

**STATE OF MICHIGAN
IN THE COURT OF APPEALS**

NORTHLAND FAMILY PLANNING CENTER, on behalf of itself, its staff, its clinicians, and its patients; **NORTHLAND FAMILY PLANNING CENTER INC. EAST**, on behalf of itself, its staff, its clinicians, and its patients; **NORTHLAND FAMILY PLANNING CENTER INC. WEST**, on behalf of itself, its staff, its clinicians, and its patients; and **MEDICAL STUDENTS FOR CHOICE**, on behalf of itself, its members, and its members' patients,

Plaintiffs-Cross-Appellants,

v.

DANA NESSEL, Attorney General of the State of Michigan; **MARLON I. BROWN**, Acting Director of Michigan Licensing and Regulatory Affairs; and **ELIZABETH HERTEL**, Director of the Michigan Department of Health and Human Services, each in their official capacities, as well as their employees, agents, and successors,

Defendants-Cross-Appellants

and

THE PEOPLE OF THE STATE OF MICHIGAN,

Intervening Defendant-Cross-Appellees /

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Court of Appeals No. 375785

Case No. 24-000011-MM

Hon. Sima G. Patel

**BRIEF OF GLOBAL JUSTICE CENTER AS *AMICUS CURIAE* IN SUPPORT OF
PLAINTIFFS-CROSS-APPELLANTS**

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INTEREST OF *AMICUS CURIAE*¹

Global Justice Center is a non-partisan, non-profit organization dedicated to promoting international law in a progressive, non-discriminatory manner to advance gender equality. The organization focuses on two primary areas: (i) reproductive and bodily autonomy as a human right, and (ii) justice for sexual and gender-based violence committed in conflicts and crises. Global Justice Center submits this *amicus curiae* brief to provide the Court with information regarding the protections that international human rights law affords to reproductive autonomy, including for abortion care, and how international human rights law and interpretation demonstrates the ways in which the coercion screening requirement at issue in this case is discriminatory.

¹ No party's counsel authored this brief in whole or in part. No party, its counsel, or other person contributed money intended to fund the brief's preparation or submission.

SUMMARY OF ARGUMENT

In 2022, Michigan’s citizens went to the polls to make their voices heard on an issue of systemic constitutional importance: the right of a woman to terminate her pregnancy. By a wide margin, Michigan’s citizens voted to enact the Reproductive Freedom for All Amendment (“RFFA”), an amendment to Michigan’s Constitution that eliminates outdated restrictions on reproductive healthcare and protects the fundamental right to reproductive freedom in Michigan, including the freedom for Michiganders to decide to end their pregnancies. The RFFA ensures that Michiganders have “the right to make and effectuate decisions about all matters relating to pregnancy,” including “abortion care,” without the State of Michigan “discriminat[ing] in the protection or enforcement of this fundamental right.” Mich. Const. art. I, § 28, cl. 1, 2.

Below, the Court of Claims correctly struck down several unconstitutional restrictions on the fundamental right to reproductive freedom. See *Northland Fam. Plan. Ctr. v Nessel*, No. 24-000011-MM, 2025 WL 2098474, at *34 (Mich. Ct. Cl. May 13, 2025). The Court of Claims left in place, however, the requirement that abortion providers screen all pregnant patients for “coercion to abort” and post notices regarding coercion and domestic abuse in their facilities as provided under MCL 333.17015(11)(i) and MCL 333.17015a (“Coercion Screening Requirement”). *Id.* at *7, 34. This was an error. The Coercion Screening Requirement violates the RFFA’s guarantee that “[t]he state shall not discriminate in” protecting the “fundamental right to reproductive freedom,” Mich. Const. art. I, § 28, cl. 1, 2, because no similar requirement is placed on anyone seeking any other form of reproductive healthcare, including on any patient’s decision to continue their pregnancy. In other words, the Coercion Screening Requirement singles out and stigmatizes, without justification, just one form of reproductive healthcare—abortion. That is discriminatory. It is a violation of Michigan’s Constitution.

It is also a violation of international human rights law (“IHRL”). U.S. courts have long looked to international law as informative and persuasive authority. *Amicus curiae* Global Justice Center respectfully submits this brief to assist the Court by providing information on the ways in which IHRL protects reproductive freedom, including by prohibiting discrimination in reproductive healthcare. IHRL grounds reproductive freedom in multiple, mutually reinforcing rights recognized in treaties the United States has ratified or signed, as well as in norms of customary international law that are binding on all nations. These international standards provide

a well-developed framework for interpreting the scope and meaning of the RFFA’s prohibition on discrimination in the protection of the fundamental right to reproductive freedom.

First, the RFFA’s non-discrimination requirement is consistent with IHRL’s clear framework for, and understanding of, discrimination. Reproductive freedom is a core tenet of IHRL, and is grounded in the rights to life, privacy, health, non-discrimination, equality, and freedom from torture and cruel, inhuman or degrading treatment. Under IHRL, discrimination occurs when a government treats groups differently in a way that prevents some groups or individuals, but not others, from exercising or enjoying their right to reproductive freedom. International human rights bodies have thus repeatedly affirmed that, consistent with these rights, governments should ensure meaningful, unobstructed access to abortion care and refrain from imposing barriers rooted in stigma, stereotypes, or paternalistic assumptions about a pregnant person’s decision-making capacity.

Second, applying IHRL principles, the discriminatory nature of the Coercion Screening Requirement is obvious. The Coercion Screening Requirement discriminates against patients seeking to terminate their pregnancy, who are largely women and girls, by introducing barriers to them exercising their right to reproductive freedom, while no similar screening requirement is placed on *any other* person for *any other* reproductive health procedure. The disparate impacts are compounded for individuals with intersecting marginalized identities, including lower-income individuals, adolescents, Black, indigenous, and people of color (“BIPOC”) communities, migrants, and LGBTQIA+ individuals, who face heightened barriers to care as a direct result of the requirement. The Coercion Screening Requirement also perpetuates harmful stereotypes about women’s roles and decision-making abilities and ultimately reinforces gender stereotypes that perpetuate harmful inequalities for them.

When viewed through the lens of IHRL, the Coercion Screening Requirement violates the RFFA’s directive that Michiganders must be free to exercise their right to reproductive freedom without discrimination. The Coercion Screening Requirement is therefore unconstitutional and should be enjoined.

ARGUMENT

I. The RFFA Aligns with IHRL Standards that Enshrine the Right to Reproductive Freedom

The RFFA represents Michigan voters’ repudiation of outdated laws that encumber the exercise of the fundamental right to reproductive freedom and discriminate against individuals seeking to exercise that right.² The Coercion Screening Requirement exemplifies those historic discriminatory encumbrances and should be permanently enjoined. U.S. courts have long considered that international law can be persuasive and informative authority for interpreting U.S. law. See, e.g., *Gamble v United States*, 587 U.S. 678, 687 (2019) (referring to customary international law); *Roper v Simmons*, 543 U.S. 551, 576 (2005) (observing that “Article 37 of the United Nations Convention on the Rights of the Child . . . contains an express prohibition on capital punishment for crimes committed by juveniles under 18” in determining that the Eighth and Fourteenth Amendments do not permit capital punishment for juvenile offenders); *Lawrence v Tex.*, 539 U.S. 558, 576 (2003) (considering caselaw from the European Court of Human Rights); *Trop v Dulles*, 356 U.S. 86, 102 (1958) (“The civilized nations of the world are in virtual unanimity that statelessness is not to be imposed as punishment for crime.”). *Amicus curiae* respectfully submits that IHRL provides a well-developed framework to analyze whether restrictions like the Coercion Screening Requirement are discriminatory, and that this framework can assist this Court, both in interpreting the constitutional non-discrimination standard that the RFFA sets out and in applying that standard to the Coercion Screening Requirement.

² In voting to guarantee reproductive rights, Michigan voters were aligned with the dozens of countries worldwide that have liberalized their abortion laws in recent decades. See *Dobbs v Jackson Women’s Health Org.*, 597 U.S. 215, 400 (2022) (Breyer J., dissenting) (“Perhaps most notable, more than 50 countries around the world—in Asia, Latin America, Africa, and Europe—have expanded access to abortion in the past 25 years. In light of that worldwide liberalization of abortion laws, it is American States that will become international outliers after today.”); Ctr. for Repro. Rts., *With its Regression on Abortion Rights, the U.S. is a Global Outlier* (Sept. 8, 2022), <https://reproductiverights.org/news/us-a-global-outlier-on-abortion-rights/>.

A. Like the RFFA, IHRL Protects Reproductive Freedom, Including the Right to Access Reproductive Healthcare Free from Discrimination

1. Under IHRL, Reproductive Freedom Is Grounded in the Rights to Privacy, Life, Health, and Freedom from Torture and Cruel, Inhuman or Degrading Treatment

IHRL grounds reproductive freedom in several individual human rights. These rights include the rights to privacy and life. See International Covenant on Civil and Political Rights arts. 6, 17(1), 26, Dec. 16, 1966, 999 U.N.T.S. 171 (“ICCPR”); see also *K.L. v Peru*, Hum. Rts. Comm., U.N. Doc. CCPR/C/85/D/1153/2003, ¶ 6.4 (Oct. 24, 2005).³ The United Nations (“U.N.”) Human Rights Committee, which is responsible for interpreting and assessing governments’ compliance in implementing the ICCPR, has directly linked restrictions on abortion access to violations of these rights, calling on countries to ensure that “restrictions on the ability of women or girls to seek abortion [do] not . . . jeopardize their lives, subject them to physical or mental pain or suffering . . . or arbitrarily interfere with their privacy.” U.N. Hum. Rts. Comm., *General Comment No. 36, Article 6: Right to Life*, U.N. Doc. CCPR/C/GC/36 (Sept. 3, 2019), ¶ 8.

IHRL also protects reproductive freedom under the right to health. See International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3 (“ICESCR”); International Convention on the Elimination of All Forms of Racial Discrimination art. 5, Dec. 21, 1965, 660 U.N.T.S. 195 (“ICERD”); Convention on the Elimination of All Forms of Discrimination Against Women art. 12, Dec. 18, 1979, 1249 U.N.T.S. 13 (“CEDAW”).⁴ The right to health in IHRL includes “the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health,” and entitles “all people full enjoyment of the right to sexual and reproductive health,” in line with the principles protected in the RFFA. See U.N. Comm. on Econ., Soc. &

³ The United States has signed and ratified the ICCPR. See Off. of the U.N. High Comm’r for Hum. Rts., *Status of Ratification Interactive Dashboard*, <https://indicators.ohchr.org/> (last visited May 1, 2026).

⁴ The United States has signed and ratified the ICERD. See Off. of the U.N. High Comm’r for Hum. Rts., *Status of Ratification Interactive Dashboard*, <https://indicators.ohchr.org/> (last visited May 1, 2026). The United States has signed, but not ratified, the ICESCR and CEDAW. *Id.* As a signatory, the United States has an obligation not to defeat the object and purpose of the ICESCR or the CEDAW. See Vienna Convention on the Law of Treaties art. 18, May 23, 1969, 1155 U.N.T.S. 331.

Cultural Rts., *General Comment No. 22 on the Right to Sexual and Reproductive Health*, U.N. Doc. E/C.12/GC/22 (May 1, 2016), ¶ 5.

Additionally, IHRL grounds reproductive freedom in the right to freedom from torture and other cruel, inhuman or degrading treatment. See ICCPR art. 7; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“CAT”), Dec. 10, 1984, 1465 U.N.T.S. 85; see also, e.g., *Mellet v Ireland*, Hum. Rts. Comm., U.N. Doc. CCPR/C/116/D/2324/2013, ¶¶ 7.3–7.6 (Mar. 31, 2016) (abortion restrictions constituted cruel, inhuman or degrading treatment); *Whelan v Ireland*, Hum. Rts. Comm., U.N. Doc. CCPR/C/119/D/2425/2014, ¶¶ 7.5–7.7 (Mar. 17, 2017) (same); *L.M.R. v Argentina*, Hum. Rts. Comm., U.N. Doc. CCPR/C.101/D/1608/2007, ¶ 9.2 (Apr. 28, 2011) (forceful continuation of pregnancy “constituted cruel and inhuman treatment”).⁵ As the U.N. Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has explained, “[w]omen are vulnerable to torture and ill-treatment when seeking medical treatment. . . . This is particularly true when seeking treatments such as abortion that may contravene socialized gender roles and expectations.” U.N. Hum. Rts. Council, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc. A/HRC/31/57 (Jan. 5, 2016), ¶¶ 42–44.⁶

2. IHRL Provides a Well-Developed Framework and Understanding of Direct and Indirect Discrimination

Under IHRL, the term “discrimination” refers to “any distinction, exclusion, or restriction or preference which is based on any ground,” including but not limited to sex, “which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.” U.N. Hum. Rts. Comm., *General Comment No.*

⁵ The United States has signed and ratified the CAT. See Off. of the U.N. High Comm’r for Hum. Rts., *Status of Ratification Interactive Dashboard*, <https://indicators.ohchr.org/> (last visited May 1, 2026). Moreover, the prohibition against torture is recognized as a *jus cogens*, or peremptory, norm that is binding on all countries regardless of their treaty ratifications and creates obligations from which no derogation is permitted. See, e.g., *Siderman de Blake v Republic of Arg.*, 965 F.2d 699, 717 (9th Cir. 1992) (recognizing that the prohibition against torture is *jus cogens*).

⁶ See also U.N. Hum. Rts. Council, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez*, U.N. Doc. A/HRC/22/53 (Mar. 12, 2013), ¶¶ 46–50, 90.

18 (*Non-Discrimination*), U.N. Doc. CCPR/C/21/Rev.1/Add.1 (Nov. 10, 1989), ¶ 6. In essence, IHRL provides that every individual possesses certain human rights, and that laws that prevent or impair some individuals or groups, but not others, from enjoying or exercising one or more of those rights are discriminatory. See U.N. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 20, Non-Discrimination in Economic, Social & Cultural Rights*, U.N. Doc. E/C.12/GC/20 (July 2, 2009), ¶¶ 3, 7. IHRL broadly prohibits discrimination. See, e.g., ICCPR art. 26; ICESCR art. 2(2); ICERD art. 5; CEDAW art. 2. IHRL also requires that governments take measures to eradicate discrimination in the context of individual human rights. See, e.g., U.N. Hum. Rts. Comm., *General Comment No. 28 (Article 3: the Equality of Rights Between Men and Women)*, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000), ¶ 31; *Mellet*, U.N. Doc. CCPR/C/116/D/2324/2013, Annex II, ¶¶ 7–8 (Article 26 of the ICCPR requires countries to ensure that their laws “including with respect to access to health services . . . do not *directly or indirectly* discriminate on the basis of sex.”) (Cleveland, S. concurring) (emphasis in original).⁷

Discrimination under IHRL can be direct or indirect. Direct discrimination occurs when laws intentionally discriminate against certain individuals or groups. See, e.g., U.N. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 20, Non-Discrimination in Economic, Social & Cultural Rights*, U.N. Doc. E/C.12/GC/20 (July 2, 2009), ¶ 10(a). For example, “requir[ing] women to present non-pregnancy certificates in order to be hired or to avoid being dismissed” directly discriminates on the basis of sex. See U.N. Comm. on Econ., Soc. & Cultural Rts., *Concluding Observations on the Fourth Periodic Report of Mexico*, U.N. Doc. E/C12/CO/MEX/4, (June 9, 2006), ¶¶ 15, 33. Indirect discrimination occurs when laws appear neutral at face value but have a disproportionate impact on certain individuals’ or groups’ exercise of their human rights. See, e.g., U.N. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 20, Non-Discrimination in Economic, Social & Cultural Rights*, U.N. Doc. E/C.12/GC/20 (July 2, 2009), ¶¶ 10(b), 13. For example, “requiring a birth registration certificate for school enrolment may

⁷ See also U.N. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 22 on the Right to Sexual and Reproductive Health*, U.N. Doc. E/C.12/GC/22 (May 1, 2016), ¶¶ 5, 39–41 (individuals must have “the right to make free and responsible decisions and choices, free of . . . discrimination, regarding matters concerning one’s body and sexual and reproductive health,” which requires governments to remove barriers in access to sexual and reproductive health services).

discriminate against ethnic minorities or non-nationals who do not possess, or have been denied, such certificates.” *Id.* ¶ 10(b).

IHRL also recognizes that discrimination is often further exacerbated by intersecting vulnerable identities. International human rights bodies, including the U.N. Committee on the Elimination of Discrimination against Women and the U.N. Committee on Economic, Social, and Cultural Rights, have recognized that “discrimination against women based on sex and gender is inextricably linked with other factors that affect women, such as race, ethnicity, religion or belief, health, status, age, class, caste, sexual orientation and gender identity.” *S.B. & M.B. v N. Macedonia*, Comm. on the Elimination of Discrimination against Women, Comm’n No. 143/2019, U.N. Doc. No. CEDAW/C/77/D/143/2019, ¶ 7.3 (Nov. 2, 2020); U.N. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 22 on the Right to Sexual & Reproductive Health*, U.N. Doc. E/C.12/GC/22 (May 1, 2016), ¶ 30 (“[i]ndividuals belonging to particular [vulnerable] groups may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health”); see also U.N. Comm. on the Elimination of Discrimination against Women, *General Recommendation No. 28 on the Core Obligations of State Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination Against Women*, U.N. Doc. CEDAW/C/GC/28 (Dec. 16, 2010), ¶ 18 (requiring that governments “legally recognize and prohibit such intersecting forms of discrimination and their compounded negative impact on the women concerned”). Looking at the United States specifically, the U.N. Human Rights Council found that abortion restrictions “have a disproportionate and discriminatory impact on poor women,” and that “immigrant women face severe barriers in accessing sexual and reproductive health services.” U.N. Hum. Rts. Council, *Report of the Working Group on the Issue of Discrimination Against Women in Law and in Practice on Its Mission to the United States of America*, U.N. Doc. A/HRC/32/44/Add.2 (June 7, 2016), ¶ 68.⁸

⁸ The U.N. Human Rights Council is a 47-member intergovernmental body that leads the promotion and protection of human rights worldwide. Off. of the U.N. High Comm’r for Hum. Rts., *Welcome to the Human Rights Council*, <https://www.ohchr.org/en/hr-bodies/hrc/about-council> (last visited May 2, 2026). Established in 2006 by the U.N. General Assembly, it addresses human rights violations through dialogue, resolutions, emergency sessions, country reviews, independent experts, and investigative mechanisms, with support from the Office of the U.N. High Commissioner for Human Rights. *Id.*

It is important to note, however, that IHRL does not treat all differential treatment as discriminatory. Rather, “[d]ifferential treatment based on prohibited grounds will be viewed as discriminatory unless the justification for differentiation is reasonable and objective.” U.N. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 20, Non-Discrimination in Economic, Social & Cultural Rights*, U.N. Doc. E/C.12/GC/20 (July 2, 2009), ¶ 13. Thus, IHRL does not imply that governments must treat everyone equally under all circumstances. Rather, it provides that equal treatment is the default, with deviations from that standard needing to be supported by a reasonable and objective justification.

As explained above, *supra* at 5-6, limitations on reproductive freedom—including restrictions on abortion—therefore affect the right of women and girls to exercise and enjoy their rights to privacy, life, health, and protection against torture and cruel, inhuman or degrading treatment. See *Whelan*, U.N. Doc. CCPR/C/119/D/2425/2014, ¶ 3.11 (“Restrictive abortion laws constitute a form of discrimination against women.”); U.N. Comm. on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, U.N. Doc. A/54/38/Rev.1 (1999), ¶¶ 2, 31(b) (governments should “eliminate discrimination against women in their access to health-care services . . . particularly in the areas of family planning [and] pregnancy” and “[e]nsure the removal of all barriers to women’s access to health services, education and information, including in the area of sexual and reproductive health”). Such restrictions are therefore at high risk of being discriminatory under IHRL unless they are based on a justification that is both reasonable and objective.

B. Perpetuating Gender Stereotypes Undermines IHRL Protections Against Non-Discrimination in the Exercise of the Right to Reproductive Freedom

IHRL recognizes that discrimination in the exercise of the right to reproductive freedom is often based on gender stereotypes. See, e.g., *I.V. v Bolivia*, Judgment, Int-Am Ct. H.R. (ser. C): No. 329, ¶¶ 186–87 (Nov. 30, 2016). Gender-based stereotypes refer to “a preconception of the attributes, conducts, or characteristics of men and women and the respective roles that they play or should play.” *Id.* ¶ 187. IHRL regards such stereotypes as foundational components of the social and cultural patterns that produce and sustain women’s inequality. The requirement that governments remove and eliminate gender stereotypes and gender-related prejudices—and the right to be free from such harmful norms—is therefore a cornerstone of IHRL flowing directly from the right to non-discrimination. See, e.g., CEDAW art. 5(a); Inter-American Convention on

the Prevention, Punishment, and Eradication of Violence against Women art. 8(b), June 9, 1994, O.A.S.T.S. No. 71.

IHRL has long recognized the discriminatory impact of gender-based stereotypes in healthcare on women's equality. In *I.V. v Bolivia*, the Inter-American Court of Human Rights observed that a woman's freedom to make decisions about her body and her reproductive health "can be undermined by discrimination in access to health care; [and] by the existence . . . of gender and other stereotypes among health care providers." *I.V.*, No. 329, ¶ 185. The court noted that "women are seen as vulnerable beings, incapable of taking reliable or consistent decisions which results in health professionals denying women the information they require" to consent—and "women are considered impulsive and indecisive and in need of the guidance of a more stable person with better judgment, usually a protective man." *Id.* ¶ 187. Similarly, in *R.K.B. v Turkey*, the U.N. Committee on the Elimination of Discrimination against Women identified gender stereotypes as a "root cause and consequence of discrimination against women" and concluded that States must not only "take steps to eliminate direct and indirect discrimination" but that they must also "modify and transform gender stereotypes" as result. *R.K.B v Turkey*, Comm. on the Elimination of Discrimination against Women, Commc'n No. 28/2010, U.N. Doc. CEDAW/C/51/D/28/2010, ¶ 8.8 (Feb. 24, 2012).

Women are pressured in a variety of ways regarding their reproductive health and lives on the basis of such stereotypes. Coercion to abort may exist in some cases, but it is certainly not the only element of coercion or pressure that women face in connection with their reproductive health. Women often face societal pressure to become pregnant and raise children, in line with gender stereotypes that classify women as naturally "more nurturing than men," while other women experience pressure to no longer have children. Off. of the U.N. High Comm'r for Hum. Rts., *Manual on Human Rights Monitoring: Chapter 28 Monitoring and Protecting the Human Rights of Women* 19 (2011), https://www.ohchr.org/sites/default/files/Documents/Publications/Chapter28_MonitoringAndProtecting.pdf; see generally *I.V.*, No. 329 (involving forced sterilization). Furthermore, pregnant women are often pressured into remaining pregnant against their wishes, see generally, *Mellet*, U.N. Doc. CCPR/C/116/D/2324/2013 (involving a woman who initially sought out but could not access an abortion in her home country); *Whelan*, U.N. Doc. CCPR/C/119/D/2425/2014 (same), while coercion for women to have more children is also prevalent, see Maya Oppenheim, *More*

Countries ‘Trying to Coerce Women to Have More Children’, Report Finds, The Independent (Nov. 30, 2021), <https://www.independent.co.uk/news/world/politics/pronatalist-countries-women-children-b1966249.html> (discussing report finding that “[a]round three in ten nations across the globe now have pronatalist policies that encourage citizens to have more children”). These harmful gender-based stereotypes often drive discrimination by furthering the notion that women are unable to make their own decisions about their reproductive health, and that they are best suited to fulfill the role of mothers.

II. The Coercion Screening Requirement is Discriminatory under IHRL

Michigan’s RFFA prohibits the state from “discriminat[ing] in the protection or enforcement of th[e] fundamental right [to reproductive freedom].” Mich. Const. art. I, § 28, cl. 1, 2. The Coercion Screening Requirement only applies to Michiganders seeking abortion—who will most often be women and girls—and not to other individuals seeking other kinds of reproductive healthcare. Thus, for example, there is no requirement that a pregnant patient who decides to keep their pregnancy be screened for coercion in that decision. The Coercion Screening Requirement further disparately impacts multiply marginalized groups and reinforces harmful gender stereotypes. It is therefore discriminatory under IHRL.

A. The Coercion Screening Requirement Exceptionalizes Abortion Care

Under MCL 333.17015 and MCL 333.17015a, only patients seeking abortion care—and not any other reproductive healthcare—are subjected to the Coercion Screening Requirement. In practice, this means that the vast majority of individuals impacted by the requirement will be pregnant women and girls.⁹ IHRL recognizes that abortion restrictions are discriminatory because

⁹ See U.N. Hum. Rts. Comm., *General Comment No. 18 (Non-Discrimination)*, U.N. Doc. CCPR/C/21/Rev.1/Add.1 (Nov. 10, 1989), ¶ 7 (discrimination occurs when there is an impermissible “distinction” which has “the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms”). The Coercion Screening Requirement also perpetuates remnants of the previous 24-hour waiting period that the Court of Claims struck down: the law requires that information about the Coercion Screening Requirement and the mandated prescreening summary be provided to patients as a physical copy “no less than 24 hours before a provider performs an abortion” in the absence of any medical emergencies. See Mich. Dep’t of Health & Hum. Servs., *Mich. Coercive Abortion Prevention Act, Screening Requirements under the Coercive Abortion Prevention Act, Information for Abortion Care Providers*, (“Training Tool for Providers 1”) at 2, <https://www.michigan.gov/mdhhs/adult-child-serv/informedconsent/michigan-coercive-abortion-prevention-act> (last visited May 4, 2026).

they uniquely burden women and girls—that is, those traditionally recognized as able to become pregnant—as compared to persons who will never experience pregnancy, regardless of intent. As the U.N. Human Rights Council explained in *Mellet*, abortion restrictions have “a distinct and specific impact on women,” imposing “severe” consequences on their “personal integrity, dignity, physical and mental health and well-being.” *Mellet*, U.N. Doc. CCPR/C/116/D/2324/2013, ¶ 5.12. The U.N. Human Rights Council has likewise found that abortion restrictions uniquely require women and girls to “disregard their health needs and moral agency in relation to their reproductive functions,” in stark contrast to male patients and patients facing other medical procedures who are not expected to “balance” their right to life with “their enjoyment of other rights.” *Whelan*, U.N. Doc. CCPR/C/119/D/2425/2014, ¶ 3.9; *Mellet*, U.N. Doc. CCPR/C/116/D/2324/2013, ¶¶ 3.17, 5.12. The Coercion Screening Requirement’s approach ignores the complex realities of pregnant women’s lives and imposes an unnecessary barrier to the enjoyment of their right to reproductive freedom in a way that does not apply to patients seeking other procedures. See *da Silva Pimentel v Brazil*, Comm. on the Elimination of Discrimination against Women, Commc’n No. 17/2008, U.N. Doc. No. CEDAW/C/49/D/17/2008, ¶ 7.6 (July 25, 2011) (finding that a government’s failure to “meet the specific, distinctive health needs and interests of women” constitutes discrimination and has a “differential impact on the right to life of women”).

The Coercion Screening Requirement is also not supported by a reasonable or objective justification. The requirement is *only* applied to people seeking abortion care, and *only* covers the provision of abortion care, thereby interfering with the full exercise of reproductive freedom envisioned by the RFFA. The State has not shown that people seeking abortions are more likely to be coerced compared to people receiving other reproductive care. In fact, the weight of the testimony in the proceedings below indicated that individuals are more likely to be coerced into becoming or remaining pregnant than into an unwanted abortion. See *Northland*, 2025 WL 2098474, at *30 (describing testimony that “coercion to abort is ‘rare.’ It is more common for a woman to be forced into or to continue a pregnancy” and “it is a much more common scenario for a woman to be coerced to maintain a pregnancy in an abusive relationship”). Independent research studies corroborate this testimony. See generally Karen Trister Grace & Jocelyn C. Anderson, *Reproductive Coercion: A Systematic Review*, 19 *Trauma, Violence & Abuse* 371 (2018) (reviewing 27 research studies and concluding that “[f]indings . . . do not support the assertion that women are frequently coerced into abortions, but rather, that they are more often coerced into

continuing a pregnancy”).¹⁰ Even so, Michigan imposes no requirements on medical providers who do not provide abortion to follow special screening procedures for coercion, or to post large signage regarding the illegality of coercion for other forms of reproductive care, including the decision to remain pregnant. Nor has the State established any other legitimate, nondiscriminatory reason why abortion—a procedure that can be and is provided safely across Michigan—should be singled out for special treatment. See, e.g., *Northland*, 2025 WL 2098474, at *33 (noting that there is “strong evidence presented by plaintiffs that many [advanced practice clinicians] already provide care similar to medication abortion and dilation procedures safely and effectively”).

B. The Coercion Screening Requirement Further Impairs the Ability of Lower-Income Individuals, Adolescents, BIPOC, Migrants, and Multiply-Marginalized Individuals to Exercise their Rights

Research shows that the impact of the Coercion Screening Requirement will be even more pronounced for pregnant women and girls subjected to multiple and intersecting forms of marginalization, including lower-income individuals, adolescents, BIPOC communities, LGBTQIA+ communities, migrants, and other groups.¹¹ The Coercion Screening Requirement creates unique and pernicious harms for such marginalized groups. For example, the risk of

¹⁰ See also A. Rachel Camp, *Coercing Pregnancy*, 21 Wm. & Mary J. Women & L. 275, 280–302 (2015) (discussing the social and legal contours of how women are coerced into pregnancy, and the resulting harms of pregnancy coercion).

¹¹ This finding is supported by extensive studies and research on abortion access in the United States which reveal unequal impacts of abortion bans among subgroups, such as low-income individuals, Black, Latino, and Indigenous groups. See, e.g., Liza Fuentes, *Inequity in US Abortion Rights and Access: The End of Roe Is Deepening Existing Divides*, Guttmacher Inst., (Jan. 2023), <https://www.guttmacher.org/2023/01/inequity-us-abortion-rights-and-access-end-roe-deepening-existing-divides>; Johns Hopkins Bloomberg Sch. of Pub. Health, *Two New Studies Provide Broadest Evidence to Date of Unequal Impacts of Abortion Bans* (Feb. 13, 2025), <https://publichealth.jhu.edu/2025/two-new-studies-provide-broadest-evidence-to-date-of-unequal-impacts-of-abortion-bans>. IHRL also recognizes the increased barriers to reproductive health care that members of such groups already face. See Off. of the U.N. High Comm’r for Hum. Rts., *Joint web statement by UN Human rights experts on Supreme Court decision to strike down Roe v. Wade* (June 24, 2022), <https://www.ohchr.org/en/statements-and-speeches/2022/06/joint-web-statement-un-human-rights-experts-supreme-court-decision> (“[S]ocio-economically disadvantaged women of color notably Black and indigenous women and others in situations of vulnerability, such as migrant women, those living with disabilities and victims of sexual violence and sex trafficking, face additional barriers to reproductive health care services.”).

intimidation posed by the Coercion Screening Requirement is particularly harmful to those in situations of economic precarity. For a patient who is financially dependent on a partner or family member, the shame of admitting that fact to a provider and the fear that a disclosure could lead to the arrest and incarceration of their only source of economic support can be powerful deterrents to disclosure. See *Northland*, 2025 WL 2098474, at *30 (describing testimony that “many patients are fearful of the police and do not want to see their loved one jailed over the coercion”).¹² This fear may cause patients to shut down, preventing the trust-based dialogue necessary for effective screening as would already occur without a requirement, and undermining the patient-provider relationship. See *Northland*, 2025 WL 2098474, at *30 (describing testimony that because the Coercion Screening Requirement directs “providers to explicitly ask the patient whether someone is forcing them to have an abortion” it is “not effective and negatively impacts the trust between patient and doctor”). Instead of feeling protected, patients who are already struggling are confronted with another significant barrier to care. See *Mellet*, U.N. Doc. CCPR/C/116/D/2324/2013, ¶ 5.12 (noting that the discriminatory nature of abortion restrictions forces women and girls to “balance” their “right to life” against the “enjoyment of other rights”). Thus, the requirement’s emphasis on criminality—evidenced by the large-font poster warning that coercion is illegal—can silence the very people it purports to protect.

Adolescents are also uniquely vulnerable to the chilling effects of the requirement. For a young person who may be dependent on the individual coercing them, this threat of mandatory reporting can be terrifying, raising fears of retribution or being placed in the foster care system if the coercing individual is a parent or guardian.¹³ The blunt, jarring questions suggested by the

¹² See also Connections for Abused Women & their Children, *Socioeconomic Risk Factors for Domestic and Intimate Partner Violence* (Aug. 30, 2024), <https://www.cawc.org/news/socioeconomic-risk-factors-for-domestic-and-intimate-partner-violence/> (explaining that “[f]inancial insecurity often also limits a victim’s ability to leave an abusive relationship” and that “[i]n relationships where the abuser controls the finances, the survivor may feel trapped and unable to leave their abuser because of a lack of financial resources.”).

¹³ See, e.g., Lanzarote Comm., *1st Implementation Report - Protection of Children Against Sexual Abuse in the Circle of Trust: The Framework*, 25, 32-33 (2017), <https://rm.coe.int/1st-implementation-report-protection-of-children-against-sexual-abuse-/16808ae53f> (assessing member states’ implementation of 2007 Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, and noting that children are often “too ashamed or too frightened” to seek support when they have been abused, and that child victims abused by a

State’s training materials may also be particularly ill-suited for young patients already intimidated by the healthcare setting. See Mich. Dep’t of Health & Hum. Servs., *Michigan Coercive Abortion Prevention Act, Screening for Coercive Abortion, Intimate Partner Violence and Domestic Abuse: Screening Tool and Protocol for Abortion Providers*, (“Screening Tool and Protocol”) at 2, <https://www.michigan.gov/mdhhs/adult-child-serv/informedconsent/michigan-coercive-abortion-prevention-act> (last visited May 4, 2026). This approach discourages the candid communication necessary to ensure a decision is truly autonomous and safe, directly contradicting the standard of care that relies on building rapport and trust. See U.N. Comm. on the Rts. of the Child, *General Comment No. 20 on the Implementation of the Rights of the Child During Adolescence*, U.N. Doc. CRC/C/GC/20, (Dec. 6, 2016), ¶ 60 (urging governments “to decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions”); *Northland*, 2025 WL 2098474, at *30 (describing testimony regarding the importance of careful questioning on coercion and trust between patients and providers).

Furthermore, the Coercion Screening Requirement disproportionately impacts BIPOC communities, which may harbor a justifiable and deep-seated mistrust of both the medical establishment and law enforcement due to historic and ongoing systemic racism. The effect of systemic racism on reproductive healthcare is not theoretical: the Committee on the Elimination of All Forms of Racial Discrimination has noted that “systemic racism, along with intersecting

family member someone in their “circle of trust” face the added fear that disclosure could have “devastating outcomes” for their family as a whole and negatively impact support, and their overall life—including the possibility that other family members could remain loyal to the abuser or take sides.); Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse art. 14, Oct. 25, 2007, C.E.T.S. No. 201 (discussing the possibility of removing victims from their family environment as part of assistance to victims); Maria Misrelma Moura Bessa et al., *Characterization of Adolescent Pregnancy and Legal Abortion in Situations Involving Incest or Sexual Violence by an Unknown Aggressor*, *Medicina*, Aug. 13, 2019, at 2 (reporting the results of a study into pregnancy and sexual violence including in cases of pregnancies resulting from incest in which the aggressor was the father, stepfather, brother, uncle, grandfather, cousin or brother and finding that “[i]n situations of incest, the close relationship with the aggressor may well be a factor that inhibits the communication of sexual violence to the police, particularly for the need to maintain the ‘family secret’ and avoid the perpetrator accountability.”)

factors such as gender, race, ethnicity and migration status, have a profound impact on access by women and girls to the full range of sexual and reproductive health services in [the United States] without discrimination” and that restrictions on abortion access have a “profound disparate impact on the sexual and reproductive health and rights of racial and ethnic minorities, in particular those with low incomes” in the United States. U.N. Comm. on the Elimination of All Forms of Racial Discrimination, *Concluding Observations on the Combined Tenth to Twelfth Reports of the United States of America*, CERD/C/USA/CO/10-12, (Sept. 21, 2022), ¶ 35; see also Am. Pub. Health Ass’n, *Structural Racism is a Public Health Crisis: Impact on the Black Community* (Oct. 23, 2020), <https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2021/01/13/structural-racism-is-a-public-health-crisis>. The law’s focus on bluntly alerting patients to the illegality of coercion and its prominent display of warnings about criminal consequences may actively trigger this deep-seated mistrust.¹⁴ When a patient’s first interaction with a clinic involves a poster invoking the criminal legal system, it immediately frames the provider as a potential agent of a system that has historically harmed their community. This undermines the provider’s ability to create a safe and confidential space, making it less likely that a BIPOC patient will disclose sensitive information about coercion or abuse, rendering the law counterproductive and making it even more difficult for historically discriminated-against BIPOC women and girls to access reproductive healthcare. See, e.g., *Northland*, 2025 WL 2098474, at *30 (describing testimony regarding patient fears of police involvement and the crucial nature of trust between patients and providers). The ICERD obligates governments to eliminate racial discrimination in all its forms to guarantee equality before the law, including in public health. ICERD arts. 1(1), 5(e)(iv). This includes both direct and indirect discrimination. U.N. Comm. on the Elimination of All Forms of Racial Discrimination, *General Recommendation No. 32: The Meaning and Scope of Special Measures in the International Convention on the Elimination of All*

¹⁴ See, e.g., Global Justice Center et al., *Diminishing Reproductive and Bodily Autonomy in the USA: Centering Lived Experiences: Coalition Stakeholder Submission for Consideration on the 4th Cycle of the Universal Periodic Review of the United States of America*, 4, <https://www.globaljusticecenter.net/wp-content/uploads/2025/04/USA-UPR-Submission.pdf> (last visited May 1, 2026) (“For those who are already criminalized, the threat of surveillance and further criminalization is exacerbated. BIPOC, LGBTQIA+, unhoused, and previously incarcerated people are most likely to be apprehended, incarcerated, and charged under restrictive laws.”)

Forms of Racial Discrimination, CERD/C/GC/32, (Sept. 24, 2009), ¶ 7. A law that foreseeably alienates and silences BIPOC patients fails this obligation.

Similarly, migrant women and girls, particularly those with precarious legal status, are placed in an increasingly untenable position by the law. The fear of any interaction with state authorities that could lead to detention or deportation is a constant reality. See, e.g., Karen Hacker et al., *Barriers to Health Care For Undocumented Immigrants: A Literature Review*, 8 Risk Mgmt. and Healthcare Pol’y, 175, 175 (Oct. 30, 2015) (“Barriers to health care for undocumented immigrants go beyond policy and range from financial limitations, to discrimination and fear of deportation.”).¹⁵ The Coercion Screening Requirement’s association with law enforcement and criminal penalties thus creates a significant deterrent, potentially preventing migrant women from seeking abortion care altogether. This deterrent may be further exacerbated by language barriers that may impact how providers relay the questions included in the State-suggested questionnaire. See Karen Hacker et al., *Barriers to Health Care for Undocumented Immigrants: A Literature Review*, 8 Risk Mgmt. & Healthcare Pol’y, 175, 178 (Oct. 30, 2015) (explaining that “[f]ear of deportation, whether real or imagined, was identified as a barrier in 65% of articles” included in the literature review, and that increased barriers to access were shown with “active surveillance of providers”).

By failing to account for the unique vulnerabilities of these populations, the State’s coercive screening mandate operates as a discriminatory barrier to reproductive freedom, contrary to IHRL standards and the RFFA’s own anti-discrimination requirement.¹⁶

¹⁵ See also The Hastings Center: Bioethics in Community Health, *Undocumented Immigrants in the United States: Use of Health Care*, <https://community.thehastingscenter.org/immigrant-health/undocumented-immigrants-in-the-united-states-use-of-health-care/> (last visited May 1, 2026) (noting that “access to health care may also be hampered by factors ranging from language, to lack of transportation, to fear of deportation”).

¹⁶ See, e.g., U.N. Comm. on Econ., Soc. & Cultural Rts., *General Comment No. 22 on the Right to Sexual and Reproductive Health*, U.N. Doc. E/C.12/GC/22 (May 1, 2016), ¶¶ 30-31 (noting that migrants, among other groups, “may be disproportionately affected by intersectional discrimination in the context of sexual and reproductive health” and that governments must “take particular steps to ensure their access to sexual and reproductive information, goods and health care” including ensuring that “individuals are not subject to harassment for exercising their right to sexual and reproductive health”).

C. The Coercion Screening Requirement Also Reinforces Harmful Gender Stereotypes, Which Fuel Discrimination in Violation of IHRL

The Coercion Screening Requirement is fundamentally based on the harmful stereotype that women are unable to make independent decisions about their bodies and reproductive health. See Off. of the U.N. High Comm’r for Hum. Rts., *Gender Stereotyping*, <https://www.ohchr.org/en/women/gender-stereotyping> (last visited Apr. 30, 2026) (a gender stereotype is harmful when it “limits women’s and men’s capacity to develop their personal abilities, pursue their professional careers *and/or make choices about their lives*” (emphasis added)). The screening questions provided by the State of Michigan make this clear: they include whether anyone has “forced or pressured you to come here today,” and whether anyone has “threatened to harm you legally or financially if you don’t have an abortion—like threatening to have you arrested, deported, or destroy your legal documents; or threatening to get you fired, kicked out of your home or taking away your financial support?” See Mich. Dep’t of Health & Hum. Servs., *Michigan Coercive Abortion Prevention Act, Screening for Coercive Abortion, Intimate Partner Violence and Domestic Abuse: Screening Tool and Protocol for Abortion Providers*, (“Screening Tool and Protocol”) at 2, <https://www.michigan.gov/mdhhs/adult-child-serv/informedconsent/michigan-coercive-abortion-prevention-act> (last visited May 4, 2026). These questions imply that women, particularly women seeking abortions, are vulnerable and incapable of making their own decisions—and are remarkably in line with the harmful gender stereotypes that IHRL bodies have singled out. For example, the Inter-American Court of Human Rights identified several stereotypes in *I.V. v Bolivia*, including that “women are seen as vulnerable beings, incapable of taking reliable or consistent decisions. *I.V.*, No. 329, ¶ 187. These harmful gender stereotypes are “frequently applied to women in the health sector” and “have serious effects on the autonomy of women and their decision-making power.” *Id.* ¶ 187.

The application of such stereotypes is not unique to Michigan. The reasoning underlying the Coercion Screening Requirement—*i.e.*, that women in general are more vulnerable to making bad decisions for their and others physical health—is being used nationwide to restrict access to abortion, with anti-abortion groups exploiting the same coercion narrative to limit access to abortion care. See Shefali Luthra, *Anti-Abortion Groups’ New Strategy: Telehealth Abortion*, *The 19th* (Aug. 27, 2025), <https://19thnews.org/2025/08/anti-abortion-groups-strategy-telehealth-abortion/> (discussing the use of coercion as an argument to end legal access to telehealth abortion).

Further, as noted above, see *supra* at 12-13, research contradicts the purported intent of the Coercion Screening Requirement to protect pregnant women against coercion and violence in their reproductive healthcare decisions. Despite this, the Coercion Screening Requirement emphasizes perceived risks that pregnant women will be forced to terminate their pregnancy, rather than the actual risks (perpetuated in part by regulations like the Coercion Screening Requirement itself) of pressure to *continue* their pregnancy. And even if the Court were to conclude, contrary to the weight of the available evidence, that the risk of coercion to abort is the same or greater than the risk of coercion to continue a pregnancy involuntarily, the Coercion Screening Requirement still perpetuates harmful stereotypes that violate IHRL because it focuses exclusively on coercion to abort and no other aspects of reproductive coercion, thereby reinforcing the societal pressures that women should fulfill roles as mothers.

In sum, the Coercion Screening Requirement is a relic of the pre-RFFA framework, stigmatizing a singular reproductive medical procedure only affecting a fraction of the population by relying on gender-based stereotypes regarding women's inability to make informed and reasoned decisions. It therefore perpetuates exactly the kinds of discriminatory barriers that IHRL requires governments to remove.

CONCLUSION

IHRL provides a well-developed framework for analyzing whether abortion restrictions like the Coercion Screening Requirement are discriminatory. When measured against that framework, it is clear that the Coercion Screening Requirement is discriminatory because it treats pregnant patients seeking abortion differently from individuals seeking any other form of reproductive healthcare, has a further disparate impact on multiply marginalized groups, and perpetuates harmful gender stereotypes that fuel unequal treatment. The Coercion Screening Requirement therefore violates the RFFA's prohibition on the State of Michigan discriminating against Michiganders in the exercise of their fundamental right to reproductive freedom—and, like the three other provisions of the law that the Court of Claims struck down, it impermissibly burdens that right. *Amicus curiae* respectfully requests that this Court hold that the Coercion Screening Requirement is unconstitutional under the RFFA and, accordingly, should be enjoined.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to MCR 7.212(B), I hereby certify that this document contains 7,298 countable words, based upon the word count of the word processing system used to prepare the brief.

Respectfully submitted,

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Dated: May 4, 2026

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ATTESTATION OF TAX-EXEMPT STATUS

Pursuant to MCR 7.212(H)(2)(f), I hereby certify that this brief is presented on behalf of an organization that is tax exempt under section 501(c)(3) of the Internal Revenue Code, 26 USC 501. Accordingly, leave to file an *amicus curiae* brief is not required.

Respectfully submitted,

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