

# Deepening the Divide: Abortion Bans Further Harm Immigrant Communities

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## INTRODUCTION

Due to enduring xenophobic and racist policies, the United States has a long history of limiting abortion access in immigrant communities. Immigrants must overcome deeply embedded systemic barriers in order to access abortion care. Last year's Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* exacerbated these barriers and sent shockwaves through the entire country. The *Dobbs* decision struck down federal protections on the right to an abortion granted in *Roe v. Wade* and created unprecedented harm by allowing states to pass outright abortion bans. The ruling had devastating consequences for bodily autonomy, economic mobility, and freedom for immigrants, people in detention, pregnant people, transgender and gender-non-conforming people, and women of reproductive age. State abortion bans and restrictions disproportionately harm communities who already face significant barriers to accessing health care, including Black, Indigenous, Latina/x, Asian, and Pacific Islander communities; communities living with low incomes; individuals with disabilities; and people living in rural areas.

Immigrants, especially undocumented individuals and those in mixed-status families, are particularly vulnerable to the harmful impacts of abortion bans due to their unique barriers to care and increased risk of criminalization based on immigration status. Immigrants' barriers to abortion care include arbitrary Customs and Border Protection (CBP) checkpoints, a five-year waiting period for legal permanent residents to enroll in public health insurance programs, and agreements between local law enforcement and federal immigration authorities. Individuals in immigrant detention face additional threats to their reproductive health and overall well-being, including denial of abortion care and medically unnecessary gynecological procedures like forced hysterectomies. This factsheet highlights how the overturn of *Roe v. Wade* exacerbated pre-existing barriers to abortion care for immigrants. We propose a set of concrete recommendations for Congress and the Administration to support immigrant access to abortion.

## I. Abortion bans put the health and well-being of immigrants at risk.

Since the *Dobbs* ruling, abortion access has been severely restricted in 20 states. Many states passing anti-abortion laws are also home to a high number of immigrant and mixed-status families, such as Texas, Arizona, and Florida. At least 2.1 million undocumented female immigrants live in the 26 states with an abortion ban or that are likely to ban abortion.

In the past year, at least 61 clinics nationwide have closed or no longer offer abortion services. Moreover, southern border communities, home to many mixed-status families, are already considered medically underserved areas. Widespread confusion among both patients and providers about abortion access and coverage due to state variation and vaguely written bans exacerbates barriers to access.

Abortion bans do not only restrict access to abortion care; in fact, they threaten all types of pregnancy and reproductive care. Patients are having a hard time [getting important pregnancy care](#), or are [being denied the care they need](#), including treatment for miscarriages and ectopic pregnancies. [The majority of OBGYNs](#) feel the *Dobbs* decision has worsened their ability to manage pregnancy-related emergencies, increased pregnancy-related mortality, furthered inequities, and damaged the prospects of attracting new providers to the field. In some places, the rising cost of providing care and the dearth of providers have forced maternity clinics and wards [to close](#), contributing to “[maternity-care deserts](#).”

Dr. Bhavik Kumar, a physician at Planned Parenthood Center for Choice in Houston, [said](#) interstate travel was often the only recourse he could suggest for patients who need abortion care. But for one patient, that wasn’t possible.

## II. Abortion bans further criminalize immigrant communities.

Even before the *Dobbs* decision, immigrants seeking care faced significant barriers to accessing an abortion. Policies like Texas’ S.B. 8, which banned abortion care after 6 weeks and invited anti-abortion vigilantes to sue those “aiding and abetting” abortion, made seeking an abortion for immigrants living along the Southern border nearly impossible almost a year before *Dobbs* was decided. Due to increasing restrictions and facility closures, many people must travel long distances to receive abortion care. In fact, the share of out-of-state patients [increased](#) in states with fewer restrictions post *Dobbs*. However, immigrants who do not have the necessary documentation, such as a driver’s license often feel unsafe traveling for the fear of being pulled over, detained, or deported. Additionally, immigrants living in Southern border states must often travel farther than others. For example, some Texans must travel [14 times farther](#), which can be prohibitively expensive, especially if they must miss work, arrange childcare, and/or do not have access to reliable transportation.

Notably, [39 percent of all Latinas](#) living in the 26 states that have banned or are likely to ban abortion following the *Dobbs* decision were born outside of the United States. This group includes people with varying citizenship statuses, among whom fear of surveillance may be particularly prevalent, due to disproportionate investigation and surveillance that many immigrant communities already face. Bans and restrictions on abortion exacerbate the fear of criminalization in immigrant communities, and contribute to a chilling effect that leads many immigrants to forego reproductive health care, insurance coverage, and health care of any kind as they navigate these intersecting risks of criminalization. Polling conducted in 2018 found [one in four Latina/o voters \(24 percent\)](#) had a close family member or friend delay or avoid health care because of fear related to discriminatory immigration policies, and one

***“Due to her pending immigration case, the patient could not travel more than 70 miles or would risk jeopardizing both her ability to remain in the country and the security of her two children... I didn’t know what to say. I was speechless because I had nothing else left... At that point, it felt like medicine was no longer the issue.”***

– Dr. Bhavik Kumar, Physician,  
Planned Parenthood Center for Choice in Houston

in five (19 percent) said the same about reproductive health care. Immigration enforcement activity and the continued [chilling effects](#) of policies like public charge make it less likely that immigrants will seek health care altogether, and abortion restrictions compound these existing fears.

***“The rise in criminalization of abortion care also affects immigrant communities who may also be facing criminalization around documentation status... I know that, for the handful of patients who are able to travel to see me, there are dozen[s] who are unable to.”***

– Dr. Gopika Krishna, OB-GYN,  
New York abortion provider,  
and Physicians for Reproductive Health Fellow

Immigrants living in border states have a heightened fear of encountering immigration enforcement because many state and local police in these states [have official agreements with Immigration and Customs Enforcement \(ICE\)](#) to arrest immigrants. CBP currently operates immigration checkpoints at more than [110 locations](#), 25 to 100 miles inland from the Southwest and Northern borders that impede travel for immigrants living within the [100 mile border zone](#). While abortion care is [available](#) in New Mexico and California, it is banned at 15 weeks in Arizona and completely banned in Texas with few exceptions. Access would be further constrained if the FDA were forced to withdraw the approval of mifepristone (i.e., the abortion pill) in an attempt to [ban medication abortion nationwide](#), as many providers do not perform procedural abortions and only offer medication abortion care.

### III. Abortion bans make it more difficult for immigrants in detention to receive timely reproductive health care.

Additional restrictions to abortion access make obtaining an abortion even harder for people in detention. While the Biden Administration has [adopted a general policy](#) to not detain pregnant people, some are detained due to strict mandatory detention laws. Because of a lack of reported data, however, it is unclear how many pregnant people have been detained, have requested an abortion, or have been granted their request.

Im/migrants<sup>1</sup> who make the journey to the U.S. face significant risks of sexual assault, and are at increased risk of unwanted pregnancy as a result of rape. Between [60% and 80%](#) of female migrants, including teenagers and children, are sexually assaulted on their journey through Mexico. Once in the United States, pregnant minors are often limited in their choices when they are placed in Office of Refugee Resettlement (ORR) custody, often contingent on political motivations. In 2017, the Trump Administration attempted to prevent unaccompanied minors from receiving abortion care while in ORR custody. As

a result of [litigation](#), however, it was forced to adopt a policy of noninterference with minors attempting to access care.

In 2020, [around 85 – nearly half](#) – of ORR-funded shelters serving children were located in [states that now have restrictive abortion policies](#). Post Texas' abortion ban and the Dobbs decision, the Biden Administration put forth [guidance](#) that if an unaccompanied minor requests an abortion while in a state where abortion is illegal, they would be transferred to a facility in a state where they are able to receive care. This solution is far from ideal for several reasons. Moving unaccompanied minors from place to place makes it more difficult for their families and legal advisors to stay in touch and keep track of them. In addition, the time it takes to transfer a young person between states often leads to delays, making it more expensive and harder to get the care they need. Finally, this transfer policy and other policies that aim to protect the rights and health of unaccompanied minors are at risk of being rescinded under a future administration.

## Recommendations

### Congress must pass legislation that supports a universal right to access abortion and protects the reproductive rights of all people residing within our borders.

- › The HEAL for Immigrant Families Act (HEAL Act) expands coverage for sexual and reproductive health care by increasing access to federal programs such as Medicaid and the Affordable Care Act marketplaces. These programs provide crucial coverage of reproductive and sexual health services, including contraception and maternal health care.
- › The Equal Access to Abortion Coverage in Health Insurance (EACH) Act is federal legislation that would eliminate the Hyde Amendment's ban on the use of federal funds to cover abortion in Medicaid and other federal health programs.
- › The Women's Health Protection Act is federal legislation that would create a statutory right to access abortion free from medically unnecessary restrictions and bans on abortion, including mandatory waiting periods, biased counseling, two-appointment requirements, and mandatory ultrasounds.
- › The Abortion Justice Act (AJA) is bold legislation that aims to remove barriers that make it more difficult for immigrant communities to access care.
- › The Reproductive Health Travel Fund Act will establish a grant program authorized at \$350 million per year for FY24 through FY28 and allow the Treasury Secretary to award grants to eligible entities to pay for travel-related expenses and logistical support for individuals to access reproductive health care.

Building support for each of these bills is critical to ensure people seeking health care, including abortion, can get the care they need regardless of income, race, ethnicity, sexual orientation, gender identity, or immigration status.

### This Administration must adopt policies that protect the bodily autonomy of people in federal and state custody, including those detained for immigration-related offenses, and remove mobility barriers to reproductive health care.

- › CBP checkpoints in border communities make it all but impossible to safely reach health care facilities located hundreds of miles away. Consistent with the Department of Homeland Security's (DHS) [protected areas guidance](#), DHS should ensure that people are able to safely reach those protected facilities, like clinics and hospitals, without CBP checkpoints impeding their travel or exposing them to potential detention and deportation. Instructing DHS to close all internal CBP checkpoints is essential in ensuring this access.

<sup>1</sup> The use of the term "im/migrant" is to recognize all persons and communities that are living in the U.S. who come from different countries or have migrated from different territories, whether temporarily or permanently.

- › DHS [should expand](#) CBP's November 2021 [policy](#) regarding the detention of pregnant, postpartum, and nursing people in CBP facilities to:

  - Expedite processing to minimize the time that people who are pregnant, postpartum, and/or nursing and their families are in CBP custody to only the time period necessary to process them for release from CBP custody. In absolutely no case should custody exceed 12 hours from the time of initial apprehension.
  - Ensure that people who are pregnant, postpartum, and/or nursing and their families are released from CBP custody as soon as possible after any discharge from an off-site hospital, and are not transferred back to CBP detention for any purposes, including processing.
- › Pregnant people should not be in detention. If pregnant persons must be detained for any amount of time, there should be no barrier to abortion. DHS should therefore issue guidance to ensure:

  - Any pregnant person in ICE/CBP custody who requests access to abortion and is in a state that bans or significantly restricts abortion shall be afforded an immediate transfer with the option to be transferred back, to a state where they can receive abortion care. The only exception to this guidance should be, if the individual affirmatively asserts a preference to stay in the current placement or state after receiving appropriate advisals.
  - Any pregnant person in ICE/CBP custody shall be promptly notified of the right to access abortion, regardless of state restrictions, in a language that the individual can understand, in a comfortable and private venue in which they feel free to ask questions (such as non-directive medical counseling). Delivery of this information should be standardized and provided by an experienced medical professional or similarly-trained person.
  - In instances where it is possible, pregnant people in ICE/CBP custody should not be placed in a U.S. state that bans or significantly restricts abortion access (e.g., that bans abortion at fifteen weeks or earlier).
  - For people who are under Orders of Supervision that require ICE's permission to travel out of state, DHS must require ICE to permit interstate travel for people who need abortion care.
- › DHS should make it absolutely clear that the Department will not take any enforcement action against people who may be arrested for or convicted of crimes related to their pregnancy outcomes. DHS must also clarify that it will not consider these arrests or convictions, or the disclosure of having obtained abortion care, to bar any form of immigration relief, including in discretionary determinations.
- › Detaining agencies — CBP, ICE, ORR — should comply with data requests that illustrate the needs of detained immigrants seeking abortion care.

  - For all pregnant people in ORR custody from FY2016 through present, provide data relating to the following information:
    - Length of custody for each pregnant person.
    - The name of the facility where they were held, their placement or admission date, and the state(s) where youth were held.
    - Date of initial positive pregnancy test and approximate gestational age at the time of test.
    - Whether termination of pregnancy (TOP) was requested and, if it was, the date and gestational age at request.
    - Whether TOP was performed and, if it was, the date, state, and gestational age when TOP occurred along with any relevant notes.
    - Pregnancy outcome (e.g., birth, abortion, stillbirth, miscarriage, unknown).
    - Country of citizenship, gender, race, ethnicity, and age at placement.
    - Placement decisions for each pregnant person (placed with sponsor, foster care, ORR-facility, etc.).
  - For all pregnant people in ICE custody from FY2016 through present, provide a spreadsheet containing the following information for each detention stay:
    - Length of custody for each pregnant person.
    - Entry status, case status, case category, and whether subject to mandatory detention.
    - For each facility in which they were held, the book-in/book-out date and reason for release (e.g., "Bonded Out"); facility name; facility code; facility state; facility type detailed (e.g., "IGSA"); detention standards governing the facility (e.g., "PBNDS 2011"); whether a medical provider was on-site; and provider type (e.g., "IHSC").
    - Date of initial positive pregnancy test in ICE custody, approximate gestational age at the time of test, and the pregnancy outcome (e.g., birth, abortion, stillbirth, miscarriage, unknown).
    - Whether TOP was requested, as well as the date of the request, the state where the request was made, and the gestational age at the time of request.
    - Whether TOP was performed and, if so, the date when it was performed, the state in which it occurred, and the gestational age at TOP, along with any relevant notes.
    - Country of citizenship; race; ethnicity (e.g., "Hispanic Origin"); gender; and age at placement.