1

THIRD JUDICIAL DISTRICT COURT FOR SALT LAKE COUNTY, UTAH

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff, *Plaintiff*, v. STATE OF UTAH, *et al.*, *Defendants.*	**DECLARATION OF DAVID TUROK, M.D., M.P.H., FACOG, IN SUPPORT OF PLAINTIFF'S MOTION FOR A TEMPORARY RESTRAINING ORDER** Case No. 220903886 Judge Kouris

I, David Turok, M.D., M.P.H., FACOG, being of lawful age, do hereby swear and state as follows:

1. I am the Director of Surgical Services at Planned Parenthood Association of Utah ("PPAU"), a non-profit organization that has provided health care services in Utah for more than fifty years. My duties include directing and supervising PPAU's medical program, including abortion services, and developing and implementing PPAU's medical protocols for surgical services, including for abortions.

2. The facts I state here are based on my years of medical practice, my personal knowledge, my review of PPAU business records, information obtained through the course of my duties at PPAU, and my familiarity with relevant medical literature and statistical data recognized as reliable in the medical profession. A copy of my *curriculum vitae* is attached as **Exhibit A**.

3. I submit this declaration in support of Plaintiff's Motion for a Temporary Restraining Order to prevent enforcement of Utah Code Ann. § 76-7a-201 (the "Criminal Abortion Ban"). I understand that the Criminal Abortion Ban, which Utah officials announced as in effect the evening of June 24, 2022, prohibits abortion at any point in pregnancy with extremely narrow

exceptions, and exposes any person who violates it to a prison term of one to fifteen years, criminal fines, and loss of licensure.

4. As a result of this law, PPAU, its staff, and I have had no choice but to stop performing abortions beyond the Act's narrow exceptions, effective immediately. At this time, we have been forced to cancel abortion appointments scheduled for today, June 25, 2022, for approximately a dozen patients. PPAU has at least 55 patients scheduled for abortion appointments in the next week, including 12 on Monday, 19 on Tuesday, and 19 on Wednesday. If relief is granted in this case, PPAU's health centers would resume providing abortions beyond those eligible for the Act's narrow exceptions.

5. The Criminal Abortion Ban is having and will continue to have a devastating impact on Utahns who need abortion. I expect that some of these Utahns will be forced to attempt to travel to other states for abortions. Those who are not able to do so will be compelled to carry pregnancies to term against their wishes or seek ways to end their pregnancies without medical supervision, some of which may be unsafe, risking damage to their health and lives. I am gravely concerned about the effect that the Criminal Abortion Ban will have on Utah women's emotional, physical, and financial wellbeing and the wellbeing of their families, including their existing children.

I. My Background

6. I am licensed to practice medicine in Utah and am board-certified in obstetrics and gynecology. I am a tenured Associate Professor in the Department of Obstetrics and Gynecology at the University of Utah School of Medicine. I also serve as Director of the University of Utah's Division of Family Planning, the University of Utah's Fellowship in Family Planning, and the ASCENT Center for Sexual and Reproductive Health.

7. I obtained a medical degree and a master's degree in public health from Tufts University School of Medicine in 1995. I completed residencies with the University of Utah's Department of Obstetrics and Gynecology and Brown University's Department of Family Medicine. I also completed a Family Practice Obstetric Fellowship with the University of Utah's Department of Family and Preventive Medicine.

8. I am on the Editorial Board of *Contraception*, an international reproductive health journal. I also serve as a reviewer on numerous academic journals, including the *American Journal of Obstetrics and Gynecology*, *Human Reproduction*, and *Women's Health Issues*. I have co-authored more than 100 research publications involving, among other issues, second-trimester abortion procedures, overcoming contraceptive and abortion access barriers, the development of novel contraceptive methods, and the use of intrauterine devices (IUDs) for emergency contraception. I lead a team that has conducted two large contraceptive initiatives in Utah that have provided no-cost contraception to more than 25,000 people. These studies, and others, have evaluated the intersection of health exposures and outcomes, specifically those assessing the social determinants of health.

9. I have provided abortions in Utah since 1997 and have done so as a routine part of my medical practice since 2003.

10. I have delivered more than 1,000 babies, with many of those births complicated by maternal or fetal conditions. I have seen the broad spectrum of human complications during pregnancy and childbirth and have a deep understanding of the complications that can cause durable disability and death.

11. As the Family Planning Division Director at the University of Utah, I lead a research team that has provided women in Utah access to no-cost contraception, with most

receiving highly effective methods they were otherwise unable to obtain. This includes more than 7,400 women reached in collaboration with PPAU through the HER Salt Lake Contraceptive Initiative. These services are an effective means of preventing unintended pregnancies, many of which would have ended in abortion.

II. PPAU and Its Services

12. PPAU is a non-profit corporation organized under the laws of the State of Utah.

13. Founded in 1970, PPAU's mission is to empower Utahns of all ages to make informed choices about their sexual health and to ensure access for Utahns to affordable, quality sexual and reproductive health care and education. PPAU provides care to approximately 46,000 Utah residents each year.

14. PPAU operates eight health centers across the State of Utah, stretching from Logan in the northeast to St. George in the southwest near the Arizona border. PPAU health centers provide a full range of family-planning services including well-person preventative care visits; breast exams; Pap tests; sexually transmitted infection (STI) testing; a wide range of FDA-approved contraception methods, including highly effective, long-acting reversible contraceptives; pregnancy testing; risk assessments for pregnant women to screen for high-risk issues; referral services for pregnant women; urinary tract infection treatment; cervical cancer and testicular cancer screening; fertility awareness services; and vasectomies.

15. Until the Criminal Abortion Ban became effective, three of PPAU's health centers, through its board-certified physicians licensed to practice in Utah, also provided abortions. Its Metro Health Center in Salt Lake City provided first and second-trimester abortions. Its Logan Health Center and Salt Lake City Center provided first-trimester medication abortion. All three health centers are licensed under Utah law as abortion clinics authorized to perform abortions.

16. PPAU's staff includes physicians and other employees who are licensed to provide care in Utah and who are involved in the provision of abortion, and it relies on pharmacy licensing for in-clinic dispensing of medications, including for the purpose of abortion.

17. PPAU's services have included both procedural abortion, available in the first and second trimesters, and medication abortion, available up to 11 weeks LMP. Which method of abortion a patient uses will depend on the gestational age of the pregnancy (medication abortion is available only up to 11 weeks LMP), whether one method is medically contra-indicated, and personal preference. Many patients prefer medication abortion, which has been available to them for over two decades,[1] because they find it to offer greater privacy. Although in Utah patients still come to a health center to obtain the medication, they are able to pass their pregnancy at a location of their choosing, usually at home, in a manner comparable to a miscarriage.

18. In 2019, the most recent year for which statewide data are available, there were 2,776 abortions obtained by Utahns in this state.[2] The vast majority of abortions in Utah are performed in PPAU's health centers or in the only other Utah outpatient abortion provider (Wasatch Women's Center, located in Salt Lake City).

19. From more than two decades of experience providing a full range of sexual and reproductive health services, including abortion, I know how important abortion is to women in Utah. My patients' lives are complicated, and their decisions to have an abortion often involve multiple considerations. Approximately half (48.6%) of abortion patients in Utah already have one

[1] *See, e.g.*, FDA, *Mifeprex (Mifepristone) Information* (updated Dec. 16, 2021), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information.

[2] Utah Dep't of Health, Off. of Vital Records & Stats., *Abortions, 2019*, at 9 tbl. 1 (Nov. 2021), available at https://vitalrecords.health.utah.gov/wp-content/uploads/Abortions-2019-Utah-Vital-Statistics.pdf.

or more children.[3] My patients with children understand the intense responsibilities of parenting and decide to have an abortion based on what is best for them and their existing families, which may already struggle with basic unmet needs. These patients frequently conclude that they will have a harder time meeting their existing children's needs for emotional, physical, and economic support. Other patients decide that they are not ready to become parents because of their age or desire to complete their education before starting a family. Some patients never wish to have children. Some patients have health complications during pregnancy and seek abortion to preserve their own health. In some cases, my patients are struggling with opioid or other drug addiction and decide not to become parents during that struggle. Others have an abusive partner, a partner they view as an unsuitable parent, or a partner they do not want to be tied to for the rest of their lives. Still other families receive grave fetal diagnoses during very much wanted pregnancies, and they may determine that the care and attention required by a new child would make it impossible for them to fulfill the rest of their family's needs. In all of these cases, my patients have determined that abortion is the right decision for them.

20. Regardless of a patient's reasons for seeking a previability abortion, our response is the same: PPAU is committed to providing high-quality, compassionate abortion care that honors each patient's dignity and autonomy. I trust my patients to make the best decisions for themselves and their families, taking into account the full complexity of their lives that we, as medical professionals, cannot fully know. This complexity includes, among many other factors, a patient's personal and moral views about abortion. In my experience, it seems that people of all religious faiths and degrees of orthodoxy have abortions, and for those who are heavily grappling with the question of when life begins, some consult lay or formal religious advisors. Some of my

[3] *Id.* at 21 tbl. R8.

patients have told me that they have consulted with their bishops in the Church of Jesus Christ of Latter-day Saints and are seeking an abortion with the blessing of their bishops.

III. The Impact of the Criminal Abortion Ban

21. Because of the Criminal Abortion Ban, PPAU and its staff have been forced to stop providing nearly all abortions in Utah, effective immediately. To my knowledge, Wasatch Women's Center, the only other outpatient provider in Utah, has also been forced to stop providing abortions in the state, except for the few allowed by the Ban.

22. In the absence of legal abortion in Utah, approximately 2,800 Utahns each year will be forced either to remain pregnant against their will;[4] go out of state for an abortion if they can find the means to do so—as well as an open appointment slot, given the number of nearby states that are poised to ban abortion; or attempt to obtain an abortion outside of the medical system by purchasing pills or other items online and outside the U.S. health care system, which may in some cases be unsafe.

23. More than 55 patients with abortion appointments next week at PPAU will be denied access to this critical care if the Act remains in effect. To my knowledge, none of these individuals will qualify for an abortion under the exceptions set out in the Act.

A. Forced pregnancy and parenting

24. Even in an uncomplicated pregnancy, an individual experiences a wide range of physiological challenges. Individuals experience a quicker heart rate, a substantial rise in their blood volume, digestive difficulties, increased production of clotting factors, significant weight gain, changes to their breathing, and a growing uterus. These and other changes put pregnant patients at greater risk of blood clots, nausea, hypertensive disorders, and anemia, among other

[4] *Id.* at 9 tbl. 2 (reporting 2,776 abortions in 2019).

complications. Although many of these complications can be mild and resolve without medical intervention, some require evaluation and occasionally urgent or emergent care to preserve the patient's health or to save their life.

25. Pregnancy can also exacerbate preexisting health conditions, including diabetes, kidney disease, hypertension and other cardiac diseases, obesity, asthma, autoimmune disorders, and other pulmonary diseases. It can lead to the development of new and serious health conditions as well, such as hyperemesis gravidarum, preeclampsia, deep vein thrombosis, and gestational diabetes. Many people seek emergency care at least once during a pregnancy, and people with comorbidities (either preexisting or those that develop as a result of their pregnancy) are significantly more likely to do so.[5] People who develop pregnancy-induced medical conditions are at higher risk of developing the same condition in subsequent pregnancies.

26. Pregnancy may also induce or exacerbate mental health conditions.[6] Those with histories of mental illness may experience a return of their illness during pregnancy.[7] These mental health risks can be higher for patients with unintended pregnancies, who may face physical and

[5] Shayna D. Cunningham et al., *Association Between Maternal Comorbidities and Emergency Department Use Among a National Sample of Commercially Insured Pregnant Women*, 24 Acad. Emergency Med. 940 (2017), available at https://onlinelibrary.wiley.com/doi/10.1111/acem.13215; *see also* Healthcare Cost & Utilization Proj., *Emergency Department and Inpatient Utilization and Cost for Pregnant Women: Variation by Expected Primary Payer and State of Residence, 2019*, at 30 tbl. D.1 (Dec. 14, 2021), available at https://www.hcup-us.ahrq.gov/reports/ataglance/HCUPanalysisHospUtilPregnancy.pdf.

[6] Kimberly Ann Yonkers et al., *Diagnosis, Pathophysiology, and Management of Mood Disorders in Pregnant and Postpartum Women*, 117 Obstetrics & Gynecology 961, 963 (2011); *see also* F. Carol Bruce et al., *Maternal Morbidity Rates in a Managed Care Population*, 111 Obstetrics & Gynecology 1089, 1092 (2008).

[7] *Id.* at 964–67.

emotional changes and risks that they did not choose to take on.[8] Almost 20% of pregnancies in Utah are unintended, and this percentage is much higher for Black and Hispanic/Latino Utahns.[9]

27. Some pregnant patients also face an increased risk of violence perpetrated by an intimate partner, with the severity of such violence sometimes intensifying during or after pregnancy.[10] According to the American College of Obstetricians and Gynecologists ("ACOG"), "[h]omicide has been reported as a leading cause of maternal mortality, the majority caused by an intimate partner."[11]

28. Separate from pregnancy, labor and childbirth are themselves significant medical events with many risks, far greater than those for legal previability abortion. A patient's risk of death associated with pregnancy and childbirth is more than 12 times higher than the risk of death associated with legal abortion.[12]

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[8] Diana Cheng et al., *Unintended Pregnancy and Associated Maternal Preconception, Prenatal and Postpartum Behaviors*, 79 Contraception 194, 197 (2009).

[9] Utah Dep't of Health, Off. of Health Disparities, *A Utah Health Disparities Profile, Maternal Mortality and Morbidity among Utah Minority Women*, at 19 tbl. 17, 20 tbl. 18 (Jan. 2021), available at https://healthequity.utah.gov/wp-content/uploads/2022/02/UtahHealthDisparitiesProfileMaternalMortalityMorbidity2021.pdf [hereinafter, "Utah Health Disparities Profile"].

[10] Am. Coll. of Obstetricians & Gynecologists, Comm. Op. No. 518: *Intimate Partner Violence*, at 2 (reaff'd 2019), available at https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2012/02/intimate-partner-violence.pdf.

[11] *Id.*

[12] Nat'l Acads. of Scis., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States*, at 75 tbl. 2-4 (2018); *see also* Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

29. But the risks and complications associated with pregnancy stem beyond mortality. Complications during labor occur at a rate of over 500 per 1,000 hospital stays and the vast majority of childbirth delivery stays have a complicating condition.[13]

30. Even a normal pregnancy with no comorbidities or complications can suddenly become life-threatening during labor and delivery. For example, during labor, increased blood flow to the uterus places the patient at risk of hemorrhage and, in turn, death. Hemorrhage leading to blood transfusion is the leading cause of severe maternal morbidity.[14] Other potential adverse events include perineal laceration (the tearing of the tissue around the vagina and rectum), unexpected hysterectomy (the surgical removal of the uterus), ruptured uterus or liver, stroke, respiratory failure, kidney failure, hypoxia (an absence of sufficient oxygen in bodily tissue to sustain function), and amniotic fluid embolism (a condition in which the fluid surrounding a fetus during pregnancy enters the patient's bloodstream).

31. The most severe perineal tears involve tearing between the vagina through the anal sphincter and into the rectum and must be surgically repaired. These can result in long-term urinary and fecal incontinence and sexual dysfunction. Moreover, vaginal delivery can lead to injury to the pelvic floor, urinary incontinence, fecal incontinence, and pelvic organ prolapse (the displacement of internal organs, resulting in some cases in their protrusion from the vagina).

32. Any anesthesia or epidural administered during labor could also lead to additional risks, including severe headaches caused by the leakage of spinal fluid, infection, and nerve damage around the injection site.

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[13] Anne Elixhauser & Lauren M. Wier, Statistical Br. No. 113, *Complicating Conditions of Pregnancy and Childbirth, 2008*, at 2 tbl. 1, 5 tbl. 2, Healthcare Cost & Utilization Proj. (May 2011), available at https://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf.

[14] ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage*, 130 Obstetrics & Gynecology e168, e168 (2017).

33. In Utah, more than one in five deliveries occur by cesarean section ("C-section") rather than vaginally.[15] A C-section is an open abdominal surgery that requires hospitalization for at least a few days and carries significant risks of hemorrhage, infection, venous thromboembolism (blood clots), and injury to internal organs including major blood vessels, the bowel, ureter, and bladder. It can also have long-term risks, including an increased risk of placenta accreta in later pregnancies (when the placenta grows into and possibly through the uterine wall causing a need for complicated surgical interventions, massive blood transfusions, hysterectomy, and risk of maternal death), placenta previa in later pregnancies (when the placenta covers the cervix, resulting in vaginal bleeding and requiring bed rest), and bowel or bladder injury in future deliveries. Individuals with a history of cesarean delivery are also more likely to need cesarean delivery with subsequent births.

34. Pregnant people with a prior history of mental health conditions also face a heightened risk of postpartum illness,[16] which may go undiagnosed for months or even years.

35. Negative pregnancy and childbirth-related health outcomes are even greater for Utahns of color.[17] Postpartum depression also disproportionately affects people of color in Utah.[18]

36. The economic impact of forced pregnancy, childbirth, and parenting will also have dramatic, negative effects on Utah families' financial stability. Some side-effects of pregnancy render patients unable to work, or unable to work the same number of hours as they otherwise

[15] Ctrs. for Disease Control & Prevention, Nat'l Ctr. for Health Stats., *2017 Stats of the State of Utah*, https://www.cdc.gov/nchs/pressroom/states/utah/utah.htm (last visited June 25, 2022).

[16] *See, e.g.*, Shefaly Shorey et al., *Prevalence and Incidence of Postpartum Depression Among Healthy Mothers: A Systematic Review and Meta-Analysis*, 104 J. Psychiatric Rsch. 235, 238 (2018).

[17] *See* Utah Health Disparities Profile, *supra* note 9, at 17 tbl. 16, 18 tbls. 16.1 & 16.2.

[18] *Id.* at 21 tbl. 20.

would. For example, some patients with hyperemesis gravidarum must adjust their work schedules because they vomit throughout the day. Others with conditions like preeclampsia must severely limit activity for a significant amount of time. These conditions may result in job loss, especially for people who work unsteady jobs, such as jobs without predictable schedules, paid sick or disability leave, or other forms of job security. Even without these conditions, pregnancy-related discrimination can result in lower earnings both during pregnancy and over time.[19] Further, Utah does not require employers to provide paid family leave, meaning that for many pregnant Utahns, time taken to recover from pregnancy and childbirth or to care for a newborn is unpaid.[20] A typical Utahn who takes four weeks of unpaid leave could lose more than $3,000 in income.[21]

37. Pregnancy-related health care and childbirth are some of the most expensive hospital-based health services, especially for complicated or at-risk pregnancies. This financial burden can weigh most heavily on patients without insurance—who make up nearly 13% of all Utahns, including more than 36% of Hispanic/Latino Utahns, more than 26% of Black Utahns, more than 23% of Native Hawaiian/Pacific Islander Utahns, and more than 18% of American Indian/Alaska Native Utahns.[22] As of 2019, over one in nine women of childbearing age in Utah are uninsured.[23]

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[19] *See, e.g.*, Nat'l Partnership for Women & Fams., Data Brief: *By the Numbers: Women Continue to Face Pregnancy Discrimination in the Workplace*, at 1–2 (Oct. 2016), available at https://www.nationalpartnership.org/our-work/resources/economic-justice/pregnancy-discrimination/by-the-numbers-women-continue-to-face-pregnancy-discrimination-in-the-workplace.pdf; Jennifer Bennett Shinall, *The Pregnancy Penalty,* 103 Minn. L. Rev. 749, 787–89 (2018).

[20] Nat'l Partnership for Women & Fams., *Paid Leave Means a Stronger Utah*, at 1 (Feb. 2022), available at https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/paid-leave-means-a-stronger-utah.pdf.

[21] *Id.*

[22] Utah Health Disparities Profile, *supra* note 9, at 9 tbl. 7.

[23] Maggie Clark et al., *Medicaid Expansion Narrows Maternal Health Coverage Gaps, But Racial Disparities Persist*, Georgetown Univ. Health Pol'y Inst., at 16 Appendix C (Sept. 2021),

38. Even insured pregnant patients must often still pay for considerable labor and delivery costs out of pocket. In 2015, of the 98.2% of commercially-insured women who had out-of-pocket spending for their labor and delivery, the mean spending for all modes of delivery was $4,569; the mean out-of-pocket spending for that same group of women for vaginal birth, specifically, was $4,314; and for C-section, specifically, was $5,161.[24] And the average proportion of costs paid by patients has increased over time.[25] These costs limit patients' resources to care for existing children and put them at greater risk of living in poverty and facing housing and food insecurity.

39. In 2021, 45% of PPAU abortion patients reported earning less than 130% of the federal poverty level. Unintended pregnancies are experienced by people with lower incomes at a disproportionately higher rate than those with middle and high incomes,[26] due largely to systemic barriers to contraceptive access.[27]

40. Research shows that only a small minority (14%) of patients who seek but are denied an abortion say after denial that they are considering adoption as an alternative, and among

available at https://ccf.georgetown.edu/wp-content/uploads/2021/09/maternal-health-and-medex-final.pdf.

[24] Michelle H. Moniz et al., *Out-of-Pocket Spending for Maternity Care Among Women With Employer-Based Insurance, 2008–15*, 39 Health Affairs 18, 20 (2020).

[25] *Id.*

[26] Guttmacher Inst., *Unintended Pregnancy in the United States*, at 1 (Jan. 2019), available at https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us.pdf.

[27] ACOG, Committee Opinion No. 615, *Access to Contraception*, at 1 (Jan. 2015), available at https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf; *see also* May Sudhinaraset et al., *Women's Reproductive Rights Policies and Adverse Birth Outcomes: A State-Level Analysis to Assess the Role of Race and Nativity Status*, 59 Am. J. Preventive Med. 787, 788 (2020).

those who give birth after denial of an abortion, 91% parent the child.[28] Ninety-five percent of women who obtain abortions feel it was the right decision for them three years later.[29]

41. Patients who decide to place their infant for adoption face extensive medical, legal, and counseling expenses, as well as the physical consequences of a full-term pregnancy, labor, and delivery. Moreover, this decision can be extremely emotionally taxing, including for patients who feel that they cannot afford to parent.[30] I have had multiple patients tell me that adoption is simply not an option for them because they understand the emotional impact of carrying a pregnancy to term and then placing a child for adoption, yet they know that carrying a pregnancy to term and parenting the new child would compromise the health of the children they already have.

42. Data show that in 2020, just over 500 children were adopted in Utah at any age,[31] with 686 children waiting for adoption[32] and, as of the last day of Fiscal Year 2020, 2,373 children remained in foster care.[33]

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[28] Gretchen Sisson et al., *Adoption Decision Making Among Women Seeking Abortion*, 27 Women's Health Issues 136, 139, 141–42 (2017).

[29] Corinne H. Rocca, et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLoS One e1, e10 (2015).

[30] Gretchen Sisson, *"Choosing Life": Birth Mothers on Abortion and Reproductive Choice*, 25 Women's Health Issues 349, 351–52 (2015) (majority of 40 study participants describing adoption experiences as "predominantly negative," including those who "felt they had no options available to them other than adoption," and finding "lack of employment" as an "enduring variable[] that led participants to consider adoption despite their desire to parent"); *see also* Gretchen Sisson, *Who Are the Women Who Relinquish Infants for Adoption? Domestic Adoption and Contemporary Birth Motherhood in the United States*, 54 Perspectives on Reprod. Health 46, 50 (2022) (majority of birth mothers who chose adoption reported annual income under $5,000).

[31] U.S. Dep't of Health & Hum. Servs., Children's Bur., *Adoption Data*, https://cwoutcomes.acf.hhs.gov/cwodatasite/adopted/index (last visited June 25, 2022).

[32] U.S. Dep't of Health & Hum. Servs., Children's Bur., *Children Waiting for Adoption*, https://cwoutcomes.acf.hhs.gov/cwodatasite/waiting/index (last visited June 25, 2022).

[33] U.S. Dep't of Health & Hum. Servs., Children's Bur., *In Foster Care on the Last Day of FY*, https://cwoutcomes.acf.hhs.gov/cwodatasite/inCareSeptemberThirty/index (last visited June 25, 2022).

43. Women who seek but are denied an abortion are, when compared to those who are able to access abortion, more likely to lower their future goals,[34] and less likely to be able to exit abusive relationships.[35] Their existing children are also more likely to suffer measurable reductions in achievement of child developmental milestones and an increased chance of living in poverty.[36] They are also less likely to be employed full-time, more likely to be raising children alone, more likely to receive public assistance, and more likely to not have enough money to meet basic living needs than women who received an abortion.[37]

B. Burdens of out-of-state travel for abortion services

44. Those patients who have the means to travel outside of Utah to obtain an abortion will still be harmed by the Criminal Abortion Ban.

45. At this time, the nearest clinics providing abortion outside of Utah are located in Idaho[38] (the closest of which is a distance of 219 miles from Salt Lake City, one way); Jackson, Wyoming[39] (a distance of 272 miles, one way); and Steamboat Springs, Colorado (a distance of 329 miles, one way). For patients who need an abortion beyond the first trimester (i.e., after approximately 14 weeks of pregnancy), the closest provider is located in Meridian, Idaho, which

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[34] Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health e1, e5–e6 (2015).

[35] Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12 BMC Med. 144, 149 (2014).

[36] Diana Greene Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. Pediatrics 183, 185–87 (2019); *see also* Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AJPH 407, 412 (2018) [hereinafter, "Foster 2018"].

[37] *Id.* at 409, 412–13.

[38] At present, Idaho's total abortion ban is set to take effect in the near future, at which point abortions will no longer be available in Idaho. *See* Idaho Senate Bill 1385, 65th Leg., 2d Reg. Sess. (2020).

[39] Like Idaho, Wyoming also has a total abortion ban set to take effect in the near future. See Wyoming House Bill 92, 66th Leg., Budget Sess. (2022).

is 347 miles each way from Salt Lake City, and the next closest provider is located in Durango, Colorado, which is 394 miles each way from Salt Lake City.[40]

46. Given the logistical hurdles of traveling out of state, I expect that people able to obtain an abortion through another provider will do so later in pregnancy than they would have had they had access to care at PPAU, thus increasing their risk of experiencing pregnancy- and abortion-related complications and prolonging the period during which they must carry a pregnancy that they have decided to end. The logistics required for out-of-state travel, including the need to obtain transportation or child care, may also force some patients to compromise the confidentiality of their decision to have an abortion. These logistical difficulties are compounded by the fact that numerous other states have banned abortion, increasing demand for appointments where they are still available.

C. Other harms the Criminal Abortion Ban inflicts on patients

47. The Criminal Abortion Ban will have a particularly devastating impact on patients whose mental or physical wellbeing is threatened by continuing their pregnancies. Some patients, such as those I have described above, may not satisfy the exception to the Criminal Abortion Ban to prevent "a serious risk" to the patient "of substantial and irreversible impairment of a major bodily function," Utah Code Ann. § 76-7a-201(1)(a)(ii), but they will still need an abortion. Those with rapidly worsening medical conditions who could have obtained an abortion prior to the Criminal Abortion Ban without explanation will be forced to wait for care until a physician determines that their conditions become deadly or pose a risk of permanent impairment so as to meet the Ban's narrow exceptions. And because not all physicians in Utah will be familiar with

[40] These clinics were identified based on information from abortionfinder.org, which includes both Planned Parenthood and independent abortion providers around the country.

the details of the Ban, and given its severe criminal penalties, these doctors may hesitate or not provide critical care out of fear for the consequences to them and their employers.

48. The Criminal Abortion Ban will also add to the anguish of patients and their families who receive fetal diagnoses. The law's exception to the ban applies only to conditions that are "uniformly diagnosable" and constitute either a "lethal" anomaly or a "severe brain abnormality." *Id.* § 76-7a-201(1)(b). Fetal diagnoses such as hypoplastic left heart (a condition that prevents the left heart ventricle from developing); bowel atresia (a malformation of the intestine); omphalocele (a protrusion of abdominal organs outside of the fetus); and congenital diaphragmatic hernia (a condition causing the migration of abdominal organs into the chest) may not qualify for the Criminal Abortion Ban's exception for fetal diagnoses. I have provided abortions to patients with fetuses diagnosed with each of these conditions.

49. I also understand that patients will be forced to show, based on the written concurrence of two physicians who practice maternal fetal medicine, that a fetal diagnosis qualifies for an abortion under the Ban. The process of obtaining this paperwork is likely to delay access to care and increase the expense and emotional toll of such a diagnosis. There are fewer than 50 maternal fetal medicine specialists in Utah, and they are geographically concentrated in the Northern urban corridor, with a small number in St. George and Logan.

50. I also understand that the exception for certain non-fatal fetal diagnoses applies only to brain conditions that leave a child able to survive only in a "vegetative state." *Id.* § 76-7a-101(10)(a). This exception would not cover many bodily conditions that may be equally debilitating or that may pose an even greater risk of death during childhood. For example, numerous heart conditions, such as hypoplastic left heart and major endocardial septum defects, can cause hypoxia, and this loss of oxygen in the blood can severely and permanently compromise

brain function after birth. Numerous other fetal diagnoses will, after birth, require extensive surgical intervention that likewise carries a significant risk of death or permanent impairment to the child, including a risk to brain function.

51. The Criminal Abortion Ban will also cause severe harm to individuals whose pregnancies are the result of rape. As I understand the Ban, we cannot provide an abortion to a patient under this exception unless we verify that the incident has been reported to law enforcement. As a result, I will not be able to provide abortions to survivors of rape who, out of shame or fear, have not involved law enforcement by the time they seek an abortion (or who will not authorize me to report to law enforcement on their behalf). I also could not provide abortions to patients who do not wish to discuss the circumstances of their pregnancy as a condition of obtaining an abortion, or who may be uncertain whether the pregnancy is a result of an assault.

52. Research indicates that as many as 88% of sexual assault survivors in Utah do not report the crimes to law enforcement.[41] Under the Ban, these patients will be faced with choosing between an abortion and maintaining their privacy in deciding whether to come forward about the assault, a "choice" that, to my knowledge, is forced on no other autonomous patient in Utah's medical system. The new reporting obligation, which applies only if an adult patient actually receives an abortion, is particularly unusual. I am not aware of any other mandatory reporting law that applies only where a patient goes through with obtaining a particular type of health care service.

53. As I understand the exception for reported rape, although it would require me to confirm that rape had been reported in order to provide an abortion to an adult Utah patient, a

[41] Christine Mitchell & Benjamin Peterson, *Rape in Utah 2007, A Survey of Utah Women*, Utah Comm'n on Crim. & Juv. Just., at 32 (May 2018), available at https://justice.utah.gov/wp-content/uploads/RapeinUtah2007.pdf.

patient who experienced the same crime could see me for miscarriage care, or health care for any other condition, without triggering a corresponding reporting obligation.

54. The Criminal Abortion Ban's reporting requirement is at odds with the positions of major medical organizations. For example, the American Medical Association's (AMA's) ethical guidelines permit disclosure of patients' medical information without the patient's specific consent in emergent situations only to third parties "situated to mitigate the threat" and where there is a reasonable probability that "[t]he patient will seriously harm [them]self" or "will inflict serious physical harm on an identifiable individual or individuals."[42] Similarly, ACOG advises that physicians provide "trauma-informed care," which includes "maximizing trustworthiness, prioritizing individual choice and control, [and] empowering individuals[.]"[43]

* * *

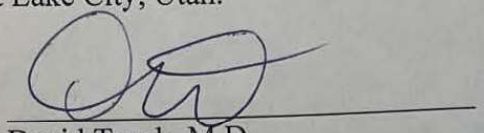
55. For all of these reasons, if the Criminal Abortion Ban is permitted to remain in effect, it will be devastating to the Utah patients who depend on PPAU for care.

[42] AMA, Code of Med. Ethics Op. 3.2.1(e), *Confidentiality*, available at https://www.ama-assn.org/delivering-care/ethics/confidentiality (last visited June 25, 2022).

[43] ACOG, Comm. on Health Care for Underserved Women, Op. No. 777, *Sexual Assault*, at e298 (Apr. 2019), available at https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2019/04/sexual-assault.pdf.

I declare under penalty of perjury under the laws of the United States of America and the State of Utah that the foregoing statements are true and correct to the best of my knowledge, information, and belief.

Signed on the 25th day of June, 2022, in Salt Lake City, Utah.



David Turok, M.D.

Exhibit A

Curriculum Vitae

Last Updated: 03/04/2022

PERSONAL DATA

Name: David K. Turok, M.D., M.P.H., FACOG

EDUCATION

Years	Degree	Institution (Area of Study)
2000 - 2003	Resident	University of Utah School of Medicine (OB/GYN) Salt Lake City, UT
1999 - 2000	Fellow	University of Utah School of Medicine (Family Practice and Obstetrics) Salt Lake City, UT
1996 - 1998	Resident	Brown University/Memorial Hospital of Rhode Island Pawtucket, RI
1995 - 1996	Intern	Brown University/Memorial Hospital of Rhode Island (Family & Community Medicine) Pawtucket, RI
1991 - 1995	M.D., M.P.H.	Tufts University School of Medicine (Medicine and Public Health) Boston, MA
1985 - 1989	B.A.	Middlebury College (Environmental Earth Sciences) Middlebury College, VT

BOARD CERTIFICATIONS

12/09/2005 - Present: American Board of Obstetrics & Gynecology (Obstetrics & Gynecology), Diplomate

07/10/1998 - Present: American Board of Family Medicine, Diplomate

UNIVERSITY OF UTAH ACADEMIC HISTORY

Obstetrics/Gynecology (Family Planning), 01/01/2019 - Present

01/01/2019	Associate Professor with tenure

Obstetrics/Gynecology (General OB/GYN), 09/01/2003 - 12/31/2018

12/18/2017 - 12/31/2018	Associate Professor
07/01/2012 - 12/17/2017	Associate Professor (Clinical)
09/01/2003 - 06/30/2012	Assistant Professor (Clinical)

Family & Preventive Medicine (Family Medicine), 07/01/2002 - Present

03/01/2018	Adjunct Associate Professor

07/01/2016 - 02/28/2018 Adjunct Assistant Professor

07/01/2002 - 06/30/2016 Adjunct Assistant Professor

Family & Preventive Medicine (Family Medicine/Residency), 06/01/1998 - 06/30/2002

07/01/2000 - 06/30/2002 Clinical Assistant Professor

06/01/1998 - 06/30/2000 Clinical Instructor

PROFESSIONAL EXPERIENCE

Full-Time Positions

2021 – Present Director, Reproductive and Sexual Health ASCENT Center, Department of Obstetrics and Gynecology, University of Utah, Salt Lake City, UT

2019 - Present Associate Professor (Tenure), University of Utah School of Medicine, Departments of Obstetrics and Gynecology and Family and Preventative Medicine, Salt Lake City, UT

2018 - Present Chief, Family Planning Division, Department of Obstetrics and Gynecology, University of Utah, Salt Lake City, UT

2015 - 2020 KL-2 Program Co-Director, Center for Clinical and Translational Science, University of Utah, Salt Lake City, UT

2012 - 2018 Clinical Associate Professor, University of Utah School of Medicine, Departments of Obstetrics and Gynecology and Family and Preventative Medicine, Salt Lake City, UT

2010 - Present Director of Surgical Services, Planned Parenthood Association of Utah, Salt Lake City, UT

2003 - 2015 Obstetrician/Gynecologist Consultant, Community Health Centers, Inc, Salt Lake City, UT

2003 – 2012 Assistant Clinical Professor, University of Utah School of Medicine, Departments of Obstetrics and Gynecology and Family and Preventative Medicine, Salt Lake City, UT

2003 - 2011 Staff Physician, Utah Women's Clinic, Salt Lake City, UT

1998 - 2000 Family Physician, Community Health Centers, Inc, Salt Lake City, UT

Editorial Experience

2014 Guest Editor for *Clinics in Obstetrics and Gynecology*

2014 - Present Editorial Advisory Board for *Contraceptive Technology Update*

2011 - Present Editorial Board for *Contraception*

Reviewer Experience

Cochrane Collaboration

Reviewer for *Human Reproduction.* 2015 Top 10% of Reviewers.

Reviewer for *African Journal of Reproductive Health*

Reviewer for *American Journal of Men's Health*

Reviewer for *American Journal of Obstetrics and Gynecology*

Reviewer for *BJOG: An International Journal of Obstetrics and Gynecology*

Reviewer for *BMC Pregnancy and Childbirth*

Reviewer for *Contraception*

Reviewer for *Journal of Women's Health*

Reviewer for *Obstetrics and Gynecology*

Reviewer for *WHO South-East Journal of Public Health*

Reviewer for *Women's Health Issues*

SCHOLASTIC HONORS

2020	Society of Family Planning Annual Meeting, Outstanding Researcher Award
2015	District VIII Mentor of the Year Award, American College of Obstetricians and Gynecologists
2015	Faculty Mentor Award, Medical Students for Choice
2015	Top Four Oral Abstracts, North American Forum on Family Planning 2015
2012	Top Scientific Poster – 2nd place, North American Forum on Family Planning 2012
2007 - Present	Fellow of the American College of Obstetricians and Gynecologists
2007 - 2008	Community Health Physician of the Year, Awarded by Family Practice Residents, University of Utah School of Medicine
2007	Dr. Jacquelyn Erbin Award, for commitment to reproductive choice, justice, and freedom, Planned Parenthood Action Council
2004 - 2005	Outstanding Clinical Faculty Award, Awarded by Chief Residents, Department of Obstetrics and Gynecology, University of Utah School of Medicine
2004 - 2005	Community Health Physician of the Year, Awarded by Family Practice Residents, University of Utah School of Medicine
2002	Outstanding Resident Research Award, Department of Obstetrics and Gynecology, University of Utah School of Medicine
1999 - 2000	Exemplary Teaching Award, Family Practice Residency Program, University of Utah School of Medicine

ADMINISTRATIVE EXPERIENCE

Administrative Duties

2018 - Present	Department of Obstetrics & Gynecology, Executive Committee member
2015 - Present	University of Utah Institutional Review Board Member.
2015 - 2020	KL-2 Program Co-Director, Center for Clinical and Translational Science, University of Utah
2014	Clinics in Obstetrics and Gynecology. Guest Editor.

2014	Contraceptive Technology Update – Editorial Advisory Board
2011 - Present	Contraception journal –Editorial Board.
2010 - Present	Fellowship in Family Planning. University of Utah Co-Director.
2010 - 2014	Association of Reproductive Health Professionals. Washington, DC. Education Committee. Co-Chair. Reproductive 2011 Conference Committee Chair.
2010 - 2013	Medical Students For Choice, National Board Member
2007 - 2018	Director of Family Planning Research Group. University of Utah multi-disciplinary group of investigators including members of various departments.
2005 - 2009	Family Practice Obstetrics Fellowship Co-Director. University of Utah School of Medicine.
2003 - 2010	Family Practice Obstetrics Morbidity and Mortality Conference Coordinator.

Professional Organization & Scientific Activities

2011	Chair, Association of Reproductive Health Professionals, Conference Committee, Reproductive Health Conference, Las Vegas, NV Topics presented: Contraception Journal - Outstanding Articles, Tools of the Trade - Demonstration of Online Interactive Birth Control Tools, Hard to Get it in: Tactics for Difficult IUD Insertions
2010 - Present	Reviewer, Cochrane Collaboration
2010 - 2014	Co-Chair, Association of Reproductive Health Professionals, Education Committee, Reproductive Health Conference
2010 - 2013	Board Member, Medical Students for Choice
2003	Medical Advisory Board, Association of Reproductive Health Professionals, New Developments in Contraception: Assisted in the creation of a national CME curriculum to introduce health care providers to new methods of contraception focusing on the levonorgestrel intrauterine system.

Grant Review Committee/Study Section

2022	ZRG1 EMNR-A (11)B- Small Business Innovation Research/Small Business Technology Transfer (R41/R42/R44)
2021	ZHD1 DSR-R (90) 1-T32
2021 - Present	Clinical Management in Community-Based Settings (CMPC) - Standing member
2019	NICHD Review Panel for Contraception Research Centers Program U54 Review Meeting
2018	Next Generation Multipurpose Prevention Technologies (NGM) (R61/R33 Clinical Trial Optional)
2017 - 2021	Nursing and Related Clinical Sciences (NRCS) Special Emphasis Panel- Standing member

Symposium/Meeting Chair/Coordinator

2011 Chair, Conference Committee Annual Meeting of the Association of Reproductive Health Professionals

2009 - Present University of Utah Family Planning Symposium

2003 - 2010 Organizer, Family Practice Obstetrics Morbidity and Mortality Conference

PROFESSIONAL COMMUNITY ACTIVITIES

2017 - Present Board Member, Physicians for Reproductive health

1997 - 1998 Organizer & Participant, Reach Out and Read, Organizer & Participant, Reach Out and Read, Blackstone Valley Community Health Center, Central Falls, RI

1996 - 1998 Physician, Traveler's Aid Medical Van, Provided primary care services to uninsured clients in conjunction with city homeless shelters. Extensive experience with people in addictions recovery. Providence, RI

1992 Volunteer Instructor, Alianza Para la Salud, Designed and executed a survey of child health. Developed an educational nutrition program based on local food sources for mothers in rural San Juan Province. Dominican Republic

UNIVERSITY COMMUNITY ACTIVITIES

University Level

2015 - Present Member, Institutional Review Board

2007 - 2019 Director, University of Utah, Family Planning Research Group, Multi-disciplinary group of investigators including members of various departments

CURRENT MEMBERSHIPS IN PROFESSIONAL SOCIETIES

American College of Obstetricians and Gynecologists

National Abortion Federation

Society of Family Planning

Utah Medical Association

FUNDING

Active Grants

09/01/21 - 09/30/24 CCTN Clinical evaluation of Daily Application of Nestorone (NES) and Testosteorone (T) Combination Gel for Male Contraception
Principal Investigator(s): David K. Turok
University of Washington, NICHD
Role: Principal Investigator

08/01/20 - 07/30/27 Contraceptive Clinical Trials Network (CCTN) Core Function Activities. Task Order Number HHSN27500001 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development.
Principal Investigator(s): David K. Turok

Role: Principal Investigator

09/02/18 - 09/27/23 CCTN-Pharmacokinetic / Pharmacodynamic Evaluation Of Levonorgestrel Butanoate For Female Contraception
Role: Co-Investigator

09/01/18 - 10/01/22 Veracept National PI. Project Number 50503504. Proposal ID 10051921
Principal Investigator(s): David K. Turok
Direct Costs: $358,170 Total Costs: $488,902
Sebela Pharmaceuticals Development LLC
Role: Principal Investigator

07/01/18 - 06/30/23 Family Planning Elevated: A Statewide Contraceptive Initiative in Utah
Direct Costs: $3,338,935 Total Costs: $4,000,000
Medical Director: David K. Turok
Laura and John Arnold Foundation
Direct Costs: $1,000,000 Total Costs: $1,000,000
Dr. Ezekiel R. & Edna Wattis Dumke Foundation
Role: Co-Principal Investigator

03/30/18 - 02/28/23 University of Utah Center for Clinical and Translational Science (CCTS).
5UL1TR001067/5KL2TR001065. The Utah CCTS serves as the major infrastructure and home for clinical and translational research in the Intermountain West. Within the Utah CCTS, the KL2 program serves as a multi-institutional mechanism to support career development awards for aspiring junior faculty.
Principal Investigator(s): David K. Turok; Maureen A. Murtaugh; Rachel Hess; Willard H. Dere
Direct Costs: $1,326,332 Total Costs: $1,432,438
NIH National Center For Advancing Translational Sciences
Role: Co-Principal Investigator

03/30/18 - 02/28/23 Institutional Career Development Core. KL2TR002539.
NIH National Center For Advancing Translational Sciences
Role: Co-Investigator

09/26/17 - 12/31/22 CCN-Denver, Project Number 54503811. Proposal ID 10047514
Direct Costs: $155,357 Total Costs: $225,427
Principal Investigator(s): University Of Colorado at Denver
Role: Co-Site Principal Investigator

08/21/17 - 05/31/22 Midcareer Investigator Award in Patient Oriented Research. Project Number 59203661. Award Number 1K24HD087436. Proposal ID 10041755
Principal Investigator(s): David K. Turok
Direct Costs: $1,078,470 Total Costs: $1,078,470
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Principal Investigator

09/25/15 - 09/30/22 Evaluation of LARCS.
Principal Investigator(s): David K. Turok; Eunice Kennedy Shriver National Institute of Child Health and Human Development
Role: Principal Investigator

Direct Costs: $225,493 Total Costs: $325,208

Past Grants

10/17/19 - 11/16/21 HER Hewlett Supplement. Project Number 51005893. Proposal ID 10051017.
Principal Investigator(s): David K. Turok
Direct Costs: $234,856 Total Costs: $250,000
William And Flora Hewlett Foundation
Role: Principal Investigator

06/01/18 - 05/31/19 Family Planning Fellowship 2018-2019. Project Number 51005773. Proposal ID 10049201
Principal Investigator(s): David K. Turok
Direct Costs: $318,356 Total Costs: $318,356
Anonymous
Role: Principal Investigator

04/01/18 - 03/31/19 Education Pregnancy and Planning. Project Number 51100074. Proposal ID 10049512.
Principal Investigator(s): David K. Turok
Direct Costs: $8,000 Total Costs: $8,000
March Of Dimes Utah Chapter
Role: Principal Investigator

01/01/18 - 06/30/19 Kaiser Contraceptive Counsel. Project Number 51005772. Proposal ID 10049726
Principal Investigator(s): David K. Turok
Direct Costs: $73,537 Total Costs: $73,537
Society of Family Planning
Role: Principal Investigator

09/14/17 - 03/31/21 Sexual Acceptability's Role in Women's Contraceptive Preferences and Behavior. 5 RO1 HD095661
Principal Investigator(s): Jenny Higgins
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Co-Investigator

07/01/17 - 06/30/18 Family Planning Elevated: Pay For Success. Sorenson Impact Center, University of Utah.
Principal Investigator(s): David K. Turok
Direct Costs: $99,034 Total Costs: $99,034
Planned Parenthood Association of Utah
Role: Principal Investigator

06/02/17 - 06/30/18 Bullock-FS-Same Day Counseling. Project Number 51005634. Proposal ID 10045851
Principal Investigator(s): David K. Turok
Direct Costs: $67,743 Total Costs: $67,743
Society of Family Planning
Role: Principal Investigator

06/01/17 - 11/30/17 Family Planning Fellowship 2017-2018. Project Number 51005574. Proposal ID 10046224

Principal Investigator(s): David K. Turok
Direct Costs: $255,352 Total Costs: $255,352
Anonymous
Role: Principal Investigator

07/26/16 - 11/01/18 Cervical Attachment Study.

Principal Investigator(s): David K. Turok
Bioceptive Inc
Role: Principal Investigator

07/05/16 - 06/30/19 Tolerability Of Levocept. Project Number 50503354. Proposal ID 10042919

Principal Investigator(s): David K. Turok
Direct Costs: $57,477 Total Costs: $78,456
Contramed LLC
Role: Principal Investigator

06/15/16 - 06/15/17 Male Partners In Contraception. Project Number 51005426. Proposal ID 10042697

Principal Investigator(s): David K. Turok
Direct Costs: $70,984 Total Costs: $70,984
Society of Family Planning
Role: Principal Investigator

05/26/16 - 05/31/17 HER SL - Merck. Project Number 50303118. Proposal ID 10040845

Principal Investigator(s): David K. Turok
Direct Costs: $18,934 Total Costs: $25,125
Merck & Company, Inc.
Role: Principal Investigator

12/01/15 - 11/20/20 HER Salt Lake Contraceptive Initiative: A Prospective Cohort Examining the Social and Economic Impact of Removing Cost Barriers to Contraception
Principal Investigator(s): David K. Turok
Anonymous Foundation
Role: Principal Investigator

11/17/15 - 11/16/18 HER Salt Lake Contraceptive Initiative: A Prospective Cohort Examining the Social and Economic Impact of Removing Cost Barriers to Contraception.
Principal Investigator(s): David K. Turok
Direct Costs: $750,000 Total Costs: $750,000
William And Flora Hewlett Foundation
Role: Principal Investigator

09/25/15 - 09/24/18 Clinical Evalutation of Long-Acting Reversible Contraceptives. Award Number HHSN275201300131
Principal Investigator(s): David K. Turok
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Principal Investigator

07/27/15 - 04/30/21 Rapid EC- RCT Assessing Pregnancy with Intrauterine Devices for Emergency Contraception. Award Number 1R01HD083340-01A1.
Principal Investigator(s): David K. Turok
Direct Costs: $1,247,577 Total Costs: $1,247,577

Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Principal Investigator

07/01/15 - 06/30/17 Highly Effective Reversible Contraception Initiative- Salt Lake: A Prospective Cohort Examining the Social and Economic Impact of Removing Cost Barriers to Intrauterine Devices and Contraceptive Implants. Society of Family Planning. SFPRF9-1.

Principal Investigator(s): David K. Turok
Society of Family Planning
Role: Principal Investigator

03/01/15 - 06/30/15 GCC VS ICC In Refugee Women. Project Number 51005207. Proposal ID 10038216

Principal Investigator(s): David K. Turok
Direct Costs: $30,000 Total Costs: $30,000
Society Of Family Planning
Role: Principal Investigator

01/01/15 - 01/01/17 Real-world Duration of Use for Highly Effective Reversible Contraception (HERC): A Retrospective Review.
Principal Investigator(s): David K. Turok
Bayer Women's Healthcare
Role: Principal Investigator

01/01/15 - 06/30/16 Copper IUD Quick Start. Project Number 51005178. Proposal ID 10037777

Principal Investigator(s): David K. Turok
Direct Costs: $69,926 Total Costs: $69,926
Society Of Family Planning
Role: Principal Investigator

12/02/14 - 12/31/16 Profiles CU IUD New Users. Project Number 50302754. Proposal ID 10035916

Principal Investigator(s): David K. Turok
Direct Costs: $164,172 Total Costs: $217,856
NIH
Role: Principal Investigator

10/01/14 - 09/30/15 Documenting Contraception. Project Number 54503017. Proposal ID 10037834

Principal Investigator(s): David K. Turok
Direct Costs: $10,725 Total Costs: $11,797
University Of Wisconsin-Madison
Role: Principal Investigator

09/09/14 - 09/18/17 Novel Products for Female Contraception. Task Order 2 Under IDIQ Contract Number HHSN2752013000161.
Principal Investigator(s): David K. Turok
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Principal Investigator

05/01/14 - 06/30/18 Tracking IUD Bleeding Experiences: An Evaluation of Bleeding Profiles in New Intrauterine Device Users.
Principal Investigator(s): David K. Turok

Teva Women's Health Research
Role: Principal Investigator

02/17/14 - 02/16/16 Cervical Retractor. Project Number 50302568. Proposal ID 10034658
Principal Investigator(s): David K. Turok
Direct Costs: $21,967 Total Costs: $29,150
Bioceptive Inc
Role: Principal Investigator

10/01/13 - 09/30/15 RCT Of Mirena Postpartum. Project Number 51002919. Proposal ID 10032191
Principal Investigator(s): David K. Turok
Direct Costs: $104,121 Total Costs: $119,998
Society Of Family Planning
Role: Principal Investigator

08/01/13 - 07/30/19 A Study of Contraceptive Failure with Unprotected Intercourse 5-14 Days Prior to Initiation.
Principal Investigator(s): David K. Turok
William And Flora Hewlett Foundation
Role: Principal Investigator

07/18/13 - 07/17/14 A Phase 1, Multi-Center Study to Assess the Performance of a LNG20 Intrauterine System Inserter . Award Number M360-L104.
Principal Investigator(s): David K. Turok
Medicines 360
Role: Principal Investigator

07/01/13 - 06/30/15 Early Versus Delayed Postpartum Insertion of the Levonorgestrel IUD and Impact on Breastfeeding: A Randomized Controlled Non-inferiority Trial. SFPRF7-3.
Principal Investigator(s): David K. Turok
Society of Family Planning
Role: Principal Investigator

06/26/13 - 06/25/20 Contraceptive Clinical Trials Network Core Function Activities. Task Order Number HHSN27500001.
Principal Investigator(s): David K. Turok
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Principal Investigator

06/26/13 - 06/25/20 Contraceptive Clinical Trials Network- Female Sites. Contract Number HHSN275201300161.
Principal Investigator(s): David K. Turok
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Principal Investigator

07/01/12 - 06/30/13 Mid-Career/Mentor Award. Project Number 51002756. Sponsor Award Number SFPRF6-MC3. Proposal ID 10028633
Principal Investigator(s): David K. Turok
Direct Costs: $40,000 Total Costs: $40,000
Society of Family Planning
Role: Principal Investigator

06/12/12 - 07/01/15 IUD Insertion Forces and Placement with Novel IUD Inserter. Project Number 50302240. Proposal ID 10028623.
Principal Investigator(s): David K. Turok
Direct Costs: $244,077 Total Costs: $244,077
Bioceptive, Inc.
Role: Principal Investigator

03/01/12 - 02/28/13 An Intervention to Manage Difficult IUD Insertions. Project Number 51002691. Proposal ID 10027137
Principal Investigator(s): David K. Turok; Amna I. Dermish
Direct Costs: $69,990 Total Costs: $69,990
Society of Family Planning
Role: Co-Principal Investigator

01/01/12 - 12/31/12 A Phase 1, Multi-Center Study to Assess the Safety and Performance of a Novel LNG20 Intrauterine System Inserter. Protocol Number M360-L103
Principal Investigator(s): David K. Turok
Medicines 360
Role: Principal Investigator

06/01/11 - 05/31/13 Family Planning Fellowship 2011-2013. Project Number 51002562. Proposal ID 10024275
Principal Investigator(s): David K. Turok
Direct Costs: $640,153 Total Costs: $640,153
Susan Thompson Buffett Foundation
Role: Principal Investigator

05/25/11 - 05/24/12 Vaginal Microflora and Inflammatory Markers Before and After Levonorgestrel Intrauterine Device Insertion. Project Number 51002559. Proposal, ID 10024348.
Principal Investigator(s): David K. Turok; Janet C. Jacobson
Direct Costs: $69,999 Total Costs: $69,999
Anonymous Donor
Role: Co-Principal Investigator

09/29/10 - 08/31/12 EC Method: Determinants for Copper IUD Use and Future Unintended Pregnancy. Award Number R21HD063028. Proposal ID 10016454
Principal Investigator(s): David K. Turok
Direct Costs: $275,000 Total Costs: $275,000
Eunice Kennedy Shriver National Institute of Child Health and Human Development

Role: Principal Investigator

04/01/10 - 04/01/15 A Phase 3, Randomized, Multi-Center, Open-Label Study of a Levonorgestrel-Releasing Intrauterine System (20mcg/day) and Mirena for Long-Term, Reversible Contraception up to Five Years.
Principal Investigator(s): David K. Turok
Medicines 360
Role: Principal Investigator

09/01/09 - 08/31/10 Family Planning Fellow Interview 2009-2010. Project Number 51002337. Proposal ID 10015791
Principal Investigator(s): David K. Turok
Direct Costs: $1,880 Total Costs: $1,880
Anonymous
Role: Principal Investigator

07/22/09 - 10/01/10 EC-Choices And Outcomes: The Copper T380A IUD vs. Oral Levonorgestrel for Emergency Contraception. Proposal ID 10012527.
Principal Investigator(s): David K. Turok
Direct Costs: $119,928 Total Costs: $119,928
Society Of Family Planning
Role: Principal Investigator

07/01/08 - 06/30/09 Program to Develop Future Leaders in Family Planning
Principal Investigator(s): David K. Turok
The Lalor Foundation, Inc.
Role: Principal Investigator

02/01/08 - 01/31/10 Increasing Family Planning Research Capacity. Project Number 51002078. Proposal ID 10007080.
Principal Investigator(s): David K. Turok
Direct Costs: $86,658 Total Costs: $86,658
Anonymous
Role: Principal Investigator

07/01/03 - 09/30/05 Kenneth J. Ryan Residency Training Program in Abortion and Family Planning.
Principal Investigator(s): David K. Turok
University of Utah Department of OB/GYN Development Fund
Role: Principal Investigator

TEACHING RESPONSIBILITIES/ASSIGNMENTS

Course Lectures

2022 PI, MDCRC 6960: Research Project, 0 students, University of Utah, S. F. E. School of Medicine

2022 PI, MDCRC 6960: Research Project, 0 students, University of Utah, S. F. E. School of Medicine

2022 PI, MDCRC 6950: Independent Study, 0 students, University of Utah, S. F. E. School of Medicine

2022 PI, MDCRC 6960: Research Project, 1 student, University of Utah, S. F. E. School of Medicine

2021 PI, MDCRC 6960: Research Project, 1 student, University of Utah, S. F. E. School of Medicine

2021 PI, MDCRC 6950: Independent Study, 1 student, University of Utah, S. F. E. School of Medicine

2021 PI, MDCRC 6960: Research Project, 1 student, University of Utah, S. F. E. School of Medicine

2021 PI, MDCRC 6960: Research Project, 1 student, University of Utah, S. F. E. School of Medicine

2020 PI, MDCRC 6960: Research Project, 1 student, University of Utah, S. F. E. School of Medicine

2020 PI, MDCRC 6960: Research Project, 1 student, University of Utah, S. F. E. School of Medicine

2020 PI, MDCRC 6960: Research Project, 0 students, University of Utah, S. F. E. School of Medicine

2019 PI, MDCRC 6960: Research Project, 0 students, University of Utah, S. F. E. School of Medicine

2019 PI, MDCRC 6960: Research Project, 1 student, University of Utah, School of Medicine

2018 PI, MDCRC 6950: Independent Study, 1 student, University of Utah, School of Medicine

2018 PI, MDCRC 6960: Research Project, 1 student, University of Utah, School of Medicine

2018 PI, MDCRC 6960: Research Project, 0 students, University of Utah, School of Medicine

2017 PI, MDCRC 6960: Research Project, 0 students, University of Utah, School of Medicine

2017 PI, MDCRC 6960: Research Project, 1 student, University of Utah, School of Medicine

2016 Developer, OBST: Metabolism and Reproduction - Contraception Small Group Activity - David Turok & Gawron 9/, University of Utah, Obstetrics/Gynecology, Contraception Small Group Activity - David Turok & Gawron 9/19/16 at 10:00 AM

2016 Developer, OBST: Metabolism and Reproduction - Contraception and Family Planning - David Turok & Gawron 9/1, University of Utah, Obstetrics/Gynecology, Contraception and Family Planning - David Turok & Gawron 9/19/16 at 8:00 AM

2016 PI, MDCRC 6960: Research Project, 0 students, University of Utah, School of Medicine

2016 Developer, OBST: Ob/Gyn Clerkship - OB/GYN Clerkship: Gynecology , University of Utah, Obstetrics/Gynecology, OB/GYN Clerkship: Gynecology

2016 PI, MDCRC 6960, 2 students, University of Utah, School of Medicine

2015 Developer, OBST: Ob/Gyn Clerkship - OB/GYN Clerkship: Gynecology , University of Utah, Obstetrics/Gynecology, OB/GYN Clerkship: Gynecology

2015 Facilitator, OBST: Metabolism and Reproduction - Contraception Small Group Activities, University of Utah, Obstetrics/Gynecology, Contraception Small Group Activities

2015 Developer, OBST: Metabolism and Reproduction - Contraception and Family Planning, University of Utah, Obstetrics/Gynecology, Contraception and Family Planning

2015 PI, MDCRC 6960: Research Project, 2 students, University of Utah, School of Medicine

2015 Developer, OBST: Ob/Gyn Clerkship - OB/GYN Clerkship: Gynecology , University of Utah, Obstetrics/Gynecology, OB/GYN Clerkship: Gynecology

2014 Developer, OBST: Metabolism and Reproduction - Contraception and Family Planning, University of Utah, Obstetrics/Gynecology, Contraception and Family Planning

2014	Developer, OBST: Metabolism and Reproduction - Contraception Small Group Activities, University of Utah, Obstetrics/Gynecology, Contraception Small Group Activities
2014	Instructor, MD ID: OB Lab Rotations, Office of the Dean/Medicine, : MS2016 M+R - OB Lab Rotations
2014	Facilitator, OBST: Metabolism and Reproduction - OB Lab Rotations, University of Utah, Obstetrics/Gynecology, OB Lab Rotations
2013	PI, MDCRC 6950: Independent Study, 1 student, University of Utah, School of Medicine
2011	Instructor, Ectopic Pregnancy, Miscarriage, Contraception, Sterilization, Abortion, : MS2013 OB/GYN Clerkship - Ectopic Pregnancy, Miscarriage, Contraception, Sterilization, Abortion
2011	Instructor, Ectopic Pregnancy, Miscarriage, Contraception, Sterilization, Abortion, : MS2013 OB/GYN Clerkship - Ectopic Pregnancy, Miscarriage, Contraception, Sterilization, Abortion
2010	Instructor, MD ID: Clinical Reasoning- Contraception, Office of the Dean/Medicine, : Medical Science - Clinical Reasoning- Contraception
2010	Instructor, MD ID: Case Based Learning Exercise, Office of the Dean/Medicine, : Medical Science - Case Based Learning Exercise
2010	Instructor, OBST 7020: Optional: Topics in OB/GYN - Abortion: Safe, Legal, and Hopefully Rare, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Optional: Topics in OB/GYN - Abortion: Safe, Legal, and Hopefully Rare
2010	Instructor, OBST 7020: Contraception Workshop, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Contraception Workshop
2009	Instructor, OBST 7020: Topics in OB/GYN - Abortion: Safe, Legal, and Hopefully Rare, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Topics in OB/GYN - Abortion: Safe, Legal, and Hopefully Rare
2009	Instructor, OBST 7020: Contraception Workshop, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Contraception Workshop
2008	Instructor, OBST 7020: Contraception Workshop, Obstetrics/Gynecology, OBST 7020: Reproductive OS- 6 - Contraception Workshop
2007	Lecturer, University of Utah, MSPH Program, Abortion and Contraception in Public Health
2007	Instructor, FP MD 6320: Perinatal and Women's Health Epidemiology, University of Utah, Family and Preventive Medicine
2006	Instructor, OBST 7020-6: Small Groups: Contraception Workshop, Obstetrics/Gynecology, OBST 7020: Reproductive OS - Small Groups: Contraception Workshop

Clinical Teaching

2010 - Present	Reproductive Health Externship- Host faculty for a visiting medical student for a month long clinical externship focused on abortion and contraception training

2008 - 2010 Medical Student IUD Insertion Project (MSIIP) Along with a group of interested students I developed a curriculum to train 2nd year medical students in contraceptive counseling and IUD insertion. Over 100 IUD insertions were performed for women desiring the service without cost at the South Main Clinic of Salt Lake Valley Health Department.

2003 - Present Active in clinical instruction of 3rd year medical students on their Obstetrics and Gynecology clinical rotation

Didactic Lectures

2006 - 2015 **Turok DK**. Abortion for Genetics Counselors. Graduate Program in Genetic Counseling, University of Utah, Salt Lake City, UT

Internal Teaching Experience

2010 *Endometrial and Ovarian Cancer. What Family Docs Need to Know*, Resident Teaching Conference, Department of Family and Preventative Medicine, University of Utah School of Medicine

2010 *Contraception*, Resident Teaching Conference, Department of Family and Preventive Medicine, University of Utah School of Medicine

2008 *Endometrial and Ovarian Cancer. What Family Docs Need to Know*, Resident Teaching Conference, Department of Family and Preventative Medicine, University of Utah School of Medicine

2008 *Contraception for Family Physicians*, Resident Teaching Conference, Department of Family and Preventative Medicine, University of Utah School of Medicine

2008 *Long Acting Reversible Contraception*, Resident Teaching Conference, Department of Family and Preventative Medicine, University of Utah School of Medicine

2006 *Emergency Contraception and Complications of Medical Abortion*, Emergency Medicine Resident Conference, University of Utah School of Medicine

CE Courses Taught

1997 Obstetric Elective in Cochabamba, Bolivia. Worked with local residency program at a high volume regional public health hospital. Taught American obstetric practices to residents

PEER-REVIEWED JOURNAL ARTICLES

1. Thorman A, Engle A, Brintz B, Simmons RG, Sanders JN, Gawron LM, **Turok DK**, Kaiser JE (2022). Quantitative and qualitative impact of One Key Question on primary care providers' contraceptive counseling at routine preventive health visits.(Epub ahead of print). *Contraception*.
2. Sanders JN, Kean J, Zhang C, Presson AP, Everett BG, **Turok DK**, Higgins JA (2022). Measuring the Sexual Acceptability of Contraception: Psychometric Examination and Development of a Valid and Reliable Prospective Instrument.(Epub ahead of print). *J Sex Med*.

3. Kaiser JE, Galindo E, Sanders JN, Simmons RG, Gawron LM, Herrick JS, Brintz B, **Turok DK** (2021). Determining the impact of the Zika pandemic on primary care providers' contraceptive counseling of non-pregnant patients in the US: a mixed methods study. *BMC Health Serv Res*, *21* (1), 1215.
4. Kramer RD, Higgins JA, Everett B, **Turok DK**, Sanders JN (2021). A prospective analysis of the relationship between sexual acceptability and contraceptive satisfaction over time.(Epub ahead of print). *Am J Obstet Gynecol*.
5. Walhof KA, Gawron LM, **Turok DK**, Sanders JN (2021). Long-Term Failure Rates of Interval Filshie Clips As a Method of Permanent Contraception. *Womens Health Rep (New Rochelle)*, *2*(1), 279-284.
6. Myers K, Sanders JN, Dalessandro C, Sexsmith CD, Geist C, **Turok DK** (2021). The HER Salt Lake media campaign: comparing characteristics and outcomes of clients who make appointments online versus standard scheduling. *BMC Womens Health*, *21*(1), 121.
7. Higgins JA, Kramer RD, Wright KQ, Everett B, **Turok DK**, Sanders JN (2021). Sexual Functioning, Satisfaction, and Well-Being Among Contraceptive Users: A Three-Month Assessment From the HER Salt Lake Contraceptive Initiative.(Epub ahead of print) *J Sex Res*, 1-10.
8. **Turok DK**, Gero A, Simmons RG, Kaiser JE, Stoddard GJ, Sexsmith CD, Gawron LM, Sanders JN (2021). Levonorgestrel vs. Copper Intrauterine Devices for Emergency Contraception. ***N Engl J Med***, *384*(4), 335-344.
9. Simmons RG, Myers K, Gero A, Sanders JN, Quade C, Mullholand M, **Turok DK** (2020). Evaluating a Longitudinal Cohort of Clinics Engaging in the Family Planning Elevated Contraceptive Access Program: Study Protocol for a Comparative Interrupted Time Series Analysis. *JMIR Res Protoc*, *9*(10), e18308.
10. Disney EA, Sanders JN, **Turok DK**, Gawron LM (2020). Preconception Counseling, Contraceptive Counseling, and Long-Acting Reversible Contraception Use in Women with Type I Diabetes: A Retrospective Cohort Study. *Womens Health Rep (New Rochelle)*, *1*(1), 334-340.
11. Chen MJ, Creinin MD, **Turok DK**, Archer DF, Barnhart KT, Westhoff CL, Thomas MA, Jensen JT, Variano B, Sitruk-Ware R, Shanker A, Long J, Blithe DL (2020). Dose-finding study of a 90-day contraceptive vaginal ring releasing estradiol and segesterone acetate. *Contraception*, *102* (3), 168-173.
12. Chen BA, Eisenberg DL, Schreiber CA, **Turok DK**, Olariu AI, Creinin MD (2020). Bleeding changes after levonorgestrel 52-mg intrauterine system insertion for contraception in women with self-reported heavy menstrual bleeding. *Am J Obstet Gynecol*, *222*(4S), S888.e1-S888.e6.
13. **Turok DK**, Nelson AL, Dart C, Schreiber CA, Peters K, Schreifels MJ, Katz B (2020). Efficacy, Safety, and Tolerability of a New Low-Dose Copper and Nitinol Intrauterine Device: Phase 2 Data to 36 Months. *Obstet Gynecol*, *135*(4), 840-847.
14. Gawron LM, Simmons RG, Sanders JN, Myers K, Gundlapalli AV, **Turok DK** (2020). The effect of a no-cost contraceptive initiative on method selection by women with housing insecurity. *Contraception*, *101*(3), 205-209.
15. Gawron LM, Sanders JN, Sward K, Poursaid AE, Simmons R, **Turok DK** (2020). Multi-morbidity and Highly Effective Contraception in Reproductive-Age Women in the US Intermountain West: a Retrospective Cohort Study. *J Gen Intern Med*, *35*(3), 637-642.

16. Royer PA, Olson LM, Jackson B, Weber LS, Gawron L, Sanders JN, **Turok DK** (2020). "In Africa, There Was No Family Planning. Every Year You Just Give Birth": Family Planning Knowledge, Attitudes, and Practices Among Somali and Congolese Refugee Women After Resettlement to the United States. *Qual Health Res*, *30*(3), 391-408.
17. Everett BG, Myers K, Sanders JN, **Turok DK** (2019). Male Abortion Beneficiaries: Exploring the Long-Term Educational and Economic Associations of Abortion Among Men Who Report Teen Pregnancy. *J Adolesc Health*, *65*(4), 520-526.
18. Thompson I, Sanders JN, Schwarz EB, Boraas C, **Turok DK** (2019). Copper intrauterine device placement 6-14 days after unprotected sex. *Contraception*, *100*(3), 219-221.
19. Campbell AD, **Turok DK**, White K (2019). Fertility Intentions and Perspectives on Contraceptive Involvement Among Low-Income Men Aged 25 to 55. *Perspect Sex Reprod Health*, *51*(3), 125-133.
20. Sanders JN, Moran LA, Mullholand M, Torres E, **Turok DK** (2019). Video counseling about emergency contraception: an observational study. *Contraception*, *100*(1), 54-64.
21. Simmons RG, Sanders JN, Geist C, Gawron L, Myers K, **Turok DK** (2018). Predictors of contraceptive switching and discontinuation within the first 6 months of use among Highly Effective Reversible Contraceptive Initiative Salt Lake study participants. *Am J Obstet Gynecol*, *220*(4), 376.e1-376.e12.
22. Geist C, Aiken AR, Sanders JN, Everett BG, Myers K, Cason P, Simmons RG, **Turok DK** (2019). Beyond intent: exploring the association of contraceptive choice with questions about Pregnancy Attitudes, Timing and How important is pregnancy prevention (PATH) questions. *Contraception*, *99*(1), 22-26.
23. Gawron LM, Pettey WBP, Redd AM, Suo Y, **Turok DK**, Gundlapalli AV (2019). Distance Matters: Geographic barriers to long acting reversible and permanent contraception for homeless women Veterans. *J Soc Distress Homeless*, *28*(2), 139-148.
24. Teal SB, **Turok DK**, Chen BA, Kimble T, Olariu AI, Creinin MD (2019). Five-Year Contraceptive Efficacy and Safety of a Levonorgestrel 52-mg Intrauterine System. *Obstet Gynecol*, *133*(1), 63-70.
25. Sanders JN, Adkins DE, Kaur S, Storck K, Gawron LM, **Turok DK** (2018). Bleeding, cramping, and satisfaction among new copper IUD users: A prospective study. *PLoS One*, *13*(11), e0199724.
26. **Turok DK**, Simmons RG, Cappiello B, Gawron LM, Saviers-Steiger J, Sanders JN (2018). Use of a novel suction cervical retractor for intrauterine device insertion: a pilot feasibility trial.(Epub ahead of print). *BMJ Sex Reprod Health*.
27. **Turok DK**, Nelson A (2018). Phase 2 efficacy, safety, and tolerability results of the VeraCept low-dose copper intrauterine contraceptive: 24-month data. *Contraception*, *98*(4), 355.
28. Higgins J, Sanders JN, Wright K, Adkins D, **Turok DK**. (2018). Beyond safety and efficacy: how sexuality-related priorities impact contraceptive method selection. *Contraception*, *98*(4), 335.
29. Geist C, Sanders JN, Myers K, Simmons R, Everett B, Gawron L, **Turok DK** (2018). Changing lives, dynamic plans? 12-month shifts in pregnancy intentions. *Contraception*, *98*(4), 362.
30. Kaiser J, Simmons R, Myers K, Sanders JN, Gawron L, **Turok DK** (2018). Predictors of contraceptive method switching and discontinuation 6-months postabortion. *Contraception*, *98*(4), 353.

31. Bullock H, Galindo E, Simmons R, White K, Nguyen B, Sanders JN, Gawron L, **Turok DK**. (2018). Increasing options for vasectomy counseling and services at Planned Parenthood of Utah. *Contraception*, *98*(4), 337.

32. Everett BG, Sanders JN, Myers K, Geist C, **Turok DK** (2018). One in three: challenging heteronormative assumptions in family planning health centers. *Contraception*, *98*(4), 270-274.

33. Roth LP, Sanders JN, Simmons RG, Bullock H, Jacobson E, **Turok DK** (2018). Changes in uptake and cost of long-acting reversible contraceptive devices following the introduction of a new low-cost levonorgestrel IUD in Utah's Title X clinics: a retrospective review. *Contraception*, *98*(1), 63-68.

34. Bellows BK, Tak CR, Sanders JN, **Turok DK**, Schwarz EB (2018). Cost-effectiveness of emergency contraception options over 1 year. *Am J Obstet Gynecol*, *218*(5), 508.e1-508.e9.

35. Gawron L, Pettey WBP, Redd A, Suo Y, **Turok DK**, Gundlapalli AV (2017). The "Safety Net" of Community Care: Leveraging GIS to Identify Geographic Access Barriers to Texas Family Planning Clinics for Homeless Women Veterans. *AMIA Annu Symp Proc*, *2017*, 750-759.

36. Sanders JN, Myers K, Gawron LM, Simmons RG, **Turok DK** (2018). Contraceptive Method Use During the Community-Wide HER Salt Lake Contraceptive Initiative. *Am J Public Health*, *108*(4), 550-556.

37. Sanders JN, Higgins JA, Adkins DE, Stoddard GJ, Gawron LM, **Turok DK** (2018). The Impact of Sexual Satisfaction, Functioning, and Perceived Contraceptive Effects on Sex Life on IUD and Implant Continuation at 1 Year. *Womens Health Issues*, *28*(5), 401-407.

38. Torres LN, **Turok DK**, Clark EAS, Sanders JN, Godfrey EM (2018). Increasing IUD and Implant Use Among Those at Risk of a Subsequent Preterm Birth: A Randomized Controlled Trial of Postpartum Contraceptive Counseling. *Womens Health Issues*, *28*(5), 393-400.

39. **Turok DK**, Leeman L, Sanders JN, Thaxton L, Eggebroten JL, Yonke N, Bullock H, Singh R, Gawron LM, Espey E (2017). Immediate postpartum levonorgestrel intrauterine device insertion and breast-feeding outcomes: a noninferiority randomized controlled trial. *Am J Obstet Gynecol*, *217*(6), 665.e1-665.e8.

40. **Turok DK** (2017). For emergency contraception, political gaps are not scientific gaps. *BJOG*, *124* (13), 1956.

41. Gawron LM, Redd A, Suo Y, Pettey W, **Turok DK**, Gundlapalli AV (2017). Long-acting Reversible Contraception Among Homeless Women Veterans With Chronic Health Conditions: A Retrospective Cohort Study. *Med Care*, *55 Suppl 9 Suppl 2*, S111-S120.

42. Sanders JN, **Turok DK**, Royer PA, Thompson IS, Gawron LM, Storck KE (2017). One-year continuation of copper or levonorgestrel intrauterine devices initiated at the time of emergency contraception. *Contraception*, *96*(2), 99-105.

43. Eggebroten JL, Sanders JN, **Turok DK** (2017). Immediate postpartum intrauterine device and implant program outcomes: a prospective analysis. *Am J Obstet Gynecol*, *217*(1), 51.e1-51.e7.

44. Roberts SCM, Belusa E, **Turok DK**, Combellick S, Ralph L (2017). Do 72-Hour Waiting Periods and Two-Visit Requirements for Abortion Affect Women's Certainty? A Prospective Cohort Study. *Womens Health Issues*, *27*(4), 400-406.

45. Sanders JN, **Turok DK**, Gawron LM, Law A, Wen L, Lynen R (2017). Two-year continuation of intrauterine devices and contraceptive implants in a mixed-payer setting: a retrospective review. *Am J Obstet Gynecol*, *216*(6), 590.e1-590.e8.

46. Wright RL, Fawson PR, Frost CJ, **Turok DK** (2017). U.S. Men's Perceptions and Experiences of Emergency Contraceptives. *Am J Mens Health*, *11*(3), 469-478.

47. Frisse AC, Marrazzo JM, Tutlam NT, Schreiber CA, Teal SB, **Turok DK**, Peipert JF (2017). Validity of self-reported history of Chlamydia trachomatis infection. *Am J Obstet Gynecol*, *216*(4), 393.e1-393.e7.

48. Berglas NF, Gould H, **Turok DK**, Sanders JN, Perrucci AC, Roberts SC (2017). State-Mandated (Mis)Information and Women's Endorsement of Common Abortion Myths. *Womens Health Issues*, *27*(2), 129-135.

49. Ralph LJ, Foster DG, Kimport K, **Turok D**, Roberts SCM (2017). Measuring decisional certainty among women seeking abortion. *Contraception*, *95*(3), 269-278.

50. Roberts SC, **Turok DK**, Belusa E, Combellick S, Upadhyay UD (2016). Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women. *Perspect Sex Reprod Health*, *48*(4), 179-187.

51. **Turok DK**, Eisenberg DL, Teal SB, Keder LM, Creinin MD (2016). A prospective assessment of pelvic infection risk following same-day sexually transmitted infection testing and levonorgestrel intrauterine system placement. *Am J Obstet Gynecol*, *215*(5), 599.e1-599.e6.

52. **Turok DK**, Gawron LM, Lawson S (2016). New developments in long-acting reversible contraception: the promise of intrauterine devices and implants to improve family planning services. *Fertil Steril*, *106*(6), 1273-1281.

53. Higgins JA, Sanders JN, Palta M, **Turok DK** (2016). Women's Sexual Function, Satisfaction, and Perceptions After Starting Long-Acting Reversible Contraceptives. *Obstet Gynecol*, *128*(5), 1143-1151.

54. Sanders JN, Howell L, Saltzman HM, Schwarz EB, Thompson IS, **Turok DK** (2016). Unprotected intercourse in the 2 weeks prior to requesting emergency intrauterine contraception. *Am J Obstet Gynecol*, *215*(5), 592.e1-592.e5.

55. Royer PA, **Turok DK**, Sanders JN, Saltzman HM (2016). Choice of Emergency Contraceptive and Decision Making Regarding Subsequent Unintended Pregnancy. *J Womens Health (Larchmt)*, *25* (10), 1038-1043.

56. Wright RL, Frost CJ, **Turok DK** (2016). Experiences of Advanced Practitioners with Inserting the Copper Intrauterine Device as Emergency Contraception. *Womens Health Issues*, *26*(5), 523-8.

57. Sanders JN, Conway H, Jacobson J, Torres L, **Turok DK** (2016). The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion. *Womens Health Issues*, *26*(5), 483-7.

58. Dermish A, **Turok DK**, Jacobson J, Murphy PA, Saltzman HM, Sanders JN (2016). Evaluation of an intervention designed to improve the management of difficult IUD insertions by advanced practice clinicians. *Contraception*, *93*(6), 533-8.

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2019 **Turok DK**, Schreiber C, Nelson A. Phase 2 Efficacy, Safety, and Tolerability Results of the VeraCept Low-Dose Copper Intrauterine Contraceptive: 36-Month Data. Poster presentation at Society of Family Planning Annual Meeting, Los Angeles, CA

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2013 Jacobson JC, Dermish AI**,** Nygaard I, **Turok DK.** Vaginal microbiome changes with levonorgestrel intrauterine device placement. North American Forum on Family Planning.

Foster DG, Grossman D, **Turok DK.**, Peipert J, Prine L, Schreiber C, Jackson, Barar,

2013 Schwarz EB. Interest in and experience with IUC self-removal. North American Forum on Family Planning. Seattle, Washington.

2012 Dermish A, Jacobson J, Murphy P, Torres L, **Turok DK**, Ward K. Oral LNG vs. copper IUD: Understanding use of EC in relation to timing from LMP. Reproductive Health 2012. New Orleans, LO.

2012 Frost C, **Turok DK**, Wright R. Advanced practice clinician perceptions of and experience with the copper IUD for emergency contraception: A qualitative study. Reproductive Health 2012. North American Forum on Family Planning. Denver, CO..

2012 **Turok DK**, Jacobson J, Dermish A, Simonson S, Trauscht-Van Horn J, Murphy P. Pregnancy rates 1 year after choosing the copper T380 IUD or oral levonorgestrel for emergency contraception: A prospective observational study. Reproductive Health 2012. North American Forum on Family Planning. Denver, CO.

2012 Dermish A, Kim J, **Turok DK**. Cost-effectiveness of emergency contraception-IUDS versus oral EC. Reproductive Health 2012. North American Forum on Family Planning. Denver, CO, October 28, 2012.

2012 **Turok DK**, Dermish A, Jacobson J, Torres L, McClelland K, Ward K. We should really keep in touch: predictors of the ability to maintain contact with contraception clinical trial participants over 12 months. Reproductive Health 2012. North American Forum on Family Planning. Denver, CO.

2012 **Turok DK**, Godfrey E, Wojdyla D, Dermish A, Jacobson J, Torres L, Wu S. Copper T380 IUD for EC: Highly effective at any time in the menstrual cycle. North American Forum on Family Planning. Denver, CO.

2012 Wright R, Frost CJ, **Turok DK**. The Meaning of Pregnancy Among Women Seeking Emergency Contraception: A Qualitative Exploration. Conference of the Society for Social Work and Research. Washington, DC.

2011 Swenson C, Jacobson J, Mitchell J, **Turok DK**. LNG IUD removals when the strings are not present: a case series. Reproductive Health 2011. Las Vegas, NV.

2011 **Turok DK**, J.C. Jacobson, S.E. Simonsen, S.E. Gurtcheff, et al. The copper T380A IUD vs. oral levonorgestrel for emergency contraception: a prospective observational study. North American Forum on Family Planning, Washington, DC.

2011 **Turok DK**, J.C. Jacobson, S.E. Gurtcheff, M. Flores. Pregnancy intendedness and pregnancy outcomes among women presenting for intrauterine device or oral levonorgestrel as emergency contraception. North American Forum on Family Planning, Washington, DC.

2011 J. Jacobson, K. Maurer, **Turok DK**. Same-day cervical preparation with misoprostol prior to second-trimester D&E: a case series. North American Forum on Family Planning, Washington, DC.

2011 A. Dermish, **Turok DK**, J. Jacobson, K. Burke, et al. Failed IUD insertions in nulliparous and parous women. North American Forum on Family Planning, Washington, DC.

2011 M.E.S. Flores, **Turok DK**, J. Jacobson. Differences in birth control use and unintended pregnancy among Latina and white populations giving birth in Utah, 2004–2007. Reproductive Health 2011. Las Vegas, NV.

2011 J. Jacobson, K. Maurer, **Turok DK,** P. Murphy. Patient travel time and distance for second-trimester dilation and evacuation in the Intermountain West. Reproductive Health 2011. Las Vegas, NV.

2011 J. Jacobson, P. Murphy, **Turok DK**. Sexually transmitted infection prevalence in women choosing the copper-T 380A IUD for emergency contraception. Reproductive Health 2011. Las Vegas, NV.

2010 Flores M, Manuck T, **Turok DK**, Dwyer J. *The "Latina Epidemiologic Paradox" in Utah: Examining Risk Factors for Low Birth Weight (LBW), Preterm Birth (PTB), and Small-For-Gestational-Age (SGA) in Latina and White Populations.* Poster session presented at Society of Maternal Fetal Medicine 30th Annual Meeting, Chicago, IL.

2009 Gurtcheff S, Simonsen S, Handley E, Murphy P, **Turok DK**. *U USE IT (University Undergraduates' Sexual Education- Investigating Teachings Survey) To Evaluate Sexual Health Education and Practice*. Poster session presented at Reproductive Health 2009, Hollywood, CA.

2009 Gammon L, Simonsen S, Handley E, Murphy P, **Turok DK**. *The End of Virginity.* Poster session presented at Reproductive Health 2009, Hollywood, CA.

2009 **Turok DK**, Handley E, Simonsen S, North R, Frost C, Murphy P, Gurtcheff S. *A Survey of Women Obtaining Emergency Contraception: Are They Willing to Use the Copper IUD?* Poster session presented at Reproductive Health 2009, Hollywood, CA.

2009 **Turok DK**, Gurtcheff S, Handley E, Sok C, Simonsen S, Murphy P. *Does Emergency Contraception Choice Impact Effective Contraception 1 month later? A Prospective Comparision of the Copper IUD and Oral Levonorgestrel*. Poster session presented at Reproductive Health 2009, Hollywood, CA.

2008 Gibson K, Jones K, Van Horn J, Murphy P, Gurtcheff S, Ellis Simonsen S, **Turok DK**. *When good contraception goes bad: a case series of operative intrauterine device removals involving perforations, difficult extractions, and pregnancy.* Poster session presented at Annual Meeting of Association of Reproductive Health Professionals, Washington, DC.

2003 **Turok DK**, Gurtcheff S, Esplin MS, Silver R, Van Horn JT, Shah M. *Second trimester termination of pregnancy: A retrospective review of complications by site and procedure type*. Poster session presented at American College of Obstetricians and Gynecologists Annual Meeting, New Orleans, LA.

ORAL PRESENTATIONS

Keynote/Plenary Lectures

International

2017 **Turok DK**, Let's Agree on Compassion: Engaging More Voices in Civil Discourse on Family Planning. Plenary Session. North American Forum on Family Planning. Atlanta, GA.

Local/Regional

2010 **Turok DK.** Endometrial and Ovarian Cancer, What family Docs Need to Know, University of Utah Department of Family and Preventative Medicine Resident Teaching Conference.

2008 **Turok DK.** Endometrial and Ovarian Cancer, What family Docs Need to Know, University of Utah Department of Family and Preventitive Medicine REsident Teaching Conference.

2008 **Turok DK.** Long Acting Reversible Contraception, University of Utah Department of Family and Preventitive Medicine Resident Teaching Conference.

2007 **Turok DK**. Abortion and Contraception in Public Health, Lecture for the MSPH Program.

2006 **Turok DK**. Abortion for Genetic Counslers, University of Utah Genetic Counseling Graduate Program

Meeting Presentations

International

2016 **Turok DK**, Becoming an Abortion Provider, International Medical Students For Choice Conference, International Medical Students For Choice Conference, Lisbon, Portugal

2016 **Turok DK**, IUDs and EC, 12th International Federation of Professional Abortion and Contraception Associates (FIAPAC) Conference, 12th International Federation of Professional Abortion and Contraception Associates (FIAPAC) Conference, Lisbon, Portugal

2016 **Turok DK,** Prospective Meta-Analysis and Individual Participant Level Data. Society of Clinical Trials Annual Meeting. Montreal, Canada.

2010 **Turok DK**. The Copper T380 IUD for Emergency Contraception in Utah. International Consortium for Emergency Contraception, New York City, NY

2009 Warren JE, **Turok DK**, Maxwell TM, Silver RM, Brothman AR. Array Comparative Genomic Hybridization (ACGH) for Genetic Evaluation of Fetal Loss between 10 and 20 Weeks Gestation. Society of Gynecologic Investigation, Glasgow, UK

National

2018 **Turok DK**, Increasing Options for Vasectomy Counseling and Services at Planned Parenthood of Utah

2016 **Turok DK**, LARC and Emergency Contraception. ACOG LARC Program Webinar.

2016 **Turok DK**, At the Intersection of EC & IUDs: A Look Into the Future from Planet Utah. EC Jamboree, Washington, DC.

2014 **Turok DK**, Dermish A. New Technologies to Improve IUD Insertion: Hardware and Software. Reproductive Health 2014, Annual Meeting of the Association of Reproductive Health Professionals, Charlotte, NC

2014 **Turok DK**. Beginning and Expanding Postpartum LARC Use. Ryan Residency Program in Abortion and Contraception National Directors Meeting, Chicago, IL

2014 **Turok DK**. Update from Utah: What's Different Here? Fellowship in Family Planning National Directors Meeting, Chicago, IL

2013 **Turok DK**. Expanding Access to IUDs as EC: Clinical Experience. The Alan Guttmacher Institute, New York City, NY

2013 **Turok DK**, Westhoff C. She needs EC: does your emergency response team offer IUDs? Risk made Real: an evidence-based approach to addressing risk in contraception. Reproductive Health 2013, Annual Meeting of the Association of Reproductive Health Professionals, Denver, CO

2013 **Turok DK**. Copper IUD for EC - Best Method to Prevent Pregnancy Now and Later. Live Webinar, California Family Health Council

2012 Conference Faculty, **Turok DK.** Topics presented: Surgical Abortion Techniques, Abortion Provider Panel, No-Scalpel Vasectomy. Medical Students for Choice Conference on Family Planning, St. Louis, MO

2012 **Turok DK**. The Teachable Moment: Optimizing EC Method Selection and Transition to Highly Effective Contraception. Online Webinar for Planned Parenthood Federation of America

2011 Swenson C, Turok DK, Ward C, Jacobson J. Misoprostol vs. placebo prior to IUD insertion in nulliparous women: a randomized controlled trial. North American Forum on Family Planning, Washington, DC.

2011 **Turok DK**. Hard to Get It In, Hard to Get It Out: Difficult IUD Insertions and Removals. North American Forum in Family Planning, Washington, DC

2011 **Turok DK,** Conference Committee Chair. Topics Presented: Contraception Journal-Outstanding Articles, Tools of the Trade- Demonstration of Online Interactive Birth Control Tools, Hard to Get it In: Tactics for Difficult IUD Insertions. Reproductive Health 2011. Las Vegas, NV.

2010 **Turok DK**. University of Utah LARC (Long Acting Reversible Contraception) Program: High Use Through diverse Outlets. Kenneth J. Ryan Residency Training Program National Meeting, San Francisco, CA

2010 **Turok DK**. Seven Reasons to Plan Your Pregnancy: Because Wanted is not Enough. Planned Parenthood Federation of America, Medical Directors Council, Park City, UT

2009 Conference Faculty, **Turok DK**, Topics Presented: Emergency Contraception: Where to Now?, First Trimester Abortion, Abortion Provider Panel. Medical Students for Choice National Conference, Salt Lake City, UT

2009 **Turok DK**. Implementing Family Planning Training for Residents and Students. Association of Professors of Gynecology and Obstetrics/Council on Resident Education in Obstetrics and Gynecology (APGO/CREOG) Annual Meeting, San Diego, CA

2008 Betstadt S, **Turok DK**, Borgatta L, Kapp N, Feng K, Arlos A, Gold M. IUD insertion after medical abortion. Annual Meeting of Association of Reproductive Health Professionals, Washington, DC

Local/Regional

2017 **Turok DK**, Civil Discourse in Family Planning, 2017 Utah Family Planning Symposium, Salt Lake City, UT

2017 **Turok DK,** The HER Salt Lake Contraceptive Initiative: Growing the Garden for Change in Utah Family Planning, 2017 Utah Family Planning Symposium, Salt Lake City, UT

2017 **Turok DK**, Simplifying Contraception, Post Graduate Course, 58th Annual OBGYN Update & Current Controversies, University of Utah School of Medicine, Park City, UT

2014 **Turok DK**. Contraception Update 2014 – Don't Delay, Insert IUDs and Implants Today. Post Graduate Course, 55th Annual OBGYN Update & Current Controversies, University of Utah School of Medicine, Park City, UT

2013 **Turok DK**. Family Planning: Why We Need to Care and What We Can Do. Department of Family and Preventive Medicine, University of Utah School of Medicine, Salt Lake City, UT

2013 **Turok DK**. No Scalpel Vasectomy: Introducing an underutilized method of contraception to your clinic. Ryan Program Webinar

2012 **Turok DK**. Prematurity Prevention: the Role of Pregnancy Planning. Prematurity Prevention Symposium, Utah Chapter of the March of Dimes, Salt Lake City, UT

2012 **Turok DK**. Family Planning: Just the Non-Controversial Stuff. The Rotary Club of Salt Lake City, Salt Lake City, UT

2012 **Turok DK**. Family Planning Update 2012. Post Graduate Course, 53rd Annual OBGYN Update & Current Controversies, Park City, UT

2010 **Turok DK**. New Family Planning Issues Every OB/GYN Should Know. Postgraduate Course, Department of Obstetrics & Gynecology, University of Utah School of Medicine, Park City, UT

2008 **Turok DK**. Adolescent Sexuality: It's Not Only about Abstinence. Issues in Pediatric Care, Pediatric Education Services, Primary Children's Medical Center, Salt Lake City, UT

2007 **Turok DK**. Contraception Update. Postgraduate Course, Department of Obstetrics & Gynecology, University of Utah School of Medicine, Park City, UT

2007 - 2010 **Turok DK**, Abortion and Reproductive Ethics. University of Utah Undergraduate Honors Program.

2006 **Turok DK,** Emergency Contraception and Complications of Medical Abortion. University of Utah, Emergency Medicine Resident Conference.

2005 Conference Faculty, **Turok DK**, Presentations on: First Trimester Bleeding, Late Pregnancy Bleeding, Gestational Diabetes Management, Utah Academy of Family Physicians Annual Meeting

2003 **Turok DK**. Contraceptive Update Focusing on the Levonorgestrel IUD. Family Practice Refresher Course, Salt Lake City, UT

2000 **Turok DK**. Evidence based electronic fetal heart rate monitoring. Family Practice Refresher Course, Salt Lake City, UT

Invited/Visiting Professor Presentations

International

2018 **Turok DK,** Growing Your Research Career with NIH Grants. Pre-conference Workshop. North American Forum on Family Planning. New Orleans, LA.

2017 **Turok DK,** The Great Debate 2017: Can Emergency Contraception (EC) be Easy? North American Forum on Family Planning. Atlanta, GA.

2005 Conference Faculty, **Turok DK**, Three lectures given and 2 workshops conducted, Family Centered Maternity Care Conference, Sponsored by the American Academy of Family Physicians, Vancouver, BC.

National

2021 Presentation to the Planned Parenthood Federation of America National Medical Committee on levonorgestrel IUD expansion

2021 RAPID EC Trial Results and IUDs for Emergency Contraception. University of New Mexico ECHO conference

2020 Abortion and Early Pregnancy Loss Complications. Contraceptive Technology Annual Conference, Pre-Conference faculty (Online).

2020 IUDs for Emergency Contraception, Finally Going Beyond Copper. Contraceptive Technology Annual Conference (Online)

2020 IUDs and Implants, Scientific Barrier Busting. Contraceptive Technology Annual Conference (online)

2019 **Turok DK,** Increasing Contraceptive Access in Utah. Improving Opportunity Through Access to Family Planning. Brookins Institution Event. Brookings Institution. Washington, D.C.

2019 **Turok DK,** Community Based Family Planning Initiatives & Conservative Allies. Program on Women's Healthcare Effectiveness Research (PWHER), Department of Obstetrics and Gynecology, University of Michigan.

2015 **Turok DK**, Sanders JN, Thompson I, Royer PA, Gawron L, Storck K. IUD Continuation when Initiated as Emergency Contraception, Top 4 oral presentation session, North American Forum on Family Planning, Chicago, IL

2013 **Turok DK**. The Best Evidence to Reduce Unplanned Pregnancies & Births: 5 Things You Should Be Doing. Department of Family Medicine, Memorial Hospital, Brown University, Pawtucket, RI

2013 **Turok DK**. Using Your Passion for Reproductive Justice to Generate Useful Research. Annual Guest Lecturer, Scholarly Concentration in Women's Reproductive Health, Warren Alpert Medical School, Brown University, Providence, RI

2013 **Turok DK**. Expanding Access to IUDs as EC: Clinical Experience. EC Jamboree, American Society for Emergency Contraception, International Consortium for Emergency Contraception, Baruch College, New York City, NY

2013 **Turok DK**. Emergency Contraception Update presented with Diana Blithe, James Trussell, and Sharon Cameron. North American Forum on Family Planning, Seattle, WA

2012 **Turok DK**. Risk Made Real Team Based Learning. Presentation Sponsored by Association of Reproductive Health Professionals, Choices Clinic, Memphis, TN

2012 **Turok DK**, Mishell D. Maximizing LARC Availability: Bringing the Lessons of the CHOICE Project to Your Community. Reproductive Health 2012, Annual Meeting of the Association of Reproductive Health Professionals, New Orleans, LA

2010 Conference Faculty, **Turok DK.** Topics presented: First Trimester Abortion, Abortion Provider Panel. Medical Students for Choice National Conference, Baltimore, MD

Local/Regional

2008 **Turok DK**. Safety of Second Trimester Abortions and Medical Treatment of Early Pregnancy Failure. Department of Obstetrics & Gynecology, Davis Hospital and Medical Center, Ogden, UT

2008 **Turok DK.** Issues in Pediatric Care, Pediatric Education Services, Primary Children's Medical Center.

2008 **Turok DK.** Contraception for Family Physiscians, University of Utah Department of Family and Preventitive MEdicine Resident Teaching Conference.

Grand Rounds Presentations

2022 Family Planning Through the Life Course presented by the Division of Family Planning. Department of Ob/Gyn Grand Rounds, University of Utah

2022 Abortion 2022: How we got here & how medical & legal professionals can help us move forward, Department of Ob/Gyn Grand Rounds, University of Utah

2021 RAPID EC Trial Results, Using the Hormonal IUD for Emergency Contraception. Dr. Sarah Hawley Memorial Lecture. Department of Family and Preventive Medicine, University of Utah

2021 RAPID EC Trial Results and IUDs for Emergency Contraception. University of Minnesota Ob/Gyn Grand Rounds (Online).

2018 **Turok DK**. The HER Salt Lake Contraceptive Initiative: Reproductive Justice Locally Applied. University of Wisconsin. Department of Obstetrics and Gynecology Grand Rounds, Madison, Wisconsin.

2016 **Turok DK**. In-Hospital Postpartum IUD & Implant Placement. Department of Obstetrics & Gynecology Grand Rounds, Montefiore Hospital, New York City, NY

2016 **Turok DK**. The HER Salt Lake Contraceptive Initiative: Developing Prospective Cohorts to Assess Social and Economic Outcomes. Department of Obstetrics & Gynecology Grand Rounds, Indiana University, Bloomington, IN

2016 **Turok DK**. A Brief History of Utah Ob/Gyn Research with Dr. Michael Varner. Department of Obstetrics & Gynecology Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2014 **Turok DK**. Don't delay, insert IUDs and implants today. Department of Obstetrics & Gynecology Grand Rounds, University of Nevada, Reno School of Medicine, Reno, NV

2014 **Turok DK**. Don't delay, insert IUDs and implants today. Department of Obstetrics & Gynecology Grand Rounds, University of Nevada, Reno School of Medicine, Reno, NV

2014 **Turok DK**. Don't delay, insert IUDs and implants today. Department of Obstetrics & Gynecology Grand Rounds, Greenville Health System, Greenville, SC

2013 **Turok DK**. Family Planning Update 2014: How Utah trainees are influencing and incorporating best practices. Department of Obstetrics & Gynecology Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2013 **Turok DK**. Family Planning Update 2014. Cayuga Medical Center, Ithaca, NY

2010 **Turok DK**. Emergency Contraception: Research Guiding New Directions. Department of Obstetrics & Gynecology Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2010 **Turok DK**. IUDs – New and Future Studies Driving the Best Bet to Reduce Unplanned Pregnancies. Department of Obstetrics & Gynecology Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2010 **Turok DK**. Contracepting Like Mad: Because Adolescents are Not Only About Abstinence. Invited, Methodist Dallas Medical Center, Dallas, TX

2009 **Turok DK**. Contracepting Like Mad: Because Adolescents are Not Only About Abstinence. Department of Ob/Gyn Grand Rounds, Beth Israel Deaconess Medical Center, Albert Einstein College of Medicine, New York, NY

2008 **Turok DK**. Adolescent Sexuality: It's Not only about Abstinence. Primary Children's Medical Center Pediatric Grand Rounds, Salt Lake City, UT

2007 **Turok DK**. Adolescent Sexuality: It's Not only about Abstinence. Department of Obstetrics & Gynecology Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2007 **Turok DK**. 25 Contraceptive Methods You've Never Heard of. Department of Family & Preventive Medicine Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2007 **Turok DK**. 25 Contraceptive Methods You've Never Heard of. Department of Obstetrics & Gynecology Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2006 **Turok DK**. Contracepting Like Mad: 2006 and Beyond. Department of Internal Medicine Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2004 **Turok DK**. When the First Trimester is the Last. Department of Family & Preventive Medicine Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2003 **Turok DK**. Abortion: A Global, National, and Utah Perspective. Department of Obstetrics & Gynecology Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

2000 **Turok DK**. 21st Century Contraception. Department of Obstetrics & Gynecology Grand Rounds, University of Utah School of Medicine, Salt Lake City, UT

Attachment 2

THIRD JUDICIAL DISTRICT COURT FOR SALT LAKE COUNTY, UTAH

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff, *Plaintiff*, v. STATE OF UTAH, *et al.*, *Defendants.*	**DECLARATION OF COLLEEN M. HEFLIN, PH.D., IN SUPPORT OF PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION** Case No. 220903886 Judge Andrew Stone

I, Colleen M. Heflin, Ph.D., being of lawful age, do hereby swear and state as follows:

1. I am currently a Professor of Public Administration and International Affairs at the Maxwell School of Citizenship and Public Affairs at Syracuse University. I am also the incoming Associate Dean at the Maxwell School and Chair of my department. In addition, I also serve as a Senior Research Associate at the Center for Policy Studies and as a Research Affiliate at the Aging Studies Center. My areas of expertise include poverty policy, social policy, and family and child policy in the United States. My *curriculum vitae* is attached as Exhibit A.

2. I submit this declaration in support of Plaintiff's Motion for a Preliminary Injunction to prevent enforcement of Utah Code Ann. § 76-7a-101, *et seq*. (the "Criminal Abortion Ban").

3. I have reviewed a copy of the Criminal Abortion Ban. I understand that the Ban, which came into effect on June 24, 2022, prohibits abortion at any point in pregnancy with extremely narrow exceptions, and exposes any person who violates it to a prison term of one to fifteen years, criminal fines, and loss of licensure.

4. I offer this declaration to assist the Court in understanding the challenges that poor and low-income women in Utah, already face when coping with an unexpected situation, such as unwanted pregnancy, and the additional hardship that the Criminal Abortion Ban will create for Utah women.

5. The opinions detailed below are based on my own research, my professional experience, and my familiarity with the relevant literature in my field, as applied to my understanding of the facts in this case.

I. Summary of Opinions

6. Even before the Criminal Abortion Ban took effect, low-income and poor women in Utah faced substantial costs associated with obtaining abortion services related to the medical costs of the procedure, travel costs to get to a provider, as well as lost wages and childcare expenses. These expenses create significant barriers to care for low-income and poor women in Utah, who lack the flexibility in their finances to cover unexpected medical and transportation costs. Moreover, to navigate these barriers related to abortion services, low-income and poor women must forgo essential expenses, making them and their existing children vulnerable to food insecurity, homelessness, utility shut-offs, and health care crises–potentially starting a cascade of negative life events. National evidence shows that it is difficult for these individuals to return to equilibrium.

7. The Criminal Abortion Ban creates a significant, additional burden on Utah women seeking abortion. It does so in part by increasing travel and associated costs for women throughout Utah—particularly for women in the Salt Lake City area, which contains about 36% of the state

population.[1] Patients will be forced to travel outside of Utah to obtain an abortion in virtually all circumstances. In my opinion, these additional travel burdens will delay many poor and low-income women's access to abortion services,[2] potentially beyond the gestational age at which it is available out of state, and prevent other poor and low-income women from accessing abortion altogether. The logistical burdens are also likely to jeopardize the confidentiality and employment of poor and low-income women as well.

II. My Professional Background

8. I have been a faculty member at Syracuse University since 2017. Prior to that, I was a Professor at the Harry S. Truman School of Public Affairs at the University of Missouri, where I was employed for a decade and held various positions, including Co-Director of the Population, Education, and Health Center, and Co-Director of the University of Missouri Research Data Center. I earned my B.A. in social sciences and my master's in public policy from the University of Michigan. I also received my Ph.D. in sociology, with an emphasis on social demography and population studies, from the University of Michigan, a program that was ranked in the top three in the country at that time.

9. For the past twenty years, my research has focused on the study of social and poverty policy, with a special emphasis on low-income households' inability to meet basic needs and on the evaluation of federal and state social programs available to low-income and poor households. I have taught research methods and program evaluation courses for more than twenty

[1] *See* U.S. Census Bur., *QuickFacts, Salt Lake County, Utah*, https://www.census.gov/quickfacts/UT (last visited June 27, 2022) (in 2020, total population of Utah estimated at 3,337,975, and total population of Salt Lake County estimated at 1,186,421).

[2] *See, e.g.*, Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (2014); *see also* Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 Contraception 334, 341 (2006).

years to master's students in public affairs. In addition, I regularly teach courses in social welfare or poverty policy at the undergraduate, master's, and doctoral levels.

10. I have conducted research at the national level documenting the vulnerability of low-income households to material hardship. In a 2016 study, for example, I analyzed how specific shocks to family stability, such as unemployment or becoming disabled, were associated with particular types of material hardship.[3] In another study, with coauthors Jim Ziliak and Samuel Ingram, I examined how participation in the Supplemental Nutritional Assistance Program ("SNAP," commonly known as food stamps) leads to a one- to two-percentage point reduction in population mortality.[4] In other recent projects, I have examined how the population using food stamps and the unemployment insurance program changed with the Great Recession (coauthored work with Peter Mueser);[5] how physical health problems associated with different types of disability are associated with household food insecurity (coauthored with Claire Altman and Laura Rodriguez);[6] and the later-life consequences for adolescent exposure to household food insecurity (with Rajeev Darolia and Sharon Acevedo).[7] Additionally, I have conducted research on the

[3] *See generally* Colleen Heflin, *Family Instability and Material Hardship: Results from the 2008 Survey of Income and Program Participation*, 37 J. Fam. and Econ. Issues 359 (2016).

[4] *See generally* Colleen Heflin, Colleen et al., *The Effects of the Supplemental Nutrition Assistance Program on Mortality*, 38 Health Affairs 1807 (2019).

[5] *See generally* Colleen Heflin & Peter Mueser, *UI and SNAP Receipt in the Sun: The Great Recession and Its Aftermath in Florida* in Helping Together: Unemployment Insurance, Supplemental Nutrition Assistance, and the Great Recession (David Stevens & Michael Wiseman eds., 2019.; Colleen Heflin & Peter Mueser, *Program Participation in the Show Me State: Missouri Responds to the Great Recession*, *in* Helping Together: Unemployment Insurance, Supplemental Nutrition Assistance, and the Great Recession (David Stevens & Michael Wiseman eds., 2019).

[6] *See generally* Colleen Heflin et al., *Food Insecurity and Disability in the United States*, 12 Disability & Health J. 220 (2019).

[7] *See generally* Colleen Heflin, Sharon Kukla-Acevedo & Rajeev Darolia, *Adolescent Food Insecurity and Risky Behaviors and Mental Health During the Transition to Adulthood*, 105 Child.

impacts of government programs and policies on specific populations. For example, in a 2015 study with Andrew London, I examined the use of SNAP benefits by active-duty military, veterans, and reservists.[8]

11. In addition to my research focused on national-level data, I also routinely analyze the impact of social and poverty policies at the state- or community-level. I have worked with states as part of this research, either through data sharing or more active collaboration. For example, I have examined the transition from welfare to work for Temporary Assistance for Needy Families ("TANF") recipients in one county in Michigan,[9] the barriers to accessing SNAP benefits in Florida,[10] and the healthcare-utilization patterns of SNAP participants in Missouri.[11] I recently completed a study of the redesign of the recertification process for SNAP benefits in a Minnesota county,[12] and the effects of children's TANF and SNAP participation during the early childhood period on kindergarten-readiness in Virginia.[13] I am currently exploring how access to child care

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& Youth Servs. Rev. 104416 (2019); Colleen Heflin et al., *Exposure to Food Insecurity during Adolescence and Educational Attainment,* 69 Social Problems 453 (2022).

[8] *See generally* Andrew London & Colleen Heflin, *Supplemental Nutrition Assistance Program (SNAP) Use among Active-Duty Military Personnel, Veterans, and Reservists*, 34 Population Res. & Pol'y Rev. 805.

[9] *See generally* Sheldon Danziger et al., *Does It Pay to Move From Welfare to Work?*, 21 J. Pol'y Analysis & Mgmt. 671 (2002). Reprinted in J. Pol'y Analysis and Mgmt. classic volume on "Poverty and Welfare."

[10] *See generally* Colleen Heflin et al., *Clients' Perspectives on a Technology-Based Food Assistance Application System*, 43 Am. Rev. Pub. Admin. 658 (2013).

[11] *See generally* Colleen Heflin et al., *SNAP Benefits and Childhood Asthma,* 220 Soc. Sci. & Med. 203 (2019); Chinnedum Ojinnaka & Colleen Heflin, *Supplemental Nutrition Assistance Program Size and Timing and Hypertension-Related Emergency Department Claims Among Medicaid Enrollees*, 12 J. Am. Soc'y of Hypertension e27 (2018); Irma Arteaga et al., *SNAP Benefits and Pregnancy-Related Emergency Room Visits*, 37 Population Res. & Pol'y Rev., 1031 (2018).

[12] *See generally* Leonard Lopoo et al., *Testing Behavioral Interventions Designed to Improve On-Time SNAP Recertification*, 3 J. of Behavioral Pub. Admin. 1 (2020).

[13] Colleen Heflin & Michah Rothbart, *SNAP Uptake and School Readiness in Virginia*, Econ. Rsch. Serv., U.S. Dep't of Agric. (forthcoming).

subsidies varies by the race, age, and county of residence of children in Virginia and how access to child care subsidies affects maternal earning trajectories after the birth of a child.

12. Over the course of my career, I have published more than 70 articles in peer-reviewed academic journals. According to Google Scholar, my research has been cited around 5,000 times by other academic researchers. In addition, I am regularly asked to lecture to international audiences on the subject of poverty and social policy in the United States.

13. I have received competitive national grants from the United States Department of Agriculture, the United States Department of Health and Human Services, the National Institutes of Health, and the National Science Foundation to support my research. On a number of occasions, I have been invited to speak to the Committee on National Statistics at the National Academies of Sciences, Engineering, and Medicine.

14. Additionally, I am regularly called on to review the scientific merit of academic research and grant proposals submitted by others. This review typically involves carefully analyzing the data and research methods used, determining if they meet scientific standards in the field, and evaluating whether authors provide a rigorous analysis and interpretation of their research findings.

III. OPINIONS

A. Background on Poor and Low-Income Households in Utah

1. A person is defined by the U.S. Census Bureau as being "poor" if she lives in a household whose total annual income is below the federal poverty level ("FPL") for her family size. For example, a household with one adult and one child is defined as poor in 2022 if the annual

household income falls at or below $18,310, or $1,526 per month.[14] For a woman living alone, the federal poverty level is $13,590 annually, or $1,133 per month.[15]

2. In Utah, 8.9% of residents—or more than 280,000 people—were poor in 2019.[16] The child poverty rate in Utah is even higher: in 2019, 9.9% of children aged 0–17 years old (91,433 children in total) lived in households with incomes below the federal poverty level.[17]

3. Poverty in Utah tends to be geographically dispersed but predominantly rural. According to the 2020 Small Area Income and Poverty Estimates, there are five counties in Utah with poverty rates above the national average of 11.9%: Carbon, Iron, Piute, San Juan, and Sanpete Counties.[18] High-poverty counties are different from other counties in ways that are relevant to abortion access. Specifically, women in these counties have a demographic profile associated with a higher demand for abortion services and also higher barriers to receiving abortion services.

4. The risk of poverty in Utah is concentrated among particular demographic groups. According to data from the American Community Survey 2019, a nationally representative survey collected by the U.S. Census Bureau, women in Utah are more likely to be poor than men (9.6% versus 8.2%), and the poverty rate is highest among Utahns of reproductive age—18–34 years—

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[14] U.S. Dep't of Health & Human Servs., HHS Poverty Guidelines for 2022, https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines (last visited Jun. 26, 2022).

[15] *Id.*

[16] U.S. Census Bur., *Poverty Status in the Past 12 Months: Utah*, https://data.census.gov/cedsci/table?q=Utah%20Income%20and%20Poverty&tid=ACSST1Y2019.S1701&hidePreview=false_ (last visited Jun 26, 2022). The American Community Survey is not releasing single-year estimates for 2020 due to survey error.

[17] *Id.*

[18] U.S. Census Bur., *SAIPE State and County Estimated 2020: US and All States and Counties*, available at https://www.census.gov/data/datasets/2020/demo/saipe/2020-state-and-county.html (last visited Jun. 26, 2022) (excel sheet linked at URL entitled "US and All States and Counties").

when the rate rises to 12.5%.[19] In addition, those who identify as Black or African American in Utah are more likely than other racial and ethnic groups to be poor (28.7%), followed by those who identify as American Indians (18.5%), another race (19.2%), and Hispanic or Latino (15.8%).[20]

5. Poverty experts widely acknowledge that the FPL measure no longer accurately reflects the income required to meet basic needs. This poverty measure was originally designed in the 1960s by taking the average amount of money required to support a modest diet and multiplying that number by three, since food comprised a third of a household's monthly expenses at that time. The standard for determining the FPL has been adjusted for inflation, but no other changes have been made since its creation. Currently, however, food purchases constitute about one-eighth of household consumption; other costs, such as housing and transportation, have increased as a share of household expenses. Additionally, new categories of spending have emerged that did not exist in the 1960s, such as cell phones, computers, and internet coverage. Furthermore, the FPL does not account for work-related, childcare, or medical-care expenses that are mandatory and not discretionary. The impact of these expenses in calling into question the FPL standard is somewhat offset by the fact that the definition of household income used for calculating the FPL does not include the value of near-cash transfers, such as food stamps, housing assistance, and the Earned Income Tax Credit, as well as regional differences in the cost of living.[21] However, poverty experts still widely acknowledge that, on balance, the FPL measure underestimates the number of households that struggle to make ends meet.

[19] U.S. Census Bur., *supra* note 16.

[20] *Id*.

[21] John Iceland, Poverty in America: A Handbook (2d ed. 2006).

6. Households with incomes up to 200% of the FPL, although not technically "poor," are considered "low-income" households, as that term is used in the literature. In Utah, 24.2% of all families (763,100 families) survived on incomes below 200% of the federal poverty level in 2019, according to data from the American Community Survey.[22] According to the National Center for Children in Poverty, between 2015 and 2019, 32% of all children in Utah (292,309 children) lived in low-income families.[23]

7. Our federal social policy acknowledges that families with incomes above the federal poverty level still need assistance in meeting basic needs. For example, in the SNAP program, federal eligibility is set at 130% of the FPL[24] and states have the option of extending income eligibility—as many do—up to 185% of the FPL.[25] Similarly, income eligibility for subsidized school meals extends to 185% of the FPL,[26] as does income eligibility for the Women, Infants and Children Program ("WIC").[27] Under federal law, states have the flexibility to set an

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[22] Kaiser Fam. Found., *Distribution of the Total Population by Federal Poverty Level (above and below 200% FPL)*, https://www.kff.org/other/state-indicator/population-up-to-200-fpl/?dataView=1&current=Timeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited June 26, 2022) (click the checkboxes for "percent," "Under 200%" and "Utah").

[23] Nat'l Ctr. for Children in Poverty, Bank Street Graduate Sch. of Educ., *Utah Demographics of Low-Income Children* (Oct. 11, 2020), http://www.nccp.org/profiles/UT_profile_6.html (last visited June 26, 2022).

[24] U.S. Dep't of Agriculture, *Supplemental Nutrition Assistance Program (SNAP): Eligibility*, https://www.fns.usda.gov/snap/recipient/eligibility (last visited Jun. 26, 2022).

[25] *See, e.g.*, U.S. Dep't of Agric., *State Options Report*, at 25 (14th ed. Oct. 1, 2017), available at https://fns-prod.azureedge.us/sites/default/files/snap/14-State-Options.pdf; Conn. Official State Website, *SNAP Eligibility*, https://portal.ct.gov/DSS/SNAP/Supplemental-Nutrition-Assistance-Program---SNAP/Eligibility (last visited June 27, 2022).

[26] U.S. Dep't of Agric., *Child Nutrition Programs: Income 2022–2023* (Feb. 17, 2022), https://www.fns.usda.gov/cn/fr-021622.

[27] U.S. Dep't of Agric., *Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Income Eligibility Guidelines, 2022–2023* (Mar. 29, 2022), https://www.fns.usda.gov/wic/fr-032922.

income eligibility threshold for the Low-Income Home Energy Assistance Program between 110% and 150% of the FPL.[28] Finally, Medicaid, which provides public health insurance for the poor, can, at state option, extend up to 300% of the FPL in some cases.[29]

8. At the national level, among low-income households in which one member is employed but does not work full-time, year-round, two out of five households report housing insecurity and two out of five households report food insecurity.[30]

9. With overall inflation at the highest rate in nearly 41 years, price increases in food, gas and housing are putting further pressure on the household budgets for poor and low-income households. According to the May 2022 Consumer Price Index estimates for the total economy, the average price of all items increased by 8.6% from May 2021.[31] However, food prices specifically increased even more—by 10.1%, with foods purchased at grocery stores or supermarkets increasing by 11.9% (and specific food items, such as eggs expected to increase by approximately 20% in 2022).[32] In addition, gasoline prices are 48.7% higher than a year ago.[33]

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[28] U.S. Dep't of Health & Human Servs., *LIHEAP Assistance Eligibility* (Jan. 11, 2016), http://www.acf.hhs.gov/ocs/resource/liheap-eligibility-criteria.

[29] Ctrs. for Medicare & Medicaid Servs., *Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels*, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html (last visited June 26, 2022). Utah began offering the Medicaid expansion to households with income below 138% of the federal poverty level, with additional community engagement requirements imposed on beneficiaries that are waived during COVID-19.

[30] Gregory Acs & Pamela Loprest, Urban Inst., *Who Are Low-Income Working Families?*, at 9, Urban Inst. (Sept. 2005), https://www.urban.org/sites/default/files/publication/51726/311242-who-are-low-income-working-families-.pdf.

[31] U.S. Dep't of Agric., Econ. Rsch. Serv., *Summary Findings, Food Price Outlook*, 2022 (last updated June 24, 2022), https://www.ers.usda.gov/data-products/food-price-outlook/summary-findings/.

[32] *Id.*

[33] U.S. Bur. of Lab. Stats., Consumer Price Index Summary, at tbl. A (June 10, 2022), https://www.bls.gov/news.release/cpi.nr0.htm#cpi_pressa.f.1.

Finally, the shelter index (a measure of the costs associated with housing) rose 5.5% over the last year, which is the largest 12-month increase since 1991.[34]

B. The Intersection of Poverty and Abortion

10. Poverty levels among women and children in Utah are relevant to abortion access because poor and low-income women face higher odds of having an unintended pregnancy and abortion.[35]

11. Among women who were poor in 2011, 60% of pregnancies were unintended, and among low-income women (i.e., those with household incomes below 200% of the FPL), 52% of pregnancies were unintended.[36] The rate of unintended pregnancies for low-income women was over five times higher than it was for more affluent women in 2011, who are likely to have better access to health care services and contraception than low-income women.[37]

12. Approximately one-half of all women seeking abortion in the United States are poor, which—as noted above—means that they live in households with incomes below the FPL for their family size.[38] Additionally, another quarter of all women seeking abortion nationally live in low-income households, meaning that their household earns below 200% of the FPL.[39] Thus, roughly 75% of all women seeking abortion in the United States are either poor or low-income.[40]

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[34] *Id.* at tbl. A & "All items less food and energy."

[35] Lawrence B. Finer & Mia R. Zolna, *Declines in Unintended Pregnancy in the United States 2008–2011*, 374 New Eng. J. Med. 843, 849 (2016).

[36] *Id.* at 846 tbl. 1.

[37] *See* Am. Coll. of Obstetricians & Gynecologists, Committee Opinion No. 615, *Access to Contraception*, at 1, 3 (Jan. 2015), available at https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2015/01/access-to-contraception.pdf.

[38] Jenna Jerman et al, Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008, Guttmacher Inst., at 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

[39] *Id.*

[40] *See id.* at 11.

13. Although Utah does not collect or report income-related data about women who obtain abortions in the state, published research based on surveys of women seeking abortion in Utah between October 2013 and April 2014 indicates that 56% of survey participants reported experiencing food or housing insecurity within the previous year.[41]

14. To better conceptualize the impact of poverty on Utah abortion patients, it is helpful to know the household composition of women seeking abortion in the state. According to data provided in the Utah Department of Health's Vital Statistics Report on Abortions, 2,922 abortions were performed in 2019 (2,776 of which were for Utah residents).[42] Just over one-quarter (29%) of Utah residents who obtained abortions were married (a category that includes women separated from their spouses), while 70% were unmarried (i.e., divorced, widowed, or never-married), with the remaining women (n=16) not providing marital status.[43] About 49% of Utah residents who received abortions in 2019 had at least one prior live birth, and this percentage rose to 60% among patients 20 years and older.[44]

15. These data suggest that it is common for women seeking abortion in Utah to live in a single-parent household with at least one child. If an unmarried woman in Utah with one child is working full-time, year-round, at the current prevailing minimum wage of $7.25,[45] her annual

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[41] Lauren J. Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95 Contraception 269, 271 (2017).

[42] Utah Dep't of Health, Off. of Vital Stats., Utah Vital Statistics: Abortions 2019 (2021), at 9 tbl. 2, available at https://vitalrecords.health.utah.gov/wp-content/uploads/Abortions-2019-Utah-Vital-Statistics.pdf.

[43] *Id.* at 11 tbl. 4

[44] *Id.* at 21 tbl. R8. This figure is consistent with published research based on surveys conducted among Utah women seeking abortion between 2013 and 2014, in which roughly 50% of the survey participants had at least one previous live birth. *See* Sarah C.M. Roberts et al., *Do 72-Hour Waiting Periods and Two-Visit Requirements for Abortion Affect Women's Certainty? A Prospective Cohort Study*, 27 Women's Health Issues 400, 402 (2017).

[45] Minimum-Wage.org, *Utah Minimum Wage for 2021, 2022*, https://www.minimum-wage.org/utah (last visited June 26, 2022).

gross household income would be $15,080, or $1,256 per month. Since her income is below the 2022 FPL for a two-person family of $18,310, or $1,526 per month, she and her child are considered poor. If she earns more than $18,310 but less than $36,620 annually—between 100% and 200% of the federal poverty level for a two-person family—she and her child would be considered low-income.

16. Alternatively, a woman without children who worked full-time, year-round at minimum wage and lived alone would be considered low-income because her annual gross household income of $15,080 is equivalent to 111% of the federal poverty level for a one-person household (i.e., $13,590 annually).

C. Existing Poverty-Related Barriers That Delay Women's Access to Health Care, Including Abortion

17. Poor and low-income women, many of whom already have children, face higher barriers to accessing health care, including abortion services, than their more affluent counterparts.[46] These barriers help explain why some women experience delays in obtaining abortions, and why it is very likely that the Criminal Abortion Ban will significantly delay women seeking abortion in obtaining one out of state, in some cases preventing them from obtaining an abortion at all.

(1) Procedure Costs

18. The need to pull together financial resources to pay for abortion services is one of the reasons most frequently cited by women who would have preferred to have had their abortion

[46] *See. e.g.*, Am. College of Obstetricians & Gynecologists, Committee Opinion No. 815, *Increasing Access to Abortion*, at e109–e112 (Nov. 2014), available at https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf.

earlier.[47] These financial pressures intensify in the second trimester of pregnancy because the cost of abortion increases with gestational age.[48]

19. Research based on a survey of abortion providers in 2014 indicates that at that time, the national average cost for an abortion by procedure (a surgical abortion) at 10 weeks of pregnancy was $508 and was $535 for a medication abortion.[49] By 20 weeks of pregnancy, the median cost of an abortion was $1,195.[50] For a woman working full-time and earning the minimum wage, the cost of an abortion at 10 weeks represents between 35% and 38% of her gross monthly income; for a woman seeking an abortion at 20 weeks the full cost of the procedure alone is more than she earns in an entire month. For women who are barely able to make ends meet, scraping together the costs for abortion procedures that were even half these amounts would represent a substantial financial burden.

20. While middle-class women may be able to rely upon savings, credit cards, or other financial services to cover unexpected medical expenses, poor and low-income households have fewer options. Recent research documents that 32% of Americans lack the savings required to cover an unexpected $400 expense and that 24% of adults would be unable to pay their bills if faced with a $400 unexpected expense.[51] Nineteen percent of Americans are unbanked or under-banked, relying upon nonstandard banking options such as check-cashing services, pawn shops,

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[47] Finer et al., *supra* note 2, at 340–42; Upadhyay et al., *supra* note 2, at 1689.

[48] Stanley K. Henshaw & Lawrence B. Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35 Persp. on Sexual & Reprod. Health 16, 19 (2003), https://www.guttmacher.org/sites/default/files/pdfs/journals/3501603.pdf.

[49] Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014*, 28 Women's Health Issues 212, 215–16 & tbl. 4 (2018).

[50] *Id.* at 216.

[51] Bd. of Governors of the Fed. Reserve Sys., *Report on the Economic Well-Being of U.S. Households in 2021*, at 36 (May 2022), https://www.federalreserve.gov/publications/files/2021-report-economic-well-being-us-households-202205.pdf.

and payday lenders that charge higher fees for financial services than traditional banking options. The use of these nonstandard banking options is much higher among low-income and poor individuals.[52] Additionally, low-income households are much more likely to have their credit applications denied.[53] And while nearly 100% of households with incomes over $100,000 have at least one credit card, for households with incomes below $25,000 this drops to 57%.[54] Thus, poor and low-income families do not have access to the same types of financial strategies that middle-class families can use to mitigate the hardship that an unexpected expense creates.

21. Accordingly, in order to afford an unexpected medical expense such as abortion, poor and low-income women make trade-offs among basic needs. For example, one study of women in Arizona reported that "the majority of women seeking abortion services had to forgo or delay food, rent, childcare, or another important cost to finance their abortion."[55] In some cases, however, the timing of abortion care will need to be juggled alongside other mandatory expenses. For example, recent evidence based on bank transaction data demonstrates that "[c]onsumers increase health care spending by 60 percent in the week after receiving a tax refund, and the majority of these payments are made in person—likely for care received on that day . . . . The findings suggest that many consumers make decisions about when to pay for and receive health care based on whether they have the cash on hand."[56]

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[52] *Id.* at 43.

[53] Id. at 47.

[54] *Id.* at 48–49 & tbl. 13.

[55] Deborah Karasek et al., *Abortion Patients' Experience and Perception of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-Hour Mandatory Waiting Period Law*, 26 Women's Health Issues 60, 64 (2016).

[56] Diana Farrell et al., *Cash Flow Dynamics and Family Health Care Spending: Evidence From Banking Data*, Health Affairs Health Policy Brief (Dec. 13, 2018), https://www.healthaffairs.org/do/10.1377/hpb20181105.261680/full/.

22. Evidence documenting what is known in the literature as the "eat or treat" phenomenon further supports my view that women will make trade-offs among basic needs to afford an abortion, and that in some circumstances, women will delay seeking abortion care to ensure that other basic needs are met. The "eat or treat" phenomenon refers to a dynamic in which individuals faced with an unexpected medical expense—particularly one for which insurance coverage is not available—may be forced to decide whether to obtain food or medical care. For example, nationally representative data establish that one in three chronically ill individuals are unable to afford food, medication, or both, and that having public health insurance, such as Medicaid, reduces levels of food insecurity and medication underuse.[57]

23. Similarly, in my own research using data from Missouri and working with a set of coauthors, I examined the relationship between emergency room ("ER") visits for pregnancy-related causes and the timing of SNAP benefit receipt. Pregnant women are very sensitive to fluctuations in the quantity and quality of food consumed, and research suggests that households tend to spend their SNAP benefits soon after receiving them, and, as a consequence, consume fewer calories at the end of the month.[58] Given that non-SNAP sources of income tend to be received early in the month and exhausted in the latter part of the month, and that SNAP benefits in Missouri are distributed based on the household head's birth month and last name over the first 22 days of the month, I explored the relationship between the within-month SNAP benefit timing and pregnancy-related ER claims against the backdrop of a late-in-month scarcity of non-SNAP

[57] Seth A. Berkowitz et al., *Treat or Eat: Food Insecurity, Cost-Related Medication Underuse, and Unmet Needs*, 127 Am. J. Med. 303, 306 (2014); *see also* Dena Herman et al., *Food Insecurity and Cost- Related Medication Underuse Among Nonelderly Adults in a Nationally Representative Sample*, 105 Am. J. Pub. Health e48, e49 (2015).

[58] Parke E. Wilde & Christine K. Ranney, *The Monthly Food Stamp Cycle: Shopping Frequency and Food Intake Decisions in an Endogenous Switching Regression Framework*, 82 Am. J. of Agric. Econ. 200 (2000).

resources. I found that among Missouri women aged 17 to 45 who were of childbearing age and on SNAP and Medicaid, women who received SNAP benefits later in the month were less likely to go to the ER for pregnancy-related causes in the weeks after they received their benefits—that is, in the latter part of the month—compared to those who received their SNAP benefits earlier in the month. This finding suggests that receiving SNAP at different points in the month helped pregnant women distribute their food consumption more evenly and maintain their health.[59]

24. Given that the majority of abortions in Utah are provided to low-income women, my research suggests that the financial burden of having to pay for and travel to access abortion services is likely to act as a barrier to care, result in other basic needs not being met, or both. Those women for whom the expense of an abortion is infeasible given other basic needs may experience a delay in accessing abortion care, if they are able to access it at all. As the Board of Governors of the Federal Reserve System recently recognized: "The likelihood of skipping medical care because of cost was strongly related to family income. Among those with family income less than $25,000, 38 percent went without some medical care because they couldn't afford it, compared with 9 percent of adults making $100,000 or more."[60]

25. It is unlikely that women seeking abortion can overcome insufficient financial resources by relying on financial help from family and friends alone. First, low-income households are likely to be embedded in family and friend networks that are also struggling economically.[61] What little empirical evidence there is around financial transfers between family members suggests

[59] Arteaga et al., *supra* note 11, at 1040–41.

[60] Bd. of Governors of the Fed. Reserve Sys., *supra* note 51, at 38.

[61] *See* Colleen Heflin & Mary Pattillo, *Poverty in the Family: Race, Siblings and Socioeconomic Heterogeneity*, 25 Social Sci. Rsch. 804, 808, 818 (2006).

that such transfers are uncommon and tend to be of low monetary value.[62] Second, while some women may receive financial assistance, it is not enough to ensure that women avoid making trade-offs in essential expenses. Surveys of women who have received abortion services suggest that despite receiving financial assistance, many report experiencing financial hardships.[63]

(2) Travel-Related Costs

26. As a consequence of the Criminal Abortion Ban, transportation barriers present a series of obstacles that women in Utah must overcome in order to obtain abortion services in states where abortion remains legal. Women in Utah seeking abortions must also consider how they will pay for associated travel costs, which may further delay the timing of an abortion. "With distance come[s] increased travel time, increased costs of transportation and childcare, lost wages, need to take time off of work or school, the need to disclose the abortion to more people than desired, and overall delays in care."[64]

27. These travel-related obstacles fall particularly hard on women with low incomes. "Lower-income women who are unable to access a car or money for gas may have to travel by bus, train, or other forms of transportation, which also becomes more difficult the farther they have to travel. Delays in care due to distance or transportation can push women seeking abortion to later gestations and are likely to disproportionately affect low-income women, who may struggle to

[62] Kathleen McGarry & Robert F. Schoeni, *Transfer Behavior in the Health and Retirement Study: Measurement and the Redistribution of Resources within the Family*, 30 J. Human Rsch. S184 (1995).

[63] Karasek et al., *supra* note 55, at 64.

[64] Alice F. Cartwright et al., *Identifying National Availability of Abortion Care and Distance from Major U.S. Cities: Systematic Online Search*, 20 J. Med. Internet Rsch. e186, 1 (2018).

cover the cost of transport."[65] Thus, transportation creates its own hurdle for abortion services for low-income women due to both distance and cost in Utah.

28. Women who rely upon public transportation for long-distance travel must figure out how to get from their homes to the bus or train station, from the bus or train station to the clinic, and back again. Even in areas where ride-sharing services like Uber or Lyft are available, those services are not generally available to low-income women because they require a smartphone and a credit card—either or both of which may be inaccessible to low-income women.

29. The travel costs discussed above do not include other related costs, such as meals, local transportation, and additional nights of hotel stays.

30. Travel for medical care imposes other, less tangible costs in addition to the financial costs of the procedure and necessary transportation. Low-wage jobs have several characteristics that make an unexpected medical expense particularly burdensome, separate from the low wages themselves. First, while over 3 out of 4 of all workers have access to paid sick leave, in the service industries, where many low-wage workers are employed, 41% of workers lack access to paid sick leave.[66] In the bottom 10% of the wage distribution, that rate rises to over 65%.[67] Without sick leave, women in low-wage jobs are very likely to need to take uncompensated time off work to deal with medical issues, making it even harder to pay for the medical expense. Some employers also require workers to disclose why they are taking time off, jeopardizing women's confidentiality. Second, low-wage workers are likely to have unpredictable work schedules, with last-minute changes to the posted schedule and the total hours worked.[68] This adds to household

[65] *Id.* at 9 (citations omitted).

[66] U.S. Dep't of Lab., Bur. of La. Stats., *News Release: Employee Benefits in the United States—March 2021*, at 1 https://www.bls.gov/news.release/pdf/ebs2.pdf (Sept. 23, 2021).

[67] *Id*. at 7 tbl. 1.

[68] Bd. of Governors of the Fed. Reserve Sys., *supra* note 51, at 31.

income instability and makes it difficult to plan ahead to schedule a doctor's appointment. Additionally, women may be risking their job security by turning down work hours offered by an employer. Thus, low-wage work itself creates barriers for women navigating unexpected needs for medical care, such as abortion.

31. In addition, arranging and paying for child care presents another logistical barrier for women seeking abortion. Even as a one-day trip with a personal car, a trip out of state to access abortion could be very long and might extend beyond normal childcare hours. A woman would therefore be required to find a family or friend to drop off and/or pick up her child from childcare and to care for the child during the additional hours she is away, or find a family member or friend to provide childcare for the entire trip. An overnight stay for one or more days to obtain an abortion would further compound these logistical barriers. Standard childcare arrangements are not available for overnight care. Once again, women must rely upon family and friends to help care for their child while they seek health care. In order to make such an arrangement, a woman likely must disclose the reason for her trip, resulting in a further loss of confidentiality.

32. According to a study conducted after Utah switched from a 24- to 72-hour waiting period, "[c]lose to two-thirds (62%) [of patients] reported the 72-hour wait affected them negatively in some way, including the lost wages of needing to take extra time off work (47%), increased transportation cost (30%), [and] lost wages by family or friend(s) (27%) . . . ."[69] The same, and further, research also suggests that between 6% and 33% of women seeking abortion in

[69] Jessica N. Sanders et al., *The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion*, 26 Women's Health Issues 483, 483 (2016).

Utah experienced a loss of confidentiality in order to make logistical arrangements required to comply with the 72-hour waiting period.[70]

33. As should be clear from the picture provided above of the challenges that poor and low-income women face in obtaining abortion services, financial and logistical challenges often delay women's access to abortion even after women are aware of their pregnancy and have made the decision to have an abortion. The suggestion that patients can avoid the hardship imposed by the Criminal Abortion Ban by simply traveling to an appointment in another state ignores the reality of poor and low-income women's lived experience.

D. Additional Burdens That the Criminal Abortion Ban Imposes on Poor and Low-Income Women

34. It is my opinion that the Criminal Abortion Ban will significantly exacerbate existing financial and logistical barriers to abortion access among poor and low-income women in Utah. These women would be forced to forgo other essential needs in order to access abortion in other states, or to forgo abortion care altogether.

35. Because the Criminal Abortion Ban has outlawed abortion in virtually all circumstances in Utah, virtually all women throughout Utah will be forced to travel out of state, and, in doing so, travel even greater distances in order to obtain abortion services, in most instances incurring significantly greater travel-related expenses and logistical burdens than if they could obtain an abortion in their home state.

[70] *Id.* (33%); Sarah C.M. Roberts et al., *Utah's 72-Hour Waiting Period for Abortion: Experiences Among a Clinic-Based Sample of Women*, 48 Persp. on Sexual and Reprod. Health 179, 183 (2016) (6%).

36. For all the reasons discussed above, this additional travel would impose severe logistical and financial burdens on women in Utah seeking an abortion, if they are able to obtain an abortion at all.

37. To the extent that poor or low-income women could afford travel to another state to obtain an abortion, I expect that the burden of that travel would force even greater trade-offs in terms of meeting basic needs.

38. Given the documented monthly instability among low-income households in both income (resources flowing in) and expenses (resources flowing out), it is widely acknowledged that many households come up short each month and, as a consequence, experience material hardship. In my own research, I have documented that over 15% of American households were unable to pay essential expenses, over 12% were unable to see a doctor or dentist when they needed to because of their inability to pay, over 11% were food insecure, and over 7% could not pay their rent or mortgage.[71] More recent evidence from a nationally representative survey conducted in late 2017 suggests rates of material hardship that are even higher—with 10.2% of American families missing a rent or mortgage payment, 13.0% missing a utility payment and 4.3% experiencing a utility shut-off, 18% reporting problems paying family medical bills, and 17.8% indicating that they had an unmet need for medical care due to cost.[72] Furthermore, according to data from the 2014 Hunger in America Survey from Feeding America, among clients receiving informal food assistance, who are likely to be low-income, approximately 2 out of 3 reported having to choose

[71] Heflin, *supra* note 3, at 365–66.

[72] Michael Karpman et al., Urban Inst., *Material Hardship Among Nonelderly Adults and Their Families in 2017*, 7 fig. 1 (Aug. 2018), https://www.urban.org/sites/default/files/publication/98918/material_hardship_among_nonelderly_adults_and_their_families_in_2017.pdf.

between food and paying for medical care, between food and utilities, or between food and transportation, and nearly 3 out of 5 reported making trade-offs between food and housing.[73]

39. Women who use their rent money to pay for abortion services can be evicted from their home, leaving them and their families homeless. Those who use money they had allocated for their phone, water, gas, or electricity bill to pay their travel expenses risk having their utilities disconnected, forcing them to go without water, heat, or light until they can pay a reconnection fee on top of their original bill in order to re-establish services with the utility company. In my own research, for example, I have documented how utility shut-offs impact the entire family:

> They could interfere with children's ability to complete homework, and extended non-payment can mean legal consequences, involvement of a collection agency, and damage to an individual's credit rating. Telephone terminations, in contrast, occurred more frequently. For some women, telephone disconnection caused emotional distress because they were unable to maintain contact with their children while they were at work and they worried about being unable to telephone for help in the case of an emergency.[74]

Other women may forgo other transportation costs (gas, car insurance, car payment, or repairs), making it impossible for them to get to work and putting them at risk of losing their job. However, in the face of an unexpected medical expense such as an abortion, most low-income households will decide to forgo food in order to keep their cars running.[75]

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[73] Nancy S. Weinfield et al., *Feeding America, Hunger in America 2014: National Report*, at 135 tbl. 5-2 (Aug. 2014), http://help.feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf.

[74] Colleen Heflin et al., *Mitigating Material Hardship: The Strategies Low-Income Families Employ To Reduce the Consequences of Poverty*, 81 Soc. Inquiry 223, 232 (2011).

[75] Kathryn Edin et al., *SNAP Food Security In-Depth Interview Study: Final Report*, U.S. Dep't of Agric., at 21–22 (2013).

40. If a woman decides to pay for her abortion services by forgoing other basic expenses and she already has children, as many women who seek abortion services in Utah do,[76] there could be dire consequences for the children as well. Children who are exposed to food insecurity face a number of negative consequences ranging from poor cognitive outcomes, physical and mental health consequences, and behavioral consequences.[77] Ultimately, the stress of living in conditions of material hardship has been shown to negatively alter the socio-emotional environment in the home and cause further harm to children.[78]

41. Not surprisingly given this context, research consistently shows that increasing the travel distance required to obtain an abortion prevents women from obtaining abortions that they would have had otherwise. For example, a rigorous study by Lindo and colleagues examines the reduction in the abortion rate in Texas after House Bill 2 ("HB2") went into effect in late 2013, causing clinics to close.[79] This study estimates the reduction in the number of abortions causally related to increased travel distances as a result of clinic closures. According to Lindo and colleagues, for women living within 200 miles of an abortion clinic, there are substantial and statistically significant effects of increasing distance to abortion providers.[80] It is my opinion that

[76] Utah Dep't of Health, Off. of Vital Stats, *supra* note 42; Roberts et al., *supra* note 44, at 402; Ralph et al., *supra* note 41, at 273.

[77] Linda Weinreb et al., *Hunger: Its Impact on Children's Health and Mental Health*, 110 Pediatrics e41 (2002), https://pediatrics.aappublications.org/content/pediatrics/110/4/e41.full-text.pdf.

[78] Elizabeth T. Gershoff, et al., *Income Is Not Enough: Incorporating Material Hardship Into Models of Income Associations With Parenting and Child Development*, 78 Child De. 70, e19 (2007).

[79] Jason M. Lindo, et al., *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortion*, NBER Working Paper No. 23366, at 1 (2020).

[80] *See id*. at 2.

the methodology used by these authors is robust and provides a causal analysis of the effect of increased travel distances on abortion rates.[81]

42. As a result of the Criminal Abortion Ban and the additional travel expenses associated with obtaining abortion services, it is likely that many women who would otherwise seek abortion services will be unable to obtain them.

43. Not obtaining an abortion can have financial consequences, too. There is good evidence that a woman forced to forgo abortion care to meet other basic needs suffers negative economic consequences. The Turnaway Study, a nationwide study conducted by researchers at the University of California San Francisco, documents that women who were unable to obtain an abortion were three times more likely to be unemployed six months later, nearly four times more likely to have fallen below 100% of the FPL, more likely to be receiving public assistance benefits, and more likely to be raising children alone, as compared to women who were able to obtain an abortion. Furthermore, the negative consequences to economic well-being were shown to persist four years later compared to women who were able to obtain an abortion.[82]

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[81] I have also reviewed studies by Fischer and colleagues and Quast and colleagues, which undertook similar analyses of the impact of increased driving distances on the abortion rate in Texas after HB2 took effect. *See* Stefanie Fischer et al., *The Impacts of Reduced Access to Abortion and Family Planning Services: Evidence from Texas* (NBER, Working Paper No. 23634, 2017); Troy Quast et al., *Abortion Facility Closings and Abortion Rates in Texas*, 54 Inquiry 1 (2017). As the studies used slightly different methodologies and/or different data compared to the Lindo study, they produced somewhat different results. It is my opinion that the Lindo study provides the best estimate to date of the reduction in the abortion rate as a result of increased driving distance. But all three studies found that increases in driving distance led to substantial reductions in the abortion rate.

[82] Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 Am. J. Pub. Health 407, 409–11 (2018); *see also* Sarah Miller et al., NBER Working Paper No. 2, *The Economic Consequences of Being Denied an Abortion*, NBER Working Paper No 26662, at 2 (revised Jan. 2022), available at https://www.nber.org/system/files/working_papers/w26662/w26662.pdf.

44. Individuals who carry a pregnancy to term and parent the child must also find a way to pay for the costs of raising a child. On average, following the birth of a child, women experience what is known in the literature as a "child penalty" in the labor force. According to recent work by two US Census Bureau researchers, "women experience a large and persistent decrease in earnings and labor force participation after having their first child. The penalty grows over time, driven by the birth of subsequent children."[83] In Utah, the median cost of infant care was more than $11,000 per year for center based care,[84] and Utah is the second least affordable state for infant and toddler care in a center.[85] These costs can be particularly impactful for people who do not have partners or other support systems in place, such as single parents.

45. Further, unlike eleven states and the District of Columbia, Utah does not require employers to provide paid family leave, meaning that for many pregnant Utahns, time taken to recover from pregnancy and childbirth or to care for a newborn is unpaid.[86] A typical Utahn who takes four weeks of unpaid leave could lose more than $3,000 in income.[87]

VI. CONCLUSION

46. The costs of an abortion procedure, associated transportation, and other related expenses already impose a significant burden on poor and low-income women in Utah. The enforcement of the Criminal Abortion Ban is likely to significantly exacerbate these burdens. And

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[83] Danielle Sandler & Nichole Szembrot, *Maternal Labor Dynamics: Participation, Earnings, and Employer Changes*, The Ctr. for Econ. Studies, U.S. Census Bur., Working Paper No. CES 19-33 (2019).

[84] Catherine Ruetschlin & Yazgi Genc, *Utah 2021 Child Care Market Rate Study*, at 4 tbl. 1.1 (May 2021), available at https://jobs.utah.gov/occ/occmarket.pdf.

[85] Utah Valley Univ., Utah Women & Leadership Proj., *Utah Women Stats: Research Snapshot*, at 1–2 (Sept. 5, 2018), available at https://www.usu.edu/uwlp/files/snapshot/25.pdf.

[86] Nat'l Partnership for Women & Fams., *Paid Leave Means a Stronger Utah*, at 1 (Feb. 2022), available at https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/paid-leave-means-a-stronger-utah.pdf (Feb. 2022).

[87] *Id.*

it is likely that many poor and low-income women would be unable to avoid its prohibitions by traveling to another state.

47. Increased travel distances come with a host of other related and increased costs, such as meals, lodging, and child care. I know from my own research, and based on the extensive literature on the subject, that in order to afford additional, unexpected costs like those required for travel out of state to obtain an abortion, poor and low-income women are forced to make trade-offs in their monthly budgets and to forgo basic necessities including food, jeopardizing their own health and well-being and that of their families, if they are able to obtain the abortion at all.

I declare under penalty of perjury under the laws of the United States of America and the State of Utah that the foregoing statements are true and correct to the best of my knowledge, information, and belief.

Signed on the 28 day of June, 2022, in Syracuse, New York.

Colleen M. Heflin, Ph.D.

Exhibit A

Colleen M. Heflin

Maxwell School of Citizenship and Public Affairs
Syracuse University

Research and Teaching Interests

Social policy, food and nutrition policy, social demography

EDUCATION

2002 Ph.D. in Sociology, University of Michigan
1995 Master of Public Policy, Gerald Ford School of Public Policy, University of Michigan
1992 Bachelor of Arts with Honors in Social Sciences, University of Michigan

Positions

2022–present	Associate Dean of the Maxwell School and Chair of Public Administration and International Affairs
2017–present	Professor, Public Administration and International Affairs, Maxwell School of Citizenship and Public Affairs, Syracuse University
2017–present	Senior Research Associate, Center for Policy Research, Syracuse University
2020-present	Research Affiliate, University of Wisconsin Institute for Policy Research
2018-present	Research Affiliate, University of Kentucky Center for Poverty Research
2014–present	Member of External Review Board, *Social Service Review*
2016–2017	Professor, Harry S Truman School of Public Affairs, University of Missouri
2014–2017	Founding Co-Director of Population, Education and Health Center
2014–2017	Founding Co-Director of the University of Missouri Research Data Center
2008–2017	Research Affiliate, Institute for Public Policy, University of Missouri
2013–2016	Member of the External Review Board, Southern Rural Development Center RIDGE Program, Purdue University
2010–2016	Associate Professor, Harry S Truman School of Public Affairs, University of Missouri
2007–2010	Assistant Professor, Harry S Truman School of Public Affairs, University of Missouri
2005–2014	Research Affiliate, National Poverty Center, University of Michigan
2002–2007	Assistant Professor, Martin School of Public Policy, University of Kentucky
2002–2007	Executive Board Member, University of Kentucky Center for Poverty Research
1997–2002	Senior Research Associate, Michigan Poverty Research and Training Center, University of Michigan

Peer-Reviewed Publications

Heflin, Colleen and Taryn Morrissey. (forthcoming). "Patterns of Earnings and Employment by Worker Sex, Race, and Ethnicity Using State Administrative Data: Results from a Sample of Workers Connected to Public Assistance Programs." *Race and Social Problem.*

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Danziger, Sandra K., Mary E. Corcoran, Sheldon Danziger, Colleen Heflin, Ariel Kalil, Daniel Rosen and Richard Tolman. 2000. "Barriers to the Employment of Welfare Recipients." In Cherry (editor). *Prosperity for All?: The Economic Boom and African Americans*. Russell Sage Foundation: New York, NY.

Corcoran, Mary, Colleen Heflin and Belinda Reyes. 1999. "Latino Women in the U.S.: The Economic Progress of Mexicans and Puerto Ricans." In *Latinas and African American Women at Work: Race, Gender and Economic Inequality*. Russell Sage Foundation: New York, NY.

Corcoran, Mary and Colleen Heflin. 1999. “Race, Ethnic and Skill-Based Inequalities in Women’s Earnings” in Proceedings and Papers: Conference for the Institute for Women’s Policy Research.

Gramlich, Edward and Colleen Heflin. 1998. "The Spatial Dimension: Should Worker Assistance be Given to Poor People or Poor Places?" In Richard Freeman and Peter Gottschalk (editors.) *Demand-Side Strategies Affecting Low Wage Labor Markets.* Russell Sage Foundation: New York, NY.

Working Papers

Meckstroth, Alicia, Andrew Burwick, Quinn Moore, Colleen Heflin, Jonathan McCay, and Michael Ponza. 2016. “The Effects of an Intensive Life Skills Education and Home Visiting Program on the Employment, Earnings, and Well-Being of At-Risk Families.” Mathematica Policy Research Working Paper.

Heflin, Colleen and Peter Mueser. 2013. “Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutrition Assistance Program.” IZA Discussion Paper No. 7772.

Wilmoth, Janet, Andrew London and Colleen Heflin. 2013. “The Use of VA Disability Benefits and Social Security Disability Insurance among Working-Aged Veterans.” Boston College Center for Retirement Research Working Paper No. 2013-5.

Heflin, Colleen. 2004. “Who Exits the Food Stamp Program After Welfare Reform?” Institute for Research on Poverty Working Paper DP-1279-04, University of Wisconsin, Madison.

Heflin, Colleen. “Exit Routes From Welfare: Examining Barriers to Employment, Demographic, Human Capital Factors.” University of Kentucky Center for Poverty Discussion Paper 2003-03.

Policy Briefs

Heflin, Colleen. April 2017. “The Great Recession and the Rise in Material Hardship.” Family Self-Sufficiency and Stability Research Consortium, 2013-2018. Office of Planning, Research & Evaluation, Office of the Administration for Children & Families.

Heflin, Colleen, Peter Mueser, and Jacob Cronin. April 2017. “How Accurate is Online Information about SNAP?” Institute for Public Policy, University of Missouri. Report 04-2017.

Heflin, Colleen, Jennifer Keller Jensen and Kathleen K. Miller. May 2013. “Community Resilience: Understanding the Economic Impacts of Disruptions in Water Service.” Institute for Public Policy, University of Missouri. Policy Brief. Report 05-21013.

Vancil, A, Sandy Rikoon, Matthew Foulkes, Joan Hermsen, Colleen Heflin, and Nicole Raedeke. April 2013. “Regional Profile of Missouri Food Pantry Clients and Households.” Institute for Public Policy, University of Missouri. Policy Brief. Report 04-2013.

Dabson, Brian, Colleen Heflin and Kathleen Miller. February 2012. “Regional Resilence: Research and Policy Brief.” RUPRI Rural Futures Lab, University of Missouri.

Heflin, Colleen and Kathleen Miller. June 2011. Geography of Need: Identifying Human Service Needs in Rural America." RUPRI White Paper.

Rysavy, Matt and Heflin, Colleen. August 2009. **"**Food Insecurity, Food Stamp Participation and Poverty: The Paradox of Missouri." Institute of Public Policy, University of Missouri.

Heflin, Colleen and James Ziliak**.** December 2008. **"**Food Insufficiency, Food Stamp Participation and Mental Health." Policy Brief. Institute of Public Policy, University of Missouri.

RESEARCH GRANTS RECEIVED

Principle Investigator. "Increasing access to SNAP for older adults through the Standard Medical Deduction". National Institute of Aging through the Center the Aging and Policy Studies. (7/1/21-5/31/22) ($34,000). Joint with Jun Li.

Principle Investigator. "Employment Instability as a Barrier to Child Care." Robert Wood Johnson Foundation. 4/15/2021-5/31/22. ($75,000). Joint with Taryn Morrissey.

Principle Investigator. "Increasing WIC Participation by Linking with SNAP and other Social Programs". Share our Strength. 3/1/2021-6/30/2022 ($25,000).

Co-Investigator. *"*Food insecurity and chronic diseases in low-income older Americans: The role of SNAP receipt in medication underuse" University of Kentucky Center for Poverty Research. 02/25/2020 – 02/24/2022 ($249,888) with Irma Arteaga (Principle Investigator), Leslie Hodges (Co-Investigator) and Chinedum Ojinnaka (Co-Investigator).

Principle Investigator. *"*Changing Patterns of Eligibility and Take up in SNAP and the Roles of Out-of-Pocket Medical Expense" University of Kentucky Center for Poverty Research. 02/25/2020 – 02/24/2021 ($49,888) with Dongmei Zuo, Co-Investigator.

Principle Investigator. "Hunger SNAPs: Food Insecurity among Older Adults." Russell Sage Foundation. 5/1/2020-12/31/22. ($35,000).

Principle Investigator. "Advancing understanding of the conditions of parents' employment on access to and maintenance of child care and child-care subsidies." Robert Wood Johnson Foundation. 1/15/2020-1/14/22. ($150,000). with Taryn Morrissey, Co-Investigator.

Principle Investigator. "SNAP Uptake and School Readiness in Virginia." Economic Research Service, United States Department of Agriculture. 8/14/18-9/14/20 ($100,000) with Michah Rothbart, Co-Investigator.

Principle Investigator. "Creating Evidenced-Based Strategies to Address Administrative Churn in SNAP." Economic Research Service, United States Department of Agriculture. 8/1/2018-7/30/2020. ($120,101) with Len Lopoo, Co-Investigator.

Principle Investigator. "Does Child Support Increase Self-Sufficiency?: Evidence from Virginia". National Institute for Health through the Institute for Research on Poverty (IRP)'s

Extramural Small Grants program for Research. 3/1/18-2/28/19. ($24,847) with Len Lopoo, Co-Principal Investigator.

Principal Investigator. "SNAP and Child Health: Evidence from Missouri Administrative Data." Economic Research Service, United States Department of Agriculture. 8/25/2016–8/1/2018 ($99,997). With Peter Mueser and Irma Arteaga, Co-Investigators.

Co-Principal Investigator. "Understanding SNAP and Food Security among Low-Income Households." University of Kentucky Center for Poverty Research; Economic Research Service, United States Department of Agriculture. 4/30/2015–6/30/2018 ($400,000). With James P. Ziliak, Co-Principal Investigator.

Principal Investigator. "Community Eligibility and Child Well-Being." Research Innovation and Development Grants in Economics (RIDGE) Center for Targeted Studies at the Southern Rural Development Center, Mississippi State University. 8/1/2015–12/31/2016 ($34,987). With Daniel P. Miller, Co-Principal Investigator.

Co-Principal Investigator. "Design Flaws: The Effect of the Coverage Gap in Food Assistance Programs on Child's Well-Being." University of Wisconsin–Madison, Institute for Research on Poverty, RIDGE Center for National Food and Nutrition Assistance Research. 7/1/2015–12/31/2016 ($39,962). With Irma Arteaga, Co-Principal Investigator.

Principal Investigator. "Family Self-Sufficiency and Stability and Material Hardship: The Role for Public Policy after the Great Recession." US Department of Health and Human Services, Administration for Children and Families. 9/30/13–9/29/18 ($500,000).

Co-Principal Investigator. "Census Research Data Center." National Science Foundation. 8/15/2014–7/31/2017 ($0).

Principal Investigator. "The Mediating Effects of SNAP on Health Outcomes for Low-Income Households." Cooperative Research Agreement. Economic Research Service, United States Department of Agriculture. 7/1/2014–6/30/2016 (in no-cost time extension; $100,000).

Principal Investigator. "Secondary Analyses of Strengthening Families Datasets: Economic Strain and Family Formation." US Department of Health and Human Services, Administration for Children and Families. 9/30/14–8/1/16 ($99,343).

Principal Investigator, "Understanding the Rates, Causes and Costs of Churning in SNAP." Urban Institute. 8/1/2013–7/15/2014 ($32,561). With Peter Mueser, Co-Investigator.

Principal Investigator, "Participation in the National School Lunch Program and Food Security: A Regression Discontinuity Design Analysis of Transitions into Kindergarten." Southern Rural Development Center RIDGE Program. 7/1/2012–12/31/2013 ($34,934). With Irma Arteaga, Co-Investigator.

Principal Investigator. "Joint Participation in SNAP and UI in Florida" USDA-FANRP Economic Research Service. 4/15/2010-5/14/2020 ($242,830). With Peter Mueser, Co-Investigator.

Co-Investigator. "The Intersection of Veteran's Benefits Programs and Disability Insurance among Veterans: A Synthetic Cohort Approach Using the Survey of Income and Program Participation (SIPP)." Boston College/Social Security Administration.

10/1/2011–9/30/2012 ($85,817). With Janet Wilmoth and Andrew London, Co-Investigators.

Principal Investigator. "Families with Hungry Children and the Transition from Preschool to Kindergarten." University of Kentucky Center for Poverty Research; Economic Research Service, United States Department of Agriculture. 7/1/2011–9/30/2012 ($45,000). With Irma Arteaga and Sara Gable, Co-Investigators.

Co-Investigator. "A Food Systems Approach to Addressing Obesity Among Food Pantry Clients in Missouri." USDA-AFRI Human Nutrition and Obesity Program. 1/01/2010–4/30/2013 ($432,171).

Principal Investigator. "Veteran Status, Disability, Poverty, and Material Hardship." National Center for Poverty Research at the University of Michigan/US Census Bureau. 2010 ($20,000).

Principal Investigator. "Localizing Estimates of Hunger: Creating County-level Estimates of Food Insecurity." Research Council Fellowship, University of Missouri. 2010 ($7,000).

Principal Investigator. "Assessing the Impact of On-Line Applications in Florida's Food Stamp Caseload." Regional Small Grant Program, University of Kentucky Center for Poverty Research. 2008-2009 ($20,000)

Principal Investigator. "Assessing the Impact of On-Line Applications in Florida's Food Stamp Caseload." 2008 RIDGE Program sponsored by the Southern Rural Development Center in partnership with the Economic Research Service, U.S. Department Agriculture. 2008-2009 ($35,000).

Principal Investigator, "The Impact of Improving Access to Benefits for Low-Income Families on Caseload Characteristics and Dynamics." Research Board Fellowship, University of Missouri. 2008-2009 ($33,498).

Principal Investigator, "Do Middle Class Members Take on Debt in Order to Help Their Poor Siblings Weather Shocks?" Summer Research Fellowship Competition, University of Missouri. 2008-2009 ($7,000).

Principal Investigator, "State-Level Variation in Material Hardship Among Households with Children." West Coast Poverty Center. 2007–2008 ($15,000).

Principal Investigator, "Does the Size of the Check Matter? New Results on the Effects of Welfare Receipt on Early Childhood Cognitive Scores." Spencer Foundation. 2006-2007 ($39,840).

Principal Investigator, "Social Capital and Race Inequality." Research Support Grant, University of Kentucky. 2005–2006 ($19,204).

Principal Investigator, "Does Variation in Transfer Program Participation and Generosity at the State Level Explain Variation in Mental Health?" University of Kentucky Center for Poverty Research. 2005 ($19,124).

Summer Faculty Research Fellowship, University of Kentucky. 2005 ($6,000).

Principal Investigator, "Determinants of Different Forms of Material Hardship in the Women's Employment Survey." Small Grant Program, Institute for Research on Poverty, University of Wisconsin-Madison. 2004–2005 ($34,913).

Principal Investigator, "Does Food Stamp Receipt Mediate the Relationship Between Food Insecurity and Mental Health?" The National Poverty Center. 2003-–2004 ($19,783). With James Ziliak, Co-Investigator.

Principal Investigator, "Household Food Insecurity and the Physical and Mental Health of Low-Income Men and Women." NSAF Small Research Grants Program, Association for Public Policy and Analysis and Management (funded by Annie E. Casey Foundation). 2003-2004 ($20,000).

Principal Investigator, "An Individual-Level Analysis of Food Stamp Dynamics." Small Grant Program, Institute for Research on Poverty, University of Wisconsin-Madison. 2002-–2003 ($31,922).

Co-Principal Investigator, "Do Women's Wages Depreciate While on Welfare?" U.S. Census Bureau/Joint Center for Research on Poverty. 2002–2003 ($29,966). With Mary Noonan, Principal Investigator.

Co-Principal Investigator, "Barriers to Work Among Housing Assistance Recipients on Welfare." United States Department of Housing and Urban Development. 1999–2001 ($49,870). With Mary Corcoran, Principal Investigator.

Collaborator. "Causes and Consequences of Food Insufficiency and Material Hardships as Welfare Recipients Move from Welfare to Work." Economic Research Service, U.S. Department of Agriculture. 1999–2000 ($200,354). With Kristine Siefert and Mary Corcoran, Principal Investigators.

Collaborator. "Food Insecurity and Welfare Reform." Institute for Research on Poverty, University of Wisconsin-Madison. 1999–2000 ($49,704). With Mary Corcoran and Kristine Siefert, Principal Investigators.

CONTRACTS

Consultant. "Feeding America SNAP Program Evaluation Multi-Site Case Study." Feeding America. June 2013–November 2014.

Consultant. "Evaluation of Missouri PREP Program." Missouri Department of Health and Senior Services. June 2011–May 2015.

INVITED PRESENTATIONS

"How will you measure the success of your intervention?" Invited Speaker for SNAP and Nutrition Support Monthly Cohort Meeting. Share Our Strength Advisory Committee. August 18, 2021.

"Building a Culture of Evidence: Opportunities and Challenges." Invited Speaker for Data and Evidence Community of Practice Learning Series on Data Visualization and Program Evaluation for American Public Health Service Association. June 29, 2021. (online)

"Examining the Hunger Crisis Among Veterans and Military Families." Invited Congressional Testimony before the Rules Committee, United States House of Representatives. May 27, 2021. (online)

"Exploring Material Hardship and Administrative Burden." Invited Speaker for TANF Workforce Development Workgroup for American Public Human Service Association. February 27, 2021. (online)

"How Does the System Hurt or Help?: Exploring Material Hardship and Administrative Burden" Invited Speaker at University of Minnesota Future Services Institute's Redesign for Whole Families Summit. October 13th, 2020.

"Reflections on household food insecurity research from a US Perspective" Keynote Speaker at 2nd UK Conference on Food and Poverty: Evidence for Change. London, England. June 23rd, 2020.

"The Value and Limits of Linking Administrative Data" Invited speaker at the National Academy of Sciences Committee on National Statistics Panel on Improving USDA's Consumer Data for Food and Nutrition Policy Research. September 21, 2018. Washington, DC.

"Household Instability and Material Hardship." Invited speaker at the 2016 MU Extension Summit, University of Missouri. October 26, 2016. Columbia, MO.

"The Mediating Effects of SNAP on Health Outcomes for Low Income Households." Invited speaker in Center for Research on Inequalities and the Life Course Seminar, Yale University. April 27, 2016. New Haven, CT.

"Community and Systematic Approaches to Hunger: Social Protections." Invited speaker at the Hunger Summit hosted by Universities Fighting World Hunger (partnership of the United Nations World Food Program and Auburn University). February 26, 2016. Columbia, MO.

"Reflecting on 20 years of Measuring Household Food Security," Invited speaker at the US Department of Agriculture - Economic Research Service, October 21, 2015. Washington, DC.

"The Mediating Effects of SNAP on Health Outcomes for Low Income Households." Invited speaker in the West Virginia University Public Health Dialogues. October 2, 2015. Morgantown, WV.

"In Tandem: Pairing Public and Private Nonprofit Assistance to Make Ends Meet." Invited speaker at The School of Public Affairs at American University and Feeding America, July, 2015. Washington, DC.

"Hot Topics for Program Evaluation." Invited speaker at Feeding America's 2014 Agency Capacity, Programs and Nutrition Annual Conference. October 30, 2014. Chicago, IL.

"Using Program Evaluation to Drive Decision-Making." Invited speaker at Feeding America's 2014 Agency Capacity, Programs and Nutrition Annual Conference. October 30, 2014. Chicago, IL.

"The War on Poverty: 50 Years Later and the Battle Continues" Invited speaker at a congressional briefing hosted by the Population Association of America and the

Association of Population Centers in conjunction with Congressman Mike Honda. June 9, 2014. Washington, D.C.

"Household Instability and Material Hardship." Invited speaker at Poverty, Policy and People: 25 Years of Research and Training at the University of Michigan. April 10, 2014. Ann Arbor, MI.

"Material hardship and the case for measurement." Invited speaker at the Presidential Plenary: Poverty Measurement and Implications for Policy. Southern Sociological Society. April 3, 2014. Charleston, NC.

"Individual and Family Coping Responses to Hunger." Invited speaker at the Workshop on Research Gaps and Opportunities in Child Hunger and Food Insecurity at the Committee on National Statistics. National Academy of Sciences, Food and Nutrition Board, Institute of Medicine. April, 2013.

"Short-Term Dynamics of Food Insecurity and Obesity." Invited speaker at Institute of Medicine Workshop on Understanding the Relationship Between Food Insecurity and Obesity. November 16-19, 2010. Washington, D.C.

OTHER PRESENTATIONS AND CONFERENCES

Chinedum Ojinnaka, Irma Arteaga, Leslie Hodges, Lauryn Quick and Colleen Heflin. "SNAP Participation and Medication Adherence Among Older Medicaid-Insured Individuals Living with Hypertension" Academy Health 2022 Annual Research Meeting. June 5, 2022. Washington, DC.

Colleen Heflin, Leslie Hodges, Chinedum Ojinnaka, Irma Arteaga and Lauryn Quick. "Churn in the older adult SNAP Population." Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Colleen Heflin, Jun Li and Dongmei Zuo. "Increasing Access to the SNAP for Older Adults Through the Standard Medical Deduction." Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Michah Rothbart, Colleen Heflin, Taryn Morrissey, and Xioahan Sun. "Does Offering Public PreK Change Social Program Participation?" Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Taryn Morrissey, Colleen Heflin and William Clay Fannin. "Room to Grow: Examining Participation and Stability in the Child Care Subsidies Using State Administrative Data." Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Colleen Heflin and Xioahan Sun. "Food Insecurity and the Opioid Crises." Annual Meeting of the Population Association of America. Atlanta, GA. April 7, 2022.

Clay Fannin, Colleen Heflin, and Leonard Lopoo. "Local Control, Discretion, and Administrative Burden: SNAP Interview Waivers and Caseloads during the COVID-19 Pandemic." Annual Research Conference of the Association for Public Policy Analysis and Management. March 28, 2022. (online)

Colleen Heflin, Jun Li, and Dongmei Zuo. “Changing patterns of eligibility and take up in SNAP and the role of out-of-pocket medical expenses.” *Understanding Food-Related Hardships Among Older Americans FNS Reporting Conference.* May 28, 2021. (online)

Colleen Heflin and Hannah Patnaik. “Material Hardships and the Living Arrangements of Older Americans” Population Association of America. April 6, 2021. (online)

Colleen M. Heflin, Michah W. Rothbart and Mattie Mackenzie-Liu. “Below the Tip of the Iceberg: Examining Early Childhood Participation in SNAP and TANF from Birth to Age Six.” Fall Research Conference of the Association for Public Policy Analysis and Management. November 10, 2020.

Leonard Lopoo, Heflin, Colleen, and Joe Boskovski. “Testing Behavioral Interventions Designed to Improve On-Time SNAP Recertification” Fall Research Conference of the Association for Public Policy Analysis and Management. November 11, 2020.

Michah Rothbart and Colleen Heflin. “Achievement Gaps” from Day 1? Evidence on School Readiness by Economic Disadvantage and Race.” Fall Research Conference of the Association for Public Policy Analysis and Management. November 12, 2020.

Colleen Heflin and Dongmei Zuo. "Cognitive Impairment and SNAP Participation among Eligible Older Americans" Fall Research Conference of the Association for Public Policy Analysis and Management. November 12, 2020

Heflin, Colleen, Leonard Lopoo, and Mattie Mackenzie-Liu, “When States Coordinate between Social Welfare Programs: Considering the Child Support Income Exclusion”. Fall Research Conference of the Association for Public Policy Analysis and Management. November 7-9, 2019. Denver, CO.

Bullinger, L.R., Heflin, C.M., & Raissian, K.M. “SNAP and Child Maltreatment” Fall Research Conference of the Association for Public Policy Analysis and Management. November 7-9, 2019. Denver, CO.

Heflin, Colleen, Leonard Lopoo, and Mattie Mackenzie-Liu, “When States Coordinate between Social Welfare Programs: Considering the Child Support Income Exclusion” Increasing Family Income through Child Support: Lessons from Recent Research. Institute for Research on Poverty, University of Wisconsin-Madison and Assistant Secretary for Planning and Evaluation, US. Dept. of Health and Human Services. September 18, 2019. Washington, DC.

Heflin, Colleen. “Food and Nutrition Policy across the Life Course.” American Sociological Association.” August 13, 2019. New York, NY.

Sharon Kukla-Acevedo and Colleen Heflin. “Adolescent Food Insecurity and the Transition to Adulthood.” Research on Food Security Using the Panel Study of Income Dynamics, September 20, 2018. Washington, DC.

Colleen Heflin, Rajeev Darolia, and Sharon Kukla-Acevedo. “Exposure to Food Insecurity during Adolescence and the Educational Consequences.” Fall Research Conference of the

Association for Public Policy Analysis and Management. November 1-4, 2017. Chicago, IL.

Claire Altman, Chaeyung Jun and Colleen Heflin. "Hardships of Undocumented Immigrants in the United States: Evidence from the 1996-2008 SIPP." Fall Research Conference of the Association for Public Policy Analysis and Management. November 1-4, 2017. Chicago, IL.

Colleen Heflin, Sharon Kukla-Acevedo, and Rajeev Darolia. "Risky Adolescent Behaviors and the Role of Food Insecurity." Fall Research Conference of the Association for Public Policy Analysis and Management. November 1-4, 2017. Chicago, IL.

Altman, Claire, Colleen Heflin, and Chaegyung Jun. "The Many Hardships of Undocumented Immigrants in the United States: Evidence from SIPP 1996-2008." 2017 American Sociological Association Annual Meeting. August 12-15, 2017. Montreal, Quebec, Canada.

Altman, Claire, Colleen Heflin, and Chaegyung Jun. "The Many Hardships of Undocumented Immigrants in the United States: Evidence from SIPP 1996-2008" (poster presentation). 2017 Population Association of America Annual Meeting. April 27-29, 2017. Chicago, IL.

Arteaga, Irma, Heflin, Colleen, Leslie Hodges and Peter Mueser. "Does the Timing Matter for SNAP Benefits and Pregnancy-Related Emergency Room Visits?" Fall Research Conference of the Association for Public Policy Analysis and Management. November 3-5, 2016. Washington, DC.

Heflin, Colleen. "Social Program Participation and Material Hardship." Fall Research Conference of the Association for Public Policy Analysis and Management. November 3-5, 2016. Washington, DC.

Arteaga, Irma, Colleen Heflin and Sarah Parsons. "The Coverage Gap." Annual meeting of the Population Association of America. March 31, 2016. Washington, DC.

Mueser, Peter, Colleen Heflin and Leslie Hodges. "The Mediating Effects of SNAP on Health Outcomes for Low-Income Households." Annual meeting of the Association of Public Policy & Management. November 12-14, 2015. Miami, FL.

Huang, Ying, Stephanie Potochnick and Colleen Heflin. "Household Food Insecurity and Young Immigrant Children's Health and Development Outcomes." Annual meeting of the Association of Public Policy & Management. November 12-14, 2015. Miami, FL.

Mueser, Peter and Colleen Heflin. "Aid to Jobless Workers in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the Association of Public Policy & Management. November 12-14, 2015. Miami, FL.

Huang, Ying, Stephanie Potochnik and Colleen Heflin. "Household Food Insecurity and Young Immigrant Children's Health and Developmental Outcomes" (poster presentation). Annual meeting of the Population Association of America. April 30-May 2, 2015. San Diego, CA.

Olson, Kate and Colleen Heflin. "The Changing Face of the United States and the Provision of Social Services." Annual meeting of the Association of Public Policy & Management. November 6-8, 2014. Albuquerque, NM.

Hodges, Leslie Beasley, Colleen Heflin and Andrew London. "TAPped out: An Evaluation of the Department of Defense's Transition Assistance Program." Annual meeting of the Association of Public Policy & Management. November 6-8, 2014. Albuquerque, NM.

Heflin, Colleen and Irma Arteaga. "Participation in the National School Lunch Program and Food Security: An Analysis of Transitions into Kindergarten." Annual meeting of the Association of Public Policy & Management. November 6-8, 2014. Albuquerque, NM.

Heflin, Colleen and Irma Arteaga. "The Child and Adult Care Food Program and Food Insecurity." Annual meeting of the Population Association of America. May 1-3, 2014. Boston, MA.

Mueser, Peter and Colleen Heflin. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the Population Association of America. May 1-3, 2014. Boston, MA.

Kukla-Acavado, Sharon and Colleen Heflin. "Participation in the Unemployment Insurance Program and Childhood Achievement." Annual meeting of the Population Association of America. May 1-3, 2014. Boston, MA.

Heflin, Colleen, Irma Arteaga and Sara Gable. "Families with Hungry Children and the Transition from Preschool to Kindergarten." Research Program on Childhood Hunger, Food and Nutrition Service. March 13, 2014. Washington, D.C.

Heflin, Colleen and Irma Arteaga. "Participation in the National School Lunch Program and Food Security: An Analysis of Transitions into Kindergarten." National RIDGE Small Grants Conference, December 17, 2013. Washington, D.C.

Potochnick, Stephanie, Irma Arteaga and Colleen Heflin. "An Examination of Household Food Insecurity among Low-Income Immigrant Children." Annual meeting of the Association of Policy Analysis & Management. November 7-9th, 2013. Washington. D.C.

Heflin, Colleen and Ashley Price. "Emergency Food Assistance and the Great Recession." Annual Conference of the Association of Policy Analysis & Management. November 7-9th, 2013. Washington. D.C.

Heflin, Colleen and Irma Arteaga. "Participation in the National School Lunch Program and Food Security: An Analysis of Transitions into Kindergarten." Southern Rural Development Center RIDGE Small Grants Conference. August 22, 2013. Denver, CO.

Heflin, Colleen and Peter Mueser. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the National Association of Welfare Researchers and Statisticians. August 21, 2013. Chicago, IL.

McKelvey, Bill, Jennifer Schnell, Nikki Raedeke, Sandy Rikoon, Matt Foulkes, Colleen Heflin, Joan Hermsen and Ashley Vancil. "A Food Systems Approach to Addressing Obesity Among Food Pantry Clients in Missouri" (poster presentation). Annual meeting of the

Society for Nutrition Education and Behavior. August 11, 2013. Portland, OR. *The abstract was published in the *Supplement to Journal of Nutrition Education and Behavior* 45:4S (July/August), p. S89.

Heflin, Colleen. "Child Poverty" Annual meeting of the American Sociological Association. August 10, 2013. New York, NY.

Heflin, Colleen and Peter Mueser. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." IZA/OECD/World Bank Conference on Safety Nets and Benefit Dependence: Evidence and Policy Implications. May 21-22, 2013. Paris, France.

Heflin, Colleen, Jacob Cronin and Ashley Price. "Best Practices for Implementing and Evaluating Evidenced-Based Teen Pregnancy Prevention Programs with Diverse Populations." Annual meeting of the Association of Policy Analysis & Management. November 4-6, 2012. Baltimore, MD.

Kukla-Acevedo, Sharon and Colleen Heflin. "Unemployment Insurance Participation and Early Childhood Development." Annual meeting of the Association of Policy Analysis & Management. November 4-6, 2012. Baltimore, MD.

Arteaga, Irma, Colleen Heflin and Sara Gable. "Hungry Children and the Transition from WIC." Annual Conference of the Association of Policy Analysis & Management. November 4-6, 2012, Baltimore, MD.

McKelvey, Bill, Jennifer Schnell, Nikki Raedeke, Sandy Rikoon, Matt Foulkes, Colleen Heflin, and Joan Hermsen. "Food Systems Approach to Addressing Obesity among Food Client Households in Missouri" (poster presentation). 45th Annual Conference of the Society for Nutrition Education and Behavior. July 14-17. Washington, DC.

Arteaga, Irma, Colleen Heflin, and Sara Gable. "Hungry Children and the Transition from WIC". Annual meeting of the Population Association of America. May 4, 2012. San Francisco, CA.

Wilmoth, Janet M., Andrew S. London, and Colleen Heflin. "Economic Well-Being among Older Adult Households: Variation by Veteran and Disability Status." Annual meeting of the Gerontological Society of America. December 2011. Boston, MA.

Heflin, Colleen, and Peter Mueser. "Aid to Jobless Workers in Florida in the Face of the Great Recession: The Interaction of Unemployment Insurance and the Supplemental Nutritional Assistance Program." Annual meeting of the Association for Public Policy and Management. November 4-5, 2011. Washington, DC.

London, Andrew S., Colleen Heflin and Janet M. Wilmoth. "Work-Related Disability, Veteran Status, and Poverty: Implications for Family Well-Being." Annual meeting of the American Sociological Association. August 2011. Las Vegas, NV.

Heflin, Colleen, and Ngina Chiteji. "My Brother's Keeper? The Association between Having Siblings in Poor Health and Wealth Accumulation." Western Economic Association Annual Meetings. June 30, 2011. San Diego, CA.

Heflin, Colleen, Andrew London and Janet Wilmoth. "Veteran Status, Disability, Poverty, and Material Hardship." Annual meeting of the Association for Public Policy and Management. November 4-5, 2010. Boston, MA.

Heflin, Colleen, Andrew London and Janet Wilmoth. "Veteran Status, Disability, Poverty and Material Hardship." SIPP Analytics Research Conference. October 14-15, 2009. Washington, DC.

Keiser, Lael and Colleen Heflin. "Impact of TANF on the Material Well-Being of Low Income Families." Reducing Poverty Conference hosted by The Institute for Advanced Policy Solutions. November 19-20, 2009. Atlanta, GA.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of Modernization on Florida's Food Stamp Caseload." Annual meeting of the Association of Public Policy and Management. November 5-7, 2009. Washington, D.C.

Keiser, Lael and Colleen Heflin. "Impact of TANF on the Material Well-Being of Low Income Families." Annual meeting of the Association of Public Policy and Management. November 5-7, 2009. Washington, D.C.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida's Food Stamp Caseload." RIDGE Conference at the US Department of Agriculture, Economic Research Service. October 15-16, 2009. Washington, DC.

Heflin, Colleen, Andrew London and Ellen Scott. "Mitigating Material Hardship: The Strategies Low-income Mothers Employ to Reduce the Consequences of Poverty." Annual meeting of the American Sociological Association. August 8-11, 2009. San Francisco, CA.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida's Food Stamp Caseload." Southern Rural Development Center Mid-Year Grantees Conference. August 5-6, 2009. Atlanta, GA.

Keiser, Lael and Colleen Heflin. "Explaining the Consequences of TANF Policy Choices Across and Within U.S. States" State Politics and Policy Conference (Hosted by the University of North Carolina-Chapel Hill and Duke University). May 22-23, 2009. Chapel Hill, NC.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida s Food Stamp Caseload." University of Kentucky Center for Poverty Research Small Grants Conference. Mat 19, 2009. Lexington, KY.

Heflin, Colleen and Peter Mueser. "Assessing the Impact of On-line Application on Florida s Food Stamp Caseload." Annual meeting of the Population Association of America. April 30, 2009. Detroit, MI.

Heflin, Colleen. "Macroeconomic Performance and Material Hardship across Time, Space and Race." West Coast Poverty Center Speaker Series. March 9, 2009. Seattle, WA.

Heflin, Colleen and Ngina Chiteji. "Do Middle Class Members Take on Debt in Order to Help Their Poor Siblings Weather Shocks?" Annual meeting of the Association of Public Policy and Management, November 6, 2008. Los Angeles, CA.

Heflin, Colleen. "State-Level Variation in Material Hardship Among Households with Children." Annual meeting of the Population Association of America. April 16, 2008. New Orleans, LA.

Heflin, Colleen and Sharon Kukla-Acavedo. "Welfare and Children's Cognitive Test Scores." Annual meeting of the Population Association of America. April 16, 2008. New Orleans, LA.

Heflin, Colleen and Sharon Kukla-Acavedo. “Does the Size of the Welfare Check Matter? New Results on the Effects of Welfare on Children’s Cognitive Test Scores.” Annual meeting of the Association of Public Policy and Management. November 4, 2006. Madison, WI.

Heflin, Colleen and John Iceland. “Poverty, Material Hardship and Mental Health.” Annual meeting of the Association of Public Policy and Management. November 3, 2006. Madison, WI.

Heflin, Colleen and Jim Ziliak. “Food Insufficiency, Food Stamp Participation and Mental Health.” Institute for Research on Poverty Summer Workshop. June 22, 2006. Madison, WI.

Heflin, Colleen and John Iceland. “Poverty, Material Hardship and Mental Health.” Annual meeting of the Population Association of America. April 1, 2006. Los Angeles, CA.

Heflin, Colleen and Seok-Woo Kwon. “Social Capital and Racial Wage Inequality.” Annual meeting of the Population Association of America. April 1, 2006. Los Angeles, CA.

Heflin, Colleen. “Dynamics of Different Forms of Material Hardship.” February 1, 2006. McGill University.

Heflin, Colleen. “Dynamics of Different Forms of Material Hardship in the Women’s Employment Survey.” Annual meeting of the Association of Public Policy and Management. November 3, 2005. Washington, DC.

Heflin, Colleen. “Dynamics of Different Forms of Material Hardship in the Women’s Employment Survey.” Food Assistance and Nutrition Research Small Grants Programs Conference, USDA Economic Research Service. October 2005.

Heflin, Colleen. “Determinants of Different Forms of Material Hardship in the Women’s Employment Survey.” Institute for Research On Poverty’s Small Grant Conference. May 20, 2005. Madison, WI.

Siefert, Kristine, Colleen Heflin and David R. Williams, David R. “Household Food Insufficiency in African American and White Women." Annual meeting of the Society for Social Work and Research. January 18, 2004. New Orleans, LA.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams, David R., "Food Insufficiency and Physical and Mental Health in a Longitudinal Survey of African American and White Women." Annual meeting of the American Public Health Association. November 17, 2003. San Francisco, CA.

Heflin, Colleen. “Who Exits the Food Stamp Program after Welfare Reform?” Annual meeting of the Association of Public Policy and Management. November 7, 2003, Washington, DC.

Swaroop, Sapna, Colleen Heflin and Reynolds Farely. “What About Arabs? White and Black American’s Attitudes Toward Arab Americans in Detroit in 1992?” Annual meeting of the American Sociological Association. August 17, 2003. Atlanta, GA.

Noonan, Mary and Colleen Heflin. “Do Women’s Wages Depreciate While on Welfare?” Annual meeting of the American Sociological Association. August 19, 2003. Atlanta, GA.

Swaroop, Sapna, Colleen Heflin and Reynolds Farely. "What About Arabs? White and Black American's Attitudes Toward Arab Americans in Detroit in 1992?" (poster presentation) Annual meeting of the Population Association of America. May 2, 2003. Minneapolis, MN.

Siefert, Kristine, Colleen Heflin, and David R. Williams. "Household Food Insufficiency and Depression in African American and White Low-Income Women." Annual meeting of the American Journal of Public Health Association. November 9, 2002. Philadelphia, PA.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams. "Food Insecurity and Hunger: Implications of Recent Research for Maternal and Child Health Programs." 15th Annual U.S. Department of Health and Human Services Regions V and VII Maternal and Child Health Leadership Conference. April 22, 2002. Chicago, IL.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams. "Food Insufficiency and the Physical and Mental Health of Current and Former Welfare Recipients." Annual meeting of the Association of Public Policy and Management. Washington, DC.

Heflin, Colleen and Mary Corcoran. "Barriers to Work among Housing Assistance Recipients." Annual meeting of the National Association of Welfare Researchers and Statisticians. Baltimore, MD.

Heflin, Colleen, Sheldon Danziger and Nathaniel J. Anderson. "Poverty Dynamics after Welfare Reform." Annual meeting of the Association of Public Policy and Management.

Siefert, Kristine, Colleen Heflin, Mary Corcoran and David R. Williams. "Food Insufficiency and Women's Health: Findings from a Longitudinal Survey of Welfare Recipients." Food Assistance and Nutrition Research Small Grants Programs Conference, USDA Economic Research Service. 2000.

Heflin, Colleen, Sheldon Danziger and Nathaniel J. Anderson. "Income Dynamics after Welfare Reform ". Annual meeting of the *National Association of Welfare Researchers and Statisticians*, Scottsdale, AZ.

Heflin, Colleen and Mary Pattillo-McCoy. "Kin Effects on Black-White Account and Home Ownership." Annual meeting of the American Sociological Association. August 2000. Washington, D.C.

Danziger, Sheldon, Colleen Heflin and Mary Corcoran. "Does Work Pay for Single Mothers?" Annual meeting of the Population Association of America. 2000. Los Angeles, CA.

Siefert, Kristine, Colleen Heflin, and Mary Corcoran. "Food Insecurity and the Physical and Mental Health of Low Income Single Mothers." Annual meeting of the American Public Health Association Annual Meeting, 1999. Chicago, IL.

Pattillo McCoy, Mary and Colleen M. Heflin. "Poverty in the Family: Exploring the Kin Networks of the Black and White Middle Class." Annual meeting of the American Sociological Association. 1999. Chicago, IL.

Corcoran, Mary E. and Colleen Heflin. "Changes in Women's Wages, 1979-1989 by Race and Ethnicity." Annual meeting of the Population Association of America. 1999. New York, NY.

Goldberg, Heidi, Colleen Heflin and Kristin Seefeldt. “Welfare-to-Work Programs and Barriers to Employment.” Annual meeting of the National Association of Welfare Research and Statistics. 1999. Chicago, IL.

Corcoran, Mary and Colleen Heflin. “Race, Ethnic and Skill-Based Inequalities in Women's Employment and Wages." Presented at the Institute for Women's Policy Research Conference. 1998. Washington, D.C.

Hall, Richard L. and Colleen Heflin. "The Importance of Color in Congress: Minority Members and the Representation of Race and Ethnicity in the U.S. House." Midwest Conference of Political Science Association. 1998. Chicago, IL.

Hall, Richard L. and Colleen M. Heflin. "The Importance of Color in Congress: Minority Members and the Representation of Race and Ethnicity in the U.S. House." Presented at the Midwest Conference of Political Science Association. 1994. Chicago, IL.

Teaching experience

Public Program Evaluation
Poverty and Social Policy (graduate and doctoral level)
Poverty Policy (undergraduate level)
Applied Regression (graduate level)

COMMUNITY Service

Member, Data Advisory Team for the Boone Indicators Dashboard Project, a collaboration of the City of Columbia, County of Boone, and Heart of Missouri United Way, 2016–2017.

Member, Indicator Review Committee, Missouri Kids Count, Fall 2015.

PROFESSIONAL SERVICE

Program Committee, Annual Meeting of the Association for Public Policy and Management, 2013 and 2015.

Invited speaker at Minnesota Department of Labor Conference, “Sustaining Employment in the New Millennium,” February 2000.

UNIVERSITY SERVICE

Syracuse University (Fall 2017 to present)

University Service

Promotion and Tenure Committee, 2018 to 2019
Maxwell Faculty Committee, 2018 to 2019
Equipment Task Force Committee, 2018 to present
SU representative to NYFSRDC, 2017 to present
Policy Studies Program Advisory Committee, 2017 to present

Departmental Service

MPA Curriculum Committee, 2017- present (Chair, 2018 to present)
Executive Committee, 2018 to present
Health Care Policy & Management Search Chair, 2019
Economics of Aging Search Committee, 2018
APPAM Policy Camp Committee, 2018

University of Missouri Service (Fall 2007 to Spring 2017)

University Service

Tenure Committee, 2016 to 2017
Lecture Committee, 2012 to 2017
Population, Education and Health Seminar Organizer, 2013 to 2014
Population, Education and Health Center Founder and Co-Director, 2014 to 2017

Departmental Service

Truman School Ph.D. Program Coordinator, 2014 to 2017
Truman School Seminar Series Co-Organizer, 2014 to 2015
Truman School Doctoral Committee Member, Fall 2007 to 2009; 2013 to 2014
Truman School Personnel Committee, 2012 to 2017
Institute for Public Policy Advisory Committee, Spring 2008 to 2010
Truman School Policy Committee, Fall 2008 to 2009; 2013 to 2017
Chair, Policy Faculty Search 2012
Food Policy Faculty Search 2013

University of Kentucky Service (Fall 2002 to Summer 2007)

University Service

University of Kentucky Center for Poverty Research Advisory Board, 2002-2007

Departmental Service

Martin School of Public Policy MPA Admissions Committee, Fall 2002 – Summer 2007
Martin School of Public Policy MPA Curriculum Committee, Fall 2002 – Summer 2007
Martin School Director's Search Committee, Fall 2002 and Fall 2003
Martin School Faculty Search Committee, Spring 2003
Martin School Internal Brownbag Seminar Organizer, 2005-2006
Revising the Capstone Committee, Fall 2005 to Spring 2006

MEMBERSHIP AND AFFILIATIONS

American Sociological Association, Member
Association for Public Policy and Management, Member
Population Association of America, Member

Attachment 3

THIRD JUDICIAL DISTRICT COURT,
SALT LAKE COUNTY, UTAH

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff, *Plaintiff*, v. STATE OF UTAH, *et al.*, *Defendants*.	**DECLARATION OF LAUREN M. HUNT IN SUPPORT OF PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION** Case No. 220903886 Judge Andrew Stone

I, Lauren M. Hunt, declare as follows:

1. I am submitting this declaration on behalf of the Rape Recovery Center (the "RRC" or the "Center"), of which I sit on the Board of Directors. The RRC is the only sexual assault service provider in Utah with the sole focus of treating, preventing, and intervening in sexual violence. As the only agency of its kind in Utah, our philosophy has remained that dignity and respect guide treatment for survivors of sexual violence.

2. The Salt Lake Rape Crisis Center, RRC's predecessor, was founded in 1974 by a group of volunteers for the purpose of supporting survivors of rape and sexual assault. In January of 1975, the organization was incorporated as a private 501(c)(3) nonprofit organization and later, in 1995, renamed the Rape Recovery Center. The RRC's mission is to empower victims of sexual violence through advocacy, crisis intervention, and therapy. The Center also seeks to educate the community about the causes, impact, and prevention of sexual violence.

3. For nearly fifty years, we have remained the leading experts in responding to sexual violence in Utah. In 1978, the RRC launched a 24-hour Crisis Line and in 2019, a stand-alone Spanish-speaking crisis line. In 1980, the RRC, the Salt Lake District Attorney's Office, local

police departments, local hospitals, and the Utah State Medical Examiner's Office jointly established a protocol for victims reporting rape and sexual assault. This procedure, called Code R, was designed to provide immediate services to victims of sexual violence through a standardized rape evidence collection process, medical care, and crisis intervention. Under this protocol, when a survivor calls the crisis line before going to a hospital, they are instructed to go to the nearest Emergency Room, and the RRC is contacted for crisis intervention support. Additionally, the RRC administered the state coalition formerly known as the Coalition of Advocates for Utah Survivors' Empowerment ("CAUSE") until it incorporated as an independent organization in 1996 to later be renamed the Utah Coalition Against Sexual Assault ("UCASA").

4. I became involved with the RRC through my advocacy for survivors of sexual violence. I have served as a board member for the last 1.5 years. I am a former criminal prosecutor with the Utah County Attorney's Office, where I worked for approximately 6 years. My primary focus as a prosecutor was within the office's former Special Victims Unit, in which I prosecuted hundreds of domestic violence offenses and sexual offenses involving children and adults. As a prosecutor, I was a member of the Multidisciplinary Sex Crimes Task Force, which met monthly to discuss best practices in the prosecution of sexual offenses. A central element of our work was the care of survivors. This task force included members from disciplines such as Special Victims Unit detectives, Sexual Assault Nurse Examiners, prosecutors, victim advocates, trauma therapists/counselors, and Title IX representatives. For the last 2.5 years, I have been in civil practice representing victims of sexual abuse, harassment, and assault in civil litigation. A copy of my resume is attached as Exhibit A.

5. I have read Utah Senate Bill 174, 2020 Leg., Gen Sess. (2020) (the "Criminal Abortion Ban"). I understand that it bans all abortions, subject to three limited exceptions. One of

these exceptions, which I will refer to as the Reported Rape Exception, requires that "the physician who performs the abortion . . . [verify] that the [rape or incest] has been reported to law enforcement."[1]

6. As outlined below, reporting sexual violence is an incredibly taxing endeavor for survivors. The Reported Rape Exception is tantamount to a de facto mandatory reporting regime for assault survivors seeking an abortion. Such mandatory reporting would have harmful effects on survivors in Utah, approximately 88% of whom do not report their sexual assault to law enforcement.[2] Because this reporting requirement is applied only to survivors who seek abortion, it does not seem targeted at the sexual assault in any way, but instead to discourage sexual assault survivors from seeking an abortion.

I. Sexual Assault in Utah

7. As used in this declaration, sexual assault is defined as any form of forced or coerced sexual contact without consent, including (but not limited to) rape, incest, molestation, and oral sex. Rape is a specific form of sexual assault and is defined in Utah as sexual intercourse without the victim's consent.[3] Sexual assault in Utah is common, though often goes unreported.[4] Even still, about one in six women in Utah report having been raped.[5] Rape is the only violent crime for which Utah's rate is higher than the national average.[6] In 2020, the reported rape rate in

[1] Utah Code Ann. § 76-7a-201(1)(c)(ii)(A).

[2] Christine Mitchell & Benjamin Peterson, *Rape in Utah 2007, A Survey of Utah Women*, at 32 (May 2008), available at https://justice.utah.gov/wp-content/uploads/RapeinUtah2007.pdf (and finding for rape, specifically, that the rate of non-reporting is approximately 85%).

[3] Utah Code Ann. § 76-5-402(2)(a).

[4] Mitchell & Peterson, *supra* note 2, at 32.

[5] *Id.* at 5.

[6] *Id.* at 2.

Utah was significantly higher than the U.S. rate at 55.7 per 100,000 people, compared to 38.4 per 100,000 people.[7]

8. Survivors have a breadth of reasons for choosing not to report sexual assault to law enforcement. Reasons for not reporting sexual assault include (among others): safety concerns, particularly in domestic violence or intimate partner situations in which survivors are still connected to or dependent financially, personally, or otherwise upon their abuser; a fear of retaliation; a fear of not being believed; a fear of being thrown into an invasive, undermining, and often unsuccessful criminal prosecution process or of facing their abuser through the legal system; fear of punitive religious, institutional, or societal implications; a failure to appreciate or process that what happened was actually assault; and/or an exercise of fundamental personal autonomy about whether and to whom to disclose a deeply private and painful matter.

9. Regardless of whether they report their rape to law enforcement, some rape survivors may still choose to get a forensic exam at a hospital (otherwise known as a "rape kit" or "kit"). There are mechanisms in place to keep this forensic exam private if the victim chooses to label their kit as "restricted."[8] In other words, the hospital does not have a duty to report the assault to law enforcement, though it is able to keep the exam in the event the survivor chooses to have the kit processed.[9] In the year 2021, RRC served over 3,000 survivors with over 600 hospital accompaniments to a forensic exam.

10. For particularly vulnerable populations, like minors, Utah already has mandatory reporting requirements in place[10]. Mandatory reporting for children and vulnerable populations is

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[7] Fed. Bureau of Invest., Crime Data Explorer, *Rate of Rape Offenses by Population*, https://crime-data-explorer.fr.cloud.gov/pages/explorer/crime/crime-trend.

[8] Utah Code Ann. § 53-10-902(3).

[9] *Id.* § 53-10-904(6)(d).

[10] Utah Code Ann. § 62A-4a-403(1).

important because these survivors lack the ability or resources to remove themselves from abusive scenarios and often require the assistance of the State to do so.

II. Reporting Sexual Assault Under the Criminal Abortion Ban

11. The Criminal Abortion Ban creates a similar, de facto mandatory reporting regime for competent adult survivors seeking an abortion. For example, a rape survivor does not need to disclose their assault to law enforcement in order to obtain a forensic exam at a hospital. However, if the same person later discovers that they are pregnant and tries to obtain an abortion, they are forced to disclose the rape to law enforcement in order to obtain this necessary medical care.

12. Mandatory reporting for competent adult survivors can inflict many seen and unforeseen harms. Mandatory reporting can endanger survivors, retraumatize them (particularly if their disclosure is met with initial disbelief), infringe upon their autonomy, violate patient confidentiality, create barriers to care, and have effects on any potential future prosecution with which they may decide to move forward.

13. In order to make an actionable report of the rape to law enforcement, a survivor must disclose their identity, personal contact information, and invasive details about the rape. Reporting a sexual assault is a grueling process that takes mental, emotional, physical, and financial tolls. It requires a survivor to recount their traumatic experience in great detail, often more than once, and to complete strangers. Survivors may have to submit to invasive physical examinations, frequently miss work or other obligations to attend meetings and court proceedings, and forgo privacy to have the most personal and intimate details of their lives exposed to the public. If the State pursues a criminal case, survivors' sexual, personal, and therapeutic histories are often examined and/or exposed, sometimes without the survivors' consent. This process frequently takes multiple years. In my experience and speaking on behalf of the RRC, if a survivor is not ready to

take these steps, it can cause harm that psychologically rivals—or even surpasses—the harm of the sexual assault itself.

14. Forcing a survivor to make these disclosures before they are ready deprives them of independence and may harm them, even if they ultimately choose to cooperate with law enforcement. Special Victims detectives, who are called in when a survivor chooses to proceed with the investigation, are trained to wait multiple days before interviewing survivors more in-depth. This is considered best practice because survivors of trauma often need time before they are able to recount their experience clearly. But the law enforcement officers that collect initial statements or reports may not be trauma-informed or specifically trained to interview survivors. This can lead to incorrect information regarding the legal process and a survivor's obligations, further traumatization of survivors, and potential compromising of survivors' privacy. Moreover, if survivors are interviewed before they are ready, there is an increased risk that they will inadvertently make inconsistent statements. Any potential inconsistencies in a survivor's early statements (which, frankly, are not uncommon due to the effects of severe trauma on the brain), may be used against the survivor in future court proceedings if they later decide to cooperate with criminal prosecution of their abuser.

15. If survivors report the rape but do not wish for the State to pursue criminal charges on their behalf, some law enforcement agencies in Utah are able to take a brief report, generate a case number, and close out the case by indicating that the "victim was uncooperative."[11]

[11] However, these reports remain available to state or defense attorneys in any future cases the survivor does choose to pursue and may be used to discredit the survivor, as discussed further below.

16. However, some law enforcement agencies in Utah may not have a procedure for "uncooperative" survivors or may not follow it in practice. In these circumstances, survivors would be forced to cooperate with an invasive investigation against their will in order to obtain a police report. Further, because the topic of abortion is so politically charged, some officers may refuse to take such a report if they suspect it is for the purpose of obtaining an abortion.

17. Mandatory reporting can create a scenario in which the State can proceed with criminal prosecution without the survivor's consent. If law enforcement has other evidence upon which the state can rely—such as third-party witness statements, physical evidence, or a confession—the State can move forward with the investigation and prosecution, even without the consent of the survivor. The State might be able to subpoena the survivor or their physician to compel testimony, which could have devastating emotional, personal, and safety effects on the survivor.

18. Forcing reports to be generated by an agency or institution with whom a survivor does not enjoy a legal privilege can have unforeseen consequences. Mandatory reporting can create a record that can be requested and, in some cases, obtained by others in legal proceedings in the future. If a survivor is forced to generate a report and have law enforcement open a case, that report can be accessed and used by defense attorneys against the survivor in any future legal proceeding—even ones unrelated to the underlying assault. For example, if a survivor is forced to report a sexual assault and is then sexually assaulted again in the future, attorneys in a future case can obtain the past report and use it to suggest the survivor is lying and has a pattern of making "false" assault accusations. Prior reports can also be requested by a defendant at trial or considered discoverable under *Brady v. Maryland*, 373 U.S. 83 (1963).

19. Mandatory reporting such as that required by the Reported Rape Exception can also exacerbate the harmful myth that people falsely report rapes. For example, it may lead to the perception that sexual assault victims are falsely reporting a rape in order to obtain an abortion. This undermines the credibility of every woman who is raped and makes prosecution of rapists that much more difficult.

20. The Criminal Abortion Ban deprives survivors of their autonomy and their ability to privately decide whether and when to report their assault. This is vitally important to survivors because sexual assault already fundamentally deprives a person of independence over their bodies, freedoms, and choices.

21. As stated, the Ban effectively imposes a mandatory reporting regime for survivors seeking an abortion, akin to the mandatory reporting regimes in place for minors and other vulnerable populations.

22. This regime has nothing to do with the health or safety of sexual assault survivors and instead serves to specifically target survivors seeking an abortion. Under the Criminal Abortion Ban, if a pregnant sexual assault survivor goes to a health center experiencing a miscarriage, they are able to obtain this care without reporting the assault to law enforcement. Yet a pregnant survivor who goes to the same health center seeking an abortion is unable to obtain medically necessary care until they can somehow verify that the assault has been reported to law enforcement.

III. Compliance with the Reported Rape Exception

23. It is also not clear under the Ban what would qualify as "verifi[cation]" of a "report[] to law enforcement."[11] The Ban does not specify where a survivor must report the assault

(i.e. in the law enforcement[12] jurisdiction where the assault took place, where the survivor lives, or where the abortion provider is located). Further, a provider would not be able to obtain a police report on an active case, as police agencies in Utah do not release them under the Government Records Access and Management Act ("GRAMA")[13] until the case has been closed. In fact, even the survivor themself would not be able to obtain their full police report under GRAMA if the case is open and ongoing. Even if the case were closed because the survivor did not want to cooperate with law enforcement, the survivor's personal details and name would be redacted in any materials furnished under GRAMA to the provider. In that scenario, the survivor would have to GRAMA request their own report and voluntarily provide it to the provider—an invasive task that, again, removes autonomy and privacy from a survivor. In addition, waiting for documents requested under the GRAMA process can take months. For health care as time sensitive as abortion, that is time a survivor does not have.

24. Providers may also feel as though they need to report the assault themselves in order to verify that a report has been made, either because the patient indicates they have not previously reported the assault but wants to receive an abortion, or because the provider is uncertain about what is required by the Criminal Abortion Ban to meet the Reported Rape Exception. As I understand it, the Act conditions abortion services on this reporting, a condition that can erode essential trust and transparency between a survivor and the medical provider. In addition, if the provider makes the report, it is likely or even certain that this report would disclose the patient's status not only as a sexual assault survivor, but as someone seeking an abortion. If the provider making the report is identifiably associated with an abortion provider or provides an address that

[12] Utah Code Ann. § 76-7a-201(1)(c)(ii)(A).
[13] Utah Code Ann. § 63G-2-204.

corresponds to a licensed abortion clinic, that, combined with the targeted nature of this mandatory reporting, is likely to disclose the patient's private health care information involving abortion.

25. If a provider feels it necessary to report a rape on the survivor's behalf before performing an abortion, law enforcement would likely need to come to the clinic directly and get an initial report. This would be an egregious violation of patient privacy.

26. In the RRC's opinion, the Criminal Abortion Ban, even with the Reported Rape Exception, will have devastating effects on sexual assault survivors and will serve only to discourage survivors from obtaining abortions.

I declare under penalty of perjury under the laws of the United States of America and the State of Utah that the foregoing statements are true and correct to the best of my knowledge, information, and belief.

Signed on the 29 day of June, 2022, in San Diego, CA.

Lauren M. Hunt

Exhibit A

LAUREN M. HUNT

LEGAL EXPERIENCE

Attorney-Of Counsel, Parsons, Behle & Latimer, Salt Lake City, *November 2019-Present*

- Represent plaintiffs in all aspects of civil litigation relating to sexual assault/harassment, Title VI, Title VII, and Title IX
- Research and analyze Title VI, Title VII, and Title IX institutional compliance
- Research and stay apprised of trauma-informed methodology and the effects of trauma
- Investigate and build cases involving alleged discrimination based on gender, race, or sexual misconduct
- Conduct outreach, advocacy, and education on trauma-informed care as a board member of the Rape Recovery Center

Deputy Utah County Attorney, Utah County Attorney's Office, Provo, *June 2014-November 2019*

- Represented the State as a member of the Special Victims Unit at hearings, arraignments, entries of plea, orders to show cause, plea negotiations, and jury trials primarily in cases involving domestic violence and/or sexual offenses
- Reviewed case files, screened police reports, and interviewed law enforcement officers, witnesses, and victims
- Acted as the liaison to two Utah County police agencies, evaluating cases under investigation regarding the existence, nature, and degree of offenses
- Consulted with staff attorneys and police officers regarding the charging of offenses and authorized the issuance of criminal charges
- Evaluated the strengths and weaknesses of the prosecution's case and prepared cases for presentation in court
- Performed legal research and prepared written pleadings and memoranda for each case
- Trauma-informed former member of the Utah County Multidisciplinary SVU task force
- Saw 20 cases through jury trial, including charges of sex offenses against children and adults, child pornography, child enticement, drug distribution, DUI, theft, and aggravated assault and kidnapping

Law Clerk, Salt Lake County District Attorney's Office, Salt Lake City, Utah, *June 2012-June 2014*

- Extensively researched in areas of criminal law, criminal procedure, and evidence
- Prepared memoranda, pre-trial motions, and an appellate brief
- Worked closely with prosecutors on an aggravated murder jury trial
- Attended court and witness meetings
- Helped prepare witnesses for trial

EDUCATION

J. Reuben Clark Law School, Provo, UT

***J.D. APRIL 2013,* CUM LAUDE, TOP 33%**

- Academic Scholarship and Dean's List
- Trial Advocacy National Traveling Team and Board Member
- American Constitution Society Executive Board Member

Bachelor of Arts in English, *April 2009*

Brigham Young University — Provo, Utah

Attachment 4

THIRD JUDICIAL DISTRICT COURT,
SALT LAKE COUNTY, UTAH

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff, *Plaintiff*, v. STATE OF UTAH, *et al.*, *Defendants*.	**DECLARATION OF JANE DOE IN SUPPORT OF PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION** Case No. 220903886 Judge Andrew Stone

I, Jane Doe, declare as follows:

1. I am submitting this declaration in support of Plaintiff's motion for a preliminary injunction.

2. I am a patient at Planned Parenthood Association of Utah. I am submitting this declaration because if Utah's abortion ban goes into effect on Monday, my abortion appointment will be canceled, and I've always known that I am not ready to have kids. I am submitting this declaration under pseudonym because I do not want random people to know about my abortion; the people who I want to know, know.

3. I am in my mid-twenties and live with roommates in Salt Lake City. I have lived on my own for the last 7 to 8 years after I was kicked out of my family's home when I turned 18. My family is scattered around the United States and does not live in Utah.

4. I'm a student in community college in Utah, but I have the summer off. When I started community college, I was not sure what I wanted to do, but I finally decided to go for an associate degree in science. I have about another year and a half left to complete my degree. I attend school part-time because I need to work.

5. I am currently a server at a restaurant. I make about $1,000 a month, give or take, depending on tips. I am not sure what I want to do long-term.

6. I am not in a relationship, and I do not currently have any children. I have not told my ex-boyfriend about the pregnancy. He cheated on me, and we decided we weren't good in a monogamous relationship. He is not someone I envision having a future relationship with. I never wanted to have kids with him, and I know that he never wanted to have kids at all.

7. I came to Planned Parenthood in Utah once before in high school because I wanted to get on the pill. I was young and didn't know any doctors, and I was not very close to my parents, so I did not feel comfortable asking them to take me to the doctor. Planned Parenthood seemed like a good option, and a friend of mine had gone there before and recommended it.

8. I realized I was pregnant last week because I missed my period, even though I was using condoms. I took three pregnancy tests at home. When they came back positive, I started freaking out. I knew that Utah was a trigger state, and that as soon as *Roe* was overturned, Utah would ban all abortions. I didn't know if I would be able to have an abortion in Utah and whether I was going to have to try to go out of state. I cried a lot and was very stressed out. I thought, if you ever get pregnant, you're forced to take care of it yourself. I don't have the right social or family support or help with raising a baby. I felt a wave of emotions.

9. I am not ready to have kids. I can barely take care of myself. I can't take care of another human being. I don't make enough money, and I would not have financial support from my family if I had a child. I want to be able to finish school, I want to go on to have a career. I would not be able to finish my degree if I had a child. I would not be able to work as easily if I

had a child. Carrying a pregnancy to term would set me back in terms of work that I've done to establish my life.

10. I have only told two friends about my abortion. They helped me calm down, find information, and set up my appointment with Planned Parenthood.

11. It was helpful to know that technically I could still get an abortion if I drive out of state, but that takes more money and time. If I had to travel out of state, I would need to take time off of work and find someone to take me. My car is older, and I'm not sure it would make it out to somewhere like Idaho, where I think abortion is still legal for now. I would not get paid to take time off. The extra expense of travel, on top of the abortion, would put me behind on bills, rent, and utilities. I would have to save up even more to go back to school for the fall semester. There are people who are in an even worse situation than I am because they might not be able to go out of state at all.

12. I wouldn't know how to bring my own lawsuit if I had to do so in order to obtain an abortion. I don't have the capacity to do everything involved in bringing a lawsuit, and I think I would get very overwhelmed and might not end up following through in the end. I would have to take time to talk to a lawyer, take days off to get the right resources. I've never had to file a lawsuit or anything like that before, and am not familiar with the legal system in this type of situation. There would be no way I could pay for lawyers or costs. I also wouldn't want the State to know me, or have to be questioned in person. I am afraid of repercussions and judgment. That's why it's important to have someone to be your voice. I just want to not be pregnant as soon as possible.

13. I would also have concerns about anonymity. That is why I'm asking to do this declaration without using my name. I don't want everyone and their grandma to know about my

had a child. Carrying a pregnancy to term would set me back in terms of work that I've done to establish my life.

10. I have only told two friends about my abortion. They helped me calm down, find information, and set up my appointment with Planned Parenthood.

11. It was helpful to know that technically I could still get an abortion if I drive out of state, but that takes more money and time. If I had to travel out of state, I would need to take time off of work and find someone to take me. My car is older, and I'm not sure it would make it out to somewhere like Idaho, where I think abortion is still legal for now. I would not get paid to take time off. The extra expense of travel, on top of the abortion, would put me behind on bills, rent, and utilities. I would have to save up even more to go back to school for the fall semester. There are people who are in an even worse situation than I am because they might not be able to go out of state at all.

12. I wouldn't know how to bring my own lawsuit if I had to do so in order to obtain an abortion. I don't have the capacity to do everything involved in bringing a lawsuit, and I think I would get very overwhelmed and might not end up following through in the end. I would have to take time to talk to a lawyer, take days off to get the right resources. I've never had to file a lawsuit or anything like that before, and am not familiar with the legal system in this type of situation. There would be no way I could pay for lawyers or costs. I also wouldn't want the State to know me, or have to be questioned in person. I am afraid of repercussions and judgment. That's why it's important to have someone to be your voice. I just want to not be pregnant as soon as possible.

13. I would also have concerns about anonymity. That is why I'm asking to do this declaration without using my name. I don't want everyone and their grandma to know about my

abortion. People have their own opinions and might have bad opinions about me if they found out. I worry that I would be judged. I definitely do not want my family to know about my abortion. I also worry that if my employer found out, she would judge me since she is a fairly religious person.

14. I have heard that there may be protestors when I go to get my abortion. I am worried about them as well, and hope I only have to see them once.

15. The fact that Utah would ban people from getting abortions makes me feel very upset. I think everyone should have the right to choose whether to stay pregnant. No one else knows what that person is going through. Why does anyone get to have a say about whether another person has to carry a pregnancy?

Signed on July 10, 2022, in Salt Lake County, Utah.

/s/ Jane Doe
Jane Doe*

For internal records only:

Signature: _____

Printed Name: _____

* I have signed a version of this declaration using my real name and signature, and I gave it to Planned Parenthood's attorneys in this case for their records.

Attachment 5

THIRD JUDICIAL DISTRICT COURT,
SALT LAKE COUNTY, UTAH

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff, *Plaintiff,* v. STATE OF UTAH, *et al.*, *Defendants*.	**DECLARATION OF ALEX ROE IN SUPPORT OF PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION** Case No. 220903886 Judge Andrew Stone

I, Alex Roe, declare as follows:

1. I am submitting this declaration in support of Plaintiff's motion for a preliminary injunction.

2. I am a patient at Planned Parenthood Association of Utah. I have an abortion appointment scheduled next week and have been to Planned Parenthood for care before. I am submitting this declaration because if Utah's abortion ban goes into effect on Monday, my abortion appointment will be canceled. I need an abortion because I cannot support another child, and I am worried about having another complicated pregnancy.

3. I am in my mid-thirties, and I live with my children in Weber County. They are eight and ten years old. I share custody, but I am their primary custodian. I am in a relationship with someone. He is not my children's father, and does not co-parent or live with me. He knows about my pregnancy and my decision to get an abortion.

4. I work as a housecleaner. My monthly income is about $1800 to support the three of us. I rely on Medicaid for health care. It is my understanding that Medicaid will not cover the abortion that I am scheduled to get at Planned Parenthood.

5. I also attend online high school for about five hours a week. If I am able to get this degree, I have a job offer to work at an information and technology help desk.

6. I realized I was pregnant last week. I was cleaning for work, and someone standing near me did something very inconsiderate and I felt a rush of anger that felt hormonal, so I took a home pregnancy test, and it was positive. I have learned that I am less than 7 weeks pregnant.

7. I immediately knew that I wanted an abortion. I do not want any more children. It is already hard for me to support and care for my two existing children on my income. I already worry about paying rent each month. I also worry about being too old to be pregnant again. My first pregnancy involved a pre-eclampsia scare and induction when I started leaking amniotic fluid. I worry that I would have another medically complicated pregnancy. With this pregnancy, I am already having cramping and intense emotions of anger and sadness.

8. I would have no idea where to go if I had to travel out of state to get an abortion. I might go to California, because I have family there, and I know that abortion is legal there, but I would worry about being out of work and falling short on rent.

9. I cannot imagine bringing a case myself to challenge Utah's abortion ban. I do not know how I would find the money, or the time. Also, I would be very scared to be in court. All my life, I've done everything I could to stay out of court. I grew up seeing my brothers go in and out of jail; to me, courtrooms are for people who have done something wrong and are facing punishment. I would also be worried about anonymity. I am keeping my abortion a secret from my

father because I am his only daughter, and I do not want to disappoint him. These are all also reasons why I am submitting this declaration under a pseudonym.

10. Utah's abortion ban makes me feel repressed, like people who don't know me are keeping me down. I am angry that these people want to make this decision for me. I was doing everything I could to not be in this position. I was using condoms and had made an appointment to have my tubes tied. Despite all of that, this happened to me, and I just want to have an abortion as soon as I can.

I declare under penalty of perjury under the laws of the United States of America and the State of Utah that the foregoing statements are true and correct to the best of my knowledge, information, and belief.

Signed on July 10, 2022, in Weber County, Utah.

/s/ Alex Roe
Alex Roe*

For internal records only:

Signature: _____

Printed Name: _____

* I have signed a version of this declaration using my real name and signature, and I gave it to Planned Parenthood's attorneys in this case for their records.

Attachment 6

THIRD JUDICIAL DISTRICT COURT,
SALT LAKE COUNTY, UTAH

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff, *Plaintiff*, v. STATE OF UTAH, *et al.*, *Defendants*.	**DECLARATION OF ANN MOE IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION** Case No. 220903886 Judge Andrew Stone

Ann Moe declares the following:

1. I am in my late thirties and I live in Sevier County.

2. I work in health care, assisting patients obtain medical care.

3. I am a single mother of three children. My eldest child is twenty years old. The others are sixteen and four.

4. I am submitting this declaration because if Utah's abortion ban goes into effect on Monday, my abortion appointment at Planned Parenthood will be canceled, and I need an abortion in order to take the best possible care of my family.

5. Earlier this month, I took a pregnancy test at home and it came back positive. I believe that at the time I was just over four weeks pregnant.

6. While this at-home test was my first official confirmation of the pregnancy, I began to suspect that I was pregnant about a week earlier. I am a highly sensitive person and have always been very aware of changes in my body. Also, when you have been pregnant before, like I have, sometimes you just know.

7. I actually first suspected I was pregnant on the same day I first heard about Utah's abortion ban. I was at work, about to start a meeting, and my first thought was that I might actually be pregnant myself and need an abortion. I had been taking a low-dose daily contraceptive pill, but I missed a couple of days. My partner and I had been intimate around that time, and I took Plan B emergency contraception, but as the pregnancy test later confirmed, the Plan B did not work.

8. So when the pregnancy test came back positive, I was not surprised. I knew immediately that I wanted to end the pregnancy and that I needed to get an appointment as soon as possible.

9. Put simply, I am not in a place financially or mentally to care for another child. Two of my children live with me, along with my significant other and his two children. One of my partner's children has special needs. My mother lives with us as well, and she is in the process of adopting my niece, who also has special needs.

10. In our household of seven—soon to be eight, once the adoption is finalized—I am the only one who works. My significant other is legally disabled and has multiple serious health conditions: he is legally deaf, and he has heart issues and emphysema. Due to his disability, he cannot work and receives monthly disability benefits from the state. His benefits plus my salary give us a monthly household income of approximately $4,800 to support the seven of us.

11. Even aside from these financial concerns, I am stretched so thin already taking care of my family. And once my mother adopts my niece, I know that I will be responsible for a large portion of that child's care, too. I do not want anyone in our home to feel that someone is getting more care over another. But when a baby comes, and you have someone else in the home with special needs, it can be challenging to make sure that everyone is getting the care they need.

I have seen that happen in other families.

12. I am also concerned about being pregnant at my age, and the health complications that could result.

13. Additionally, my significant other is in his late forties, and as I mentioned above, he already has two children and multiple serious health conditions. I worry that his health will not allow him to assist in the care of another baby, and if we were forced to move forward with this pregnancy, he could very well pass away before the child graduates from high school. Even under the best of circumstances, if we had this baby, my partner would be in his late sixties by the time the child became an adult. Given his age, and also his disability, the situation is just not conducive to having another child. Ironically, even before I became pregnant, he had made an appointment for a vasectomy, which he is still scheduled to attend.

14. For all of those reasons, I knew immediately that I wanted to have an abortion. When I discussed my decision to have an abortion with my partner, he was supportive and agreed that it was the best thing for us and our children, given where we are in our lives.

15. As soon as I decided to have an abortion, I called out of work and drove two hours to the Planned Parenthood in Orem to complete what I have been told is a state-mandated session at the health center that has to happen at least 72 hours before an abortion in Utah.

16. I have been to Planned Parenthood in Utah before to get contraception, first when I was sixteen and then again in my twenties.

17. Once I arrived at Planned Parenthood, the health center staff told me about the abortion ban and explained that it is currently blocked by a court order, but that it could go back into effect on Monday. If the ban stays blocked, I will be able to have my abortion early next week in Salt Lake City, after the required 72-hour waiting period is over. I will need to drive

three hours each way to get to the appointment, but I am determined to be there.

18. If the ban goes into effect, however, I will have to find another way to have my abortion, and quickly. I am guessing that I would need to drive several hours to a state where abortion is still legal.

19. To get to an appointment in another state, I would have to find childcare for the children, since I would want my significant other to join me for the appointment. I would have to take time off of work. My job provides paid time off but no paid sick leave, so any time off to travel would come out of my PTO, which I need to attend my children's doctor's visits and therapy appointments and which is already running low.

20. This travel would also set our family back financially, particularly with the price of gas and just about everything else right now. A new school year is coming up, and that means doctor's appointments and new clothing for the children. If I had to pay to travel to another state to have an abortion, my children might have to go without these things. I might overdraft my bank account or have to use a credit card with a very high interest rate that I would rather avoid.

21. As difficult as it would be for me to travel to another state for an abortion, it would be even harder if I did not have access to a car or paid time off from work.

22. Still, all of these logistical difficulties and expenses are less than the ones that come with having a baby.

23. When I first heard about the abortion ban, as I said, I was at work, and in that moment I mostly just took it as a situation that I had to deal with. But that evening, as I thought about it more, I thought about how incredibly cruel this law is to women and families. The abortion ban does not only affect women: it also affects men who may have health issues or other circumstances that mean they are unable to support a child and be an effective parent to the best

of their ability. I became angry, sad, and shocked. It made me wonder how on Earth someone could decide to pass a law like this when they have never experienced the things that will make this law so harmful for others, like a complicated pregnancy or a disability. It is senseless and thoughtless.

24. I am a highly private person. Until now, I have not told anyone other than my partner about my decision to have an abortion. Having an abortion is not a secret, exactly, but it is not something I am going to share openly unless it is necessary to do so.

25. I understand that the state thinks women should go to court themselves to challenge this law, but that would be incredibly difficult for me. I would need to find a way to balance that obligation with all of my other responsibilities. It would be pretty overwhelming. On top of my job, which requires more than forty hours per week, and my family responsibilities—caring for the kids and getting them to school, to dance practice, to other appointments—I imagine that I would need to find time to meet with a lawyer, to go to meetings, to attend hearings. As I explain above, I need to save my PTO so that I can attend my children's medical appointments. My significant other's daughter recently had to spend a week in the hospital, and I used a lot of my saved PTO to be with her during that time. If I had to file a lawsuit to have my abortion, I do not think I would have enough PTO to attend the required meetings and court hearings as well as my family's doctor's appointments.

26. Additionally, if I filed a lawsuit in order to obtain an abortion, I worry that news of the lawsuit would spread on social media and my children would see the repercussions at school. People have their opinions about abortion, and I am nervous about how it would affect my family, particularly if any of the reactions became physical.

27. I definitely could not file a lawsuit if I had to pay for a lawyer or thought I might

be responsible for paying other lawsuit costs someday, since I do not have money for that. My children's insurance does not cover the full cost of their medications and doctor's appointments, so covering those expenses is my priority. Particularly after paying over a thousand dollars for the travel and hotel stay during my partner's daughter's week in the hospital, I simply could not afford to pay for a lawsuit on top of everything else.

28. While filing a lawsuit would be extremely challenging for me, I believe it would be impossible for many others, given the public scrutiny and the cost.

29. I believe strongly in advocating for families and their right to choose what is best for them, because it is no one's business but their own. Nobody should be prevented from doing what is right for the benefit of their family. I have decided that the right decision for me and my family is an abortion, and I support Planned Parenthood's lawsuit to protect patients like me.

30. I have chosen to submit this declaration under a pseudonym because of the highly personal information I share here, and to protect myself and my family from public scrutiny.

I declare under penalty of perjury under the laws of the United States of America and the State of Utah that the foregoing statements are true and correct to the best of my knowledge, information, and belief.

Signed on July 10, 2022, in Sevier County, Utah.

/s/ Ann Moe
Ann Moe*

For internal records only:

Signature: _____

Printed Name: _____

Attachment 7

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**pro hac vice forthcoming*
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IN THE THIRD JUDICIAL DISTRICT COURT

SALT LAKE COUNTY, STATE OF UTAH

PLANNED PARENTHOOD ASSOCIATION OF UTAH, on behalf of itself and its patients, physicians, and staff, Plaintiff, vs. STATE OF UTAH, *et al.*, Defendants.	**BRIEF OF AMICI CURIAE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION** Case No. 220903886 Judge Andrew Stone

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Amici Curiae the American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), and the Society for Maternal-Fetal Medicine ("SMFM") respectfully request leave to file the attached proposed Brief of *Amici Curiae* in Support of Plaintiff's Motion for a Preliminary Injunction.

INTEREST OF *AMICI CURIAE*

ACOG is the nation's leading group of physicians providing health care for women. With more than 62,000 members, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care. ACOG has appeared as *amicus curiae* in courts throughout the country. ACOG's briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court, as a leading provider of authoritative scientific data regarding childbirth and abortion.[1]

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and

[1] *See, e.g.*, *June Medical Servs. LLC v. Russo*, 140 S. Ct. 2103 (2020); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG in assessing disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions); *see also Gonzales v. Carhart*, 550 U.S. 124, 170-171, 175-178, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's brief and congressional submissions regarding abortion procedure).

other physician groups seated in the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policymaking process. The objectives of the AMA are to promote the art and science of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state. The AMA's publications and amicus curiae briefs have been cited in cases implicating a variety of medical questions in courts across the U.S., including the U.S. Supreme Court. The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

SMFM, founded in 1977, is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM represents more than 5,500 members who care for high-risk pregnant people and provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing a high-risk pregnancy.

INTRODUCTION AND SUMMARY OF ARGUMENT

Abortion is an essential part of comprehensive health care. When abortion is legal, it is safe. *Amici curiae* are leading medical societies representing physicians, nurses, and other clinicians who serve patients in Utah and nationwide, and whose policies represent the

education, training, and experience of the vast majority of clinicians in this country. *Amici*'s position is that state laws that criminalize and effectively ban abortion:

(1) are not based on any medical or scientific rationale;

(2) threaten the health of pregnant patients;

(3) disproportionately harm patients of color, patients in rural settings, and patients with low income; and

(4) impermissibly interfere with the patient-physician relationship and undermine longstanding principles of medical ethics.

As the AMA has recently recognized, "it is a violation of human rights when government intrudes into medicine and impedes access to safe, evidence-based reproductive health services, including abortion and contraception."[2]

In the wake of *Dobbs v. Jackson Women's Health Org.*, 597 U.S. ___ (2022), Utah now intends to enforce Utah Crim. Code § 76-7a-101, *et seq.* (the "Criminal Abortion Ban"), which imposes criminal penalties on individuals who provide abortions. The Criminal Abortion Ban was designed to become effective upon certification to the Legislative Management Committee by the legislative general counsel that "a court of binding authority has held that a state may prohibit the abortion of an unborn child at any time during the gestational period," subject to certain exceptions.[3]

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[2] AMA, *Press Release: AMA bolsters opposition to wider criminalization of reproductive health* (June 14, 2022), https://www.ama-assn.org/press-center/press-releases/ama-bolsters-opposition-wider-criminalization-reproductive-health.

[3] 2020 Utah Laws Ch. 279, § 4(2).

Amici oppose Utah's Criminal Abortion Ban because it would—without any valid medical justification—jeopardize the health and safety of pregnant people in Utah and place extreme burdens and risks upon providers of essential reproductive health care.

ARGUMENT

I. Abortion Is a Safe, Common, and Essential Component of Health Care

The medical community recognizes abortion as a safe and essential component of reproductive health care.[4] Abortion is a common medical procedure. In 2020, over 930,000 abortions were performed nationwide.[5] More than 2,700 abortions were performed in Utah in 2019.[6] Approximately one quarter of American women have an abortion before the age of 45.[7]

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[8] Complication rates from abortion are extremely low, averaging

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[4] *See, e.g.*, Editors of the *New England Journal of Medicine*, the American Board of Obstetrics and Gynecology, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) (stating the view of the Editors of the New England Journal of Medicine along with several key organizations in obstetrics, gynecology, and maternal-fetal medicine that "[a]ccess to legal and safe pregnancy termination … is essential to the public health of women everywhere"); ACOG, *Abortion Policy* (revised and approved May 2022); Soc'y for Maternal-Fetal Med., *Access to Pregnancy Termination Services* (2017).

[5] Jones et al., Guttmacher Inst., *Long-Term Decline in US Abortions Reverses, Showing Rising Need for Abortion as Supreme Court is Poised to Overturn* Roe v. Wade (June 15, 2022).

[6] Utah Dep't of Health, *Utah Vital Statistics: Abortions 2019,* at 20 (Nov. 2021), https://vitalrecords.health.utah.gov/wp-content/uploads/Abortions-2019-Utah-Vital-Statistics.pdf.

[7] Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 Am. J. Pub. Health 1904, 1908 (2017).

[8] *See, e.g.*, National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 10 (2018) ("*Safety and Quality of Abortion Care*") ("The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E, or induction— are safe and effective. Serious complications are rare.").

around 2%, and most complications are minor and easily treatable.[9] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[10] In 2019 there were only 5 abortions in Utah with reported complications, which was 0.2% of all abortions in Utah.[11] The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.[12] By contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[13] In fact, abortion is so safe that there is a greater risk of complications or

[9] *See, e.g.*, Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (finding 2.1% abortion-related complication rate); *Safety and Quality of Abortion Care*, at 55, 60.

[10] White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015). This is also true for medication abortions, which account for more than 40 percent of all abortions in Utah and about half of abortions nationwide. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 30 (2013) (regarding major complication rates for medication abortion); Utah Dep't of Health, *Utah Vital Statistics: Abortions 2019*, *supra* note 6, at 24 (number of Utah medication abortions, category labeled "medical non-surgical"); Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022) (nationwide data).

[11] Utah Dep't of Health, *Utah Vital Statistics: Abortions 2019*, *supra* note 6, at 25.

[12] *See* Kortsmit et al. U.S. Dep't of Health & Human Services, Centers for Disease Control and Prevention, *Abortion Surveillance—United States, 2019*, 70 Morbidity & Mortality Weekly Rep. 1, 29 tbl. 15 (2021) (finding mortality rate from 0.00041% to 0.00078% for approximately five-year periods from 1978 to 2014); Zane et al., *Abortion-Related Mortality in the United States*, 1998-2010, 126 Obstetrics & Gynecology 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

[13] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[14]

Similarly, there are no significant risks to mental health or psychological well-being resulting from abortion care. Recent long-term studies have found that women who obtain wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion," and that receiving an abortion did not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to women who were forced to continue a pregnancy to term.[15] One recent study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[16]

II. Despite the Safe and Routine Nature of Abortions, Utah's Criminal Abortion Ban Would Prohibit Nearly All Abortions with No Medical Justification

Utah's Criminal Abortion Ban will—without any valid medical justification—jeopardize the health and safety of pregnant people in Utah and place extreme burdens and risks upon

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[14] ANSIRH, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (Dec. 2014) (2.1% of abortions result in minor or major complications—with 1.88% resulting in minor complications and 0.23% resulting in major complications—compared to 7% of wisdom-tooth extractions, 8-9% of tonsillectomies, and 29% of childbirths); American Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011) (33% of colonoscopies result in minor complications); Grazer & de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000) (mortality rate from liposuction in late 1990s was 20 per 100,000); Kortsmit et al., *Abortion Surveillance—United States, 2019*, 70 Morbidity & Mortality Weekly Rep. 1, 29 tbl. 15 (2021) (mortality rate from legal induced abortion was between 0.52 and 0.63 per 100,000 in late 1990s, dropping to 0.41 in the years 2013-2018).

[15] Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psychiatry 169, 177 (2017).

[16] Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLoS ONE 1, 7 (2015).

providers of essential reproductive health care by criminalizing nearly all abortions.[17] The State legislature offered no specific findings justifying its Criminal Abortion Ban, but in support of prior abortion restrictions, it has cited, *inter alia*, the State's interest in saving the lives of pregnant women and "prevent[ing] grave damage to [pregnant women's] medical health."[18] The Criminal Abortion Ban does not further those stated interests and is not medically justified. To the contrary, the Ban will harm the health of pregnant people in Utah, as described *infra* Part III, and creates arbitrary, unnecessary, and conflicting responsibilities for medical providers, see *infra* Parts III.B, V.

The Criminal Abortion Ban prohibits abortions,[19] with only three narrow exceptions: (1) where the abortion is necessary to avoid death or "serious risk of substantial and irreversible impairment of a major bodily function"; (2) where two physicians who practice maternal-fetal medicine agree, in writing, that the fetus has a defect that is "uniformly diagnosable" and "uniformly lethal" or a "severe brain abnormality"—defined narrowly—that is "uniformly diagnosable"; and (3) where the pregnancy is the result of rape or incest ***and*** the physician who performs the abortion verifies that the rape or incest has been reported to law enforcement and complies with any additional reporting requirements.[20]

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[17] The Criminal Abortion Ban's definition of "abortion" includes that the termination be done "through a medical procedure carried out by a physician or through a substance used under the direction of a physician." Utah Crim. Code § 76-7a-101(1)(a).

[18] Utah Crim. Code § 76-7-301.1(4).

[19] Utah Crim. Code § 76-7a-101(1)(a); *id.* § 76-7a-201(1).

[20] Utah Crim. Code § 76-7a-201(1).

The criminal penalties established by the Ban will prohibit nearly all abortions from occurring in the state. Individuals convicted of violating the Criminal Abortion Ban are subject to a penalty of one to fifteen years of imprisonment and a fine of up to $10,000.[21] Moreover, physicians and facilities risk losing their professional licenses under the Ban.[22]

Prohibiting the vast majority of abortions deprives pregnant patients of important health care with no medical justification. Abortions are extremely safe,[23] and eliminating access to abortions does not improve the health of pregnant patients; rather, it jeopardizes their health and safety without advancing any legitimate medical interest and forces physicians to make the untenable choice between their ethical obligations to serve the best interest of their patients and their livelihoods.

III. By Prohibiting Abortions, the Criminal Abortion Ban Will Harm Pregnant Patients' Health

Utah's Criminal Abortion Ban would cause severe and detrimental physical and psychological health consequences for pregnant patients who want to obtain an abortion. First, while abortion is overall a safe medical procedure, the risk of complications and associated costs are lower the earlier the abortion is performed—and the Criminal Abortion Ban will likely cause delays in obtaining an abortion. Second, pregnant individuals may be more likely to attempt self-managed abortions using harmful or unsafe methods—that is, self-managed methods other than procuring appropriate medications through licensed providers.[24] Third, continuing a

[21] Utah Crim. Code § 76-3-203(2); *see also id.* § 76-3-301(a).

[22] Utah Crim. Code § 76-7a-201(4)-(5).

[23] *See supra* Part I.

[24] The safety of medication abortion is well established. *See supra* note 10.

pregnancy to term presents higher risk to the health and mortality of the pregnant patient than obtaining a safe, legal abortion. Each of these outcomes increases the likelihood of negative consequences to the patient's physical and psychological health that could be avoided if abortion were available.[25]

The Criminal Abortion Ban's limited exceptions (defined *supra* Part II) are insufficient to protect the health of pregnant patients because they do not permit abortion care in a wide range of circumstances that could risk substantial harm to patients. They also contain elements that are too vague to provide workable guidance that clinicians can rely on when attempting to structure their practices in compliance with the Criminal Abortion Ban, and they compromise clinicians' ability to rely on their sound medical judgment to determine the best treatment plan and provide care.

A. *The Ban Will Endanger the Physical and Psychological Health of Pregnant Patients*

Criminalizing safe abortions provided by a licensed clinician in the State of Utah will likely result in delays in obtaining abortions. Typically, many delays in seeking an abortion are caused by the patient's lack of information about where to find abortion care.[26] The need to travel out of state and consider various states' individual criminal and/or civil penalties related to abortion is likely to further increase confusion for patients about where they can find needed health care. In addition, almost a third of delays are caused by travel and procedure costs.[27]

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[25] *See, e.g.*, ACOG, Committee Opinion No. 815, *Increasing Access to Abortion* (Dec. 2020).

[26] Udapdhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (Sept. 2014).

[27] *Id.*

With no in-state abortion providers, the travel and procedure costs for Utahns seeking abortion will likely increase. For example, a 2020 analysis demonstrated that the closure of Utah's abortion clinics would result in an over tenfold increase in the average required travel distance for Utahns seeking an abortion.[28] This distance could increase even further if states surrounding Utah, including Idaho, adopt similarly restrictive abortion bans. Though the risk of complications from abortion care overall remains exceedingly low, increasing gestational age results in an increased chance of a major complication.[29] Moreover, abortions at later gestational ages are typically more expensive, further increasing the barriers to obtaining care.[30]

By removing access to safe, legal abortion, the Criminal Abortion Ban will also increase the possibility that a pregnant patient will attempt self-managed abortions through harmful or unsafe methods.[31] Studies have found that women are more likely to self-manage abortions when they face barriers to reproductive services, and methods of self-management outside safe medical abortion (i.e., abortion by pill) may rely on harmful tactics such as herbal or

[28] Bearak et. al., Guttmacher Inst., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care* (updated Apr. 23, 2020) (finding that, on average, Utah abortion clinic closures would increase an abortion-seeking Utahn's driving distance from 27 miles to 299 miles).

[29] Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 9, at 181.

[30] Jones et al., *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009).

[31] *See, e.g.*, Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, at 3, 8 (2019) (noting a rise in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest).

homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing dangerous hormonal pills.[32]

Those patients who do not, or cannot, obtain an abortion due to the Criminal Abortion Ban will be forced to continue a pregnancy to term—an outcome with significantly greater risk to the health of the pregnant individual and of mortality. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[33] and rates have sharply increased since then.[34] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.[35] A pregnant patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[36]

Continued pregnancy and childbirth also entail other substantial health risks for the pregnant person. Even an uncomplicated pregnancy causes significant stress on the body and involves physiological and anatomical changes. Moreover, continuing a pregnancy to term can exacerbate underlying health conditions or cause new conditions. For example, approximately 6-7% of pregnancies are complicated by gestational diabetes mellitus, a condition which frequently

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[32] Grossman et al., Tex. Pol'y Eval. Proj. Res., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015).

[33] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 13, at 216.

[34] MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6% increase in maternal mortality rates between 2000 and 2014).

[35] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 13, at 216.

[36] *Id.*

leads to maternal and fetal complications, including developing diabetes later in life.[37] Preeclampsia, another relatively common complication, is a disorder associated with new-onset hypertension that occurs most often after 20 weeks of gestation and can result in blood pressure swings, heart disease, liver issues, and seizures, among other conditions.[38]

Labor and delivery are likewise not without significant risk, including those of hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that occurs when the placenta is unable to detach at childbirth), hysterectomy, cervical laceration, and debilitating postpartum pain, among others.[39] Approximately one in three people who give birth in the United States do so by cesarean delivery, a major surgical procedure that carries increased risk of complications.[40]

Evidence also suggests that pregnant people denied abortions because of gestational age limits are more likely to experience negative psychological health outcomes—such as anxiety, lower self-esteem, and lower life satisfaction—than those who obtained a needed abortion.[41]

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[37] ACOG Practice Bulletin No. 190, *Gestational Diabetes Mellitus* (Feb. 2018).

[38] ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (Dec. 2018).

[39] ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017); ACOG Obstetric Care Consensus, *Placenta Accreta Spectrum* (July 2012, reaff'd 2021); ACOG Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery* (Sept. 2018); ACOG Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management* (Sept. 2021).

[40] CDC, *National Vital Statistics Reports Vol. 70, No. 2, Births: Final Data for 2019* (2021); ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery* (Mar. 2014, reaff'd 2016).

[41] Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, *supra* note 15, at 172.

B. *The Narrow Exceptions to the Criminal Abortion Ban Do Not Adequately Protect Patients' Health*

The narrow maternal health-related exceptions of the Criminal Abortion Ban are insufficient to protect the health of the pregnant patient. Pregnancy can exacerbate existing health issues that do not necessarily or always lead to death or permanent impairment of a major bodily function, but nevertheless pose serious health risks for patients during pregnancy. Examples include: Alport Syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve), lupus (a connective tissue disease that may suddenly worsen during pregnancy and lead to blood clots and other serious complications), pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy), and diabetes (which can worsen to the point of causing blindness as a result of pregnancy).[42]

Further, the Criminal Abortion Ban fails to take into account whether patients experienced issues that threatened their lives or the permanent impairment of a major bodily function during prior pregnancies. Any of these prior conditions can progress or reoccur if abortion care is not available. Various complications that present danger to the health of the pregnant patient also can directly affect fetal development and survival. For example, if a patient experiences premature rupture of membranes and infection, preeclampsia, placental abruption,

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[42] *See* Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (Feb. 2007); Stout & Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (May 2007); Cortes-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646-647 (2002); Kiely et al., *Pregnancy and Pulmonary Hypertension; A Practical Approach to Management*, 6 Obstetric Med. 144, 153 (2013); Greene & Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004).

and/or placenta accreta, that patient may be at risk of extensive blood loss, stroke, and/or septic shock, all of which would negatively affect the fetus. Each of these examples demonstrates why decisions about whether to continue a pregnancy are properly left with the clinicians and patients involved, rather than entrusted to legislators without reference to facts and medical evidence.

Other elements of the Criminal Abortion Ban's exceptions are equally problematic. For example, by limiting the maternal life and health exception only to death and "substantial and irreversible impairment of a major bodily function," the Criminal Abortion Ban fails to consider maternal mental health issues that can put a pregnant patient's health and life at risk.[43]

Additionally, the requirement that two physicians agree in writing that a particular fetal defect or brain abnormality qualifies a patient for an abortion is a medically unnecessary roadblock to care, and the legislature's standards for what constitutes a qualifying defect or abnormality intrude on physicians' judgment and the patient-physician relationship. Not to mention that the narrow definition for fetal defect or brain abnormality may exclude a wide range of fetal anomalies that are serious, but not necessarily fatal.

Further, the exception for pregnancy resulting from rape or incest applies only where the patient seeking an abortion has reported (or has authorized the physician to report) the attack to law enforcement. This requires pregnant patients to choose between accessing the abortion services they need and their ability to maintain privacy and control over the intensely personal decision of whether and how to report their assault. This may dissuade patients from seeking an

[43] *See, e.g.*, Mangla et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019).

abortion or endanger patients by forcing them to report an assault to law enforcement against their wishes.

It is untenable to force pregnant patients to wait until their medical condition escalates to the point that an abortion is necessary to prevent death or permanent injury to a major bodily function or life-sustaining organ before being able to seek potentially life-saving medical care. Nor should physicians be put in the impossible position of either letting a patient deteriorate until one of these narrow exceptions is met or face potential criminal punishment for providing medical care in contravention of the Criminal Abortion Ban. Indeed, that impossible choice could cause some physicians to second guess the necessity of critical abortion care until the pregnant patient has a serious medical complication or it is too late to save the pregnant patient's life. The limited exceptions described here indefensibly jeopardize patients' health.

IV. The Criminal Abortion Ban Will Hurt Rural, Minority, and Poor Patients the Most

The Ban will disproportionately impact people of color, those living in rural areas, and those with limited economic resources. *Amici* are opposed to abortion policies that increase the inequities that already plague the health care system in this country.

In Utah, approximately 27.1% of patients who obtained abortions in 2019 were Hispanic and approximately 4.8% were Black.[44] In addition, 75% of abortion patients nationwide are living at or below 200% of the federal poverty level.[45] Patients with limited means and patients living in geographically remote areas will be disproportionately affected by the closure of clinics,

[44] *See* Utah Dep't of Health, *Utah Vital Statistics: Abortions 2019*, *supra* note 6, at 20.

[45] Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (2016).

which requires them to travel longer distances (and pay higher associated costs) to obtain safe, legal abortions. These travel and procedure costs are compounded by the fact that other Utah laws create substantial financial barriers to abortion care (e.g., lack of coverage under insurance policies).[46]

The inequities continue after an abortion is denied. As explained *supra* Part III.A, forcing patients to continue pregnancy increases their risk of complications, and the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion. Nationwide, Black patients' pregnancy-related mortality rate is 3.2 to 3.5 times higher than that of white patients, with significant disparities persisting even in areas with the lowest overall mortality rates and among patients with higher levels of education.[47] Black patients in Utah experience severe maternal morbidity, defined as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to health, at a rate 1.5 times higher than white patients,[48] making continuing an unwanted pregnancy to term disproportionately dangerous for them. The Ban thus exacerbates inequities in maternal health and reproductive health care, disproportionately harming the most vulnerable Utahns.

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[46] Guttmacher Inst., *State Facts About Abortion: Utah* (June 2022).

[47] CDC, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019) (3.2 times); MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 11 Am. J. Pub. Health 1673, 1676-77 (Sept. 22, 2021) (3.55 times).

[48] Utah Dep't of Health, *A Utah Health Disparities Profile Maternal Mortality and Morbidity among Utah Minority Women*, at 16 (Jan. 2021), https://healthequity.utah.gov/wp-content/uploads/2022/02/UtahHealthDisparitiesProfileMaternalMortalityMorbidity2021.pdf.

V. The Criminal Abortion Ban Forces Clinicians To Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law

Abortion bans such as the one at issue in this case violate long-established and widely accepted principles of medical ethics by: (1) substituting legislators' opinions for a physician's individualized patient-centered counseling and creating an inherent conflict of interest between patients and medical professionals; (2) asking medical professionals to violate the age-old principles of beneficence and non-maleficence; and (3) requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

A. *The Criminal Abortion Ban Undermines the Patient-Physician Relationship by Substituting Flawed Legislative Judgment for a Physician's Individualized Patient-Centered Counseling and by Creating Conflicts of Interest Between Physicians and their Patients*

The patient-physician relationship is critical for the provision of safe and quality medical care.[49] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests with the best available scientific evidence.[50] ACOG's Code of Professional Ethics states that "the welfare of the patient must form the basis of all medical judgments," and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the

[49] ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaff'd and amended Aug. 2021) ("*Legis. Policy Statement*").

[50] AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion 1.1.1* ("The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.").

patient."[51] Likewise, the AMA Code of Medical Ethics places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[52] The Criminal Abortion Ban forces physicians to supplant their own medical judgments—and their patients' judgments—regarding what is in the patients' best interests with the legislature's non-expert decision regarding whether and when physicians may provide abortions.

As described above, abortions are safe, routine, and, for many patients, the best medical choice available for their specific health circumstances. There is no rational or legitimate basis for interfering with a physician's ability to provide an abortion where both the physician and patient conclude that is the medically appropriate course. Laws that have the effect of banning abortion in nearly all circumstances are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

The Criminal Abortion Ban also creates inherent conflicts of interest. Physicians need to be able to offer appropriate treatment options based on patients' individualized interests without regard for the physicians' own self-interest.[53] Here, however, by prohibiting physicians from performing abortions, the Utah Criminal Abortion Ban profoundly intrudes upon the patient-physician relationship. For example, if a patient's health were compromised, the law would only allow an abortion in the face of death or substantial and irreversible impairment of a major bodily function, regardless of the overall medical advisability of the procedure or the desire of

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[51] ACOG, *Code of Professional Ethics* 2 (Dec. 2018).

[52] AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion 1.1.1*.

[53] *See* ACOG, *Legis. Policy Statement*, *supra* note 49.

the patient. A physician and patient together may conclude that an abortion was in the patient's best medical interests even though the risk posed by continuing the pregnancy does not rise to the narrow standard set forth in the Criminal Abortion Ban's exceptions. The Ban thus forces physicians to choose between the ethical practice of medicine—counseling and acting in their patients' best interest—and obeying the law.[54]

B. *The Ban Violates the Principles of Beneficence and Non-Maleficence*

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions nearly 2,500 years ago.[55] Both of these principles arise from the foundation of medical ethics which requires that the welfare of the patient forms the basis of all medical decision-making.[56]

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make a decision informed by both medical science and their individual lived experiences.[57]

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[54] *Cf.* AMA, *Patient Rights, Code of Medical Ethics Opinion 1.1.3* ("Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.").

[55] AMA, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology* 1, 3 (Dec. 2007, reaff'd 2016).

[56] *See supra* notes 49-52 and accompanying text.

[57] ACOG, Practice Bulletin No. 162: *Prenatal Diagnostic Testing for Genetic Disorders*, 127 Obstetrics & Gynecology e108 (May 2016).

The Criminal Abortion Ban pits physicians' interests against those of their patients. If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the physician to recommend that course of treatment. And if a patient decides that an abortion is the best course of action, those principles require the physician to provide, or refer the patient for, that care. But the Criminal Abortion Ban, with its narrow medical exceptions, prohibits physicians from providing that treatment and exposes physicians to significant penalties if they do so. It therefore places physicians at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or protecting themselves personally. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

C. *The Criminal Abortion Ban Violates the Ethical Principle of Respect for Patient Autonomy*

Finally, a core principle of medical practice is patient autonomy—the respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[58] Patient autonomy revolves around self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[59] The Criminal Abortion Ban would deny patients the right to make their own choices about health care if they decide they need to seek an abortion.

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[58] ACOG, *Code of Professional Ethics*, *supra* note 51, at 1 ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental").

[59] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021); AMA, *Code of Medical Ethics Opinion 2.1.1*.

CONCLUSION

For the foregoing reasons, this Court should enjoin enforcement of the Criminal Abortion Ban.

RESPECTFULLY SUBMITTED this 8th day of July 2022.

/s/ David C. Reymann

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 8th day of July 2022, I electronically filed the foregoing **BRIEF OF AMICI CURIAE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION**, which served all counsel of record.

/s/ David C. Reymann