

No. 20-1791

IN THE
United States Court of Appeals for the Eighth Circuit

IN RE LESLIE RUTLEDGE,
in her official capacity as ATTORNEY GENERAL
OF THE STATE OF ARKANSAS, ET AL.,

Petitioners.

On Petition for a Writ of Mandamus
from the Eastern District of Arkansas
No. 4:19-CV-00449-KGB
Hon. Kristine G. Baker

**BRIEF OF THE AMERICAN PUBLIC
HEALTH ASSOCIATION AND EXPERTS IN
PUBLIC HEALTH AS *AMICI CURIAE* IN
SUPPORT OF RESPONDENTS**

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INTEREST OF AMICI CURIAE¹

Amici curiae are public health experts, clinicians, and epidemiologists. Their work is devoted to understanding how diseases spread in populations, how best to prevent and treat them, and how to use that information to ensure that public policies are supported by rigorous medical and scientific evidence.

The American Public Health Association is an organization of nearly 25,000 public health professionals that champions the health of all people and all communities, strengthens the profession of public health, shares the latest research and information, promotes best practices, and advocates for public health issues and policies grounded in research.

The individual *amici* are leaders in their field: they include professors at Yale, Harvard, Columbia, NYU, Emory, and Johns Hopkins, and directors of public health institutes. *Amici* have

¹ No party's counsel authored this brief in whole or in part. No party, party's counsel, or any person other than amicus or its counsel contributed money intended to fund preparing or submitting this brief. A complete list of amici is attached as Appendix A. Pursuant to Fed. R. App. P. 29(a)(2) & (6), *amici* have filed a motion for leave to file this brief.

responded to SARS, Zika, Ebola, HIV/AIDS, Tuberculosis, and other local and global disease outbreaks, working as, or with, front-line public health practitioners, public health researchers, government advisory panels, legislators, global health security teams, and non-profit organizations to develop innovative solutions to emerging infectious diseases.

Amici share a professional commitment to evidence-based research and public health. From that perspective, *amici* are deeply concerned by Arkansas’ decision to restrict access to abortions during the COVID-19 pandemic because it will endanger public health.

ARGUMENT

I. Burdening Access To Essential Reproductive Healthcare During A Pandemic Is Not Justified Under Public Health Principles.

Public health control measures must be “evidence-informed”: Pandemic response should be guided by the best available scientific evidence and respect for individual autonomy.² Any public health

² Ethics Subcomm. of the Advisory Comm. to the Dir., Centers for Disease Control & Prevention (CDC), *Ethical Guidelines in Pandemic Influenza* 8-9 (2007) (“CDC, *Ethical Guidelines*”), <https://tinyurl.com/yam7f63u>; CDC, *Field Epidemiology Manual*:

measure must be “proportional to the risk presented by those affected, scientifically sound, transparent to the public, the least restrictive means to protect public health, and regularly revisited to ensure that they are still needed as the epidemic evolves.”³ Restrictions that are not evidence-informed and carefully tailored can cause the very harms to public health that the response to the pandemic intends to avoid.

A. Essential healthcare must be maintained during a pandemic.

An effective public health response must contain the spread of the contagion and maintain access to essential healthcare services.⁴ One category of pandemic-mitigation measures, referred to as

Developing Interventions (2018), <https://tinyurl.com/yc3bnr4d>; Yale Sch. of Pub. Health & Yale Law Sch., *Achieving a Fair and Effective COVID-19 Response* 4 (Mar. 2, 2020) (“Yale COVID-19 Letter”), <https://tinyurl.com/squkg6w>; Am. Med. Ass’n, *AMA Underscores Importance of Science, Data in COVID-19 Fight* (Apr. 7, 2020), <https://tinyurl.com/ya2wtccs>.

An “evidence-informed” standard is “somewhat less rigorous” than an “evidence-based” standard because it acknowledges that public health officials responding to a pandemic may have to make decisions with imperfect information. CDC, *Ethical Guidelines*, *supra*, at 8.

³ Yale COVID-19 Letter, *supra* n.2, at 1; *see also* CDC, *Ethical Guidelines*, *supra* n.2, at 5.

⁴ World Health Organization, *COVID-19 Strategic Preparedness and Response Plan 2* (Feb. 12, 2020), <https://tinyurl.com/yadtahgu>.

“nonpharmaceutical interventions,” reduces the effective rate of human-to-human transmission of the virus through means such as community hygiene, surveillance and diagnostic measures, isolation of the sick, and social distancing.⁵ These interventions can help maintain healthcare capacity until pharmaceutical interventions—vaccines and antiviral drugs—become available.⁶ But because nonpharmaceutical interventions can limit individual freedom and, like other kinds of interventions, cause unintended negative consequences, they must be approached with “great care” and carefully tailored to avoid outsized social harm.⁷

Restricting access to healthcare services during a pandemic should only be undertaken if there is evidence that it will improve public health and not endanger the health of patients who require

⁵ Julia E. Aledort et al., *Non-pharmaceutical Public Health Interventions for Pandemic Influenza: An Evaluation of the Evidence Base*, 7 BMC Pub. Health 208, 210 (2007), <https://tinyurl.com/y7b39dwz>.

⁶ A. Wilder-Smith & D.O. Freedman, *Isolation, Quarantine, Social Distancing and Community Containment: Pivotal Role for Old-Style Public Health Measures in the Novel Coronavirus (2019-nCoV) Outbreak*, 27 J. of Travel Med. 1, 3 (2020), <https://tinyurl.com/yd4xx8hj>; CDC, *Ethical Guidelines*, *supra* n.2, at 2 n.8.

⁷ CDC, *Ethical Guidelines*, *supra* n.2, at 4.

access to those services. Guidance on nonpharmaceutical interventions discusses restrictions on social gatherings by closing schools, encouraging workplace telecommuting, and cancelling mass gatherings such as concerts, festivals, and sporting events; not the restriction of access to essential healthcare.⁸

When considering postponing nonessential healthcare in a pandemic, one of the key questions is which health services are essential and “time-sensitive” and which are not.⁹ In evaluating particular procedures, officials should seek guidance from public health

⁸ *E.g.*, CDC, *Community Mitigation Guidelines to Prevent Pandemic Influenza—United States, 2017*, 66 *Morbidity & Mortality Wkly. Rep.* 1, 1-2, 6 (2017) (“CDC, *Community Mitigation*”), <https://tinyurl.com/y7fotw5d>; Joseph Barbera et al., *Large-Scale Quarantine Following Biological Terrorism in the United States*, 286 *J. Am. Med. Ass’n* 2711, 2711, 2716 (2001); Harunor Rashid et al., *Evidence Compendium and Advice on Social Distancing and Other Related Measures for Response to an Influenza Pandemic*, 16 *Paediatric Respiratory Revs.* 119, 121 (2015); Howard Markel et al., *Nonpharmaceutical Interventions Implemented by US Cities During the 1918-1919 Influenza Pandemic*, 298 *J. Am. Med. Ass’n* 644, 645 (2007), <https://tinyurl.com/r2sbucg>; Aledort, *supra* n.5, at 213.

⁹ World Health Organization, *COVID-19: Operational Guidance for Maintaining Essential Health Services During an Outbreak 4* (Mar. 25, 2020), <https://tinyurl.com/razyn78> (“WHO, COVID-19 Operational Guidance”).

experts who can apprise them of the likely consequences of postponement based on evidence and sound medical judgment.

Without essential health services, many will suffer serious medical consequences or even die from conditions that were otherwise treatable. Experience in past epidemics has shown that lack of access to essential health services can result in increases in morbidity and mortality that last long after the epidemic, and can result in more deaths than those caused by the epidemic itself.¹⁰

In addition, denying access to essential health services undermines the effectiveness of public health guidance to self-isolate and practice social distancing. People are less likely to cooperate with public health directives if they need to seek other means of obtaining medical services for themselves or their family members.¹¹

¹⁰ Inter-Agency Working Grp. on Reproductive Health in Crises, Programmatic Guidance for Sexual and Reproductive Health in Humanitarian and Fragile Settings During the COVID-19 Pandemic 1 (Apr. 10, 2020), (“IAWG, COVID-19 Guidance”), <https://tinyurl.com/y99jxnlc>; cf. Nishant Kishore et al., *Mortality in Puerto Rico after Hurricane Maria*, 379 *New Eng. J. Med.* 162, 168 (2018).

¹¹ Yale COVID-19 Letter, *supra* n.2, at 3-5; Robert J. Blendon et al., *Public Response to Community Mitigation Measures for Pandemic*

B. Abortion is essential healthcare.

“Abortion is an essential health service.”¹² *Amici* agree that access to abortion must be maintained during the COVID-19 pandemic. This is consistent with the views of prominent medical and public health organizations, including the American Medical Association, American College of Surgeons, and the American College of Obstetricians and Gynecologists.¹³

Influenza, 14 *Emerging Infectious Diseases* 778, 780 tbl.1 (2008), <https://tinyurl.com/y8mfxt5>.

¹² Michelle J. Bayefsky et al., *Abortion During The Covid-19 Pandemic—Ensuring Access to an Essential Health Service*, *New Eng. J. Med.* (Apr. 9, 2020), <https://tinyurl.com/ycgyv7qw>.

¹³ Am. Med. Ass’n, *AMA Statement on Government Interference in Reproductive Health Care* (Mar. 30, 2020), <https://tinyurl.com/y8m7bv95>; Am. Coll. of Surgeons, *COVID 19: Elective Case Triage Guidelines for Surgical Care: Gynecology* (Mar. 24, 2020), <https://tinyurl.com/ybqt99sd>; Am. Coll. of Obstetricians and Gynecologists, *Joint Statement on Abortion Access during the COVID-19 Outbreak* (Mar. 18, 2020) (“ACOG Joint Statement”), <https://tinyurl.com/y8n3p4xu>; *accord* United Nations Population Fund, *COVID-19: A Gender Lens* 1, 1 (Mar. 2020) (“UNFPA, Gender Lens”), <https://tinyurl.com/y9l7fetu>; Royal Coll. of Obstetricians & Gynaecologists, *Coronavirus (COVID-19) Infection and Abortion Care* 5 (Mar. 21, 2020), <https://tinyurl.com/y9l5n34s>; Int’l Fed. of Gynecology and Obstetrics, *Abortion Access and Safety With COVID-19* (Mar. 31, 2020), <https://tinyurl.com/y7q897dn>.

Abortion is a time-sensitive medical need. Pregnant women have a limited amount of time during which to seek a safe and legal abortion. While abortion is safe, potential health risks increase as it is delayed.¹⁴ Moreover, the risk of complications from abortion increases as gestation progresses.¹⁵ And delay in care can be especially “devastating” for “high risk groups,” like pregnant women “with significant co-morbidities, or who are seeking termination for reasons of fetal anomaly.”¹⁶

Restricting access to abortion may also mean that delay renders abortion unavailable to women whose pregnancies are at later gestational ages when fetal abnormalities are diagnosed, or who face barriers in reaching a clinic. Pregnancies carried to term have far higher rates of mortality and morbidity than abortions¹⁷ The recent Ebola outbreaks in West Africa demonstrated the importance of maintaining reproductive health services during an epidemic, as

¹⁴ ACOG Joint Statement, *supra* n.13; Int’l Fed. of Gynecology and Obstetrics, *supra* n.13.

¹⁵ *See* ACOG Br. at 9.

¹⁶ Royal Coll. of Obstetricians & Gynaecologists, *supra* n.13, at 6.

¹⁷ *Id.* at 5; Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216-17 (2012), <https://tinyurl.com/ybph5ujz>.

obstacles in obtaining essential reproductive healthcare there led to dramatic increases in maternal morbidity and mortality.¹⁸

Given these risks, public health officials must ensure that the expected impact of any nonpharmaceutical intervention during a pandemic, such as restricting access to an essential healthcare service like abortion, will advance and not endanger public health.

II. Arkansas' Restriction Of Abortions Will Exacerbate This Public Health Crisis With No Corresponding Benefit.

A. Interstate travel increases when abortions are not available locally.

Effective public health measures account for the negative consequences of interventions used to curtail a health crisis.¹⁹ Any potential intervention can be ill-suited to a particular health scenario,

¹⁸ Benjamin Black & Gillian McKay, Covid-19 and Reproductive Health: What Can We Learn From Previous Epidemics? (Mar. 19, 2020), <https://tinyurl.com/yad4mdp6>; Patricia A. McQuilkin et al., *Health-Care Access During the Ebola Virus Epidemic in Liberia*, 97 *Am. J. of Tropical Med. & Hygiene* 931, 934 (2017), <https://tinyurl.com/y7phxy65>; Laura Sochas et al., *Counting Indirect Crisis-Related Deaths in the Context of a Low-Resilience Health System: The Case of Maternal and Neonatal Health During the Ebola Epidemic in Sierra Leone*, 32 *Health Policy & Planning* 32, 37-38 (2017), <https://tinyurl.com/yy3753v7>.

¹⁹ Kathryn Oliver et al., *Understanding the Unintended Consequences of Public Health Policies: The View of Policymakers and Evaluators*, 19 *BMC Pub. Health* 1, 1-2 (2019), <https://tinyurl.com/y6wg7o8w>.

either because the intervention causes “paradoxical effects”—i.e., it worsens the adverse outcome it is designed to mitigate—or “harmful externalities”—i.e., it has negative secondary effects that can outweigh the intervention’s expected benefits.²⁰

Arkansas contends that it is necessary to restrict abortion to reduce social contact and control transmission of COVID-19. But not only has Arkansas failed to implement less drastic recommended interventions—e.g., temporarily closing nonessential businesses—its efforts to restrict local access to abortion will likely increase social contact by forcing women to travel to obtain care out of state.

Research shows that it is now far more likely that the virus will spread within the United States by daily and interstate travel than from international sources.²¹ Reducing interstate travel is vital to any

²⁰ Chris Bonell et al., *Dark Logic: Theorising the Harmful Consequences of Public Health Interventions*, 69 *J. Epidemiology & Community Health* 95, 95 (2014), <https://tinyurl.com/yacsmchv3>.

²¹ Joseph R. Fauver et al., *Coast-to-Coast Spread of SARS-CoV-2 in the United States Revealed By Genomic Epidemiology* 7 (Mar. 26, 2020), <https://tinyurl.com/yabr7wt9>.

evidenced-informed mitigation strategy aimed at slowing transmission of the virus.²²

For pregnant people, some travel is unavoidable whether for pregnancy-related care or abortion care. But rather than minimize the distance traveled by women seeking this care, Arkansas' abortion restriction will further increase interstate travel.²³ Procedural abortions currently account for more than 80% of abortions performed in Arkansas.²⁴ Pregnant women in states with more restricted abortion access are likely to travel farther to obtain an abortion.²⁵ Under Arkansas' restriction, pregnant women will need to travel significantly

²² See, e.g., CDC, *Public Health Recommendations for Community-Related Exposures*, <https://tinyurl.com/t7fnvba>; CDC, *Community Mitigation*, *supra* n.8, at 1; Scott Gottlieb et al., Am. Enter. Inst., National Coronavirus Response 3-4 (Mar. 28, 2020), <https://tinyurl.com/vldomvg>; World Health Org. Writing Grp., *Nonpharmaceutical Interventions for Pandemic Influenza, National and Community Measures*, 12 *Emerging Infectious Diseases* 88, 92 (2006), <https://tinyurl.com/y8u53zbz>.

²³ Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 *J. Women's Health* 708, 708 (2013); Jonathan Bearak et al., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care*, *Guttmacher Inst.* 1 & tbl. 1 (updated Apr. 8, 2020) <https://tinyurl.com/y7u299dn>.

²⁴ Tara C. Jatlaoui et al., *Abortion Surveillance – United States, 2016*, 68 *Morbidity & Mortality Wkly. Rep.* 1 (2019).

²⁵ Jones & Jerman, *supra* n.23, at 710.

farther to receive procedural abortions—84% will need to travel more than 100 miles to access abortion care in another state.²⁶

Because increasing interstate travel will increase contacts, Arkansas' abortion restriction is likely to increase transmission of SARS-CoV-2, the virus that causes COVID-19. Pregnant women who travel out of state to obtain abortions will likely interact with more people, including at gas stations and stops along the way for food and bathrooms.²⁷ If pregnant women are exposed to SARS-CoV-2 during their out-of-state travel to obtain abortions, it will endanger their own health and create additional potential transmission events during their time away and when they return home. These consequences of restricting abortion run counter to an evidence-informed approach to controlling the current pandemic.

B. When abortion is restricted, longer pregnancies require more healthcare contacts and use more PPE.

Restricting abortion access will also require more women to carry their pregnancies longer, including to term, leading to an increased risk

²⁶ Bearak et al., *supra* n.23.

²⁷ See, e.g., Emergency Application, App.14, 151-52, 163, 233, 307-08, *Planned Parenthood Center for Choice v. Abbott*, No. 19A1019 (U.S. Apr. 11, 2020).

to pregnant women, and an increase in healthcare contacts, and PPE use.

Women who remain pregnant longer because of restrictions on access to abortion will have more contacts with the healthcare system. First, forcing women to wait until the directive expires to obtain a procedural abortion will impose delay, as would requiring pregnant women to arrange to travel out of state.²⁸ Delaying a procedural abortion can require a two-day procedure, which is more complex and requires more clinic visits than a one-day procedure.²⁹

Second, pregnant women attend an average of 11.4 prenatal visits during their pregnancy.³⁰ And a substantial proportion of pregnant women seek emergency care during their pregnancy.³¹ In one recent

²⁸ See Kari White et al., *Experiences Accessing Abortion Care in Alabama among Women Traveling for Services*, 26 *Reproductive Health* 298 (2016).

²⁹ Pltfs.' Opp. 4-5, 8.

³⁰ Urania Magriples et al., *Prenatal Health Care Beyond the Obstetrics Service: Utilization and Predictors of Unscheduled Care*, 198 *Am. J. Obstetrics Gynecology* 1, 5 (2008), <https://tinyurl.com/ydb2xq27>.

³¹ 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, 940-41 (2017), <https://tinyurl.com/yan96osp>.

study, 49% visited the emergency department at least once, and 23% visited twice or more.³² Pregnant women with a comorbid condition—about 27% of the pregnant population in the United States—are even more likely to seek emergency care both before and after their pregnancy due to complications.³³ Restricting or delaying access to abortion increases risks to maternal health and increases the frequency of healthcare contacts, thereby undermining the effectiveness of social distancing policies in reducing viral transmission.³⁴

Women who receive timely abortions, in contrast, use far fewer healthcare resources than when they are forced to delay their abortions or continue their pregnancies. Abortions generally do not require hospital facilities—most take place at an outpatient facility.³⁵ Major complications from procedural abortions are rare—occurring in only

³² *Id.*

³³ *Id.* at 943.

³⁴ See Sonja A. Rasmussen et al., *Pandemic Influenza and Pregnant Women*, 14 *Emerging Infectious Diseases* 95, 97 (2008), <https://tinyurl.com/ybkkch67>.

³⁵ Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *Obstetrics & Gynecology* 175, 175, 177 & tbl.1 (2015), <https://tinyurl.com/y74qp2dg>; Grace Shih & Robin Wallace, *First-Trimester Pregnancy Termination: Uterine Aspiration*, UpToDate (Jan. 2020).

0.21% of abortions—and so rarely require hospitalization, with its attendant PPE usage and contacts with healthcare workers.³⁶

Restricting access to abortion during the COVID-19 pandemic thus creates a “paradoxical effect”: rather than conserving PPE and limiting contacts, causing women to carry their pregnancies further than they otherwise would results in increased contacts and PPE use.

An evidence-informed evaluation based on scientific evidence and sound medical judgment leads *amici* to the exact opposite conclusion from that of the State: There is no public health benefit to restricting access to abortion during the COVID-19 pandemic. The State’s directive forecloses access to an essential healthcare service, reduces the effectiveness of social distancing by increasing travel and contacts, and requires more healthcare resources. Restricting access to abortion needlessly endangers the welfare of pregnant women and the general public.

³⁶ Upadhyay, *supra* n.35, at tbl.3 178-79.

III. Arkansas' Restriction Of Abortions Will Exacerbate Deeply-Rooted Health Inequities.

Because of longstanding segregation by income and race, reduced economic mobility, and the high cost of medical care, pandemics exacerbate existing structural inequities in access to healthcare for low-income communities and people of color.³⁷ Any effective public health response to a pandemic should seek to minimize risk of morbidity and mortality by accounting for existing inequity in healthcare access, underlying social determinants of health, and broader social inequities.³⁸ Restricting access to essential reproductive health services worsens preexisting inequalities by placing disproportionate burdens on low-income and women of color, thus undermining public health.

³⁷ See Human Rights Watch, *US: Address Impact Of Covid-19 On Poor* (Mar. 19, 2020) (“HRW, *Covid-19 On Poor*”), <https://tinyurl.com/y8wbv4w7>; Sandra Crouse Quinn & Supriya Kumar, *Health Inequalities and Infectious Disease Epidemics*, 12 *Biosecurity and Bioterrorism* 263, 265-67 (2014) (“*Health Inequalities*”), <https://tinyurl.com/y8kal3wv>.

³⁸ See *Health Inequalities*, *supra* n.37, at 265-67.

Poverty, race, ethnicity, gender, and low social status all correlate directly with poorer health outcomes during pandemics.³⁹ “Low-income communities are more likely to be exposed to the virus, have higher mortality rates, and suffer economically.”⁴⁰ Black communities are contracting COVID-19 at disproportionate rates.⁴¹

Nonpharmaceutical interventions like social distancing are more onerous for low-income communities and people of color.⁴² During past influenza pandemics, “socially disadvantaged groups have fared the worst of any population.”⁴³

³⁹ See *id.* at 263; Ian Askew et al., *Sexual and Reproductive Health and Rights in Emergencies*, 94 Bull. World Health Org. 311 (2016); HRW, *Covid-19 On Poor*, *supra* n.37.

⁴⁰ HRW, *Covid-19 On Poor*, *supra* n.37.

⁴¹ John Eligon et al., *Black Americans Face Alarming Rates of Coronavirus Infection in Some States*, N.Y. Times, Apr. 7, 2020, <https://tinyurl.com/rtd25vj>.

⁴² Blendon, *supra* n.11, at 782.

⁴³ Debra DeBruin et al., *Social Justice in Pandemic Preparedness*, 102 Am. J. Pub. Health 586, 586 (2012), <https://tinyurl.com/y8olbrek>; accord Sandra Crouse Quinn et al., *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, 101 Am. J. of Pub. Health 285 (2010), <https://tinyurl.com/y8rvghce>.

The “social and economic upheaval associated with epidemics” has a particularly “negative[] impact on sexual and reproductive health.”⁴⁴ Three out of four pregnant women who seek abortions are low-income.⁴⁵ The children of women who are denied abortions are more likely to live in poverty.⁴⁶ Arkansas ranks 46th out of 50 states in maternal mortality, with 44.5 deaths overall and 76.3 deaths for black women per 100,000 births.⁴⁷

Low-income pregnant women are also unlikely to have the means to travel out of state to seek medical care.⁴⁸ When reproductive healthcare is restricted, even temporarily, low-income pregnant women may seek unsafe abortions.⁴⁹ Structural inequities in accessing healthcare make low-income women particularly vulnerable to the

⁴⁴ Black & McKay, *supra* n.18.

⁴⁵ Guttmacher Institute, *Induced Abortion in the United States* (Sept. 2019), (“*Induced Abortion*”), <https://tinyurl.com/l789emu>.

⁴⁶ ANSIRH, *Women’s Access to Abortion Improves Children’s Lives* (Jan. 2019), <https://tinyurl.com/y9xjtkwg>.

⁴⁷ United Health Foundation, *Maternal Mortality in Arkansas 2019*, <https://tinyurl.com/yayozkjy>.

⁴⁸ Kari White et al., *The Potential Impacts of Texas’ Executive Order on Patients’ Access to Abortion Care 3*, Tex. Pol’y Evaluation Project, Mar. 2020, <https://tinyurl.com/y7krvh8f>.

⁴⁹ Susheela Singh et al., *Abortion Worldwide 2017: Uneven Progress and Unequal Access 4*.

serious and life-threatening complications that result from unsafe abortions.⁵⁰

Obtaining abortion services, even once the restriction is lifted, will be disproportionately burdensome for low-income women, who are more likely to be facing economic hardship.⁵¹ Low-income women often have more difficulty getting abortion appointments.⁵² Moreover, because demand for treatment will surge when access is restored, a shortage in treatment capacity is probable, which will be shouldered disproportionately by disadvantaged communities.⁵³

Restricting access to abortion also harms disadvantaged communities that are at greater risk for intimate partner violence. Reproductive healthcare providers are often the first and only point of contact for low-income women who experience intimate partner

⁵⁰ *Id.*

⁵¹ Alan Berube & Nicole Bateman, *Who Are the Workers Already Impacted by the COVID-19 Recession?*, Brookings (Apr. 3, 2020), <https://tinyurl.com/ydcx5vbl>.

⁵² *E.g.*, White, *Potential Impacts*, *supra* n.48, at 3.

⁵³ *Id.* at 2.

violence.⁵⁴ Unwanted pregnancy is a risk factor for intimate partner violence.⁵⁵ The rate of intimate partner violence is higher among low-income women.⁵⁶

As in past pandemics, it is likely that intimate partner violence will increase during the COVID-19 pandemic,⁵⁷ particularly for pregnant women denied abortion.⁵⁸ Unintended pregnancies, a risk factor for intimate partner violence, will be more prevalent.⁵⁹ Home confinement and shelter-in-place orders will raise the probability of reproductive coercion. These consequences of restricting abortion will disproportionately impact disadvantaged communities.

⁵⁴ Elizabeth Miller et al., *A Family Planning Clinic Partner Violence Intervention to Reduce Risk Associated with Reproductive Coercion*, 83 *Contraception* 274 (2011).

⁵⁵ CDC, *Violence Prevention: Risk and Protective Factors for Perpetration* (“CDC, *Violence Prevention*”), <https://tinyurl.com/kzpobtg>.

⁵⁶ Callie Rennison & Mike Planty, *Nonlethal Intimate Partner Violence: Examining Race, Gender, and Income Patterns*, 18 *Violence & Victims* 433, 436-41 (2003).

⁵⁷ UNFPA, *Gender Lens*, *supra* n.13, at 6; *accord* IAWG, *COVID-19 Guidance*, *supra* n.10, at 3.

⁵⁸ 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 (2014), <https://tinyurl.com/y9ucrlqx>.

⁵⁹ Black & McKay, *supra* n.18; CDC, *Violence Prevention*, *supra* n.55.

IV. The Pandemic Will Continue for Months And Any Delay In Access To Abortions Will Cause Substantial Negative Public Health Consequences.

The COVID-19 pandemic is projected to last several months, if not longer. Until a vaccine or antiviral treatment becomes available, controlling the spread of the virus presents a major public health challenge. As this initial wave of COVID-19 cases is brought under control, strict social distancing measures will be relaxed.⁶⁰ But as that happens, viral transmission will increase. It is expected that strict measures will need to be reinstated periodically to “slow the spread” of the virus.⁶¹ Some experts have warned that nonpharmaceutical interventions to control the spread of COVID-19 could continue to be necessary as late as 2022.⁶² If access to abortion is restricted any time the State must return to these strict nonpharmaceutical interventions to bring COVID-19 under control, there will be profound consequences on women’s ability to access timely, safe abortion.

⁶⁰ The White House, Guidelines for Opening Up America Again, <https://tinyurl.com/y7rwpj78>.

⁶¹ Gottlieb, *supra* n.22, at 7-8.

⁶² *E.g.*, Stephen Kissler et al., *Social Distancing Strategies for Curbing the COVID-19 Epidemic* 1 (Mar. 2020), <https://tinyurl.com/t6fjdw>.

CONCLUSION

The Court should deny the petition for mandamus.

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This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and 21(d)(1) because this brief contains 3893 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the appellate CM/ECF system on April 21, 2020.

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