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WEBINAR

REPRODUCTIVE RIGHTS AND JUSTICE: THE POST-ELECTION LANDSCAPE

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UNCORRECTED TRANSCRIPT

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PELL: Welcome to today's webinar on reproductive rights and justice, the post-election landscape. I'm Stephanie Pell, a fellow in Governance Studies at the Brookings Institution. You can submit questions for our panel via X formerly Twitter @BrookingsGov. With the #ReproductiveRights. The 2024 election results will shape the reproductive rights and justice landscape for years to come. When the Supreme Court overturned Row v Wade in June of 2022, a great deal of power was placed in the hands of states to determine whether and under what circumstances women and pregnant people would be able to access reproductive health care. Following the Dobbs decision, a number of states, whether through trigger laws already on the books or through new legislation passed in the wake of Dobbs banned or severely restricted abortion care. But that isn't the entire story. A number of states, through ballot initiatives, have enshrined abortion rights in their state constitutions. Some abortion protective states have passed shield laws, which, among other things, enable providers in these states to prescribe medication abortion via telehealth to people living in states with abortion bans or severe restrictions. These abortion protective efforts are bolstered through actions taken by the FDA under the Biden-Harris administration that expanded access to medication abortion. The election of Donald Trump further challenges and complicates efforts to protect reproductive rights and provide equitable access to reproductive health care. Today we have assembled a distinguished set of panelists to explain the terrain that is before us. I'll briefly introduce everyone. Before we begin the discussion. Caroline Sacerdote is a senior attorney at the Center for Reproductive Rights, where she litigates reproductive rights cases across the United States. Allison Kiser is the senior director of external affairs at Planned Parenthood South Atlantic, and serves as the executive director of its advocacy and political arm. Planned Parenthood Votes South Atlantic. In these roles, she manages the organization's community organizing communications, public policy and electoral work across North Carolina, South Carolina, West Virginia and Western Virginia, Greer Donely is the associate dean for research and faculty development and an associate professor of law at the University of Pittsburgh School of Law. She is a national expert on abortion and the law and is widely published on topics related to medication, abortion, inter jurisdictional abortion conflicts and the impact of abortion bans on other aspects of reproductive health care. Beth Schlachter is the senior director of US external relations at MSI Reproductive Choices, where she leads engagement with US based partners and the US government. Beth has worked in the women's health and rights sector for close to 20 years and has also worked for 15 years in the US State Department, where she led US government policy on sexual and reproductive health rights. Caroline, I'd like to start with you. Since the Supreme Court issued the Dobbs decision, the Center for Reproductive Rights has been engaging in litigation at the state level. Can you talk about the strategy behind this litigation? What is its focus and goals, and what are some of the examples of cases you all have litigated?

SACERDOTE: Sure. Thank you for that question, Stephanie. Good morning to everyone. And I'm so grateful to be here and to have this conversation with all of you and the other amazing panelists. First off, I cannot stress enough that state constitutional protections are hugely important. This has always been the case. We know Row was a floor. It was not a ceiling. And working in state courts is a way to try to establish rights that are broader than Row rights that would both protect a wider swath of reproductive rights and justice issues. And that would force states to actually justify their attacks on access to abortion care, including holding them to a higher standard that doesn't allow for junk science or hateful rhetoric. Losing the federal constitutional right to abortion in 2022 ramped up the urgency of the state work. But it has always been vital, and the center has actually been doing it for decades. To that end, we have brought a number of cases in state courts to establish reproductive rights under state constitutions. So that we are not relying solely on the federal constitution. And we have actually had a lot of success in that area. For example, in July, we actually secured two landmark victories in the Kansas Supreme Court. Successfully striking down harmful abortion restrictions. These wins are the result of 13 years of legal battles against a web of Kansas laws that unfairly targeted abortion care. And they actually build on a 2019 when in one of these same cases which established that the Kansas Constitution protects the right to abortion. So we're already using these two additional 2024 wins as a foundation to continue challenging other laws that stigmatize and delay abortion care in Kansas. And this is just one example of how state constitutional protections can be used. And I'll just add that since Dobbs, we really have continued to do this work. And we have also brought cases around the country challenging exceptions to abortion bans. This includes state court litigation in Texas, Tennessee, North Dakota and Idaho, where we actually have a team of attorneys right now in a three week trial. And in one of those cases, a North Dakota trial court blocked the state's abortion ban and recognized that that state constitution protects the right to procreative autonomy, including to seek and obtain pre viability abortion care. So this is huge. And we'll continue fighting for North Dakota as that case makes its inevitable way up to the North Dakota Supreme Court. And the center will continue doing this work around the country.

PELL: So, Caroline, one of the bright spots of the election or maybe the only bright spot in terms of reproductive rights and rights and justice was state ballot initiatives. Can you talk about what happened with these ballot initiatives, as I understand it? Ten states had ballot initiatives in the 2024 election.

SACERDOTE: Yes, that's correct. And I'll start by saying we were thrilled to see so many ballot measures passed this year. You know, as a litigator, I am primed to run into court. That's what I do every day. But we

have seen that courts change the way that they interpret rights over time. And so ballot initiatives are really crucial because they are an avenue for voters to establish explicit protections firmly in their own state constitutions. We've seen the power of strong protections in states like Michigan, where the center is currently challenging multiple restrictions on abortion under the state's 2022 reproductive freedom for All amendment. So what happened last week in this latest election, voter initiated, proactive constitutional amendments were on the ballot in eight states Arizona, Colorado, Florida, Missouri, Montana, Nebraska, Nevada and South Dakota. And voters approved these initiatives in five states Arizona, Colorado, Missouri, Montana and Nevada. Unfortunately, proactive amendments failed to pass in three states in Florida, Nebraska and South Dakota. While 57% of voters in Florida, my home state, voted yes. Florida actually requires a supermajority of 60% to amend the Constitution. The constitutional amendment in Nebraska, which would have protected the right to abortion through at least the first two trimesters of pregnancy, also failed to pass, while the constitutional amendment that was backed by anti-abortion groups that would ban abortion after the first trimester was unfortunately approved by voters in that state. And finally, the constitutional amendment in South Dakota that would have established a right to abortion also failed to pass. And I'll tell you that a variety of factors, including well-funded oppositions, high voting thresholds and anti-abortion groups creating dueling ballot initiatives contributed to the failure of these amendments but nevertheless, the support, particularly in Florida, is really an encouraging sign for future abortion advocacy in those states and was extremely exciting to see. And I'll end by noting that voters also approved two legislatively referred proactive constitutional amendments in New York and Maryland. And just as a practical note, what does this actually mean? In Missouri, which had banned abortion, the state constitution was amended to protect the right to reproductive freedom including abortion. And in a state with a total ban on abortion and a hostile legislature, the amendment opened new pathways for litigation to challenge that existing ban. And indeed, litigation has already been filed to do just that. In Missouri and in Arizona, advocates now have a constitutional protection for abortion that could lead to challenges against the state's 15 week ban, as well as support for the legislature to repeal numerous unnecessary restrictions on abortion. So, you know, while abortion was already protected in Colorado, Montana and Nevada, the amendments to these state constitutions will strengthen abortion protections in those states for the reasons I cited as this explicit protection that is so hugely valuable.

PELL: So, Alison, I'd like to turn to you now for a clinic perspective. You work at Planned Parenthood, South Atlantic, which has clinics in four different states North Carolina, South Carolina, West Virginia and Virginia. And each of these states has different abortion laws and in some cases, ban abortion with very limited

exception. So then how is Planned Parenthood South Atlantic navigating and providing care in a post Dobbs environment where states have different abortion laws?

KISER: Thanks, Stephanie. And it's so nice to be with you today. It's great to be among my friends and to talk about these important issues. So, yes, Planned Parenthood, South Atlantic, we do cover four states and have 14 health centers where we're providing care across those four states. As you noted, though, the abortion laws across these states are very different. West Virginia has a total ban with only very narrow exceptions. South Carolina has a ban where abortion is nearly inaccessible past around six weeks of pregnancy. Then in North Carolina, it is the only other state besides Virginia where abortion is available in the southeast past six weeks of pregnancy. And then North Carolina does have a 12 week ban in addition to a host of other restrictions that make abortion less accessible even before 12 weeks. And then in Virginia there, that is the only state in the southeast where abortion is accessible past 12 weeks of pregnancy. So it's a very diverse landscape for abortion access in our region. And I'll just highlight that Virginia is kind of a case study in why elections matter, because, in fact, the most onerous restrictions that are were previously in place in that state were repealed shortly before jobs, which now obviously after the fall of Roh, has facilitated much more access in Virginia. But it's really difficult to overstate how Planned Parenthood, South Atlantic has been impacted by the bans in the states that that we serve and the states that surround us. So as we've noted, Florida now with a six week ban. South Carolina, as I mentioned, and Georgia as well with a six week ban. I would also add Tennessee, which is, you know, a has a total ban with very narrow exceptions, is also really influencing how patients receive care in in that state and having to move across state lines. So in these bans states where we have a ban around six weeks of pregnancy all year. South Carolina as an example, we find that we can only help about 20, 25% of the patients that come through our doors. Everyone else must be referred out of state, usually to North Carolina, because it's the closest. And as a result of all these total bans and near-total ban, since, you know, six weeks of pregnancy is before many people know they are pregnant at this time, 40% of the patients we're seeing in North Carolina are seeking care from out of state. They're coming to us from out of state and direct response to this. We have launched a patient navigation program that is specifically designed to help people receive care who have to travel to receive it. This includes people within the state who mainly live far from operating clinic. And it also includes people from out of state as well. And the sort of support we provide folks through our patient navigation program includes assistance covering the cost of their abortion, but also travel costs and incidental costs such as child care hotels. We are getting more and more people onto airplanes in order to receive care as they're forced to travel longer distances. And so just as a sort of example of what the impact of these bans around us looks

like, the number of patients we helped navigate to North Carolina and Virginia from out of state tripled between April of this year and May. And of course, what happened on May 1st of this year is Florida's six week ban went into effect. And just to go a little bit deeper on Florida, because it also can't be overstated how devastating that ban has been for access in the southeast. Last year, 2023, there were approximately 80,000 abortions performed in Florida. And for contacts in North Carolina, all the providers together, Planned Parenthood and non Planned Parenthood providers provided about 49,000 abortions. So, well, everyone in our infrastructure has done their level best to expand access. Two patients from out of state who need care. We have to acknowledge the reality that it's never going to fully be enough to meet the need. Not just for Florida, but for all these states, all these patients who need care. And the fact is that some people will find their way to care and access states. Others will be forced to seek care outside the formal health care system or are forced to remain pregnant against their will. So with that first reality in mind, we are doing our very best to meet the demand. Currently, our wait times for our services range from about 10 to 14 days. These wait times to get appointments are made longer by some of the restrictions we have on the books, particularly in North Carolina, that were designed for that very purpose to make abortion harder to access. And, you know, at the end of the day, the all the efforts we have put in to expand access to care and serve as many people as possible, we just also have to acknowledge that access is very tenuous and there's little room for error. And just as an example, I will list the Planned Parenthood Asheville Clinic in Asheville, North Carolina, which was recently impacted by Hurricane Helene and had to shut down for more than a month because we didn't have electricity then. We didn't have access to water. This was a huge blow to access and the region because 60% of the patients we were seeing in Asheville prior to that forced closure were coming in from out of state. So we're really having to meet these huge challenges of navigating people to other areas, really just responding in the moment to meet the needs. And the last thing I'll note is just there is also a human impact here that we're seeing that is really difficult to quantify because what we're hearing through our navigation program is that people are fearful. They're fearful about returning home to their van state if they need to seek additional medical care. Some people feel that's limiting their options. They're more likely to choose a procedural abortion than a medication abortion because they just want to know when they leave that day that they are no longer pregnant and that it's done. So this is this is not a choice that patients should be having to make because they are fearful about what it looks like after they leave our health centers. So, you know, it's a very challenging environment right now. But we are committed to continuing to provide care and fighting back against additional bans as they come up in our states to maintain what access we do have and can't provide in our region.

PELL: And is it is it fair to say that, you know, you all at Planned Parenthood, South Atlantic, have really quite rapidly adapted to the changing landscape in the Southeast?

KISER: We have really had to adapt quickly in in our region, both because we see these bands happening in our surrounding states and because of the changing legislative landscape in the states that we do cover. So just to lift up North Carolina as an example, a North Carolina is not alone in the fact that we have many restrictions on abortion, but it is a case study in how kind of these arbitrary gestational bans interplay with restrictions that were on the books since before Roosevelt. And so, you know, just as an example of how we've had to respond quickly, when the 12 week abortion ban was passed in North Carolina in May of 2023, it required that patients make two in-person visits to our health centers in order to receive care. This was a new requirement. There were previously two visits required, but the first one could take place by phone. In this new law that was no longer the case. Two in-person required visits, which means that we had to completely restructure our operations. It had a huge blow to capacity because if you think about that restriction, every one patient is really like two because it's two appointments we have to make for them. So it had it really reduced capacity. We stepped up to expand access as much as we could, adding new appointments, having to providers and clinic on any given day whenever we could. And you know our motto at Planned Parenthood clinic when it comes to our operations is defiance through compliance. We are going to comply with the law so we can continue to provide care to all those who need it. But we are committed to to figuring out how to navigate these cruel bans that are being put in place in addition to the other restrictions that are clearly designed to shame patients to make it harder to access care. And, you know, we were it took us about a month to figure out how to operationalize SB 20. But once we put the systems in place, we were seeing more patients than ever before. Just two months after that ban went into effect. So we are certainly putting our motto into into action and serving as many people as as possible, even in the face of these challenging circumstances.

PELL: So, Greer, I'd like to turn to you next. We've been talking about state litigation challenges or about state litigation and the challenges of providing reproductive health care in states with restrictive abortion laws. But there are things, positive things to talk about in terms of efforts by abortion protective states to make it easier for their providers to deliver reproductive health care to patients living not only in those states, but also to patients who live in banned states or states with highly restrictive laws. So can you talk about the role that telehealth and medication abortion is playing in these efforts and how abortion protective states like Massachusetts have enabled their providers to deliver care?

DONELY: Yeah. So first thanks to Stephanie and Brookings for putting this together and for the other wonderful panelists. It's always great to learn from you. So just as, you know, a little bit of level setting for those who don't know. Right. Abortion can happen via a procedure or via a medication regimen. So, you know, before about the year 2000, all of the abortions in this country happened with a procedure. But in 2000, the FDA approved the first medication abortion regimen. It's a two drug regimen. The first drug is called mifepristone and the second drug is called misoprostol. Only the first drug in that two drug regimen is actually approved for abortion. The second drug is approved as a stomach ulcer medication and is being used off label for a variety of obstetric purposes. But, you know, this drug regimen was approved in 2000, but it actually didn't really take off in terms of like, you know, having a large number of people that were taking advantage of it because the FDA had imposes very onerous restrictions on it that made it really hard for people to access. And over time, they started kind of to remove some of these burdensome restrictions, write restrictions that do not exist for most the vast majority of approved drugs on the market. So in 2016, the Obama administration removed some of them. And then, of course, the big one happened right in the wake of the Covid pandemic where the Biden administration came in and remove what was known then as the in-person dispensing requirement, a federal requirement that forced throughout the country. Right. Because it's federal, not state that forced people to show up in person to do nothing more than pick up a prescription. Right. So, you know, a lot of data was starting to come out, particularly in the Covid pandemic, that this requirement was completely medically unnecessary. Of course, the docs had been talking about that for a long time and the FDA followed the science and removed the in-person dispensing requirement. Once Biden came in, this opened up the doors and and wildly opened up the doors to allowing medication, abortion to really transform the abortion landscape. So ever since then, we've seen a significant rise of the percentage of abortions which are accomplished with medication alone. So the data is always a little bit behind. But the most recent data we have is that it's to two thirds of abortions are now accomplished with medication. So if you're obtaining an abortion with medication, there's some really you know, there's tradeoffs between medication and procedural abortion. But some of the benefits of it are that you can have the abortion in the privacy of your own home. If you don't have to go to a clinic, you can avoid the protesters who are there. You might not have to have fine child care. So there are a lot of benefits. And, you know, not for nothing, but the virtual abortion providers that kind of entered the space were also providing care at a much cheaper price, which is really important when you think about the fact that, you know, I think it's 75% of abortion patients or are at or below the federal poverty line, right? We have a high proportion of people who are poor or low income in this community who need care. So all of this stuff was happening in the background. And after

Dobbs came along overturning Row, there was an advocacy level at the States, which was thinking creatively about what it could do to try to increase access to people who were in banned states. And full disclosure, I was, you know, part of this a little bit, but there was a decision to pass what was known, what became known as shield laws. The first generation of these shield laws were just around to protect providers in blue states who were treating patients who had traveled from the South or Midwest into those states to receive care because they were. There was a lot of confusion at the time about whether states like Texas could prosecute those providers for treating their citizens. But the next generation of shield laws passed and a handful of states now, I think there's seven of them, allow providers protect providers who in states where tell abortion, telemedicine, abortion is already the norm for them for doing that, for patients who are not physically located in their state. And so this has allowed and many people refer to these people, the providers, as shield providers. This is allowed providers in places like New York and Massachusetts and California to meet with meet with people who are still sitting in Texas who never have to go to New York or North Carolina or wherever it is and can meet with the provider online and the provider can make sure that this is a safe option for them, talk through it with them, and then ship them the medication so that they could have the abortion at home alone by themselves. Now, there are some, you know, hypothetical legal risks that are very important for people to think about. But, you know, this has led to something close to 11,000 abortions. Being provided per month by shield providers. So we're talking about massive numbers of people who have been able to get care that may have not been able to travel. And so far, you know, the criminal risks have been very, very, very, very small. So we're talking about pretty massive benefits are pretty massive that like the shield providers are really mitigating some of the damage that jobs could have or did kind of create. So I'm going to, you know, put up this shiny like, you know, small silver lining only to dash everyone's hopes by saying that now with Trump coming in this this thing that has mitigated a lot of harm, that has really helped some people not fall through the cracks, particularly vulnerable people who are least likely to travel probably because they can't afford it and they're not able to find the funds and the patient navigators to help them. There are a lot of different levers that an incoming Trump administration could press to make that very difficult to to access in the future. And so, you know, one of those things is that the Trump administration could try to reimpose the in-person dispensing requirements, essentially at the federal level, banning telehealth for abortion. That would be very devastating for all virtual telehealth providers. So not just shield providers. But there are also virtual abortion providers that are operating completely, completely intrastate and that are helping to take away some of the burden from the brick and mortar clinics that that have come about since jobs and because of travel. So there's that there's potential things that the Trump administration could do at the FDA. But there's also this kind of there's this really important one that probably

many of you have heard of called the Comstock Act, a law, a federal law that was passed before women had the right to vote in 1873 that was never repealed and that anti-abortion advocates are trying to potentially bring back to life. So, you know, I assume we'll have some more time to talk about that in the Q&A. But it's worth noting that there's also a potential that the Trump administration could try to actually go after a virtual a virtual abortion provider, shield providers and even just regular providers that are offering care where it is legal through the Comstock Act. But, you know, we don't know for sure if and to what extent the Trump administration is going to, you know, use Comstock. But it is certainly a very serious risk that we all need to be starting to plan for.

PELL: I also would like to hit upon another effort taken by the Biden-Harris administration to ensure that women suffering pregnancy complications who need emergency care are able to receive such care in emergency rooms across the country. Under the Emergency Medical Treatment and Labor Act, commonly known as MTALA. So what is the current status of those efforts and how do you see them faring in a Trump administration?

DONELY: So so again, just for those of you who don't know, because I think this is a shocking statistic that very few people appreciate. You have six states in the country that have bans that don't even have a health exception. They only have a life exception. And those are the states where being pregnant is just a is is becoming a risky activity. Right? Of course. Hopefully everyone on this call knows that that every person who who chooses to be pregnant has a risk of death. Right. That's the reason we have a more maternal mortality number in every country. But in states that don't even allow people to get abortions for medically necessary reasons unless they are on death's door, that those risks increased significantly. So the Biden administration thought we have this great federal law, a law that requires all Medicare, emergency rooms, all emergency rooms that are reimbursed with Medicare to treat and stabilize patients who are experiencing medical emergency. And of course, sometimes pregnancy is the medical emergency that requires stabilization, and that stabilization happens through abortion. So they thought, you know what, let's try to use MTALA to tell all emergency rooms in states with bans that don't have a health exception that they are forced under federal law to provide this care, even if the state bans it. Why? Because the supremacy clause says that federal law trumps state law. It was a very important argument, even if it was only going to have an impact that this small, because we're talking about a very small number of of abortions in this country. But but a really important number of abortions in this country. Right. Because we're talking about people who could die without this care. So one of the most shocking things to me that sometimes I'm really surprised by the anti-

abortion movement was when Texas decided, you know, I thought this would be low hanging fruit. Right. Why would the anti-abortion movement go after, you know, medically necessary abortions? This is going to be totally unpopular. Well, immediately, Texas sued the Biden administration, right? They said, no, we demand that we have a right to be able to deny people medically necessary abortions. Right. Texas has been a very. Bad environment, post ops, environment. And so you know that cases is going on. And then we have on the other hand, the Biden administration sued Idaho and said Idaho is one of the states that lacked one of these health exceptions and said that was inconsistent with federal law. That case, we thought, went up to the Supreme Court the last term, only for the court to say we shouldn't have granted cert here anyway. Let's bring it back down to the Ninth Circuit. So that case is ongoing as well. I think the Trump incoming Trump administration is going to change. You know, I'd be really interested to hear Caroline's perspective on this as a litigator because she knows more about this than me. But we'll have to kind of see like how that what happens in the agency that could could shift how the litigation happens. Right. So presumptively, the Trump administration might remove that into the guidance. Now, I think that there's you know, we the litigation could continue with new plaintiffs. Right. Arguing not necessarily you don't necessarily have to have the government saying that or arguing that federal law protects folks. But, you know, we're going to have to see how think the procedural issues that will be involved with a different administration in the White House.

PELL: And zooming out a bit as these Biden-Harris administration efforts are abandoned or outright reversed under a Trump administration. How should we understand the impact on reproductive justice, which includes the right to have personal bodily autonomy, to have or not have children, along with equal access to reproductive health care for all communities?

DONELY: Yeah, I mean, I think that. There's a lot to say there, right? I mean, I think that one of the one of the most important lessons I think everybody is learning in this post jobs moment is that you cannot separate abortion from all other aspects of pregnancy care and reproductive health care. Right. So there's this is this fiction that the anti-abortion movement has been pressing and that I think so many people adopted without thinking about that. There's this thing called elective abortion and therapeutic abortion. Right. Good abortions, bad abortions. And we're learning in real time that that was always an artificial distinction, that all pregnancies carry the risk of death and in some sense, all abortions, therefore, are health saving abortions that for many people, choosing to get an abortion is also an important aspect of their mental health. So a lot of these distinctions are falling apart, in my opinion. And it's also it's thanks in part to the litigators like Carolyn, who are also litigating these exceptions that are making sure that people are appreciating and

hearing every day about the medical reasons why abortion is so necessary. So I think, you know, as we start to see the federal government now turn now, I think there's still some open questions, at least in my mind, about what Trump is going to do. I mean, RFK, he's a nut job, but he is actually not anti-abortion. I was I spent a lot of time looking this up yesterday. So, you know, he has spoken pretty outwardly about supporting abortion through viability. So, you know, maybe maybe he doesn't make that a part of his time at HHS. Maybe he doesn't roll back the MTALA rule. So we'll have to kind of see what happens there. But but certainly you are going to see really important changes that are going to happen across, you know, about people's expectations of safety in pregnancy. And then, of course, if if shield provision really does fall apart, I do think she'll provision has become a really important part of ensuring that low income communities are still able to get care. And, you know, I think that we are going to see really devastating outcomes in that respect because people are unable to get health care because they can't afford to travel and because abortion fund money is running out and because the movement is is, you know, is less has less money than it did right after Dobbs was overturned. And that's that kind of shield. The shield provision has kind of provided somewhat of a safety net that if it crumbles, we're going to see it's going to be really devastating to watch how many people become left behind.

PELL: So before turning to Beth, Caroline, if there is anything additional you want to add from a litigators perspective, love to hear that.

SACERDOTE: Sure. I can just chime in to say, you know, it's it's tough. We don't have a crystal ball. And I obviously can't speak to any, you know, confidential information about potential litigation. But what I can say is that we at the center, the other litigating reproductive rights, health and justice, or that we work with advocates at the national, state and local levels. We're all paying attention and we're not going anywhere. And so, you know, we we knew this was a possibility and we'll keep fighting.

PELL: So, Beth, for most of this discussion, we've been talking about the impact of the election on reproductive rights and access in the United States. But the coming Trump presidency will also impact women's health care internationally. Can you talk about some of the policies we may see under a Trump administration and how they could create some dramatic changes in women's health care globally?

SCHLACHTER: Thank you, Stephanie. I'm happy to do that. And I just want to thank the other panelists as well for their work and for sharing their experiences and and what they see ahead. When it comes to foreign

policy, it's important to understand the role the US plays currently, and this is a role that we have taken on as a responsibility when it comes to help. It's a moral responsibility when we work in partnership through a multilateral system or a bilateral system of country to country assistance. The US government provides over 65% of the overseas development assistance when it comes to global help, and that includes funding for HIV, Aids care, reproductive and maternal health care for sexual and reproductive health care, and for adolescents as well. So for good or for bad, the system is hugely dependent on the funding that's provided by the US government. We also have a really big footprint when it comes to funding the multilateral organizations that work in partnership with countries to expand their health programs through the World Health Organization, through the UN Population Fund Act. We are the largest funders to both of those organizations. So when you have an articulated framework like we see under Project 2025, which for right now is sort of the best indicator we have of where Trump administration might go with regard to reproductive health policy, What we're looking at is a massive disruption to the services and to the framework that work with countries to move us forward. When it comes to reproductive health care. So what was proposed under this bill, a lot of it is taking forward work that was started under the first Trump administration where they rewrote sort of norms and frameworks around reproductive health care using both the offices of state where Under Secretary of State Mike Pompeo, he convened what he called a commission on unalienable rights. They did a review of the US posture when it comes to human rights. And what this Commission determined and which was adopted as Trump administration official policy. Was that God's law, or what they call natural law, in their view, supersedes human rights law and should be the guiding framework for all US foreign assistance or foreign foreign affairs, foreign policy, if you will, to implement this worldview. The person who had been the leading this through HHS, who had the global purview, was Valerie Cooper, drafted a framework that they called the Geneva Consensus declaration. And they don't call it Geneva on accident. Geneva is the home of the Human Rights Council, but this is the framework that sits outside of the multilateral system. And what it did is it articulated a one page worldview, which was a heteronormative framework. That family only exists between one man and one woman and their offspring, and that there is no right to abortion. And in fact, abortion should not exist. So the Trump administration used the might of US foreign assistance and our our weight in the world to form partnerships with 36 countries who signed on to this declaration. Now, when this was in the in the latter part of the Trump administration, so when the Biden administration came in, they withdrew from the Geneva consensus declaration. And this Commission on Animal Rights just sort of gather dust on a shelf. But Valerie Huber and many others who were anti rights extremist have continued to push forward this anti right framework on forming partnerships with countries around the world to say, you know, the Trump administration might be coming back. And if they are, then

you want to be on the right side of this agreement. So Project 2025 proposes that this Geneva consensus declaration will be studied for US foreign relations beyond foreign assistance. Now, there's another process that has been going on for the last 40 years that was launched by Ronald Reagan, and he called it then the Mexico City policy, because it was launched in Mexico City. But it's been known for organization as a global gag rule, because what this gag rule said was that if you receive US family planning assistance and again, the US is the largest provider of family planning assistance, so what the policy to get attached to that money have a huge impact on the countries who receive that funding. So the global gag rule said for any international organization, if you receive if you are a partner with this foreign assistance, then you can not work on abortions, not refer for abortions. And you must be silent on this even within your own country. And you must ensure that all of your sub grantees also comply with this, even if it's not related to the funding. So it creates this sort of vast network that silences or gags everyone within this circle. For many years it only applied only to this $600 million of family planning assistance. The Trump administration expanded that to a program they called Preserving Life or Protecting Life in Global Health Assistance, though it went from 600 million to $7 billion. Now Project 2025 proposes that this be expanded again to all of us foreign assistance. So it would go from $7 billion to $50 billion. They also proposed to try and attach it to US based organization. So many of those who are based in the US are important partners through USAID and implementing these programs through PEPFAR and through global health assistance. Now, this was litigated in the early 2000s under the second Bush administration, and the Supreme Court at that point found that we had a constitutional right to abortion and that the US government could not constrain the free speech of US based organizations if they were doing that with their own money from another funder, because other restrictions always are imposed on all foreign assistance. In fact, in 1974 that you cannot use foreign assistance for purposes of abortion. But the global gag goes beyond that constraint. So what Project 2025 proposes is that they try again to impose this restriction on US based organizations. And we're already seeing a chilling effect on those who work on who receive US foreign assistance or based in the United States, an unwillingness to step forward on statements. There's an international family planning conference. It's considering how it how it positions itself as well and how rights implications within that. So we're seeing or self-censorship only nine days. And that's really quite surprising because organizations are businesses and they have to survive and they do more than reproductive health care and they can't put the entirety of their programs at risk because the threat of this global gag being imposed on their work. This will, of course, be litigated in organizations like Sierra are already working with others on how we can push back against this. But we know we have a Supreme Court that's hostile to reproductive rights. And so there's an anticipation that we might not prevail. So we have those threats. The US is also hugely important when it comes to the diplomats, the technical

experts that work at USAID, who work at the UN level and who work in partnership with countries as well. So this threat of Schedule F, which we now know that Elon Musk and Vivek Ramaswamy are overseeing, which proposes that they will purge the US government of those who are deemed to be unlawful. Many lists were already created under the last days of the Trump administration. So if we purge the system of the technical experts that are within it, and there's also a threat of defunding the U.N., we, the Republicans, always defund UNFPA. Right now, the US is the largest donor, 230 million, and about 190 million of that goes to humanitarian assistance. It's reproductive health care for women in a humanitarian crisis. That money will go away or it won't be refunded beyond what's already been expended. So that's going to have a massive impact on the most vulnerable women around the world. So if we look at this system where the UN is defunded, there's a threat of defunding US assistance. The technical experts within the US government are gone. Then we're looking at a vastly destabilized global development framework where other governments are going to have to reprioritize, reprioritize their investment to make up for the gaps that will come when the US imposes whatever is going to happen under the Trump administration. We also know that chaos is one of their operating frameworks and so other governments won't be able to plan for how they're going to fill these holes are just going to have to react to whatever the US government decides to do under a Trump administration. The last thing I'll say is that we've also proposed to create new positions at the White House, a proposed deputy assistant to the President for family and life and to have counterpart positions and all of the development and foreign affairs agencies so that this family heteronormative family framework, anti-abortion framework guides US foreign affairs and would be positioned through the NSC so that they would oversee all agencies in terms of how they implement that. When the global gag rule was last imposed. Just for my organization, Amici, who is the largest provider of reproductive health care in the 36 countries where we work, we saw that there were over 8 million women who lost access to reproductive health care, and that resulted in the deaths of over 20,000 women under the maternal health care. So what we're playing with are the lives of real people. And again, we made a moral pact when we get into agreements. Around funding and around technical assistance and improving health care systems. But this political football, which we're seeing, have a devastating impact on the lives of women, girls and all people who could become pregnant. The United States has a similar effect on countries around the world, and yet that never becomes a talking point within the broader context of what Americans understand is our role in the world. It's a huge tragedy that we take this responsibility on, and then we just play with it as if it has no meaning in the lives of people that we will never meet. And again, this irony is that they're doing it because they think that preventing abortion is a life affirming position. And yet we know that it's women and girls who will be dying. And we have the data and the numbers to back this up because it's been happening for 40 years. So I'll stop with that.

PELL: So let me ask you one additional sort of forward looking question. It sounds like after the next four years are over, we're really going to have to reconstitute. A new development framework, really redefine how our international assistance is going to work, because from what you are saying, it's just going to be devastated as we think forward. You know, what kinds of policies what do you think the next secretary of state chosen by a Democratic president, should focus on implementing to improve access to reproductive health care globally?

SCHLACHTER: Well, let me say this first that. You know, when the US government comes into these relationships and things come and go. It always depends on what they actually do with this funding now. Money is power. And so this idea that we're going to cut all this funding means that we're going to cut our influence with governments that we partner with. So I'm really curious to see how much of that development assistance a Trump administration is willing to walk back from, because that's giving away their power to compel others to behave in ways that they want for a variety of reasons. We I believe in global health assistance because I think it helps people everywhere to have better opportunities in their lives and to live healthier lives. But government often invest in foreign development assistance because of power. And so let's see how they work with that money and power and then what that framework looks like, because it's really Congress who who writes these laws and restrictions onto foreign assistance. So if there is foreign assistance that exists at the end of this from from the US when it comes to reproductive health care, then we will turn that back around. We have data and evidence on what the services are that people need. It's not terribly complicated. And in many ways, we're looking to include a justice framework as well that is holistic as we're talking about in the US and goes raises the opportunities for all people. So when a new secretary of state comes in, they'll have to work with the laws and pass the laws that get enacted by government and then create the policies that be able to move that forward. But we have never we have never had a US foreign assistance leadership that moves forward and compelled the US government to go up to where the restrictions are. They always exist. Well back of that because of the threat and the scrutiny that we're under from Congress. I love that line of defiance through compliance, because the typical fear that is really baked into the system now because of all of these decades of back and forth goes, is overly compliant. In many cases, it anticipates scrutiny that is heightened because they know that everything that everybody does is really under a microscope. And so what I hope we would have is instead of foreign assistance governance, that is brave and is absolutely compliant but doesn't self-censor and doesn't and isn't overly compliant and deals with that fear in that freezing that we impose into the global system along with our funding. And so I

think there's a leadership gap when it comes to Democrats as well. On reproductive health care is a foreign affairs issue. And I hope that someday we will we will do more on that line and not just recover from what happens. And Republicans are power in power, but to create a different paradigm that brings us all forward.

PELL: So before we turn to audience questions, Greer I'd like to ask you one additional thing based on some more recent work that you have done. How are different definitions and understandings of abortion and pregnancy complications further complicating many of the issues that all of the panelists have discussed?

DONELY: Yeah. So, I mean, I think that we all have this idea that we know what the word abortion means, but I think we're learning in real time that it's much more complex than we know. So I think I wrote a 115 page law review article about what is abortion mean, which is ridiculous. But there's a lot of there there, actually. Why? Because it turns out, you know, in medicine, the word abortion means miscarriage and what we normally think of as abortion. You know, I did a state by state survey comparing every single state's definition of abortion included in this appendix, discovering that there is actually, you know, a tepid pregnancy. It would be counted as an abortion if it's not specifically excluded within the abortion definition. So you often hear this refrain all the time from anti-abortion people where it's like, you know, the abortion rights movement is making this up. I'm going to show you our statute. Miscarriage is excluded. And it is true that in almost most states that ban abortion, they specifically exclude removal of a dead fetus. But the problem is that there is a lot of ambiguity about when fetal death occurs. So in you know, most miscarriages happen before any cardiac activity has been identified and, you know, many kind of miscarriage symptoms that we think of as being diagnostic like bleeding and pregnancy happen in 25% of normal pregnancies. And so, you know what we have? There's like medical guidelines that say that if you're going to diagnose fetal death with certainty, you have to do a series of ultrasounds over a period of time to make sure that there's no fetal growth. And that has led physicians in states with bans to send people who are having miscarriages home to basically, you know, bleed out and have the miscarriage by themselves without any medical assistance, which causes fear, pain, medical complications. And in some places, people are nearing death because of that. So, you know, that's just one example. The other example, the famous one, a man is a roski. And many, many, many, many, many other people is later in pregnancy. When you have a miscarriage, that's inevitable. But where the fetus, which is usually more developed at this point and still has cardiac activity, is at a miscarriage, is at an abortion, Maybe it's both, but it's people aren't able to provide care in that situation. So there is just this confusion about just what our terms mean. That is affecting kind of the risk aversion of providers on the ground. And, you know, as much as people want to be very critical of

providers on the ground, why aren't they helping people more? Why aren't they're willing to take more risks? I think it's important to think about and and remember that these people are being asked to potentially risk, you know, in Texas, life in prison for making the wrong call. And, you know, I think it's really hard for most people to imagine, like, well, how risk averse would you be if that were the stakes for you, for your life? So anyway, I think that, you know, this is, you know, something that I think we're all going to have to grapple with. And the anti-abortion movement is going to seriously have to grapple with and the litigation that really concerns a lot of these things, like fetal anomalies, miscarriage care, etc., is really, you know, bringing the attention to the fore that this is not this is not some this is not as clear as people want to make it out to be. And that, in fact, maybe all of this ambiguity and all of these blurred lines in pregnancy just reveal that, you know, pregnancy is too complicated to be legislating at all.

PELL: So before we turn to audience questions, I'd like to invite any of our panelists to to respond to what Greer said or to add any additional comments you'd like. Okay. We're going to turn to some audience questions now. And I'd like to remind everybody in the audience that you can still submit questions for our panel via X, formerly Twitter @brookings.gov with the #reproductiverights. So one question we've gotten from an audience member is will Republicans pass a national abortion ban? And that's probably a more complicated question and answer than it might seem. Where would you.

DONELY: Like? I was going to say I'm sorry. I'm talking too much. I'll make sure I set up for the future. But. So the national abortion ban. This is something, in my opinion, that I think is low or risk. Of all the things I'm worried about happening in the next four years, this is something that is actually lower on my list of fears. Why? Because the Republicans do not have a filibuster proof majority in the Senate. So and I just don't think the Trump administration cares enough about this issue that they're going to abolish the filibuster over it. You know, as much as, you know, I teach legislation and regulation as much as as my students and oftentimes love to complain about the filibuster. And I do, too, sometimes. Right. This is the benefit of the filibuster, right? Is that when your party's not in power, it prevents. It requires a really, really high threshold to get something through Congress. So I think that passing a national abortion ban is probably not going to happen, particularly because, you know, if the anti-abortion movement really wanted to, they could use the comes up or try to use the Comstock Act to create a national ban. Right. In their mind and their imagination, at least in the imagination of Jonathan Mitchell and his followers. They already have a national abortion ban on the books. That's not 15 weeks. It's period. It's writ large, right? Comstock Act prohibits shipping articles used for abortion and interstate commerce. Now, you know, look, people like me, I've think, you know, all the

ways around. Comstock It's not. There are some some things to be done to kind of evade Comstock Even if the Supreme Court were to say that, yes, it's still good law and it it means everything that Jonathan Mitchell thinks it does. But I would expect that the that the Trump administration and the anti-abortion movement generally would be more inclined to go through Comstock than to try to pass a national abortion law given the filibuster problem in the Senate.

PELL: So another audience question and addressed this to all panelists is, you know, what can we do? What are some really concrete steps? And I think a very dark environment to keep trying to improve things. Caroline, do you want can I start with you?

SACERDOTE: Sure. You know, I think the best thing you can do is pay attention to what's going on in your local community and your state. It's probably clear from the conversation there is so much work happening at that level. And I would say, you know, providers and advocates, including abortion funds, are doing everything they absolutely can to get patients care. But it is still incredibly difficult. And I think sometimes something that gets lost is, you know, even if someone say, is in Florida and can make it out of state to North Carolina, they still have to leave their families, their communities, their support network to access that care. And, you know, for some people seeking abortion care might be the first time they're getting on a plane. And so even if they are able to get that care, there is a ton of harm that is being done. And so anything folks can do to shore up protections where they live, I think will pay huge dividends. And also supporting the funds who are really. Working and doing everything they absolutely can to help pregnant people get the care they need. And, you know, it's not just connecting them to the nearest clinic or provider. It is so much more. It is talking them through what it means to, you know, get that plane ticket and get on the plane and what to expect at the airport and how to get to the hotel. It is all of this. And it takes a huge a lot of work, a huge amount of work and a huge amount of funding, too. So that is where I would recommend, you know, putting your time and resources.

PELL: Alison.

KISER: Yeah, and really important points that Caroline just made. And we absolutely see that in our navigation program as well. You know, we we're booking hotel air travel. We are taking all those steps for for people. We even have arrangements with hotels to book under our name and not their name to protect their their privacy because we recognize the huge amount of of fear and confusion that people who are being

forced to travel are contending with. And absolutely any protections and support that can be offered and in the different communities is is really important. On that point, one of the things that is really concrete that anyone can can do is we talk a lot to Planned Parenthood about reducing stigma around abortion. So we we know that abortion and these points have been made is is a life saving service in many cases, but yet it has been stigmatized to the point that people feel so much shame. And, I mean, a lot of this is baked right into the system and to these laws and the restrictions that people are up, up against to receive care. And then that leads to silence there. People are afraid to talk about it. And I think since the election, we're seeing even more of that. And just to strike on a theme from this conversation that we should absolutely avoid preemptive compliance. Don't let our silence be complicity. Talk about I mean, obviously, everyone has to assess their own their own safety, their own well-being. But to the extent possible, to talk about these issues, if someone who disagrees with you, you know, makes a joke or an offhand comment, you don't necessarily need to try to change their mind. But don't let your silence be complicity. You can say, I'm not sure what you mean by that or I think we really disagree on this. I'm not sure a conversation will be fruitful right now. But, you know, let let folks know that. That we are, in fact, the majority. Just like in Florida, the majority of people believe that these are the that abortion is health care, that it is a vital part of comprehensive reproductive health care. And in spite of the challenges that lie ahead of us, that we can't let our our silence become complicity with the challenges that lie ahead. So we're going to keep focusing on encouraging folks to speak up to the extent they feel they can report reducing abortion stigma in our communities and in some of these banned states, really focusing on programs we've launched one in West Virginia called the Abortion Ambassador Program, which is focused on the points that Caroline is just making, like supporting people in communities, letting them know how they can receive services, keeping up to date on the information so people can understand and educate their own friends, families and communities. You know, how how can people access care even in the face of total bans? So those are the sort of top lines for us, but I'm sure others will have more great points to add.

PELL: Beth

SCHLACHTER: Many I know many of the Brookings audience are foreign policy wonks and very interested in development and assistance. And so my ask is that as you're watching things unfold domestically and, you know, we're all we're all quite concerned about things that will happen within our own borders as to pay equal attention to what it's going to mean internationally. I've had friends say I wish that the rest of us had a vote in the US elections because what happens in the US has such an impact on so many places around the world.

So I do feel we all have this responsibility to understand what our impact is since we insist on playing this important role globally. We should bring our own values to that work as well, and to not abuse our US foreign assistance as part of our our US battles domestically. So I just ask that people continue to understand and track what's happening in this sector to learn to advocate within your own channels as you can. If you can provide assistance to these organizations that are working to meet the needs of women and girls, and you see that there are gaps in that assistance. Then please consider being one of the supporters of the many organizations that do this important work. And again, to just advocate as you can to be part of this foreign policy community that insists that we're insisting that women and girls in the United States have the care that they need. That we insist on that for all people everywhere. Thank you.

PELL: Greer.

DONELY: So, I mean, I could talk about policy things, but I but for most audience members, I'll say that I think, you know, what what others have said is is dead on, right? Put your money where your mouth is. Donate to funds a storytelling. Right. Alison's point about about stigma is so important. I think we are really still deep in the in the in the battle of hearts and minds right now. We are we need to change people's hearts and minds. And how do you do that? You share your abortion story. Something that I chose to do a few years ago was even hard for someone like me who writes about this stuff. It's a real act of bravery in some ways. But so many people have had abortions or they know someone or love someone who's had an abortion. And I think actually, like, that's one step you could take today, right? Is like talking to other people in your life about that story. That is the type of thing that changes hearts and minds. You know, the Villante, the Jessica Valenti just had a new newsletter last night that talked about a lot of the things that Biden could do on the way out the door. Really encourage you to take a look at that. My colleague David Cohen has been really pushing this idea of pardons for Comstock so it wouldn't necessarily be forward looking, but could ensure that all the shield providers who've been operating the past few years could know that they're at least safe until until Trump comes in and then they can reevaluate their risk at that point, maybe decide to stop providing. FDA could do some actions like potentially approving mifepristone for miscarriage. That could create some really interesting things for the future, you know, finalizing the birth control rules, stockpiling to ensure that there's some some, you know, some medication left if it comes out, comes into effect. So there are lots of things that people are working on from a policy perspective. But I, I really do want to push everyone, you know, working in your own local communities on the hearts and minds as you.

PELL: Any final thoughts that anyone would like to add? Well, I want to thank our audience for joining us. And I want to thank all of these wonderful panelists for coming today to share your expertise. And in, you know, a time when I think we are all struggling to figure out next steps. Thank you for providing some concrete steps for things that we can start doing today. With that, we will end today's webinar and I hope everyone has a good day.